



Sexual harassment – a touchy subject for nurses

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Abstract

Purpose – The purpose of this paper is to examine prevalence of sexual harassment (SH) in nursing and the environmental factors that contribute to incidents of SH.

Design/methodology/approach – A mixed-method research methodology is adopted. A total of 538 questionnaires are collected from nurses working in eight different hospitals across metropolitan and rural areas in Australia. A total of 23 in-depth semi-structured interviews are conducted.

Findings – Prevalence of SH in nursing is high with 60 percent of female nurses and 34 percent of male nurses reporting a SH incident in the two-year period prior to this paper. The questionnaire data suggest that patients are the most likely perpetrator, however, the interviews name physicians as typical perpetrators. A model is tested via structural equation modelling and revealed that leadership behaviors, an unbalanced job gender ratio and no prior socialization are positively associated with SH.

Research limitations/implications – This paper closes gaps in theory by introducing a new framework explaining the contextual factors that heighten a nurses' probability of being harassed. Some variables such as organizational culture and specific nursing units have not been explored and can be considered a limitation of the paper.

Practical implications – The results of this paper assist health professionals to adopt proactive practices for managing SH and plan a workforce where SH is minimized.

Originality/value – This paper illustrates the prevalence of different types of SH and the causes for male and female nurses that have not been investigated previously. The results help health managers make informed decisions in regard to intervention strategies.

Keywords Sexual harassment, Violence, Leadership, Gender, Nursing, Australia

Paper type Research paper



The US Merit Systems Protection Board's (USMSPB, 1982) survey of 10,000 employees reported 1 percent of federal workers had experienced actual or attempted rape while at work. In the same study, it was reported that 42 percent of federal employees had experienced sexual harassment (SH) within the preceding two years. In the recommendation, it was suggested that health care settings were more likely than other employment contexts to have higher than average rates of harassment, however, no rates of harassment among specific health care professionals were reported. Grieco's (1987) research was commissioned as a result of the USMSPB data and reported a SH prevalence rate of 76 percent in the nursing profession.

Since Grieco's (1987) study, limited work on SH in nursing has been undertaken. From the available studies, estimates of the percentage of nurses who have experienced SH vary from 30 percent to as high as 97 percent (Cox, 1987; Cholewinski and Burge,

1990; Donald and Merker, 1993; Kinard *et al.*, 1995; Finnis and Robbins, 1994; Dan *et al.*, 1995; Madison and Minichiello, 2001; Bronner *et al.*, 2003). Actual incidence rates are difficult to determine because of the differences in the research method employed (e.g. sample size and diversity, definition/categorization of SH, and time frame). Nevertheless, in a review of all studies found, we computed the median percentage of nurses who have experienced SH at some time during their career to be 74 percent (Grieco, 1987; Cox, 1987; Cholewinski and Burge, 1990; Donald and Merker, 1993; Kinard *et al.*, 1995; Finnis and Robbins, 1994; Dan *et al.*, 1995; Madison and Minichiello, 2001; Bronner *et al.*, 2003).

High SH prevalence rates provide strong justification for strategies such as policy development, grievance handling procedures, and awareness training to be implemented. However, these initiatives are largely reactive and concerned with responding once claims have been made or a SH episode has taken place. In this paper, we argue that if health managers are to adopt a proactive orientation for dealing with SH an understanding of what heightens a nurse's vulnerability to being sexually harassed is needed. Such data are a pre-requisite for developing initiatives geared at prevention. Despite the progress that has been made on understanding this phenomenon, researchers know little about the external factors that make a nurse more susceptible to SH.

This research closes the gap in theory by establishing the contextual factors that heighten a nurses' probability of being harassed. In addition, unlike other research efforts which have focused on the SH of women[1], this paper will not study female nurses in isolation, but will examine SH non-exclusively because of the increasing numbers of men who experience SH, as well as growing incidences of same gender harassment (Uggen and Blackstong, 2004; Cugin and Fish, 2009).

In this paper, a model is introduced that examines three characteristics of an employment environment and incidence of SH in nursing. In addition to the empirical results, we review data derived from semi-structured interviews with nurses. Following a discussion of the results, future directions for research and practical implications for health organizations are given. At a time when containment of health management costs is a widespread international concern, data relevant to counterproductive behaviors in the nursing profession should be of interest to researchers and health managers.

We begin by defining SH and outlining the strategic consequences of SH in nursing. Following this, existing models and the literature, which illustrate causes of SH are examined. This analysis forms the basis for the proposed model. The research methodology, results and discussion sections follow before recommendations for future research are made.

Definition of sexual harassment

At an international level SH has been recognized and addressed by a number of bodies, including the International Labor Organization (ILO). Governments, employers' and workers' organizations in both industrialized and developing countries have introduced a range of laws, policies, and procedures aimed at preventing and combating SH (McCann, 2005). The kinds of behavior considered sexually harassing appear to vary among different cultures, however, the ILO has outlined a definition and range of example behaviours of what constitutes SH which has been widely adopted (Pryor *et al.*, 1997). We adopt this definition in this study.

SH is defined as conduct of a sexual matter, which is unwelcome to its recipient, which results in feelings of humiliation, embarrassment or intimidated (McCann, 2005). This definition allows a distinction to be drawn between inoffensive and unacceptable behavior according to the context in which it takes place. The justification usually offered for adopting this "unwelcomeness standard" is that it permits consensual sexual behavior while prohibiting workplace mistreatment (McCann, 2005). This definition identifies the importance of the target's evaluation of the harassing behavior. Behavior that may be acceptable and even desirable to one person may be intolerable to another.

