FOLLOWING DOCTORS ORDERS: UNDERSTANDING THE PHENOMENON OF
GENDER BASED HARASSMENT IN ACUTE CARE HOSPITAL’S AS EXPERIENCED BY
FEMALE NURSES

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Abstract

Sexual and Gender Harassment are top of mind in the current cultural landscape, with marked increase in conversations and testimonials coming forward by women of diverse backgrounds, ages, careers and workplaces, both in the US and globally. The topic has created a vast channel of myriad communications and multi shaded responses to those women who have been courageous enough to open-up and share these oftentimes, shame filled and buried experiences. In organizations where there are more males in power over their female subordinates, as in healthcare, we see an increase in these types of gender/sex harassment/behaviors. In phase one of this mixed method study a survey was used to collect occurrence, type and frequency of gender/sex harassment/abuse behaviors. In phase two, an interview process took place with the goal to better understand the lived experiences of female nurses who experienced some type of this behavior, and the impact and effects these experiences had on them psychologically, physically, and on their jobs. The conclusion was that acute hospitals have an organized patriarchy in place, male physicians are held in higher esteem and have more clout than female nurses. Male physicians use gender harassment language and behaviors to control, thereby maintaining their power within the organization, whilst the implied authority of the MD is supported, even in the case of sexual assault. This renders a sick culture of sex/gender harassment/abuse where these types of behaviors occur with alarming frequency, leaving the emotional and psychobiological effects up to the nurse to deal with alone.
Acknowledgements

I cannot express in words what I feel upon the completion of this monumental journey. I speak from my child’s heart. A mop topped little girl, ever smiling, trusting, seeking to understand, who sought to forgive those who had harmed her-dampened her light & stole her innocence, through their trauma and abuse. Protecting herself, shutting her light. A pregnant high school dropout who was proving them right-she would “never amount to much”. Who couldn’t imagine she had anything of value to offer to this world. Fast forward to today.

There are many to thank for this blessed transformation – this journey of Hope. First is my Lord, Jesus Christ and His divine Love. My faith in God has been instrumental in walking through the dark paths of my human history, to recognizing I am truly Loved. That I am Loveable. That every human has a right to be heard and to be seen. No matter where or what you come from.

To my own “boy next door” my Love. My life. My own Prince Charming. My husband of 38 years; Claude. With his quiet loyalty & love, he became my source of constant strength, my biggest advocate. This man as my constant. My true North. He tethered me, supported me, loved me, through the chaotic revelations & struggles, working & healing through a history of sexual abuse and trauma. Safe & secure in his love: I’ve found my wings-my freedom. My Self. Claude, I will Love You through eternity.

To my parents: Dad who gave me his strong work ethic, my Mom, who have me her faith and acceptance. I love you both, your sacrifices & passing has resulted in much healing. My siblings: Donna, Dawn, Jerry, Gary & Darlene: my Tribe. I love you all so completely. My children; Adam & Tamara, who renewed my ability to love, who inspire me daily with their intellect and insights. I love you both. My grandchildren: Maevan, Mason, Ruby, Jonathan &
Ethan. They were the catalyst for my child’s salvation. I will love them fiercely and tell them daily how amazing they are and the gift they are to this earth.

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And finally, but certainly not least, to my thesis committee: My amazing Doctoral chair; Dr Patricia Mason. You have been instrumental in holding a supportive and guiding space that has enabled me to dig deeply into my own pain and experiences of sexual abuse, to bring this topic out of the dark, framing it within the scholarly light. You are a blessing! To Dr Melissa A. Parenti, my second reader: Your insight and objective perspective was instrumental in delivering that 360° perspective. To my third reader: Dr Candace Smith, my colleague and friend. As a nursing executive, your review and firsthand insights into gender/sex harassment the culture of healthcare, are invaluable to the validity and the potential sequelae of this topic. Thank you all.
Dedication

“To all my beautiful brave sisters, who have faced many monsters tall & born their darkness...yet continue to Love & Hope”

Now. Now is Our time... ~Doreen

Haseya: Ajeet Kaur

(Haseya is a Dine' word meaning SHE RISES or to RISE UP. It calls on the Sacred feminine to Rise Together.)

I am the river of life I am the keeper of this dream
Walk with me I'll tell you a thousand stories...Long ago given to the Earth.

These mountains tall
They are my only walls
In this temple...where I bow
Haseya

Rise up my sisters rise up
We are the water the sacred cup
It's in our hands that all life grows
It's in your dance- it's in your hands
It's in your love we rise above
It’s in your song I hear my Soul
So rise up my sisters rise up
Let us lift each other up
Sing it from your heart
And from your Soul
Haseya

The sun and moon they shine together
She moves the waters
And dances with the heavens
In your eyes I see Haseya rise
In your eyes I see the giver of this life
Haseya

In your eyes I see Haseya rise
In your eyes I see the giver of this life
Haseya
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Chapter One: Introduction

Sexual and Gender Harassment have become top of mind in the current cultural landscape, with marked increase in conversations and testimonials coming forward by women of diverse backgrounds, ages, careers and workplaces, both in the US and globally, with sexual harassment in particular being “legally labeled an organizational phenomenon (Clair et al., 2019, p. 111). The topic has created a vast channel of myriad communications and multi shaded responses to those women who have been courageous enough to open-up and share these oftentimes, shame filled and buried experiences (Clair et al., 2019). Oddly enough, or not, if you have an awareness of the historical patterns of these types of harassing behaviors, instead of an empathetic shout out to those who have experienced this harassment, an almost “misplaced judgment and blame” toward the woman, has served to only further validate the choice these women made in not coming forward when the harassment/abuse occurred (Clair et al., 2019, p. 113)

The blanket under which sexual harassment and abuse occur, is oftentimes associated with the levels of acceptance within the environment it occurs, frequently affecting the employees with a decreased morale, job satisfaction, and increased absenteeism and attrition rates (Schneider, Swan, & Fitzgerald, 1997; Pryor, Lavite, & Stroller, 1993). The prevalence of such gender and sexual harassment events is increasingly becoming elucidated and acknowledged to be more widespread than anyone had thought: Which isn’t surprising when one considers the psychological and psychometric impact the victim of the abuse faces if these events are reported ((McLaughlin, Uggen, & Blackstone, 2017; Schneider et al., 1997; Fitzgerald, Gelfand, & Drasgow, 1995). With a suspected one in three women affected by gender/sexual harassment, there is much to learn from these women’s stories of degradation and harassment,
as well as the environments which may have either supported these behavior’s through a casual dismissal of respective reports, or an abject refusal to lend any credence to the purveyor’s validity. (Schneider, Swan, & Fitzgerald, 1997; Pryor et al., 1993; Lim & Cortina, 2005; McLaughlin et al., 2017).

With a recent study by Vogt, Bruce, Street, & Stafford (2007), reporting some estimates as high as fifty percent of all women within the workforce may experience some form of sexual or gender harassment within the women’s lifetimes (879) we are truly faced with this detrimental and psychological impact in not only our workplaces, but as a human race. The evidence is becoming increasingly more staggering as more of these women come forward to share torrid stories and experiences. Research is needed to uncover these environments where these types of behaviors exist vs. flourish and where these behaviors are rewarded. Researchers are now discovering that there is relational cause within certain environments where sexual/gender harassment may be considerably more prevalent and have a higher tolerance for gender or sexual harassment behaviors given the nature of higher ratios of men versus women in administrative or positions of power, occupations that rely upon more traditional gender roles, as well as larger overall populations with higher ration of men versus women in general positions (Vogt et al., 2007). It is in the healthcare landscape dominated by male physicians and executive administrators, where further examination of this phenomenon should occur.

The subsequent sections of this chapter serve to surround and elucidate this problem of practice facing nurses in healthcare while providing some detail and rationale for the research question posited within this study. Two theoretical frameworks derived from the literature were used to frame this problem of practice. The paper presents a brief discussion and review of the
current literature on patriarchy, sexism and gender-based harassment and oppression, and associated effects on those victimized.

This chapter is divided into five subcategories. The first section discussed the problem of practice, examining the literature on historical factors like the onset of patriarchy, social dominant organizations, sexism and gender-based harassment and the psychological and psychometric impact on the abused and harassed. The second section discussed the significance of this problem within the literature, and potential international and local impacts. The third section served to identify the authors personal bias with relation to this topic, and the fourth section served to qualify the research questions and aims of this study. The fifth and final section, details the theoretical underpinnings used in this study as a construct for this research. The use of Max Weber’s Theory of social and economic organization provides a structure of power and patriarchy (Weber, 1947, p. 341). Sandra Lee Bartky’s theory of femininity and domination (1990), provided a critical intersection and feminists lens with which examined gender-based harassment and psychological oppression exists. The use of these theoretical frameworks served to construct ground and elucidate this research in scholarly insight (Creswell, 2013).

**Problem of Practice**

Nursing is a predominantly female profession that exists within a historically male dominated organizational structure (Ashford & Mael, 1989). Female nurses make up at least 80% of all nurses in the US (Sen & Samdup, 2009), despite rising male nurse matriculation, females make up most of the nurse workforce (AACN American Association of Colleges of Nursing, April 2014; Bureau of Labor Statistics, 2013). Female nurses have worked within the male dominated healthcare structure, experiencing sexism and many forms of gender-based
harassment and abuse by male superiors; primarily physicians, the very people whom it is expected to have a close synergistic relationship with (Bartky, 1990; French, 1994; Davies, 2003; Kouta & Kaite, 2011; Morgan, 2006). Despite the common occurrences of sexual and gender harassment, this behavior has not been easily recognized externally, many believing that because the licensed nurse, is legally accountable and responsible for the entire plan of care, to the degree the nurse is required to question a physician and his orders, these nurses are falsely lulled into a sense of belief that both parties are on equal footing (Cox, 2006). Healthcare is facing pressure from payers pushing for increased efficiencies and cost effectiveness as a response to the healthcare staff shortage of doctors and nurses (Bourgeault & Grignon, 2013, p. 202). The inter-professional team has become the framework for patient care to provide these efficiencies. With the increase of licensed independent practitioners (LIPs), Nurse Practitioners (NP’s) and Physician Assistants (PA’s), each of these clinicians have challenged the power seat of physicians (Bourgeault & Grignon, 2013) resulting in power plays and lines being drawn in the proverbial sand. Due to the increased access to patients of these practitioners, many patients are reporting satisfaction and preference of personal care, reporting increased comfort with attentiveness and comprehensive care provided by these LIPS (Hevesy, Aitchison, Ruiz, & Bechmar, 2016). The current number of LIPS in practice was over 175,000. Many NP’s are female, given the fact that women make up most of the profession (Bureau of Labor Statistics, 2013; Sen & Sendup, 2009). Gender domination continues to (Kouta & Kaite, 2011) play a significant role in the way these nurses’ practice, as nursing remains a predominantly female profession, and physicians, predominantly male (Bureau of Labor Statistics, 2013; Sen & Sendup, 2009). Despite this rise in advanced practice nurses, the licensure level and denoted responsibility and singular accountability for patient care in its entirety, stereotypes and
patriarchal power norms still dictate that nurses “accept “and carry out “orders” without question or challenge (Davies, 2003).

This professional disparity as well as the traditional occupational roles of male physician - female nurse, provides a ripe organizational landscape that enables male-superior/female subordinate oppressive power plays to thrive (Birnbaum, 2017; Vogt et al., 2007). Many women who speak out about this form of gender harassment, have been signaled out if the women chose to deviate from this norm (Davies, 2003). So, too, like gender oppression, gender-based harassment is often identified and accepted as a fact of life within this male dominated environment, especially in younger, less tenured female nurses, and is frequently played off as an accepted side shoot of doing business (Finnis & Robbins, 1994; Kouta & Kaite, 2011).

Despite much literature on the topic of power and dominance in organizations, diversity training and the implementation of anti-discrimination laws, these seeming anomalous dominant power structures remain a reality for many females in healthcare (Roscigno, 2011; Gottfield, 1998). Such remains the case in similar organizations with strong male superior to female subordination ratios like the military and other “fraternal” organizations (Cortina, Kabat-Farr, Leskinan, Huerta, & Magley, 2013; Vogt et al., 2007). Lim and Cortina (2005), define this phenomenon and marginalizing behaviors as “gender-based harassment” defined as executed acts of rude and lascivious behavior meant to offend females, are considered benign, frequently expected, tolerated as contextually acceptable, and oftentimes not reported or dealt with seriously (p. 493). Cortina et al., (2013) calls this gender-based harassment phenomenon “workplace incivility” (p. 1580), occurring frequently when there exists a male dominated structure within the organization, especially when majority of power positions are held by males, and an inverse number of subordinate roles are filled by females (Davies, 2003). There is a pervasive undertone
that legitimizes these behaviors against women, especially those women who speak out against the injustices. It is understood that there is an approved way that one should “perform gender” that is congruent both culturally and socially. It is recognized when these females speak out or don’t adhere to these expected behaviors and may lead to some form of punishment when the “gender” isn’t done “right” (Silva, 2008, p. 941). Silva (2008), speaks of an increase in the activity of sexual or gender harassment in those situations in which female nurses don’t hold to the usual sexist gender stereotype of “passivity” and “femininity” instead these nurses continue to voice opinions and concerns where patient’s safety and health are reliant, despite repercussions that may follow due to such actions (Silva, 2008). In healthcare, there exists this type of closed, social male dominated, patriarchy, which promotes female subordination, by discouraging female nurse communication, deemed “unnecessary” or considered “challenging: to the physician’s position, bringing with it, verbal abuse, repercussions, shaming and labeling (Gordon, 2005, p. 81).

Female nurses are being defined through stereotyping and sexism, and not for what these nurses can or cannot do, but for qualities that render them “lacking” when compared against the desired characteristics of the male physicians (De Saxe, 2012). These nurses are treated unfairly in accordance with those beliefs, resulting in sexism and gender harassment (Gordon, 2005). This appears to be shaping the way nurses communicate with physicians (Cuban, 2009). To effectively disrupt this hegemonic oppression within the healthcare ranks, it is imperative to increase the awareness and effects of these types of behavior, not only on the nurse’s psychological state, but also the state of the patients. Female nurses need to feel confident and comfortable when making accurate decisions, feeling safe that when valid concerns are brought
forward to the physicians, and confident that there will not bear some sort of social and psychological punishment for reaching out (Davies, 2003; Bagguley, 1991).

In an interesting article on staff decision making within the male dominated healthcare environment, Laschinger et al. (1997), studied Kanter’s theory of structural power, and how it applied to the patient care unit (Spence-Laschinger, Sabiston, & Kutscher, 1997). The findings identified that difficulty occurs when the Registered nurse is put into situations where there is delegation and coordination of care for patient populations, requiring them to speak out in advocacy (Spence-Laschinger et al., 1997). This is important in the overall scheme of provision of care.

The nurse provides direct and supervisory care for the patient, coordinating the care team. This female nurse is in contact with the patient more than any other ancillary healthcare worker, as well as the physician. The nurse is expected to elevate an understanding and act autonomously, while employing leadership skills to facilitate effective and safe nursing care. Spence-Laschinger et al. uses Kanter’s framework to investigate the nurses work experiences, behaviors and the attitude these nurses have over the environment and the people within it (Spence-Laschinger et al., 1997).

The literature tells us that oppressive environments and sexist gender-based behaviors applied to females within these patriarchal structures, may cause psychological oppression, resulting in lower self-esteem and confidence levels (Bartky, 1990). This was validated in Spence-Laschinger (1997) research, as well as this study. Kanter, as cited in Spence-Laschinger (1997), believes that a person’s attitudes and behaviors, are directly impacted by the way the work environment treats them, as well as what the current position, responsibility and circumstances are and not necessarily a personality predisposition (Spence-Laschinger et al.,
Given these data, is it any wonder when there is hesitancy, and frequently anxiety and fear, when a nurse communicates to the harassing physician or male superior. The concern is that this becomes a paradox of caring that is putting patients and nurses in positions of compromise (2005).

**Rationale and Significance**

The rationale for this study was the researcher’s interest and desire to understand what impact these patriarchal structures, sexism, and gender-based harassment have upon female nurses in healthcare, and how that phenomenon impacts the affected target and subsequent communication with those harassing individuals (Davies, 2003; Cortina et al., 2013). To that end, the significance of understanding this social phenomenon through the eyes and experiences of those female nurses who have lived it, have served to bring awareness by shining a light on these marginalizing, abusive & psychologically oppressing behaviors (Finnis & Robbins, 1994).

Such in the way that economic oppression has in creating a sustaining force that allows for the dominated to exercise will over respective subordinates, so too does psychological oppression thrive systemically within institutions (Bartky, 1990). The goal of the patriarchal order, is to see to it that females remain oppressed, understanding that the females are not as good as the organization “higher ups”. This reinforces the males in powers’ own sense of legitimacy, serving to support ascendancy to greater realms of power within that structure (Bartky, 1990; Morgan, 2006). This formalized legitimacy of rank or class also succeeds in creating a lull of acceptance and tolerance and corollary despondency in subordinates, that might lead to acts of sexual violence and abuse (Bartky, 1990; Vogt et al., 2007; Lim & Cortina, 2005).

Stereotypes of any kind have succeeded in wrongly applying a cluster of characteristics or beliefs to a specific race, gender, or culture (Bartky, 1990). These stereotypes can suppress
the growth and ascendance to power of the group being stereotyped. Through the experience of this social type of powerlessness and stereotyping, tacit communication is conveyed to the subordinate deemed not as integral to the overall goals of that structure (Birnbaum, 2017). Sex based stereotypes have been clearly defined over the years, and it is these definitions that have existed within society, especially in places such as healthcare where a doctor is still considered a male role, and a nurse, a feminine role (Manchester, 2013).

These gender stereotypes have been so deeply embedded within the fabric of our cultures both nationally and internationally. In one study by Paramore, Wilbourne & Kee, (2012), children aged eight, were given a series of occupations and male and female names and asked to pair up a name with an occupation. The results demonstrated that children at this age clearly held gender stereotypes regarding roles and occupations, placing “Henry” as a male oriented role despite his role as a nurse, and identifying female names with historically accepted female occupations like nurse, teacher, librarian and housekeeper, among others (Parramore-Wilbourne & Kee, 2010, table 1).

Of interest to this stereotyping of historical feminized nursing and masculinized physician roles, there have been increasingly more females entering the medical programs, successfully graduating and practicing, attempting to create diversity within the profession. Although, despite this influx, most physicians in American remain male (Uhlenberg & Looney, 1990). Of note, even when females enter the medical field, they are still earning 13% less upon hire initially than their male counterparts, and on average 28% more overall, approximately eight (8) years later continuing to demonstrate gender bias within the healthcare field (Esteves-Sorenson & Snyder, 2012, p. 37).
Aranda, Del Rosario-Castilli-Mayen, & Montes-Berges, (2015), studied these gendered effects as applied to nurses within three separate groups resulting in a conclusion that supports the narrative that gender stereotypes exist. Most of the attributes assigned to females, were less than positive (Aranda et al., 2015). Anecdotally, patients will turn away from the female nurse or even female doctor in charge, requesting validation of what the female is saying by asking the male in the room to weigh in, though he may be the subordinate. This is also supported in the literature where physician profession is given the ultimate trust, having had created their own legitimacy (Bourgeault & Grignon, 2013; Uhlenberg & Looney, 1990). Patients and society typically relate the male gender to the role of physician which is equivalent in healthcare to the one in power (Parramore-Wilbourn & Kee, 2010).

The questions that guided this research were focused on how this stereotyping of gender roles within healthcare had affected these female nurses and the way they perform their roles. Their retelling of their lived experiences of this phenomenon of sexism, and gender-based harassment and how it impacted and affected their self-esteem was insightful and is detailed in chapter four, where we also present the evidence on the lasting impact of this kind of harassment/abuse have on the one experiencing it.

The implications for this study are wide reaching. Astoundingly, even in today’s diversity aware environment, sexism, sexual harassment and abuse, gender oppression and general abuse of power in patriarchal dominated organizations are the best known “secrets” are just now being brought to light across the globe (Bagguley, 1991; Cuban, 2009; Rawat, 2014). These phenomena are not just found in healthcare (Finnis & Robbins, 1994) or the military (Cortina et al., 2013) these power based abuses come in many forms and occur in myriad organizations around the world, from healthcare to Hollywood ("Women of Hollywood ...casting
couch," 2017), to governing bodies like the United States congress ("Sexual abuse in Congress?" 2006), to corporate America and corporations and societies around the globe (Aranda et al., 2015; Bagguley, 1991; Kouta & Kaite, 2011; Roscigno, 2011). As the literature asserts, the outcomes of patriarchal power structures, like those in healthcare (Gottfield, 1998) lead to psychological oppression (Bartky, 1990), accepted sexual/gender harassment and abuse (Finnis & Robbins, 1994; French, 1994; Lim & Cortina, 2005; Cortina et al., 2013) while giving rise to feelings of shame, self-doubt, powerlessness and low self-esteem (Lips, 1994) to the women experiencing the harassment/abuses. The psychological and psychometric impact on women of these such acts have been accepted and gone unnoticed for decades, and it’s time nurses and physicians act to start to change this phenomenon.

