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Managing Sexual Harassment Through Enacted Stereotypes: An Intergroup Perspective

Debbie S. Dougherty, Elizabeth A. Baiocchi-Wagner, & Tammy McGuire

This qualitative study applies an intergroup communication approach to examining the lived experiences of nurses who were sexually harassed by their patients. Twenty-eight interview transcripts were thematically analyzed; results illustrated how a combination of self-categorization and stereotyping functioned both constructively and destructively in harassment situations. Nurses consistently explained their communication behaviors and those of their patients in light of respective social identities. The intergroup lens proves to be a useful tool for examining the occurrence and perpetuation of sexual harassment in health care organizations. Theoretical implications and practical applications for scholars researching organizational communication, health communication, and intergroup communication, are discussed.

Keywords: Health Care; Intergroup Communication; Sexual Harassment; Social Identity Theory; Stereotypes

According to many scholars, the nursing profession boasts the highest rates of sexual harassment (see Robbins, Binder, & Finnis, 1997). In fact, studies show that 69–85% of nurses reported experiencing some type of sexual harassment while at work (Lobell, 1999). Perhaps most alarming was nurses' reports of sexual harassment from a patient. In a recent study by Ulrich and colleagues (2006), registered nurses' complaints of patients' sexual harassment accounted for nearly half of all sexual

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harassment encounters reported. These sexually harassing episodes catalyzed nurses' emotional distress, occupational disruption, and physical illness—factors that could seriously impact patient care (Valente & Bullough, 2004). All these reasons necessitate immediate attention to this topic.

Scholars acknowledge that sexual harassment is a communication phenomenon: as a medium *for* sexual harassment (Kreps, 1993) and *synonymous with* sexual harassment (Bingham, 1994). Organizational communication researchers have explored how and why sexual harassment occurs (Clair, 1994a), particularly the phenomenon's link to power. Study examples include examining mental links between power and sex (Bargh & Raymond, 1995), gender differences in power construction (Dougherty, 1999, 2006), power and individual differences (Wayne, 2000), and attention to victims' narratives of power (Clair, 1993; Wood, 1992). Taken together, these studies suggest that social identity is most likely influential, not only when sexual harassment occurs, but when organizational members socially construct the meaning of sexual harassment (Dougherty, 2001). Consequently, it is important to address social identity processes during discourse about sexual harassment. An intergroup communication approach would allow for such an examination.

Communication that shapes or is shaped by individuals' group memberships is said to be intergroup in nature. An intergroup communication approach—comprised of multiple theories espousing the significance of social identity—is particularly well suited to address the phenomenon of sexual harassment. A well known set of intergroup theories (e.g., Social Identity Theory, Tajfel, 1978; Self-Categorization Theory, Turner, 1982) posits that individuals often define themselves in terms of a social group. When this particular ingroup membership is valued and salient, the individual's social identification guides his or her communication and related behaviors, as well as chiefly influences positive evaluations of self and fellow group members. Therefore, this approach may offer unique insight into how a sexually harassing interaction is shaped by social identity. Although some scholars have applied an intergroup perspective to testing attitudes toward sexual harassment (e.g., Smith & Citti, 2006), additional research is necessary in order to understand intergroup communication processes.

This study uses an intergroup approach—and social identity theory specifically—in its investigation of sexual harassment of nurses by patients in hopes of contributing a greater understanding of both sexual harassment and intergroup communication literature. Specifically, we analyzed nurses' reactions and explanations of patients' sexually harassing behaviors. The conclusion of this study presents practical application for health care workers as well as theoretical implications for scholars.

Intergroup Communication

Intergroup communication encompasses several overlapping microtheories from various disciplines—including the communication field—useful in explaining the role of prejudice, discrimination, and other intergroup related issues (Harwood, Giles, & Palomares, 2005; Nkomo & Cox, 1996). Intergroup communication explains

how one's transmission and receipt of messages is dependent on the individual's salient social identity at that time. A social identity is "that part of an individual's self-concept which derives from his [*sic*] knowledge of his membership of a social group (or groups) together with the value and emotional significance attached to that membership" (Tajfel, 1978, p. 63). Contrastingly, communication in which one's *personal* identity is most salient is categorized as interpersonal in nature.

Interpersonal/intergroup distinctions are not mutually exclusive, however. Some scholars conceptualize interactions as highly interpersonal and intergroup (both personal and social identity are salient), highly interpersonal and low intergroup (salient personal identity), low interpersonal and high intergroup (salient social identity), or both low interpersonal and low intergroup (neither personal nor social identity is salient; Harwood et al., 2005). Implicit in this conceptualization are three important assertions: (a) intergroup communication is *not* communication that occurs between groups, (b) only one person in the interaction needs to be operating from a salient group identity for intergroup communication to occur, and (c) self and other categorizations are linked (in other words, individuals may define themselves by identifying what they are *not*; Harwood et al., 2005).

This process of placing oneself within a social category or group is also a prominent feature of social identity theory (SIT; Tajfel, 1978; Turner, 1982). SIT asserts that individuals position themselves within social categories or groups (e.g., nationality, sports team, gender) in which they feel they belong. These memberships are examples of social identities. Because certain individuals may ascribe to many groups and therefore have many social identities, in a particular context a certain group identity—and rules for communicating—can become salient. This salient social identity then describes and prescribes how one should think, feel, and behave in order to be considered part of the ingroup (Harwood et al., 2005). Furthermore, when a particular social identity becomes salient, group members are more inclined to make positive evaluations of the ingroup, and therefore, of themselves. Conversely, group members are likely to cast negative evaluations of outgroup individuals (Reid, Giles, & Harwood, 2005).

