Chapter 1

The Research Approach of the Thesis

The problem explored and analysed in this thesis involves the experiences and perceptions of Registered Nurses (RN) with sex-based and sexual harassment in the Australian health care workplace. There is very little empirical research in Australia on this topic, thus there is a paucity of reliable evidence even to begin to study the problem. In fact, prior to the commencement of this research project, a computerised search of Australian health care literature failed to find articles with Australian Registered Nurses and sexual harassment in the titles. This is not to say there is no mention of harassment within an individual publication, but it is certainly not the main topic of discussion or investigation.

Although this research project is not a comparative study, exploring the experiences of women, and particularly nurses, from overseas is necessary because that information is all that is currently available. It is difficult, however, to know whether there are similarities or differences in the incidences and experiences of RNs in Australia compared to their counterparts overseas. There are good reasons, however, to question whether research regarding harassment from overseas is valid in the Australian context.

Australia is a unique country. Colonial Australia was basically a British settlement and the British influences continue today. Like most of the world and certainly the western countries, North America also contributes a strong influence on Australian social and organisational life. Australia is a young country like the Americas, however Australia's roots and culture are quite different from either Britain or America where most of the research

has been conducted on sex-based and sexual harassment (U.S.MSPB 1981; Gutek 1985; U.S.MSPB 1988; Stockdale 1996; Fitzgerald, Drasgow, Hulin, Gelfand and Magley 1997). The harsh tyranny of distance and relative geographical isolation seem to keep Australia in a position of always 'catching up' with its overseas, western counterparts.

With a population approximating that of Southern California (18 million), Australia enjoys a diverse, multicultural 'public' reputation, when in fact its population is largely of white, European descent. The image of the strong, taciturn, pioneering Australian male 'battler' prevails despite the beginnings of a fledgling movement towards the Sensitive New-Age Guy (SNAG) or Men's Movement. Women in Australia, like many of their counterparts overseas, continue to be marginalised and isolated in lower paid positions and occupations (Najman and Western 1988). A highly visible women's movement in the late 60s made little real difference to the status of women in Australia.

Of importance to this research, Australia has a different, hybrid, socialised public/private health care system. According to *Australia's Health 1996* the ever decreasing minority of citizens opting for a faltering private health scheme in 1995 was at 34.3%. The health care workplace has seen almost continuous upheaval, hospital closures, 'restructuring' and 'co-locating' in an effort to cope with increased service demand with diminishing financial resources. Job (in)security is a highly visible workplace problem. Employees, even long term, compete for similar 'restructured' jobs. Picone (1996:2) notes large numbers of Australian nurses leaving the health system and Pelletier, Donoghue, Duffield and Adams (1998:29) found a decreasing number of graduates who intend to stay in nursing for longer than five years (as compared to a 1992 study). The Australian health care organisation is currently an unstable and insecure workplace (Bryson 1996; Healthcover 1998).

In addition to this current stressful work 'culture', it was only fairly recently that the education of Australian RNs moved out of hospital-based programs and entirely into the university system. The health care workplace thus, is confronted with two differently prepared nurses; some are educated in the traditional, familiar hospital setting, often in supervisorial positions, and some have a university degree and concomitant expectations, often in entry or staff positions. The more experienced, traditionally (hospital) 'trained' nurses are confronted with usually younger, university-based nurses with a broader, more eclectic education (Marquis, Lillibridge and Madison 1993:139). This dichotomy can create certain tensions in the workplace and differing professional, promotional and career expectations (NRBNSW 1997:97).

As this research was conducted, severe and controversial government funding cuts were experienced in both education and health (Duffield and Lumby 1994). Nursing education, like medicine, is an expensive item on a university budget due to the high clinical component. Nursing education in the tertiary setting is under threat and nursing academics continue to experience ever increasing workloads and burnout (Worrall-Carter 1998). Picone (1996:2) and Kermode, Emmanuel and Brown (1994:16) also noted increased workloads of RNs in the health care system. This, along with the social and cultural factors noted above, provides a different, difficult workplace for the Australian RN. These factors would seem to place RNs in a state of transition and stress, possibly more than the already, inordinately high levels Registered Nurses might expect. This workplace context places nurses in a vulnerable and powerless position in relation to sexual harassment.

The exploration of a politically and professionally controversial topic such as sex-based and sexual harassment in the current environment poses considerable challenges. The question has to be asked, why is there so little known about this problem in Australia? Because nursing education has

been considered an emerging discipline in academia, extensive, serious nursing research was hampered in Australia and continues at levels lower than amongst academics in other disciplines (Roberts 1996; Roberts 1997). It can be no surprise then that nursing research here in Australia lagged behind other western countries. Additionally, nurse academics embarking on scholarly research found a cool reception to funding requests from their new, predominantly male university counterparts. This was particularly true if the research could be considered as emanating from a social science perspective as opposed to 'science' or more concerning yet, be viewed as 'women's business'.

Additionally, and not surprisingly, health care organisations have little interest in approving or supporting research into a topic that could, and probably would, prove embarrassing or problematic. Most health care organisational hierarchies, like the rest of the corporate world, are male dominated domains with few women in decision making roles. Accessing Registered Nurses from the workplace, for research into a controversial topic such as sexual harassment, could prove problematical. Few health care organisations have a predominance of women on their ethics committees and are traditionally conservative and bound up in the medical model ethos. Nursing focused research has enjoyed significantly less health care research funding than medical research. Little serious money has been expended on popular nursing issues, much less unpopular ones.

As experienced and commented upon by other researchers in this area (Stockdale 1996), this research project moved forward despite repeated, failed efforts to acquire funding over the life of the project. The lone exception was a small grant from the Australian Institute of Nursing Research, a nursing organisation in Adelaide devoted to issues of interest to nursing and not surprisingly, controlled by nurses. This research project was also possible because it was conducted by an academic with the security of a tenured university position. The academic environment and concomitant

freedom to delve into controversy and conflict, without threat from powerful interest groups, was essential to a comprehensive exploration into sex-based and sexual harassment. It is difficult to believe that much interest or support could be generated by nurse researchers on such a topic if they were employed in a hospital.

Interestingly Genovich-Richards (1992), in an American study, found a similar paucity of research into health care professionals and sexual harassment in her investigation into health care research and publications. She found that empirical work on sexual harassment was sparse and where harassment exists, it is rarely reported. She also noted that although many health care organisations use surveys to test the organisational climate or explore employee satisfaction, few identify or speak to sex-based or sexual harassment in the workplace.

One problem associated with sex-based and sexual harassment that is not covered in depth in this research project is the harassment of male RNs. Of the 13 males surveyed in Phase I of this research project, eight complained of harassment. There is no longer any doubt that males are subjected to sex-based and sexual harassment; all the relevant literature supports this (U.S.MSPB 1981; Gutek 1985; U.S.MSPB 1988). It is, however, beyond the scope of this research project. No matter how harassment is viewed, it is not the same problem for men that it is for women. In addition, the numbers of male participants to the survey questionnaire was thirteen and only one of the sixteen interview informants was a male. As will become evident, there are some overlapping dynamics between the harassment of women and men, but the issue of harassment is so complicated, it was not wise to try to cover both genders in this one project. This is not to say that harassment of males is not a problem, or of interest, but it will be suggested as a separate topic for future research rather than attempting to cover it here.