This timely and relevant study served to shed a ray of light on the shroud of darkness which oftentimes blankets this dismissed subject matter. This study succeeded in bringing encouragement while these women became empowered in their storytelling, voicing their experiences and insights, out loud, without judgment, suspicion or shame. The goal of having them tell their story was realized. These women interviewed were able to bring forward their insights, as those who have lived and experienced this phenomenon. These women’s words have provided the reader an insightful look inside those who lived through these experiences.

Through the “telling” of their stories, these women have begun to heal. Through presenting their stories, we desire the reader to learn. To do. To act. Storytelling is a common way for humans across the globe and in all cultures to communicate lived experiences (Gladding & Drake-Wallace, 2010, p. 15). Through their stories of harassment/abuse and effects of misuse of power, these women have, for the first time, had a way to release the emotions attached to the experiences, making meaning and adding value to the greater narrative (Gladding & Drake-
Wallace, 2010). Not being able to tell one’s story, shuts off one’s voice. Untold stories may cause internal suffering and may impede their growth and development. Freud himself stated that telling of one’s story is validating and required to move forward (Gladding & Drake-Wallace, 2010, p. 16).

This discourse served to contribute to the seeming pandemic of psychological oppression, sexism, sexual and gender harassment, abuse, and gender stereotyping, through transparent and thoughtful scholarly investigation into this phenomenon and its potential for negative impact. These results may transform the way we reach out and support nurses who enter the profession, providing male dominated healthcare administrations insight into the norms that guide their organization which had been formerly accepted and supported (Weber, 1947; Morgan, 2006; Vogt et al., 2007), and implications for this research are detailed in chapter five.

**Positionality and Bias**

This research developed organically from my years of observation, and of my own experiences of this very phenomenon within the healthcare landscape. As a female registered nurse, with over 20 years of acute care experience in multitudes of care areas and positions across acute care, including nursing leadership, I have been on the receiving end of the very behaviors this research elucidated; from passive aggressive behaviors (Bartky, 1990) employed by a male cardiologist who dismissed my input during rounds when it was contrary to his own (Churchman & Doherty, 2010) to sexual assault and intimidation (Finnis & Robbins, 1994) by a male physician who grabbed my ponytail one night shift, pulled me to him, whispering “things he could do to me” in my ear, to the verbal sneering and shaming (Lips, 1994) in front of patients, my peers and my manager, by a renown chief of vascular surgery when I was a novice nurse, informing everyone around us that I was “worthless” dismissing my communication
regarding a serious drug interaction involving one of his patients (Churchman & Doherty, 2010),
to the orthopedic surgeon who behaved like a child, throwing both a tantrum and large metal drill
across the room during surgery whilst the patient was under anesthesia (Lim & Cortina, 2005).

These are just some of many such incidences of these types of gender and sexual
harassment/assault (Finnis & Robbins, 1994) that I have experienced from a diverse cluster of
male physicians in varied hospitals across two states. Imagine my surprise when I attempted to
file complaint the first time and my manager, (who witnessed the event in question) was, told me
to just shake it off as the physician in question had that kind of a personality. When later in my
career I was sexually assaulted, I communicated the event to the nursing supervisor who told me
I should consider myself “lucky” that Dr. X found me so “attractive” as he was so “handsome”
and there were many nurses who wished he noticed them. This type of “moral disengagement”
occurs frequently as indicated by the results of using the Moral Disengagement in Sexual
Harassment (MDiSH) tool as cited in (Page, Pina, & Giner-Sorolla, 2016), where a group of
people begin to believe that their behaviors are “harmless” and they don’t mean anything by it.

It is this pervasive type of acceptance that lends itself to continued abuse (Lim & Cortina,
2005; Lim & Cortina, 2005; Vogt et al., 2007). I was an older female nurse, being in my early
thirties when I graduated, and had the ability to resist this type of behavior, speaking out and
charging the perpetrators. The most disheartening thing was the way everyone accepted their
behaviors, citing the physician as the ones who brought the “money” to the facility by way
of their patients, or that that was “just how he is”, advising me to somehow stop speaking about
it, and just accept that these things were commonplace if you wanted to work within acute care
(Brown & Starkey, 1994).
My awareness of these lived experiences presented as a singular challenge during the interview process, as I felt a certain solidarity with these women interviewed, I did remind myself it was their story, I was an avid supporter and active listener, providing a nonjudgmental environment, surrounding them within the safe space for them to tell their stories. I learned and gained much insight listening with objectivity, and empathy, while maintaining a therapeutic boundary where the richness of their experiences, though painful, did flourish. My goal of avoiding the melding of both their and my story together was met, while I placed the focus on the three women as they told their stories (Behar, 2007). In the analysis of these data collected, I was fully informed and aware of the underpinnings of each of the stories. I cautioned myself before each interview, reminding myself to make assumptions based on the participants experiences, giving each of their stories a place where it could thrive and grow and teach. I did use bracketing to sidebar my own feelings and assumptions made from my own experiences (Vagel, 2014).

**Research Question and End Goals**

The purpose of this research study was to investigate and explore the phenomenon and impact of sexual/gender harassment of female nurses within the patriarchal organization of healthcare as told through their lived experiences. This study had the primary end goal of considering and gaining insight into other female nurse’s experiences, as they made meaning of them, and to validate them (Vagel, 2014). The investigator viewed these stories told throughout this study, through the lens of feminism and the organizational construct of patriarchal theories (Weber, 1947; Bartky, 1990; Creswell, 2013). The key questions that guided this study were:

1: How frequent was the occurrence of gender/sexual harassment within healthcare among the purposive sample participants, and the other more frequently occurring behaviors
(Finnis & Robbins, 1994; Fitzgerald et al., 1995). This data was extracted from the quantitative survey portion.

2. What were the types, frequency, level of severity and of occurrence of sexual/gender harassment behaviors? Again, this data was extracted from the quantitative survey.

3. What behaviors and experiences reflect a similar slant, as related by the female nurses lived experiences? This data was extracted from qualitative interviews.

4. How did these female nurses define and describe their personal experiences of sexual and gender harassment within the acute care environment? This data also was extracted from the qualitative interviews.

5. How did these female nurses describe the effects of sexual/gender harassment on their health, careers and the way they practiced? Also extracted from the qualitative interviews.

(Latchieva, 2017; Farquharson et al., 2013)

**Definition of Key Terminology**

**Term 1**-Patriarchal organization as defined by Max Weber (Weber, 1947) and his theory on social dominance.

**Term 2**-Psychological oppression as defined by Bartky in her study of critical feminist theory and the phenomenology of oppression (Bartky, 1990).

**Term 3**-Sexual harassment as defined by Fitzgerald, Gelfand and Drasgow (1995), is the construct defined by three spheres reflecting the spectrum of behaviors from hostile environment: gender harassment and unwanted sexual attention, to quid pro quo; sexual coercion.

**Term 4**- SEQ-W instrument used in this study, as defined, validated, revised and re-tested with rigor by Louise F. Fitzgerald, (1995).
**Term 5**- Acute care, healthcare is defined as a care environment where acutely ill patients are care for on the health care continuum, usually any hospital environment.

**Theoretical Framework**

This research study on female nurse’s experiencing sexual/gender harassment within acute care organization and their perception on those experiences required the use of two theoretical frameworks with which to ground the results (Van Manen, 2016). The underlying framework and construct with which these data were studied required a critical lens to view, accomplished through the application of Max Weber’s theory on Social Organizations, specifically Patriarchy and Domination by which we view the healthcare organization from, providing a roadmap to better inform the reader (Weber, 1947). The patriarchal structures are environments ripe with male domination, sexual harassment, and gender harassment/oppression (Bagguley, 1991).

The literature on gender within male dominated organizations, informs us that there is nothing we don’t experience without gender (Kouta & Kaite, 2011; Lim & Cortina, 2005). To better frame this intersection within that structure, we applied the lens and context we viewed the rich data presented by the women interviewed, based on their lived experiences. Sandra Lee Bartky’s theory of femininity and domination; specifically, gender oppression, was instrumental in viewing and understanding these data (Bartky, 1990).

**Social and Economic Theory: Patriarchal Organizations**

In defining types of social relationships in his Theory of Social and Economic Organizations, (Weber, 1947, p. 139), Max Weber seeks to define the relationships and commonalities which drawn people together socially. In viewing the description of “open and closed” groups, we gain valuable insight into the underpinnings of the healthcare organization.
Physicians, through the creation of the American Medical Association (AMA), have created their own authority and legitimacy, by presenting their power in the form of the production of their own knowledge and expertise to society (Bourgeault & Grignon, 2013), fostering a trustworthiness in their profession that is derived directly from the source (2013, p.202). Weber refers to a closed social group in which the members themselves determine subjectively who they allow inclusion to into their group, building it so that those who have been determined maligned, or were perceived as a direct threat to their power, are not allowed in the ruling class (Weber, 1947).

Closed organizations, such as healthcare, per Weber (1947), have the goal of monopolizing on their exclusivity, keeping the ruling ranks within, relatively controlled, and appropriating certain rights among those included. With this solidarity, comes a recognized authority, a sort of seniority so to speak that lends itself to a hierarchal corporate group (p. 148).

This “corporate group” which can be identified for the purpose of this study, as healthcare, operates under the auspices of legitimacy, creating and enforcing their own rules. Corporate groups impose their rules on members and non-members of this ruling order alike. A corporate group may present as “autonomous or heteronomous, autocephalous or heterocephalous” (p.148). Healthcare is autonomous and autocephalous in nature as it is a group organized by its own members operating on their own self-anointed authority. The autocephalous nature of healthcare promotes an atmosphere of exclusivity and power by its very dominion over its own structure. It is here where we begin to discuss the power and dominion within healthcare.

**Power and Domination within Healthcare: A Historical Perspective**
As defined by Weber, “power” is the probability that one person within the group/or social relationship, holds a position where his will can be carried out just by the nature of the position he holds within the social structure (p. 152). To this degree, physicians have long been identified as such undisputed authority over all within the social structure called healthcare, especially with the creation of the American Medical Association (AMA) in 1845 (Http://www.ama-assn.org/ama-history). From its earliest beginnings, this closed group created an exclusivity and authority unto itself that succeeded in shutting down other groups of healthcare providers such as female herbalists, healers, and female midwives.

The AMA effectively delegitimized all other healthcare practices to the sole inclusion of their own self-produced knowledge as legitimate, relegating other types of healing practices as quackery and charlatan. The AMA were successful in this endeavor as they had the support of other male-dominated organizations that had also succeeded in usurping the natural order of things, like the Catholic Church and the political congress. Laws were put into place, by the male-only US Congress, and enforced by another male-dominated group: Fraternal order of Police, making it illegal and dangerous to practice medicine unless you were a member of this new group (Fee, 2015).

The AMA set up and controlled the creation of knowledge (Bourgeault & Grignon, 2013) forcing the statute that if anyone wanted to practice medicine in the US, they had to apply for inclusion into the AMA approved schools (Http://www.ama-assn.org/ama-history) effectively eliminating traditional healers; many of which were women, subjugating them to non-entities not recognizing their “knowledge” as legitimate (Bourgeault & Grignon, 2013, p. 102).

They further decreed by their own authority, the particular “type” (described as educated and male) of person who could become a medical doctor (Http://www.ama-assn.org/ama-history).
Women, still hadn’t been given the right to vote in the US at that time, is it any wonder that they weren’t even considered a viable candidate to become a doctor.

Max Weber (1947) states power and domination were rampant within the closed social groups defining “imperative control”, as the “command with a given specific content that will be obeyed by the given group” (Weber, 1947, p. 152). We see this system mirrored in the creation and ultimate domination of the American Medical Society, which, from its genesis, sought to identify the male gender as the authority in power and the sole order of power unto itself. To Weber’s own description, this creates the hierarchy (p.154).

We can further frame the organizational hierarchy known as healthcare into power structures and people through identifying layers of authority. Take traditional authority for example. Weber states that this comes in a couple of forms. Traditional authority may exist with or without an administrative group. If there is an administrative staff, the pool is most often filled with those parties that have pledged allegiance or are recognized as loyal to the authority, or as Weber refers to it; “patrimonial” recruitment (p.342).

In healthcare and in the definition of traditional domination the authority figures are all too frequently males, setting up male dominated patriarchy. Patriarchy was intriguing to Weber, as it achieved dominance not through threats of violence or fear, but occurring in subtle ways, achieving compliance and adherence to the authority’s will just because he states it’s so (Morgan, 2006, p. 294). This exists in healthcare, where the power and authority of the male physician has given the right to “rule” over the other professionals, leaving many of which are female, “duty” to follow” (p. 294).

In traditional dominance, we see the appointed authority in the position of absolute power, creating the rules because it is his right to do so, in the case of patriarchy, the rationale is
that males are inherently of more value than women, as they were identified as those who did “more” than just the work of reproduction, unlike the females (French, 1994). To understand this phenomenon, we look at social structures laid down thousands of years ago.

Archeologists have evidence of tribal structures as early as 10,000 BC. During that time frame, and not until approximately 6,000 BC, we find an inverse tribal structure with the female being in a reverent position within the tribe (French, 1994). There was no recognizable domination within the tribal system. The female was relied upon to provide the continuation of the species through reproduction of the lineage, and the maintenance and care was a part of her obligation to the tribes as well (French, 1994). Despite the seemingly superior place the female should hold (if the “matriarchal” model was followed), there were no power plays and there appeared to be a sense of peace and harmony within the ranks, with the females honoring both child and male, supporting the contributions of all to the greater good.

This “matrilineage” provided prosperity for all (French, 1994). It wasn’t until 6,000 BC, that the archives uncovered artifacts of a “patriarchal” tribal structure, where male domination, upheaval and selling of their woman and children, became the tribal norm (French, 1994). Patriarchy can be defined through both ideological and social constructs which promote males (identified as the patriarchs) as” superior to females” (Rawat, 2014, p. 43). Patriarchy seeks to enforce the social stereotypes of gender in both society and organizations with a focus on promoting a power structure that thrives on strengthening male domination and oppression over women (Gottfield, 1998). The Feminist movement growing momentum in the late 1960’s, challenged the male dominated social Patriarchal constructs through challenging these assumptions of male superiority (Gottfield, 1998) while elucidating this male dominated power structure.
Femininity and Domination: Oppression of gender

Laud, (1988), as cited in Hezekiah (1993), speaks to certain challenges women face in both education and nursing, as they are identified as “true professions” for women (Hezekiah, 1993, p. 54). This stereotyping and sexism are what female nurses are facing within their healthcare environments. There is a dominating traditional male power structure embedded within healthcare from its patients, to administration and nursing and other ancillary providers. The environment thrives on the tacit knowledge of this legitimatized male dominated power with its underpinnings and destructive sexist behaviors that support gender-based harassment effecting the self-esteem and psychological state of female nurses and women in general (Hezekiah, 1993; Byrne et al., 2014).

Postmodern feminism is concerned with the fundamental issue that frequently lend themselves to pointed conversations focused on the status of women, their self-reflection and representation of themselves (Kushner & Morrow, 2003). The examination of these dominating principles that govern the marginalization of female nurses, is critical to the health and wellbeing of these female nurses, role satisfaction, self-esteem, body image and overall happiness within their workplace (Davies, 2003; Finnis & Robbins, 1994).

To deconstruct this pedagogy, the power structure must come under scrutiny, as must the embedded layers of the nurse/doctor archetype, crystalizing this phenomenon through the lens of the feminist (De Saxe, 2012). By the very preamble of the United States of America in The Declaration of Independence, if all “men” are created equal, where does that leave women? To get beyond this way of thinking, the focus must be on identifying the dogma that define the female gender as not having the equivalent value as the male gender (Bartky, 1990). In her book Femininity and Domination, Bartky (1990), examines ways in which American women, as
defined by both white and black women, are stereotyped, culturally dominated and sexually objectified (p. 23). She likens the governing stereotypes of women, are similar to those of race, as both assign both positive and negative attributes in accordance with another groups view. She concludes that neither the “positive” connotation or the negative ones, are appropriate, both serving to feed the uninformed narrative while assuring dominance over the identified group; in this case; gender (p. 23).

When referring to the nature of oppression, Bartky (1990) further defines a fragmentation of the collective whole leading to objectification and the viewing of the person as not quite a “whole” total sum of its collective parts, yet as by its stereotypical attributes (p. 24). To provide deeper understanding into gender oppression, Bartky (1990) likens the feelings one has when one has been identified as an object of either domination, or a sexual object, as demeaning and psychologically oppressive (Bartky, 1990). Through the normalization and acceptance of these behaviors that support gender marginalization, sexism and dominance among other things, a woman may experience estrangement from the attributes of personhood, deeming herself as “not worthy” (Bartky, 1990).

The gender oppression and sexism that occur within the patriarchy of healthcare, succeed in limiting opportunities for those parties who are oppressed, in this case the female nurse due to the disproportionate nature of the males in power over females. Female nurses have experienced their fair share of abuse whether it be in the form of verbal or sexual abuse, gender or sexual harassment. The end goal is one and the same by the male perpetrator, to dominate and submit others to their will (French, 1994).

These nurses who have experienced any type of gender or power related events within their professional environment are oftentimes met with a cavalier attitude by those in charge,
frequently witnessing others in the firing line searching for recourse, only to discover there isn’t any forthcoming from administration (Churchman & Doherty, 2010; Cortina et al., 2013). The unfortunate truth is similar in all cases of gender abuse and domination, the onus of proof is the burden of the victim, leaving them with a feeling of powerlessness, while the reward for keeping quiet is usually a much easier, yet harmful, path (Churchman & Doherty, 2010; Lips, 1994).

Female nurses are conditioned then to not speak out or upset the apple cart as the adage states. They run the risk of being labeled as “ridiculous” or not being able to do their job by other nurses who don’t wish for the same label to befall to them, so they support the norm (Finnis & Robbins, 1994). The tacit understanding of the governing rules obliterates the fact that some of these behaviors may be criminal in nature (Finnis & Robbins, 1994). So instead of this behavior being shamed or the offending physician being called out as perpetrators of these behaviors, they become socially acceptable (French, 1994).

To what end though, does this silence serve? Does this psychological or psychometric harassment also foster a silencing of voice? Are women who are abused not speaking up due to fear of rejection or retaliation, or worse even, the loss of their careers and livelihood (Cortina et al., 2013)? We asked these three women these questions. In chapter 4 we uncover the deep level of impact that occurred with those women interviewed, who were subjected to this gender/sex harassment/abuse.

**Chapter Two: Literature Review**

As there is a rich repertoire of empirical evidence on gender disparity and sexual/gender harassment, an intensive examination of the literature was required to inform this research, providing structure and identifying existing gaps in the literature that this study filled. The chapter was to provide a summary of the existence and impact sexism, sexual/gender-based
harassment have had on women across healthcare and other similar organizations with male dominated majorities. To accomplish this task effectively, the researcher scrubbed the indexes of current catalogued empirical evidence in the form of primary sources, peer to peer journal articles and seminal works on the topics using keywords; sexism, gender harassment, male domination, patriarchy, stereotyping, psychological oppression and impact on self-esteem, and psychological and psychometric impact, in relation to the above listed phenomena.

To assist the reader in understanding this collected body of evidence, the information was further broken down and synthesized and is presented in the following three sections; the first, patriarchy is further divided into subcategories; the rise of patriarchy, and male dominated power structures and legitimate authority. This serves to introduce the reader to the development and rise of the male dominated structures and the effects of power upon its organizational members.

The second section: Sexism, is organized into subsections on; stereotyping, verbal abuse and sexual assault, which provide the insight into the types of gender-based issues and insults occurring and with what frequency and breadth they occur, and how the behaviors themselves continue and are acceptable. The third section investigated various forms of gender-based harassment, by looking at psychological oppression and its impact on these women, both emotionally and physically, as well as the impact on the organization and its staff and communication. A fourth section that directly followed, summarizes the above, drawing conclusions to those areas where this research will be of good use.