Strategic consequences of sexual harassment

SH has significant negative consequences that have been widely reported in the literature. The potential psychological effects of a SH incident include lowered self-esteem, difficulty with interpersonal relations, increased stress, depression, frustration, and anxiety (Paludi and Barickman, 1991). Those who are sexually harassed display common coping strategies; i.e. indirect expression of anger, denial or minimization of the incident, and compliance; as well as feelings of powerlessness, aloneness, fright, humiliation, and incidence of post-traumatic stress disorder (Willness *et al.*, 2007). Madison *et al.* (2002) examined the experiences of perioperative nurses and reported that SH, sexual intimidation, physical assault, and verbal abuse accounted for 45 percent of all traumatic events reported by perioperative nurses and was a significant source of occupational stress. Diaz and McMillin (1991, p. 101) report the negative impact on self-esteem of nurses. One nurse who encountered SH from a physician remarked "we are only warm bodies in white shoes filling a spot. Low self-esteem is a pre-requisite."

Somatic outcomes refer to physical disturbances as a result of a SH incident. Dansky and Kilpatrick (1997) found numbness and tingling in extremities, pains in the chest and shortness of breath to be common symptoms of SH. Crull and Cohen's (1984) examination of SH experiences of nurses report nausea and gastrointestinal disturbances, while Lawler (1991) concluded that headaches, exhaustion, insomnia, jaw tightening, teeth grinding, and weight loss or gain in nurses could be attributed to a SH experience.

The effects of SH on work performance have also been widely documented. Glomb *et al.* (1999) suggest that SH can have a very detrimental effect on both morale and satisfaction. They found that job performance was affected in 75 percent of people who reported a SH episode, largely through reduced levels of concentration following sexual innuendos. A reduction in job motivation and confidence in skill levels was also reported. In addition, Gutek and Koss (1993) observed that SH is able to totally affect career plans with respondents giving up employment or being willing to move to less well-paid jobs or ones which offer less opportunity for advancement in order to avoid harassment. Cox's (1987) examination of verbal abuse in nursing (which included sexually harassing comments) highlights the effect on turnover. In introducing her figures Cox (1987, p. 49) stated that, "based on the frequency percentage results, verbal abuse is so prevalent in nursing it is surprising that any of us stay."

Studies of university students also suggest that an individual who experiences SH will change career plans, swap majors, and drop courses to avoid harassment, exhibiting what might be considered job withdrawal from the job of "student"

(Fitzgerald *et al.*, 1988). Cholewinski and Burge's (1990) examination of student nurses enrolled in an undergraduate degree report similar findings. Most disturbing was that 95 percent of nursing students had experienced SH during training at university or in a hospital.

The effects of SH are not limited to the person who experiences it. SH in an organization exacts financial and productivity costs. The most obvious business expense is the direct cost associated with damage settlements and court costs. Connected with these expenses are the costs of investigating a complaint.

The indirect business outcomes of SH have been estimated to be far more costly (Glomb *et al.*, 1999). Outcomes include decreased productivity, low morale, turnover, and absenteeism not only on the part of the harassed employee but also co-workers who may witness and be distracted by the situation (Fitzgerald *et al.*, 1997). Dan *et al.* (1995) explored female nurses' experiences of SH and found far-reaching effects on their personal life, work performance, and level of patient care. For example, one respondent attributed a marriage breakdown to being sexually harassed by a superior and remaining in the employment situation rather than resigning as her spouse preferred. Others took sick leave rather than continuing to deal with perpetrators at work. Crull's (1982) survey of nurses who had sought assistance in regard to SH reported equally staggering job loss outcomes. More than 25 percent of nurses had been fired or laid off, and an additional 42 percent had quit their jobs because of SH.

In addition, while it has been noted that SH affects work performance and emotional well-being, it is also likely to affect the job performance of the harasser. An individual who devotes work time and energy to his/her own personal needs for power is divesting the company of those same energies needed to perform work optimally (Cogin and Fish, 2007).

Finally, Fitzgerald *et al.* (1997) report that although 50 percent of people who experience SH say that they simply try to ignore it, they experience an average productivity decline of 10 percent. They also found that 24 percent of those harassed take leave to avoid the harasser, while 10 percent choose to leave their jobs at least in part because of the harassment.

Causes of sexual harassment

In developing a framework for this study a number of models that explain cause of SH were evaluated. Each model is summarized below, followed by a critique.

The biological model

The biological model holds that SH is a manifestation of the natural attraction between men and women. This model assumes that men have stronger sex drives than women, and they therefore behave in a sexually aggressive manner both in the workplace and other settings (Tangri *et al.*, 1982).

The organizational model

The organizational model assumes that firms facilitate SH through power differentials created by hierarchal structures (Tangri *et al.*, 1982). Individuals in legitimate positions of authority have the opportunity to abuse their power for their own sexual gratification through the harassment of subordinates. In addition to power differentials, other organizational characteristics are viewed in this model as contributing to incidence of SH.

These include; the ratios of males to females in the workplace, occupational norms, job functions, job alternatives, and the availability of grievance procedures.

The sociocultural model

This model posits that SH in the workplace is a manifestation of general male dominance (Farley, 1978; Mackinnon, 1979). Harassment is one mechanism for maintaining male dominance over women, both occupationally and economically, by limiting their growth or by intimidating them to leave the work arena. This model holds that men and women are socialized in ways that maintain this structure of dominance and subordination (Farley, 1978).

