“‘Paradoxing the dialectic’ refers to the process of moving from the fluid set of choices afforded by dialectics to the set of fixed and mutually contradictory choices offered by paradoxes.”

“PARADOXING THE DIALECTIC”

The Impact of Patients’ Sexual Harassment in the Discursive Construction of Nurses’ Caregiving Roles

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Using the concepts of paradox and dialectics, this qualitative study examines the tension that contradictions bring to nurses' narrative construction of their roles as caregivers. The nurses in the study reveal that they negotiate their roles as caregivers within the dialectical poles of closeness and distance in relation to their patients. The sexual harassment of nurses by their patients, however, serves to destroy this ability to move between these poles and instead calls for a single response—distance. This "paradoxing of the dialectic" changes the ability to negotiate between closeness and distance and presents nurses with a paradoxical set of decisions on how to cope with such harassment and maintain their role as caregivers. Implications for theory are discussed.

Keywords: *sexual harassment; dialectical tensions; paradox; contradictions*

Recent studies in organizational communication highlight the richly varied landscape of possibilities available to scholars who examine contradictions and irrationalities in organizations (e.g., Martin, 2004; Tracy 2004). Taken as a whole, this body of research suggests an unexplored relationship between the specific contradictions known as *paradoxes* and *dialectical tensions*, terms that are often subsumed together as similar types of tensions in organizations (see Ashcraft & Trethewey, 2004). However, a more nuanced examination of how paradoxes and dialectical tensions relate to one another and interact together would enrich the usefulness and applicability of both constructs to the study of organizational tensions.

What is more, understanding the relationship of paradoxes and dialectical tensions creates a more richly textured understanding of their impact in a variety of organizations. Health care organizations serve as one such arena. In particular, understanding the nature and interplay of paradoxes and dialectical tensions might highlight types of tensions that affect patient care, employee satisfaction, stability, and efficiency. Given the central importance and value to society of health care organizations, such an impact bears examination.

Within the health care system, nurses present one of the key linchpins in providing the everyday care afforded to patients. Because of nurses' frontline duty with regard to patient care, these caregivers must often wrestle in a day-to-day manner with tensions and contradictions that may directly affect patient care (e.g., McVicar, 2003). More specifically, nurses are often presented with a particular type of tension generated when they are faced with sexual harassment—a significant problem in the workplace (e.g.,

Madison & Minichiello, 2000; Robbins, Bender, & Finnis, 1997). Much of this sexual harassment stems from coworkers and physicians (e.g., Beganny, 1995); however, a large portion of this harassment originates from patients themselves (Libbus & Bowman, 1994). Although patient and nurse caregiving relationships can be subverted by the sexual harassment of nurses by their patients (e.g., Crull, 1982) and although such implications may thus affect both the quality of health care and the quality of nurses' working conditions (e.g., Hamlin & Hoffman, 2002; Valente & Bullough, 2004), how nurses interpret and respond to this form of sexual harassment and how such harassment creates dialectical tensions and paradoxes that affect the caregiving role nurses play in health care organizations remains an area in need of further exploration.

Of particular interest to organizational communication scholars is how nurses discursively respond to sexual harassment by patients. However, responses to sexual harassment have only rarely been studied specifically from the frame of paradoxes (for exceptions, see Clair, McGoun, & Spirek, 1993; Dougherty, 2001b) and have not yet been examined within the broad concept of dialectical tensions. Nevertheless, because both of these forms of contradictions are important in the study of organizational tensions (see Ashcraft & Trethewey, 2004), their dual use in examining specific responses to tension-generating incidences such as sexual harassment holds much promise in enhancing our understanding of the complexity inherent in organizational tensions and contradictions.

On a broader level, understanding sexual harassment and the contradictions associated with this behavior are of particular interest to organizational members, managers, and organizational communication scholars alike. Sexual harassment is a well documented form of organizational discourse (Bingham, 1994; Dougherty, 2001a; Kitzinger & Thomas, 1995; Wood, 1994) with implications for the overall health and well-being of both organizational members and the organization as a whole. Understanding the processes of sexual harassment as discourse is of central concern to managers, especially in health care organizations where those processes could affect the quality of patient care.

In sum, nurses' discursive strategies in coping with patients who sexually harass provide an opportunity to further our understanding not only of the process of sexual harassment as discourse in

organizations but also of how responses to such incidents may affect the performance of the nursing role in health care settings. Finally, such an examination presents organizational communication scholars with a potentially rich field to explore the nuanced nature and relationship of specific contradictions such as paradoxes and dialectical tensions.

PARADOX, DIALECTICS, AND TENSIONS IN ORGANIZATIONS

The nature of tensions and contradictions in organizations has often been examined in light of paradoxes and dialectics. Therefore, a closer look at these two constructs is necessary to understand how they have been conceptualized by organizational communication scholars as well as to understand their differences and peculiar nuances.

PARADOX

The construct of paradox is one that has been used in a multitude of disciplines. Originally understood in the realm of logic as characterized by the presence of contradictory propositions, both of which are logically derived (see van Heigenoort, 1972), paradoxes have also long been part of literary rhetoric in the forms of figures of speech, for example, in which an apparent contradiction contains a truth. Emily Dickinson's line "Much madness is divinest sense" might serve as an example (Dickinson, 1924). However, paradoxes taken out of such rhetorical, grammatical, or literary contexts are referred to as *pragmatic* paradoxes (see Quinn & Cameron, 1988); these are the paradoxes of everyday life. As such, they are relationship oriented and socially created.

