Chapter 5

Discussion of Survey Findings

The Sample Population

In order to determine how closely the survey questionnaire sample represents the wider Australian RN population, student enrolment records were examined from the NSW University within which this study was conducted. This revealed that all states, and the Northern Territory were represented in the selected student population. The demographic portion of the survey indicated that 65% of the participants were employed in a metropolitan setting and 27.9% described a rural or remote work place (four percent did not respond and three percent indicated 'other'). Seventy-five percent (75.1%) worked full time. Interestingly, 92% of the RN participants were female which is in keeping with the 1991 census noted in the literature review. The survey results need to be considered in light of this predominantly female sample.

The demographics also included the highest qualifications, demonstrating a wide range of academic preparation of the participants at the time of the survey. Thirty-five percent (35.5%) of the participants had a certificate, twenty-five percent (25.4%) had a post-graduate certificate, thirteen percent (12.7%) had a diploma, and eighteen percent (17.8%) had a bachelors degree. The participants in this survey were all RNs who had returned to the tertiary setting to acquire advanced educational preparation. In this respect these participants could be distinguished from many other RNs found in the Australian health care setting as most had some university qualifications.

The additional time, interest and energy required of RNs studying at the tertiary level could make this sample population somewhat different from

other RNs. While it is very difficult to describe 'typical' RN tertiary students, it might be safe to describe them as not interested in remaining in the 'status quo', as they were taking active steps to change their own status. The lack of uniform standards, definitions and classifications across Australia also makes a composite picture of RNs difficult, since each state has career ladders idiosyncratic to that state.

The sampling technique selected for this study was a convenience sample, the most commonly used sampling technique for nursing studies (Polit and Hungler 1991). However, the demographics as identified by the participants and noted above would seem to indicate a wide variety of experiences, qualifications, residences and workplaces. In discussing the findings of this survey questionnaire, this aspect of the participants' demographic profile needs to be considered. Caution is exercised in generalising to the entire Australian RN population from this convenience sample, particularly where, in come cases, the number of responses was small.

The social context

For RNs, a critical factor in harassing situations is the social context in which harassment takes place. The first section of the survey questionnaire, where statements were proposed about behaviour at work, provided some insight into the perceptions of RNs. In this section, survey participants were fairly unanimous in believing that morale was affected when employees use their sexuality to get ahead at work. Participants thought that those who sexually bother others were usually seeking power over those they bother. Very few thought that when people say they've been sexually harassed, they are usually just trying to get the person they accuse into trouble. These RNs did not believe that people who receive annoying sexual attention were usually asking for it. Few thought that the issue of sexual harassment has been exaggerated.

However, opinions were divided about whether people should have sexual affairs with people with whom they work. Further divisions occurred over whether women in positions of power are just as likely as men in such positions to sexually bother the people who work for them. RNs were also divided on whether people should be so quick to take offence when someone expresses a sexual interest in them. There was no unanimity over whether to call something sexual harassment even if the person doing it did not mean to be offensive.

Although agreeing or disagreeing with a negatively phrased statement can be decidedly confusing, the responses to this section revealed that on some important issues there was little consensus among survey participants. Interestingly, over one third of the participants said that unwanted sexual attention could be stopped simply by telling the person to stop. Yet 58% acknowledged that the situation may be more complicated and that saying no just might not stop the harassment. A surprising number (42.6%) thought sexual activity between people who work together was 'all right'. The US MMSPB study, as reported in Chapter 2, found that few respondents to their survey believed that sexual activity between people who work together was acceptable.

These responses capture the ambiguous nature of the health care workplace. A variety of individual reactions as well as workplace 'cultures' can exist in the same department or health care workplace. A sense of what is 'right' or 'OK' can vary considerably depending on perceptions or experiences of individual people, creating an uncertain social context for people who are harassed. This workplace atmosphere would tend to reduce discussion and empathy with those who experience sex-based and sexual harassment. The responses to this section of the survey revealed that tolerance or intolerance for certain behaviours in the workplace may inhibit complaints of harassment. For instance, opinion was almost evenly divided about whether to call certain behaviours sexual harassment if the person said they

did not mean to be offensive. Therefore, when the harasser responds to accusations of harassment by saying 'I didn't mean anything by that (behaviour)' an RN should expect about half of her co-workers to be mollified. The other half would not be persuaded by the harasser's professed intention. This study supports the notion that sexualised behaviour in the work place can be viewed quite differently by RNs.

Definitions of harassment

The survey participants were asked about seven categories of behaviours commonly used to describe sex-based and sexual harassment. The behaviours were all uninvited. They included pressure for sexual favours, deliberate touching, leaning over, cornering or pinching, sexually suggestive looks or gestures, letters, phone calls or materials of a sexual nature, pressure for dates, sexual teasing, jokes, remarks or questions or stereotypical or demeaning comments. Not unexpectedly there was little disagreement about pressure for sexual favours, deliberate touching, leaning over, cornering or pinching and letters, phone calls, or materials of a sexual nature. Well over 90% of the survey participants agreed that this would bother them and that this kind of behaviour, whether from a supervisor, medical officer or another health professional, would be considered sexual harassment.

Although the majority agreed about the other behaviours being bothersome and harassment, the percentages are slightly reduced. When these RNs considered sexual teasing, jokes, remarks or questions, approximately one in ten participants would not be bothered or call it sexual harassment. Six to eight percent of the participants would not be bothered by uninvited sexually suggestive looks or gestures nor would they call this behaviour sexual harassment. Not surprisingly, stereotypical or demeaning comments, the area that is clearly gender or sex-based harassment, evoked the most interesting response. Although slightly over 90% of the RNs would be bothered by this behaviour, whether from a supervisor, medical officer or

other health care professional, only approximately 75% of the participants would consider it sexual harassment.

The literature suggests that there is little confusion about what constitutes harassing behaviour and these current findings are consistent with research in this area (except for gender harassment). Some small differences of opinion exist, but generally, these RNs are clear about almost all of the behaviours that are suggested as possibly bothersome or harassing. Considering the mostly female survey participants here, one would expect more unanimity in recognising gender or sex-based harassment. One would also expect that if behaviour was bothersome, it was at least inappropriate in the workplace, although this was not a possible choice offered to these survey participants. For these RNs, gender harassment evoked a slightly ambiguous response. This finding does suggest that almost two out of ten RNs would not be interested in or reactive to complaints from colleagues of gender or sex-based harassment in the health care workplace.

Generally, behavioural expectations of supervisors, medical officers and other health care professionals were very similar. The only category of behaviour where there appeared to be a different expectation was in 'pressure for dates'. There was almost a ten percent difference between what RNs would expect from another health professional than what they would expect from a supervisor and a medical officer. Or in other words, although a large majority would be bothered by this behaviour, ten percent fewer of the participants would be bothered by being pressured for dates from other health professionals. The US MSPB study found that respondents expected a higher standard of behaviour from supervisors than from co-workers. The implication here suggests that RNs expect a similar level of behaviour from supervisors, medical officers and other health professionals.

One drawback to this section of the survey was the use of the phrase 'health care professional'. Whether participants included wardsmen, nurse aides or

other unlicensed personnel in the workplace as 'health care professionals' is unclear. There are many categories of workers in the workplace that might not be considered 'colleagues' or 'other health care professionals' and this needs to be considered when evaluating the analysis of this section of the survey questionnaire.

Hypothetical (re)actions for the harassed

Less than two percent of the RN survey participants felt that there was little an employee or an organisation could do to reduce or eliminate sexually bothersome behaviour in the workplace. Asking or telling the person to stop was identified hypothetically as the most effective action to reduce or prevent sexual harassment by over 97% of the survey participants. Reporting the behaviour, and filing a formal complaint, were other strategies of choice by over 84% of the RNs. Most of these participants did not believe that passive or covert 'responses' such as avoiding the person or ignoring the behaviour were effective strategies to use. Generally, in the hypothetical situation, aggressive action-oriented strategies were supported by most RNs, although one in three RNs thought that ignoring the behaviour would be effective and 20% suggested that the harasser should be avoided. In other words RNs could expect that a majority of their RN peers would support formal reporting of harassment, while a significant minority would not.

Over eighty percent of the RNs agreed that six actions were important for organisations. The actions were described as the establishment and publication of policies which prohibit sexual harassment, swift and thorough investigations, publication of formal complaint channels, counselling services for the harassed, awareness training for all employees and training for managers and EEO officials on responsibilities for decreasing sexual harassment in the workplace. None of these organisational actions are new or unreasonable or even difficult to institute.

Considering the extent of harassment described in this survey, these organisational remedies do not seem adequate to the RN participants. When queried about the availability of many of these actions in their workplace, a distinct organisational lassitude is identified by these RNs. Less than 20% thought they could request an investigation by an outside agency through their employer and less than 40% thought there were special channels set up for sexual harassment complaints in their health care organisation. These findings would suggest that these RNs view many of their employers as disinterested in aggressively pursuing a professional, positive workplace free of harassment.

The harassed

In this study, two out of three RNs reported being targets for SB&SH in the workplace and the harassers of SB&SH were usually male. The most frequently described SB&SH behaviour was unwanted sexual teasing, jokes, remarks and questions, experienced by 54% of the participants. The literature suggests that much unwanted sexual teasing, jokes, remarks and questions would fall into the category of behaviours in which female and male perceptions differ. Some would argue that 'words' are not nearly as 'serious' as overt, physical contact. This study found that many harassing behaviours described by the participants are in the area of harassment where there is general agreement between women and men, such as touching, pinching, and leaning over. However, a significant number of the behaviours consist of jokes and remarks of a sexual nature where there is less agreement.

As reported in the literature review earlier, some men, and even some women, seem surprised that uninvited sexual teasing and jokes are considered SB&SH, especially when behaviour that is not specifically sexual but is based on gender is included in the definition of SB&SH (U.S.MSPB 1981). The problem for the RN in the work place is that many women, and

only a few men, agree that these behaviours are 'against the law', and offensive. At a minimum, uninvited sexual teasing and jokes can be the most obvious outward sign of a hostile and 'harassing' work environment. This study supports the view that a number of nurses experience a variety of behaviours they consider unwelcome and harassing. The health care industry as well as different health care professional groups may be viewed as condoning harassing behaviour when it is described as occurring so extensively. This finding would reinforce the importance of education for all health care workers.