**Patriarchy**

**The Rise of Patriarchy**

Anthropologists have long studied tribal structures as far back as 10,000 years ago (French, 1994, p. 24). “Matrilineage” (p. 24), defined as a way of life that was supported by the
female of the species to avoid extinction was considered the “natural order” of the humanoid species. Females by their biological nature are given an instrumental social role as they have the ability to conceive and bring children into the world, feed them from their own bodies, bear the responsibility of their care and in that, the preservation of the whole of the species (French, 1994, p. 15). The males “natural “contribution to the continuity of the species, was not readily identified apart from their sex drives (p.16). Anthropologists believe that once the male realized he was unequal in reproductive power to the female, he sought to elevate himself by choosing to dominate the female, subjugating her and her children to his elevation (French, 1994). This behavior was non-existent when the female was in the opposite position.

As early as 6000 BC, Patriarchal power structures were identified in tribal cultures. These male dominated organizations soon introduced the male as having dominion over woman, children as well as land or property. The males began to deconstruct the defined female matrilineage structures that historically promoted equality, peace and species preservation, using force and violence to separate and sell off the women and children in their tribes that once provided the blanket of security for their society, forcing the women into isolation and abandoning their families, bringing in other females from other tribes to propagate while creating a social culture of male dominance which regaled male superiority that is still thriving in societies and organizations today (French, 1994).

We have extensive artifacts that supports the Rule of Patriarchy in the Roman Empire. Males were considered to have dominion over some males that were deemed unworthy, children and women. It was considered a badge of honor to serve the empire through aggression and acts of war, with men aspiring to what they determined was honor and a certain recognizable glory (Richards, 2013). The evidence of the importance of the male warrior can be found in the pomp
and circumstance found in the presenting of themselves via chariots to the Emperor and the citizens into the forum, and then being seated in alignment on ivory chairs. These ceremonies and rituals reinforced the patriarchal relationships between these fathers and sons, perpetuating the need to identify with the family honor (Richards, 2013). Because of the importance of war and honor within this patriarchal society, men were seldom found within their households, so the matrons; sisters and wives played an instrumental subordinate role within this patriarchal system.

Women and children were treated as chattel, used by men in power plays to promote their own level and expansion of power and increased dominion. Marriages were arranged, as they still are today in many countries, with men “selling “their own daughters, many times promising them at birth and handing them over whilst still a child (Richards, 2013). There is recorded archeological evidence in Egypt, that tells us the viable age of marriage for a female would be one who had reached menarche, sometimes this occurred around eight or ten years old. There are some artifacts depicting a child with a child. This was considered acceptable as females were being transferred over from their fathers’ care to their husband’s care (Tyldesley, 1994).

Patriarchy was clear in the historical texts, passages and manuscripts written and kept under lock and key by male clergy in monasteries in the Carolingian middle ages during the reign of Charlemagne, approximately 814 AD. The fact that these texts were solely written by ecclesial and secular men incorporating Graeco-Roman law, demonstrates the level of domination men had over women and children at that time. Sadly, women passed on their knowledge to one another through oral traditions, they were not allowed to author or inform any aspects of these texts and manuscripts (Garver, 2012). The travesty is there is not much rich documented evidence that does contain female experiences or perspectives, even when discussing female specific functionality such as reproduction, conception, pregnancy and
childbirth (2012). Emphasis was placed on the fertile female, preferably one who could birth sons. If a female was found to be “barren” it was the ultimate loss of position, with the laws stating a husband could dismiss his marriage obligation to her in lieu of finding another woman who could bear sons. Garver (2012) cites Sedulius Scottes on the importance the king has in finding a “prudent and virtuous wife” saying that “For truly an inept wife is the downfall of a household…the lingering of all evil and vice” (Garver, 2012, p. 220). To further demonstrate patriarchal culture, she cites Hranbanus, a male scribe and advisor who states that “women is hindered from learning by [man and woman] and are distinguished by the strength and feebleness of their bodies” which clearly shows the “smarter” stronger male as being of more value over the “weaker” less learned female (Garver, 2012, p. 220).

In current times Patriarchy is further defined through both ideological and social construct which promote males (identified as the patriarchs) as” superior to females” (Rawat, 2014, p. 43). Patriarchy seeks to enforce the social stereotypes of gender in both society and organizations with a focus on promoting a power structure that thrives on strengthening male domination and oppression over women (Gottfield, 1998). Patriarchy has been steeped and programmed into the very foundation of our social and cultural fabric for thousands of years—is it any wonder it is so evidently ingrained in our epistemology?

**Male dominated power structures and Legitimate Authority:**

The distribution of power and authority has long been held that he who drives economic missive, creating its structure and identifying those processes by which the “organization” will require to achieve those goals, remains the “key distributor” of the resources, creating layers of hierarchy, superior and subordinate to devise the group in which the project will be coordinated (Schein & Schein, 2017, p. 170). Legitimate authority may also be awarded to those who have
the knowledge, as this becomes a personal power seat, such as the females who had the ability to create a child (Gottfield, 1998).

In one recent article on the idea of legitimate authority, Applbaum, (2017), defines legitimate authority as pertains to physicians, as the normative power over others in which they have the legitimate power to make decisions which can and do change the normative situation of others, while the “others” have a corollary expectance to be governed (Applbaum, 2017, p. 208). In scrutiny, he further expands on the topic of legitimate authority as a claim or a right to govern whilst the subjects have a duty to obey (p. 208).

Of significance to this research problem of practice involving healthcare and male dominated physicians within that space, Applbaum (2017) seeks to communicate to his colleagues within the physician’s trade journal, when he makes the claim that “physicians, of course, are epistemic authorities…they possess superior knowledge and judgement” (Applbaum, 2017, p. 209).

As previously mentioned, the American Medical Association created its own closed social group (Weber, 1947), defined its inclusion criteria, closed out any competitor or qualified descendants who held claim to the title of physician, erected houses of knowledge they kept, exclusive and controlled with limited admission, then assigned their own overarching patriarchal authority unto themselves, directing all others not chosen by their criteria to “dutifully” submit to their authority and expertise (Http://www.ama-assn.org/ama-history). They have accomplished this without any form of pushback or any type of remorse, despite the dissident nature of their actions. Can we attribute this to the deeply embedded sense of self superiority that patriarchal power embodies? As with prior patriarchal power and domination in other historical time frames and cultures, the AMA has been built in accordance to the foundations and epistemology of the
Church, which has been documented, demonstrates a common thread of philosophy that runs directly through from ancient civilizations (Garver, 2012), which thrived on all forms of sexism to control, oppress and hold dominion over women.

**Sexism**

**Stereotyping**

Gender stereotypes regarding women, nursing, and sexuality have existed for over a century since the creation of the profession by Florence Nightingale during the Crimean war (Fee & Garofalo, 2010). The seemingly benign and endearing stereotype of “ministering angels” (1591), was given to Florence Nightingale’s army of thirty-eight nurses comprised of young girls from poor homes as viewing a man and touching him in a state of undress was still considered an action for women of ill repute (2010). Despite Florence having scientifically hypothesized the correlation between contamination and sanitation and disease and mortality, her matter of fact behavior of taking charge of the unsanitary conditions of the hospital by discharging her nursing team to perform acts of housekeeping associated with wifely duties—(from cleaning the floors, emptying the trash, eliminating the bloodied insect infested rags used to clean the wounds of the soldiers, to the elimination of garbage and food scraps that the rats were feasting on, to the basic hygiene of acquiring clean basins and washing the men with soap and water and applying clean clothes), led to nurses being held synonymously with housewives and housekeepers (Fee & Garofalo, 2010).

Gender stereotypes in general have been characterizing women for decades as objects, either for sex, or as to command and serve, branching out and discovering a new medium widely influencing both males and females, young and old through the vast landscape of online anonymity, social media and video games (Fox, Cruz, & Young-Lee, 2015). Sexual stereotypes
of women are heavily pervasive in our culture and societies through media promotion; magazines, movies, articles, advertisements, music, commercials etcetera (Jewell & Spears-Brown, 2013). They are fraught with sexual objectification, violence against women and power and dominion over females which leads to the implicit adoption of these societal and seemingly cultural accepted norms. Over 80.5% of men’s magazines studied, portrayed women as sexual objects (594).

In one article on nurse stereotypes, Ferns and Chojnacka (2005), describe the five traditional nurse stereotypes; doctor’s handmaiden, ministering angel, battleax and the naughty nurse (Ferns & Chojnacka, 2005, p. 1028). There are television programs; like Greys Anatomy (Grey’s Anatomy episode guide-Full episodes list-ABC.com, 2015), earning Hollywood accolades that surround the hypersexual females, doctors and nurses, who are so sexual, they are unable to control themselves at the workplace, with every episode showing multiple sexual encounters in the “call room” (Grey’s Anatomy episode guide-Full episodes list-ABC.com, 2015). If a female nurse is older and acts professionally, she is compared unfavorably to “Nurse Ratchet” as portrayed brilliantly by Louise Fletcher in the 1975 Avant Garde film classic; One flew Over the Cuckoo’s Nest (Forman et al., 1997). Halloween costume companies wouldn’t know what to do if we eliminated the “sexy nurse” outfit.

In one study on sexual stereotypes and nurses, nurses were assigned nearly as many sexual characteristics as actresses were, with word choices like “kinky”, “sexy” and “naughty” as examples (Ferns & Chojnacka, 2005, p. 1031). As the authors discovered, these sexist images provoked sexual fantasies in the males that viewed them, with the naughty nurse in her white dress uniform and “stockings” coming in as the number one fantasy, with the nursing angel as
close second, female doctor as the third most thought about sexual fantasy, followed by the policewoman and “page 6 babes” bringing up the list (Ferns & Chojnacka, 2005, p. 1030).

Is it any wonder these images and stereotypes lead to actions of both verbal and sexual abuse/assault with the expected outcome of banality?

**Verbal abuse**

In the U.S. unwanted gender-based comments and behaviors determined to be offensive is defined psychologically as Sexual harassment (SH), and are comments and or behaviors that may place the recipient in a situation they have no available coping mechanisms for. These behavior’s and comments may be “perceived to be a threat to the individual’s well-being” (Stockdale, Logan, Sliter, & Berry, 2014, p. 55).

There have been some workplaces that Stockdale et al.(2014) have identified as high risk for SH, these environments would include “those that are dominated by men have a masculinized or sexualized work environment, have a working climate that tolerates SH, or in other ways place abuse survivors in contact with people who have a greater propensity to engage in sexually harassing behavior” (Stockdale et al., 2014, p. 57). Healthcare, as is discussed previously, is considered a high-risk SH environment (Finnis & Robbins, 1994; Vogt et al., 2007).

Verbal abuse has long since been ill defined by the empirical evidence, as many studies inquire of whether verbal abuse occurred, either yes or no, and then a place where there could be elaboration as to the language used (Jackson, Hutchinson, Luck, & Wilkes, 2013). There is compelling evidence that although verbal abuse is frequently underreported, it may in fact be the form of sexual harassment that occurs most frequently (Jackson et al., 2013). Due to the professionalism and the role of the nurse in this environment, there is a desire to not rock the boat, with these verbal assault episodes being absorbed as part of the daily workflow.
Jackson et al. (2013), discovered that there is a negative sequela that is not often assumed. It was further shown that gender sex role stereotyping, verbal sexualized commentary or remarks, swearing with derogatory sexual undertones and demeaning gender remarks, all may contribute to psychiatric or psychological symptoms by wearing away at the targets self-esteem, confidence and own perceived self-worth-while the inverse is true of the aggressors, who thrive on the power and gratification gained through these actions of control, humiliation, degradation and sexualized demeaning languages (Jackson et al., 2013). Nurses reported common feelings helplessness, humiliation and depression in response, which were heightened when left unreported or unsupported, which frequently led to increased stress in the workplace and ultimately burnout (Jackson et al., 2013; Jewell & Spears-Brown, 2013; Lim & Cortina, 2005). The more common, acceptable verbally abusive behaviors may very well escalate to increased psychometric and psychological experiences in the individual effected (Fitzgerald et al., 1995; Cortina et al., 2013).

**Sexual Harassment/abuse**

The reality of sexual based harassment and gender-based violence in the workplace is experienced so frequently in nursing it appears to be part of the actual job and is accepted by many nurses (Raftery, 2015, p. 831). Perhaps some credence should be investigated into the education of nurses who are educated to care for diverse ill populations, without judgment. A nurse is adept at rerouting the patient who has either sexually, physically or verbally assaulted them to gain patient compliance and produce positive results in the patient’s best health interest. Perhaps this experience within the patient populations makes it difficult to sort out sexual/gender harassment behaviors in those people who have no impairment Sexual harassment/abuse is like
general harassment in that there are power plays at work that motivate the aggressor, attempting to maintain or elevate his power level within the hierarchy (Lopez, Hodson, & Roscigno, 2009).

Sexual harassment/abuse does not have its sole genesis in organizational power, however. Both domestic abuse and sexual abuse are perpetrated against females making sexual abuse part of the larger social construct (Lopez et al., 2009). Lopez et al.(2009), defined sexual abuse in three categories theorized; male dominance, the male is seeking to delegitimize the importance of the females’ role. Gender spillover refers to the way men and women have been socialized within their own personal lives, as well as how these sexual derogatory norms exist within the fabric of societal culture, it then “spills over” into their workplace affecting their relationships within it. The third; sex ratio, looks at the numerical ratios and the dominant gender, and the disparities that those superior/subordinate relationships sets up (Lopez et al., 2009). In occupational settings that are heavily populated by females, like healthcare, there was a greater risk for sexual abuse (Lopez et al.,2009).

Sexual abuse was categorized and placed into levels of seriousness, with patronizing sexually offensive behaviors such as unwanted touching, petting, or referencing some sexual body part (Lopez et al. 2009). Predatory behaviors were listed as the most serious of these behaviors, like sexual innuendos, or sexual advances when there are no witnesses, or situations where pornographic materials are being shown without consent, either referring to acts that the aggressor would like to perpetrate against the female, or even referring to sexual photos and stating they would like to see a female’s body parts. In some male dominated power situations, the escalation can sometimes lead to the male exposing himself or requesting sex acts ((Lopez et al., 2009; Latchieva, 2017).
The devastating reality is that sexual harassment in the form of both verbal abuse and sexual abuse is prevalent globally. Statistics from one study (Latchieva, 2017), noted that over 75% of top-level female managers have experienced sexual harassment in one form or another since they were 15, while 74% of professional women admitted to the same startling statistic (Latchieva, 2017, p. 1858). In the same study, 25%, and 29% (respectively), stated they had some form of sexual abuse occur within the 12 months leading up to the research (p. 1858). These behaviors were defined as; sexually suggestive comments in a group or alone, hugging grabbing their body part in a sexual way and referring to the female’s body part in a sexual way, kissing, sexually charged text messages or email. (Latchieva, 2017).

There remains much associated shaming, psychological and psychometric repercussions for the female following such abuse, notably in the form of depression, embarrassment, anxiety, and fear. When forced to work in close proximity with the aggressor, such as in the nurse/doctor relationship, these feelings display themselves in reducing self-concept and self-esteem, as well as withdrawal and feelings of vulnerability affecting the way the abused interacts with not only others around her, but especially the aggressor (Latchieva, 2017; Cortina et al., 2013; Lips, 1994; Lim & Cortina, 2005). In giving that the physician/nurse relationship is one of the most intimately involved (Brown & Starkey, 1994), it only stands to reason that if you have experienced any type of sexual harassment/abuse, this professional relationship will become impaired. We will discuss these data in chapter four.

**Gender Based Harassment and Psychological Oppression**

**Emotional and psychological impact**

Those professionals that work within the healthcare environment can attest to its highly charged stress levels. In any environment where you are dealing with the health and wellbeing
of individuals, it is assumed that stress escalates when bearing complete responsibility of those human beings who are acutely ill (Farquaharson et al., 2013). Nurses are not afforded the luxury of relaxation, as the patient is always the top priority, especially in high acuity areas like the Emergency department, the operating suite and the critical care areas. By the very nature of the role and the environment, these working conditions ordinarily would be enough to cause physiologic and psychological effects (2013). Therefore, these acts of any kind of gender/sexual harassment can become the catalyst that pushes a nurse over her limits, especially in those women who have previously experienced some type of sexual abuse/harassment (Stockdale et al., 2014).

Though the antecedents for sexual harassment and their effects on the targeted female in the workplace have been widely studied, there is still much to learn about the physiological effects of workplace violence. In one study, Stock and Tissot (2013), investigated a few variables in relationship to reported nurses’ neck pain, sexual harassment being one that had a high relative relationship to the physical trauma (Stock & Tissot, 2013). In situations where male to female ratios are high, we frequently see corresponding evidence of increased sexual harassment (Thacker & Gohmann, 1996). There is evidence of residual feelings of discomfit, shame, anger, fear and even guilt regarding the events that occurred (Jackson et al., 2013; Finnis & Robbins, 1994).

This is increased in situations where there is forced intimacy such in the case of a close working relationship such as the physician/nurse relationship. The impact of being targeted by a superior in gender/sexual harassment situations has been found to increase stress levels resulting in a psychological oppressive environment (Bartky, 1990). Where one has the power to coerce a subordinate, such in the case of the physician over a female nurse. Thacker and Grohmann
state that the aggressors have the ability to inflict a higher level of damage to the target female, as they have legitimate authority over the individual (1996). When there is an implied risk to your livelihood or reputation, there is an elevated physical and emotional response (Thacker & Gohmann, 1996). Ironically in the male aggressor, the sexually aggressive and abusive behaviors are not seen as anything that could or should cause harm, so they are unaware of the harm they have inflicted, and the evidence tells us otherwise.

The feelings of helplessness and despair are well documented sequelae of sexual harassment and gendered workplace violence (Bartky, 1990; Farquaharson et al., 2013). Nurses who have suffered abuse from someone in a superior position, have expressed feeling like they are not in control over their own environment, as they are in subordinate roles. They have expressed uncertainty about their ability to stop or change the workplace violence that exists, citing an external locus of control in the hands of their superiors (Thacker & Gohmann, 1996).

In their study on the effects of workplace sexual harassment, Schneider et al., (1997), present some chilling statistics on the psychological impact of sexual harassment and abuse. Of note, 63% of women who had reported or sought help to deal with their harassment issue, reported they experienced adverse physical effects such as nervousness and anxiety, whereas 94% expressed significant emotional distress (Schneider, Swan, & Fitzgerald, 1997, p. 401). When asked about how they’ve coped with the abuse, many reported not feeling like they’ve coped adequately enough, many reported that they never told anyone, choosing instead to avoid the aggressor, but at the same time also reporting a decreased sense of satisfaction with their current jobs and overall psychological wellbeing (Schneider et al., 1997, p. 403).

The most common way they chose to deal with the harassment/abuse was to avoid any face to face communication, choosing instead indirect ways instead. In addition to avoidance, it
was reported that they had “denied” the event and attempted to talk themselves out of the event though questioning themselves and their own interpretation of the events, choosing to believe the aggressor had “their own bets welfare” in mind and the behaviors were more benign than they thought (403). Many of the female victims reported blaming themselves for putting themselves in the situation or through some way they had led them on. Many just “put up with it” but reported it having an emotional and physical impact on them (Schneider et al., 1997, p. 403).

The organization and staff suffer the impact of sexual harassment as there is an increase in reported attrition rates, sick calls and overall decreased interest in the job, reporting decreased feelings of job satisfaction and feelings of well-being (Jewell & Spears-Brown, 2013) With the close proximity and interpersonal relationship that is required between a nurse and the doctor through the provision of care, it is evident that sexual abuse or gendered acts of harassment is definitely impacted by the progression of physical and emotional response to the abuse by the women (Cuban, 2009; Kouta & Kaite, 2011).

**Summary**

Sexual and gender harassment and abuse have been well documented in the literature, with specific emphasis on high male to female ration environments. Legitimate authority and ultimate power and control was given to physicians by their own male dominated organization the AMA. Patriarchal structures have become steadily embedded in modern day society, and in high male dominated areas like the military and healthcare. Male dominated power and control frequently accept gender-based harassment and abuse, oftentimes the behaviors are not called out change/discipline doesn’t occur when it is reported. It is established in the literature that the impact these demeaning and marginalizing gender-based actions has on the target of these events is emotionally, physically and psychologically detrimental to the overall general health and
wellbeing of the targeted female. Given the proximity and intimacy of the nurse/doctor relationship, we can see that level and quality of communication, is negatively impaired through the perpetration of these acts of assault. This is revealed in chapter four.

Chapter Three: Research Design

This study investigated the lived experiences of female nurses working within the acute care environment, and discussed the impact, that gender harassment has had on their lives, both professionally as well as personally. The subsequent chapter will depict the study’s research design and will provide some evidentiary support to the authors’ choices of methodological design, population sampling and recruitment. The beginning of this chapter details the authors approach to this research. The latter half serves to focus on those elements that were required for the implementation procedure, detailing the specifics on how this study was conducted, including the researcher’s consideration given to the ethics, trustworthiness, anonymity of participants, storage of collected data and possible limitations of this research. A brief re-visitation is given to the authors positionality, which was discussed in detail in Chapter One.