The notion of organizationally created paradoxes has received increasing attention from organizational communication scholars (see Poole & Van de Ven, 1989; Stohl & Cheney, 2001; Trethewey, 1999). Many paradoxes in organizations come from role conflicts when, for example, an individual may receive incongruent mes-

sages about job expectations (Putnam, 1986). Dougherty (2001b) examined the sexual harassment paradox of women in health care organizations who feared that their stories would not be believed but who also did not believe the stories of other women who reported sexual harassment. Such incongruent messages differ only slightly from Stohl and Cheney's (2001) characterization of a paradox as a situation in which the pursuit of one goal undermines the pursuit of a second goal (i.e., "be spontaneous, creative, vocal, and assertive in the way we have planned!" p. 354). Such types of paradoxes in their many forms serve to create tension (see Barnard, 1968; Pratt & Doucet, 2000). Wood and Conrad (1983), in their delineation of the paradox of the professional woman, outline four classes of responses to such tensions, including acceptance, counterdisqualifications, withdrawal, and reframing. Closely paralleling this classification of responses to paradoxes, Tracy's (2004) work with correctional officers highlights how these officers responded to the many contradictions in their work (i.e., be nurturing but be disciplinary): splitting or vacillation, simultaneously attending to conflicting norms, and withdrawal. This body of work heeds the call of some organizational communication scholars (e.g., Ashcraft & Trethewey, 2004) who invite the examination of paradoxes and other types of contradictions (i.e., dialectics, double binds), not so much in light of how these might be managed or resolved but in the ways that they are communicatively manifested in organizations and how organizations and their members respond to contradictions. This research highlights the increasing centrality that paradoxes hold in the study of organizational irrationality.

DIALECTICS

The tensions in organizations created by paradoxical goals and mandates are not the only type of contradictions inherent in organizations. Tracy (2004) suggested that organizations are by their very nature situated in a number of tensions that include not only paradoxes but also complementary dialectics (see also Stohl & Cheney, 2001; Ashcraft & Trethewey, 2004). The concept of dialectics carries many similarities to paradoxes and other such tensions but also stands apart in conceptually significant ways.

Dialectics entered the realm of communication study primarily through the interpersonal scholarship of Baxter (1988, 1990) who posited that dialectical forces both constrain and enable relationships. Baxter argued that oppositional forces are the basis of all social phenomena, that change is constant, and that the contradictory forces of these dialectical tensions are interdependent and mutually negating (see also Baxter & Montgomery, 1996). Like paradoxes, which also involve two poles that are mutually negating (i.e., two contradictory propositions such as "cooperate, but show independence"), Baxter (1993) points out that both ends of the dialectic continuum are "simultaneously present and functioning" and that the "forces complete a whole that is incomplete without the other" (p. 201). In other words, paradoxes involve conflicting forces that are either/or decisions. Dialectics allow for the simultaneous presence of such conflicting forces.

Another primary difference between paradoxes and dialectics is the ability to adapt and transform contradictions depending on relational goals and/or constraints. Baxter (1988) identified three primary dialectical tensions: autonomy or connection, openness or closedness, and predictability or novelty. For example, two people involved romantically might find the need for both predictability and novelty in their relationship. They may plan, therefore, to do something completely spontaneous every Friday evening. Such a coping strategy illustrates the ability that dialectics afford for moving between two seemingly mutually negating poles. In this sense, dialects allows for choices and movement between the poles. Although a paradox calls for either/or choices (i.e., either spontaneity or predictability), dialectics allow choice and negotiation between seemingly negating poles. Baxter (1998) calls this the both/and nature of dialectics that distinguishes them from dualisms such as paradoxes. Dialectics has proved to be a fruitful metatheoretical grounding for interpersonal scholarship in numerous areas, including relational maintenance and dissolutions (e.g., Johnson, Wittenberg, Villagran, Mazur, & Villagran, 2003; Rawlins, 1989), power and conflict (e.g., Erbert, 2000), and long-distance relationships (e.g., Sahlstein, 2004), to name a few.

Ironically, the call to study organizations from a dialectical perspective predated Baxter's work (see Benson, 1977), but until recently, relatively few organizational communication studies have

incorporated the concept directly. Recent organizational communication scholarship suggests, however, that dialectical tensions are an important part of the organizing process. For example, Howard and Geist's (1995) study examined the dialects of change and stability in organizational mergers. Tracy (2004) framed the tensions faced by correctional officers as exhibiting characteristics of dialectics (i.e., consistency versus flexibility) and double binds and illustrated how each influences employee responses to those tensions. The communication dynamics in other types of organizations such as community theatre groups (Kramer, 2004), schools (Kellet, 1999), and battered women shelters (Vaughn & Stamp, 2003) have also been examined using the dialectical perspective. The potential of dialectical tensions for organizational scholarship has led some organizational communication scholars to call for a more systematic use of this perspective. For example, Fairhurst's (2001) review of leadership research suggests that the use of dialectics as a metatheoretical frame would provide productive ground for organizational scholars in addressing organizational relationships such as Leader Member Exchange (e.g., Zorn, 1995). Kramer's (2004) ethnography of community theaters called for an extension of his proposed communication theory of group dialectics to other organizations and groups. Clearly, organizational communication scholars increasingly recognize the great potential for the use of dialectical tensions as a theoretical construct.