Some of the findings were to be considered cautiously in light of the small number of respondents in different variables or categories. Nevertheless, they may be important for future research. There was a relationship between being a 'Registered Nurse' and being harassed by an older person, particularly a person in authority. Interestingly, 'Registered Nurses' (as opposed to the other possible categories of DON, DDON, CNC, etc.), who were married were much more likely to be harassed by a peer than any other person. Being married did not deter harassment, as 42% of those who described an harassing incident were married. Further, being overweight or obese did not reduce, but rather increased experiences of harassment. Not surprisingly, those who identified themselves as a 'Registered Nurse' and who were unmarried were the persons most likely to be harassed, with unwanted sexual teasing being the most commonly harassing behaviour described. This suggests that as one moves up the organisational or professional career structure from 'Registered Nurse', the chances of being harassed decrease. Providing that education is a requirement for career advancement, then these findings imply that education may act as a deterrent to harassment. Obesity apparently does not deter SB&SH.

The harasser

There was a high number of medical officers described as the harasser. It was not possible in this study to determine if one harasser was responsible

for many harassing episodes or if there were many harassers. Forty-two percent (42%) of the participants did indicate that the harasser they were describing 'bothered others'. This finding would suggest that not all medical officers harass, but rather a limited number harass often. The power and authority bestowed on medical staff is often similar to that which is reserved for 'supervisors' in other disciplines and industries (Madison and Gates 1996). In fact, medical staff are frequently 'visitors' or customers of the employer of RNs and thus less amenable to control or remediation. The medical community must assume responsibility in being pro-active in educating and (self) discipline. Hospital executives must support and encourage these efforts in their responsibility to both their RN employees and all other employees.

The number of co-workers (22.1%) compared to supervisors (21.3%) described as harassers was similar to findings in the US MSPB study. This finding is important for the supervisor and health care executives who hold the responsibility to maintain a hostility-free, positive work environment. Managers must monitor not only their own behaviour, but the behaviour of all other (co-worker) employees. Clear messages must be disseminated regularly that sexual harassment is unacceptable in the workplace.

The survey asked participants to describe how often they experienced the behaviour. Slightly over one fourth of the participants experienced the behaviour every day, every few days or two to four times a month. This would seem to be a fairly frequent occurrence and a cause for concern for health care organisations. Not only did many nurses experience harassment, but for some it was experienced frequently over a relatively long period of time. If this finding is a comment on the broader RN population, it suggests that Lawler (1991) is correctly curious about why RNs have not conducted research into this area. The responsibility of the profession of nursing in this issue is no small matter. At an individual and organisational level support for nurses who speak out is essential.

Collective wisdom and action is necessary to combat such a personally and professionally damaging problem.

Although the numbers were very small, it is difficult to ignore the possibility that for these participants, supervisors and medical officers may demonstrate a different pattern of harassment. Harassment from a medical officer was more likely to be touching, leaning over, cornering or pinching and it was more often identified as happening once. The behaviour was apparently easily discouraged or stopped. For supervisors the harassment consisted most frequently of demands for sexual favours, occurred over a longer period of time and was less easy to discourage or stop. It would be important for employees and employers to know about possible patterns of harassment based on employment categories. If assertive actions with medical officers are as effective as these findings indicate, this might encourage assertive behaviours from the harassed in all circumstances.

The response to harassment

A significant finding of this survey was apparent in the dichotomy that existed between what participants identified as appropriate strategies in response to harassment and those they actually employed when confronted. Participants were quite clear in their view that the most effective response to SB&SH was the assertive or active response such as asking that the behaviour stop, reporting the behaviour to supervisors or filing a complaint. Even though over 97% said harassers should be 'told to stop', slightly less than 50% of these participants actually employed this strategy when confronted with a harasser.

This dichotomy was identified in the US MSPB study also, with participants 'knowing better' but choosing a less confrontational strategy. Likewise, this study found that a significant number of nurses rationally, analytically suggest an assertive, active strategy be employed when harassment occurs, and yet often fail to use such assertiveness in practice. The supervisor, and

the health care organisation, has a responsibility not only to educate employees, but also to encourage a more proactive response to harassing situations as well.

The outcome and effects of harassment

When queried if any changes had happened in the participants' work situations as a result of unwanted sexual attention, few changes were actually described. The participants, however, reported fear that such changes would occur. For example, almost a quarter of the participants thought the person(s) or other workers would be unpleasant or would embarrass the respondent, 13.7% thought their working assignments or conditions would get worse and 13% thought they would be 'blamed', if they did not go along with the unwanted sexual attention. This finding of fear of negative consequences would explain in part the great reluctance to confront the harasser or to use the suggested assertive strategies.

One of the most distressing findings in this survey was the large number of psychologically damaging effects of SB&SH in the workplace. As a result of the harassing experiences the participants reported a variety of damaging effects. Thirty percent felt worse about their work and 26.7% reported their emotional or physical condition became worse. Productivity is of serious concern to health care professionals and the well being of the health care system. Sexual harassment is costly, according to these participants. Motivation, productivity, incentive and attendance are all factors closely associated with the effects noted by the participants. These findings should serve as a catalyst to health care supervisors and organisations to be more proactive in dealing with SB&SH. This study found that serious consequences exist when harassment occurs in health care organisations.

RNs also need to assume responsibility for a professional, positive workplace. Although the charge nurse, nurse unit manager, shift supervisor and all 'line' positions have heavy organisational responsibilities

in reducing and eliminating SB&SH, all RNs have a professional responsibility to their colleagues and the workplace environment. Ignoring or avoiding widespread problems does nothing to reduce or eliminate those problems. Until the issues associated with SB&SH are better understood, and behaviours change, the workplace will remain hazardous for RNs.

Sexual harassment complaints

Almost one in four participants indicated they did not feel they could bring up general work related concerns with their supervisor. If RNs do not feel comfortable bringing up general concerns to their supervisor, they can hardly be expected to bring up such serious concerns as sexual harassment. Only seven percent of the participants indicated they took formal action when confronted with sexual harassment. These two responses should make health care organisations aware that the absence of complaints about unwelcome sexual attention in the work place should not be used as an indicator of the absence of inappropriate behaviours in the workplace. The literature supports the view that few victims of harassment actually report the behaviour or use formal reporting procedures. The number of complaints should therefore not be used as a guide to determine the extent of harassment in a workplace.

The ambivalence RNs associate with sexual harassment is noted in this survey as two out of three participants reported harassment, yet 73% of the participants did not believe sexual harassment was a problem at work. Several explanations regarding this finding could be developed. One interpretation is that these RN participants found sexual harassment endemic in the workplace and less than half saw employers as concerned and making every effort to stop harassing behaviours. RNs do not always take active steps to 'fight' the stereotypes that persist and are depicted in the popular media. RNs themselves need to evaluate their responsibility for the professionalism found in their workplace. When harassing behaviours occur do RNs 'encourage' their repetition by failing to speak out actively and

assertively against it? Do they accept it as 'part of the job' or do heavy workloads and job responsibilities consume the energy that would be required to combat widespread sexual harassment in the workplace?

Organisational policies

Forty-six percent of the participants did not know or did not believe their organisation had a formal policy for dealing with sexual harassment in the workplace. In the current environment, with well established legislative requirements in place, one would assume that quite adequate policies should exist in all health care organisations, even in the most rural and remote establishments and certainly in every metropolitan hospital. If such policies and procedures are in place, it would seem that in many instances they are very poorly advertised.

Organisational education

Three quarters of the participants did not know or did not believe that employees in their organisations had received education about sexual harassment in the workplace. This question is important because it goes beyond policies and procedures, and focuses on education concerning what constitutes sexual harassment. Organisations need to acknowledge the confusion that exists about what constitutes sexual harassment and take steps to educate all health care workers and health care professionals. The literature implies that prevention of sexual harassment is far superior to any 'cure' and that organisations will be better served with a strong preventative educational program in place.

Almost 90% of the participants did not know or did not believe that the medical staff associated with their organisation had been formally trained concerning what constitutes sexual harassment. The harasser most commonly identified by the participants in this survey was the medical officer. This being the case, it would behove health care organisations and medical officers themselves to consider the most effective (and visible)

strategy to educate medical officers, and medical students, in what constitutes harassing behaviour. The literature suggests that perceptions about what constitutes harassment varies between individuals. In the absence of a concerted and focused organisation-wide educational effort, these misperceptions will be perpetuated. Far better a preventative group educational program than an after-the-fact individual effort.

Almost three quarters of the participants did not know or did not believe that a formal policy to govern relationships among employees and medical staff existed. Developing a policy of this sort could be an effective and positive interdisciplinary project within which an open and non-threatening discussion about not only general professional relationships, but also inappropriate sexualised behaviours could occur. It is unreasonable to expect compliance with a standard that is not clear, in writing and accepted by the various professionals involved.

A disturbing finding appears to be that less than half of the participants felt their organisation makes every effort to stop sexual harassment. This observation about the workplace would suggest that even if policies and procedures exist, and management profess appropriate behavioural expectations, these efforts appear ineffectual. Is sexual harassment addressed directly in orientation and induction programs? Has the chief executive and governing body spoken out formally against harassing behaviours in the workplace? Are posters and pamphlets about sexual harassment readily available to all staff? It is not reassuring to note that 62% of participants believe that, or don't know if, their organisation resents dealing with sexual harassment.

According to these participants, there were many effective actions for an organisation's management to take regarding sexual harassment. The RN participants were keen to see that educational approaches as well as swift and thorough investigations of complaints were based on well publicised

policies. The findings associated with this survey questionnaire are a powerful message to health care organisations. There should be no doubt about the inadequacy of current approaches to sexual harassment in the Australian health care facilities. RNs seem to find the approaches unsatisfactory and inadequate. Hospitals, health care facilities and health care professionals would be wise to assess their own workplaces and work towards more effective sexual harassment education, policies and procedures.

This survey questionnaire format closely approximated the widely respected and frequently cited US MSPB study of 1981. There are several reasons why it was and remains impractical and inappropriate to compare this Australian based study and the U.S. study. The first U.S. study was conducted in May 1980, almost 18 years ago. In this Australian study, experiences of harassment were not restricted to the previous two years as it was in the U.S. study, thus comparing the frequency of harassment between the two surveys would be faulty. Also the addition of 'medical officer' and 'patient' to the survey was necessary to represent more adequately, the health care workplace. Thus comparisons between the surveys regarding the 'title' of the harasser would also be faulty. Although this research project is not meant to be a comparative study with the US MSPB project, some general observations can be made.

Both studies found that sex-based and sexual harassment is widespread in the workplace. More women than men are victims of harassment. More of the harassers are men and both studies found that the most common form of unwanted sexual attention in the workplace was unwanted sexual teasing, jokes, remarks or questions. When actually confronted with a harassing situation only seven percent of Australian participants and five percent of U.S. participants took formal action.

Some differences can be explained by the several additions and changes to the Australian survey. The US MSPB studies indicated that 42% of female participants and 14% of male participants complained of experiences of harassment. The Australian study, with its open-ended time frame, found that 66.5% of participants complained of harassment in the health care workplace. The US MSPB study found that coworkers were significantly more often the harasser. The Australian study (with the addition of medical officer and patient) found medical officer, co-worker and supervisor to harass, all at fairly similar levels.