The fundamental attribution error and the self-serving bias, both offshoots of attribution theory (see Heider, 1958), may be helpful in explaining why ingroup members make negative evaluations of outgroup members while maintaining positive evaluations of ingroup members. Attribution theory highlights the ways in which people attribute causes to behaviors (Kelley, 1967; Weiner, 1985). The fundamental attribution error hypothesizes that when dealing with others' behaviors, people are more likely to make attributions that are internal and stable and underestimate external causes (Gilbert & Osborne, 1989), although that effect appears to be influenced by the valence of the behavior. For example, McPherson and Young (2004) found that students are more likely to attribute internal locus of control to teachers who express negatively valenced anger in the classroom than they are to teachers who express positively valenced anger. The self-serving bias notes the tendency for people to attribute causes to their own behaviors in ways that enhance their self-esteem (Mark et al., 1984). Intergroup processes likely play a role in the fundamental attribution error

and the self-serving bias in two ways. First, ingroup and outgroup membership can be roughly equated with self and other attributions. As a result, we may see ingroup members being treated with the self-serving bias while outgroup members are more likely to face the fundamental attribution error.

Whether through attribution or other intergroup processes, stereotyping typically ensues. This is especially true when in the direct presence of an outgroup member. Mastro (2003) clearly articulates the link between self-categorization and stereotyping:

Stereotypes are considered shared beliefs. . . . It is this feature that allows self-categorization to take place. The representative characteristics of both ingroups and outgroups can be socially understood due to this shared meaning and as a result, the norms and beliefs of the category are defined. (p. 100)

As such, one's perceptions that others share in one's belief regarding the normativity of a particular stereotype actually reinforces the belief in the stereotype's legitimacy. Tajfel (1981) remarked that when this shared stereotype becomes a reality, it transcends to a *social* stereotype. In turn, individual and social stereotypes guide social actors' expectations for interactions with outgroup members, particularly with strangers (Gudykunst, 1994).

These same truths hold in the organization. In their review of diverse identities in organizations, Nkomo and Cox (1996) reviewed the contributions of SIT in addition to "neighboring" theories and studies of identity, including embedded intergroup relations theory, organizational demography, research on racioethnicity and gender, and models of diversity (e.g., the interactional model of diversity; however, see also Clair, McConnell, Bell, Hackbarth, & Mathes, 2008). Nkomo and Cox reiterated the importance of continued application of intergroup theories to the organizational context, citing that individuals "don't leave their racial, gender, or ethnic identities at the door when they enter an organization" (p. 342). We explore the consequences of this statement—and their connection to sexual harassment—in the following section.

Sexual Harassment as an Intergroup Phenomenon

The impact of these intergroup elements in the organizational context are paramount. Essentially, because individuals *in* organizations are also members *of* organizations, nearly all interactions are intergroup encounters. Surprisingly, however, the application of intergroup-related theories to organizational communication studies is limited (Paulsen, Graham, Jones, Callan, & Gallois, 2005). Past research illustrates the potential influence salient group identity might have on victims and perpetrators involved in sexual harassment episodes. For instance, the highly masculinized nature of the military has led some researchers to believe it is an environment conducive to sexual harassment (Firestone & Harris, 1999), while Shelton and Chavous (1999) observed how race of victim and harasser played a role in how women perceived sexually harassing behaviors. Other scholars make it clear that gendered identity plays a key role in the construction of and responses to sexual harassment (Clair, 1998;

Dougherty, 1999, 2001, 2006; Townsley & Geist, 2000). Taken as a whole, these studies implicate salient group identities as potentially influential factors in the occurrence and continuance of sexual harassment.

Although her work does not specifically reference intergroup communication theory, such as SIT, Robin Clair's (1998) book *Organizing silence* provides a clear and nuanced link between intergroup processes and sexual harassment. Clair reminds the reader that people's lives are composed of many subject positions. As a result, "to speak of women as a group is simplistic to say the least. Women also represent a variety of races, religions, ages, ethnicities, classes (and the list goes on)" (p. 57). Clearly intergroup communication simultaneously speaks from multiple group memberships, making it complex. The complexity of intergroup processes is probably best illustrated in Clair's (1994a, 1994b) study exploring the sexual harassment of a male nurse by a group of women nurses. The female nurses sexually harassed the male nurse by questioning his masculinity and sexuality, illustrating the complexity of intergroup communication.

There are a number of ways in which group privilege is constructed (Clair, 1998). When discussing sexual harassment, within group privileging occurs when some targets of sexual harassment are privileged over others. Because of various group memberships such as age and social class, some sexual harassment targets may be blamed for the behavior while others are viewed as victims. Between-group privileging occurs when the status of the harasser impacts the target's response to the harassment. Specifically, behavior from higher status individuals may be viewed as more acceptable than the same behavior by lower status individuals. Finally, some practices of oppression may be viewed as more serious than others. Specifically, quid pro quo harassment or harassment that rises to the level of physical assault tends to be viewed as "real" whereas harassment that involves sexual jokes or other hostile language tends to be trivialized. Clair's work suggests that intergroup categorizing is applied unevenly within a group, depending on the other subject positions to which people are accredited membership.

As such, the sexual harassment of nurses by patients provides a particularly interesting link between identity and sexual harassment. Wood and Conrad (1983) note the paradox of the professional woman in which women cannot be perceived as both female and professional. Nursing has historically been highly feminized, as is illustrated in the history of the profession. Traditionally, women have an obligation to care for others, making nursing a natural extension of a "good woman's" identity (Reverby, 1987). As a result, nursing was associated with "women's work" and carried the same status as the laundress, cook, or other domestic servants in the early 19th century (Roberts & Group, 1995). As Kalisch and Kalisch (2004) summarize in their review of nursing's history, "The strength of the link between women and nursing was perhaps one of the strongest in any occupation" (pp. 376-377).