To explore and understand such a complex problem as sex-based and sexual harassment adequately, it was necessary to approach this research project from both quantitative, as well as qualitative methodologies. Initially, a broad brush was taken to the topic through a comprehensive literature review and survey questionnaire in an effort to assess the problem from a macro perspective. According to Polit and Hungler (1991:193), survey questionnaires function well to focus on obtaining information regarding the status quo and their greatest advantage is their flexibility and broadness of scope. After careful analysis of the survey questionnaire findings, a qualitative in-depth interview approach was used to acquire insight into important micro level questions that the survey could not explain.

The survey questionnaire described here revealed that sex-based and sexual harassment was widespread and experienced by many Australian RNs. Their harassers were, for the most part, medical officers, co-workers and supervisors. Although almost half of the participants told the harasser to stop, many participants ignored the behaviour or avoided the harasser. Few reported the behaviour or made a formal complaint. The survey questionnaire, similar to other surveys from overseas, indicated that although two out of three participants reported experiencing sexual harassment in the workplace, 73% stated that uninvited and unwanted sexual attention (the commonly accepted definition of sexual harassment) was not a problem where the participants work(ed). In addition, telling the person to stop was identified as an effective deterrent by almost all participants when dealing in the abstract, yet only half used this strategy when actually confronted with unwanted sexual attention. These two findings fuelled the second phase of the research project.

The second phase of this research project explored the experiences of harassment as described by the informants. The unstructured interview encouraged the informants to identify how they constructed the episode(s) of harassment and what meaning was attached to the experience. They were

encouraged to explain how they recognised harassment, how they felt about it, and how they responded and explained their own and the harasser's behaviour. The informants also described some of the political and professional consequences of such widespread harassment in the Australian health care arena. The third phase of this research project involved a focus group interview to validate the discussion and conclusions associated with Phase II of the project.

The framework

While Phase I of this research project provides a broadly based foundation for determining the quantifiable aspects of sex-based and sexual harassment, little can be determined from the survey questionnaire about what nurses say about harassment, how they think about it and what it means to them. What is missing is the meaning these experiences have had for the individual nurse(s). What words or language do these RN informants use? Are there any common themes in their stories? How did they come to know their experience was harassment? How did they explain the harassment to themselves or significant others? Did they try? How did that interaction happen? At what level were they concerned about harassment? What and how lasting were the consequences to each of them and to their profession?

Phase II of this thesis listens to Registered Nurses talk about their experiences of sex-based and sexual harassment in the workplace. The aim is to understand some of the interpersonal dynamics, the contextual issues and the meanings and interpretations of the harassing interactions for these informants. This phase of the research project provides an opportunity for the voices to be heard and every effort is made for them to be understood.

The perspective employed in accomplishing this inquiry is from the symbolic interactionist framework. The qualitative phase of this thesis focuses on the nature of the interaction, the dynamic social activities taking

place between two people--- the harassed and the harasser. Most human action is regarded as symbolic, as representing something more than what is immediately perceived (Charon 1979:40). A clenched fist may represent the fact that the other person is about to take a swing. To others it may mean 'black power', to still others it may symbolise victory. Symbols have meaning to people. As we interact with others our language and action is symbolic and meaningful.

Denzin (1989:24) suggests that interactionism is founded on the study, expression and interpretation of subjective human experience. The 'why' question is replaced by the 'how' question. That is, how is social experience, or a sequence of social interactions, organised, perceived, and constructed by interacting individuals? How were the experiences of harassment organised, perceived and constructed by the RNs participating in this phase of the research project?

Manis and Meltzer (1978:8) describe how human beings construct their behaviour in the course of its execution. Human behaviour is an elaborate process of interpreting, choosing, and rejecting possible lines of action. Manis and Meltzer say that behaviour that emerges from the interactions within an individual, according to many symbolic interactions, is not necessarily a product of past events or experiences. That is, the behaviour may be unpredictable and constructed in the thought processes of the actor, or alternatively in the course of interaction with others. For people involved in an episode of harassment, their interactions may not only be based on past events or experiences. According to symbolic interactionism, behaviour or actions are much more dynamic and complex.

Charon (1979) describes how symbolic interactionism supports the notion of an active image of human behaviour, acting, involved in situations, acting in relation to each other, perceiving, and interpreting and acting again. Unlike other sociological perspectives, symbolic interactionists emphasise

the unpredictable, constantly changing, complex nature of human beings. Action is not only determined by past 'socialisation' but also based on the conversation people may have in their head with themselves, in a way, talking to themselves. It could also be based on conversations people are currently having, or again, action could be based on potential conversation or action that is anticipated in the future. Denzin (1989:25) agrees by reminding us that every human situation is novel, emergent, and filled with multiple, often conflicting, meanings and interpretations. This research project attempts to capture the core of these meanings and contradictions for RNs as they talk about their harassment experiences. It is assumed that the language of these RNs can be used to explicate their experiences. Chapter 6 will show how such a theoretical approach can shed light on the phenomenon of constructing meaning to the sexual harassment experience.

Meltzer, Petras and Reynolds (1977:1) describe how humans construct their realities in the process of interaction with other human beings: i) human beings act toward things on the basis of the meanings that the things have for them; ii) these meanings are a product of social interaction in human society; and iii) these meanings are modified and handled through an interpretive process that is used by each person in dealing with the things s/he encounters. We must get inside the reality of the actor in an effort to understand this reality as the actor does.

Even when we talk to ourselves we evaluate our behaviour based upon the norms agreed upon by others. Human and thus sexual interaction is full of symbolic meaning and it is known that symbols denote value and meaning. Since meanings are primary properties of behaviour, it follows that how role participants "act" in a given situation is based upon both societal and individual interpretations of their role. Therefore, it cannot be surprising that each participant in an interaction might interact somewhat differently

or individually, and also each might follow somewhat different societal expectations of behaviour.

When people's definition of themselves or others changes, through educational efforts, counselling, coaching, or even the passage of time and personal growth, the individual has the ability to expand old roles and new roles are made possible. When symbols in any society are changed, then individuals are required to learn some new roles. As a result of the new role behaviour exhibited, the responses of other people to the individual will also change. As well, a particular individual and that inidvidual's personal conception of themselves will also undergo some modification. It is like a 'change' reaction. If women or society begin to interpret the role of wife differently, a gradual change occurs in everyone's expectation for that role and of how others interact with that role. Therefore, as society modifies what is acceptable behaviour regarding say, the role of 'nurses' or the role of 'sexual harassment', change will occur between people interacting with that role.

The process of researching sex-based and sexual harassment is incomplete without a view of how RNs interpret and construct meaning for their roles as women, nurses, and recipients of harassment. Although it would be expected that these informants might have, and probably would have, different interpretations and meanings attached to their actions and experiences, it would be reasonable to expect some common ground where greater understanding and enlightenment might occur. Without a framework that focuses on meaning and interpretations of events, the issues associated with harassment for Australian RNs will remain unclear. Health care, nurses, doctors, and life and death situations are the 'grist' for novels, movies and contemporary television. The roles and contexts associated with them are full of symbols and meanings, both positive and negative. It is not surprising that the problems associated with sexual harassment in these circumstances are complex, never static and forever challenging.

Individual humans, of course, are not the only creators of symbols and meaning. The media provides powerful images that affect meaning and symbols, maintaining and perpetuating society's perceptions and views of roles, gender, power, control and relationships. The literature review, as well as the informants associated with this research project, speak to the influence of these public perceptions and how they affected the RNs in their interactions and reactions with their harassers.