Important to this research project, despite many experiences of harassment described in both studies, less than 27% of participants in the US MSPB survey and 16% of Australian participants agreed that uninvited and unwanted sexual attention was a problem where they worked. When considered in the abstract, the US MSPB survey found that assertive, direct, but informal responses to harassment would be most effective, but like this Australian study, only half of the participants elected to use these responses when confronted. The more likely response was to ignore the harassment or avoid the harasser.

These somewhat superficial comparisons do generate some questions about studying harassment in a discipline specific way, that is studying RNs as a specific group rather than all women at work. Clearly this survey indicates that sex-based and sexual harassment are widespread experiences for Registered Nurses in Australia, but the literature supports the view that harassment is common for most women in the workplace. The comparisons with the US MSPB studies would lead one to believe that there are probably few differences between health care workplaces and the workplaces of women in general. Although some changes in the survey questionnaire tool have been identified as necessary to depict the work situation under study here more accurately, the similarities between the US MSPB studies and this study, are nonetheless, remarkable.

Conclusion

This survey questionnaire of sex-based and sexual harassment in the Australian workplace raises several issues. The findings of this study include descriptions of those SB&SH behaviours identified most frequently by RNs, frequency of occurrence, and responses to unwelcome sexual attention. The participants described feelings about work, emotional or physical conditions and their ability to work with others as becoming worse as a consequence of harassment. Many participants reported fear of consequences was a factor in their response to harassment.

It would appear that RNs believe current efforts to educate employees and health care professionals about sexual harassment are inadequate. If policies and procedures regarding sexual harassment exist, they are not well known to RNs. A significant amount of harassing behaviour is perceived by RNs and little is seen in the workplace in the way of education or preventative policies. These findings seem to say that the health care industry is perceived by RNs as failing to take sexual harassment problems seriously. These RN participants believe health care organisations fail to recognise that a hostile and harassing work place is vulnerable to the manifestations of sexual harassment. In contrast, this survey should be reassuring to many RNs. They are not alone in perceiving sexual harassment and 'their problems' are not isolated.

The findings discussed here have highlighted why SB&SH may be a problem for RNs and for the organisations in which they work. It is essential to understand and reduce the experiences and consequences of harassment. All Australian health care professionals need to ensure that educational processes keep pace with the research presented here. It would seem that further research would be appropriate and helpful, linking these quantitative findings with the words, meanings and interpretations of RNs themselves. Talking with individual RNs about their perceptions and experiences would

generate data of a different nature and aid in a better understanding of the issues raised as questions in the survey questionnaire and these insights will be presented in Chapters 6 and 7.

Chapter 6

Recognising Sexual Harassment: Qualitative Insights

The first phase of this three part research project was a quantitative survey questionnaire of Australian RNs. Quantifying the incidents of harassment is important: it can confirm its frequency, identify the common characteristics of the harassed and harasser and highlight the more common behaviours associated with episodes of harassment. However, what has been ignored in the previous chapters is the interactional context surrounding sexual harassment.

Over 80 years ago, Taft (1987) introduced some of the earliest thinking associated with symbolic interaction. She suggests that we must strive to recognise and understand complex social interactions in order to build awareness and develop a richer self understanding. Extending a qualitative analysis to the complex, context relevant, human relations problem of sex-based and sexual harassment is essential if meaning and explanation is ever to rise to our collective human consciousness. This chapter explores the premise that sexual harassment is a socially constructed symbolic interaction.

The analysis focuses on this interaction, how RNs acquire or process knowledge about harassment and how this knowledge is personally and socially reproduced. That is to say, how these RNs come to 'see' and 'understand' harassment. The interview process is one of the most effective ways to explore the issues associated with how RNs come to recognise harassment, label it, deal with it and interpret their action or inaction when confronted with it. It is important to remember that only recently has a name been attached to the behaviours that are now labelled sex-based and sexual harassment. The purpose of the qualitative phase of this research is to

explain and give meaning to the social interactions related to sex-based and sexual harassment as experienced and perceived by a group RNs.

The previous chapters also indicated that a wide variety of behaviours are described as harassing, including such varied behaviours from sexual innuendoes up to and including sexual assault or rape. Implicit in some of the responses was that not all incidents of harassment are 'equal'--- that recognising and labelling an incident as harassment might vary according to the knowledge and experience of the harassed as well as the context (time, location, interaction) in which the harassing incident occurs.

The first phase of this research project indicates the high level of sex-based and sexual harassment described by Australian RNs. Similar to studies overseas (U.S.MSPB 1981; U.S.MSPB 1988) the survey questionnaire associated with this research portrays some inexplicable findings. Although two out of three respondents 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 respondents work(ed). In addition, although telling the person to stop was identified as an effective deterrent by almost all respondents when dealing in the abstract, only half used this strategy when actually confronted with unwanted sexual attention.

By allowing RNs themselves to talk about their experiences of harassment and listening to how they describe the personal and social processes by which they construct harassment, a better understanding of sexual harassment might result. Why do RNs say unwanted sexual attention in the workplace is widespread, but that it is not a problem? And as well, why, when confronted with harassment, do RNs chose not to use strategies they have identified as appropriate? These two findings fueled the second phase of the research project.

This chapter explores the complex nature of harassment as identified in 16 in-depth interviews with Australian RNs. The word informant in this and the next chapter refers to these 16 individuals. Six major areas are analysed and these are outlined in Figure 6.1.

Figure 6.1 Analysis categories emerging from the qualitative data

- **LABELLING**: how the RN informants label the event of harassment
- **RECOGNITION**: how the RN informants recognise that harassment may be imminent: what some of the features or benchmarks are
- **CLASSIFICATION**: what classifications were used by the RN informants to describe the harasser
- **RESPONSE**: emotional and physical responses of the RN informants experiences with harassment
- **RATIONALISATION**: what rationalisations the RN informants used to explain their and their harassers actions or inactions
- **ANTECEDENT CONDITIONS:** what contextual issues exist in relation to sex-based and sexual harassment.

Addressing the issues described in Figure 6.1 may help to explain some of the contradictory findings outlined in the preceding chapter. The previous chapters do not explain why harassment continues to be a thoroughly ambiguous phenomenon in our society. This ambiguity exists despite fairly aggressive legislation, community scrutiny, media exposure and organisational programs aimed at preventing and dealing with sex-based and sexual harassment in the workplace. Until relatively recently harassment has not been open to scrutiny and for Australian RNs the phenomenon has been silenced. Harassment has, however, been part of everyday living and working, and harassers have received personal and professional pleasure

and advantage from participating in it. Since harassment was given a name in the 1970s (Farley 1978) a new social order has begun to question the appropriateness of certain behaviours in the work setting. Twenty years hence, it is still evident that it is difficult for many people to shift their perspective from 'this is normal' workplace behaviour to 'no, this is offensive'.

The aim of this chapter is to reproduce some of the difficulties associated with this recent phenomenon or new social order that has included a revolution in gender roles. This revolution expects much of women and men in that they are expected to conduct their social business in very different ways from the past. Embedded in old ways of thinking about their behaviour and the behaviour of those with whom they come in contact, people still struggle to think and accept new ways of interacting at work. It is clear that harassment has a subjective reality or meaning which needs to be studied and understood.

What is NOT harassment?

Many informants discussed the contextual and personal elements associated with harassment. In doing so, it was anticipated that they may help shed light on the fine 'line' that harassers step over with their unwelcome, uninvited behaviour; the same 'line' that others never cross with sometimes almost identical behaviours. So it is useful before exploring and interpreting the experiences of these RNs and their experience with sex-based and sexual harassment to look at what the informants described as *not* being harassment. The informants readily acknowledged that recognising and labelling behaviour as harassment is highly individual or personal and context dependent. The informants described how one person can do almost exactly the same touching, use almost identical words, stand just as close and be acceptable, whereas the actions of another person will be recognised as offensive and unwanted, uninvited sex-based/gender or sexual harassment. Most informants noted the importance of the context in recognising the

presence or absence of harassment. For example, Mary seemed to question the notion that anyone could recognise or label an episode of harassment unless they were there.

> *Mary: People need to interact and they do interact in different ways ... it would depend on how comfortable I felt in the situation. I guess Jeanne I couldn't tell you that unless I was there. (Metropolitan, community-based, an RN for 13 years)

Michelle made an effort to explain 'the line'.

> *Michelle: Ostensively I guess I don't know, there's no ...there's no *line* I have. For me, it's a gut feeling that this person's gone too far, you know, that they're getting too personal ... but I don't know that I can sit there and say it's when they say this, or it's when they say that. Certainly, if they're too graphic, they've already stepped (over the) line. (Metropolitan, community-based, an RN for 13 years)

The informants gave many examples of the person/context debate that seems to go on inside the RN's head when describing the difference between acceptable and unacceptable behaviour. Several informants spoke about that difference and seemed quite clear in their minds, even if they had difficulty explaining it.

The informants talked about how people are 'different' and have different cultural norms. These childhood or family experiences make some people more comfortable with touching or physical intimacy than others. One informant from a Non-English speaking background who had grown up in a culture that encouraged touching, seemed to have more tolerance for physical touching, which seemed to be an anathema (in the work setting) for most of the other informants.

> *Frances: Well, say for instance, somebody gives you a pat on the bottom - to me that's nothing but another person may say ah that's harassment, you know. But as I said, it's how you perceive what sexual harassment is. Maybe it depends on your values because to me my values I love, I don't mind touching, as long as it's clean touching. Again, it depends on how you, you know, you take clean touching as clean touching but it's mainly the person - the receiver of the thing-y, but maybe to an onlooker it would be sexual harassment - it's an individual, an individual perception. (Metropolitan, nursing home, an RN for 8 years)

Several informants also spoke about the wide variety of people encountered in the RNs' work place. This was particularly evident for those who had also worked outside of the health care industry prior to embarking on a career in nursing. They had a basis for comparison and noted that other workplaces were markedly different from that experienced by RNs. Working closely, even intimately with a wide variety of people from different cultures and educational backgrounds, different ages and gender, is a daily occurrence for most RNs.

Paula came the closest to describing what was harassment and what it was not. In a short and succinct comment she says:

> *Paula: (W)hat I class as sexual harassment is something I feel I couldn't handle. Or something where someone else is in a situation they couldn't handle. (Metropolitan, hospital-based, an RN for 14 years)

David, however, the only male perspective amongst the 16 informants, put forward a view of harassment that demonstrated his confusion about where the 'line' is between harmless flirting and sexual harassment.