Although nursing has historically been associated with extreme femininity, nurses themselves adhere to a second group identity: the health care professional (Schwirian, 1998). This identity as a professional is central to the way nurses do work and interact with patients. However, because of the strong link between nursing and feminine

stereotypes, the identification of nursing as a profession has been historically contested (see Schwirian, 1998, for a review). Even as nurses developed their own professional codes and educational standards, the media continued to display nurses as either ministering angels, battleaxe matrons, or sex symbols (see Bridges, 1990; Gordon & Nelson, 2005). Such media portrayals reify the feminine nature of nursing by emphasizing the appropriate intergroup relationship between men and women (see Karpf, 1988).

Because nurses value their professional group identity, they resist the highly feminized identity portrayed in the media and elsewhere. Organizations exist to debunk the continued delegitimization of nurses by the media (e.g., The Center for Nursing Advocacy, n.d.). It is clear that nursing does not typically come with a history of high status and positive public identity. It seems likely that those who continue in the nursing profession would need to enact strong social identity work in order to maintain their valued professional identity while contesting the feminized identity portrayed in the media.

Sexual harassment is one strategy used to contest nurses' professional identities. Sexual harassment is a discursive strategy in which targets are feminized and their sexuality is highlighted (Clair, 1998). Given the hyper feminization of nursing and the ongoing sexualization of nurses in media, it is not altogether surprising that the nursing profession is infused with sexual harassment—from physicians, administrators, and patients (Hanrahan, 1997). Each time a nurse is sexually harassed, it threatens a valued social and/or professional identity. Consequently, of great interest in the present study is how nurses manage their social identities when responding to sexual harassment and other sexually inappropriate behavior and—in intergroup fashion—how nurses employ group memberships to evaluate and explain perpetrator behavior.

RQ1: How do nurses employ group memberships during their explanation of patients' sexual harassment?

RQ2: How do nurses employ stereotypes in the management of sexual harassment by patients?

Methodology

The interpretive research paradigm represents an inductive approach to knowledge. Specifically, instead of focusing on behavior or cognition as the unit of analysis, interpretive research “centers on the study of meanings, that is, the way individuals make sense of their world through their communicative behaviors” (Putnam, 1983, p. 31). The interpretive paradigm requires that findings emerge from the data instead of being imposed by the authors' expectations. Interpretive scholars tend to be cautious in their application of theory because of the risk of imposing expectations on findings (Bryman, 1999). However, theory is often used in an iterative fashion, serving as a space for initial questions and discarded for more appropriate theories when the data dictates (Kvale & Brinkmann, 2009). Because the purpose of the present study is to examine how nurses make sense of sexual harassment by patients, using the interpretive paradigm is appropriate.

Participants

In this study we used an interpretive approach to interview 28 nurses from across the country (California, Colorado, Missouri, Florida). These states represent a variety of regions, allowing for saturation of findings across regions. Twenty-four women and 4 men were interviewed. In order to participate, participants had to (a) be over the age of 18, (b) have worked in the nursing profession, and (c) have either experienced inappropriate sexual conduct from patients (25 participants) or observed coworkers experience inappropriate sexual conduct (19 participants). Of the participants, only 3—all men—had not experienced inappropriate sexual conduct from patients. Only one participant—a male nurse—recounted inappropriate sexual conduct from a female patient. This man recounted two experiences with inappropriate sexual conduct—one experience was with a female patient, the second experience was with a male patient. Because of a lack of information on sexual harassment from female patients, this analysis focuses on male patients. Most of the participants had both experienced inappropriate sexual conduct from patients and recounted stories of colleagues who had experienced inappropriate sexual conduct from patients. We selected participants using a snowball sampling technique (Lindlof & Taylor, 2002). We ended the data collection phase of the study when data saturation occurred. Saturation occurs when “a critical threshold of interpretive competence has been reached—when, for example, we cease to be surprised by what we observe or we notice that our concepts and propositions are not disconfirmed as we continue to add new data” (Lindlof & Taylor, 2002, p. 129).

Participants represented a variety of health care organizations and backgrounds ranging from nursing homes, to emergency room nurses, to those currently working in doctors’ offices. Participants’ ages ranged from 22 to 88. Job experience ranged from a few months to 45 years. Twenty-one of the participants were European American, 3 participants were African American, 1 participant was Filipino, and 3 participants were Hispanic. Interviewees included a nursing student, part-time nurses, full-time nurses, and retired nurses. The interviews lasted approximately 45 minutes to an hour and a half.

Procedures

IRB approval was obtained before beginning this research. We conducted open-ended interviews in locations comfortable to both parties (e.g., homes, cafés, offices). We started with an interview guide (see Appendix A) that asked participants to describe inappropriate sexual behavior from patients. Both planned and spontaneous probes were used to generate richly textured stories about these incidents. Because discussing sexual harassment can be somewhat intimidating, we chose to broach the topic after a warm-up period during which related topics were addressed. For example, we asked participants to tell us about their jobs and about the ideal patient. After the warm-up period we asked participants to describe “inappropriate sexual behavior” by patients, with a follow-up question asking if the

nurses believed the behavior was sexual harassment. This strategy was used because nurses do not always label their experiences as sexual harassment—the frequency of sexual harassment in the health care setting has made it normative and, therefore, invisible (e.g., Hanrahan, 1997). Prior to analysis, the audiotapes were transcribed by the authors and checked for accuracy. Transcriptions totaled over 290 single-spaced pages.

Data Analysis

We identified concepts that revealed how nurses talked about their sexually harassing experiences with a male patient. First, audiotapes were transcribed by the authors. Transcriptions were then checked against the audiotapes for accuracy. Specifically, the audiotapes were played while the authors read the transcripts. When the audiotapes did not match the transcripts, the transcripts were corrected. The authors then listened to the corrected segments to ensure the changes were accurate.