Research Questions

It was the authors desire to seek to better understand, examine and analyze the lived experiences of the female nurse and what experience if any these behaviors, defined as sexual/gender harassment abuse within the acute care hospital landscape. The centric questions that guided this study were:

1: How prevalent was the occurrence of gender/sexual harassment within healthcare, and the more frequently occurring behaviors among the purposive sample (Finnis & Robbins, 1994; Fitzgerald et al., 1995)
2. What were the types of identifying behaviors as defined by the validated instrument designed by Louise F. Fitzgerald on the SEQ-W tool (Fitzgerald et al., 1995, p. 436), these women had encountered within their work lives?

3. How these women’s lives have been impacted by being subjected to these behaviors and how did they view the effects these behaviors and this environment had on the way they did their job, and what was the impact on their physical and emotional health? (Latchieva, 2017; Farquharson et al., 2013). We discuss and answer these research questions in detail in chapter 5.

**Mixed Methods Approach**

This study utilized a mixed method, convergent design approach which served to offset the weakness that usually occurs in a single method: either quantitative or qualitative, approach (Creswell, 2013, p. 213; Curry & Nunez-Smith, 2015). The design was able to weigh each data set individually and equally. Both collection methods targeted the identical purposeful population as this study focused its critical lens on the lived experiences of females from their gender seat. The researcher’s rationalized the interview process was a more intimate process where sharing of this type of sensitive information is difficult to communicate in its entirety, which succeeded in yielding rich results within the details. It also provided a view into both data sets to examine (Behar, 2007). The quantitative tool used collected statistical numerical frequencies and occurrences of those behaviors rigorously identified as characteristic of sexual/gender harassment, and the phase two qualitative interview portion, provided rich intimate inferential data.

The limitations of concurrent data collection were mitigated by using a validated, scientifically rigorous quantitative data collection instrument: Sexual Experience Questionnaire (SEQ-W), developed, validated, revised and re-validated for scientific rigor, by Louise F.
Fitzgerald (Fitzgerald et al., 1995). The tool was designed using a theoretical construct that took into consideration both the behaviors exhibited by sexual harassment intersecting both legal and sexual harassment concepts, that allowed for a more generalizable set of data (Curry & Nunez-Smith, 2015). The study also employed a qualitative phenomenology approach using Interpretive Phenomenology Analysis (IPA) that allowed the researcher a better way to understand the deeper, lived experiences of those interviewed.

The author believed that the mixed method approach worked out well, and it did lend itself to creating a more comprehensive view of both data sets (Curry & Nunez-Smith, 2015). The first two questions were successful in integrating the quantitative survey data set and the experiential data collected through qualitative methods, allowed for meaning making of the combined data sets (Curry & Nunez-Smith, 2015). By using this method, the author was better able to understand and report the impact of sexual/gender harassment on a broader scale, with the benefits of the deeper meaning making these experiences have had on these women’s lives (Creswell, 2013; Curry & Nunez-Smith, 2015). These data are discussed in chapter four.

The next section, Methodology, describes the study’s construct and philosophical assumptions, which led the researcher to choose to frame this study. It also will provide the reader a better understanding of why a mixed methods approach using phenomenology was most appropriate for this study topic.

**Methodology**

As stated earlier, this study utilized a mixed method, convergent design approach which served to offset the weakness that usually occurs in either quantitative or qualitative single method approach (Creswell, 2013, p. 213). The limitations of concurrent data collection were mitigated through the use of a validated, scientifically rigorous quantitative data collection
instrument: Sexual Experience Questionnaire (SEQ-W), developed, validated, revised and re-validated for scientific rigor, by Louise F. Fitzgerald (Fitzgerald et al., 1995). The tools design enabled the researcher to view certain behaviors in identified groupings, to which the data are reported out through. It reports out through gender harassment, unwanted sexual attention and lastly, through sexual coercion and asexual assault. These were designed using a theoretical construct that took into consideration both the behaviors exhibited by sexual harassment intersecting both legal and sexual harassment concepts, to allow for a more generalizable set of data. The research also employed the qualitative Interpretive Phenomenological Approach to gain better insight into the deeper, lived experiences of the women interviewed and how they’ve made sense of their experiences in their own voice (Smith, Flowers, & Larkin, 2009).

**Construct and philosophical assumptions**

The researcher’s choice was to construct this study through the intersection of Max Weber’s social and economic Organizational theory: Power and Patriarchy (Morgan, 2006), and Bartky’s Critical Theory of Femininity and domination (Bartky, 1990). These theories provided a strong and valid context in which to frame these data collected and gave way for this study to use the philosophical underpinnings of Interpretative Phenomenological Analysis (IPA). IPA focuses on the subject, and the way they have perceived their “personal” experiences of an identified phenomenon, understanding the way they have embedded these experiences in their lives (Creswell, 2013; Smith et al., 2009). This approach to this study was successful in yielding the three participants, rich, personal meaning from their own perspective, and enabled the researcher to employ hermeneutics to interpret those data applying them in the broader context.

IPA is described best on its commitment to exploring experiences in their own way, by those who are experiencing the phenomenon (Smith et al., 2009), with the work being grounded
within three specific areas; phenomenology, hermeneutics and ideography, and is discussed in greater detail in the subsequent section.

**Phenomenology**

Phenomenology is a philosophy of being and experiencing (Creswell, 2013). It has its humble beginnings in the “unified progression” from the Pre-Socratic, through the philosophers Socrates, Plato, Aristotle, the Stoics and the Neoplatonists” (Mattens, Jacobs, & Ierna, 2010, pg. 5). In using phenomenology as an approach to research, the researcher identifies a phenomenon by which they explore the individual’s experiences of the phenomenon, and how they have made sense of it through their own lens and perspectives (Smith et al., 2009).

In research, Phenomenology is further divided into two different approaches: both an interpretive and descriptive branch (Smith et al., 2009; Vagel, 2014; Van Manen, 2016). The person most widely known for the founding Phenomenology is the German philosopher, Edmund Husserl, who based it on his belief of a subjective experience absent of the single conscious belief, where thought is free from preconceived ideas and the layers pulled back to reductive reasoning, different from the *epoch* -or the empathy of experience (Van Manen, 2016). His revolutionary idea that the experience or “phenomenon” does not exist without the one experiencing it. The action of bracketing; understanding those thoughts by the researcher that arise from their own bias and perspectives and setting those aside, provided the researcher a way to understand the subjects experience and understanding that all aspects reported/recorded; whether in feelings, gestures, actions and the participants own interactions, had meaning (Vagel, 2014).

Therein lies the most significant element of descriptive phenomenology according to Husserl; peeling back those layers to reveal the pure consciousness of the subject, where they
make meaning of events, to better understand the phenomenon being investigated. This process required the researcher to make clear the processes of data gathering, but to also define the limits of analyzing and presenting said data and findings to better appreciate the essence of the phenomenon. Certainly, the foundation of Husserl’s innovative work in this field, and the bracketing of one’s biases and preconceived notions, lent itself greatly to the descriptive process and IPA (Van Manen, 2016; Vagel, 2014).

Heidegger, himself a student of Husserl, sought to further advance the approach to a more interpretive and existential approach, focusing on the understanding over any description, exploring the shared relationships of our interaction within the world (Behnke, 1995). Heidegger emphasized “being in the world” to remind that experiences are intertwined in the context of something within that meaning making process, linking Heidegger’s construct of interpretation or “hermeneutics”, a second pillar of IPA theory.

**Hermeneutics**

Hermeneutics is the theory of interpretation and one of the standing pillars of the IPA methodology (Smith et al., 2009). This theory focuses on the varied methods of interpretation and wrestles with the probable possibility of discovering the origin of the original meaning within ancient texts, like Heidegger’s findings and work. This process, and the researcher’s knowledge of the subject’s interaction within the world, required a meticulous examination of the phenomenon and the first blush analysis, diving deeper to get to the original meaning. Hermeneutics was originally a process used in identifying/uncovering the origin of thought within ancient texts, it has a very special role with the IPA structure; investigative work (Smith et al., 2009). The role of hermeneutics within the IPA process was multipronged, given the level of active engagement of this researcher within the interpretive or detective phase, both the
researcher and the women interviewed experienced the process of “meaning making”, with the researcher making sense of the subject making sense, resulting in a double hermeneutic experience, which extracted the richness of experience within the multi-faceted interpretations of the phenomenon being investigated.

**Idiography**

IPA Idiography is committed to focusing on the detail in relation to the researchers given dedication to those details, especially throughout the analysis phase, combing through the understanding of both the phenomena, and all facets (Smith et al., 2009). IPA can also be viewed within both the singular structure as well as the collective context, examining and comparing the individual experience to the collective.

**Rationale for Using IPA as the qualitative method in this Mixed Methods Study**

IPA, when used as a methodological approach can serve to elucidate the duality in existence between the individuals self-reported experience, within the sea of collective experiences enabling the IPA researcher to bring into clarity the individual experience within the shared aspects of the human experience (Van Manen, 2016). The use of IPA in this study helped the researcher better understand the dynamic interplay of details gained from the phenomenon, as experienced by the individual female nurses. It detailed and analyzed the impact and effects gender and sexual harassment had on these subjects, individually, and as a group experiencing a common occurrence. The researcher was able to see the effects of gender/sexual harassment on the collective whole which allowed for a deeper understanding of the shared tenants of such a phenomenon. Through the understanding of these ontological patterns within the subjects and a cross-relational understanding of the researchers own experiences with the phenomenon, the researcher was able to produce rich and generalizable results upon data interpretation.
Rational for using the SEQ-W survey instrument as the quantitative Method in this Mixed Method study

The SEQ-W instrument has been widely used to collect data surrounding sexual/gender harassment within the workplace. Louise F. Fitzgerald (Fitzgerald et al., 1995), has designed and created a rigorous tool to better ascertain the subject’s response to certain behaviors that over decades, have been identified and defined as characterizing sexual harassment both in the field of psychology, and then matrices it against the legal definitions of sexual harassment and quid pro quo behaviors to give a more comprehensive understanding of the occurrence of the behaviors themselves, identifying that subjects in previous empirical studies, were hesitant to identify certain behaviors as “sexual harassment” (Fitzgerald et al., 1995; Cortina et al., 2013). The instrument has been validated and reworked to reflect the limitations that were identified from study to study. The SEQ-W tool has been widely used by other researchers studying the effects of incivility and gender harassment behaviors specifically within fields where there is a higher ration of men in positions of power and large populations of women in subordinate positions within that institution such as the armed forces (Cortina et al., 2013; Finnis & Robbins, 1994), making this field of acute healthcare, a prime area to utilize this tool to better understand the frequency of behavioral occurrences defined through the literature, psychology and the legal system, as sexual/gender harassment.

Participants

This study explored the lived experiences of female nurses with at least 10 years of experience working within the acute care hospital sector of healthcare. The targeted sample set by design was a homogeneous population, purposeful and required, as most female nurses currently working within hospitals have over 10 years of experience (AACN) American
Association of Colleges of Nursing, May 2018). No preference was given either way to age, level of position within the organization, sexual orientation or religious affiliation. Female nurses who were retired, and who had worked at least 10 years or more within the acute care environment were allowed to participate, and give their perspective related directly to those years spent within the acute care space. Interested participants were excluded if they;

- had less than 10 years working within acute care hospital environment
- worked in any other care area outside of the hospital environment

The above identified exclusion criteria assured the results gained were specific and consistent to those experiences occurring within acute care hospitals and happening to female nurses with at least 10 years’ experience specifically within acute care hospitals.

**Recruitment and Access**

A purposive sampling was used to identify participants to this study, enabling the researcher to select those participants who met the objectives of the study and the identified criteria. The plan consisted of a call to participate which included both inclusion and exclusion criteria. It was socialized via Instagram and Facebook, targeting specific nurse hashtags and groups through the researchers account. The researcher directed any and all communication and activity through her Northeastern University email account, not through the social media communication. A signed informed consent was required for participation in both survey phase and interview phase, and described the study, risks, benefits and collection privacy and storage trustworthiness.

**Sampling procedures**

Participants to this study were recruited as stated above, using a purposeful homogenous sampling to better serve and inform the questions of inquiry (Creswell, 2013). This was needed
to create a group of participants who were informed by their gender and experience within the environment as is in keeping with IPA research (Smith et al., 2009). Participant recruitment followed these steps:

1. An initial recruitment announcement was sent through social media Instagram pathway to targeted nursing hashtags, nursing groups as well as the researcher’s social media pages. The announcement included a digital copy of written consent form, briefly describing the study and its two parts; phase I-survey and phase II-the interview, and once consent had been signed and sent into northeastern email a link to the survey questionnaire and the opportunity to participate in the interview phase was delivered. Female nurses that were interested in learning more about the interview phase, were asked to respond to the researcher directly through her Northeastern email address.

2. One week later, the same request to participate, was once again socialized following the above protocol. It was sent to all the initial hashtag and media groups once again, to encourage a response, as well as a repost within the social media space Contact through researchers’ Northeastern email.

3. The researcher sent out a personalized response and survey link to all participants through her Northeastern email account in addition to the interview guide (Appendix A) within 24-48 hours, with a direct reply to all nurses that expressed interest in participating in the structured interview process. An initial contact meeting to discuss details and logistics was arranged for the initial meeting. The researcher was able to answer any additional questions that subjects had before they agreed to participate. They were assured they could withdraw at any time during and after the interview.
4. (5) Nurses met criteria and were chosen and agreed via written consent to participate. They were offered a $25 Amazon gift card to thank them for their time. Two nurses withdrew from the study, while three participated in the interview phase.

Research site

The research targeted nurses from around the US and other countries, who participate on social media following the widely used nursing hashtags and groups. The call to participate did not state the expressed inclusion criteria, and also defined the targeted research site as an acute care hospital. The definition of an acute care hospital is defined as a community or university hospital, that directly serves the acute healthcare needs of the population, is constructed of multiple medical surgical units, operating room and emergency rooms. Participants meeting inclusion criteria, who had retired and were no longer working, were considered for inclusion if they had met the experiential requirements for this site space.

Procedures

The researchers’ decision to use a mixed methods approach using a quantitative validated statistical survey questionnaire (SEQ-W, Fitzgerald, 1995), and IPA as the qualitative methodology, best served to compare the two data sets, and used a sequential data collection design. The design took time to implement, but the researcher took into consideration a few things, one of which was the action given to the analyses and integration of both these data sets, while focusing on the analysis and integration of these data sets through a similar lens. The thought was to utilize several essences of the SEQ-W tool, mainly the subsections, while delving deeper within the qualitative phase, using those numeric data to inform analysis. The following describe in detail both the data collection and analysis processes for both the quantitative survey questionnaire, (SEQ-W), and the IPA portion used in the interviews.
Data Collection

The initial step was to apply for Institutional Review Board (IRB) approval, and once that was accomplished successfully, with the researcher receiving the stamped approval documents, the quantitative phase began, following the structure described in the previous section, entitled Recruitment. Upon collection of the questionnaires, anonymity was assured as the surveys were collected without any name identification, in accordance with the IRB application. The phase I survey goal of participation was at least n= 50, with 161 completing by the end of two weeks’ time, which was the set aside goal. The commencement of the second phase, the qualitative IPA phase occurred almost concurrently, with the survey including a call to action to participate in interviews, where they could communicate their contact through the Northeastern University email. Each participant self-identified and reached out to contact me to learn more about participating. Upon identification of those (5) qualified candidates as defined in the participants section herein, which discusses the purposive sample, inclusion and exclusion criteria for participation (Creswell, 2013; Smith et al., 2009), the interview process was set up as designed and discussed.

The questionnaire was tabulated by the researcher ongoing, concurrent with the IPA phase of data gathering. The collection did occur as recommended for the responsive interview design as set forth in Rubin & Rubin’s book *Qualitative Interviewing; the art of hearing data*, which did allow for a more fluid way to interact within the flow of the interview and the direction set forth by key points the researcher had been queued into from interviewees responses, yet maintained a semi-structured, yet informal flow (Rubin & Rubin, 2012). The benefit of having a semi structure for the interview, was to allow the participant a space for the topic to unfold, to allow for a certain breathability to the life of their story and experiences. The
interview structure served to provide a framework to allow for the researcher’s questions set for this study to be addressed. The semi-formal approach was able to deformalize the interview, it set up an environment of trust, and allowed the fullness and richness of the participants memory to move into the space provided.

The interviews were recorded with the participant’s permission. A backup was available, but not used. The secondary qualitative phase of the study was three pronged. First, we scheduled a quick informative meeting with the chosen participants to set up a semi-formal interview. Upon receipt of their written consent, an interview guide a (Appendix A) was given and reviewed for their reference and to give a better understanding of the questions that were to be asked in the interview phase. The interview guide followed the semi-structure format to encourage the participants to relax, allowing for a rich flow of data to emerge (Smith et al., 2009; Rubin & Rubin, 2012). These initial brief meetings gave the interested participant a more comprehensive purview into the study, the end goals and the format, and ensured informed written consent was collected. Their biographical and demographic information was also collected with the interview guide. Written consents were obtained and are being maintained in accordance to the privacy policies set forth from the Northeastern Institutional Review Board (IRB) and are described in the privacy and trust section of this paper. The initial call provided an opportunity for researcher and participants to establish a rapport and started building trust between the researcher and the subject. During this meeting, primary interviews were set up as per participant’s preferences.

As a second step in the three-pronged process, the researcher conducted interviews that ranged from 45 minutes to 95 minutes. The interviews used a semi-structured interview guide and allowed for free communication from participant to explore their thoughts and feelings on
that which they related, with gentle probing to expand on the thoughts being expressed or to seek clarification. The women that were interviewed were allowed to choose their method for the interview, whether face to face, via audio only or audio and video using a face to face like ZOOM. All choose ZOOM audio calls. Active listening was in the forefront of the interview, with the researcher holding that space for the participant’s story while it was relayed. Although many of the communications by the participants invoked an emotional response from the interviewer, the level of therapeutic boundaries was maintained (Behar, 2007). The data was transcribed immediately post interview for accuracy.

The third step in this process was to allow the participant the opportunity post interview, to choose to review their transcript. Only one of the original five participants requested their transcript. This participant chose to withdraw from the study during this phase (Creswell, 2013). All participants in the second phase of data gathering agreed to a pseudonym that was used to ensure privacy and protection of their identify throughout the research process (Rubin & Rubin, 2012; Creswell, 2013).

Each participants file; both written and audio, is being kept on the researcher’s personal computer, protected by a password known only by the researcher, and filed under that participants pseudonym. The researcher has backed up these files onto a password protected external thumb drive, which was only for use of this study. It is contained in a locked file drawer within the researcher’s office space. Security and file passwords are employed as a redundant method of protection. The researcher is the only person with said access to these files. All physical documents have been scanned into the personal computer, with all of them subjected to the above security pathway, in addition to being included in the password protected thumb drive, and locked draw (Creswell, 2013). Each one of these steps was taken to ensure and provide the
participants with confidence that their words, their stories, were taken into strict confidence and all measures necessary are being utilized to maintain their trust throughout the interview process and throughout the subsequent storage of their words.

**Data Analysis**

Data analysis was concurrent to allow for easy flow and identification to maximize the time frame during the quantitative collection phase (Miles, Huberman, & Saldana, 2014). This IPA process is iterative as well as inductive. The onus was on the researcher to be reflective and to provide detailed attention to each one of the participants stories, deducing which themes have emerged and view them in the light of the relationship of sexual/gender harassment under the guide of male dominance & critical feminist inquiry, relating back to the larger whole (Smith et al., 2009). The process ensued as below in the following section.

**First Cycle: Step One.**

Step one entailed the commitment of the researcher of time and place to the interview transcripts and audio recording, reading then re-reading once again (Smith et al., 2009), with the end goal of being immersed in the data itself, identify through bracketing, the nuances of the statements and the authors own bias. The initial pass was to familiarize the researcher with the tone and prose of the participants, second pass was done to glean the details that may not have fallen out so easily during the initial pass, really submerging into the participants accounting and perspective (Smith, et al., 2009; (Chan, Brykczynski, Nalone, & Benner, 2010).

In -vivo coding was applied during this first cycle of coding. During the re-reading of the transcripts, the researcher highlighted particular words and phrases used by these nurses that are were consistent with their microculture to better highlight the idiomatic meaning behind the participants words to better illuminate their voice and bring the researchers specific focus to
those terms and phrases utilized as part of the nursing vernacular (Saldana, 2013). The process ensued that allowed the researcher to call out the use of specific terms that are used in the nursing or healthcare culture by highlighting and the use of underlining, especially those unmitigated terms that were used frequently were called out in the sequences to assist with crystallizing the underlying meaning. The in vivo process was used on each line of data reviewed and quotations were used to highlight the participants voice versus the voice of the researcher.