> *David: I mean, when does behaviour stop being appropriate as far as men and women interacting? 'Cos, men, to be sexually attracted to women is quite normal, and vice versa, and, sometimes from people ... you get sort of mixed signals and ... some of the time the signals are really difficult to interpret. Like ... what is harmless flirting, or what's the difference between flirting and sexual harassment, for instance ... where does the flirting stop and when does the harassment begin ... when are we just having a joke or ... when does a serious relationship, sexual relationship start ... the lines are very fuzzy ... I must admit some people are better than others at picking up the correct signals, and, some people ... are just not socially adept enough to pick up ... when men are behaving inappropriately ... what's the difference between a sleaze and just ... a buffoon? (Regional/rural, hospital-based, manager, an RN for 13 years)

Unlike most other informants, David was not sure he knew, at least with the same certainty as the others, exactly where the line was. For most informants there was a distinct lack of clarity in verbalising how they recognised harassment, differentiating it from generally unpleasant, rude or inappropriate behaviour, but they seemed to 'know' when it was harassment. For most informants, they saw a 'line', albeit wavy, or constantly moving, or in different places for different people, but a 'line' was there. It was just difficult to put it into words.

Labelling

It is important to become familiar with the vocabulary that informants use when describing and discussing harassment. Calling something by its real

name is important and for these informants the language they used was revealing. Rarely, when these informants tried to put a label on harassment did they use the words sex-based or sexual harassment. It sometimes seemed the informants expended great effort to avoid using those words. Words used by informants to label the harassing event included, the behaviour would 'belittle' or 'intimidate', the behaviour was 'angry', 'quite heated', and included 'shouting', 'giving me a hard time', or a 'complaint'. Bess struggled with the labelling of harassing behaviours.

> *Bess: ... you probably won't like me a lot. I guess ... some experiences and they vary from anything that was fairly innocuous to being dragged into bed by a patient, and I think that a lot of sexual based harassment and the innuendo that surrounds is ... overrated. I don't know whether it's actually harassment, I guess there wouldn't be a day go by that there's not ... something that you could either class as harassment or as a, I don't want to say over friendly, because, I'm trying to think of a more appropriate word, I guess, that is not some slight or innuendo, slight innuendo from another, from a male or a female for that matter within the workplace about some sexual issue or towards yourself in some sexual context. (Regional/rural, hospital-based, manager, an RN for 15 years)

Most informants never used the term 'sexual harassment' or 'sex-based harassment'. Some of the words they chose to use indicated that they usually wished to minimise the event.

> *Lucy: ... only *really just very small* (with the patient) ... it *wasn't a major sort of incident* although in itself *it wasn't good* ... (patient touching her leg or 'backside'). (Regional/rural, community-based, an RN for 7 years)

> *Lucy: You realise that what happened was *sort of a sex-based sort of thing* (patient's husband kissing her). (Regional/rural, community-based, an RN for 7 years)

> *Bess: I don't think I should have to put up with *that type of talk* ... (Regional/rural, hospital-based, manager, an RN for 15 years)

> *Jane: I had two *incidents* over a very close period of time ... (Metropolitan, hospital-based, an RN for 15 years)

Helen is a director of several health facilities, and she too, fails to put the label sexual harassment on inappropriate behaviour, choosing similar words to other informants.

> *Helen: Once again, I thought, well, if you're talking about *something like that*, which for some people is very threatening and *could be a personal thing* ... (Regional/rural, nursing home, manager, an RN for 10 years)

Lucy described washing an elderly patient's penis, who wanted his foreskin retracted and his penis washed 'very well'. At interview she asked the interviewer, "but probably that's...?" In other words she did not have a label for it, she looked to the interviewer hoping it would be labelled for her. The implication here is that she hesitated to label this as harassment. To Lucy was 'it' something else and not harassment at all? Did the label harassment not occur to her, was she afraid of the label 'harassment' or was there another explanation for the absence of calling harassment by its name?

Some of the problems that can occur between the harassed and the harasser when the proper label is not applied to harassing behaviours were revealed

when Bess described her evasive strategies as she made sure that there was a desk between her and the 'invasive' doctor. She hoped the use of this kind of 'body language' would indicate to him her lack of appreciation for his behaviour. Bess explained choosing this strategy to communicate displeasure or discomfort with harassing behaviour rather than a more direct form of verbal communication:

> *Bess: I don't think that I have ever said to him 'look don't do that! You stay there and I'll move back', I don't think I've ever done that. I guess inadvertently I've put an object between us, like a desk at the nurses station itself, I'll walk around it and lean against it so he can't ... so there is something between us ... I guess that body language wise, maybe, maybe so, but I certainly haven't directly approached him with that issue, no. (Regional/rural, hospital-based, manager, an RN for 15 years)

And in this situation Bess labelled the harassment as 'that issue'... again evading the label harassment.

Jocalyn, who was fairly articulate, described the 'touching' performed by a wardsman. During the interview, she returned to a particular incident of harassment she had alluded to earlier in the interview. She implied, in this particular situation, the harassment was physical touching which had occurred several times. But, exactly what the behaviour was remained unclear. Throughout the interview she was unable to put words (labels) to the behaviour. It became apparent that Jocalyn would need to be pressed for particulars. She was asked, did the wardsman use his hands or his body? Did he pat, rub, caress? What part of her body did the harasser touch? Even this articulate nurse was unable to be very descriptive or precise in exactly what the behaviour involved... but, importantly, she was absolutely certain it was unwanted and that it was of a sexual nature. She avoided labelling or articulating what actually happened.

> *Jocalyn: ... every time he was on shift it would happen ... (he) would go out and wash his hands, and that's when he'd do it. Or he'd do it also in the shower, you know, when you were taking your patient to the shower, in a very confined space, whereas, you know, other wardsmen wouldn't do this sort of thing ... it was never really anything that you could grab hold of and say, 'Well, God, that was disgusting, or ...' It was always, you know ... it wasn't mild, it was (-) but it was constant and it was always there, but it just, you know, sort of just a regular thing. You just sort of got used to it. It was usually like, um ... I shouldn't say that (-) - a lot of the young ones wouldn't do it, and then a lot of the older ones would, and then some of the young ones would ... (Regional/rural, hospital-based, an RN for 16 years)

This is another example of the unwillingness or inability of an informant to call sex-based and sexual harassment by its name.

Jane described an encounter with a patient's husband (alone with her in an elevator) who put his arms on her shoulders and invited her to come to his home. In another incident a female patient deliberately placed Jane's hand on her breast in a provocative way. Yet Jane was not sure whether these incidents were 'relevant' or not? Following her description of the 'incident' with the female patient Jane questioned this.

> *Jane: So, I don't really know if that ... what you'd call that, but it did make me feel very uncomfortable. (Metropolitan, hospital-based, an RN for 15 years)

Amanda described harassment as 'giving me a hard time' when a series of harassing episodes had been dealt with officially by her employing

Figure 6.2 Recognising harassment

- *Invasion of space* - when someone corners you or enters your personal space
- *Confirmation* - when another person/colleague recognises and confirms your suspicions of harassment
- *Lack of respect* - when past or present behaviour of the harasser is perceived to be disrespectful
- *Deliberate nature of behaviour* - when harassment is intentful, planned, 'orchestrated'
- *Perceived power or control* - when circumstances put the harasser out of the control of the harassed organisationally, hierarchically, physically
- *Overly friendly behaviour* - behaviour that is considered too friendly, or falsely friendly
- *Sexualised work place* - when innuendoes, explicit jokes or pictures are common in the workplace
- *No benchmarks, surprise* - no preceding action or clues

Invasion of space

One of the clues or conditions available to be able to assess that something is amiss and that it is clearly or somewhat problematic is the 'invasion of space'. Descriptions used by the informants always included the notion that this behaviour was unwanted, unwelcome and unreciprocated. For some informants the invasion was an actual touch, though it was more often an invasion of personal space. For others it was a sense that someone was 'leering'.

Bess and Jane were clear when using the expression 'invade' or 'invasion' to recognise harassment. Bess described a particularly offensive General Practitioner who 'leers' or 'invades' her space and proceeded to touch her or make her feel like he was 'undressing' her by the way he looked at her. Bess used some form of the word 'invasion' several times in her interview when

trying to recognise harassment. This word seemed to be her best description of a forewarning that harassment was imminent. She struggled to describe why many other doctors to whom she felt quite close and with whom she worked quite regularly, might touch her and yet she was not in the least offended (an example of how important the person and the context is when an RN is trying to recognise harassment). She described a doctor who did not invade and why his behaviour was acceptable.

> *Bess: ... but, um, I don't know why ... I don't know why ... Can't tell you I'm sorry. I certainly don't feel invaded, I don't feel affronted by him in any way ... it must be his body language or the way we interact, but it doesn't offend me. (Regional/rural, hospital-based, manager, an RN for 15 years)

'Invasion' may be an impression of being too close or 'in your face' or imposing into the RN's personal or physical 'space'. Informants had different ways of describing invasion. Jane described a patient's husband and the way he would move physically too close to her.

> *Jane: I used to find him quite threatening, and I didn't particularly like it when he'd stand very close to me, or you'd be sitting on the bed talking to his wife about something and he'd come and sit right on top ... not on top of you, but very physically close to you, and I found that quite threatening. (Metropolitan, hospital-based, an RN for 15 years)

Sometimes invasion was not restricted to personal space, but extended to the physical environment, such as an office or work space. Amanda described such a situation when a person had been leaving her unwelcome 'notes'. The harasser had actually entered her office to leave a note inside, instead of slipping it under the door.

> *Amanda: They'd gone beyond slipping paper under my door, they had actually been in my office, invaded my own space. (Metropolitan, community-based, an RN for 24 years)

Even the lone male RN informant was able to comprehend this invading behaviour described by the female informants and interestingly used the same word, 'invade'.

> *David: Yeah, there's a couple of particular people at work who ... I can understand that ... if you're a woman that they'd make you nervous even just being in close proximity ... you know, they invade people's personal space and you see the girls, cringe and ... it might be just putting an arm around them ... (Regional/rural, hospital-based, manager, an RN for 13 years)

Confirmation

Informants described situations where they did not seem to trust their own perception of harassment and they did not acknowledge the harassment until it was recognised and confirmed by someone else. A good example of this was when Bess described her feelings when confronted by a particular doctor. She had a nurse colleague who felt the same way as she did when confronted by the same doctor.

> *Bess: The GP makes her skin crawl just as much as it does me. (Regional/rural, hospital-based, manager, an RN for 15 years)

This could support the notion that it is sometimes necessary to acquire 'confirmation' from someone to recognise harassment. In fact Bess intimated that she did not confront a cleaner who was harassing her until she heard complaints from other staff members. In this situation she recognised harassment only when others complained and it was through

their complaints that she was enabled to acknowledge and recognise harassment on her own.