Consistent with the interpretive paradigm, an emergent thematic analysis was conducted. It is essential that findings emerge inductively from the data instead of deductively being imposed by the theory (Putnam, 1983). The following process was utilized. We began the analysis with a very general sense of theory. Specifically, during the interviews and transcription processes we came to believe that stereotypes were an important part of the coping mechanism for sexual harassment. During the analysis we were sensitized to intergroup theories, but maintained a careful openness to findings that could build and/or contradict these theories. The second author used the following coding processes: After transcription, the data were read and large chunks of text suggesting categories were identified. Then, transcripts were read again. In this process the emerging categories were solidified, and expanded. Some categories were dropped and others were combined. Categories were developed using a highlighter, underlining, and margin notes. Throughout this process, memoing on a separate pad of paper helped shape the interpretive process. Specifically, it was noted that many of the emergent categories involved stereotyping. This finding confirmed the earlier impression formed during the interview and transcription processes. Upon deeper examination, it became clear that two forms of stereotypes were being utilized: identifying stereotypes used by others, and stereotyping others. During this process, a few of the original categories were integrated, resulting in a final set of emerging categories and subthemes.

Interpretive analysis was concurrent with thematic coding (Lindlof, 1995). Specifically, the authors engaged in a process of identifying a deeper level understanding of themes as they emerged. As stereotyping began to emerge as an important theme, we engaged in an ongoing discussion about how these stereotypes functioned when nurses talked about sexual harassment by patients. These discussions were both verbal and written. The second author wrote a draft of an initial interpretation. The first author provided comments and suggestions. Then, the authors collaborated on a revised interpretation. The first author then made the final changes and edits to the interpretation.

Results

This study explored how nurses enacted social identity during discourse about patients' sexually harassing behaviors. Two main themes emerged: *Nurses' Stereotypes of Themselves* and *Nurses' Stereotypes of Patients*. Both themes centered on characteristics ascribed to the individual, but were rooted in the individual's group membership. Three types of *Nurses' Stereotypes of Themselves* were identified: (a) *Just a woman*, (b) *Because of my ethnicity*, and (c) *Young little nurse*. Three types of *Nurses' Stereotypes of Patients* were also identified: (a) *The horny male*, (b) *The dirty old man*, and (c) *The biker guy*. The productive and destructive consequences of these themes are discussed. Additionally, discussion focuses on how each theme offered nurses the opportunity to create and utilize these stereotypes to reconstruct identity.

Nurses' Stereotypes of Themselves

When asked, most of the participants attributed unwanted sexual attention by patients to the patients' overreliance on nurse stereotypes. These perceived stereotypes were pulled directly from broad intergroup categories that limit identity options for group members. Primarily, nurses discussed patients' behaviors in relationship to nurses' gender, ethnicity, and youth. Each of these subthemes was mentioned multiple times by a majority of the participants.

Just a woman

Sixteen of the participants attributed patient behavior to gender stereotypes. Specifically, women in society have traditionally been viewed as having limited function. One such function is to sexually satisfy men, if not willingly, then by force (Scully & Marolla, 1993). This function is particularly salient in the nursing profession because nurses are often portrayed in the media as hypersexual. It is not altogether surprising, then, that nurses attributed their patients' behavior to the patient holding gendered stereotypes. The following exemplars illustrate this subtheme.

Nurse 1 explained how it was her gender that catalyzed the patients' behaviors and acknowledged how the situation would have differed had she been born a man: "I doubt he would have done that if I was a man. I don't think he did anything like that to the doctor, and the doctor was a man, so . . ." Nurse 10 made a similar argument:

He wanted me to masturbate him I guess. I mean that's what he wanted me to do. I mean, I don't, and again maybe I'm making an assumption, but I can't imagine he would ask a man to do that . . . We had men nurses. They didn't flash men like that.

In these two instances, simply being a woman explained why a patient would act so inappropriately. Nurses 1 and 10 communicated that the patients' behaviors might have never occurred if they had been men. Nurse 5—a male nurse—agreed with his colleagues:

. . . for guys, I think it's a lot easier than it is for women because you've got someone who's saying it just because you're a woman. And I'd probably say nine times out of ten, they're not going to say the same thing if I'm the nurse.

Each of these nurses identified the cause of patients' sexually harassing behaviors as gender-related. According to nurses, simply being a woman was enough to make the patient treat the nurse as if she was sexually available. Other nurses viewed the stereotype as a bit more complex. For example, Nurse 16, a woman nurse, dissected the issue in relation to power negotiation:

Researcher: So in the dynamics, the sexual harassment dynamo between nurses and patients, you see a different power dynamic . . . ?

Nurse 16: Yeah I do. To me, it's the man over the woman, you know, and 'gee, you're just a woman'.

According to Nurse 16, sexually harassing behaviors were intimately linked with gender. This nurse said that men perceived an inherent power differential between themselves and females—even if those females were competent health care providers. Sexual harassment of nurses by patients was viewed as an extension of those power assumptions.

Two points of interest emerge. First, researchers generally concur that sexual harassment is a product of gendered behavior that attempts to feminize the targets—whether they be male or female (Clair, 1998). The relationship between gender and power has been particularly well attended to in the literature (see Dougherty, 2006). That is, the gendered explanations for the patients' behaviors are consistent with the scholarly literature. Second, these participants viewed the use of stereotypes to justify sexual harassment as an indictment of the harasser. Several nurses expressed feelings of nervousness and shock at the inhumane behaviors of their male patients. The perceived use of such limited stereotypes by harassers seemed to create the opportunity to negatively evaluate the harasser's humanity.