The potential for dialectical tensions in the study of health care organizations is particularly pronounced. Not surprisingly, given the theory's most extensive development in the interpersonal realm, studies in this area have focused primarily on roles and relationships involving doctors, patients, and nurses. For example, Geist and Dreyer (1993) framed their examination of the tensions enacted in patient and doctor dialogue within the realm of Baxter's (1988) early work on dialectical tensions; specifically, their analysis illustrated the tensions between expectations for both relational closeness and professional distance in patient and doctor interactions. More recently, Apker, Propp, and Zabava Ford (2005) integrated dialectics and role theory to examine the tensions that emerge in health care teams. They illustrated, for example, that the need to build team attachments and the biomedical model that demands social detachment serves as one of the many dialectical

tensions presented to nurses as they negotiate their professional identities in the changing landscape of healthcare organizations. These studies make it clear that using dialectical tensions as a theoretical lens has great potential for unraveling the intricacies involved in health care–related organizational communication.

THE NATURE OF NURSES' CAREGIVING ROLES IN HEALTH ORGANIZATIONS

The advent of managed care and the dynamic nature of the expectations afforded to registered nurses, nurse practitioners, and licensed practical nurses in the health care system frames the discussion of nurses' roles in both communication literature (e.g., Apker, 2001; Miller, Joseph, & Apker, 2000) and nursing literature (e.g., Fullbrook, 2004b; Pearson, 2003). Apker (2001) examined how managed care has shaped and changed nurses' professional roles, expanding these roles outside of direct patient care to include tasks such as answering phones and ordering medical supplies. Other studies have focused on the strategic ambiguity used in defining the roles of nurses who serve as care coordinators and how such ambiguity leads to feelings of stress and frustration on the part of these nurses (Miller et al., 2000). Both of these studies center their discussion of roles in Katz and Kahn's (1978) definition of roles as "specific forms of behavior associated with given positions" (p. 1201). As such, roles are defined in the sense of defining nursing tasks and responsibilities. Nurses might take the role of wound specialist or trainer, for example. As one nurse in Apker's (2001) study reports, "My job is 25% patient care, 50% collaboration with others, and 25% documentation of care" (p. 127). In this sense, roles are conceptualized in the day-to-day microduties and expectations nurses might be expected to perform. These duties, for example, may look different for surgical nurses than for those who work in a long-term care center (see Pearson, 2003).

However, outside of the purview of these types of specific job expectations and role boundaries lies a more pervasive and global dialogue of nurses' roles as caregivers to patients. This expectation is often referred to in terms such as *timeless values* (Manthey,

2000) or *the big picture* (Loewenstein, 2003). No matter how a nurse's specific day-to-day duties may differ depending on the type of nursing he or she performs (i.e., public health nurse versus surgical nurse), this global expectation of a nurses' role as caregiver remains. This global role as caregiver is of particular interest because it speaks to the professional identity of nurses or who they aspire to be at work. Consequently, it is this more overarching application of the term *role* that we have chosen to employ in this study. The literature suggests the importance of the following research question:

Research Question 1: How do nurses discursively construct their role as caregivers?

SEXUAL HARASSMENT AND THE NURSING PROFESSION

Sexual harassment has been extensively studied by organizational communication scholars (Jansma, 2001). Because in its strictest sense sexual harassment is a discursive practice found exclusively in organizational settings, it is acutely interesting to those who wish to understand the particularities of organizational life.

Organizational power is one central theme in the scholarship surrounding this topic (Bargh & Raymond, 1995; Cleveland & Kerst, 1993; Conrad & Taylor, 1994; Dougherty, 1999; Jansma, 2001; Payne, 1993; Townsley & Geist, 2000; Wayne, 2000). Although some of the early work in this area conceptualized power as simple authority, more recent scholarship has viewed sexual harassment–related power as highly complex and enacted in myriad ways (Cleveland & Kerst, 1993). Understanding the interplay between the sexual harassment of nurses by patients and organizational contradictions and irrationalities provides an opportunity to strengthen this understanding.

Not surprisingly, given the centrality of nurses in the day-to-day functions of health care organizations, the influence of sexual harassment on the nursing profession has engendered interest (e.g., Fiedler & Hamby, 2000; Goodner & Kolenich, 1993; Julius & NiGiovanni, 1990; King, 1995). This body of literature includes work by organizational communication scholars such as Dougherty

(2001a, 2001b) who studied sexual harassment in a health care organization. In the nursing profession itself, the majority of the literature concentrates on the nature and consequences of the sexual harassment of nurses by physicians and coworkers (e.g., Beganny, 1995; Donald & Merker, 1993). However, research is clear that nurses are sexually harassed by their patients as well (e.g., Hanrahan, 1997; Valente & Bullough, 2004). In fact, Grieco (1987) suggested that patients are the most frequent sexual harassers (among physicians, coworkers, and patients), with 87% of the nurses reporting this form of harassment. Although the low participation rate of Grieco's study bears some room for caution in generalizing the results, other work suggests a similarly high number as well (e.g., Bronner, Peretz, & Ehrenfeld, 2003; Finnis & Robbins, 1994). A study by Finnis, Robbins, and Bender (1993) found that 60% of nurses (all female) reported being sexually harassed by male patients—most often while bathing them. These studies and others indicate that sexual harassment by patients is a common occurrence in the experience of nurses.