> *Bess: But I had had complaints from staff members so it was something I needed to address with him. Well, even for my own satisfaction, of course. (Regional/rural, hospital-based, manager, an RN for 15 years)

Informants described how younger nurses would look to them as more experienced nurses for some confirmation of harassing behaviour. The younger nurses had asked the informants if they too found certain behaviour as a 'bit off', a process which seems to be associated with confirmation. It is apparently not essential that confirmation come from other females or RNs. Informants described the gratitude they felt when other colleagues in the workplace confirmed their observations about a harasser's behaviour.

Confirmation can be an 'early warning system' that is occasionally employed between co-workers in some hospitals. Younger, newer or less experienced RNs are warned that they should be cautious or behave in certain ways in the presence of certain health professionals or colleagues.

> *Mary: ... right in the beginning of the nursing education at the hospital we were warned that our medical superintendent was an interesting personality and the way to get on with him was to smile a lot. (Metropolitan, community-based, an RN for 13 years)

> *Mary: Um, I think within the females, someone had said to me, 'Don't get near that guy, he's a sleaze bag,' you know? 'He's sleazy,' or 'he's strange,' ... there was an underground of ... female nurses, would say to each other, 'He's just a sleaze bag.

> Look at the way he looks at you ...' (Metropolitan, community-based, an RN for 13 years)

Lack of respect

Informants described another benchmark for recognition as a general demeanour of disrespectful behaviour or attitude on the part of the harasser. Informants seemed to be saying that they believed that harassing behaviours could easily move from the covert or subtle 'minor', words, gestures, insinuations, to the overt 'major' touching, cornering, accosting behaviours. In other words, the disrespectful demeanour could move easily and quickly into more overt behaviour. RNs seem to anticipate the disrespectful person moving to the next stage of gender or sex-based harassment, that is loud, patronising, belittling, and discounting behaviours. In patient care situations, errors, disagreements, differing viewpoints and agendas can set the stage for personal and professional conflict. When mutual respect is absent or negligible, inappropriate behaviours sometimes escalate. Jenny described a doctor's behaviour:

> *Jenny: ... he doesn't treat any of us as if he respects us ... we're there to do what he says ... it's just his whole attitude towards the nursing staff in general, and everyone used to complain about him ... (Metropolitan, hospital-based, an RN for 5 years)

A good example of how confusing sexual harassment can become is Jocalyn's description of a doctor who failed to demonstrate a respectful and collegial demeanour. In fact, this clue or precursor to harassment actually occurred late in this particular harassing situation. Jocalyn described one (married) doctor who had asked her for a date and she had refused. His first noticeable behaviour was touching and brushing up against her, but following the refusal, turned into 'aggressive' harassment. His behaviour upon being rejected became a problem for her as he became 'difficult to work with'. He

would ignore her, refused to discuss patient problems with her and generally treated her with disrespect.

> *Jocalyn: Well, this doctor, married, he'd asked me out ... and I'd said no, and from then on that's when it sort of started. He'd just try, ... touching, mainly, when I didn't respond to that, I'd just ignore it, cues like that, he just became really aggressive, I found that I couldn't work with him ... just very difficult to work with, ... make your life on the ward hell, just ... 'I asked for this to be done and it wasn't done,' and it was done ...just totally ignoring you. You'd try to ... discuss a patient's care with him and he'd just totally ignore you, or wouldn't even listen to you, just walk off. (Regional/rural, hospital-based, an RN for 16 years)

Some disrespectful behaviour was demonstrated more generally, was less personal and not particularly directed towards one individual. Several informants described the 'prima dona' medical officer who displayed an unwelcome, loud and belittling approach to all staff, in general.

Interestingly, David, the one male RN informant, acknowledged his experience in the clinical setting. He believed he was given additional respect from the medical practitioners because he was male. It was an advantage to be male David thought, which would tend to confirm the female RNs' concerns about lack of respect in the workplace. David saw some similarities between proving himself as a male RN in a highly female occupation and women struggling for legitimacy in the workplace. David seemed to confirm this aspect as an issue.

> *David: ... doctors can usually talk to me about problems and they know that I know what they're on about and that type of stuff ...they're much more ready to take advice from me than maybe from one of my colleagues who's probably just as capable

> ... because of the sexual harassment thing, they know that they don't have to be as wary of me in social interaction as they do with my female counterparts. (Regional/rural, hospital-based, manager, an RN for 13 years)

Deliberate nature of behaviour

Informants noted how a harasser would pick his time, context and his target. In other words, the behaviour was 'premeditated', it was not 'accidental'. Jocalyn was quite clear that a wardsman who harassed knew exactly what he was doing. Once she became 'conscious' or recognised the behaviour she was very clear that his behaviour was deliberate, conscious, planned and careful.

> *Jocalyn: At first it ... appeared to be accidental, but it wasn't accidental, because after a series of the same sort of gestures you kind of get the picture that ... it was premeditated. (Regional/rural, hospital-based, an RN for 16 years)

Perceived power or control

Informants described power, either physical or organisational, and control or controlling behaviour as closely linked to harassment. Jocalyn described how a wardsman had both kinds of power and 'control' over her work setting. His physical strength was part of his job and contributed to making her job possible, or certainly easier. His physical strength was used in lifting patients and dealing with uncooperative, difficult to handle, sometimes large patients. This same wardsman also used controlling behaviour as he could delay or speed his arrival to her unit depending on her 'cooperativeness'. Losing his cooperation would negatively impact her work and the work of colleagues working with her.

> *Jocalyn: He had control completely over me basically. He'd come when he wanted to come and if he didn't want to come, he didn't come ... He had complete control over the situation ... cos

> I relied so much on him because of his physical-ness. I relied on that completely and he knew it ... (Regional/rural, hospital-based, an RN for 16 years)

Although on any organisational chart the wardsman would be reporting to the RN, his cooperation was important to efficient work practices. Controlling behaviour as described by Jocalyn is not unusual in some work situations. The wardsman as described by Jocalyn actually seemed unusually powerful to her because of his controlling behaviour as well as his physical power. Power or control could emanate from sheer physical size, and may not necessarily be associated with (conscious) controlling behaviour.

Several informants gave good descriptions of the various kinds of power, not restricted to controlling behaviour or physical power, but including organisational power as well. The psychiatric or old 'Fifth Schedule' hospitals were described by several informants as heavily male dominated with males in most positions from 'charge' positions up to the highest levels of the organisation. The sense of powerlessness was evident in many responses from RNs harassed in this environment. When Helen considered lodging a complaint she described the response from males further up the organisational chart from the harasser.

> *Helen: Yeah. 'Come on, that's Tony, you know. You can put in a complaint if you want to, but, you know, he's a bloody good bloke. Do you know how long he's been here and what he's been doing ...?' So ... you really felt disempowered as to, well, 'How hard am I going to make it on myself if I take it any further?' ... but it would have certainly made it a lot more difficult because of the 'old boys' network', and Tony was one of the 'old boys'. (Regional/rural, nursing home, manager, an RN for 10 years)

Overly friendly

For another informant a warning or precursor to sex-based or sexual harassment was an overly friendly person. Jane's internal antenna extended when a patient's husband was noted by Jane and other co-workers as overly friendly.

> *Jane: ... he was always trying to ... make friends or develop relationships with the nursing staff, and he used to try and be everyone's pal ... (Metropolitan, hospital-based, an RN for 15 years)

And Angela found the wardsmen in her workplace too demonstrative.

> *Angela: ... the harassment was quite strong and ...over a long period of time. I would not only get comments made, but the wardsmen would actually physically touch my person, even though I'd ask them not to ... if I was sitting in the chair they'd come up behind me and ... half give me a cuddle, and ... rest their hand on my shoulder, or whatever ... It was actually not overtly sexual but I felt really uncomfortable, had told them to stop and they didn't, basically. (Metropolitan, hospital-based, an RN for 8 years)

Sexualised work place

Several informants recognised harassment as imminent or likely to occur in what the literature labels a sexualised workplace. The absence of respectful inter-professional relationships, the presence of sexual jokes and innuendoes, sexist behaviour or remarks, and overly friendly, physical touching would be hallmarks of this category. Michelle described some of the characteristics of a sexualised work place.

> *Michelle: ... it was very much 'nudge, nudge, we know what we're up to,' ... they just never knew when to stop, until you just got up and walked away because you just got fed up with it. And it was always males, you know, no females would do that ... (Metropolitan, community-based, an RN for 13 years)

Occasionally informant's work situation found them working alone in an office. They described the isolation they felt sometimes as a lone female amongst an almost all male organisation, an example being an occupational health and safety nurse who noted the physical isolation associated with a single person office.

> *Amanda: ... you are just so vulnerable to so many people and ... (-) Some of them see you as fair game because you're isolated, you are a female in an all male environment often. (Metropolitan, community-based, an RN for 24 years)

No benchmarks, surprise

There are other times, particularly when a trusting relationship is assumed or has been established, that there are no clues or benchmarks that precede the incident or episode of harassment and it is only during the (surprise) incident that harassment is recognised. Invariably the RN describes the incident as a surprise; she is 'stunned'.

When a patient pulled one informant onto his bed, it really took her 'by surprise' and she did not anticipate or recognise harassment coming. When a patient's husband tried to kiss another informant she was 'stunned' and ran from the area. This suggests that informants do not always recognise harassment before it happens; in the above two examples the informants certainly did not. This may mean that sometimes a harasser does not send signals, does not invade, seem disrespectful or have any obvious power or

control. This suggests that for these RN informants, not all classifications of harasser send warning signals.

In both of the incidents where informants were surprised, the harasser was a patient or a patient's family. The element of trust and role definition would seem important in both of these situations. In her role the nurse is firmly 'in charge' of the interaction and unprepared for unwelcome or unwanted sexualised behaviour which may change the social/professional interaction between roles.

The absence of clues or benchmarks that alert RNs to recognise harassment can take another form. As opposed to sudden, unexpected behaviours, harassment can take an insidious form. Slowly escalating behaviours can be elusive to pin down and recognise. Jocalyn described several incidents with a wardsman that were unlike harassing situations described by others. She was in a new job, in a new role and 'concentrating' on that role, not really recognising the gradually escalating harassment from a wardsman. She said six months had gone by before she recognised his behaviour as sexual harassment. Jocalyn described the length of time it took for her to recognise the harassing behaviour and something about its characteristics.

> *Jocalyn: I didn't recognise it. I don't know why ... I should have been more attuned to it - probably because I was new and I just wanted to fit in, I suppose. ... one particular wardsman was actually sexually harassing me and it took me a while for it to click - 'Hey, this isn't right, something's wrong here.' And just ... from joking around, like, as a group ... then for them to become really quite offensive - that sort of thing. And then ... just the different comments and the touching and ... when you'd be lifting someone, he'd sort of come up and rub against you ... (Regional/rural, hospital-based, an RN for 16 years)

The various clues or benchmarks described by these informants provide some insight into how RNs recognise harassment. One problem with the list is that sometimes there are no clues. Harassment can be completely unexpected or slow and insidious. Also the problem of recognition is compounded because, for these informants, harassment has no label.

