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Sexual Harassment in Healthcare: A Psychological Perspective

Dana Kabat-Farr, PhD
Ellen T. Crumley, PhD

Abstract

Social science research shows that sexual harassment is still occurring in the modern workplace, including in healthcare settings. This article discusses sexual harassment in healthcare from a psychological perspective, identifying unique contextual factors in nursing that may influence harassment experiences, such as sexual harassment to protect status, the healthcare hierarchy, and the challenges of reporting. We highlight the faults of using official reporting of harassment as the "gold standard" response and explain the range of responses victims may take as part of their coping process. Also included are recommendations for improving organizational cultures to address sexual harassment, and implications for future research.

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The #MeToo movement and recent media coverage have drawn much needed attention to the existence and pervasiveness of sexual harassment in organizations all over the world. In the United States (U.S.), Title VII of the Civil Rights Act of 1964 makes discrimination based on sex illegal. For some, it seems like sexual harassment may now be a "thing of the past." Social science research shows that sexual harassment is still occurring in the modern workplace, including in healthcare settings. A recent meta-analysis, which examined 33 studies of over 18,000 nurses, revealed that 28% report experiencing sexual harassment (Spector, Zhou, & Che, 2014). Furthermore, although Cholewinski and Burge (1990) demonstrated in a study of nursing students some time ago that that sexual harassment occurs long before they begin their professional lives, this remains a current topic of concern.

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However, the prevalence rates in the nursing field may be an underestimate since healthcare surveys of sexual harassment often ask a single question (e.g., Have you experienced sexual harassment?). Research has shown that individuals may experience sexual harassment without being willing or even able to name it as such (Ilies, Hauserman, Schwochau, & Stibal, 2003). Social science surveys that ask a series of questions without the requirement to label such experiences as harassment, result in higher numbers of women reporting this behaviour. These may include such questions as: Has someone made offensive remarks about your body; has someone told sexually suggestive stories or offensive jokes; or has someone attempted to establish a romantic or sexual relationship despite your efforts to discourage it?

Even with the possibility of an underestimation, the 28% affirmative rate of sexual harassment in nursing is alarming (Spector, et al., 2014). Because these negative experiences can occur during schooling, there is a risk that acceptance of sexual harassment is ingrained into students' idea of what it means to be a professional. These statistics reveal the uphill battle that women face when pursuing careers in healthcare; for those who remain in the field, sexual harassment may be a regular part of their professional experience.

Decades of psychological research has found a host of negative personal and professional outcomes for the targets of sexual harassment. These include lower job satisfaction; withdrawing from one's work; lower commitment to one's organization; and negative physical and mental health (see Ilies et al., 2003 for a meta-analytic review). Additionally, simply working in an environment with sexual harassment, termed "ambient harassment," is linked with similar negative outcomes, even for individuals not directly targeted (Glomb, Richman, Hulin, & Drasgow, 1997). Sexual harassment is not just a concern for individual employees; teams with ambient sexual harassment have higher rates of conflict, lower team cohesion, and lower financial performance (Raver & Gelfand, 2005). This is especially important because healthcare professionals and staff frequently work in team environments, in which close communication and teamwork are vital to providing effective patient care.

To better understand the sexual harassment experiences of healthcare professionals, this article draws on research from social and organizational psychology. We start with an outline of basic terminology, apply a theory of sex-based harassment to understand the social and contextual risk factors in healthcare, and end with consideration of how victims tend to respond and what organizations can do to help.

In the U.S., the Equal Employment Opportunity Commission (U.S. EEOC, 2009) defines sexual harassment as:

> Unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature … when this conduct explicitly or implicitly affects an individual's employment, unreasonably interferes with an individual's work performance, or creates an intimidating, hostile, or offensive work environment (para. 2).