Because of my ethnicity

A nurse's membership in a particular ethnic group was identified by 14 nurses as a reason why male patients sexually harassed nurses. Nurses have no control over their ethnic membership and, therefore, could not prevent or control the patient's behavior. Just as in the former subtheme, nurses spoke of their ethnicity as a causal link to a patient's sexual harassment. This subtheme was most poignantly illustrated by a Filipino nurse who was called a prostitute by a patient—a Vietnam veteran. She explained:

Nurse 29: I kind of theorize that, that maybe during the time when they were there [Vietnam], they [male patients] associate Asian women to, um, prostitutes at that time that they encounter in Saigon . . . And . . . being Asian, I think that that reminds them a bit, and so they try to . . . They try to suggest something. Or try to touch you in a way that is sexual.

In this example, not only does the nurse attribute the problematic behaviors to her ethnicity, but also offers a negative stereotype of men in military service. Note the intersectionality of group membership. This woman attributed the harassment not only to her race, but to her gender as well. In addition, it was not just that the

patients were male, but that they were Vietnam veterans. In contrast, an African American nurse provided an example of a time she was *not* sexually harassed because of her race:

- Nurse 26: The patient . . . I used to do home visits and there was a patient who was known for that, but he didn't bother me. He was an older man and he loved those pretty young white girls.
- Researcher: You were safe from only half of that! (laughter)
- Nurse 26: He'd tell me all about these women and this and that, but he never bothered me. And I was the only one that didn't mind going to see him. He didn't bother me (laughter). And this was years ago.
- Researcher: Did those young white girls think it was sexual harassment?
- Nurse 26: Yeah.

Clearly, researchers suggest that race influences experiences of sexual harassment (Shelton & Chavous, 1999). Here, not only is race important, but also age, and appearance (pretty). Note the complexity of the age classification. The problem was not just that the nurses were young (see the next subtheme), but that the patient was older. Nurse 26 simultaneously uses a combined category of gender, race, and age to explain why some women are harassed and others are not. This attribution is consistent with Clair's (1998) conclusion that people operate from multiple subject positions.

Young little nurse

A third nurse stereotype that, according to 17 of the nurses, catalyzed patient harassment, was age-related. Specifically, nurses suggested patients were more likely to target inexperienced and younger nurses. Ageism is a well-established phenomenon with communication implications (Harwood, 2007). People are often treated differently based on their age. In fact, studies suggest that younger women are somewhat more likely to be harassed than older women; it is likely, however, that this relationship is more a product of low organizational status than age (Welsh, 1999). Specifically, younger women tend to be lower in status and therefore more vulnerable to sexual harassment. Although age is somewhat correlated to sexual harassment, it does not represent a strong relationship (Welsh, 1999). Other variables such as power, prior socialization, and job gender ratio are all more significant predictors of sexual harassment (Cogin & Fish, 2007).

The nurses in the present study speculated that younger women symbolize more completely male sexual virility. In other words, these nurses believed that men are more physically attracted to younger women. There is also the implicit assumption among these nurses that sexual harassment is stimulated by physical attraction. Consequently, many of the interviewees described past sexual harassment episodes which they attributed to their youth and inexperience in the nursing field. The following women nurses illustrate this concept.

- Nurse 2: I think I kind of look back and kind of laugh at a lot of stuff like that. A lot of that stuff happens when, I think when you're younger. When

you're a new young nurse. As we get older we either know how to divert the situation [*sic*] I think.

* * * *

Nurse 10: I think they see you as a young nurse and a young person and they think that maybe they can intimidate you . . . Maybe I'm making assumptions but you know, maybe he thought 'Oh here's a young, little nurse. I can get her to do this.'

* * * *

Nurse 23: I don't know what goes on because I'm older and guys don't say anything . . . I suppose the same thing happens to the young girls now. To the younger nurses.

Nurses attributed their (age) group membership as a leading cause of sexually harassing encounters. That is, they assumed that youth and inexperience, exacerbated sexual harassment episodes. These exemplars seem to suggest that these participants perceived young, inexperienced nurses as having fewer available response scripts, and therefore, are more vulnerable to the sexual harassment by patients. Dougherty (2009) argues that a lack of response scripts to sexual harassment makes people more vulnerable to sexual harassment. It is likely that inexperienced nurses have not had enough tenure to develop effective responses.

In summary, two general conclusions can be drawn in regard to nurses' group memberships and their role in understanding a patient's aggressive sexual behaviors. First, behavior-inducing factors—particular group memberships—were outside of the nurses' control. In other words, nurses assumed their group memberships—of which they had no choice but to be a part—played a crucial role in patients' behaviors. Nurse 6, a woman, summarized this point:

And that's probably the same way with those stories too about the sexual stuff. It's like, "Okay, well this happened to them, it's happened to me, it's happened to her." You know? It's happened to everybody, so I guess I'm not alone in the world.

By focusing on the patients' uses of group stereotypes, nurses were able to *displace the blame*, thereby maintaining their *self* identity as competent professionals. This finding is consistent with the self-serving bias, in which people are likely to make attributions that serve their self-esteem and identity needs (Mark et al., 1984).

Using group identity stereotypes as a barrier served a productive role for nurses postharassment. To further protect themselves, many of the nurses (ironically) called upon negative stereotypes when evaluating the sexual harassers. We explore this slippery slope of stereotyping in the second resulting theme: *Nurses' Stereotypes of Patients*.

Nurses' Stereotypes of Patients

By identifying the patient-enacted stereotypes, the nurses were able to maintain their identities as competent professionals. In other words, they concluded that the behavior was not caused by the nurse's personality flaw, but instead by problematic

assumptions made by the patients. However, the nurses used a similar stereotyping process to evaluate the sexual harassers. This use of stereotypes resulted in a switch from blaming the harasser to blaming the harasser's (perceived) social group. Interestingly, this transition led to nurses' justification and eventual *excusing* of the behaviors. The following four subthemes illustrate how, by excusing patients' unacceptable behaviors as typical of the patient's social group, nurses regained their own positive group identity as health professionals, but contributed to stereotype perpetuation.