The four-factor model

The four-factor model (O'Hare and O'Donohue, 1998) argues that the variables related to SH can be grouped into four factors that must be met for harassment to occur:

- (1) *Factor 1.* Motivation, such as sexual attraction or a desire for power.
- (2) *Factor 2.* Overcoming internal inhibitions against harassment, such as viewing SH as illegal or immoral.
- (3) *Factor 3.* Overcoming external inhibition against harassment, such as organizational mechanisms found in explicit grievance procedures and clear consequences to harassers.
- (4) *Factor 4.* Overcoming "victim" resistance, such as the target's ability to recognize and stop inappropriate behavior.

Factors 1 and 2 address individual variables related to the harasser, while factor 3 addresses situational and organizational relevant variables. Factor 4 addresses individual factors related to the target of SH. For SH to occur all four factors must be satisfied.

The sex-spillover model

The sex-spillover model (Gutek and Morasch, 1982) attributes SH to the carryover into the workplace of gender-based expectations that are irrelevant to, and inappropriate at, work. According to this model, SH is most likely to occur in work environments where the sex ratio is skewed in either direction. For women in male-dominated or men in female-dominated work, sex role becomes a more salient feature than work role, thus facilitating SH. For example, a woman's gender would become a distinctive feature because of her singularity if working as an engineer on a building site.

Tangri *et al.* (1982) tested three of these models in an analysis of the data (more than 10,000 respondents) from the USMSPB (1982) study. Overall, the data did not support the natural/biological model, with only limited support for the organizational and sociocultural models. This analysis suggests that these models are not sufficient to fully explain the causes of SH.

The models also appear to be out of date with today's thinking. They do not account for same gender SH, and the female in the role of the harasser, both of which have become more prevalent (Cogin and Fish, 2009). Also, subsequent research has determined SH to be more associated with power than sex (Pryor and Whalen, 1997;

Segrave, 1994; Rosell *et al.*, 1995), contradicting the core assumptions made by these models.

Gutek and Morasch (1982) found that the sex-spillover model held up well under empirical analysis. Women who were employed in non-traditional jobs experienced more SH behavior and more negative consequences from SH than the average working woman. Gutek and Morasch (1982) also reported that non-traditionally employed women experienced more harassment than women in traditional female jobs.

Since, the sex-spillover model was first reported in the literature several studies have examined the effect of an unbalanced gender ratio on SH. Schilling and Fuehrer (1991, p. 126) argued that fewer incidences of SH would be expected in sex-balanced organizations because there would be "less demand for men and women to behave in sex-stereotypic ways." Recent investigations support earlier assertions that an unbalanced job gender ratio (in favor of men) increases SH incidents for women (Jackson and Newman, 2004; Vance *et al.*, 2004). Morgenson (as cited in Segrave, 1994, p. 10) went so far as to predict, "SH would decline" as women continued to enter the workplace and balance the gender ratios. However, Bronner *et al.*'s (2003) large-scale study of SH in the nursing profession (an occupation that has globally been resourced mainly by women) reported an incidence rate of 90 percent.

We argue that this apparent contradiction is due to the working environment that nurses operate in. First, we support the earlier research of Gutek and Morasch (1982) and contend that a skewed job gender ratio increases the probability of being harassed. However, we argue that it is irrelevant whether the occupation is a "traditional" female job; the salient feature is the gender ratio in the immediate environment. Therefore, the job gender ratio in respect to nursing should account for patients, doctors, and other colleagues in the immediate work area, in addition to other nurses. This represents a typical working environment for a nurse. When this environment is skewed in either direction, favoring men or women, we hypothesize that SH is more likely. Second, a paradigmatic feature of SH is that it occurs in a hierarchical situation (Dan *et al.*, 1995). Because, nursing is situated at the intersection of several hierarchies, including the professional status hierarchy, the hierarchy of gender, and often the hierarchies of class and ethnicity, it is likely that SH influences the nursing work environment in multi-faceted ways, such as keeping nurses, particularly female, "in their place" and contributing to the high job turnover rates (Dan *et al.*, 1995).

Despite a lack of empirical evidence in the literature to support the four-factor model, it appears to incorporate the best aspects of the organizational and sociocultural models, and is therefore more comprehensive than the other models. While the four-factor model (O'Hare and O'Donohue, 1998) recognizes the importance of organizational variables as a cause for SH, it does not consider job gender ratio, which as noted above Gutek and Morasch (1982) found to be an important predictor of SH.

Other studies have investigated whether socialization impacts SH. Weber-Burdin and Rossi (1982) found that a prior working relationship between individuals usually engenders lower ratings of SH. Collins and Blodgett (1981) similarly found that when a prior working relationship existed a person would be less likely to view a sexual interaction as harassment. Weber-Burdin and Rossi's (1982) and Collins and Blodgett's (1981) studies, however, both focus on office workers. In addition, neither study examined whether a lack of socialization was a cause of SH. We hypothesize that a lack of socialization to be an important factor in predicting SH.

The literature on employee abuse suggests that the likelihood of abuse or bullying is increased when working under the supervision of managers who demonstrate certain behaviors. In particular, de Coster *et al.*'s (1999) research finds that employees reporting to managers who actively respond to abusive behaviors are less likely to be abused. They suggest that supportive managers may serve as capable guardians against mistreatment. This can be viewed in two ways. First, supportive managers may be more proactively protective of potential targets. Second, the presence of a supportive manager may increase potential employees' ability to serve as their own "guardians." In other words, individuals with supportive supervisors are likely to feel more confident that their manager will support them if they proactively attempt to protect themselves from abuse. The literature on bystander intervention (Bowes-Sperry and O'Leary-Kelly, 2005) supports the development of a culture where others feel an obligation to step into prevent abuse.