This definition, used in employment policy and law, shares commonalities with definitions that psychologists have established for sexual harassment, such as: "behavior that derogates, demeans, or humiliates an individual based on that individual's sex" (Berdahl, 2007, p. 644). Sexual harassment may also be gendered (for example, harassment because a woman is perceived to not live up to feminine ideals or because a man is not "man enough;" more on this below. The range of sexual harassment behaviors is classified into a tri-partite model: sexual coercion, unwanted sexual attention, and gender harassment (Gelfand, Fitzgerald, & Drasgow, 1995).

The first part, *sexual coercion*, can be equated to quid pro quo harassment, or behaviors that coerce individuals to engage with perpetrators sexually (e.g., "you need to sleep with me if you want a promotion"). The second, *unwanted sexual attention*, is behavior that involves sexual or romantic advances, both verbal and physical, that are unwelcome and unreciprocated by the target person (e.g., unwanted placement of one's arm around another's waist, repeated requests for dinner dates). The third, *gender harassment*, is often overlooked as a form of sexual harassment. It entails "a broad range of verbal and nonverbal behaviors not aimed at sexual cooperation but that convey insulting, hostile, and degrading attitudes" about a particular gender, often women (Fitzgerald, Gelfand, & Drasgow, 1995, p. 430). This can include comments claiming that women are not suited to be healthcare specialists, that men are not welcome as pediatric nurses, or the use of terms that are denigrating based on one's gender (e.g., calling a someone the colloquial term "pussy"). Other examples include displaying pornography at work or insulting someone's sexual prowess.

Sexual coercion, unwanted sexual attention, and gender harassment are all unlawful, based on sex discrimination laws. Public and legal attention largely focuses on sexual coercion and unwanted sexual attention, under the assumption that these two forms are what "really matter." In actuality, however, research has indicated that gender harassment is the most widely experienced by women (Leskinen, Cortina, & Kabat, 2011). Indeed, experiencing "just gender harassment" is linked to negative outcomes such as less mental and physical health, thoughts of leaving one's organization, and job dissatisfaction (Leskinen et al., 2011). In the U.S. legal arena, gender harassment can contribute to "hostile environment harassment" and is illegal when it is "sufficiently severe or pervasive from the perspective of a reasonable person to alter the terms or conditions of the target's employment and is perceived by them as such" (U.S. EOC, 1990).

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Although gender harassment poses serious personal and professional consequences and is a form of gender discrimination, women who experience gender harassment are seven times less likely to label their experiences as sexual harassment compared to women who experience either sexual coercion or unwanted sexual attention (Holland, & Cortina, 2013). As a result, gender harassment is erroneously considered not as severe as the other two forms, meaning that women and men who experience it are less likely to bring their cases forward. Regardless of the form, in order to eradicate sexual harassment, it is first necessary to understand why it exists.

To begin, we would like to make a note on terminology and scope. Throughout the article we use the term *sex* to reflect the fact that harassment is rooted in the nature of status differences based on distinctions between males and females. At the same time, we acknowledge that inherent in any social interaction is the social construction of *gender*, which can also influence experiences of sexual harassment. Examples might include a man experiencing harassment because he is deemed "not man enough", or a woman because she is violating socially-accepted gender norms by being too "butch" (colloquial slang to indicate male qualities in a woman often associated with lesbians).

We use the term "sex" to be consistent with recent psychological research and established U.S. legal terminology which indicates harassment is "based on sex." Additionally, both men and women can and do experience sexual

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harassment. However, women experience it at significantly higher rates than men. For example, in a recent study of U.S. Federal Employees, women reported at least twice as much sexual harassment compared to men (U.S. Merit Systems Protection Board, 2018). Further Berdahl and colleagues (1996) found that perceptions of sexual harassment differ, in that, on average, men feel less threatened by sexual harassment then do women. Likewise Berdahl and Aquino (2009) found men are more likely to appraise sexual behaviors at work as positive or neutral whereas women are more likely to view these behaviors as negative. For these reasons, and given the context of the predominantly female profession of nursing, this article focuses primarily on the sexual harassment experiences of women, while acknowledging that sexual harassment is not gender specific.