The horny male

13 of the nurses attributed sexual harassment by male patients to the male sex drive. Specifically, men in general were perceived as having a nearly uncontrollable sex drive that required them to pursue women, even when the women were unwilling partners. Sometimes this stereotyping was unelaborated but all inclusive. For example, Nurse 23 could not explain precisely why a male patient tried to pull her on top of him and into his hospital bed, but strongly implied that this was simply a behavior that men in general practice:

Nurse 23: You know, it's things that you talk about when you get into the nurses' lounge, you know, 'That man tried to pull me in bed with him,' but, you know, things like that happen.

Researcher: So how'd that make you feel when he pulled you like that?

Nurse 23: I didn't care for him (laugh). You know, things like that happen. Men, I guess.

Nurse 23 interprets this patient's inappropriateness as a side effect of being a man. Other nurses provided a more detailed explanation for men's sex drive. During the interview with Nurse 8, the researcher noted the unique nature of the nursing profession that seemingly allowed males to unnecessarily expose their private areas to nurses on a frequent basis. Nurse 8 offered her understanding of the men's behaviors:

Nurse 8: I don't know if that's part of the male, you know, they're very visual creatures. The theory is that they're very visual creatures and you know, I guess how they would be wanting to get into pornography and how they're very visual and they like a few things that they're in retrospect trying to, you know, display themselves. You know, if they saw someone dressed down they would be completely excited and in awe.

The nurse began with the stereotype that the natural instincts of all men led them to be sexually driven and into pornography. This initial reasoning led to a slippery slope of incorrect attributions, ending with the conclusion that men would be "completely excited and in awe" if they saw exposed genitalia. This group stereotype of men was used to justify patients' inappropriate sexual behaviors. These nurses' attributions of sexual harassment to male hypersexuality are consistent with the biological model of sexual harassment in which men sexually harass because they are more sexual than women. Although this model has not been supported by the research (Cogin & Fish,

2007), it continued to operate in the perceptions of the nurses participating in the present study. Consequently, although the biological explanation may function to allow the nurses to continue to provide health care to patients who harass, this explanation is not functional in helping them understand why such harassment occurs in the first place.

The dirty old man

One of the most frequently mentioned stereotypes was the idea of a “dirty old man.” Fourteen nurses used the dirty old man stereotype, and did so repeatedly. This *in vivo* title suggests an elderly man who “doesn’t know any better,” conducting himself in an inappropriate manner toward a nurse. These attributions are consistent with social stereotypes of aging people, in which age is associated with mental and physical decline (Dahmen & Cozma, 2009). In fact, 80% of older people are able to lead normal lives. The dirty old man stereotype is prevalent in the media, being one of the common ageist terminology used with regard to older people (Dahmen & Cozma, 2009). Nurses justified these behaviors simply because, “That’s part of getting old.” In other words, the patient’s age group membership played a major role in both explaining and excusing the patient’s behavior. For instance, Nurse 7, a woman, stated:

There’s the elderly gentleman that’s confused and you can’t really blame them [*sic*] for, you know—I mean you can’t reproach them for that because they probably won’t remember, you know, and they’ll do it again And you can’t really hold them accountable or responsible I don’t think because technically it’s not their fault. You know, they can’t help it.

Due to the elderly patient’s “confusion” he could not be held accountable for his actions. Here there seems to be a strong association between elderly men and dementia, an assumption related to the stereotype of age and mental decline (Dahmen & Cozma, 2009). The nurse declined to admonish the patient because she believed the behaviors would only persist. In this way, not only were all male patients in this “elderly group” constructed to be likely harassers, but they were also viewed as repeat offenders. While the elderly were often dubbed as confused and ignorant—reason enough to excuse the behaviors—younger male patients were not given the same treatment:

Nurse 6: Like if it were a younger person I might feel a little bit more uncomfortable, but when it’s you know, old guys, you know . . .

This quote from a woman nurse implies that identical sexually harassing behaviors toward this nurse from a young man and an old man were met with differing levels of comfort: an uncomfortable response with the younger man, but a less uncomfortable situation with the older man. Restated, such inappropriate behaviors were atypical of one group, but prototypical of the second. Furthermore, Nurse 10, a woman, unknowingly illustrated the pervasiveness of the stereotype:

On a very consistent basis you have these, I mean, what we would consider little dirty old men, you know, and they would, a lot of their comments would have,

you know, sexual type undertones, but for some reason they like to be exhibitionists. And then it's like, you know you walk in the room and they have their gown up and all exposed.

These types of exhibitionistic behaviors from "little dirty old men" were often discussed among nurses, indicated by Nurse 10's use of the phrase, "what *we* would call." This phrase implies that the stereotype does not stop with the individual nurse; it is shared with other nurses as well. Therefore, like the other subthemes in this category, a nurse's individual stereotype becomes a social stereotype. This rings truer when the stereotype extends outside of the hospital walls, reinforcing the undeniable "truth" of the perception. Nurse 20, a small town resident, was bathing a male patient when he began to speak inappropriately toward her. In retrospect, she stated the following story regarding her patient and son:

He's [the patient] just got a dirty mind. My boy was working for the public service the same time he [the patient] was. And I said to my Bob, I said, 'That is a dirty old man.' And he said, 'well, now, everybody that worked down there and all the girls know this' and all. They get a big kick out of his stories.

This quote demonstrates the cyclical nature of stereotypes. When individuals share negative perceptions, they reinforce the original stereotype. In this case, Nurse 20 held the dirty old man stereotype, and this stereotype was later confirmed by her son and his fellow employees. In another interview, Nurse 18 was confident that the researcher would also understand the dirty old man stereotype. When the researcher asked nurse 18 to describe her least favorite type of patient, her answer was void of personality traits or detailed descriptions. She simply responded with the patient's group membership: dirty old men.