Chapter overview

The thesis continues now with Chapter 2, a comprehensive literature review of current information, research and understandings of sex-based and sexual harassment. Following the literature review, Chapter 3 describes the research design used in this project. The rationale for using quantitative and qualitative approaches is discussed. The results of the survey are discussed and analysed in Chapter 4, describing the Registered Nurse participants, their experiences with harassment, the types of harassment and characteristics of the harasser. It concludes with the findings of the survey questionnaire and discusses the health care workplace where the participants experienced the harassment. Chapter 5 summarises and presents conclusions from the first quantitative phase of the research project.

Chapter 6 presents the qualitative findings from the second phase of the research project. The ways RNs label, recognise, classify, respond and rationalise their and their harassers actions are explored. Chapter 7 presents the antecedent conditions or contextual issues associated with sex-based and sexual harassment to the Registered Nurse. Chapter 8 identifies the key findings associated with this research project and its contribution to the current body of knowledge surrounding RNs and their experiences with sex-based and sexual harassment. Recommendations for the workplace and

health care professions, as well as suggestions for future research directions, are included.

Chapter 2

Literature Review

It is almost 14 years ago that Bronwyn Ridgway (1984) delivered a paper, "Sexual Harassment: It's not a compliment...", to the 39th Annual Conference of the NSW Nurses Association. Although the Conference adopted a sexual harassment policy (including definitions that would hold up well in today's environment), very little if any empirical research has been reported on sex-based and sexual harassment (SB&SH) and RNs in the Australian health care industry since that time.

There has been, however, considerable comment on sex-based and sexual harassment in the overseas nursing and health care literature (examples being Bullough 1990; Horsley 1990; Chapman 1993; Goodner and Kolenich 1993). Certainly there are claims in the nursing literature which suggest it is a major problem for the profession, but little Australian empirical evidence exists to support these claims. This being the case, it would seem that Australian research is important to heighten awareness of some potential issues associated with SB&SH and Registered Nurses (RNs) in the Australian health care industry and to add to the body of knowledge associated with this important topic.

Although there has been increasing research and media exposure recently, misperceptions about SB&SH in the workplace persist in the minds of individuals. These misperceptions are important to this research project and RNs practising in the Australian health care industry. A most obvious and troublesome misperception or myth that persists today is that since sex-based and sexual harassment is now against the law, it is therefore no longer

a problem for women in the workplace. The results of this research project will dispel that myth.

This chapter aims not only to review the literature on SB&SH, but also to open up the complex multifactorial issues associated with SB&SH so that factors which may be critical to understanding this behaviour can be identified. Some of the literature identifies issues that are politically sensitive and which sometimes tend to be excluded from discussion of SB&SH. It is important to raise these issues in spite of their contentious nature as, without fully exploring them, potential understanding and thus solutions to the problem may be inadequate. A fuller understanding of the topic from a wide range of legal, social, cultural, organisational and biological perspectives is required.

The literature includes little experimentally designed research. From the review, it became clear that the nature of experimentally designed research projects into SB&SH eliminates or changes some of the crucial behavioural and interactional elements found in typical harassing situations. This is recognised and noted by other researchers in the area of SB&SH (Burgess and Borgida 1997; Soloman and Williams 1997). Subjects in a laboratory or experimental setting are not fearful of losing something as critical as their job and means of earning a living. Experimental subjects are not usually in a subordinate/supervisor position with co-subjects. In addition, subjects in laboratory experiments are frequently younger (often university student volunteers) and lacking in experience in workplace phenomenon and (inter)professional dynamics.

It will be found later in this literature review and in the survey results that there is a significant discrepancy between what 'subjects' say they would do or think when dealing in the abstract and what recipients of harassment actually do or think when confronted with harassment. This is consistent with the sociological literature which shows that there is a discrepancy

between what people say they do and what they actually do (Deutscher 1973). Thus, this literature review focuses on research on or about actual, rather than pseudo recipients of harassing behaviours.

The Australian health care workplace

According to *Australia's Health 1998* (AIHW 1998:183) 276,882 Australians were employed in health occupations. The data collected from the 1996 census noted the largest group, 155,243, were RNs. An increasing number of males are working in nursing with males constituting eight percent of nurses aged under 45 years compared with between five and six percent of male nurses in older age groups. Although it is recognised that today's RNs work in a wide variety of work settings, most RNs work in institutional or hospital settings. According to the 1998 figures, over 75% of RNs were employed in hospitals, nursing homes or community health centres (AIHW 1998). This research focused on the RN working in institutions, although much of the discussion is pertinent to many other health-related work environments.

Legal Issues

Definitions of sex-based and sexual harassment

Sex-based and sexual harassment is against the law, and widely recognised as a serious work place problem (U.S.MSPB 1981; U.S.MSPB 1988; McMillan 1993a; McMillan 1993b; Mrkwicka 1994). It has been reported that most women experience SB&SH at some time in their workplace (Paludi 1990:xiii). Although the legal definition of SB&SH continues to evolve, there is little doubt what constitutes unwelcome behaviour of a sexual nature when it is experienced by an individual. Sexual harassment covers a range of unsolicited behaviours including sexually stereotypical comments, propositions for sexual activity, personal questions about one's private life, brushing up against another's body, offensive pictures, and jokes or verbal abuse, just to name a few.

When exploring the legal definition of harassment it is necessary to distinguish between sex-based harassment and sexual harassment. Sex-based harassment is sex based, or gender-based harassment, typified by such behaviours as stereotypical remarks and paternalistic labels. It might be described as a 'milder' form of sexual harassment. Sexist remarks such as calling a woman a 'bitch' is, according to Australian law, sex-based harassment (Spender 1991). In this category of sex-based harassment, other common terms such as 'luv' 'honey' 'girls' are found. Sexual harassment, as opposed to sex-based harassment, includes more extreme behaviours sometimes including attempted or actual sexual assault. The multitude of behaviours considered as sexual harassment include for example, sexual teasing, unwanted phone calls, writing letters or sending material of a sexual nature, intentionally leaning over, pinching, and persistent requests for dates.

The harassment continuum

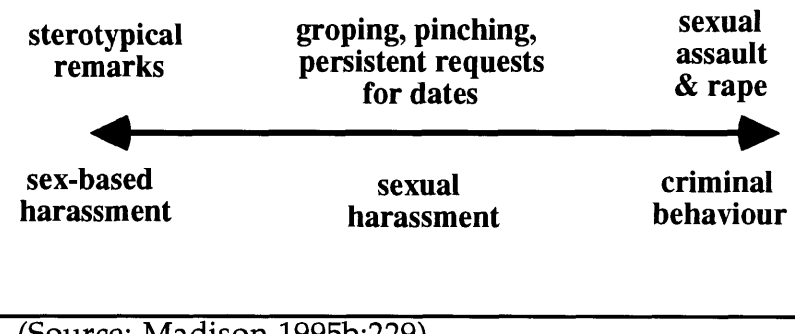
Madison (1995b) found it useful to depict sex-based and sexual harassment, as well as sexual assault and rape, on a continuum. Some may not see sexual assault and rape on the same continuum as 'harassing' behaviours. The more blatant, aggressive, harassing behaviours can, however, move towards the assault end of the continuum. In the survey questionnaire described in this research project there were two RNs who each described incidents of 'actual or attempted assault or rape' in their health care workplace.