An opportunity exists to apply the learnings from studies on abuse to SH. In line with the four-factor model this equates to increasing the strength of factor 3, via the external inhibitions (positive leadership behaviors) and factor 4 through victim resistance (perceived protection from SH). We argue that an increase of strength in each of the factors makes it more difficult for a harasser to overcome impediments to SH.

While the four-factor model recognizes the importance of organizational variables in predicting SH, it fails to acknowledge that an unbalanced job gender ratio, no prior socialization or negative leadership behaviors exhibited by a manager can all be central factors in explaining SH. In an attempt to develop a framework for the study of SH, a new model (Figure 1) has been developed which further explores the organizational variables (factor 3) of O'Hare and O'Donohue (1998) four-factor model by examining job gender ratio (from Gutek and Morasch's (1982) sex-spillover model), prior socialization (Weber-Burdin and Rossi, 1982) and the role the manager plays as protector or guardian (de Coster *et al.*, 1999). While these factors are discussed in different literatures, their empirical and synergistic effects have not been formally linked with SH, making this study an original piece of work that contributes to our body of knowledge. Such information allows health professionals to plan a workforce where SH is minimized.

The hypotheses statements are listed below:

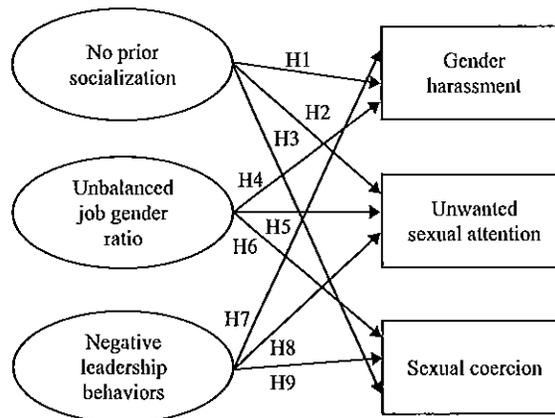


Figure 1.
Proposed SH model

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- H1.* There will be a significant positive relationship between an unbalanced job gender ratio and gender harassment of nurses.
- H2.* There will be a significant positive relationship between an unbalanced job gender ratio and unwanted sexual attention of nurses.
- H3.* There will be a significant positive relationship between an unbalanced job gender ratio and sexual coercion of nurses.
- H4.* There will be a significant positive relationship between a nurses' negative perception of their supervisor's management style and gender harassment.
- H5.* There will be a significant positive relationship between a nurses' negative perception of their supervisor's management style and unwanted sexual attention.
- H6.* There will be a significant positive relationship between a nurses' negative perception of their supervisor's management style and sexual coercion.
- H7.* There will be a significant positive relationship between no prior socialization and gender harassment of nurses.
- H8.* There will be a significant positive relationship between no prior socialization and unwanted sexual attention of nurses.
- H9.* There will be a significant positive relationship between no prior socialization and sexual coercion of nurses.

Methods

The health care setting provides an interesting arena to study SH. First, SH in the nursing profession presents many difficulties that alternative professions do not exhibit. Since nurses undertake a career of caring for patients, their duties break many of the "social rules" governing touch, bodily exposure, and sexuality. Second, as previously noted, past research has claimed that women in "traditional female occupations" experience reduced levels of SH (Gutek, 1985; Gutek and Morasch, 1982). Although, the nursing profession is female dominated (Daly *et al.*, 2004), high levels of SH are unexplained. We hypothesize that a nurses' job gender ratio should extend beyond the numbers employed in the profession and include patients, doctors, and other colleagues in the immediate work areas.

The population for this study is potentially all registered, enrolled or student nurses working in an Australian hospital. For the purpose of this research, and in order to ensure a manageable research cohort, the population has been restricted to Australian public hospitals in New South Wales and Victoria (metropolitan and rural areas). In total eight hospitals participated in the study. The hospitals in the rural areas of New South Wales and Victoria are considered base hospitals, which service an average catchment population of 90,000 people. Each metropolitan hospital is a large teaching facility aligned with various universities. In addition, student nurses were restricted to those who have spent a minimum of six months training in a public hospital in Sydney, New South Wales. In the full course of a nursing degree, students spend no more than 12 months in a hospital.

A mixed methods methodology was adopted. Gill and Johnson (2002) argue that a mixed method approach provides greater validity and reliability than a single methodological approach. The quantitative component included 538 usable questionnaire responses collected from 2,489 mailed surveys (response rate 21.6 percent). The qualitative component included in-depth interviews. The aim of the interviews was to enhance, elaborate, or illustrate the results obtained from the questionnaires (Gill and Johnson, 2002). It was anticipated that examples of SH incidents would add richness to the statistical results and provide an opportunity to test any contradictions (Gill and Johnson, 2002). The interviews were semi-structured with questions formulated at the conclusion of the quantitative data collection. A total of 23 in-depth interviews were conducted which took between 60 and 90 minutes each.

The data available from the Australian Institute of Health and Welfare (2005) clearly describes the total nursing population and allows for assessment of the representativeness of the sample. Confidence in the representativeness of the usable questionnaires was supported by demographic comparisons with the targeted population. Moreover, by sampling a geographic area containing a variety of specialty areas in both metropolitan and rural hospital settings, generalization of the findings can be made. Respondent characteristics are given in Table I.