Classification

Informants identified not only a variety of harassing situations but also a variety of harassers. It is quite clear there are several different kinds of harasser. For the informants in this study the descriptions they use seem to fall into several categories or classifications. In order to understand harassment better it is helpful to identify some common characteristics of harassers and to see how this information is used by these RNs in an episode as harassment.

When, from the previous sections labelling and recognising harassment seems somewhat more difficult for these informants, describing the harassers and classifying them seems to be easier. Words and descriptions are more vivid and a clearer picture emerges. This suggests the informants may be more comfortable, or able to draw on a vocabulary that depicts what they are seeing, hearing and feeling, in classifying harassers. Nurses depend on a range of vocabulary when describing patients, and this may assist them when describing classifications of harassers.

Figure 6.3 outlines the different types of harasser identified by the informants in this study.

Figure 6.3 Classification of harassers
• Obvious sexual harasser
• Sex-based (gender) harasser
• Unexpected (trusted) harasser
• Mixed behaviour harasser
• Same sex harasser

Obvious sexual harasser

The obvious sexual harasser does not harass unexpectedly. There are many signals that allow RNs to know what to expect with this harasser. This harasser invades personal space, follows RNs into smaller, more intimate physical space, touches without invitation. The harassment is overt, not subtle and the informants did not doubt that the behaviour was inappropriate and they seemed confident when describing it. The informants described evasive strategies to deal with this harasser. The descriptive words would often include words like 'sleaze', 'cocky', or 'God's gift'.

Bess notes a doctor who 'invades' and 'undresses' her (by his look) and was definite about this behaviour as harassing. She indicated that he never touched her, only that she found him 'very, very difficult'. She proceeded to describe her evasive strategies to avoid being near or with him. She felt 'cornered', that he was 'leering' and as a result she was 'terribly uncomfortable'.

> *Bess: ... so there's one doctor who invades your personal space all the time. And with him I find it very, very difficult ... I feel as though he is undressing me every time he looks at me ... I find him very hard to take ... it just repulses me and I always feel

> invaded by him and I'll know that I always go out of my way not to do a round with him not to associate with him ... I always feel that he is standing too close to me ... if I back away then he will take a step forward and I've been in a corner, I've been cornered by him. I mean I find that terribly uncomfortable ... and I always feel as though he is leering and you make sure your top button is done up ... (Regional/rural, hospital-based, manager, an RN for 15 years)

Informants noted how deliberate and careful some harassers usually were. Harassers would select a time when there were either no witnesses or only patients nearby that were confused or disoriented, and thus poor witnesses.

Michelle described a psychiatric patient who ended up 'stalking' her, following her home and frightening her. Initially that harassment began with a phone call.

> *Michelle: ... I don't know (how), but he got my phone number at home and rang me up at home and said would I like to go out with him, and I said to him, 'Well, no, I wouldn't, actually, because you're a patient at the hospital and I'm a nurse and it wouldn't be the right thing to do, and, in any case, I'm in another relationship, so, no ... And he pressured me a lot and was quite intimidating towards me ... (Metropolitan, community-based, an RN for 13 years)

Amanda identified a doctor, patient and co-worker, who harassed. The doctor would touch and corner her, the patient wanted a kiss, and the co-worker had sent unsolicited 'notes'. Somehow these all seem to fall into the category of the obvious harasser because of their invasive, clearly inappropriate behaviour. They are not subtle. First the doctor:

> *Amanda: ... this one doctor in Outpatients, who ever really did physically touch you, physically touch, and really corner you in a room on your own in Outpatients. (Metropolitan, community-based, an RN for 24 years)

Then the patient:

> *Amanda: Well, he put his arm around my waist, pulled me to him and said, 'A kiss would really make him feel better from such a pretty young lady.' (Metropolitan, community-based, an RN for 24 years)

Finally, the coworker:

> *Amanda: ... the notes started coming back again. Um, this person thought I was lovely and I was ... that sort of thing, and that was hard - that's harassment of the worst kind. It's anonymous, you don't know where it's coming from. The fact that someone's gone to these incredible lengths to cut cards and pictures out, um, and put them in my office ...it was awful, it was just awful. You've got ... it's just sick. (Metropolitan, community-based, an RN for 24 years)

Sex-based (gender) harasser

The sex-based/gender harasser is closely associated with and generally described as disrespectful of women and nurses. This type of harassment is usually verbal, and associated with inappropriate expressions, descriptions or labels for the professional setting.

> *Mary: It was always verbal, to me it was generally verbal as in sort of, you know, teasing or personal comments about me or

> my face or my figure or talking about me personally when I was in a given situation in a professional capacity. (Metropolitan, community-based, an RN for 13 years)

Addressing the staff as 'honey', 'luv', or other overly familiar, sexist terms is typical of this classification of harasser. It can also involve a raised voice, mocking, patronising behaviour, often in front of other staff, families or patients. This harasser can use his physical strength or size to intimidate or harass. Informants described the intimidating, patronising behaviour of sex-based (gender) harassers they had encountered. Informants usually described lack of respect for nurses in general, often noting they did not feel singled out by this kind of behaviour. This harasser often treats RNs in a cavalier fashion, for example, by walking away or chosing to ignore them when one of them questions a planned treatment or approach to patient care or assessment. The harasser does not particularly single out a particular RN, but is generally disrespectful.

Bess talked about similar disrespectful behaviour from a cleaner. She described comments, made almost in passing, by the cleaner to Bess, a nurse unit manager. The cleaner's comments were not only disrespectful but also are classified as gender, sex-based harassment. When asked to be specific about remarks from the cleaner Bess says:

> *Bess: From anything like 'you've got a smile on your face, you must have got some last night' to 'that skirt makes your butt look a bit bigger than it should'. (Regional/rural, hospital-based, manager, an RN for 15 years)

Paula discussed conversation she had with colleagues from other near-by theatres. She confirmed the prevailing sexualised atmosphere in some workplaces by her comments.

> *Paula: ... they seem to have some enormous problems with surgeons because they're the gods that earn the money: 'If the god's not happy, I can lose my job, so I have to put up with all these tasteless remarks'. And I think that's the type of sexual harassment we probably come up against more than the touchy, feely or the whatever. I think it's the lewd comments and the very tasteless remarks. I'm all for a bit of dirty joke too, but I think when someone walks into a gyny theatre and a woman's got her legs up and someone says 'Come on honey, get all soft, I'm coming in', that type of thing which is the sort of thing you hear that happens in some areas. I think that to me is probably one of the worst types of sexual harassment because it's not actually directed at anybody but you know jolly well you're expected to hear it and you're expected to take it ... (Metropolitan, hospital-based, an RN for 14 years)

Mixed behaviour harasser

Some harassment includes several characteristics from other classifications and can be described only as mixed behaviour. Jocalyn described the behaviour of the wardsman who did not limit his harassment to offensive jokes but would include physical touching and rubbing up against the harassed. According to Jocalyn the wardsman also told 'really quite offensive' jokes.

> *Jocalyn: ... from joking around, (to) he'd sort of come up and rub against you ... things like that. (Regional/rural, hospital-based, an RN for 16 years)

> *Helen: It was ... the suggestive remarks, the swearing, the touching, the patting on the bum, 'Come on get your big butt out

> of the way while I get past ...' (Regional/rural, nursing home, manager, an RN for 10 years)

Unexpected (trusted) harasser

Many informants described harassment from someone completely unexpected, usually associated either with someone who is trusted, or a patient or a patient's family. The harassment is usually a physical assault, kissing, grabbing, touching. Lucy talked about the more personal nature of home nursing and the trust that is established with patients and families. The nurse enters the patient's home as a 'guest'. She described a patient's husband who 'invites' her to see his home brew in another part of the house, and trusting him, she obliges.

> *Lucy: ... (about a patient's husband) and I think nurses are also trusting, and he, just started saying, 'Oh thanks for looking after my wife, I'm really grateful' and sort of grabbed me and started kissing me. (Regional/rural, community-based, an RN for 7 years)

Informants also described patients who touch them and probably touch other nurses. Lucy intimated that when patients abuse that trust with harassing behaviour nurses become wary.

Interestingly, most examples in this classification were patients or members of the patient's family. There seemed to be a generally matter-of-fact way to deal with the patient who was inappropriate. Although some informants were completely thrown by a patient's behaviour, it was usually when the informant was younger and less experienced.

Not all unexpected harassers are patients or patient's families though. Jocalyn described a different situation with a colleague, rather than a patient or patient's family. The behaviour was harassing and unexpected. It was a

gradual, slowly escalating behaviour pattern and the full recognition was equally slow in coming.

> *Jocalyn: Because, like me, they just didn't even think about it because it was such a busy ward and it happened ... smoothly ... at first, till he just did a total ... just turned it up, really, and hit everyone with it, and all of a sudden we went, 'Hey, what's going on here?' And people then started asking questions. (Regional/rural, hospital-based, an RN for 16 years)

Same sex harasser

The 'same sex harasser' classification shares some of the characteristics of the 'unexpected (trusted) harasser' but it is clearly different in that it is unwanted sexual attention from a member of the same sex and usually generates some of the associated homophobic issues. Informants describe their surprise and concern, sometimes wondering either about their own sexuality or if they had encouraged the behaviour.

Jane described a female patient who surprised her while giving the patient a back rub.

> *Jane: I don't know if it's sexual harassment or not, but I had a lady patient I was looking after and I was doing her back rub and she grabbed my hand and put it on her breast, and, yeah, I was a bit stunned. She grabbed my hand and put it on her breast and said, 'Can't you feel my heart beat? Can't you see what you're doing to me?' (Metropolitan, hospital-based, an RN for 15 years)

During part of Carmel's career, she was a 'straight' RN, but more recently she has been a lesbian. She identified the harasser for lesbians as more commonly female, and similar to the male harasser by having somewhat of a disrespectful attitude.

> *Carmel: Certainly as a heterosexual woman, no matter whether as a registered nurse or as a student nurse ... I think you're fair game ... that the harassment is much more open and evident. I think, certainly, working as a lesbian registered nurse in a senior position, it was much more covert, as against the overt male responses to you ... the negative values and attitudes which are held by other women towards lesbians is far, far more damaging than the attitudes and values which are held by men towards lesbians. (Metropolitan, nursing home, manager, an RN for 29 years)

Angela, a lesbian, provided some articulate descriptions of her experiences with harassment with a homophobic connotation.