Sexual Harassment to Protect Status

A common misperception of sexual harassment is that it stems from sexual desire on the part of the perpetrator (i.e., harasser). However, an examination of the various forms and functions of sexual harassment indicates that it is not about sexual gratification or access to another person's body (Berdahl, 2007). Rather, most workplace sexual harassment occurs to reject and exclude people from full participation in the workforce (Schultz, 1998). Berdahl (2007) aptly captured this, theorizing that all sexual harassment should be thought of as harassment based on an individual's sex. At the root of Berdahl's theory is the notion that harassers "derogate others based on sex to protect or enhance their own sex-based social status, and are motivated and able to do so by a social context that pervasively and fundamentally stratifies social status by sex" (2007, p. 641). That is to say, individuals are invested in protecting their social status in organizations, which in healthcare is often reflected in a gender-based hierarchy, and they do so by targeting others with harassment.

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Not only does this help us to understand more "traditional forms" of sexual harassment (e.g., older, more powerful male coerces younger subordinate woman into granting sexual favors in exchange for promotion) but it also allows us to recognize how both men and women may use sexual harassment as a way to maintain social standing and power. Therefore, sexual harassment in a hierarchical workplace such as a hospital may be undertaken by either sex, including female-to-female, female-to-male, or male-to-male. Thus, this theory provides a unified theoretical rationale for gender harassment and unwanted sexual attention experienced by both women and men.

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Furthermore, Berdahl's (2007) theoretical perspective underscores the relationship between the workplace social context and rates of sexual harassment. Factors particular to the healthcare environment that may create a fertile environment for sexual harassment include a historically male hierarchical structure, isolated working environments, and care of patients with cognitive impairment. Each of these factors is discussed below.

Hierarchy of Healthcare

The healthcare field has a strong history of hierarchy, with predominantly male physicians and administrators occupying the most powerful positions. In order to "protect or enhance" their status, men in healthcare may use sexual harassment to reinforce their superior status within the organization (Berdahl, 2007). Indeed, the most common form of sexual harassment, gender harassment, functions to exclude and undermine full participation by women in the workplace. Workplaces that have more men are associated with an increased risk of experiences of gender harassment (Kabat-Farr, & Cortina, 2014). Other research has theorized that higher rates of sexual harassment in surgery and emergency medicine may be rooted in the hierarchical and authoritative nature of the settings (Frank, Brogan, & Schiffman, 1998). Interestingly, women who are training in these specialties face higher rates of sexual harassment; however, Frank et al. (1998) found that, once working, such women report rates are comparable to other specialties.

Regardless of the instigators, it remains clear that numerous parties feel entitled to sexually harass in this context.

The hierarchical structure of healthcare organizations normalizes the power differential between men and women, and, accordingly, provides a context in which harassing and demeaning behaviors may be perceived as inconsequential and "part of the job." A hierarchical context may permit physicians to harass nurses, but it also may serve as a signal to outside parties, such as patients, families and staff, that lower status (and mostly female) employees are not valued highly and it is acceptable to harass them.

Research provides some insight into who is perpetrating these offenses; however, the findings are not consistent.

In some studies, physicians committed over 50 percent of reported sexual harassment against nurses (Boafo, Hancock, & Gringart, 2016), while in others, patients, relatives and escorts were the main perpetrators (Chang & Cho, 2016; Gabrovec, 2017; Sisawo, Ouédraogo, & Huang, 2017). Regardless of the instigators, it remains clear that numerous parties feel entitled to sexually harass in this context.