Measures

Sexual harassment

Fitzgerald *et al.* (1995) sexual experiences questionnaire was used to measure SH. The questionnaire measures the frequency of exposure to SH and is designed to address varying levels of severity. The measure is composed of scales:

- (1) *Gender harassment*[2] – the most common form of which includes verbal, physical, or symbolic behaviors that convey hostile, offensive, and misogynist attitudes.

<i>Gender</i>		
Female	442	(82.2)
Male	96	(17.8)
<i>n</i>	538	
<i>Age</i>		
18-21 years	154	(28.6)
22-29 years	189	(35.1)
30-39 years	67	(12.5)
40-49 years	91	(16.9)
50 + years	37	(6.9)
<i>Years experience as a nurse</i>		
Student nurse at university (minimum six months and maximum 12 months hospital training experience)	251	(46.7)
Qualified <1 year	23	(4.3)
Qualified 1-3 years	29	(5.4)
Qualified 3-5 years	47	(8.7)
Qualified 5-10 years	62	(11.5)
Qualified >10 years	126	(23.4)

Table I.
Full sample characteristics

Notes: Percentage values are given within parentheses; some percentage values do not add up to 100 percent due to rounding

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- (2) *Unwanted sexual attention*[3] – which includes both verbal and nonverbal incidents such as sexual imposition, touching, or repeated requests for dates.
 - (3) *Sexual coercion*[4] – where the target's job or rewards are contingent on sexual cooperation.

These three scales and associated items align with the ILO's definition of SH introduced earlier (McCann, 2005).

All SH behavioral items were listed against a five-item Likert type scale (never, rarely, sometimes, often, and all the time). Gender harassment and unwanted SH are comprised of behaviors that constitute hostile environment harassment, whereas the third subscale, sexual coercion includes those behaviors under the legal definition of quid pro quo harassment. Respondents were asked whether they had experienced any of the behaviors listed that were accompanied by feelings of humiliation, embarrassment or discomfort in the previous 24 months.

Job gender ratio

The nursing literature has not examined the effect of an unbalanced job gender on SH. As such, there is no benchmark or known starting point for measuring this. However, as detailed earlier, we argue that job gender ratio in respect to nursing should account for patients, doctors, and other colleagues in the immediate work areas, in addition to other nurses. This represents a typical working environment for a nurse. Gutek and Morasch's (1982) sex-spillover model was used as the basis of the measure for this variable. Respondents estimated the gender ratio of all persons in the immediate work environment (for instance, doctors, medical professionals, other nurses, and patients).

Leadership behaviors

The measure for a respondent's perception of their manager's leadership style draws on the research of de Coster *et al.* (1999) concerning leadership behaviors and abuse. Some examples of items used to measure this construct include rude, abrupt, disinterested behavior in addition to supportive, attentive, and approachable. Items were listed against a two-item Likert scale (yes and no).

Prior socialization

A forced-choice question ascertaining prior socialization was presented to respondents who indicated that they had experienced SH. Drawing on the research of Collins and Blodgett (1981) and Weber-Burdin and Rossi (1982), respondents who had been sexually harassed were asked the prior working period with the perpetrator. It should be acknowledged that Collins and Blodgett's (1981) research identified socialization periods that are more long-term (from six months onwards). However, additional short-term options (i.e. one week) were added due to the particular needs of the nursing profession. This was deemed necessary as a result of Grieco's (1987) research, which identified patients as the major source of SH for nurses.

Quantitative analysis techniques and results

The first stage of the analysis employed descriptive statistics to determine frequency of SH and the differences among male/female nurses and qualified/student nurses. The second and third stages included factor analysis and structural equation

modelling (SEM). The final stage compares the interview results with quantitative findings.

The descriptive statistics prevalence of SH in nursing is high, with 60 percent of female nurses and 34 percent of male nurses experiencing a SH incident, in the two years prior to the study (Table II).

Surprisingly, no patterns emerged when SH was analyzed across different age groups.

Prevalence was higher for student nurses (68 percent) than qualified nurses (45 percent), a significant point as the student nurse respondent group reported in this research had only limited work experience in a hospital, in all cases less than 12 months. As the student nurses were working in a trainee and learning role, their duties are theoretically, fully supervised (Table III).

Respondents identified perpetrators of SH on the survey and later during interviews. Questionnaire results highlight patients as being the main perpetrator with 58 percent of the 305 respondents who experienced a SH incident naming a patient as the perpetrator. This was followed by physicians (27 percent), work colleagues (13 percent) and visitors to the hospital (3 percent) (Table IV). These results were not altered in any significant way when the experiences of male/female nurses and trained/registered nurses were analyzed separately.

Additional analysis was carried out to determine differences between other groups, nurses located in metropolitan and rural hospitals. No significant differences were found.