Sexual harassment in whatever form has a negative effect on the workplace environment, with the long-term and short-term effects of sexual harassment on the individual and organizations well documented (see Magley, Hulin, Fitzgerald, & Denardo, 1999). Not only has sexual harassment been found to affect nurses' job performance and satisfaction (e.g., Crull, 1982), but research also indicates its detrimental outcomes on nurses' physical (nausea, headaches, and tiredness) and mental health (irritability, nervousness, anger, and alienation) (e.g., Gutek & Koss, 1993; Loy & Stewart, 1984). As such, sexual harassment has been found to affect nurse retention (Loy & Stewart, 1984) and productivity (Decker, 1997; Finnis et al., 1993). It remains clear that sexual harassment carries negative impacts for individuals and organizations alike. Based on these potential negative impacts, we initially posed the following question:

> Research Question 2: How do patients' sexual harassment of nurses affect the performance of those nurses' caregiving roles?

As the data were collected, it became clear that organizational tensions were an important part of the participants' experiences, sug-

gesting that health care organizations present an opportunity to examine organizational contradictions from the specific frames of dialectics and paradoxes, particularly the tensions precipitated by patients' sexual harassment of nurses. Thus, given the centrality of dialectics and paradoxes to the examination of contradictions and tensions in organizations, and given the negative impact on nurses precipitated by sexual harassment from their patients, the following research question was used to guide the analysis:

> Research Question 3: What dynamics of dialects and paradoxes present themselves in nurses' responses to sexual harassment by their patients?

METHOD

PARTICIPANTS

Participants were selected using a snowball sampling technique (Lindlof, 1995), in which initial participants provided names of additional contacts. To qualify, participants needed to be above the age of 18 and have worked in the nursing profession. Participants were told in advance that the interview would explore issues of the sexual harassment of nurses by patients.

Initially, interviews were conducted with 17 female nurses and 4 male nurses. These nurses served as the foundation for the following analysis. Seven additional female nurses were then interviewed. These interviews affirmed the original interpretation. The interviews were conducted in locations across the United States (California, Colorado, Florida, and Missouri).

Participants were from a variety of organizations and backgrounds, ranging from nursing homes, to emergency rooms, to doctor's offices. Participants' ages ranged from 22 to 88 with job experience ranging from a few months to 45 yr. 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 from approximately 45 min to an hour and a half.

Open-ended, interpretive interviews were conducted. An interview guide was used (see the appendix) in which the participants were first asked to describe their work with patients. Both planned and spontaneous probes were used to address issues raised by the participants and to create greater insight into their experiences. The design of the interview was used to approach the topic of sexual harassment slowly with the view that participants are more comfortable discussing sexual harassment after a warm-up period in which related topics are addressed. The initial questions focused on inappropriate sexual behavior with a follow-up question that asked these nurses if the behavior constituted sexual harassment. This strategy was used because nurses do not always label their experiences as sexual harassment because the frequency of sexual harassment in the health care setting has made it normative and therefore invisible (e.g., Hanrahan, 1997).

DATA ANALYSIS

Prior to analysis, the audiotapes were transcribed and checked for accuracy. Transcriptions totaled more than 290 single-spaced pages. A thematic analysis of nurses' discursive description of their roles and their strategies for dealing with patients who sexually harass them or exhibit sexually inappropriate behavior was conducted. Themes were developed and analyzed using the selective or highlighting approach (Van Manen, 1990) with the reduction, explanation, and theory steps suggested by Lindlof (1995). These steps represent cyclical processes with large areas of overlap. First, the data were sorted according to potential emerging themes with tentative labels given to each theme. Comments and other notes were made in the corresponding margin. Then the transcripts were examined again; each time a theme was noted in the margin of a transcript, its location (page number and manuscript number) was noted in a separate data file until all themes in all transcripts had been noted. As these themes were collected, corresponding memos and exemplars were also included under each theme heading in the database file. Within this database, the strongest themes were

identified based on their persistence across participants. Once these themes emerged, the transcripts were examined once more to identify any contradictions and/or inconsistencies in the original analyses.

The themes were discussed and modified frequently to ensure that we achieved interpretive integrity. As the themes emerged, it became clear to us that there was an unexpected interplay between dialectics and paradox in the participants' accounts of sexual harassment by patients.

VERIFICATION

Verification represents a standard of quality in qualitative research (Creswell, 1997), providing a means for researchers and readers to assess if an interpretation of the data is accurate for the phenomenon under investigation. Creswell recommends at least two forms of verification. Three forms were used for the present analysis. First, researcher convergence, or the convergence of multiple researchers on the same interpretation, was achieved through ongoing memos and conversation between the first and second author. Unlike intercoder reliability, in which the coding is done separately, researcher convergence is a highly collaborative process in which each researcher challenges emerging interpretations until they converge on a common interpretation. Second, following the initial analysis, eight additional interviews were conducted, providing confirmatory evidence of the original themes. Finally, the study uses a form of face validity in which the readers are invited to assess the efficacy of the themes based on the evidence presented (Creswell, 1997). The thick rich quotes provide the necessary evidence.

THEMATIC ANALYSIS

Four major themes emerged in the analysis of the data. The first is the nurses' discursive construction of their caregiver roles as composed of both relational and technical (or task) components.

Second, this role construction is dialectical in nature. To offer the best care to their patients in either of these relational and/or technical capacities, nurses report negotiating the dialectical poles of closeness and distance from their patients—a fluid and dynamic process.

Third, when nurses are faced with patients who sexually harass them, they respond (or wish they had responded) by distancing themselves both relationally and physically from their patients.