Isolated Environments

In addition to authoritarian hierarchies, healthcare employees often work in isolated environments. As an example, nurses often are in close and intimate working quarters with patients; families and caregivers; visitors; co-workers; organizational leaders; and other professionals (e.g., physicians), all of whom may target them with harassment (Zhang et al., 2017). The isolated working environment may be in the community (Gabrovec, 2017) or in patient rooms, often with the door shut to protect patient privacy. Providing in-home care is a particularly isolating environment which may amplify the risk (Cheung, Lee, & Yip, 2017). Harassment behind closed doors in patient homes can be especially disturbing. The necessity of having to revisit harassing patients can foster feelings of anxiety and fear, cognitive distraction, neglect on the job, and lower commitment to the organization (Barling, Rogers, & Kelloway, 2001).

Other factors that may increase a nurse's risk of experiencing sexual harassment include working rotations, evening/night shifts (Ridenour, Hendricks, Harley & Blando, 2017), or working in emergency departments (Sisawo et al., 2017). In rotations or off-hour shifts there may be fewer staff and professionals present. This, coupled with isolated private care in patient rooms, may result in an increased occurrence of sexual harassment incidents. The emergency department is one in which time pressures, the necessity to act quickly, and patient/family demands or demeanor may be used as excuses for misbehavior. These are unique working environments for nurses and more research is needed to understand the ways in which these unique contexts foster risk for harassment.

Organizational and locational context risk factors may work jointly to increase the likelihood of sexual harassment.

Organizational and locational context risk factors may work jointly to increase the likelihood of sexual harassment. For example, the hierarchy of a surgical team, coupled with the intense work environment, may amplify risk for individuals to use gender harassment as a way to police gender roles, such as those of female nurses and male team leaders. A male physician who refers to a female nurse as a "stupid bitch" under his breath is questioning the competency of his co-worker in a way that ties her gender to a lower status. Likewise, making sexually explicit gestures to a fellow male physician can demean and degrade women, while also maintaining a "boys club" culture, which holds higher organizational status. This is an example of how the gendered substructure of the medical workforce can be produced and reified through the social interactions of its organization members (see Acker, 2012 for more on a theory of gendered organizations.

Cognitively Impaired Patients

Finally, another characteristic that may result in sexual harassment in healthcare is working with patients with dementia or other cognitive impairments. Long-term care facilities represent the overlap of the workplace with a patient home, and are a unique context in which nurses may experience harassment. A recent qualitative study of cognitively impaired patients (e.g., suffering dementia or with brain injuries) in Denmark found that although many care workers (e.g., nurses, doctors, eldercare workers) report experiencing behaviors that would be classified as sexual harassment, they resist labeling their experiences as such because they did not attribute intent on the part of the perpetrator (Nielsen et al., 2017). That is to say, many patients exhibiting these behaviours may not be able to understand the consequences of their actions or exhibit self-control (Alagiakrishnan et al., 2005).

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Despite the possibility of lack of patient intent and resistance by nurses to label an experience as "sexual harassment," many nurses in these contexts still reported negative outcomes such as burnout, shame, withdrawal, and stress. Nurses' own work behaviors are also complex in an environment where patients may be unable to judge acceptable behavior. For example, a nurse notes that the care team has specific guidelines for specific patients, as behaviors that are seen as caring (e.g., an offer of a hug) can be misinterpreted by some patients as opening the door to sexual advances (Nielsen et al., 2017). The complexity of caring for cognitively impaired patients, along with the fact that intentional and non-intentional sexual harassment can still result in negative outcomes for nurses, highlights the need for further research in this area.

Challenges of Reporting

Failure to Report

...without reporting,

Many ask, "If it was as bad as she says it was, why didn't she report?" Filing an official report of sexual harassment has been held up as the "gold standard" response of organizations and legal cases. Indeed, without reporting, many

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assume the behavior does not matter, or worse yet, that it did not occur. This was recently exemplified in President Trump's tweet regarding Dr. Blasey Ford's sexual assault allegations against Supreme Court nominee Brett Kavanaugh: "if the attack on Dr. Ford was as bad as she says, charges would have been immediately filed with local Law Enforcement Authorities by either her or her loving parents." (Gay Stolberg, 2018). This attempts to delegitimize Dr. Ford's experience and places sole blame on her for not taking the "correct" action. In these situations, outsiders are able to brush off harassment (and even assault) as unimportant and even question whether or not the harassment happened. This means bad actors avoid all negative consequences and perpetuates a society that does not believe women who say they were harassed.