The very phrase dirty old men suggests three levels of outgroup membership. The term dirty suggests a number of vague possibilities, including social class or morally tainted people (Kidder, 2006). Either way, the term dirty appeared to be associated with declining mental health, suggesting a complexity to the stereotype. Old is a specific reference to these men's ages. What specifically constituted old remained vague for these participants. The ages seemed to vary from middle-aged men to frail elderly retired men. The third group referenced was men. This category seemed to link strongly to the horny male theme. It seems that for this group of participants, age enhances the stereotype that men in general are sexually out of control. In other words, morally tainted men who are older are more likely to enact the horny male stereotype. Again, note the multiple subjectivities of the outgroup stereotypes utilized by these nurses (Clair, 1998).

Interestingly, there is no evidence in the scholarly literature that older men are more likely to sexually harass than younger men. However, research has found that negative stereotypes of the elderly inspire people to use more directive and patronizing language toward the elderly (Hummert et al., 1998). Furthermore, this effect is compounded in hospitals where patronizing language toward the elderly is used regardless of the positive or negative stereotypes at play (Hummert et al., 1998). Given the scholarly research, it seems unlikely that older patients are more likely

to harass than younger patients. Instead, it is possible that the attribution of age may be more a product of a larger social stereotype. As a result, this stereotype may help nurses continue their care for their patients, but it is not functional in helping them identify the causes of sexual harassment from patients.

The biker guy

Sixteen nurses used culture and background to stereotype about male patients who sexually harassed. *The biker guy* represents a myriad of attributions regarding a patient's membership to a particular culture, ethnicity, or socioeconomic status, among other classifications. Nurses excused numerous sexual harassment attempts based on such attributions, and once again, one stereotype led to another:

I think he was . . . he was like, a biker guy? I remember him having lots of tattoos. That was a while ago. But I think he might have been a biker guy. He was rough and tough. And I know they don't have much respect for their women at all.

First, Nurse 9 equates tattoos with motorcycle riding in order to communicate one final conclusion: tattooed men who ride motorcycles commonly disrespect women. Not only did this nurse "know" that biker guys disrespected women, but she also assumed, by her use of the phrase "their women," that these men feel a particular sense of ownership and control over women.

A patient's race also gave nurses grounds to excuse inexcusable behaviors. When an African American man grabbed Nurse 22 inappropriately around the neck, she immediately presupposed that the behavior stemmed from his struggle for acceptance as a member of a minority race: "He was trying to get me to accept him as being black and a lot of times they will . . . a lot of times they want to have someone extra . . . like a white girl to like them."

This nurse was enacting a much larger societal problem: racial stereotypes. She seemed to assume that Black men need the affection of a White woman to be "accepted" in society and that therefore, they were more likely to resort to sexual harassment of White women.

For Nurse 8, considering a patient's economic status helped her to "understand" her patient's needs and behaviors.

Well, I'm sure you're aware, being with the university we do Medicare and Medicaid. Most of those are low income families. So they don't have a whole lot of coping skills to begin with But it seems like a lot of them are fairly crass in how they approach situations and the things that come out of their mouth—and not necessarily just sexually, just in general—and their behavior toward you can be very violent They just, you know, they don't care. They have an audience. That almost encourages them.

Without considering other external factors, Nurse 8 assumed that a low income patient a) had a limited ability to cope with the stress and discomfort associated with a hospital experience, which led to b) norm-violating coping behaviors, such as sexual harassment or even violence, however, c) that was only to be expected, since other

members of the group (e.g., low income friends and family members) acted similarly and condoned such behaviors.

The above instances all demonstrated the same process of inductive reasoning. Nurses frequently took one specific patient's actions and made sense of the occurrence by generalizing the behaviors as prescriptive of the patient's group membership. Moreover, the stereotypes of these groups extended not just to other patients, but also to those group members outside the hospital walls.

Taken together, nurses' stereotypes of patients' groups—whether sex, age, or culture—shared one major commonality: they all justified and excused a patient's inappropriate sexual behaviors. Once again, this process produced constructive and destructive outcomes. On one hand, stereotyping a patient's group to justify his behaviors led to a nurse's initial ability to explain the reason for the behaviors as one less associated with themselves, and more associated with a problematic out-group. On the other hand, negative stereotypes reinforced destructive discriminatory social processes. In this study, the use of social stereotypes oversimplified the patients' sexual harassment and consequently prevented the nurses from engaging in more effective management strategies.

With this thematic analysis, we aimed to display how individuals' communication of perceptions was altered based on the application of stereotypes to both self and other. A unique relationship was discovered between the constructive and destructive aspects of social stereotyping. As such, the following discussion spotlights these relationships and offers additional practical and theoretical contributions.

Discussion

The first research question posed in this study asked how nurses employ group memberships during their explanation of patients' sexual harassment. Overarchingly, the interview data indicated that social identity strongly influenced nurses' discourse. Nurses consistently ascribed patient behaviors to various group memberships and explained the impact of their own group memberships on their patient. Unlike the nurses in Valente and Bullough's, (2004) study, the nurses in this study failed to completely internalize the blame for their patients' sexually harassing behaviors. More specifically, nurses concluded that patients behaved according to their group's "behavioral rule book," or, "in terms of the belief system held by the larger identity group" (Hecht, Jackson, & Pitts, 2005, p. 24).