> *Angela: ... people started making comments ... about being a bloody dyke [laughs] and, um ...
> *JM: People as in...?
> *Angela: My colleagues. It wasn't medical staff, it was all nursing staff and auxiliary staff, like wardsmen, and yeah, particularly nursing staff and wardsmen ... my nursing unit manager was quite offensive, her comments, her treatment of me, my rosters, all had to do with the fact that I'm a lesbian, so ... And I couldn't prove that at the time, but I knew that's where it was coming from. (Metropolitan, hospital-based, an RN for 8 years)

Responses to harassment

The survey and the literature support the large number of emotional or hidden and physical or outwardly apparent consequences of harassment to the recipients. Figure 6.4 shows that these characteristics or responses fall into two major classifications, the emotional, covert, less obvious and the overt, more visible, physical responses.

The informants had little trouble finding the vocabulary to express the sequelae of harassment adequately. Since a major part of the work of RNs is in describing patients and their symptoms, this articulateness is not surprising. This part of their interview was quite different from those areas where they were fumbling in their attempts to discuss how they labelled harassing episodes.

Figure 6.4 ***External, physical and internal, emotional responses to harassment***
External, physical responses
flight (and fright)
tearful
squeaky, high voice
screaming
physically threatened
feeling weak
blushing
Internal, emotional responses
knotted stomach
embarrassing
scared stupid
frightened
totally mortified
nervous wreck
stunned
being overrun
resentment
insulted
degraded
angry
threatened
isolated
'feeling dirty'

The survey that preceded these interviews identified two of the most common responses or (re)actions to harassing situations. Ignoring the behaviour or avoiding the harasser were common strategies for the RN survey respondents. The implication is that when confronted with unwanted, inappropriate behaviour the tendency is to ignore it or avoid it or as Jenny says 'finish the whole situation'. Ignoring the behaviour or avoiding the harasser can take two forms, the physical or the emotional distancing.

External, physical responses

The responses described by many of the informants are in keeping with the emotional and psychological responses described not only in this survey questionnaire but also in the literature on harassment. The informants here go further, describing physical signs and symptoms as well and almost to the same degree as internal, emotional (and probably less observable) responses. The informants' nursing education includes describing and documenting physical and psychological signs and symptoms which probably assist in providing them with the unique vocabulary necessary to describe these responses. Although some informants were not forthcoming or even at all, regarding their reactions, two examples, one of 'fright and flight' and one of 'scream'(ing), indicate a certain level of physical, external response.

Physical reactions or responses include screaming or running away. When harassed by the patient's husband, Lucy ran out of the basement area, typical of a 'fright and flight' reaction. (Interestingly, she also immediately started to 'forgive' the harasser and blame herself). Some informants used expressions like it 'scared me stupid at the time' and described being very surprised and unprepared for the harassing behaviour. They described themselves as naive, young, innocent, protected, and never expecting such behaviour in the workplace. Although some of these situations happened early in their careers, the situational dynamics have stayed with them. Jenny noted feeling

physically threatened by a taller 'beefy' doctor. She felt 'a bit frightened when he was raising his voice at me'. She described her voice getting 'all wavery'.

> *Jenny: ... you get that kind of knotted feeling in your stomach, and you, think ... 'I wish this was happening to someone else,' (laughs) but ... that's where I think men do have an advantage or women that have that sort of deeper timbre in their voice have an advantage over the rest of us because they are able to, even if they're not feeling, calm or in control, they've still got that kind of presence in their voice, whereas if you go all wavery and your voice gets a bit squeaky ... sometimes it's hard to not get tearful, and I've found with a lot of my colleagues that women have a more emotional response. (Metropolitan, hospital-based, an RN for 5 years)

Jenny talked about the advantage men have in that anger seems to make them more in control, a 'sort of reserve' that is empowering when they are confronted with an angry person. For her, anger makes women feel 'weak'.

> *Jenny: I mean, I've never seen a man so frustrated that he cries. Well, not in a work setting anyway. So in that sense they ... can retain that, sort of reserve, and that gives you power because if you know you're going to cry then you tend to want to finish the whole situation ... (Metropolitan, hospital-based, an RN for 5 years)

Internal, emotional responses

Informants were able to articulate a significant number of internal responses as depicted in Figure 6.4. The overwhelmingly negative descriptions left little doubt about the extent of these informants' discomfort when confronted with harassment. The internal or emotional consequences were

enormous and were vividly recalled, despite sometimes lengthy periods of time that had passed since the episode that produced them.

Lucy does not say she was frightened when accosted by her patient's husband, rather she implies that she was surprised and uses the word 'stunned'. This suggests that Lucy was probably so surprised (and trusting) that she did not or could not draw on other strategies. The literature and the survey associated with these interviews suggest that, in retrospect, Lucy may have known she should calmly say, 'I think this is inappropriate behaviour,' or, 'I want this behaviour to stop'. However under the circumstances in which she found herself, this more assertive response seems like an unreasonable expectation.

Mixed external, physical and internal, emotional responses

Several informants described an overwhelming, physical and emotional reaction. Not all responses were clear, or one dimensional. Some informants described a form of mortification or almost being beyond a response. Mary gave a description of her more generalised, non-specific reactions to harassment.

> *Mary: And I would never have an appropriate response and I guess the more uncomfortable and the more shy and embarrassed I was about it, the more I would be I guess a suitable target for the teasing. I was totally mortified - to me this was very embarrassing, ... and that was just totally, totally embarrassing, I'd be a nervous wreck after this. (Metropolitan, community-based, an RN for 13 years)

Jenny too, made a generalised comment about passively accepting unwelcome behaviour and alluded to the more aggressive male role and the more passive female role.

> *Jenny: Well, I think sometimes it's more subtle than the examples that I've given. I think sometimes it's just about, men being assertive and confident and, a female nurses still adopt a more passive ... an accepting sort of role, so I think sometimes we're ... overrun when we shouldn't be ... (Metropolitan, hospital-based, an RN for 5 years)

The most eloquent description of the consequences of harassment came from Angela.

> *Angela: The feeling of living with harassment is like it's you against the world. It is just the most amazing isolation, especially if the harassment goes on over an extended period. From my experience anyway, it was just horrendous. It ...yeah, it's like you're a total entity cocooned and you can't get any help from anyone because nobody wants to know, you know. It's devastating. It really is quite soul destroying. (Metropolitan, hospital-based, an RN for 8 years)

Responses were complicated by the fact that for some harassing incidents, responses were immediate, while for others responses were delayed. If harassment needed to be confirmed by others or if the harassed was unsure whether or not the behaviour was inappropriate, it would stand to reason that the extent or intensity of the response would vary. Sometimes an indignant response developed as recognition slowly occurred.

Rationalisation

The informants have a plethora of rationalisations for harassing behaviours and their own actions or lack of action to harassment. Figure 6.5 summarises some of the rationalisations used by harassers to explain their own behaviour as well as the behaviour of the harasser.

Figure 6.5 Rationalising the actions or inactions of the harassed and the harasser
• Expected role behaviour 'Nurse', 'Patient', 'Male' • Self-flagellation Self-blame, stupidity • Inaction 'Don't make waves', 'it's not my problem' denial • Emotional illness jealousy, 'mental' • Assertive

The informants seem to have no problems when discussing why harassing situations occur. Informants spoke easily and clearly about how they explained their own behaviour as well as the behaviour of the harasser. Unlike the difficulty they had in calling sex-based and sexual harassment by its clear and correct label, the informants explained with clarity their interpretations of *their* reasons for the harasser's behaviour and/or their own response.

Expected role behaviour

Patients are expected to behave in unexpected ways. RNs are inculcated with the notion early in their undergraduate study that patients are capable of any number of sometimes bizarre behaviours due to the stress of their illness and anxiety. RNs are usually encouraged to depersonalise these behaviours and are usually able to employ different and effective strategies to deal with unusual patient behaviour including harassment. Lucy described this well.

> *Lucy: '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' ... (Regional/rural, community-based, an RN for 7 years)

Informants commented on how some patients encourage each other to misbehave and tease, particularly in a ward situation. Harassment is expected from them... but it was not very serious according to most of these informants and they did not seem to regard it as a significant problem.

> *Paula: ... you can always think of the young guy who ran his hand up your leg, but again they were always things you'll cope with. Poor patient - they're bored, they're this, that or 'Either cut that out or you'll get the cold washer treatment'. (Metropolitan, hospital-based, an RN for 14 years)

One of the themes associated with rationalising harassment was the notion that unacceptable or unwelcome behaviour was to be expected from males. Males, according to these informants, are expected to act in certain ways. The idea that some males seem to feel they had a role to play and were merely fulfilling that role was apparent to several informants. Bess described a hospital cleaner who told her 'that skirt makes your butt look a bit bigger than it should'. She described him as a person who 'I don't think he could help himself'. Bess tried to explain the behaviour of the cleaner.

> *Bess: Whether it was his personality that ... that's what he thought of women, or I don't think that he did it to men. (Regional/rural, hospital-based, manager, an RN for 15 years)

Generally these informants believe that most harassers would be nonplused if confronted with a complaint, since for these informants the harassers were merely acting according to their (male) role expectations. To some of the informants, sexual harassment may have different connotations for different

age groups. What some RNs found unacceptable, the 'older' generation might ignore as it would be considered expected male behaviour.

> *Sarah: I mean, they probably, as I said before with the groping and all that sort of thing, to people of my generation, my age-group, is, but to that age-group, it's just something that men do to women. (Metropolitan, community-based, an RN for 8 years)

The old 'Fifth Schedule', psychiatric hospitals were roundly criticised by the several informants who had experience working in them. More than one informant had experience in psychiatric facilities which from their accounts were heavily male dominated with high numbers of male RNs and uniquely sexualised atmospheres.

> *Helen: ... well ... what should I have done? But I didn't know what to do. There were no policies on that, and because it was these males ... he reported to a male, who reported to a male, who reported to a male ... (Regional/rural, nursing home, manager, an RN for 10 years)

Nurses expected certain behaviours for themselves. Certainly informants had role expectations, particularly the idea that nurses are educated to 'cope' with all kinds of behaviours. Nurses are educated to avoid any display of revulsion at patient's draining wounds, patient's anger at constraints imposed by health problems, and sudden, unexpected patient outbursts or other untoward events. This calmness in the face of adversity may be significant and extend beyond the RN's relationship with patients. In fact it does seem that they are expected to 'tolerate' a significant amount of unusual behaviours from colleagues in the workplace too.

Many informants described the prevailing sexist or highly sexualised work atmosphere where they worked and their role in that environment.

> *Jane: No, I didn't really feel like it was me because it was me, I felt it was me because I was a nurse, not because I was, um, myself ...I didn't think it was personal. It was personal, but it wasn't me. I just felt like it was the position, that I was a very junior nurse and ... he was a much older person than I was. (Metropolitan, hospital-based, an RN for 15 years)

There was a sense that informants felt they trapped themselves in their roles and/or were held there by others.