Why do women not report sexual harassment? One reason is that official reporting may not result in remediation. Instead, it may represent further risk to women. Women cite "fear of blame, disbelief, inaction, retaliation, humiliation, ostracism, and damage to one's career and reputation" as reasons they chose not to report (Cortina, & Berdahl, 2008, p. 484). The risk of retaliation is enhanced when the harasser is of higher status than the target, which is often (Knapp, Faley, & Ekeberg, 1997). Low-status or contractual workers in an organization may be particularly leery of bringing accusations forward.

Women who report their experiences also may face the stresses of a loss of income and economic insecurity (Unger & Crawford, 1996). Doubts that the process will be effective, along with a fear of further harassment and stress, lead women to refrain from any formal grievance process, using official reporting only as a "last resort" (Fitzgerald, & Cortina, 2018). All of this leads to very low rates of reporting by sexual harassment victims: it is estimated that between 11-25% of such victims file an official report (Cortina, & Berdahl, 2008; U.S. Merit Systems Protection Board, 2018).

Instead of filing a report, women manage their traumatic experience both with internal (e.g., emotions, thoughts) and external (e.g., seek social support) responses (Wasti, & Cortina, 2002). Some of the more common techniques include ignoring the harasser (e.g., laughing it off); detaching psychologically from the situation; or just enduring the harassment (e.g., stating that "boys will be boys"; Magley, 2002). Another common response is to try to avoid the perpetrator. However, in the healthcare context, where teamwork is often required for patient care, avoidance of harassment from co-workers or supervisors can be difficult. When the patient or family member(s) are the perpetrators, nurses may have a co-worker accompany them when caring for a patient or ask for the patient to be reassigned (Nurse.org Staff Writer, 2017).

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It is important to realize that these types of responses are not an indicator of weakness or lack of autonomy. Rather, these responses indicate what women consider to be acceptable, and less risky, responses when faced with mistreatment. This range of responses represents a coping process (Fitzgerald, & Cortina, 2018) that may or may not include official reporting. To disregard an experience of sexual harassment based solely on whether or not the victim reported it is an ill-informed and unjust approach.

#MeToo

Following and posting on the #MeToo Twitter feed has become part of women's coping process. The #MeToo movement has allowed women to share their sexual harassment experiences, gain support from allies, and shine light on the misogynistic and sexist cultures that permeate organizations. The collective outrage has prompted some organizations to respond by removing accused, high-profile perpetrators. The movement is part of catalyzing systemic and societal change.

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However, #MeToo is only one piece of a larger puzzle. For every case that is disclosed, thousands remain unheard. The proliferation of victims telling their stories on social media through tweets and posts is not the whole solution or any guarantee that their harassment will end. Indeed, some victims are unable to publicly condemn their perpetrators for fear of losing their job, retaliation, and ostracism.

Male victims also note the difficulties of publicly accusing their perpetrators. Terry Crews, an American actor, blames a system of toxic masculinity that discourages men from speaking out and attaches a stigma to male survivors (Arceneaux, 2018). Tarana Burke, creator of #MeToo, sees the hashtag as appropriate for both men and women and would like the conversation to move from talking about individuals to talking about systems of power (Arceneaux, 2018). For victims unable to identify their perpetrators, or those who choose not to, following #MeToo can be a source of support. Even anonymous stories can contribute to the larger narrative that seeks to change the societal and cultural values of inequity and the power imbalance that drive harassment (Burke, as cited in Langone, 2018).

The #MeToo movement has changed the global conversation around sexual harassment and is tasked with the

lofty and noble goal of changing society's values and treatment of women. But organizations need to listen to this conversation, and to women's stories, and take their own steps to address sexual harassment and reduce barriers to reporting.