Some may not agree that stereotypical remarks belong on a harassment continuum. Madison argues, however, that all these behaviours have some characteristics in common. They can all be unwanted, unwelcome behaviours of a sex-based or sexual nature and all three groupings, sex-based harassment, sexual harassment and sexual assault and rape, are against the law. The behaviours described on the continuum fall under the jurisdiction

of different authorities. Sex-based and sexual harassment behaviours are subject to anti-discrimination legislation and sexual assault and rape are criminal behaviours and adjudicated under criminal law.

The behaviours noted on the continuum can often be related depending on the circumstances or context, with behaviours falling at different points on the continuum. For example, sexist remarks may be accompanied by groping or pinching, moving it towards the centre of the continuum. The behaviours associated with harassment can occur alone, but often occur concurrently or sequentially with other harassing behaviours. These behaviours are separated in the Australian legal context into the categories identified in Figure 1.

Figure 1 The Harassment Continuum



(Source: Madison 1995b:229)

The continuum is useful as a reference and discussion point for researchers as well as organisations. The continuum and the legal differentiation is also helpful because it can provide a framework for thinking about the different forms of SB&SH and includes all categories of harassing behaviours.

This research project will identify some of the common misperceptions associated with harassment, particularly those associated with sex-based harassment. It will be evident later in this chapter that research into sex-

based harassment indicates it is often almost invisible, possibly because it is so common in the workplace. It is interesting to note that discussions about harassment usually emphasise sexual harassment where behaviours are clearly and flagrantly, inappropriate, unwelcome and unreciprocated. Therefore, in recognition of the prevalence and importance of all kinds of harassment in the workplace the term sex-based and sexual harassment (SB&SH) is used consciously and deliberately throughout this thesis, rather than restricting the expression to sexual harassment.

There is considerable variation in a precise definition of sexual harassment between the different anti-discrimination statutes throughout Australia, but they all describe unwelcome and unsolicited behaviour of a sexual kind, which detrimentally affects a person's ability to participate in various aspects of employment and education (Marles 1990). Any attempt to sustain power by treating members of the opposite sex as sexual objects and inferiors, while 'acceptable' in the past, is now clearly defined as sexual harassment in the workplace (Goodner and Kolenich 1993). The Australian Law Reform Commission (Agnew 1993) describes sexual harassment as consisting of i) unwanted sexual attention or ii) the creation of an inappropriate sexual atmosphere in the workplace. For health care facilities these two definitions are important. The first, unwanted sexual attention, focuses on the experience(s) of an employee, while the second focuses on the workplace 'atmosphere'.

The first description of sexual harassment includes such behaviour as demands for sexual favours of various kinds, touching, sexual jokes and displays of erotic pictures (Marles 1990). Confusion exists in perceptions of harassment, with some individuals unaware that patronising and degrading remarks can be included in sexual harassment policy, procedures and legislation. Part of the confusion according to Gutek (1985) is that men describe fewer behaviours as harassing than women. Further, sexual harassment can be context related and is frequently ambiguous (Marles

1990). She described situations where one individual may find certain behaviour (in certain contexts) offensive and another may not. Both of these issues will be discussed later in this literature review.

Sex-based and Sexual Harassment and Registered Nurses: research findings

An early U.S. study (Cox 1987) found that 82% of staff nurse participants reported experiencing multiple episodes of verbal abuse in their practice, and that 78% of their harassers were medical doctors. Seventy-seven percent of Directors of Nursing experienced verbal abuse in their role as Directors, and 84% of their harassers were medical doctors. Cox concluded that nurses accept verbal abuse as 'part of the territory', perceived a lack of support from their employer and that the harassing behaviour adversely affected their nursing practice.

Another early study of RN students (Cholewinski and Burge 1990) focused on students complaining of harassment in the academic environment. Eight percent of the students complained of harassment by members of the faculty. Most harassment was verbal abuse, followed closely by sexist remarks, resulting in physical and emotional symptomatology. The researchers surmised that much harassment goes unreported because of the general lack of assertiveness skills amongst the participants and the endemic nature of harassment in the health care workplace. Twenty percent of participants (51 of 256) who denied harassment in the academic environment complained of harassment in the clinical practice environment. Other international research supports these early studies that sexual harassment of nursing staff is a major problem. Donald and Merker (1993) studied 461 RNs (licensed by the Kentucky Board of Nursing) and found that approximately one in three participants had been the target of sex-based harassment. The perpetrator was often a medical doctor who was not the target's supervisor.

Libbus and Bowman (1994) found that 71.8% of 78 randomly selected Missouri Registered Nurses reported sexual harassment in the workplace. The most common harassers were male patients followed by co-workers and medical doctors. The most common harassing behaviour was sexual remarks. Anger, embarrassment and disgust were the most commonly described responses to harassment. A particularly salient issue for future research according to Libbus and Bowman is the tendency for their participants to ignore the actions of co-workers and at the same time, their willingness to deal with harassment from patients.

A 1994 (Kinard, McLaurin and Little 1995) study of 450 randomly selected hospitals (members of the American Hospital Society for Health Care Human Resources Administration of the American Hospital Association) found that of all sexual harassment complainants, nurses filed the greatest number of complaints. The most common complaints were that the atmosphere of the workplace was made offensive by sexual harassment. The most common harasser involved in a complaint was a male, and a co-worker rather than a supervisor. Although that study looked at complaints, no mention was made of the number of incidents that occured but did not generate a complaint.

Other research from overseas supports the contention that SB&SH of RNs is widespread. In a recent study which involved 92 registered and student nurses in Britain (Finnis and Robbins 1994), it was found that over half of the participants had experienced SB&SH. For RNs the harassers were, most frequently, doctors or patients. For student nurses the harasser was often a patient. Frequency of harassment was found to be similar to industries outside health care. In a summary of implications for practise, the authors note that the perception of nursing continues to be highly sexualised by both patients and other health professionals. They suggest that this view may contribute to a lack of awareness of the seriousness and extent of SB&SH, or or perhaps alternatively, ignoring it will make it go away.

Dan, Pinsof and Riggs (1995), using an in-depth interview approach, explored 10 female nurses' experiences of sexual harassment and the impact of those experiences in clinical settings. The interview informants could not provide any consistent description of the 'typical' harasser, although many harassers were identified as harassing others. The changing interpretation of the harassing incident was evident from these informants. It was only after some initial doubt, uncertainty or confusion that they identified a situation as harassing. The informants described emotional and some physical distress, but rarely described effects on work performance. Dan, Pinsof and Riggs (1995) suggested that to complain about deteriorating work performance might increase feelings of guilt or self-blame, a fairly common response to harassment. Because the nurse's response can affect both the duration of the harassment and its overall impact, these researchers suggested responses be included in future studies.

Seventy-seven percent of the Kentucky RNs who reported experiencing sexual harassment did not formally report their complaints (Donald and Merker 1993). Interestingly, the same percentage of participants perceived that their employers did not have formal policies to deal with sexual harassment in place. In the Finnis and Robbins (1994) study the majority of the participants took no action (confronting or reporting) in response to sexual harassment. These findings were supportive of the larger US MSPB studies (U.S.MSPB 1981; U.S.MSPB 1988) described later in this literature review.

Some studies have found that sexual harassment of nurses is widespread (Donald and Merker 1993; McMillan 1993a; McMillan 1993b; Finnis and Robbins 1994). These studies described a variety of harassers in the workplace (eg. medical officers, patients, co-workers and supervisors), and found most harassers to be male. These studies support the view that most

Registered Nurses, like many women in the workplace, experience some form of sexual harassment during their working life.