Finally, the sexual harassment of nurses by their patients illustrates a paradoxing of the caregiving dialectic. In response to this harassment, nurses attempt to distance themselves from their patients. As such, patients' sexual harassment essentially forces nurses to respond with a single pole of the dialectic—distance. In doing so, sexual harassment and nurses' responses to it destroy the ability to move along the closeness and distance continuum necessary in the caregiving role and create a set of uncomfortable paradoxes for nurses as both caregivers and as victims of sexual harassment. We have termed this process of moving from the set of fluid choices provided by a dialectical tension to the set of fixed choices offered in such paradoxes as the "paradoxing of the dialectic."

THE RELATIONAL AND TECHNICAL COMPONENTS OF NURSES' CAREGIVING ROLES

The nurses in our study clearly define their roles, not in light of their specific job expectations but in the more global and all-encompassing sense as caregivers to patients, and they characterize this care in both relational and technical terms. Their descriptions of their roles as caregivers revealed both the need for rational, logical, and objective skills in assessing and addressing patients' medical needs (the technical) as well as the skills needed to interact with patients on a relational level. Unlike other organizational contexts such as that described by Wood and Conrad (1983) in the paradox of the professional woman, this combination of relational and rational elements posed no sense of constraint or double bind to these nurses.

The relational component of caregivers' roles. The nature of this dual construction is primarily evinced in nurses' talk about what they like most about their jobs as caregivers. Not surprisingly, the nurses in this study echoed the sentiments found in much of the nursing literature that indicate what health care professionals find to be the most salient and rewarding aspects of their work—the delight in working with people and making a difference in their patients' lives (e.g., Curran, 1999; Loewenstein, 2003; Manthey, 2000). As one nurse illustrates, they often speak of the rewards of establishing a relational connection with their patients.

> Nurse 3: The thing I like best about my work with patients? Well, the classic nursing answer is "helping people" [laughs]. I've heard that five thousand times.
> Interviewer: And the real answer is . . .
> Nurse 3: I like talking with people. I mean, I like being able to help people feel relaxed and comfortable when I'm talking with them, so I do try to relate to them and meet them on a common ground as much as possible.

Although nurses may relate tales of frustrating patients and sometimes difficult working conditions, they also speak in chorus that their profession's rewards are largely centered in making connections with their patients and that these connections are forged communicatively. As one male nurse shares enthusiastically,

> I enjoy when a physician or a nurse has taken their time . . . to put it [care] on a personal level, on caring for human needs. Not necessarily for other things. But I think that everybody is so busy doing everything else that sometimes we as nurses and physicians forget that outside of medical needs there's human needs and that people need to talk to people, and people need to feel like they're cared for. Not "caring" as in hanging IV bags but that someone [caregiver] genuinely cares about how they're [patients] going to do when they're out [unconscious]. And I think that sometimes there isn't a good communication between physicians and nurses with patients. But [I like] just being able to go in a room and say, "Hey, how's it going today?" and be able to talk to them as a person. (Nurse 4)

This nurse frames the caregiving role as more than "hanging IV bags." He discusses the need for nurses to interact with patients on a

relational level as well. All but one of the participants in this study echoed these sentiments to a greater or lesser degree.[1] Creating relationships with patients provides satisfaction for these nurses and centers the relational components of their roles as caregivers.

The technical component of caregivers' roles. The identification of nurses' roles as caregivers on the relational level is frequently balanced with the rational, technical, and skill-based aspects of nurses' professional lives. As such, the participants in this study would speak of their role not only as one that called for relational connections with patients but as one requiring technical or "puzzle-solving" skills as well.

> Well, I love the heart patients. It's fun to try to figure out what they need, you know, because they're in cardiogenic shock when they come back from heart surgery. Their heart is just like, "Whoa! What did you do? I stopped for a while, and now I'm going. . . ." And you just have to pick a puzzle. Have to figure out what they need right then and help them get through that time. (Nurse 6)

Many nurses spoke of the satisfaction of using their technical skills and training to assess patients and intervene meaningfully in their care. Nurse 5 (a surgical intensive care nurse) comments, "I'm more the type that likes to do the technical work—that likes to have to do more the thinking aspect of it."

This idea of rationally solving puzzles or meeting medical challenges is a major theme in nurses' talk about their roles as caregivers. Nurse 7 speaks of why this might be:

> Because you like to test your skills, and you like to—it kind of gives you a gauge as to how really good you are and how perceptive you are in helping to fix that patient or make that patient well.

As these examples point out, nurses speak of the joy of successfully meeting the needs of patients based not only on the relationships they may build with patients but of exercising their rational skills in solving and meeting more technical medical needs as well. The dual elements of their work (the relational and technical) combine to help define their roles as caregivers. As one nurse summarized,

> I think that's what being a nurse is all about. You really care about people and you want to help people. And so when you get a patient that acts thankful and is appreciative, you know, that's the whole purpose of your job. (Nurse 21)

This nurse's discourse identifies an important aspect of her nursing role as one who cares about and helps people; these sentiments are reflected in much of the nursing literature as well (e.g., Curran, 1999; Fullbrook, 2004a; Loewenstein, 2003). In this particular study, nurses' ideas about what it means to be a caregiver to Their Patients Also Reflect The Concept That Their Roles As Nurses Encompass Both Relational As Well As Technical Skills.

THE DIALECTICAL NATURE OF NURSES' CAREGIVING ROLES

The enmeshed and deeply held assumptions revealed in these nurses' narratives is that patient care is priority one and that their roles are naturally intertwined with the giving of that care. Yet to give proper care, nurses must negotiate a dialectic tension in their relationships with their patients. In Baxter's (1998) catalogue of dialectical tensions, three are mentioned as typical or common: autonomy or connection, predictability or novelty, and openness or closedness. Related in nature to these primary dialectics is the tension that these nurses report negotiating most often—that of closeness and distance. Nurses define this closeness and distance to their patients both relationally and proxemically.