**First Cycle: Step Two.**

Continuing on in Cycle one, step two consisted again of a line by line analysis, using in vivo coding and quotations and highlighting and underlining was used to extract cultural idioms and language upon the re-reading of the transcripts (Saldana, 2013; Curry & Nunez-Smith, 2015). The researcher was engaged in purposeful exploration of the narrative, while continuing to scrub the data to better identify the hidden meaning within the data, making sure to identify the use of nursing idioms and other cultural vernacular when applying codes (Smith et al., 2009; Miles et al., 2014; Saldana, 2013).

**Second Cycle: Step Three.**

In the second cycle of coding, axial coding was used in step three. The use of axial coding in the second cycle was based on the ability to group like themes and to relate themes and subcategories. The axial code; socially acceptable/exceptable, was used to assist in pairing down like themes which arose in the first cycle and to also identify and qualify culture norms and acceptable behaviors each individual participant, but also the researcher was able to apply the data across the broader matrix of the collective group of participants, and their organizations and cultures of each participant herself, to give a more generalizable meaning to responses to sexual
or gender harassment or abuse (Saldana, 2013). These data identified the reactions and actions of the participants, her peer’s managers and physicians’ reactions or actions, which assisted to better understand whether the culture was in support of these types of behaviors based on what was culturally socially acceptable or acceptable (Saldana, 2013). If data reported specific reactions, actions, inactions, the researcher was able to engage memo writing as a means of bringing her own thoughts on these data outside of the vivo coding of participants. Being socially accepted in the case of this study represented the actions, patterns and behaviors of the nurse and others within the surrounding in response to the occurrences of sexual or gender harassment or abuse (Saldana, 2013). These data and the memoing of the researcher assisted in answering research questions surrounding culture and environment. When the participant spoke about her experiences, all three also noted the “acceptable” ways they were “supposed” to behave. Their behaviors in reporting an abusive or harassment situation were unacceptable thereby leading to her being out of acceptance. The researcher was able to apply certain interpretations of these key themes, while grouping the initial codes into categories which further enhanced understanding and insight (Rubin & Rubin, 2012),

**Cycle two: Step Four.**

Step four of the process entailed a deductive approach where the researcher found connections and relationships across all emergent themes, chunking the data and further highlighting the most salient within. It was imperative that what emerged interpretively be thought of in context with the theoretical structure and consider what and how the participant felt more strongly about. For example, when a participant spoke or mentioned the same word or event more than once or spoke with an elevated tone or quickened cadence when describing certain events, or even when they became choked with emotion, or attempted to rationalize or
make sense of the situations or their responses or responses of others, the researcher gave more
weight to these statements when determining themes and sub and super ordinates.

Step Five.

After the scrubbing all the interviews and identifying those subordinate themes derived
from each individual participant, the researcher applied a similar process across all of the
interviews within the phase-seeking out subordinate and superordinate themes in common,
making meaning of events and occurrences and experiences in common, identifying patterns and
experiences in common, applying the intersections of male dominance and critical feminist
inquiry to better give “voice” to those stories humanity share in common, providing structure to
the discussion of key findings, again using both cycles to categorize and best represent the three
participants stories in context of the theoretical framework.

Quantitative data collection

The quantitative data collection and analysis phase answered the first two research
questions on the occurrence and frequency of the 19 sexual/gender harassment/abuse behaviors
of the SEQ-W survey tool (Fitzgerald et al., 1995). Completion of the survey indicated a
willingness to move forward, knowing that participants may withdraw at any time. The survey
was open initially for two weeks, with an additional week while contact was made to those self-
selecting to [participate in the interview phase, and initial meetings were set up. The initial
minimum expected participation rate was n=50. A total of n=161 participants from 14 countries
and 10 ethnicities around the world were represented. The SEQ-W tool was data entered into
Google Forms, and questions were tabulated through this system. These data were then
downloaded into Microsoft Excel for analysis. Additionally, demographic data was collected at
the beginning of the survey. The data are further categorized in Dr. Fitzgerald’s recommended
three Categories: Gender Harassment; Unwanted Sexual Attention, and Sexual Coercion, to better draw upon the supraordinate themes as resourced through the allocation of key questions to each category (Fitzgerald et al., 1995), and are presented in Chapter four.

**Qualitative data analysis**

The results were tabulated and totaled and are reported in Chapter Four. The quantitative data was then crossed and integrated within the qualitative results, seeking to identify commonalities and or to check for divergence of results from the two separate collection methodologies (Curry & Nunez-Smith, 2015; Miles et al., 2014). These were then sifted through the intersecting lenses of male dominance theory and critical feminist inquiry lenses to better make sense of individual experience within the collective body, also in Chapter Four.

**Ethical Considerations**

As this study interviewed consenting adults of sound mind and body, its likelihood of causing harm to its subjects was minimal. The researcher was mindful of this sensitive topic and was alert and prepared for those issues that arose during the interview process. No untoward effects were experienced beyond the sadness and emotions awakened by the retelling of these traumatic experience, and the research who is trained in this area, was vigilant and provided a space and support for the participants (Creswell, 2013). This study was submitted through the Northeastern University IRB review Board and approved. Additionally, the researcher constructed an awareness of the power structures in existence between self and the interviewer and was ever mindful of trust and integrity of practice. The researcher employed non-judgmental attitude throughout both the interview process itself, as well as the analysis and reporting stages. The participants were informed and assured that they may withdraw their participation from this
study at any point along the pathway, as participation was completely voluntary. Two of the Five participants withdrew from the study.

Trustworthiness

The researcher ensured proper methods were employed, assuring a level of trustworthiness throughout both data collection, and analysis, again being mindful of the personal exchanges that were offered to the researcher in that trust; from data collection, storage as well as analysis and reporting. The researcher assured the participant through the interview, offering multiple touchpoints to flow and share their stories, while interacting with the researcher throughout, reinforcing trustworthiness. Researcher also enabled feedback from participants. No edits were requested. The end study includes biographical and demographical information to better assist the reader to apply transferability of the results, making their own informed decisions.

Potential Research Bias

As stated previously, the researcher understands her bias as a female nurse who has had experiences of gender and sexual harassment within the critical care space. I’ve detailed these in Chapter two. The goal of this study and the rationale for mixed methods approach, using IPA as the qualitative arm of the study, was to provide an interpretive approach to the findings, making sense of those reports and discoveries, while at the same time understanding the individual perspective and experiences through their lens, while keeping in mind all phenomenon happen to the individual, but as Heidegger also referred, relating those individual experiences to the collective experiencing the same phenomenon was key to understanding our world and those within it (Behnke, 1995).

Limitations
The first limit to this study was the time and resources required to complete. The ability to get the research study out and the recruitment of subjects was key to the more generalizable results. The second limit identified in this study, was that participant sample was purposeful and homogenous, studying only females in acute care nursing, and requiring the 10 years’ experience be in acute care. The researcher discovered through the return of communication, that it would have been interesting to note if these behaviors and experiences happened to young and old, novice and expert registered nurses, as well as the Licensed Practical Nurse, and or female nursing assistants and female secretaries.

In addition to limiting the study to discussion of experiences in relation specifically to male Physicians, excluding possible male manager, administrative involvement. And finally, due to the sensitive nature of the study topic: sexual/gender harassment, many women have struggled to elucidate their experiences or effects, so participants might not have been as forthcoming as they could be, but the survey was anonymous, so the researcher believed that helped to mitigate this potential limit. There was a suspected potential for risk through bringing up highly sensitive information in the form of past experiences, the researcher was prepared and addressed the emotions appropriately during the interviews. The researcher had received education and training in identifying emotions outside the norm which may not be easily re-integrated. These implications are discussed in Chapter Four.

Summary

In summary, this starts the process of delving into the organizational workplace of acute care healthcare, and the occurrence and frequencies of gender/sex harassment/abuse defined by Louise F. Fitzgerald on the SEQ-W questionnaire (Fitzgerald et al., 1995). The field of nursing is one of caregivers, the women and now men who have dedicated their lives to fulfill a
vocational calling to care for those ill and burdened under their watch. The impact that sexual and gender harassment has on the individualized psyche is devastating (Finnis & Robbins, 1994; Jackson et al., 2013; Kouta & Kaite, 2011; Lopez et al., 2009), oftentimes resulting in attrition rates, burnout, psychometrics and psychological distresses, which may lead to the exiting of the profession (Pryor et al., 1993; Raftery, 2015; Stock & Tissot, 2013). Given the current heightened awareness of this topic, it may have far reaching implications for the way relationships between males in power treat female subordinates. When given the circumstance of the nurse, especially females, they are already educated on managing the abuse directed at them by those patients who do not have their right mind or are acting in full capacity.

Chapter Four: Results and Findings

This purpose of this mixed method, IPA, study was to investigate the frequency and occurrences of gender/sex harassment behaviors as defined by Dr. Louise Fitzgerald, in her extensive research on sexual experiences within the workplace. To that end, permission was obtained to implement the SEQ-W survey tool in the first phase of the quantitative portion of this study to examine the frequency and occurrence of those defined behaviors that qualify as sex/gender harassment-abuse. Sexual and gender harassment are highly sensitive topics to discuss and relive. The Second Phase: the qualitative IPA double hermeneutic portion of this study, sought to investigate those lived experiences of the 5 female nurses working within the acute care environment, their overall experiences, and the impact, if any that sex/gender harassment has had on their lives, both professionally as well as personally. Both the quantitative survey data, and the rich experiential data of the participants, reveal that these behaviors are widespread, and at times considered a hazard of the position. These data were collected to answer the following (5) research questions:
1. How frequent was the occurrence of gender/sexual harassment within healthcare among the purposive sample participants, and the other more frequently occurring behaviors (Finnis & Robbins, 1994; Fitzgerald et al., 1995). This data was extracted from the quantitative survey portion.

2. What were the types, frequency, level of severity and of occurrence of sexual/ gender harassment behaviors? Again, this data was extracted from the quantitative survey.

3. What behaviors and experiences reflect a similar slant, as related by the female nurses lived experiences? This data was extracted from qualitative interviews.

4. How did these three female nurses define and describe their personal experiences of sexual and gender harassment within the acute care environment? This data also was extracted from the qualitative interviews.

5. How did these three female nurses describe the effects of sexual /gender harassment may have had on their health, careers and the way they practice? (Latchieva, 2017; Farquharson et al., 2013).

This chapter aimed to present the findings and results of this study in two phases: The quantitative (Descriptive Statistics) and then qualitative (IPA) phase. The emergent themes which developed through the qualitative portion, in the form of superordinate and subordinate themes, will then be presented and analyzed through a double hermeneutics’ lens.

**Phase One: Quantitative-SEQ-W Descriptive Statistics**

This section contains the findings and results of SEQ-W (Fitzgerald et al., 1995) survey and an interpretation of those findings. Quantitative data were captured through participation in the validated SEQ-W survey instrument via google forms. This instrument served to provide a valid and standardized language of sex/gender harassment and abuse, which set forth the
foundation of vernacular used in the interview phase of this study, enabling consistency. This tool was comprised of a 20 question sexual experiences questionnaire, (SEQ-W) specific to the workplace. One of the questions; Number 20: “Treated You badly if you didn’t have sex” Yes: 19.4% (n=31) No: 80.6% (n=129), was used as a criterion question, and is not included within any of the three categories. Participants were instructed to respond, in accordance to the instructions provided at the beginning of the survey. The tool utilized a 5-point Likert-scale to evaluate frequency, occurrence and distribution of the behaviors denoted, with “0” representing “never” experiencing the behavior, to 4 representing “many times” experiencing the behavior (Fitzgerald et al., 1995).

Each question was further classified into the following three categories: Gender Harassment (1-5: Table 4:1), Unwanted Sexual Attention (6-13: Table 4:2), and finally, Sexual coercion & Sexual Assault (14-19: Table 4:3). In addition to reporting question results, these data are further aggregated and aligned within their respective category and are reported out in Table 4:1, Table 4:2 and Table 4:3 respectively. In addition to discussing these data Tables here and their findings, they will be discussed and integrated within the phase two: qualitative IPA discussion as well.

Survey Participants

The survey rendered a very diverse group of female RNs’. Of those (n = 161), women who responded to the survey, it was noted that there were (16.1%) (n=10) ethnic groups represented, in over fourteen countries, which speaks to the broader problem of sex/gender harassment/abuse and its widespread impact across the Globe. Their ages ranged from 25 - >56 years of age. With 77.6% (n= 125), of participants identifying as European Caucasian, 22.4% (n=36) representing from the 16.1% (n =10) ethnicities participating. 64.6% (n=104) of
participants having ten years of experience, and 35.4% (n= 57) of participants had 11 years or more experience. Within the population, 59.6% (n= 95) remain actively working in a hospital, with 40.4% (n=65) of them having moved to other care areas or outside of the organization in Academia. Their level of education varied as well, with 49.6 % (n=80) at bachelors’ level, and slightly over 26% (n= 43) with their 2 years associates degree/equivalent. 5% (n= 8) were working with their non-degree diploma, a 3-year clinical education, and 15.5% (n= 25) master’s level, and 3% (n= 5) with their doctorates. While all the participants were part a part of a purposive sample, there was a level of enhanced generalizability, due in part to the diversely & geographically represented group (Curry & Nunez-Smith, 2015; Creswell, 2013). The findings are represented and discussed in the next section.

**Quantitative Results and Findings**

*Gender Harassment.* As previously discussed in Chapter Two, for decades, women have been both characterized and stereotyped, unfairly and oftentimes unfavorably, as objects, either for sex, or as to command and serve (Fox, Cruz, & Young-Lee, 2015). In, Bartky, (1990), she presents her theory on Feminity and Domination, and the oppression experienced by women, when defined by certain patriarchal characteristics which serve to promote oppressive cultures for females within male dominated workplaces, like healthcare (Bartky, 1990). These pervasive beliefs lend itself to the belief that women are inferior to men, and as such are acceptable to control and manipulate (Bagguley, 1991).

Outdated patriarchal ideas based on a women’s biological traits, and the concepts of femininity, are viewed as negative within the workplace, and strike a specific social culture between men and women. We see this playing out in the form of stereotyping by employers that still refer to female employees as less “profitable” and less cost efficient (Rimashevsk, 2008, p.
Another stereotype promotes that a woman “less capable of improving her qualifications” therefore is a “second-rate” employee (Rimashevsk, 2008, p. 37).

In this study, the results show that this type of gender harassment is thriving within the acute care hospital setting. Only 13% of the female nurse respondents stated that they had never experienced sexual/gender harassment behaviors (see table for detailed questions that comprised gender harassment), with the highest percentage of occurrences in categories assigned to experiencing the defined behaviors “once or twice” (38.62%) and “often” (37.15%). Sadly, 17% of these women experience this type of abuse “many times” over. These data are presented for viewing in Table 4:1.
Table 4.1

Quantitative Results: Gender Harassment n=161

<table>
<thead>
<tr>
<th>Category &amp; Scale</th>
<th>Never</th>
<th>Once or Twice</th>
<th>Sometimes</th>
<th>Often</th>
<th>Many Times,</th>
</tr>
</thead>
<tbody>
<tr>
<td>1…habitually told suggestive stories or offensive jokes?</td>
<td>35.4%</td>
<td>11.2%</td>
<td>31.7%</td>
<td>16.8%</td>
<td>5%</td>
</tr>
<tr>
<td>2…made crude and offensive sexual remarks, either publicly (for example, in the office), or to you privately?</td>
<td>52.2%</td>
<td>9.3%</td>
<td>29.8%</td>
<td>5.6%</td>
<td>3.1%</td>
</tr>
<tr>
<td>3…made offensive remarks about your appearance, body, or sexual activities?</td>
<td>34.2%</td>
<td>12.4%</td>
<td>34.2%</td>
<td>12.4%</td>
<td>6.8%</td>
</tr>
<tr>
<td>4…displayed, used, or distributed sexist or suggestive materials (e.g., pictures, stories, or pornography)?</td>
<td>82%</td>
<td>5%</td>
<td>9.3%</td>
<td>1.9%</td>
<td>1.9%</td>
</tr>
<tr>
<td>5…frequently make sexist remarks (e.g., suggesting that women are too emotional to be scientists or to assume leadership roles)?</td>
<td>49.7%</td>
<td>13.7%</td>
<td>23.6%</td>
<td>8.7%</td>
<td>4.3%</td>
</tr>
</tbody>
</table>

Average % experiencing multiple forms of Gender Harassment

<table>
<thead>
<tr>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>13.34%</td>
</tr>
<tr>
<td>38.62%</td>
</tr>
<tr>
<td>6.76%</td>
</tr>
<tr>
<td>37.15%</td>
</tr>
<tr>
<td>17.02%</td>
</tr>
</tbody>
</table>

*Note.* All questions were prefaced with … have you been in a situation in which any of your MALE Physicians…

*n=161*
Summary: Gender Harassment

In summary, gender harassment behaviors are quantifiable. This survey was able to give us the frequency and occurrence of behavior types. Of the 161 participants queried, in 14 countries around the world, approximately 14% of all participants had experienced some frequency of gender harassment at least once. The frequency and occurrence of gender/sexual harassment overall was 65%. 65% of participants experienced this type of behavior more than once, and many, 16% put up with this type of sexual harassment many times over. The occurring behaviors ranged from being told jokes or offensive stories, putting up with sexist comments, or being shown pornographic materials, to 65.8% living with offensive remarks made about their appearance, body or their sexual activity, or making comment. Gender harassment is about power and dominance over another gender (Bartky, 1990). The survey yielded that more than 50% of all women participating had experienced remarks about women being too emotional to be scientific or able to assume leadership roles. This type of disparaging sexual/gender harassment is disempowering. The evidence this survey collected shows that gender harassment is frequently occurring across the globe, more than 50% of the time.

Unwanted Sexual Attention. We see in the literature, and mirrored here within the study questions scored for “Unwanted Sexual Attention”, that exposure to sexual harassment is quite prevalent among female employees, especially where they are working more directly with “clients” such is the case of nurses within healthcare (Hogh, Crowley, Clausen, Huitfeldt-Madson, & Burr, 2016, p. 2). When it comes to “unwanted sexual attention” it has actually been defined as the “second most common form of workplace sexual harassment after gender harassment” (Hogh et al., 2016, p 2). Unwanted sexual attention comes in several forms, both
verbal and nonverbal, always unwelcomed, and are focused on power plays and belittling on the grounds of gender. Some of the behaviors targeted in the SEQ-W, sought to include acts which were offensive, which presumed an air of familiarity with the nurse. They might include, texting and telephone calls both during work hours and post work, touching and grabbing, using their body as a threat, or any other type of intrusive behavior that put the man in control (Finnis & Robbins, 1994; Hogh et al., 2016).