Table II.
Prevalence rate of SH

	<i>N</i>	Sexual coercion	Unwanted sexual attention	Gender harassment	At least one type of SH
Female	442	112 (25)	185 (42)	225 (51)	267 (60)
Male	96	13 (14)	30 (31)	19 (20)	33 (34)

Note: Percentage values are given within parentheses

Table III.
Prevalence rate of SH for trained and student nurses

	<i>N</i>	Sexual coercion	Unwanted sexual attention	Gender harassment	At least one type of SH
Trained nurses	287	32 (11)	96 (33)	117 (41)	129 (45)
Student nurses	251	90 (36)	115 (46)	145 (58)	171 (68)

Note: Percentage values are given within parentheses

Table IV.
Perpetrators of SH

	Patient	Doctor	Work colleague	Visitor
Any form of harassment	174 (58)	80 (27)	40 (13)	10 (3)

Note: Percentage values are given within parentheses

The data were transferred into a SEM file using LISREL 8. Initially, an acceptable fit was not obtained between the observed data of the full sample and the proposed model. The model was altered by eliminating the dependent variable, "sexual coercion" in line with Byrne's (1994) suggestion that small samples of people having experienced such treatment in a work environment makes it difficult to empirically test via SEM. Considering that one of the items for sexual coercion included "forced attempts at sexual intercourse," it is not surprising that small numbers of respondents had experienced such treatment at work. Indeed, only one respondent (out of 538) experienced this item. In fact, some of the items that measured sexual coercion could be regarded as sexual assault. As a result, it seemed appropriate to alter the model in this way. The output was examined for common anomalies, such as negative error variances and large parameter estimates. No such anomalies were noted.

The modified model yielded excellent fit statistics suggesting that the model captured the intercorrelations in the data (Table V). The fact that the model converged in only seven iterations for the combined sample adds further credence to an excellent fit. Table VI displays the correlation matrix.

Figure 2 shows the path figure with standardized estimates for the modified model. The error variances are all acceptable and below 0.50.

Discussion quantitative results

The empirical results found that 60 percent of female nurses experienced SH in the two-year period prior to this study. The SH of male nurses is also of concern though, with more than 34 percent experiencing SH in the same period. The large numbers of student nurses who reported a SH incident (68 percent) raise important questions about supervision of trainees and how the educational curriculum helps to prepare undergraduate nursing students prepare for and cope with SH.

Index	Results combined sample
χ^2	284.229 (df = 163, $p < 0.001$)
Sample size	538
Goodness-of-fit index	0.948
Tucker-Lewis index	0.981
Comparative fit index	0.981
Root mean squared residual	0.0391
Root mean square error of approximation	0.0385

Table V.
SEM measures
and results

	Gender harassment	Unwanted sexual attention	No prior socialization	Unbalanced job gender ratio	Negative leadership behaviors
Gender harassment	1				
Unwanted sexual attention	0.529	1			
No prior socialization	0.687	0.493	1		
Job gender ratio	0.379	0.595	0.407	1	
Negative leadership behaviors	0.418	0.423	0.554	0.542	1

Table VI.
Correlation matrix

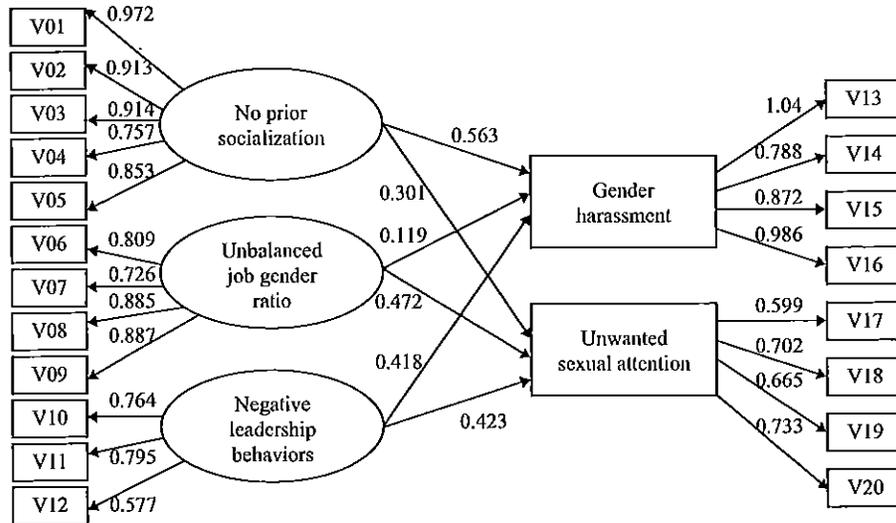


Figure 2. Standardized parameter estimates for the modified model

Notes: All paths significant at $P < 0.001$

The questionnaire results support Grieco's (1987) study, which found the most likely perpetrator of SH of nurses to be patients. In this study, 58 percent of SH episodes were initiated by patients followed by physicians (27 percent), work colleagues (13 percent) and visitors to the hospital (3 percent). The well documented coping strategies of SH targets, such as reduced communication with the harasser, increased anxiety and distraction or distancing from work commitments associated with harassers (Dan *et al.*, 1995) presents potentially disastrous outcomes considering the life saving role played by nurses and the large number of patient perpetrators.

The SEM results obtained and reported in Table V suggest strong support for the proposed model on the environmental causes of SH. Figure 1 that shows the structural relations, supports hypotheses *H1*, *H2*, *H4*, *H5*, *H7*, and *H8* revealing that:

- No prior socialization positively affects gender harassment (*H1*) and unwanted sexual attention (*H2*) of nurses.
- An unbalanced job gender ratio positively affects gender harassment (*H4*) and unwanted sexual attention (*H5*) of nurses.
- A nurse's perception that her/his manager exhibits negative leadership behaviors positively affects gender harassment (*H7*) and unwanted sexual attention (*H8*).
- Hypotheses statements (*H3*, *H6*, and *H9*) were not supported due to insufficient number of respondents who experienced several of the items that measured sexual coercion.