As has earlier been delineated, when nurses talk about their role as caregivers, they consistently speak of this identity as tied to a relational aspect with their patients—a factor that corresponds to the closeness end of this dialectic. The nurses speak, for example, of getting to know their patients as people, becoming enmeshed in their care, and delighting in their patients' expressions of thanks. On a more technical level, nursing care often requires the type of close physical proximity rarely granted to strangers. Nurses give baths, put in catheters, change dressings, and monitor vital signs, for example. Thus, their roles as caregivers require closeness both physically and relationally.

However, the nature and degree of this proximity, whether physical or relational, varies on a dialectical continuum of closeness and distance. For example, nurses mention how they might attempt to create more distance when executing certain procedures that may prove a threat to patients' dignity or of their own attempts to keep certain procedures in the realm of professional nursing care:

> If you're giving a bed bath or something, you keep everything covered except what you're washing at that time. . . . So it keeps the patient warm. . . . But it also promotes modesty. And even when doing things like putting a catheter in a patient, partly for keeping a clean field of work, but also for modesty, we're covering the legs. We're covering pretty much every area except for right where we need to place our attention. And it depersonalizes it. Which sounds bad, but, but actually in that situation, it also would defuse any kind of inappropriate thoughts on the part of the patient that either I'm interested or that I have a thing about doing this. And to me, it's just part of my job, and it doesn't ever get onto an emotional level. (Nurse 21)
>
> Nurses really go out of their way to be very professional. To be very authoritative when they're providing patient information or doing patient care because it, it takes any, um, sexual overtones out of the situation. If you're giving somebody a bed bath, it's because they're incapacitated. We're always told, and it's actually a good idea, you know, you'll wash their arms, legs, whatever, but you hand them the washcloth to take care of the private areas. (Nurse 20)

This need to maintain a balance of closeness and distance with their patients in the process of caregiving in both the relational and technical aspects of care is echoed again and again as these nurses talk about their professional duties. The need to create a type of relational and emotional distance by depersonalizing technical aspects of caregiving, such as putting in catheters or bathing patients, is necessary to provide proper procedural care ("keeping the patient warm"), to preserve a patient's modesty, and to establish the proper relationship between nurse and patient ("It's part of my job" and "nurses go out of their way to be very professional"). In the first excerpt above, distancing was necessary in that situation and illustrates how the need to depersonalize or distance oneself relationally is a necessary component of caregiving. She further indicates that at times, nurses actually distance themselves emotionally and relationally from their patients. The second excerpt was quite simi-

lar, indicating a need to create the distance afforded by professionalism so that nurses' roles as caregivers are not misconstrued (i.e., "to keep sexual overtones out of the situation")—a reflection of the closeness and distance continuum in the relational realm. This nurse speaks about the need to wash arms or legs, which obviously requires physical closeness. She then achieves distance by handing patients the washcloth to take care of their private parts.

Although nurses speak of providing "emotional support" (Nurse 5) or "forming a bond" (Nurse 9) with their patients, they also indicate a need for the flexibility to distance themselves relationally. Such examples capture how nurses must negotiate between closeness and distance to fulfill their roles as caregivers.

NURSES' RESPONSES TO PATIENTS' SEXUAL HARASSMENT

How, then, do nurses cope with patients who cross the boundaries of nurse and patient relationships and treat their caregivers in a manner not consistent with the help-giving dynamics that make up nurses' caregiving roles? To explore this question, it is first important to establish the need for nurses to have some means for coping with patients who sexually harass them.

Most nurses in our study recalled an incident in which patients treated them in a sexually inappropriate manner; many specifically defined such incidents as sexual harassment. Incidents ranged from verbal innuendos or invitations, to unwanted or uninvited touching, to inappropriate exposure or display. These nurses call patients who initiated unwanted touching as "gropey," or they might comment that "he got a handful." Sometimes, the harassment was more verbal in nature, such as "I'm going to knock you upside of the head with my penis." Two nurses told stories about their patients requesting them to call them by certain names (i.e., "Mr. Studly," and "Longdong"). Nurse 16 reports a further request by one of these patients:

> He'd say, "why won't you call me that [Longdong]?" And I'd say, "because that's not your name." And he said, "well, it could be, and if you would just whup me, you would find out it is."

Not only does the sexual harassment of nurses encompass unwanted touching and/or verbal comments, but a number of nurses reported incidents of inappropriate exposure on the part of their patients. Nurse 1's story is typical:

> This one particular college age man was calling me [with his call light] frequently. . . . And then one time when I went in the room, he was underneath the sheet and he was making all kinds of movements underneath the sheet, like scratching himself. And he said he was itching. And I said "where?" He rips down the sheet. He was totally naked; he'd taken off his gown, and he had a big erection and said "right here" [points to crotch].

These nurses shared many similar stories of patients who exposed themselves. It is clear from their narratives that such instances of improper verbal comments, inappropriate exposure, and unwanted touching are not uncommon and often lie within the bounds of sexual harassment.