The results from this survey, demonstrate that this is a widely experienced phenomenon (Finnis & Robbins, 1994, Hogh et al., 2016), which is thriving in the patriarchally rich, male dominated healthcare environment (French, 1994). The SEQ-W instrument asked very specific questions that have been shown to fall under the umbrella of “unwanted sexual attention” (Fitzgerald et al., 1995). In the categories of touch; we see over 26% (n=42) describing the frequency of unwanted “touches” to them, occurred “sometimes”, with 21% (n=34) describing that they’ve “sometimes” had male physicians attempt to “stroke or fondle their leg, neck or breast”. These data are presented in Table 4:2
Table 4:2

_Unwanted Sexual Attention
n=161_

<table>
<thead>
<tr>
<th>Event</th>
<th>Never</th>
<th>Once or Twice</th>
<th>Sometimes</th>
<th>Often</th>
<th>Many Times,</th>
</tr>
</thead>
<tbody>
<tr>
<td>6. made unwanted attempts to draw you into a discussion of personal or sexual matters (e.g., attempted to discuss or comment on your sex life)?</td>
<td>49.1%</td>
<td>7.5%</td>
<td>29.8%</td>
<td>9.3%</td>
<td>4.3%</td>
</tr>
<tr>
<td>7. gave you unwanted sexual attention?</td>
<td>55.9%</td>
<td>8.7%</td>
<td>23.6%</td>
<td>8.1%</td>
<td>3.7%</td>
</tr>
<tr>
<td>8. was staring, leering, or ogling you in a way that made you feel uncomfortable?</td>
<td>52.2%</td>
<td>9.3%</td>
<td>29.8%</td>
<td>5.6%</td>
<td>3.1%</td>
</tr>
<tr>
<td>9. attempted to establish a romantic or sexual relationship despite your efforts to discourage him?</td>
<td>65.8%</td>
<td>14.9%</td>
<td>10.6%</td>
<td>5.6%</td>
<td>3.1%</td>
</tr>
<tr>
<td>10. has continued to ask you for dates, drinks, dinner, etc., even though you have said &quot;no&quot;?</td>
<td>68.9%</td>
<td>9.3%</td>
<td>13%</td>
<td>6.8%</td>
<td>1.9%</td>
</tr>
<tr>
<td>11. touched you (e.g., laid a hand on your bare arm, put an arm around your shoulders) in a way that made you feel uncomfortable?</td>
<td>49.7%</td>
<td>16.1%</td>
<td>26.1%</td>
<td>4.3%</td>
<td>3.7%</td>
</tr>
<tr>
<td>12. made unwanted attempts to stroke or fondle you (e.g., stroking your leg or neck, touching your breast, etc.)?</td>
<td>63.4%</td>
<td>11.8%</td>
<td>21.1%</td>
<td>2.5%</td>
<td>1.2%</td>
</tr>
<tr>
<td>13. made unwanted attempts to have sex with you that resulted in you pleading, or physically struggling?</td>
<td>88.2%</td>
<td>7.5%</td>
<td>1.2%</td>
<td>1.9%</td>
<td>1.2%</td>
</tr>
</tbody>
</table>

Average mean of Participants (n=161) experiencing no or some form of: unwanted sexual attention

25.95%  8.9%  14.9%  4.64%  2.6%
Summary: Unwanted Sexual Attention

Unwanted sexual attention is a subject experience, yet still has an ability to quantify the behaviors and identify those associated with common standard terms that define what sexual assault or harassment are by law (Fitzgerald et al., 1995). These data reveal that the occurrence and frequency of unwanted sexual attention exists across the globe, as participants of this survey represented ten countries, demonstrating standardization across the behaviors as identified by Dr. Fitzgerald in her research on sex/gender harassment /abuser. These participants stated they had experienced the subtle and not so subtle touching and or groping without permission or having to bear the starting and ogling from the physicians that hold power over you, while attempting to care for your patients. Such a juxtaposition from the nurses who are caring for sickly patients, whilst facing the sexually charged environment, with its unwanted touching or vocalizing about sex, pushing the nurse to engage against her will, touching her inappropriately, all has its impact on her life, and her workplace.

Sexual Coercion & Sexual Assault. (Garret, 2011, p. 17), defines “sexual assault” as an act of “power and control” that includes a broad spectrum of abusive behaviors and deeds which goes against a person’s wishes (p 17). Sexual coercion is defined and categorized in conjunction with coercive acts committed against another person’s will, that threaten a person’s value system in some way, if they do not yield to the demands of the perpetrator, and are used in exchange that are threatening in nature.

Sojo, Wood, & Genat, (2016, p. 15), reason, that to either separate sexual coercion and unwanted sexual attention as the more harmful than gender harassment and other harmful gender/sexual categories, implies that there is a higher potential to cause either psychological or physical harm, within the former categories. The need to take into consideration not only the
short-term harm from the intensity of the act, but also the pervasiveness of multiple occurrences, is paramount when seeking to understand the psychobiological impact on these victims (Pryor et al., 1993).

We also see that it is recognized that certain occupational groups are more susceptible to the abuse, with nursing and health care providers falling into the top categories (Sojo et al., 2016). This is echoed in the prevalence of data behaviors found in the results of the SEQ-W and are presented in Table 4:3 Sexual coercion & Sexual Assault. When we view the questions, we see that close to 12% (n=19), of participants say they have experienced some form of sexual assault at least once. This is in keeping with the pervasive culture of power and domination, as we continue to see over 36% of respondents having been sexually coerced “once or twice”, and sickeningly, almost 47% have experienced sexual coercion “sometimes” within their careers by a male physician in a position of power. These results are detailed in Table 4:3 below and will be discussed and integrated within the phase Two IPA section as well.
Table 4:3

Sexual coercion & Sexual Assault n=161

<table>
<thead>
<tr>
<th>Question</th>
<th>Never</th>
<th>Once or twice</th>
<th>Sometimes</th>
<th>Often</th>
<th>Many times,</th>
</tr>
</thead>
<tbody>
<tr>
<td>14. made you feel like you were being subtly bribed with some sort of reward or special treatment to engage in sexual behavior?</td>
<td>77.0%</td>
<td>9.9%</td>
<td>9.9%</td>
<td>1.9%</td>
<td>1.2%</td>
</tr>
<tr>
<td>15. made you feel subtly threatened with some sort of retaliation for not being sexually cooperative (e.g., the mention of an upcoming evaluation, review, etc.)?</td>
<td>80.7%</td>
<td>9.9%</td>
<td>6.8%</td>
<td>1.9%</td>
<td>0.6%</td>
</tr>
<tr>
<td>16. implied faster promotions or better treatment if you were sexually cooperative?</td>
<td>84.5%</td>
<td>8.7%</td>
<td>4.3%</td>
<td>1.9%</td>
<td>0.6%</td>
</tr>
<tr>
<td>17. made it necessary for you to respond positively to sexual or social invitations in order</td>
<td>78.3%</td>
<td>8.1%</td>
<td>9.9%</td>
<td>3.1%</td>
<td>0.6%</td>
</tr>
<tr>
<td>18. Made you afraid or scared that you would be treated poorly/differentl</td>
<td>79.5%</td>
<td>6.8%</td>
<td>9.3%</td>
<td>3.7%</td>
<td>0.6%</td>
</tr>
</tbody>
</table>
20. Treated you badly for refusing to have sex? Yes: 80.6% (n=129) No: 19.4% (n=31)

**Summary Sexual Coercion & Sexual Assault**

When behaviors of sexual harassment and unwanted sexual attention go unchecked, these behaviors can escalate into actual sexual abuse or assault, especially in cultures that are supportive of these types of behaviors, through their silence and inaction taken against the perpetrators (Finnis & Robbins, 1994; Fitzgerald et al., 1995; Garret, 2011). The results from the survey in this category demonstrate a strong existence of that escalation when sexual harassment and unwanted sexual attention go unchecked. These data reveal that at least 33% of all women participating were in a situation that could be described as sexual coercion or sexual assault. It wasn’t just the coercive behavior that was noted, over 19% of these nurses were subtly threatened with retaliation of some sort, for refusing to engage in sexual acts with the male physician. Over 15% of female nurse participating in this study reported that it was implied they would get a promotion if they cooperated with the male physicians, while 21.7% stated the male
physicians made it necessary for the women to respond positively if they wanted to keep their jobs and 20% were afraid that they would be treated differently if they didn’t cooperate sexually. The one question targeting actual criminal sexual assault, asked if the male physician had ever made unwanted attempts to have sex with them that resulted in them pleading, crying or physically struggling, to which 7.5% said once or twice, 1.2% said sometimes, 12.4% said Often, and 3% said Many times! The question of treated you badly for not having sex with him was answered by those women who answered above yes- 82. % of the time.

**Phase Two: Qualitative IPA**

The qualitative data collection was obtained through the analysis of in depth, semi structured personal interviews, (APPENDIX A) where time was given to each participant to reflect, make sense of and raw conclusions of their own on what they were communicating, and the IPA methodological framework applied.

**Data Analysis**

As stated in Chapter 3, data from both the SEQ-survey (quantitative phase), and the interviews (qualitative) were analyzed concurrently. This maximized flow and conduction of analysis while enabling access to data from the survey which informed the analysis phase (Miles, Huberman, & Saldana, 2014). As IPA is an iterative as well as inductive process, the researcher took the reflection time and attention to detail of the unfolding participant stories, deducing emergent themes and viewing them through the intersection of the theoretical lenses of sexual/gender harassment under Webers Social theory of Power and Patriarchy (Morgan, 2006), and Bartky’ s theory on Femininity and Domination and Oppression (Bartky, 1990), applying back to the larger whole (Smith et al., 2009). The process ensued as described in detail in Chapter 3 and summarized in the following section.
First Cycle: Step One.

Step one employed in vivo coding and took the interviews and placed the recordings into a transcription app—which provided an imprint of the recording. The researcher committed to reviewing the transcript against the recording to ensure accuracy was capture, and then read the interviews for a first pass, gathering thoughts and identifying those phrases that “popped out” then re-reading once again (Smith et al., 2009). The researcher immersed herself in the data and was able to identify phrases that poked at the authors own bias, bracketing these to assure that the meaning of the participants came through, not the researcher. The second pass was completed to identify if any details had fallen out that weren’t recognized during first pass, gaining a better understanding of each individuals tone and perspective (Smith, et al., 2009; (Chan, Brykczynski, Nalone, & Benner, 2010).

First Cycle: Step Two.

Step two was a line by line analysis, with initial coding (Curry & Nunez-Smith, 2015). Areas that stood out were highlighted through the exploration of the participants words, while continuing to scrub out and uncover any hidden meaning in key words and phrases. These initial codes were placed within a margin and marked for iteration throughout, to highlight the intended recurrence of certain key phrases and words spoken, to assist with going deeper into expressed vernacular, tone, pauses and redirections, all designed to uncover any hidden meaning (Smith et al., 2009; Miles et al., 2014).

Second Cycle: Step Three.

In step three, the researcher applied interpretations of those key themes, grouping the initial codes into further information to enhance understanding and gain insight (Rubin & Rubin, 2012), identifying those emerging patterns and interconnection during previous steps, identifying
what was most salient from each interview, while framing the interpretations within the construct, to provide further evidentiary support to their validity.

**Second Cycle: Step Four.**

In step four, the researcher used a deductive thematic approach, identifying themes from all codes identified from all participants. The goal here was to identify connection and relationship across the emergent themes within the cluster, in addition to analyzing them through the lens of the quantitative data collected, resulting in the extraction of the most salient themes throughout (Curry & Nunez-Smith, 2015; Miles et al., 2014; Larkin, Watts, & Clifton, 2006)

**Step Five.**

These emergent themes were further analyzed through the analytic process of subsumption, placing the emergent themes within a table, viewing those in relationship with one another, and identifying the super-ordinate themes that presented themselves and provided a comprehensive way to view the themes themselves (Smith et al., 2009, p. 97). These data are presented in Table 4:4. The analysis of these rendered three superordinate themes and six subordinate themes were identified and are presented in detail in table 4:5, along with the theoretical framework that structures the themes, and the research questions they answer. These three superordinate themes and six subordinate themes will be discussed in detail in the next section.

**Table 4:4**

*Subsumption leading to the development of superordinate and subordinate themes*

<table>
<thead>
<tr>
<th>Codes/Emergent themes</th>
<th>Superordinate Themes</th>
<th>Subordinate Themes</th>
<th>Question answered</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organizational culture supportive of sex/gender harassment-oppression)</td>
<td>1. Implied Physician authority</td>
<td>2. Bystander effect</td>
<td>Q3-Q4</td>
</tr>
</tbody>
</table>
avoidance of talk of behaviors/doctor’s actions

defensive when abuse brought to light

relief that it was no longer happening to them (elder nurses)

everyone knew—even the managers—everyone

significant lack of any accountability/action once reported

victims are reprimanded—told to “avoid” the doctors

It was implied fault of nurse when actions reported

Psychological consequences (of sex/gender harassment/abuse) 3. Powerlessness—Isolation

So ashamed/embarrassed

it must have been my fault

rewarded for being a “good nurse”

I stopped engaging on shift—didn’t ask for help

I couldn’t leave—needed money

3. Powerlessness—Isolation

4. Shame, blame, guilt

Q3-Q4
what could I do—he’s the doctor you know?

couldn’t even tell my husband about it

nurses don’t make money “doctors make the money”
i had issues with sex with my own husband

I dreaded going to work— I freaking hated the way it made me feel

I called in sick… a lot

I even stopped calling this doctor for patient issues—I couldn’t do it

he had me believing I was a shitty nurse

if I reported an issue—he would ignore me...just walk away—the bastard

I didn’t think I was a good nurse—I didn’t have any friends

I couldn’t trust anyone

Career related effects (of sex/gender harassment/abuse)

5. Withdrawal—absenteeism
6. Lack of confidence on the job—questioning self

Q5-Q3
Table 4.5

Emergent Themes: Superordinate and subordinate & relationship to theoretical frameworks & research questions.

<table>
<thead>
<tr>
<th>Superordinate Themes</th>
<th>Subordinate Themes</th>
<th>Theoretical Framework</th>
<th>Research question</th>
</tr>
</thead>
</table>
| Organizational culture supportive of sex/gender harassment-oppression | 1. Implied Physician authority  
2. Bystander effect | Social Power/ Dominance & Patriarchy     | Q3-Q4                                        |
|                                                           |                                           | Femininity & Dominance & Oppression        |                   |
| Psychological consequences (of sex/gender harassment/abuse) | 3. Powerlessness-Isolation  
4. Shame, blame, guilt | Feminity and Dominance & Oppression       | Q3-Q4                                        |
| Career related effects (of sex/gender harassment/abuse)   | 5. Withdrawal from work-absenteeism  
6. Lack of confidence on the job-questioning self | Feminity & Dominance & Oppression          | Q5-Q3                                        |

Qualitative Findings

Participants

Interview participants:

The response to the SEQ-W survey was quite robust—with 161 participants, representing fourteen countries, and ten ethnicities. To further enhance the IPA ideographic, a purposeful homogenized sample was derived directly from the broader survey. This smaller sampling is in keeping with the IPA methodology of giving voice and deriving rich meaning from the smaller
homogenous sample, through a shared phenomenon (Smith et al., 2009; Larkin, Watts, & Clifton, 2006)

From the survey, ten participants identified themselves as wanting to interview and provided email or other contact information. Once contacted, of those ten, seven agreed to setting up times to interview. Only five of those responded to the agreed upon time and method and successfully participated in the interviews. ZOOM was used as it was a global audio/visual conference application. Two of the interviewed subjects withdrew from the study after interviewing, while reviewing transcripts: One participant (RND5) cited her belief that “someone will know she was the one telling me about this” doctor, and it would possibly ruin her “chance” of getting chosen to come to work in the US. She stated this was a primary goal of many nurses in her country. The other participant (RND4), simply was “not yet comfortable with sharing” this information “publicly”, as she had “buried it for so long”. She said she needed “for it to breathe” and to be able to “tell my husband first”. The Participant Demographics of the interviewed participants can be found in table 4:6.
Table 4:6

Interview Participant Demographics

<table>
<thead>
<tr>
<th>Participant Pseudonym</th>
<th>Age</th>
<th># years as RN</th>
<th>Highest Degree</th>
<th>Ethnicity</th>
<th>Geographical area</th>
<th>Marital Status</th>
<th>In study</th>
</tr>
</thead>
<tbody>
<tr>
<td>RND1</td>
<td>57</td>
<td>32</td>
<td>Masters</td>
<td>Spanish</td>
<td>US</td>
<td>M</td>
<td>✓</td>
</tr>
<tr>
<td>RND2</td>
<td>35</td>
<td>11</td>
<td>Bachelors</td>
<td>Indigenous Australian</td>
<td>Australian</td>
<td>M</td>
<td>✓</td>
</tr>
<tr>
<td>RND3</td>
<td>42</td>
<td>14</td>
<td>Associates</td>
<td>Pilipino Malay</td>
<td>Philippines</td>
<td>D</td>
<td>✓</td>
</tr>
<tr>
<td>RND4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Withdrew</td>
<td></td>
</tr>
<tr>
<td>RND5</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Withdrew</td>
<td></td>
</tr>
</tbody>
</table>

Subsumption process leading to development of superordinate and subordinate themes

The process leading up to identification of the superordinate themes has been discussed at the beginning of this chapter in review of the process. Using the extracted statements derived from the interviews, coding of similar statements from each participant led to stated superordinate themes. These superordinate themes were matrixed upon the frameworks utilized within this study structure to further give reliability to the both subordinate and subsequent superordinate themes which were additionally related back to both the theoretical framework they arose from and the research questions they answered. These data were represented earlier in this section in table 4:5.

Superordinate and Subordinate Themes

There were three superordinate themes identified: Organizational culture supportive of sex/gender harassment/oppression, Psychological consequences of sex/gender harassment/abuse, and Career related effects of sex/gender harassment/abuse. These superordinate themes will be discussed in detail in this section, including their corresponding theoretical frameworks and research questions.
Pervasive culture of sex/gender harassment/oppression

The first super-ordinate theme identified was pervasive culture of sex/gender oppression. This became a theme based on the persistent use of language used by all three participants to define an environment of pervasive behaviors categorized by sex/gender harassment and abuse (Fitzgerald et al., 1995). Two convergent themes derived from the interview transcripts were: Implied physician authority and Bystander effect. This theme falls within the theoretical framework used herein of Weber’s Social Power/Dominance & Patriarchy (Morgan, 2006; Weber, 1947), and Bartky’s Feminity and Dominance & Oppression (Bartky, 1990). The research questions these themes answer is Questions 3 & 4.

The participants were asked to describe their work environment, its culture (people and relationships-rules and regulations) and to talk about their experiences as an RN within the hospital, with their peer groups, managers, physicians and administrators. Their descriptions of these elements all served to create a vivid depiction of their organization-its governing structures and power seats, and the focus on gender inequity within. All participants spoke with a matter of fact way about the inequity experienced between the physicians and the nursing staff by administration. There was an expressed certainty of absolute -that they “had no power” and the “physicians “brought in the money”, so they (the nurses) held no real “voice within the organization, especially if they were “women”.

RND1, a 57-year-old married female from the US with over 32 years in the field and a master’s degree, spoke with hesitancy at first, saying:

“I’m sure it was because I was a young “cutie” nurse, so “naturally these kinds of things happen”. But as she moved further into the depth and detail of the conversation, her voice changed, to one who experienced injustice, getting stronger and with more breaths
and side words like “man” “its freaking crazy” as she commented “I really just sucked it up-I came from a patriarchal family structure and this felt normal to me-but after I got older, left that hospital and that cultural sickness, it was only when I had went through my own childhood traumas, that I realized how very wrong this was-and how there wasn’t a thing you could do back then , at least it felt that way, because the entire hospital supported the sicko physicians, not the nurses, and EVERYONE knew that” (RND1).

RND2, 35 years old bachelor’s prepared married indigenous Australian nurse, living in Sydney, Australia, was extremely heated in her word exchange. When describing the environment and the general feel and response of the everyone to any types of events-or just beliefs in general she stated:

It’s like multiple abuses daily everyone just stopped telling the administration and managers because absolutely nothing was done in fact, she said, it makes it worse for the nurse telling on the doc, because they (the girls) actually get in trouble with their supervisors and the docs. When asked about peer interactions, opinions, she laughed out loud stating “yeah-good on ya mate- right-the younger nurses are scared shitless-the older nurses are like ‘glad it’s you now not me’, and the whole things shit”.

RND2 was quite candid in her general assessment of the lack of support from administration, and their acceptance of this “dirty” behavior, saying:

“I remember this one time, on the renal unit, dialysis ya know, the docs there were all freaking sleazy everyone knew it-they would stay in their own place-they would take over the nurses break room or something, all the time, laughing about it, like they were best gift to girls, and finally one girl was like ‘screw this’ I’m not eating in here with my food on my legs because this guy is fucked and wants to sit and play wiggle with the
youngies’ we all told her she shouldn’t report to the supervisor-it wouldn’t do anything-but she was new and from a different unit to ours, and they are like different from the cancer ward you know, the docs, I mean, so, not like the guys in renal ward, so she was all stormy and didn’t come back for a bit and when she did she was like out of her mind because the head told her the docs could basically do what they wanted, and that she could go back to her own ward. She was blown away- but we were all like yea, that’s the way it goes down here- it’s like we didn’t even exist because they (the docs) had all the power-everyone was under their control like and it was like something that was normal or something…so dumb really (RND2).

When asked about her experiences and thoughts about the culture and the environment in the Philippines, RND3, a 42 year old Pilipino Malay divorced nurse with an associate’s degree and 14 years’ experience in acute care was upset, speaking quickly and with elevated tone when talking about the way the nurses had to “stick together” because no one else would do it”. When asked if she could tell a bit more, and her insights about them she said:

It was really a hot environment, so filled with it all the time. There was this one doc, everyone knew, an older Indian guy, married, but that didn’t stop him none. He was such a pig you know. He would get up in the side of you, especially the younger girls, and pretend he was getting something and brush his hand against your ass or boobs or something he shouldn’t touch, like breathe on your neck real close Uhm… He would act like he didn’t ever do anything, but he had this one nurse, she was married too, that was like his, umm you know, like a girlfriend he was having sex with, in the hospital and all. She protected him from being told on because she was the manager on the ward, and she was so strange setting up her desk in the middle of the ward so she could watch him
like that. Girls, especially the younger girls, would get ummm felt up and grabbed by him you know, they would try to tell on him to her. She would not recognize the complaint-like never-so crazy because she was umm there all the time, like a sick witch watching him. We were all like how Effed is she right? The girls tried a couple times to get out and had a chat with the higher ups you know, the money people, and they just told the girls they would have to have evidence to build the case and then that the patients would suffer if we did report it like that, but then that would take him away from his patients, and they were saying the girls who were getting felt up by this jerk were putting the patients at risk because they wanted to report him and take him away from patients. So yeah- no-one cared, and they got pretty defensive when it was brought to light. Everyone knew…everyone, but there was this avoidance after that to even talk about the behaviors and this guy particularly, because he wasn’t the only one, he was just the biggest pig of all of em (RND3).