The SEM results highlight a positive relationship between a nurses' negative perception of their manager's leadership style and incidence of SH. This result

suggests that resources should be invested in developing the leadership qualities of health managers as daily interactions with supervisors were predictors of protection and/or perceived protection from SH. Following the underlying philosophy of the four-factor model, a focus on developing leadership skills (external inhibitors of SH) places an additional obstacle in the path of a potential SH perpetrator. Attention also needs to be invested in cultivating a supportive work group culture in order to increase the number of capable guardians and caretaker behaviors among peers.

The results confirm a higher probability of SH for nurses when interacting with a person without a working history than those with an established working relationship of any length. These results imply that if two people know each other personally, one party is likely to interpret behaviors (which could be associated with gender harassment or unwanted sexual attention) as a joke or prank rather than an attempt to humiliate, embarrass or intimidate. This presents important information for health managers in regard to developing cohesive work relationships among employees. The investment in building relationships and social networks appears worthwhile in preventing a SH incident.

This study also provides empirical evidence to support Jackson and Newman (2004) and Vance *et al.* (2004) that an unbalanced job gender ratio positively correlates with SH. This is perhaps the most difficult issue to address. While, we do not address the issue of attracting men to the profession; some obvious barriers remain in place, for example, the use of the term "mid-wife." Where possible, human resource planners should use some of the more sophisticated rostering tools, for example, RotaPlan or Smart Deployment, to account for gender differences within a unit. Other options may be careful placement of patients in wards, job rotation, and targeted selection and in some cases multi-skilling. In addition, education for patients on what constitutes SH and the effects on individuals can assist in reducing incidents in contexts where the gender ratio is skewed. In line with the four-factor model, all of these strategies increase the strength of factors which a perpetrator needs to overcome before a SH incident occurs.

Qualitative results and discussion

Data obtained from the interviews provided additional insights on the perpetrators of SH, and various components of the proposed model.

Perpetrators

The interview results did not confirm the questionnaire results on the identity of harassers. Interview respondents suggested physicians were the primary source of SH of nurses and provided insight on why the questionnaires results named patients as the likely perpetrators.

Each interviewee concurred that patients regularly engaged in behavior that could be classified as SH. It was discovered; however that one of the crucial ingredients that defines whether SH has occurred is often missing. All interviewees agreed that patients make sexual comments and propositions on a daily basis, however, there were only a few occasions where nurses felt in a vulnerable position or where these incidents were accompanied by feelings of humiliation or embarrassment. Half of the interviewees regarded SH by patients as part of the job. This is evident in the following comments made from two experienced female nurses:

It comes with the territory.

I don't tend to regard sexual comments from an elderly male patient as sexual harassment. It doesn't make me feel uncomfortable. I feel sorry for them. They are sick; and most of the time, don't know what they are doing. When a member of staff delivers these same comments, this is a different thing. They should know better.

The interviews provided an interesting perspective on the feelings associated with being sexually harassed by a physician. It appears that due to the hierarchical structure within hospitals and the authority given to doctors, nurses feel limited in their response to a SH incident initiated by a physician. This is evident in the following passage made by a female nurse with more than ten years experience:

Sexual harassment by a powerful doctor left no option but to leave the hospital. I left and a student nurse had to put up with him. I don't know how she fared.

Following hospital guidelines by being present during a gynaecological exam, one interviewee, a young female student nurse, was clearly disturbed when a physician made the following comment: "I'll do the next [vaginal] exam on you." One respondent, an experienced female nurse provided additional insight on this issue and raised the question of power. The interviewee believed there was a significant difference between the behavior of patients and physicians when determining whether SH had in fact occurred:

When it happens with a patient, you are still in control. You have the power not to treat them or get someone else to do it. Most of these people are sick, elderly men who have got no idea what they are doing. If you take offence for every lewd comment made by a patient, you shouldn't be in this job. On the other hand, even though I don't directly report to any doctors, they can make my life very difficult. They have authority and power over me.

The interviews provide some interesting information about occasions when feelings of intimidation are most likely to occur. It appears that when the behavior is initiated by a person in authority (such as a doctor), the nurse is more likely to interpret the situation in a negative way. However, interview respondents indicated that they coped with their SH experience by trying to avoid the person who bothered them; but at the same time, most noted that the nature of their work role required ongoing interaction with this person. These results have important implications for day-to-day functioning. If nurses who experience SH are required to interact with the offender in order to carry out their work, not only are the chances for further incidents increased, but also their avoidance strategies are likely to have a negative impact on the level of care given to patients. If patients are the perpetrators the potential outcome is disastrous.

Leadership behaviors

The interview results confirmed the importance of the leadership behaviors of a direct manager. On the whole the interviewees had been subjected to a regime of "dirty talk" and unwanted touching. In most cases the harassment continued for a significant period after the initial incident.

One female nurse with five years experience in a regional hospital described an on-going pattern of SH that continued for several years. It began with sexual comments, then "accidental" touches before an incident where the nurse was pinned

down on a bed during night shift when no one else was around. When the nurse complained to her manager she was advised to ignore the situation for a few months when the perpetrator was due to retire. The nurse explained the impact of events on her life:

It was one of the worst times of my life. My husband wanted me to go sick every day; I avoided the person and was afraid of being anywhere alone. I had no idea what to do. Eventually another nurse convinced me to involve HR. It was resolved very casually between the ward manager and the other party. He [the perpetrator] transferred to another position for his few months left without any formal warning or notice on his file. I felt great, until I heard it was happening again to a ward clerk. I wish I had the courage to really do something about it.