Organisational Issues

A hostile, harassing workplace

Important to any discussion of sex-based and sexual harassment is what is described as a 'hostile, harassing workplace'. Definitions of harassment would be incomplete if the workplace atmosphere or context in which harassment occurs was not described or made apparent. Sex-based and sexual harassment more commonly occur in what is described as an inappropriate 'sexualised' workplace atmosphere (Marles 1990). It seems it is easier for sexual harassment to occur in a 'hostile' workplace where 'banter', innuendo, sexist jokes and patronising behaviour are commonplace. Julius and DiGiovanni (1990) described the employer's obligation to evaluate their work environment to determine if it is 'sexually hostile'. They stated that if the sexist or sexualised nature of the workplace is sufficiently severe or pervasive, employers must act. Schucher (1994) concluded that it is expensive for employers to ignore sexual harassment in light of its impact on employee performance, morale, and turnover.

In order to obtain some notion of where Registered Nurses are placed with regard to SB&SH, it is useful to look at studies which have examined the problem across a wide range of occupations. Two widely quoted studies of SB&SH are the 1981 U.S. Merit Systems Protection Board (US MSPB) (U.S.MSPB 1981) study of 20,000 federal employees, and a second follow-up survey in 1987. These studies found that sexual harassment was widespread with 42% of all female employees and 15% of all male employees reporting SB&SH. The findings supported the view that women were more often the target of harassment than men and the harasser was more often a man.

The targets were likely to be young, not married, educated, and/or members of a minority group (racial or ethnic). In addition they were likely to hold

trainee positions or hold 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 US MSPB study, employed in non-traditional work roles, reported being targets of sex-based harassment. Interestingly for RNs, the US MSPB study showed that when women were working in 'traditional roles', four out of ten women reported being harassed.

Other findings indicated that the targets of SB&SH were generally unaware of any formal procedures for dealing with SB&SH in their organisation and were sceptical about their effectiveness. The US MSPB findings also indicated that most victims of harassment thought that there was much the employer could do to reduce sexual harassment. Few victims pursued formal remedies, but many who did found them useful (U.S.MSPB 1981; U.S.MSPB 1988).

The follow-up study in 1987 (U.S.MSPB 1988) showed no significant changes had occurred since the earlier study, despite increasing national attention and study into the issues associated with SB&SH. The 1981 study took place before widespread preventative and reporting policies were in place in United States federal workplaces. In summarising the 1987 findings, it seemed that since (and maybe because of) the 1981 study, employees described more behaviours of a sexual nature as constituting SB&SH. Both studies identified co-workers more often than supervisors as the source of SB&SH (U.S.MSPB 1981; U.S.MSPB 1988). Although some recent criticism (Stockdale and Hope 1997) suggests that these studies may underreport some forms of harassment, they continue to provide a major source of data on harassment.

The demarcations between acceptable banter, workplace frivolity, sexist and sexual jokes, sexual suggestions and innuendo and sex-based and sexual harassment are difficult for employers and employees alike. However, it is

an employer's responsibility to create a work environment that is free from hostility, offence and harassment (Childers-Hermann 1993; Goodner and Kolenich 1993; Neuhs 1994). This is particularly difficult in a workplace that is known for its 'off the wall humour' and where RNs continue to be stereotyped as sex objects (Muff 1982; Madison and Gates 1996).

Madison (1997) described the importance for employers to create and assure a workplace free of sexist and sexual jokes, innuendos and suggestive banter. Such a hostile and harassing work environment promotes an atmosphere where unwanted sexual attention can occur, promulgating all of its unwelcome and troublesome effects. Prevention or educating the workforce before problems occur is a far easier approach to sexual harassment than to try to 'sort out' the aftermath of a divisive, destructive and emotive situation.

Hughes (1992) suggested another approach for employers to consider in addressing sexual harassment in the workplace. Three prerequisites for the eradication of sexual harassment were described. First, sexual harassment must no longer be condoned by employers. Second, a realistic method of obtaining redress is necessary in the workplace. Third, professionals must recognise that sexual harassment is a serious impediment to women's ability to participate equally in their professions.

Employers must display a strong anti-sexual harassment attitude, or risk appearing to condone sexual harassment or a hostile and intimidating work place (Goodner and Kolenich 1993). When employers evaluate their workplace for offensive and hostile characteristics they may mistakenly use the number of complaints as an assessment tool. In fact, few victims of harassment use formal or informal complaint procedures (U.S.MSPB 1981; U.S.MSPB 1988). Individual women can sometimes internalise the fact that sexual harassment is normal, believing that 'everyone does it'. Therefore, if every woman experiences it, a complaint is not justified (Ussher 1992).

Gutek (1985) also noted the tendency for many organisations to conclude that harassment is virtually non-existent by labelling the target who complains as a 'troublemaker', instead of attempting to reduce or eliminate a hostile and harassing environment.

Health care organisations and sex-based and sexual harassment

Sexual harassment, mired in power, politics and historical tradition, is shrouded in silence in nursing, (King 1995) and this is particularly so in the Australian health care industry. In addition, there is little empirical research, discussion or assessment of Australian hospitals to determine the effectiveness of policies and procedures that aim to reduce or eliminate sexual harassment. With few exceptions, it has been necessary to rely on studies conducted overseas to evaluate the extent of sexual harassment and the responsiveness to it by health care organisations. No empirical studies were found that assessed the extent or effectiveness of policies and procedures associated with sex-based and sexual harassment in the Australian health care setting.

Although a positive and productive workplace is likely to be the goal of most organisations, there is also increasing evidence that explicit policies and internal complaint procedures can help protect an organisation from liability for managing a hostile work environment (Julius and DiGiovanni 1990). Health care organisations, with their complex hierarchical and patriarchal organisational structures, seem to be high risk organisations for harassment. The largely male organisational hierarchy and the predominantly male visiting medical staff working in close proximity to a largely female nursing and hospital staff seem to contribute to a potentially hazardous situation.

Finnis and Robbins (1994) call for a formal organisational response to the issue of harassment. They state that policies, management education and publicity were essential to the reduction and elimination of SB&SH.

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 and Gates (1996) noted that the problems of SB&SH may be worse in health care organisations because of the nature of the work itself. The emotional demands of intimate life matters are clearly increased in the health care industry. '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.

The issue of SB&SH is complicated in health care because larger, teaching hospitals have an educational component where teacher-student relationships are present. The potential for harassment clearly exists in these relationships because of the power differential between teachers and students (Ryan and Kenig 1991; Bacchi 1992; Little 1992). This special form of supervisory relationship may add to the complex dynamics of harassment. A student nurse may not only be subjected to harassment by the supervisor but also by the teacher, the doctor and the patient. In addition, other students may also harass; all this occurring at a time when the nurse is new and uninitiated in the intricacies of the professional health care workplace.

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 and Short 1989;

Bates and Linder-Pelz 1990; Lloyd 1994). There are no obvious supervisors watching over the behaviour and actions of doctors. If there are supervisors, they are usually other doctors who may be present in name only (Madison and Gates 1996). It should also be recognised that there are newer management relationships involving multidisciplinary teams. These arrangements may have some influence on hierarchical power structures and the incidence of SB&SH, but male-dominated steep hierarchical structures still predominate.

Members of the health care industry, and particularly the medical fraternity, are difficult to access for study of sexual harassment. 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 and Short 1989; Bates and Linder-Pelz 1990). Hospital administrations and medical staff also may have tense relationships. Hospitals are loathe to, 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 issues associated with SB&SH.