Even those nurses who could recall no single remarkable or memorable incident to share from their own experience could speak of what they would characterize as common occurrences regarding other nurses. Nurse 6 reveals the tenor of these nurses who could not bring to mind any personal instances of sexual harassment but who were able to articulate its prevalence in the workplace nevertheless:

> Nurse 6: But I never had anybody just grab my boob or grab my butt or anything. But I have had them holding my waist and they've gone down and (laughter)—you know? That's okay. I just reach behind me, pull it back up, off my butt. You know (laughter)?
> Interviewer: Uh-huh. Once again, not grabbing, just putting it [hand] . . .
> Nurse 6: Yeah. Just putting it there, you know, 'cause he's right there. You know? Yeah. No. I've never had anything real overt. That's why I was worried that I wouldn't have anything to talk about with you.
> Interviewer: Well, nothing's really overt to me.
> Nurse 6: Yeah. I've never even said anything to anybody. Then I just joked about it with my coworkers though. "Hey, he got it, you know, he got a handful," you know, or whatever, and everybody laughs because it's happened to everybody I think.

One can hardly imagine another profession besides sex workers where such behavior would not be characterized as sexual harassment, but this nurse laughed it off as a commonplace occurrence. All but one of the nurses who could not recall personal incidences could relate experiences shared with them by colleagues, seeming to echo this nurse's observation that "it's happened to everybody." Dealing with patients who sexually harass or behave in sexually inappropriately ways are aspects of nurses' jobs to a greater or lesser degree.

CREATING DISTANCE—NURSES' RESPONSES TO PATIENTS' SEXUAL HARASSMENT

As we have seen, nurses construct their roles as caregivers along the dialectical continuum between the poles of closeness and distance. When nurses are confronted with sexual harassment from their patients, however, this negotiation of the closeness and distance dialectic is changed in significant ways. As one nurse reports,

> It [sexual harassment] just catches you off guard. You're trying to do your job and you're trying to gain rapport with the patient and then suddenly it's taken to a whole different level. (Nurse 4)

Essentially, patients who sexually harass attempt to force this dialectic exponentially to the closeness end of the scale, whether physically or emotionally. Patients who may "just reach out and grab your boob, or pinch your butt" (Nurse 17) or say "would you like to look [at my penis]?" (Nurse 14) attempt a forced closeness with their caregivers. In whatever form, such attempts are unwanted, unwelcomed, and uninvited.

Nurses consistently respond to sexual harassment and its related forced closeness by attempting to create distance between themselves and their patients. When they fail to create distance, they speak of how they wished they had created more distance or how they would create more distance if faced with a similar situation again. For example, when asked if she would have handled an incident of sexual harassment any differently, one nurse emphatically

replied, "Oh yes! I would have run!" Although the nursing role requires a healthy negotiation of the closeness and distance tension, a healthy response to sexual harassment requires distance, creating a paradox for nurses who view themselves as both caregivers and victims of sexual harassment. Two distancing strategies were used by the nurses in this study: discursive distancing and physical distancing.

Discursive distancing strategies. Nurses' discursive distancing strategies create emotional space between themselves and their patients who sexually harass. Nurses speak of "putting patients in their place," either by laughing at them, formalizing verbal interactions, and most frequently through the use of jokes or put-downs to create emotional and relational space between them and their patients. We focus on jokes and put-downs to illustrate discursive distancing.

> And finally, I was like, "You know what? If I had things [testicles] that looked like that, I wouldn't be showing 'em to nobody." [laughs] . . . And so I tried to make kind of a joke of it. But it would get really old. You know, it's like, "this is nasty." (Nurse 10)

The use of jokes as a discursive reaction on the part of the nurses serves as an attempt to restore or reestablish a relational distance between patients and nurses but not in response to their roles as caregivers. Such distancing strategies no longer stem from the caregiving role but from a personal response to the patients' behavior. Thoughts of "this is nasty" or derogatory comments concerning patients' genitals are antithetical to nurses' normative descriptions of caretaking behavior. In fact, one nurse speaks of the potential cost to the patient associated with the strategy of discursive distancing in the form of put-downs:

> And if you put them down, you know, then, then that is kind of emotionally, um, not damaging, but it's hurtful to them. And, you know, then right away, they know that you don't care. You know—if you've seen one [penis], you've seen them all. (Nurse 7)

The irony of coping with patients who sexually harass by using potentially hurtful put-downs as discursive attempts to create dis-

tance illustrates how sexual harassment reframes the caregiving role as one that may not safely include relational closeness with patients. Such a reframing disallows the essence of good caregiving as built on a dialectical negotiation of relational closeness and distance with patients. Such discursive strategies on the part of nurses originate not from the role of caregiver but from the perspective of a recipient of sexual harassment—a much more personal reframing.

Physical distancing strategies. Not only do nurses respond with discursive distancing strategies to patients who sexually harass, but they use actual physical distancing from these patients as well. Even when talking about the advice they might give another nurse on the appropriate reaction to patients who sexually harass, these nurses tend to reiterate the literal physical distancing that nurses see as appropriate responses to such behavior:

> I would probably have said something to them [another nurse] like, "you don't have to take that. You don't have to stay in an environment where you're uncomfortable. Just get up and leave." (Nurse 3)

Not only do nurses give advice that sanctions such distancing strategies ("Go home. Get somebody else on. Call somebody else in. Walk off" Nurse 18), but they also often reveal their desire to exit the situation or distance themselves physically when faced with harassment by patients. They speak of leaving the room, truncating, or terminating procedures. Such reactions to sexual harassment are a common theme in the nurses' narratives. One participant reports after a male patient exposed himself to her, "I was just really shocked, and my first reaction was to get out of the room" (Nurse 1). To a 16-year old patient who wanted to show the nurse his penis, a nurse says simply, "I wanted to just do what I had to do and leave the room." As another nurse relates her response to an incident with a patient who had requested her to stimulate him to insert a catheter, she further illustrates this reaction:

> Nurse 10: It was like I didn't want to put his catheter on. I didn't want to take care of him anymore, you know. . . . I told the supervisor I didn't want to take care of him anymore. I did not want to take care of that man anymore. I'm so sorry.