In contrast the following two comments demonstrate the difference a supportive manager makes. The first comes from an experienced male nurse and the latter from a female nurse, recently graduated:

As a male nurse I am constantly bombarded with comments in regard to my sexual preference. When we got a new unit manager who observed what was happening she outlined what my rights were and what would happen if anyone crossed the line. The comments have just about stopped and I feel she will support any actions I take to eliminate these types of comments.

People have this stereotype about nurses. They think we are all walking mattresses and open to any sexual encounter offered. Because I offer warmth and compassion in the way I deal with my patients and their visitors, people think I am coming on to them. One guy (visitor) waited until my shift finished and confronted me in the staff car park. He said I gave him mixed signals. Can you believe it? – His mother was in intensive care. The next day my UM (unit manager) spoke to him and made clear that if he wished to continue to visit his mother he needed to treat all staff with respect. He completely changed and we all felt supported that our supervisor would stand up for us in this way.

Socialization

The interviews also support the importance of socialization. One experienced female nurse commented:

Once I have gotten to know a patient and cared for them for a while we may have a little joke and engage in some innocent flirting. It is harmless.

In another interview, one respondent indicated that without a positive working relationship in place a nurse is likely to interpret one event as harassment. This same event however, could be interpreted as a joke if a cohesive working relationship was in place. The interviewee, an experienced female nurse described a practical joke where her clothes and towel had been removed from staff facilities during a shower that resulted in her entering the male locker room and then the ward in the nude. "It was a riot [laughing] [...] we would never try that on someone new."

When this nurse was probed for more information on why this practical joke would not be attempted on a new recruit she remarked that a new employee would take the prank in a negative way, suggesting that the prank in this case did not result in any of the negative outcomes usually associated with SH and detailed earlier in this paper.

In this study, we confirmed that all of the participating hospitals in the study had a SH policy, a grievance-handling mechanism and compulsory SH awareness training.

Despite this, large numbers of nurses had experienced a SH incident in the 24 months prior to the research. This suggests that reactive measures (such as grievance-handling mechanisms and SH awareness training) are by no means sufficient in managing this growing problem with wide-ranging implications. Other methods for combating SH need to be considered, such as leadership development as a means to develop caretaker behaviors. In addition, team-building and social events that build rapport should be encouraged, together with education for patients.

Limitations and further research

Potential limitations inherent in this study include the use of self-report data. We must consider whether the use of self-report data influences the findings in any way.

A second potential limitation concerns the low response rate obtained in the sample. However, since the sample is representative of the full nursing population and a large sample size has been obtained, it is suggested that the findings are not a function of the response rate.

Other moderating and intervening variables such as organizational culture, nursing units (such theatre, intensive care, and general care nurses) have not been explored and could be considered a limitation of the study.

A number of areas for further research are recommended. The model introduced in this paper could be extended to explore outcomes of SH (e.g. turnover, productivity, etc.). In addition, there are a number of opportunities to study how men and women perceive different sexual behaviors as appropriate or inappropriate. The relatively low level of gender harassment of male nurses (in comparison to the more severe unwanted sexual attention) is worth exploring. Is this the result of socialization, or do male nurses encounter the behavior without feeling humiliated, offended or embarrassed, or due to differences in a person's value system? More work is needed.

The human resource management and psychological literature outlines the effects of SH on work performance. Such studies need to be extended to the nursing profession. In light of the global nursing shortage (Daly *et al.*, 2004) such research may pinpoint areas for future attention. Further, such investigation may reveal that SH affects a nurse's quality of care of patients. As mentioned, a SH incident results in lowered self-esteem (Willness *et al.*, 2007). This is a cause for concern as a person with lowered self-esteem may not be able to provide adequate health care in a medical setting, let alone perform critical life-saving tasks.

Conclusion

Like other occupations the prevalence of SH in nursing is high, one may even argue that it is a normative experience for the nurse, rather than a rare occurrence. Current mechanisms however, such as awareness training, grievance handling processes and policy develop have failed to reduce the frequency of SH incidents. Rather than just acknowledge the prevalence of SH this study has made a significant contribution to our understanding of SH by identifying some of the core organizational facilitators of it. The individual relationships of these facilitators to SH were empirically tested and their synergistic effects on one another have been linked. The existence of multiple relationships was measured and substantiated by testing the model using SEM.

It was found that a nurse's negative perception of the leadership style of his/her manager to be an important variable in predicting SH. The contradictory evidence in the

literature regarding job gender ratio was also explored. This study found that an unbalanced job gender ratio, favoring men or women positively correlates with incidence of SH. Finally, it was concluded that a lack of socialization is associated with SH.

Data from the interviews supported these results but also provided a greater understanding of who the perpetrators are and how nurses respond. While the questionnaire determined patients to be the most likely offender, the interviews suggest that when patients adopt behaviors that could be defined as SH it is less likely to be accompanied by feelings of intimidation, humiliation or embarrassment. When physicians or work colleagues adopt the same behaviors it is more likely to evoke negative feelings and outcomes.

The focus on organizational variables that contribute to incidents of SH assists health professionals develop preventative measures for eradicating this growing phenomenon. Such a proactive approach is in line with calls for research on "strategic" health management issues.

Notes

1. Some studies have surveyed a large population only to eliminate male responses (Waldo *et al.*, 1998; DuBois *et al.*, 1998).
2. In this study, Cronbach Alpha coefficient = 0.81.
3. In this study Cronbach Alpha coefficient = 0.91.
4. In this study Cronbach Alpha coefficient = 0.95.

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462

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