Power

SB&SH is not about sex, but about power (Cleveland and Kerst 1993; Lippman 1993; Finnis and Robbins 1994). Twenty years ago, Farley (1978) one of the first authorities to use the expression sexual harassment, discussed the links between harassment and male versus female power. She asserted that sexual harassment is more a function of the power differential between women and men in society, and less a result of the employer and the employee power relationships in the work setting.

Because research frequently is in the domain of academia, many studies into sexual harassment have emerged based in the tertiary setting. The obvious power held by academic staff over their students crystallises the relationship between sexual harassment and power. This relationship between harassment and power is discussed at length by Bacchi (1992), one of Australia's authorities on harassment in academia. She suggested members of academe should develop and adhere to codes of behaviour or ethics to reduce the possibility of inappropriate or confusing communication between lecturing staff and students. She noted that sexual contact between staff and students needed to be considered unacceptable and unethical behaviour due to the uneven power held by the two parties. Little (1992) agrees by supporting the notion that where one has power over another it would be 'professional suicide' to enter into a sexual relationship with a student.

Dey, Korn, and Sax (1996) suggested that changing the gender balance in academia may help change the nature of an institution to one where harassment is uncommon, rather than expected. He also noted the importance of the careful observation of 'campus climate' in order to avoid reinforcing a hostile and harassing organisation wide environment. Further, he noted that too often informal policies regarding inappropriate sexualised behaviour leave the harassed in the position of being required to end the harassment. He suggested that institutions should deal directly with the harasser in a proactive rather than reactive way.

Padgitt and Padgitt (1986) examined whether 1,000 male and female students can and do meaningfully distinguish between offensive and harassing behaviours and whether behaviours are systematically organised along a continuum. Their findings suggested that students, particularly females, do distinguish or identify such behaviours. The authors expressed concern that if students are fairly clear in their thinking about what constitutes harassment, then faculty members should refrain from further arguments

over ambiguity of the concept of sexual harassment and educate themselves to a similar knowledge level as their students.

Further research based in a university setting (Benson and Thomson 1982) explored the experiences of 269 women regarding the teacher-student relationship. The students were asked if they had received any unwanted sexual leers, suggestions, comments or physical contact which they found objectionable in the context of the teacher-student relationship. This study suggested that changes in sexual attitudes and practices may have led to a greater acceptance of both casual and intimate teacher-student relationships. The study highlighted the substantial coercive effects of sexual intrusion by powerful academics, particularly in post-graduate study, when 1:1 teaching is the norm. Benson and Thomson suggested that sexual harassment in the university setting reflects and reinforces the devaluation of women's competence and reduces their commitment to competitive careers.

In an Australian study Gardner and Allen (1996) found that students described widespread sexual harassment. Of those who saw themselves as harassed the most commonly described behaviour was gender harassment (27.5%), especially sexist remarks about women. This finding was in contrast to previous work that indicated that gender harassment was not always included in descriptions of harassing behaviours. Their findings suggested that perceptions regarding harassment may be changing with increased study and publicity. They noted that very little work has addressed the process(es) used by the harassed in labelling experiences as sexual harassment.

Paludi (1990:11) in *Ivory Power: Sexual Harassment on Campus* concludes with a call for change in academia as a first step in changing the larger, oppressive society. When calls for a changed society seem impossible, a more manageable change with far-reaching consequences would be to change academia. Paludi discusses sexual and gender

harassment as the 'confluence of power relations and sexism in an institution stratified by sex':

> *The very fact that sexual harassment is one of many culturally ingrained and promoted expressions of women's oppression and serves to perpetuate that oppression, means that academic institutions must take responsibility for programs, policies and structural revisions that will discourage and create a hostile environment for the exploitation of women ... the veil of secrecy must be lifted.* (Paludi 1990:171)

Although the literature recognises the association between SB&SH and power, nurses may not see a clear connection. Madison and Gates (1996) reported that less experienced, younger (thus more vulnerable to SB&SH) nurses often bestow much power and authority on medical officers, often attributing line or management power and authority where it may not exist. Many new, younger nurses erroneously believe that medical officers can influence 'hire and fire' decisions, when in fact that is rarely the case (Madison and Gates 1996).

Madison and Gates (1996) noted that no institutionalised structures or processes were present to dispel or counteract this prevailing attitude. While medical officers can make life difficult for those with less power, only occasionally are they directly responsible for the hiring or firing of RNs. 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.

Sociological Issues

Sex role differences

Empirical evidence suggests that male and female sexualities differ and that women and men perceive sexual harassment behaviour in different ways (U.S.MSPB 1981; Gutek 1985; Padgitt and 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).

Studies suggest there is general agreement between the sexes about what constitutes SB&SH except for behaviour that tends to be indirect and subject to different interpretations. A good example would be sexually suggestive remarks and 'looks' (U.S.MSPB 1981; U.S.MSPB 1988). In the US MSPB study, men tended to view suggestive looks and sexual remarks as sexual harassment less often than women. Regardless of gender, these studies indicated there was agreement between women and men that sexual assault and rape are the most extreme form of 'uninvited, unwelcome sexual attention' and obviously appropriately 'against the law'. There was also agreement that the mid-range behaviours on the continuum such as groping, pinching, and persistent requests for dates were unacceptable in the workplace. It is at the other end of the continuum, in what is considered to be sex-based harassment, that confusion and a general lack of agreement is found.

Gutek (1985) in her study of 1200 working people in Los Angeles noted that women identified more behaviours as harassing than men. Cleveland and Kerst (1993) posited that some harassing behaviours are not understood as such by the harasser and may not be motivated by a desire either to attain or to exercise power. Stockdale (1993) and Williams and Cyr (1992) described

the tendency for some men to perceive a woman's friendliness in a sexual way.

Gutek (1985) identified what she called a 'giant' gender gap in attitudes with men consistently saying that they are flattered by sexual overtures from women in the workplace and women consistently saying that they are insulted by sexual propositions from men. Males frequently rationalise their behaviour, shifting the responsibility and claiming the target of harassment 'can't take a joke' (Ridgway 1984; DeAngelis 1993) and they were 'just being friendly, I kiss and hug my staff to reward them, I touch everyone, I'm that kind of person' (Niland 1994:270). These are two examples of responses the harasser may use to rationalise their behaviour or actions.

Padgitt and Padgitt (1986) developed a sex-based and sexual harassment 'continuum' while studying gendered differences in perceptions of behaviours that could be considered SB&SH. They found that women were more definite and consistent than men in what behaviours they considered harassment. Men were less willing to define a behaviour as harassing and as a group were less consistent. Padgitt and Padgitt suggested that one could conclude that the male participants were either ignorant of or insensitive to how their behaviours are perceived by women.

Fiske and Glick (1995) suggested one explanation of why harassment can seem so different to various recipients. They described two main categories of sexism. One is 'Hostile Sexism' which includes dominative paternalism, competitive gender differentiation and hostile heterosexuality. The key words here are domination and hostility. The other is 'Benevolent Sexism' which includes protective paternalism, complementary gender differentiation and heterosexual intimacy motives. This second category is a fatherly attitude, protective of women and children. Both sexisms can result

in harassment, but the underlying motives generate different behaviours and add confusion to recognising and labelling harassment.