A second important finding involved the dialectical relationship between nurses' personal and social identities. This finding addresses the second research question, which asked how nurses employ stereotypes in the management of sexual harassment by patients. These nurses' constructive use of group stereotypes enabled a nurse to blame a patient's behavior on her group membership/s, enhancing her own individual identity (Hewstone & Jaspars, 1984). In this way, stereotypes helped nurses make sense of their situations, resulting in less taxation on both their emotions and psyche. It is also likely that using stereotypes allowed nurses to continue to provide care for their patients after they were harassed. Unfortunately, destructive outcomes were

enacted simultaneously: many of the patient group stereotypes reinforced negative images of marginalized groups. Additionally, offering patient group stereotypes provided nurses with a reason to actually trivialize, justify, and excuse sexually harassing behavior. These findings support Clair's (1998) findings that women targets minimize, reify, and trivialize sexual harassment. Interestingly, unlike the participants in Clair's studies (e.g., Clair, 1993), the participants in the present study did not privatize sexual harassment. This difference may be a result of the diffusion of sexual harassment in the health care setting. Nurses are so often targets (Valente & Bullough, 2004) that sexual harassment may no longer be constructed as private by this particular group of people. Rarely was an individual patient blamed directly for the episode, and therefore, was not held responsible for his actions. On a grander scale, nurses' acceptance of these behaviors also resulted in acceptance—even resignation—to patriarchal ideologies (Clair, 1994b). By conceding to a male patient's sexual harassment, nurses accepted his group's dominating behaviors. They gave in to the belief that in some way, their ingroup membership stood less important or powerful. Unwittingly, they ascribed power not only to the individual harasser, but also to any member of the harasser's perceived group. Future research needs to explore the sense making function of stereotypes as well as the unintended outcomes of those sense making processes.

This study also has implications for the interplay between the fundamental attribution theory and the self-serving bias. Specifically, these nurses did use a form of self-serving bias that allowed them to retain their self-esteem and personal identities as competent professionals. Historically, the self-serving bias has been used to theorize about and study goal achievement. This study suggests possibilities for the study of other attributions of cause. The fundamental attribution error suggests that people are likely to over attribute internal causes to others' behaviors. Stereotypes provide an interesting counterpoint in that they are both external and internal. Groups are external to a person until the person is placed in the group. At that point the person takes on the stereotypes commonly associated with the group. The stereotypes are considered to be both dispositional (part of the person's personality) and situational (part of the larger social forces at play). Future research on the fundamental attribution error needs to explore this theory at the intergroup level to better assess how attributions of cause are made for both ingroups and outgroups.

From these implications, helpful guidelines for health care professionals and other organizational members who encounter harassment emerged. These findings suggest (and other research concurs) the importance of individualizing group members (see Gudykunst, 1994). By recognizing and emphasizing differences between ingroup members, the common inclination to categorize broadly should diminish. This is especially important for those who have been the targets of sexual harassment. On the other hand, it is important that nurses and other sexual harassment victims continue to recognize that sexual harassment is not about the individual. In other words, one does not necessarily target a person because that person is weak—although that may happen. Harassers may target a person because he/she is a member of a social group that is stereotypically weak.

Finally, we note some important implications for the intergroup communication approach's future in empirical research. Given the premise that only one interactant needs to have salient group identity in order for intergroup communication to occur (Harwood et al., 2005), the four interpersonal/intergroup categorizations outlined in the literature review seem limited in their ability to explain the findings cited here. Indeed, this study demonstrates how the salient group identity from which an interactant operates greatly influences the interaction, but perhaps more important is the discovery that the group identity one *applies to the other* has an equally significant impact. In this study, for example, patients' perceptions of a nurse as a female, rather than a medical professional, resulted in several uncomfortable situations for nurses. Thus, it may be important for scholars not only to examine distinctions between interpersonal and intergroup communication (i.e., personal identity vs. social identity), but to take exploration one step further: Examining what *specific* social identity is salient for each interactant and *how* this identity influences one's actions and reactions in the encounter is merited.

Furthermore, we note an interesting opportunity to adjoin intergroup phenomena with a dialectical approach. An intergroup dialectic between self (nurse) and others (patient's group) is evident. The current study depicted how reliance on social identity protected nurses' inner-selves while simultaneously marginalizing others. Although some scholars have given attention to an intergroup dialectic as it pertains to close, personal relationships (see Altman, 1993), research has yet to tackle specifically the intergroup dialectic in less intimate relationships.

Conclusion

This study demonstrated the unique and beneficial application of an intergroup communication approach to sexual harassment in health care organizations. Specific to this industry, it would be interesting to assess the role of the administration and the hospital physicians in the perpetuation of these social stereotypes. Naturally, more empirical research on sexual harassment using intergroup theory in other organizational contexts is merited also. The potential for a model of sexual harassment based on intergroup theory exists. This study examined the "second half" of this model. Attention is needed, therefore, to earlier stages, when soon-to-be perpetrators' ingroup identity is salient and threatened. Although interviews were the method of choice for this study, triangulation of methods is strongly encouraged in future studies.

In summary, after noting the few studies on sexual harassment in health care organizations, and the absence of an intergroup approach to help explain this phenomenon, this investigation has hopefully fulfilled these research voids. Applying an intergroup perspective to victimized nurses' sexual harassment narratives has captured microlevel outcomes as well as larger scale implications. We hope to see similar lines of investigation build upon these findings and continue to work toward alleviating the prevalence and detrimental consequences of sexual harassment.

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Appendix A: Interview Guide

1. Tell me about your job (at the time of the incident).
2. Describe your work with patients.
 - What do you like best about your work with patients?
 - What do you like least about your work with patients?
3. Describe your favorite type of patient.
4. Describe your least favorite type of patient.
5. Tell me about a time when a patient behaved in a sexually inappropriate way toward you.
 - How did you feel?
 - How did you respond?
 - Who did you tell?
 - What did they do?
 - What happened after the event?
 - How was the patient treated by your colleagues and management?
 - Do you consider this event to be sexual harassment?

What do you think motivates people to behave this way?
If you had it to do again, how would you respond?

6. Describe any training you have had on how to deal with patients who behave sexually inappropriately.
7. Tell me about advice you have received regarding patients who behave sexually inappropriately.
8. Is there anything else you think I should know?