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Improving Organizational Cultures to Address Sexual Harassment

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Research shows that the most powerful determinant of sexual harassment is the organizational climate for harassment, or the degree to which employees perceive an organization tolerates harassment (Willness, Steel, & Lee, 2007). This is heartening because organizational leaders can take tangible steps to improve the climate, including instituting policies that reduce risk to those who report sexual harassment; taking reports of harassment seriously; and sanctioning perpetrators for misbehavior (Hulin, Fitzgerald, & Drasgow, 1996). These evidence-based steps have been supported by research, including a study in which male employees reported perpetrating less sexual harassment when they thought there would be an organizational consequence (Dekker, & Barling, 1998).

Effective sexual harassment policies ensure transparency and accountability. Recent recommendations from the National Academies of Science, Engineering, and Medicine (2018) include adopting policies that are easy to understand and distributed in plain language on one-page flyers. Disciplinary consequences should be tangible and have a range to match the severity and frequency of the harassment, such as counseling, modifications to work tasks, reduction in compensation, and dismissal. Organizational leaders should show employees that they are responsive to complaints, conduct investigations in a timely manner, and hold perpetrators accountable. Often investigations are conducted behind closed doors and any consequences are invisible to other employees. Instead, leaders can publicize anonymous basic information regarding the number of reports and results of investigations. This will translate into perceptions that the organization is intolerant of sexual harassment and start to change behaviors and expectations.

To further reduce sexual harassment, organizational leaders should work on shifting the norms.

To further reduce sexual harassment, organizational leaders should work on shifting the norms. For example, the institutional hierarchy may need to be flattened to reduce power disparities inherent in organizational roles. If this can be done, perpetrators will be less likely to take advantage of the power imbalance and acts of coercion and retaliation will lessen. This is more difficult to implement in the healthcare context, given that physicians are often still perceived as the top of the hierarchy. However, an increased number of doctorally-prepared nurse practitioners with expanded scope of nursing practice can lead to hierarchical changes that are not physician dominated. Not wanting to participate in institutional hierarchy may be a reason for some nurses to choose a community care focus, where they can be more independent. However, this does not mean they are exempt from sexual harassment as the isolation of community care can be a contributing factor (Cheung et al., 2017; Gabrovec, 2017).

The often isolating work environments of nurses can lead to the possibility of "he said, she said" situations. This outcome can pit powerful men against women, patient against caregiver, and customer against contracted employee. It is, therefore, imperative that complaints of harassment are taken seriously, and that the risks of retaliation are mitigated. This will take "institutional courage," a shift from organizations controlling damages related to harassment to believing and recognizing the target and her experience (Smith, & Freyd, 2014). Many hospitals have sexual harassment training, but the content and emphasis may need updating. Sexual harassment training should address not only inappropriate sexual touching and unwanted sexual attention, but also gender harassment.

Employees who experience sexual harassment should know that there is no "one size fits all" approach to responding. It is important to record experiences that make you feel uncomfortable (e.g., saving emails, text messages, taking photos of notes left on whiteboards) and reach out to other colleagues or friends for support. Organizations may also employ an ombudsman who can provide confidential assistance and resources if the victim does not feel compelled or comfortable with formal reporting.

Training should also include bystander intervention.

Training should also include bystander intervention. To change organizational culture around harassment, peers and coworkers should feel comfortable and empowered to speak up to intervene in problematic situations. In this, there are five steps: "(1) notice the event, (b) interpret the event as a problem, (c) assume personal responsibility for doing something, (d) decide how to intervene, (e) act" (Banyard, 2011 as cited in Holland, Rabelo, & Cortina, 2016, p. 4). Instituting a strong, publicized, and enacted anti-harassment policy, and encouraging co-workers to intervene if harassment occurs, are initial steps to improve the

organizational culture to reduce sexual harassment.