> *Frances: ... maybe it's rampant in nursing but because we just take it anyhow, we just took it that it's part of the job and the patient/nurse relationship is that, it's like they can do everything and we can't do much about it. (Metropolitan, nursing home, an RN for 8 years)

Frances touched on a theme that was heard from most of the RNs who had experience in other work situations before entering the nursing profession. The theme revolved around the many and varied people with whom an RN was expected to interact. RNs had frequent contacts and interactions with professional people, various trade and service people and the public; far more than for individuals in other work situations.

> *Frances: But to me because we deal more with different types of people and well and sick, to me we are in a position to maybe cop it and maybe we are also in a position to understand it. But whether we have to put up with it is a different sort of thing. (Metropolitan, nursing home, an RN for 8 years)

Self-flagellation

Self-blame in some form or another was described by the informants. Lucy had many rationalisations readily available to deal with harassing behaviours. She encapsulated in one narrative, several of the rationales for harassment. When accosted by her patient's husband she quickly experienced a series of responses, all some form of self-flagellation.

> *Lucy: ... I sort of almost ran out I guess, but also thinking that it's not really happening and we sort of have to forgive these people or think or maybe ... it was your fault or it didn't really happen, he didn't really intend it like that, sort of trying to say no, it wasn't what it was, sort of the more you think about it, the more it is ... (Regional/rural, community-based, an RN for 7 years)

Mary believed she lacked social skills or 'lacks something'.

> *Mary: I thought that the problem was that I was socially inept ... I didn't have the witty ... comebacks that were needed or know how to put them off so ... I just thought it was something lacking in me and just went on. (Metropolitan, community-based, an RN for 13 years)

Mistake was a word that informants used to rationalise a harassing episode. Informants seemed to decide that they or the harasser were 'mistaken', and there was a mistake or misinterpretation of events by the harassed or the harasser. This rationalisation was not restricted to verbal or gender based harassment, but to actual physical contact.

> *Helen: Or the first time ... he probably touched me passing, but ... how can I put it? You don't really sort of stop to think what's

> happening, and then when you realise that there's no need for them to grab you on the butt ... (Regional/rural, nursing home, manager, an RN for 10 years)

Stupidity, or their own distinctly silly or stupid behaviour was sighted by some informants as the cause of harassing behaviour. This self-castigation was associated with why informants were also loathe to discuss or complain about the incident. The fear of being perceived as stupid by others, usually colleagues or co-workers, played a significant role in the harassing incident.

> *Lucy: ... and maybe, 'Oh, you're really stupid - you put yourself in that position in the first place, so how can you complain about it?' you know. (Regional/rural, community-based, an RN for 7 years)

Inaction

Denial served many of the informants well. Not surprisingly, several informants found this approach useful and effective.

> *Lucy: ... maybe you try to find excuses ... for their behaviour, like ... this guy wasn't a patient, he was a spouse, so you can't even excuse - [laughter] but I think you do find excuses and maybe it's to deny to yourself that it actually happened, that you think that, oh well, 'Maybe if I can pretend it didn't happen, then it didn't occur and I can put it out of my head'. (Regional/rural, community-based, an RN for 7 years)

RNs usually have a sense of responsibility as a patient advocate. Though by way of contrast, 'it's not my problem' worked well for some informants, when they observed what they considered to be harassment occurring to someone else, a colleague or patient. A good example of this is Bess who described the advocacy role that a nurse often acquires. She described the

doctor who, according to Bess's standards, was inappropriate with patients. The problem for Bess was that the patients seemed to 'like' the doctor's behaviour. In other words, Bess decided 'it's not my problem'.

> *Bess: ... when he is with the patients, especially females, he ... invariably ... stands behind the chair and puts his hands down on her shoulders and chest, and I often feel that he (is) gyrating against the chair. ... it just repulses me and ... if they're happy with it, (the patients) then I have no right of advocacy to step in on their behalf ... when they're feeling quite comfortable with it, certainly, it obviously (is) not an issue to me ... (Regional/rural, hospital-based, manager, an RN for 15 years)

Bess suggested here that there is a 'line' with patients and doctors... when a doctor's behaviour is questionably inappropriate and if the patients do not seem upset, then the RN should ignore the doctor's behaviour with the patient. Probably for Bess, if the recipient does not (appear to) mind, the behaviour does not amount to harassment.

If Bess's rationale is typical, this suggests that RNs may make judgments on whether behaviour is harassment by observing the outward, visible, response of the harassed. Recipients of harassment most frequently ignore the behaviour or avoid the harasser and do not use assertive or aggressive or, in other words, visible strategies. Typically, one is not always able to 'see' the real response. In fact the survey suggests responses can be deceptive. Bess may or may not be correct in assessing the patient's 'response' to the doctor's behaviour.

RNs have advocacy responsibilities in their interactions with patients and professional colleagues. RNs described the attitude of not wanting to recognise, label or deal with harassment. It was in the 'too hard' basket. Paula supported this when she was confronted with a colleague who was

involved in a formal harassment hearing. Few colleagues were willing to confront the harasser and support their colleague, despite privately admitting to experiencing the same unwelcome behaviour themselves from the same harasser.

> *Paula: There were a lot of people who had actually had that type of thing happen over the years and were not prepared to stand up and say so. And as it turned out, it was only the three of us were prepared whereas there would have been - I think we did a count - there were 7 people who admitted that they could have, but wouldn't. (Metropolitan, hospital-based, an RN for 14 years)

Some informants 'gave up' trying to stop inappropriate behaviour, overwhelmed with the consequences and sometimes public humiliation of complaining.

> *Helen: ... probably be once a week. You'd say, 'Tony, I really don't like it. Will you stop it. I've had enough.' And he'd just pat you on the head and walk out the door and say, 'You having a bad day, love? Got your periods, have ya?' And so at morning tea ... time, he'd just say, 'Oh, Helen's a bit touchy today, folks. Go easy on 'er.' And that'd be it. So in the end you just gave up. (Regional/rural, nursing home, manager, an RN for 10 years)

Emotional illness

Jealousy, mental or other emotional illness was a not infrequent excuse for inappropriate behaviour. Michelle described a psychiatric patient, hospitalised and under her care, who had made unwelcome and uninvited sexual advances. Even Michelle, who is an experienced psychiatric nurse, demonstrated some confusion about the patient's 'intent'.

> *Michelle: ... he came up and started rubbing my neck, as a shoulder massage, and I sort of moved out of the way and said, 'Don't do it,' ... and I felt quite threatened by it. But that was delusionary, I think, on his part. I mean ... there were no sexual innuendoes or ... it wasn't so much ... I didn't feel sexually harassed in the same way that a colleague would do it - I felt threatened ... and so it was different in that way. (Metropolitan, community-based, an RN for 13 years)

Assertiveness

Not all responses were passive or unassertive. One nurse manager described a contract drawn up by a domiciliary nurse with a particularly inappropriate patient for whom she was caring in his home.

> *Sarah: ... she (a nurse who was harassed) was actually out there contracting with the guy as to what she felt was acceptable behaviour and what wasn't. And she's got a really good relationship with that man now. (Metropolitan, community-based, an RN for 8 years)

Michelle described changing shifts to avoid a highly sexualised work place.

> *Michelle: ... And after a while I just got annoyed, to the stage where I would swap shifts so I didn't have to work with the particular people. I did that a lot, actually. I swapped shifts so I wouldn't have to work with some of (them) ... (Metropolitan, community-based, an RN for 13 years)

Michelle described the psychiatric patient who 'stalked' her, pestering her for dates and finding out where she lived. Eventually Michelle actually changed residence to avoid that patient.

Assertive or aggressive responses to harassment can generate a backlash from the harasser. Amanda described the aftermath of an assault, an harassing episode with an Emergency Department doctor. Her comments indicated her confusion in describing his behaviour after she had aggressively reacted to his physical assault. Her comments seemed to indicate that he did not assault her again, but his behaviour was verbally aggressive and intimidating and typical of sex-based or gender harassment. Yet, interestingly, she continued to insist that she had no more problem with harassment. She described talking to her nurse manager:

> *Amanda: I said, 'I felt embarrassed about it, and perhaps I over-reacted.' I certainly had no more problem with him from him harassing me, and certainly he never physically touched me. His conversation was always strictly clinical. Instead ... he would become paranoid and make my life very, very difficult in the clinic. And that, I guess, was his revenge. He would go out of his way to yell at me if there was not a pathology report, he'd go out of his way to carry on if I didn't have an ultrasound, um ... That was okay. I guess ... I felt really quite vulnerable. That went on for about two months ... (Metropolitan, community-based, an RN for 24 years)

The consequences of assertive confrontational behaviour had serious implications for informants or their colleagues. Carmel described a suicide of a colleague and the general atmosphere that prevailed at the workplace. Silence was certainly a preferred option in this psychiatric facility.

> *Carmel: ... these game playing episodes would take place where, especially senior males, would denigrate openly, they would, ... put you in dangerous situations with no back-up assistance, and then they would say, 'Well, what would you

> expect?' So confrontation could never take place, it was just a lost game. (Metropolitan, nursing home, manager, an RN for 29 years)

The one male RN informant expressed his rationale for his assertive response to harassment rather simply.

> *David: But I have had situations where I've had, unwanted sexual attention from other staff members ... but it's something that you sort of ... again, as a male, it's something that's easy to be assertive about and, you state where you are. (Regional/rural, hospital-based, manager, an RN for 13 years)

Conclusion

The five categories discussed in this chapter were labelling, recognition, classification, response and rationalisation. The discussion sheds light on the problems identified in the survey questionnaire. If sex-based and sexual harassment is widespread in the workplace of the Australian RN, why is it not viewed as a problem by so many RNs? If RNs believe that telling the person to stop is an effective strategy when confronted with harassment, why do they chose not to use this strategy? These interviews identify the difficulty RNs have in labelling behaviour as harassing. The term sex-based and sexual harassment are not part of the RNs' vocabulary. Harassment can come as a surprise or be so obnoxious that the RN is either almost immobilised or so mobilised that she leaves the area, precluding an 'appropriate' response. A response or lack of response is accompanied with myriad physical and emotional sequelae.

The power of the role of women in the workplace in addition to the nurses' education and role behaviour are combined for these informants to prevent assertive and aggressive responses to harassment. For these informants the pervasive, invasive presence of harassment in the workplace seems indeed

to be a 'part of the job'. That attitude is common and widespread. And one would have to suspect that for these informants it is too big and too amorphous to develop quick and appropriate strategies with which to react on any wide scale. The next chapter deals with the more global consequences of harassment in the Australian health care workplace. It will be evident that the five areas, labelling, recognition, classification, responses, and rationalisation, already analysed and discussed, will combine to present powerful political consequences to the individual RN as well as to the profession of nursing.