**Summary Organizational Culture supportive of sex/gender harassment/abuse**

As previously discussed within Chapter 2, organizational cultures that have inverted ration of men in power seats and women in subordinate seats, such as in the military, finance and healthcare, we see an implied dominance arise within the culture almost organically and without thought (Bagguley, 1991; Gottfield, 1998; Hogh et al., 2016). These results from this particular category demonstrate a strong existence of implied support in healthcare as evidenced by the inaction of anyone in a formal position of power. This inaction created a hostile work environment for the female nurses and enabled and empowered these male physicians to become bolder and to continue without thought to consequences as discussed by Weber and Morgan in viewing organizations of power and dominance (Morgan, 2006). When the environment and
culture become compliant and inactive against these complaints of gender/sex harassment, then the sequelae follows that there will be continued behaviors if not increased. We discuss the psychological impact in the next section.

**Psychological consequences of sex/gender harassment/abuse**

The second superordinate theme was psychological consequences of sex/gender harassment/abuse. This type of consequence is usually found and well documented. It shows up in the organization attrition and sick/call out rates of the nursing teams (Finnis & Robbins, 1994; Hogh et al., 2016; Schneider et al., 1997), and psychological effects such as powerlessness, shame and guilt are highly experienced with sexual/gender harassment/abuse, (Thacker & Gohmann, 1996; Thacker & Gohmann, 1996; Stock & Tissot, 2013). There were two convergent themes noted: *Powerlessness & isolation, and shame, blame and guilt.*

Bartky’s theory of Feminity and Dominance & Oppression, supplies a framework for these data, answering the research questions 3 and 4 (Bartky, 1990). The participants responses in support of this superordinate theme are as follows.

All three participants spoke in great detail about the ways they’ve dealt with sex/gender harassment/abuse in the workplace and were comfortable telling other nurses’ stories. All three participants spoke emotionally, when encouraged to go deeper by the researcher, about their own gender/sexual/harassment abuse. Their conversations surrounded shame and guilt, and all of them used the actual term “powerless” many times over. All of them believed they in some way started it, or perpetuated the abuse/behavior, or “should have stopped it”, or “stopped wearing dresses” as if they were the initiator of the abuse. All three reported being “isolated” from other nurses if the doctor had signaled them out. RND3 stated “it was as if I had asked him to do this
“to me—treat me like a piece of meat” she said the worse part was her peers “treated her like she was asking for it” and they stopped including her in their activities or even in conversation.

RND1 spoke about this in great detail. She herself had been a victim of physician related sexual abuse, experienced multiple episodes of sexual and gender harassment and bullying by the doctor, the administration, the supervisors and the rest of the staff. She tells this story:

I was a young nurse—went right into college nursing school out of high school. The experience for me in nursing school I think set me up to think that I had no power anyway. I was quiet and shy. They almost preyed upon this. The nursing instructors abused us—verbally, not empowering, they worked hard to make you feel like you didn’t know what you were doing, always question yourself. The preverbal “rite of passage” or initiation into the nursing “sisterhood”. Being a young impressionable adult, I listened to them.

She goes on to describe her abuse within this environment with a particular male surgeon and the way it affected her both emotionally and physiologically.

I remember starting at the hospital and feeling completely overwhelmed just because I was thrown into the work—patients in the hallway, not really an orientation—just jumped right in. It was really hard work—we would move beds—caring for the patient was rewarding. I worked a surgical unit, and there was this surgeon who was very prominent as member of the hospital and the community. He had a reputation. He was known to have a “cutie nurse” he would pick out of the new girls. They were always picked because of their age, and everyone knew it, talked about it, and never did anything about it. Never supported the girl, just turning their heads, even the management. Well I was identified as a “cutie nurse” and he began first flirting and touching me inappropriately
and getting in my space, speaking about my looks and my physical body. I was young and respectful, and even though it didn’t feel right, he was still an older father figure and a well-respected surgeon. It (the behaviors over time) quickly progressed over the years… from touching, to rubbing to grabbing, to this one time where I felt trapped with him.

RND1 gets very emotional at this point in the storytelling as she begins to think out loud, making sense of her behaviors, trying to rationalize why she felt the way she felt—upset with herself, she begins to slow down, her voice starts to break, she begins to cry lightly at first, quietly, while still trying to make sense of the abuse out loud as she starts to relive the moment:

I remember I was working as DR X’s private nurse in the office with him. We would need to go to the hospital to do rounds together. I wore a scrub dress at the time, and he got in real close to me and put his face next to me and stuck his hand under my dress and put his fingers in me. He was sexually aroused and pressing into me… I think if that would happen now, I would know what to say—what to do. I always felt powerless back then. I was so ashamed. I felt so guilty like I could have done something, I should have done something. I remember telling my husband about it—crying, almost asking permission from him to leave this job. We were struggling financially at the time as a newly married couple. I’ll never forget the response to this day: there was no support there— he was like ‘suck it up’. I remember thinking fuck it— fuck him, and then I just almost submitted to the doctor at that point… horrible, but it was almost like ok, if this is how it’s going to be, then I’m going to control it.

RND2 spoke about an experience with an ICU doctor, who wouldn’t leave her alone when she was just starting out:
I was like 22, I think. I remember he and I and some other girls worked on a project together, and he asked me for my number so that I could contact him if I needed to about this project after hours if he wasn’t in the hospital. I worked second shift., and I didn’t think anything about it at the time. After the project was done, I didn’t think he would connect with me, but he started to text me, and then call me if I answered the text messages. He always started them off like it was a patient question—but when I texted back, and he would call, it would turn personal really fast. He would call me beautiful and sexy, and kept asking me if I had a boyfriend, and if I was a virgin. How do I kiss, and what do I like a guy to do to me, asking how far I’ve gotten with my boyfriend? I would ignore or tried to get around the questions, but he was really persistent. He started calling more frequently asking to meet up, telling me he was a real man and could give me what I needed. I felt obligated to answer his calls, because sometimes he would call about patients, he would mix it up so I never knew when it would be patient focused or his own sick stuff. Like this one time where I ignored his call, and the next day I was brought into the unit leaders office and was told I was expected to answer him at all times. I felt so guilty because she told me I was responsible for an issue that happened with the patient—because he told her I didn’t call. I was so shook up about it, I questioned my actions. I told a few of my peers about it, thinking I would get some advice, but they told me I was asking for it. I felt isolated after that, they ignored me. I felt alone. I felt powerless to stop him. My manager wanted me to continue, I didn’t have support. I started to believe that I was to blame for this. It wasn’t until he attacked me in the back room that I left the job, even though I couldn’t afford it and doctors all talk together there.

RND3 spoke about her experiences with the psychological stressors she experienced at her hospital:
I was so ashamed when it happened. He was an old doctor and I was like 30 or something. This doctor had been someone who was found responsible for impregnating a young girl who was in a vegetative state. Talk about sick bastards, yeah? He was a filthy man. When the hospital finds out, everyone’s like umm, what’s going to happen now, he’s finally going to get the hook. But he didn’t. We were not surprised. He started taking up with me, grabbing my boobs, saying he liked them small but juicy. He was a sicko for sure. I tried to stop him, he pushed against me with his body and his penis was aroused and he was smelly and breathing hard down my neck. He wouldn’t let me go.

RND3 stops suddenly. She takes a deep breath, and then her voice starts to break. She says she sorry. When asked why she was “sorry”, she says because she didn’t avoid him in the room, that she couldn’t see him, or she would have not been with him. She takes another deep breath; through her tears she says:

I felt guilty, I still do. I knew he was like that. I put myself in a place he could get me. I feel shame. I could never tell my mother about this. Absolutely not my father at all. That’s not something we talk about in my culture. I remember trying to tell someone and got told to “be a good nurse” and that I should just “avoid” him. I knew at the time I couldn’t leave because I was providing for my entire family, and I was in my early twenties. I think that’s who he took advantage of all the time, the young ones. He was a disgusting old man. But after my manager told me to be a good girl, I was silent. I stopped communicating on shift, I isolated myself. I was paranoid and nauseous all the time. I blamed myself for getting in that room with him in the first place. Now that I have kids, two, a boy and a girl, I would never tell her to just be a good girl. I teach her to fight back if that happens. She’s my strength now. I got divorced because the man I married
was hurting me. I don’t know if it was the sexual abuse from that old doctor, but I had issues with sex with my own husband because he was kind of like that. I felt proud I stopped it. He wasn’t going to hurt my kids.

**Summary: Psychological consequences of sex/gender harassment/abuse**

As devastating as these abusive situations are while they are happening, the real concern is the long-lasting effects the situation has on the women and their physical and emotional health (Schneider et al., 1997; Pryor et al., 1993). Abuse of any kind is damaging. These women interviewed stated they were directly impacted by these instances they described: reporting physical ailments, from nausea, diarrhea and general fatigue and anxiety, psychological feelings of depression and low self-esteem to shame and guilt or belief that they were somehow responsible for these atrocities. They reported feelings of isolation and fear of retribution or retaliation of some kind. Additionally, these psychological affects spilled over into their work lives, and their own personal lives. We discuss the third superordinate theme in the next section, Career related effects of sex/gender harassment/abuse.

**Career related effects of sexual/gender harassment/abuse**

The third superordinate them identified was Career related effects of sexual/gender harassment/abuse. As mentioned previously, sex/gender harassment/abuse impacts the quality of life for the nurse from both psychologically and physiologically. Nurse victims of these abusive harassing behaviors in the workplace feel especially stressed and experience issues, especially if they are required to closely relate to the person who assaulted (Finnis & Robbins, 1994; Hogh et al., 2016; Schneider et al., 1997) There were two convergent themes that were extracted and shared in common among the participants: Withdrawal from work – work absenteeism and Lack of confidence on the job, and questioning themselves.
When asked to elaborate on the impact these behaviors had on their careers, if any the group all shared similar physiologic symptoms of nausea, anxiety and overall lack of confidence in themselves. They all shared that because it felt like no one did anything, they might have been the one to blame, and that just put them in a place where their own confidence in their skill set was impacted.

RND2 spoke this way about her experiences:

After that experience it was like I was always nervous about going to work, like all the time. It didn’t matter. When I was there, I was thinking all the time what if he does it again, what would I do. Do I have money to leave and do something else, who am I going to let down, all of that? This one doctor who was always abusive verbally, continued to tell me I was a shitty nurse. I didn’t want to go to work. It was umm, like I got sick just thinking about it. I called out a lot. I mean a real lot. It felt anxious and like I was all alone because I didn’t have anyone on the unit or friends to rely on. The other nurses kept going along, pretending he was a no issue. With me, I was all, is it me? Maybe I just don’t get it, maybe I am a shit nurse.

RND1 tells it this way about her experiences on the job and the impact on her career and performance after the sexual abuse:

I just went to a place where I didn’t talk to anyone. I couldn’t trust anyone. Not even my husband. I started questioning myself, and never questioned the physicians, even when it was something I had to say about the patient. My thoughts or opinions I was told were irrelevant by my husband and my managers and peers-the behaviors were silent, we all protected them. I was always sick to my stomach, anxious, had diarrhea all the time. I was a nervous wreck physically and mentally. I went from working forty hours a week to
calling out at least 1-3 times a week. I couldn’t stay there- I couldn’t face him. I was sick all the time, really sick. I manifested it in my body, physical symptoms. I was so stressed. I kept it from my husband, well you saw how he reacted to the abuse. I don’t remember, but I think I got pregnant, and was able to leave. I was never the same. I am a nursing professor now. I think it’s because of my experiences that I work hard to empower the nursing student. I make sure they know they are strong and smart, capable, and can do anything. And importantly, not to accept this type of abuse from anyone, especially docs.

Summary: Career Related Effects of sex/gender harassment/abuse

Nursing is an art and a science. Many would state that nursing is a vocation. A call to help those in need (Fee & Garofalo, 2010). The education is arduous, as the nurse is responsible for caring for the patient holistically, in addition to identifying abnormalities and communicating those changes to the physician caring for the patient. When that relationship becomes tainted by sexual/gender harassment/abuse, the professionalism of the communication changes (Sojo et al., 2016). The nurse becomes isolated and concerned, believing the statements that she is not good at her job, and she starts to believe it (Hezekiah, 1993). There is no support for her, even after telling her story to her manager, there is simply a matter of fact attitude that it is in fact your issue (Byrne et al., 2014). These nurses interviewed tell their stories of and how the stress and anxiety caused by these sex/gender harassment/abuse behaviors, the impact it had on them while it happened, directly after it happened, how their environment changed, and they no longer had any support, in their peer group, their supervisors or even the administration. They tell of how they became ill, isolated, paranoid and fearful because no one was courageous enough to do anything about it (Kushner & Morrow, 2003; Schneider & Swan, 1997). These women interviewed tell of how they felt about themselves at their job, unsure of themselves, hesitant,
and calling out many times, even though the only reason many stayed in the abusive situation
was because they suffered financially (Thacker & Gohmann, 1996; Cortina et al., 2013). In their
voices, now as the retell the stories and discuss their emotions and the impact at that time in their
life, they speak about what is right, and gain some strength from telling their stories (Davies,
2003). They are still caring individuals with a purpose in life to care for those in need, but also
tell of a time when their fears and anxieties and their culture, pushed them away from what they
educated themselves to do, their calling, to care for the sickest of us (Finnis & Roffino, 1994).
Their patients in need. That’s the tragedy, the impact that sex/gender harassment/abuse had on
these nurses. That’s what needs to end. In chapter five we will discuss the theoretical
frameworks used and the research questions were answered by the two separate phases:
quantitative and qualitative. The limitations and implications for practice will also be discussed.

**Chapter 5: Discussion, Research Questions & Implications for Practice**

**Introduction**

This chapter will first remind the reader of the theoretical frameworks that guided this
study, then move to discuss and integrate data collected and analyzed in both phases of this
research: quantitative and qualitative, within the context of answering the research questions. We
will discuss the framework or categories of behaviors used to quantify the survey data; Gender
harassment, Unwanted sexual harassment and finally Sexual coercion/sexual assault. It will then
move to discuss the three superordinate themes derived from the interview of phase two of the
study: Organizational culture supportive of sex/gender harassment/abuse, Psychological
consequences of sex/gender harassment/abuse and Career related effects of sex/gender
harassment/abuse, and how they answered the qualitative research questions. The chapter will
conclude with an identification of study limitations and implications for practice, as well as recommendations for future research and then close with a final conclusion.

**Theoretical frameworks**

This study required the use of two intersecting theoretical frameworks to underpin and view the data collected from this study: Weber’s theory of Social Power/ Dominance and Patriarch (Morgan, 2006; Weber, 1947), through the intersection of Feminity & Dominance & Oppression (Bartky, 1990). This intersection provided a scientifically rigorous way to frame the data collected in both quantitative and qualitative phases, make sense of the stories and statistics, to offer a structure to the reader in which to better understand the importance and context of this information from the intersectionality of these two theoretical lenses.

**Quantitative Categories/Superordinate Themes/Answering the Research questions.**

In order to provide a consistent standardized way to capture and measure the responses to questions that may be felt as subjective, a validated tool was used that allowed for quantification and categorization of groups of behaviors that made up the category. They were derived after years of study and implementation and refinement of the SEQ-W tool (Fitzgerald et al., 1995). The three categories used to quantity the behaviors were: Gender harassment, Unwanted sexual attention, and Sexual coercion/assault. The first two questions were obtained through the quantitative data collection phase and answer these questions in the following subsection.

**Research Question 1 and 2.** How frequent was the occurrence of gender/sexual harassment within healthcare among the purposive sample participants, and the other more frequently occurring behaviors? And question two, what were the types, frequency, level of
severity and of occurrence of sexual/gender harassment behaviors? We look at this from the three categories; gender harassment, unwanted sexual attention and sexual coercion and assault.

**Gender harassment.** The results of this study provided an intimate look at the culture and experiences from the female nurse’s perspective. When speaking of gender harassment, there is a sense that we know what it means, but this survey was able to give us the frequency and occurrence of behavior types. Of the 161 participants queried, in 10 countries around the world, approximately 14% of all participants had experienced some frequency of gender harassment at least once. The frequency and occurrence of gender/sexual harassment overall was 65%. 65% of participants experienced this type of behavior more than once, and many, 16% put up with this type of sexual harassment many times over. The occurring behaviors ranged from being told jokes or offensive stories, putting up with sexist comments, or being shown pornographic materials, to 65.8% living with offensive remarks made about their appearance, body or their sexual activity, or making comment. Gender harassment is about power and dominance over another gender (Bartky, 1990). More than 50% of all women participating had frequently made remarks about women being too emotional to be scientific or able to assume leadership roles. This type of disparaging sexual/gender harassment is disempowering. The evidence this survey collected shows that gender harassment is frequently occurring across the globe, more than 50% of the time.

**Unwanted Sexual Attention.** There is much to be said about “unwanted” sexual attention. We have been taught that “no means no”. Unwanted sexual attention does not serve to make the target of this attention feel “wanted” or feel “valued”. Unwanted sexual attention is just that. Unwanted. With these women in subordinate roles with the male physicians in positions of dominance and control not only hierarchal roles, but also from the monetary value that is placed
upon them by the institution. Nurses cost money. Doctors bring in money. You’ll never see a hospital cut a physician yet will almost always see nurses fighting and struggling to stay viable within the workplace, usually going above and beyond to the point of emptying themselves, leading to burnout (Garret, 2011). The results of research question two can be found in the frequency and type of offensive behaviors as seen in gender harassment, but also those that blend and are categorized in the unwanted sexual attention and the following sexual coercion assault categories. 50% of all participants suffered from unwanted attempts to draw the nurse into conversations about their sex life, while 44% were given unwanted sexual attention, many nurses wrote to clarify this on survey, that they were grabbed inappropriately or that they suffered from the doctors putting themselves very close to them, speaking in their ears while holding onto a shoulder, or telling them how good they smelled. These behaviors escalate to at least 47% experiencing the repeated experience of the doctor not being able to understand “no” when asked out and continued to ask them out repeatedly. Unwanted sexual attention comes in many types and forms, one of which is touching the woman without her expressed agreement/permission. 50% of participants have been touched inappropriately on the bare arm or shoulders in a way that made them feel comfortable. 36.6% reported being fondled, either on their breasts their thigh without their permission, 21% said they sometimes had this happen to them. The most devastating statistic is 11.8% of these female participants had been the victim of these male physicians putting their hands on them in an attempt to have sex with them that resulted in the woman pleading for them to stop, or physically struggling. The issue was that many female nurse participants, stated they faced these kinds of unwanted sexual attentions often and some many times.
Sexual Coercion and Sexual Assault. When these behaviors of sexual harassment and unwanted sexual attention go unchecked, these behaviors can escalate into actual sexual abuse or assault, especially in cultures that are supportive of these types of behaviors, through their silence and inaction taken against the perpetrators (Finnis & Robbins, 1994; Fitzgerald et al., 1995; Garret, 2011). When answering these first two research questions about the occurrence, type and frequency of sexual/gender harassment/abuse, we are able to view the severity of these behaviors in the escalation of behaviors in the population surveyed. This category delves into the horror faced daily by female nurses while working caring for the world’s sickest patients. That they have been putting up with this for decades, is testament that these men have been empowered to continue- there does not seem to be an opposition to their sexual harassment, even to the severity of it leading to sexual coercion and actual sexual assault! In the query, questions asked of these women that fall under the category of sexual coercion and sexual assault. These results demonstrate that escalation when sexual harassment and unwanted sexual attention go unchecked. These were disheartening statistics to say the least. 33% of all women participating felt they were in a situation where they were being subtly bribed into engaging in some sort of reward or benefit if they would engage in sexual behavior with the male physician. Over 19% were subtly threatened with retaliation of some sort, for refusing to engage in sexual acts with the male physician. Over 15% of female nurse participating in this study reported that it was implied they would get a promotion if they cooperated with the male physicians, while 21.7% stated the male physicians made it necessary for the women to respond positively if they wanted to keep their jobs and 20% were afraid that they would be treated differently if they didn’t cooperate sexually. There was one question that actually asked about criminal sexual assault. It specifically asked if the male physician had ever made unwanted attempts to have sex with them
that resulted in them pleading, crying or physically struggling, to which 7.5% said once or twice, 1.2% said sometimes, 12.4% said Often, and 3% said Many times! The question of treated you badly for not having sex with him was answered by those women who answered above yes- 82. % of the time.