Implications for Future Research

Much of the research related to sexual harassment is dated, although the current importance of this topic as a societal concern will hopefully encourage new studies to inform evidence-based practices. As noted earlier, our knowledge about prevalence rates of sexual harassment is often limited by the design of questionnaires. A common approach is to ask "Have you experienced sexual harassment?" in a survey. This requires first that employees label their experiences as sexual harassment (which they may be unable or unwilling to do), and next that they realize the full scope of behaviors that constitute sexual harassment. For instance, employees may not realize that gender harassing behaviors are sexual harassment.

Future research should consider using validated and reliable sexual experience questionnaires created by psychologists (e.g., Fitzgerald et al., 1995). However, there are also critiques of these established measures which are based in women's experiences of harassment. Researchers need to be mindful that sexual harassment targeted at men may take different forms, such as punishment for deviating from traditional masculinity norms (Holland, Rabelo, Gustafson, Seabrook, & Cortina, 2016). More development is needed in this area.

How the gender context of nursing affects the dynamics of who harasses whom, and why, is ripe for future inquiry.

Past research with employee samples of academia, court systems, and the military has found that the gender composition of one's workgroup (i.e., the proportion of males versus females) affects the risk of experiencing gender harassment (Kabat-Farr & Cortina, 2014). Specifically, the more male-dominated the workgroup, the greater likelihood that women will report gender harassment. The same does not occur for men. In fact, men who are numerical minorities in their workgroup do not face a greater risk of harassment, and may actually be buffered from gender harassment (Kabat-Farr & Cortina, 2014).

The salience of gender-role stereotypes helps to explain this effect. When men are scarce in their work unit (as they may be in teams of healthcare providers), their gender role becomes more prominent, making their high social status salient, and reduces the likelihood that they will be mistreated by others (Stockdale, Visio, & Batra, 1999). In the field of healthcare, an established body of work finds men in traditionally feminine fields, such as nursing, tend to benefit from their structural advantage and advance more quickly than their female colleagues (Furr, 2002; Padavic, & Reskin, 2002; Williams, 1992). This does not mean that men face no barriers in feminine fields. For example, male childcare workers may be viewed with suspicion or ill will (Sargent, 2004). However, it does suggest that gender underrepresentation affects experiences of derogation and exclusion differently for men and women. How the gender context of nursing affects the dynamics of who harasses whom, and why, is ripe for future inquiry.

Conclusion

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In closing, experiences of sexual harassment are not unique to nursing, but some unique factors of the profession and work setting make the context particularly fertile for these incidents. By understanding various forms of sexual harassment (sexual coercion, unwanted sexual attention, and gender harassment) and functions, nurses and organizations are better suited to appropriately address this concern. Importantly, we need to look beyond reporting of harassment to understand experiences. The #MeToo initiative is one piece of a larger puzzle that will involve changing societal values, gender role expectations, and ultimately the power imbalances between men and women that drive harassment based on sex.

Authors

Dana Kabat-Farr, PhD
Email: Kabatfarr@dal.ca

Dana Kabat-Farr is an Assistant Professor of Management at Dalhousie University in Nova Scotia, Canada. She earned her PhD from the University of Michigan in 2012. Her research program focuses on workplace social experiences – both negative (incivility, harassment) and positive (citizenship). She has examined relationships between workgroup "tokenism" and gender harassment; incivility as covert discrimination against women and people of colour; and positive and negative experiences that influence employees' ability to thrive.

Ellen T. Crumley, PhD
Email: ecrumley@dal.ca

Ellen T. Crumley is an Assistant Professor at Dalhousie University in Nova Scotia, Canada. She has a PhD from the University of Alberta (2012). Dr. Crumley has conducted healthcare research since 1999. Her qualitative research investigates professional role change and organizational change. She currently examines how new roles and the integration of new vocabularies change professionals' perceptions of their identity; and the creation and innovation of practice models. Her current study examines the role and organizational changes that physicians, nurses, pharmacists and health administrators undertook to accommodate medical assistance in dying in Nova Scotia and nationally in Canada.

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