Gutek and Dunwoody (1986) identified the importance that gender roles play in most sex-based and sexual harassment situations. But they themselves admit that when one considers the most extreme forms of harassment, that of assault and rape, power and misogyny must be the most influential force. Fitzgerald (1990) described the two most common forms of power, formal and informal, the former consisting of the power that comes from a position or role, supervisor, employer, professor. Informal power, on the other hand, according to Fitzgerald arises from the male sexual prerogative, which imbues men with the 'unfettered right' to assert their supremacy over women and, importantly to emphasise the role of the woman over the role of employee, student or subordinate. The prevailing view of many feminist women is that sex-based and sexual harassment is the clear and deliberate intention of men to remind women of, and keep women in, subservient social and organisational roles (Paludi 1990).

Sex-based and sexual harassment and traditional and non-traditional occupations

There are conflicting views about the frequency of SB&SH 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 where there is a more balanced gender mix. In traditional (education, liberal arts, nursing) female fields of study, Ryan and Kenig (1991) found evidence there was a higher incidence of reports of harassment by teachers and students in those fields than by those studying or teaching in non-traditional fields. According to Ryan and Kenig, jokes of a sexual nature about nurses, for example, are encountered frequently, indicating such behaviour may be institutionalised. In their discussion they surmised that women in non-traditional fields might possess effective personal

strategies for dealing with harassment, rather than accepting harassment as 'part of the territory'.

On the other hand, Gutek and Morasch (1982) described female-dominated occupations as experiencing few complaints of SB&SH. SB&SH is still common, however, and perhaps women in these occupations make few complaints because they expect harassment as a matter of course. It is 'part of the job,' so to speak. This possibility is consistent with the view that harassing behaviour has become, effectively, institutionalised. Lawler (1991), one of the few Australian nurse scholars who has explored some aspects associated with harassment, has identified this as a major problem in the health care industry. Nurses may have come to expect SB&SH as 'part of the territory'.

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 (Muff 1982). Lawler (1991) explored the myths and stereotypes associated with the interaction between RNs and patients. She identified and discussed the 'sexualised' nature of nursing. She described the difficulty nurses encounter when moving from harassing patient care situations to the harassing co-worker, supervisor or medical staff.

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 may develop elaborate tactics to deal with unwelcome sexual advances from patients. Lawler (1991) noted the low level of empirical research that exists in this area. She raised a rhetorical question about the reasons why nurses have not investigated this issue more carefully. This would be important because SB&SH is known to have a significant impact on work performance and

professional and personal image (Bullough 1990; Horsley 1990; Chapman 1993; Goodner and Kolenich 1993; McMillan 1993a).

Recognition and responses to sex-based and sexual harassment

A number of informal actions were believed by victims to be effective in stopping unwanted sexual behaviour in the US MSPB (1981) studies. The studies indicated that the most direct and assertive responses were considered by the participants to have the potential to be the most successful. When actually confronted with harassment, however, participants used the more passive approaches, 'ignored it' or 'went along' with the behaviour. Loewenstein (1996) described the discrepancy that exists when people fail to act in their own self interest, even in full knowledge they are doing so. He illustrated the influence of 'visceral factors' on decision making and the ways people are prevented from acting in a cool or dispassionate way. Loewenstein found that avoidance and aversion to pain or negative consequences can be far more influential on behaviour than had been previously anticipated.

In Hinson's (1995) study of ACT government high schools, she described the marginalisation that occurs as a response to SB&SH. She noted that harassment advantages all males, including those who do not harass and also noted that there are few, if any disadvantages to men or boys who harass. Hinson made the observation that there is considerable resistance to changing the status quo that occurs when women are disadvantaged and men empowered by the marginalisation of women.

Fitzgerald, Swan and Fischer (1995) discussed the increased incidence of holding the victim legally and socially responsible for responding 'appropriately' and thus placing the burden of non-consent or 'unwelcomeness' on the harassed. She identified several response strategies and included the possible explanations or interpretations of these strategies. For

example, ignoring the harassment, a common response from actual victims of harassment, may have a wide variety of meanings for the harassed. It may mean doing nothing, denying what it could mean, pretending it did not happen, not caring that it happened, tolerating the unavoidable, being afraid, or not knowing what else to do. Fitzgerald noted the dearth of information on the meaning behind the employment of such strategies for the harassed.

Fitzgerald also argued that requiring the harassed to prove the harassing conduct was unwelcome assumes that sexual attention by any man to any woman is by definition welcome, unless the harassed proves otherwise... an 'odd assumption'. Rather, she suggested, should not the harasser demonstrate how he knew the attention was welcome? Shifting the burden of communication in this way limits the blame-the-victim mentality. Fitzgerald noted the wide number of possible responses of victims of harassment and their association with context, fear of retaliation, and consequences.

Kidder, Lafleur and Wells (1995) examined how some women construct and recall sexual harassment. Twenty-one informants described how they recognised harassment at the time of the incident or only recognised it much later, sometimes 20 years later. Kidder made the point that having words, a name, a category however flawed, enabled women to put words and meaning to their experience. They conclude their accounting with the reminder that if the social construction of reality is continually negotiated, then what makes behaviour offensive or normal will always be fluid.

Kitzinger and Thomas (1995) interviewed 21 informants willing to discuss harassment and explored why sexual harassment was or was not an appropriate label for a particular incident and what discursive mechanisms were used actively to exclude an incident from the SB&SH category. Four issues among others were developed to help understand the decision. Some

informants would refuse to accept the status of victim(hood), and often in essence, ignore it. Others found harassment so pervasive that they determined it could not be harassment and therefore a problem. Still others found much sexual harassment as not sexual and therefore it could not be sexual harassment. And lastly, harassment to some was more about power, 'taking you down a peg or two', therefore it was not harassment. All of these findings according to Kitzinger and Thomas, helped to make harassment under-reported, unlabelled and invisible.

Cultural Issues

Presumption of innocence

Western societies in the main work under the presumption of innocence. People must be proven guilty before they are punished or perceived as offenders. This idea is inculcated in the minds of school children and pervades our adult thinking. We go to great lengths to protect all accused people, shielding them from exposure and unwelcome publicity. This thinking must play a role in the issues associated with sexual harassment.

The usually private, one-on-one experience of harassment frequently finds the harassed and the harasser as the only witnesses. Not only are there usually no witnesses, making 'proof' his word against hers, but there is powerful presumption of innocence. Australians, like most western countries, value individual freedom and a democratic society, and tend to give individuals the benefit of doubt rather than the presumption of guilt. This cultural and social ethos works to enhance the position of the harasser and limit the possible successful options available to the harassed.

'She'll be right, mate'

Another factor which might be at work in perpetuating SB&SH 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 'okay' 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. Madison and Gates (1996) questioned whether the 'she'll be right' thinking works against enlightened discussion and consequent action and reduction in the incidence of SB&SH. Failing to assume personal responsibility facilitates the continuation of harassing behaviours. 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 or not this feature of Australian culture impacts on incidence and severity of SB&SH 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 in order to make sure that a complaint is brought against a harasser. Madison and Gates (1996) note that 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 SB&SH. 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 US, 77% of RNs studied in Kentucky who had experienced sex-based harassment, did not report their complaints (Donald and Merker 1993). It is a serious concern that the same percentage indicated employers did not have formal policies in place. What the situation is for Australia, and particularly for the health care industry, is currently unclear.

'Never dob in a mate'

The Australian ethos, 'never dob in a mate', could be another factor constraining the reporting of SB&SH. In addition, a number of Australian court judgments have acted to impede people from taking legal action against perpetrators of SB&SH. 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 trouble-makers and unfortunately may experience difficulty finding a job in the health care profession or difficulty in remaining in an existing position. 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).