**Research Questions 1 and 2 Summary**

The frequency, occurrence type and severity of sexual /gender harassment/assault is occurring across the globe. The frequency has been shown to occur with regularity with more than 50% of our surveyed population experiencing some form or another within each of the three categories. Fitzgerald speaks of the implications behind the type of organization that, through its silence and no accountability culture, these behaviors escalate. In phase Two, the interviews, we take a look into these experiences intimately. As horrific the statistics is, these women who were interviewed put a face if you will, to the numbers. They carry the effects with them and give testimony to the emotions and psychological and physiologic impact these experiences have had on their lives, and the way they view themselves. We will discuss research questions 3, 4, and 5 within the superordinate themes identified.

**Superordinate themes, Research Questions,4,5 and 6.** As revealed in qualitative phase and summary of research questions 1 and 2 above, additionally in chapter three, quantitative findings, we find similar findings which are revealed through the retelling of these female nurses who were interviewed, stories. This research has revealed that there is an ongoing issue of sex/gender harassment/abuse occurring within the acute care hospital setting. From the various countries and nurses surveyed, their answers were consistent with the literature surrounding sexual/gender harassment/abuse in the workplace as commonplace, goes widely unrecognized as such, is absorbed and frequently supported through rationalization from the administration, which forces
a certain silence of the victims of this phenomenon. It has become the best kept secret, and widely results in attrition, stress resulting anxiety, PTSD, physiologic and psychologic (Finnis & Robbins, 1994; Garret, 2011; Hogh et al., 2016; Jackson et al., 2013). There were three superordinate themes that arose from the analyzed data that address the research questions 3,4, and 5, which will be described and discussed in detail within this section.

As stated in chapter three, this study was designed as a mixed methods study to collect data to answer both statistical data about the frequency and occurrence and type of gender/sex harassment/abuse in acute care, and qualitative deep probing questions, to better understand the lived experiences of the nurses interviewed. The subject of gender/sexual abuse/harassment is one that needs to be approached respectfully and with an openness to hear the truth within the horror. The qualitative IPA portion of this study was instrumental, and provided data rich, honest, poignant stories of the three women interviewed, that would draw the reader in to just a moment in their life, to gain a better understanding of the destruction this type of phenomenon, can have, directly from one who has lived it. All three of these women participating in the interview phase, have reported psychological, physical and career pain and suffering as a result of the impact from the male physicians who perpetrated the abuse/harassment, and have felt the isolation and loneliness, wavering confidence, shame and guilt that comes from experiencing this kind of abuse. They also reported frequently witnessing or were aware of numerous issues and abusive situations their peers had experienced. These women felt the need to participate and reveal these atrocities, so that they might shed the light upon a system which in their eyes is “sicker” than the patients it cares for.

The importance of “hearing” these voices rise up, sometimes for the first time since the events they described, created an understanding of this devastating phenomenon, and the reality
behind them. These women are Real. Flesh and blood people. Women. Caregivers. Mothers. Lovers. Wife’s. Sisters and daughters, who demonstrate so poignantly, the long-lasting devastation and impact sexual/gender harassment/abuse has had on them and their lives. These stories were in response to research questions 3, 4, and 5 and are as follows:

Research Question 3. What behaviors and experiences reflect a similar slant, as related by the female nurses lived experiences? When viewing the results of the survey and the interview responses, there were relational qualities shared between the survey responses and the interviewees answers. Both phases of data yielded a similar push to “silencing” the abused, while the abuser was not held “accountable. The retelling of their experiences served to provide substantiation of the statistics, while bringing to light the devastating occurrences and their emotions of trying to fend off an actual sexual assault, which when reported, served to put the nurse on the blacklist with her peers and the physicians and the facility. The women interviewed corroborated the almost accepted “ordinary” nature of these types of behaviors, and their “widely accepted” occurrences within the hospital. The nurses interviewed spoke about the self-esteem issues they experienced, the negative and derogatory sexual harassment experienced, the unwanted sexual advances and unwanted sexual touching-suggestive language, demeaning attitude and sexual coercion.

Superordinate Theme 1: Organizational Culture supportive of sex/gender harassment/abuse.

Research Question 4. How do female nurses define and describe their personal experiences of sexual and gender harassment within the acute care environment? The retelling of their stories, often with multiple experiences, demonstrated and corroborated the survey results. Both data sets revealed that the “physicians held the power” whilst they, the nurses, felt
“powerless. These women interviewed discussed at great length their culture, the environment, their peers and the administrators in addition to the actual experiences of sex/gender harassment/abuse. All of them stated that there was a pervasive acceptance of the males who perpetrated the gender/sex harassment/abuse. They describe a complacent environment, not holding any support for them, even from the peers they worked with. Even with the women who had themselves suffered at the same doctors hands the same way. The desolation and isolation they all described, was, they said, monumental when making decisions and affecting the way they interacted within the workplace. They described the diseased way the culture accepted these physicians, not only through silence, but in actually supporting and many times defining the physician. They all agreed they experienced a sort of “excommunication” from their peer groups, and that even though their own supervisors may have either experienced or witnessed the events, after they were told, they experienced retaliation and amped up levels of the conduct, many experiencing psychological and physiologic devastation.

Superordinate themes 3 and 4: Psychological consequences and Career Related Effects of sex/gender harassment/abuse

Research Question 5. How do female nurses describe any effects of sexual /gender harassment may have had on their health, careers and the way they practice? Sadly, all the female participants interviewed describe the multiple effects resulting from the abuse. They revealed the “physiologic and psychological” symptoms that developed because of the abuse. What I noted most about the women interviewed, is that they all shared similar feelings, of shame, guilt and self-blame. They all described with emotion, the way they felt when it happened, they spoke about doubting themselves and their ability to care for their patients, the isolation and wrongful identification of them as “shit” nurses. The stories of their experiences
were heart wrenching, affecting their emotions still. All nurse broke down during the elements of their stories as they were describing the abuses. They were struggling to make sense of it all. They pondered out loud how incredulous they were then, they were stunned and had their perceptions of the profession and physicians in general dashed, and just couldn’t believe that anything like that could have happened. But it did. And frequently. Now, in looking back, they were making sense of the experiences, talking to themselves, out loud, coming to the same conclusion, realizing that what they experienced was not their fault, it was the fault of the physician, the administrators whom fostered the rule of law that physicians were valued and nurses were not, their managers, who refused to be courageous or to speak out against the abuse for fear of their own retaliation from the administrators and the physicians. All of them made several attempts out loud to rationalize why they didn’t do anything more. Why they felt like they contributed to the situations in some way; too young, a “cutie nurse”, too inexperienced, etc.

All three spoke of experiencing the physiologic effects of nausea and psychological effects of anxiety and fear. All faced monetary financial reasons for staying and had limited self-esteem to believe they could get another job with what had happened for fear of retaliation and not getting a good reference. They all three were ostracized from the other nurses on shift and whispered about on and off shift. because they one participant All of the women told of the debilitating way the physician’s opinion would make them feel, oftentimes believing the male physician attacker and his cutting skewed viewpoint. They felt they were powerless to do anything, and through that they isolated and became withdrawn, often creating major illness and calling out of work frequently. The abuse has had long lasting effects on their relationships with their husbands and how they view themselves as sexual beings. Despite these behaviors happening a couple to a couple of decades ago, all three of the women, stated they hadn’t
thought it still affected them as much because they were different, stronger, and had children of their own, girls, whom they have empowered to fight this type of abuse or harassment in their lives, empowering their girls to not accept this behavior or to think they’ve caused it in any way. RND1 says it all “…the worst part is having been sexually assaulted in a place where you work, held down by a “guy” who is supposed to have taken an oath to “protect and serve” and sexually touched against your will, and then having the very environment view me, the abused, as the “outcast”, like I’m the one who did something wrong…so fucked up”. (RND1)

**Limitations**

This study used a purposive sampling to gain a real understanding of a specific type of phenomenon: female nurses who had worked at least 10 years in acute care hospitals. As the study phase one got underway, it was evident by the number of participants who wrote in to inquire if this researcher was going to do another study for LPN’s, for CNA’s for EMS, hospital admin staff, all women working under this patriarchal rule within the healthcare setting, that the study limitations could have been more inclusive. Additionally, the number of participants for phase two the qualitative study, although yielding rich data and stories from the three brave women who participated, if increased, One could see the broader set of implications and insights we would have to decide if these events occur in a like fashion, on a particular unit, to a particular type of nurse, response etc…. Time was also a factor in phase two. If this study was done beyond this academic boundary, it could have incorporated a vast network of observations, segmented interviews, focus groups etcetera.

**Future Research Potential**

The potential for future research is wide reaching and nuanced on this type of phenomenon within the healthcare environment. Currently, there is a broader light being shed
upon these types of abusive behaviors in other areas of the workforce from the economic implication (McLaughlin et al., 2017), to the implications of the current nursing shortages and attrition rates (Allen & Aldebron, 2008; Gordon, 2005), to the psychological and damaging effects of this type of behavior on women (Pryor et al., 1993), to the damaging cultural social power & patriarchal belief systems & “legitimate authority” given to these physicians which is running rampant in our healthcare organizations (Applebaum, 2017). Each of these areas serve to provide an increased need for a call to action to stop.

Future studies to assist with drawing some light into these areas could be studying females from varied subordinate roles within the healthcare landscape, to investigate whether the hierarchal system of power and dominance exists and is it patriarchal in nature to determine if the environment is a supportive one to the social power and dominance-hierarchal organizations exist, it is in areas where the subordinates are mostly women, and their supervisors mostly men, where we see this precipitating the environment for abuse (Lopez et al., 2009). Additionally, studies into the family lives of the participants, their cultures, their geographical location, their value sets etcetera would add to a better understanding of the broader more tacit and subliminal patriarchal structures of dominance in place.

Perhaps a retrospective view and comparison with nurses who have experienced sexual/gender harassment/abuse in healthcare and investigate what their thoughts are on the implementation of gender and sexual harassment policies, and whether they see or experienced an improvement.

A study to investigate the perspective of physicians, surveying them for behaviors that qualify as sex/gender harassment/abuse, would give us the perspective of the identified “superior” studying those tenants taught to them in medical school, and determining what in the
curriculum gives the students the implied “legitimate authority” (Applbaum, 2017). Another study would look at female nurse of all ages and experience levels and view them in comparison to determine if the youth or novice nurse is being targeted and set up programs within nursing schools to inform and prepare our student nurses with more confidence and a bigger voice. Similar to RND1 and what she is doing within her program. No matter what the study, healthcare is the perfect environment to begin these investigations as it is a primary source of hierarchy, dominance and power structures.

Additionally, this researcher feels that investigating the female nurses who have experienced this sex/gender harassment/abuse in the hospital, and uncovering if they have also experienced some sort of sexual abuse or domestic violence or trauma at another point/time in their life, would further shed light on the sustained negative impact that abuse, violence and trauma have on reaction and beliefs.

Conclusions

Implications for Practice

This study served its purpose by demonstrating through survey questions that quantified sexual/gender abuse/harassment, and through intimate retelling of abuse from the women who experienced this, that gender/sexual harassment/abuse is thriving in the healthcare environment. The hierarchy that has men in more positions of power, and women in higher subordinate roles only serves to justify the dominance and power culture that exists within this female marginalized workplace (Weber, 1947; Morgan, 2006). Healthcare itself is a dichotomy that has women in the majority, yet they still remain in subordinate roles (AACN, 2014). This study has only yet touched the tip of the iceberg of sex/gender harassment/abuse that occurs within the healthcare workplace.
This study provided the categorization, frequency and occurrence of identified sexual/gender harassment/abuse behaviors as quantified and defined by Fitzgerald’s SEQ-W tool (Fitzgerald et al., 1995), in addition to being able to view the qualitative data set through rich interviews with women who have survived beyond these atrocities. We have gained a knowledge of the horrible long-lasting impact these abuses have on the physiologic and psychological self, and the impact on both the females, their jobs, their careers and their families. The research questions were all answered, and unfortunately revealed what was already suspected at the start of this study: sexual/gender harassment/abuse occurs frequently and in varied ways within the healthcare hospitals. The organization culture is set up and designed to affords male physicians a certain implied authority and are considered sources of income (Rawat, P.S., 2014). There still is much work to do within the organizational structure itself, and hopefully over time as more and more women enter into a physician’s role, and more men into a nurse’s role, these scales will balance out (Sojo et al., 2016)

Next Steps

There are three ways the results of this study can be used to improve the awareness of these statistics on sexual or gender harassment or abuse in acute care hospitals. The first is to increase the awareness of nurses who are currently enrolled within nursing programs (Schneider, K.T. & Swan, S., 1997). Nursing professors and clinical faculty are responsible for providing the foundation of education for the nursing student. One element of a nursing curriculum is ensuring the students understand and are competent in a leadership role (AANC, 2014). Augmenting this Curriculum to contain courses that empower the student nurse, especially if they are female, to recognize these types of insidious behaviors and to give them tools and a script to push back (Bartky, 1990). Through the provision of educational materials designed to
equip the student and future nurse with an understanding of the effects of sexual or gender harassment or abuse, can give rise to dialogue that can shed a light on acceptable versus unacceptable behaviors within the workplace (Thacker, R.A., & Gohmann, S.F, 1996).

The Second thing we can do with this information, is creating a national awareness of how to identify these sexual or gender harassing or abusive behaviors and know when to trust their own intuition and predict when things may escalate (Sojo et al., 2016). As we have learned from the literature and now this study, is that the culture that supports sexual or gender abuse or harassment, can be isolative, with power structures deeply embedded in the organizational fabric (Roscigno, V.J., 2011). Experiencing this type of phenomenon can lead to withdrawal and self-doubting behaviors of the abused (Thacker, R.A. & Gohmann, S.F., 1996; Stock, S.R., Tissot, F., 2013). Through encouraging inclusion of these students, and other nursing professionals to societal or nursing organizations like the American Nurse Association (ANA), can provide support through membership. These organizations provide national and international narratives and focus on topics that are rising within the nursing profession and the environments they work in (Bourgeault, 2013). Preparation and supportive mechanisms for their continued support outside of the organizations they work in should be introduced and nurtured before they even leave school to assure there are resources available.

The third way we can shed the light upon the toxic environment of sexual or gender harassment or abuse, is to expose the stigmas and wrongful stereotypes of nurses who have not often been supported in reporting this type of offense to their management (Bourgeault & Grignon, 2013). The patriarchal organizational structure that exists within healthcare, has been a tacit one of implied authority driven by the male physicians who founded their own legitimatization (Applebaum, 2017). Gender or sexual abuse or harassment exists under the cloak
of silence and flourishes within the vein of complacency (Finnis & Robbins, 1994) and stereotypes about female nurses are often perpetuated within the media and on television (Birnbaum, S., 2017). It is a start that we are beginning to have open dialogues about what it means to experience sexual abuse or gender harassment, and their associated behaviors to help people qualify those subtle and nuanced actions (Fitzgerald, 1997) that are now being delegitimized if a female reports them (Finnis & Robbins, 1994).

It is just a start. It requires persistence in order to deconstruct the way hospitals have done business since the beginning, with a focus on actively participating within the environment if you are a manager. Nursing leaders need to unite with one voice against these previously unidentified and accepted behaviors continued to occur. It cannot be done without the support and implementation of a multimodal approach that includes the initial education, awareness, supportive reporting structures and provision of a safe environment where we do not ostracize the abused for the work of their abusers, instead, these reports must be viewed with an open mind, while reserving judgement, and expedient action when an event has been denoted true (Vogt et al., 2007). It is true that not all men who are physicians will commit these acts. It is also true there are many physicians around the world that abhor and do not support these types of behaviors form their colleagues. But it is time now to speak up for those voices who have gone unheard for decades. Time for us to become a better people. A people of respect. It IS a hard topic to speak about. It IS a topic that is difficult to hear. It is a behavior that is hard to believe of anyone. It IS disruptive. It WILL change things within the environment though if we give it a voice. That is the purpose of this study: To give at least these female participants a voice-a place where their words were sacred and heard.
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Women of Hollywood tell their casting couch horror stories. The fall of Harvey Weinstein has been swift. In the last week multiple reports have been published detailing decades of sexual harassment and assault, and more break every day. (2017, October 11, 2017). *Daily Beast*. Retrieved from http://www.thedailybeast.com
Introductory Statement: This interview is part of a study on sex/gender harassment in acute care hospitals between doctors and female nurses with 10+ years’ experience within the environment. I ask that when reflecting and offering your reply, you consider only those events occurring within the hospital setting. I respectfully appreciate your participation in this study and look forward to providing a nonjudgmental environment for you to share your story. Because your responses are integral to the authenticity of this narrative, I want to assure I capture everything you say. To that point, this interview will be recorded. I will also be taking some written notes during the interview. Is this process acceptable to you?
To meet our human subjects’ requirements at the university, you must sign the form I have sent and explained to you. (assure form is signed and in my possession) Essentially, this document states that: (1) all information will be held confidential, (2) your participation is voluntary and you may stop at any time if you feel uncomfortable, and (3) we do not intend to inflict any harm (allow time to review form). Do you have any questions about the interview process or this form? I would also like to audiotape this interview. May I have your assurance that your signed consent explaining this process is amenable to you as well? (refer to original consent form that includes possible recordings)

I can assure you that all responses will be confidential – I will use an assigned pseudonym when quoting from the transcribed text. This will be the only interview. We already discussed the research goals in our first meeting, and you have read and signed the Consent Form. Do you have any other questions about the process currently? Do you still agree to sign the Consent Form? Let’s begin

1. We are going to collect some demographic information at first ok?
   a. How many years have you been a nurse?
   b. How old are you?
   c. What was your entry degree into nursing? ASN-Diploma-BSN-MSN other
   d. What is your highest academic degree?
   e. Are you currently working in a hospital? If so, how many years in this place? What unit type is it? What is your role there?
   f. What state are you working in? Is this a university hospital or community hospital or other type?
   g. Is your direct supervisor a male or female?
   h. Would you say there are more male or female doctors in your hospital?
2. In your own words, can you summarize your view on the doctor/nurse relationship within your experiences? Does the relationship look any different between a male doctor and a young/older female nurse?
3. What are your thoughts on the current #MeToo movement? Do you know anyone who has participated in this movement? Have you had any experiences that could qualify you for participation in this movement at any time/place in your life?

4. Could you share some insight into your experiences as an RN in the hospital? What was the culture like in your opinion? How were physicians treated in relationship to nurses by the administration? In your recollection, were there any standout male physicians that staff were “aware” of and that were talked about more frequently?

5. Let’s review your survey, were there any experiences that come to mind across your time in acute care that may have qualified as meeting one of these behaviors?
   a. Have you ever been a recipient of sex/gender harassment in the hospital workplace? Please share with me that (those stories).
   b. Were there regular occurrences? Was it widespread, or concentrated by specific doctor?
   c. What did you do about it? Who did you tell if anyone? Why did (or) didn’t you report? What was the communication to you if you did report? If you did report the incident(s), did the perpetrator of those behaviors know it was you who reported?
   d. Share with me how the environment/you felt after these event(s)? Did you feel supported by management? Your peers? Other physicians? Administration? Your family?

6. Can you share with me the way these behaviors made you feel? About yourself? Your role? Your hospital? Your peers? Your management?
   a. Describe any role/ job changes that occurred during this time? How soon after the episode was it?
   b. What were your primary reasons for leaving do you think?
   c. Did you feel that you shared any responsibility in facilitating/instigating these events?

7. How has these events/behaviors in your words, effected impacted the way you conducted yourself? Your professional relationships? Doctors and nurses and administrators/managers?

8. Were there any other solutions/positive or negative outcomes in your opinion that resulted because of these events? Were you supported?

9. What is your thought on patriarchal power structures within hospitals between male physicians and female nurses? Between Female doctors and female nurses?

10. What is your opinion on a nurse who reports an episode of sex/gender harassment? Has this changed any over the years?
Closing the Interview: I am finished with my questions at this point. Is there anything that we did not discuss that you think would be important to add at this time?

I thank you again for sharing your story with me at this time! I know how sensitive this topic can be and how difficult it can be to speak about it with a stranger- I so pleased to have had your participation in this study. It has been integral to my research. I will be back in touch with you when I have your transcripts and you can review them if you wish.