Education

Substantial amounts of money and publicity have been expended over the last decade in Australia and overseas to increase public awareness and assure a wider social and cultural understanding of harassment. Most large and medium sized Australian organisations have policies and procedures in place in an effort to reduce problems and increase awareness. Sexual harassment is newsworthy and a common feature in the media. No less than twenty-five radio and television interviews were conducted following the delivery of conference papers which promulgated the findings of the survey questionnaire described here in Chapter 4. Certainly, the issue of sexual harassment has been argued from many perspectives in the early months of 1998 as President Clinton attempts to extricate himself from accusations of sexual harassment (Thomas and Isikoff 1997; Carlson 1998; Cloud 1998a; Cloud 1998b).

Despite all these efforts and publicity, different levels of awareness persist. Action by the harassed continues to be problematical, with many formal complaints dropped for various reasons (Scott 1995) and informal complaints apparently viewed as ineffective. The question must be asked, how effective are all the publicity, policies, programs and punitive possibilities? Why do the harassed continue to construct harassment in a way that leads to dismissing it or ignoring it? What happens between the objective, high level of information now available and the subjective encounter with the experience of harassment?

Feminist influences

MacKinnon (1979), one of the earliest and most influential feminists to deal with sexual harassment as an issue, was responsible for seeking and obtaining legal mechanisms to deal with harassment in the United States. It was through her work that sexual harassment was viewed as a discriminatory activity against women, since she identified it as largely a woman's issue. Just the previous year, Farley (1978) had defined the concept of sexual harassment and provided multiple examples of workplace harassment. The proliferation of research into sexual harassment by feminists began with and continues to be based on these two seminal works.

In Australia, three high visibility harassment cases have received notoriety. In 1993, Pybus provided an in-depth look at the 'Orr case' which was an infamous situation between a professor and his female student in the 1950s and 1960s in Tasmania. Looking at power differentials from the student/professor relationship, Pybus explored the phenomenon of harassment from the perspective of the possibly seductive student as well as the maybe lecherous professor. The second highly publicised case involved the public resignation in June 1994 of the Minister for Police in New South Wales, the Honourable Terry Griffiths (Niland 1994). Nine former members of his staff had allegations of sexual harassment against the minister

necessitating an independent inquiry ordered by the then Premier of NSW, John Fahey. Mr Griffiths subsequently resigned his high profile position.

Garner (1995) followed with a popular, widely read and divisive treatise about another Australian university sexual harassment case at Melbourne University. Garner portrayed a sympathetic account of the harasser providing the groundwork for a very public Australian feminist debate about sexual harassment. The issue of blame and culpability fueled controversial and differing perspectives among feminists on both sides of the Pacific (Ehrenreich 1998; Paglia 1998; Talbot 1998). The debate has shifted emphasis recently as the accusations against U.S. President Bill Clinton escalate and receive unprecedented attention. Feminists are divided in their perceptions of workplace harassment.

Talbot (1998) chides feminists who failed to support Bill Clinton's accuser, Paula Jones. She states:

> *But if, as a feminist, you have long promoted the idea that female accusers are to be given every benefit of the doubt; if you argue that sexual harassment can be defined in terms not only of crude quid pro quo demands but also of consensual relationships between people on different rungs of an office hierarchy; if you think that women constitute not only an interest group but a sisterhood, and that silence is the enemy of justice --- then you had better speak up for Jones...*

Ehrenreich (1998) argues that America's 'First Feminist', Hilary Rodham Clinton, is no longer qualified to wear that label (since Hilary continues to 'support her man'). Ehrenreich suggests that the feminist idea that women 'go to work to get a job done, and unless that job is lap dancing, it's an insult to be judged by one's body parts and willingness to share them with others'.

She further suggests that feminists lost valuable moral capital when they failed to support Paula Jones with the 'wrong kind of hair' against the pro-choice President.

On the other hand, Paglia (1998) recently described efforts to address a sexualised workplace as inappropriate, calling an 'antiseptically sex-free workplace' impossible and unnatural. She seems to concur with Garner in believing that women assume responsibility for harassment when they fail to exercise caution in their attire and behaviour. 'For every gross male harasser, there are 10 female sycophants who shamelessly use their sexual attractions to get ahead', Paglia opines. This spirited public debate in the popular press adds to the confusion regarding sex-based and sexual harassment.

President Clinton's situation has, however, served a useful purpose. Clearly linking the relationship between power and sex-based and sexual harassment forces the question, how consensual is sex with the most powerful man on earth? There is not a more visible and controversial case to discuss and debate. Much of the discussion revolves around issues that have been researched and published in refereed journals, but have not worked their way into the public consciousness. Over the last year, it has become difficult to find a newspaper or popular magazine that is not analysing sex-based and sexual harassment from one perspective or another. The consequences of a major split amongst feminists on the issue does not bode well for long-term changes in workplace harassment, particularly if the blame-the-victim contingent receives more credence.

Biological Issues

Influences of evolutionary biology

The biological basis of sexual harassment has received scant attention. While much information exists about the sociological, organisational and cultural characteristics associated with SB&SH, the biological side of the

issue has been neglected. There may be a variety of reasons why the biology of SB&SH has been overlooked. Madison and Gates (1996) suggested that it is likely that it is the politically-sensitive nature of the topic which may have led to this outcome. 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. To ignore the biological components seems inappropriate considering that it could be useful when taking an assessment from a larger overview. Proponents of evolutionary biology (Symons 1987; Diamond 1992) would contend that restricting a discussion on such a topic as SB&SH to the social sciences could eliminate some important contributing factors.

Some things could 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, and marital status have roots in evolutionary biology and increase the probability of certain people being targeted for SB&SH (Symons 1987b). In addition, understanding some of the biological features of SB&SH in perpetrators may help to deal with the problem more effectively. It is clear that not all males are perpetrators and there may be biological markers which distinguish who does and who does not 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.

Madison and Gates (1996) noted 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 which 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 1987b; Diamond 1992). Women appear to seek

out a strong and powerful protector for the long gestation, lactation and childhood of 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 behaviour of women and men may well influence SB&SH, with females being very selective with whom they allow intimacy, while males are not so choosy and are 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- 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 behaviours. While they may not be able to change their fundamental natures, in most cases they can change actions and behaviours.

Conclusion

This literature review has examined sex-based and sexual harassment in general and as it might apply to RNs in the Australian health care arena. This review touched on some of the major influences at work with this

difficult and controversial problem. It is clear that sex-based and sexual harassment is widespread, a not uncommon experience for women at work, regardless of the kind of work they do. SB&SH is costly in human terms and impacts on an organisation's effectiveness. The complexities of SB&SH 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 in the Australian context does not help to understand or resolve the problem. While Equal Employment Opportunity legislation may have helped to raise consciousness concerning SB&SH, legislation is only part of what is needed to solve the problem. And certainly research into such a complex problem would need to be Australian based before any conclusions and recommendations for the Australian health care industry can be made.

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'.

It would seem reasonable that the male-dominated power hierarchies of the health care industry might create additional vulnerability to SB&SH for nurses. To what extent this hierarchical organisational structure reflects some of the mechanisms described in this literature review is unclear, but it is possible that the mechanisms of formalised organisational power combined with social and even biological imperative and related issues specific to health care, may be a difficult combination 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 SB&SH.