> Interviewer: And so then you didn't have to go back in? That was it?
> Nurse 10: Nope. Nope. And when I did, I just made as least amount of eye contact with him as possible and I tried to kind of ignore him and whatever. If I had to go back in there, I did what I absolutely necessary had to do, and that was it.

Many examples of similar reactions abound. Not only do nurses report wanting to physically leave the scene, but they also, not surprisingly, are often reluctant to return to care for these patients. One nurse shares her reaction to a patient who groped her:

> [The patient] would say, "you have the most beautiful figure I've ever seen." One day, I was standing at his tray, arranging his lunch . . . and he grabbed me from behind, and I almost jumped over the table. He just grabbed and groped and held on. . . . I didn't go into his room if I didn't absolutely have to anymore after that. (Nurse 18)

These examples illustrate a natural reaction for nurses to distance themselves from patients who sexually harass by limiting contact or leaving the scene altogether. Such reactions highlight the physical distancing strategies nurses employ in response to patients' sexual harassment.

PARADOXING THE DIALECTIC: COMPROMISING THE CAREGIVING ROLE

The term "paradoxing the dialectic" refers to the process of moving from the fluid set of choices afforded by dialectics to the set of fixed and mutually contradictory choices offered by paradoxes. This process serves to illuminate how the sexual harassment of nurses by their patients affects these nurses' caregiving roles.

In essence, these roles as caretakers normally require nurses to negotiate the continuum between closeness and distance with their patients both relationally and technically (i.e., while performing procedures). Many procedures such as bathing or putting in a catheter, for example, require this delicate balance. In other words, the ability to fluidly move from closeness to distance is a central component of nurses' caregiving roles. The nature of dialectics allow for this freedom of choice. Thus, dialectics allows for caregiving.

However, sexual harassment removes the fluid nature of this dialectic by radically restricting the ability to negotiate the closeness and distance dialectical tension normally managed by nurses in their roles as caregivers because sexual harassment calls for a response from only one end of the closeness and distance continuum; as these nurses' narratives reveal, because it forces closeness, sexual harassment calls for distance. Therefore, the harassment serves to disallow nurses' ability to fluidly move between closeness and distance, choices that make up the nature of nurses' caregiving roles. Dialectics allow for choices; paradoxes eliminate them. Thus, the sexual harassment of nurses by their patients serves to illustrate the process of paradoxing—the movement from dialectic to paradox.

How sexual harassment predicates this paradoxing of the dialectic is further illustrated with the paradoxical set of choices presented to nurses who are sexually harassed by their patients—choices that inevitably affect patient care. If nurses continue to exercise their role as caregivers, the closeness called for in that role allows them to become victims of sexual harassment, and simply by being victims of sexual harassment, their caregiving roles have been compromised because sexual harassment by its very nature denies, misapplies, and/or ignores these caregiving roles. However, just as closeness precludes the ability to administer proper care in cases of sexual harassment by patients, if nurses distance themselves from their patients, they still cannot fully enact their role as caregivers (either relationally or procedurally).

In this way, the sexual harassment of nurses by their patients serves as an illustration of the "paradoxing of the dialectic," the process of moving between the fluidity offered by dialectics and the impossible choices paradoxes provide, and illuminates its impact on the nature and quality of nurses' caregiving roles.

CONCLUSIONS

The first research question framing this study asked how nurses discursively construct their role as caregivers. When nurses talk about their caregiving roles, they construct those roles as ones that

involve both relational and technical aspects. They view their patients as human beings, not simply objects to be cared for, and these nurses exhibited a delight and satisfaction in the relationships they often establish with their patients. At the same time, nurses must attend to the purely physical and medical needs of those in their care. They must perform procedures such as putting in catheters, giving baths, or changing dressings, for example. As the nurses in this study talked about their duties in the healthcare setting, these two elements (the relational and the technical) made up their discursive construction of their role as caregivers.

The second research question sought to explore how patients' sexual harassment of nurses affected the performance of those nurses' caregiving roles. Not surprisingly, this study illustrates that patients' sexual harassment of nurses negatively affects the performance of those nurses' caregiving roles. Because caregiving is predicated on the nurse's ability to move between the dialectical poles of closeness and distance, the elimination of fluid choices thus affects the nature of that caregiving role; the sexual harassment of nurses by their patients carries such results by calling for a single response—distance. In other words, nurses cannot both respond as victims of sexual harassment and fully enact their caregiving roles.

Finally, Research Question 3 asked what dynamics of dialectics and paradoxes might present themselves in nurses' responses to sexual harassment by their patients. In the first place, these nurses' narratives illustrate that although nurses cannot be both caregivers and victims of sexual harassment at the same time, the sexual harassment of nurses by their patients essentially presents them with this paradoxical choice. Although they still attempt to provide care, these nurses' professional roles as caregivers are abrogated. The roles of caregiver and sexual harassment victim are paradoxical, not dialectical, because nurses cannot reasonably negotiate between them. In the face of sexual harassment, nurses are no longer free to negotiate the closeness and distance dialectic because, for example, trying to establish a closer relational bond or even reducing the literal physical distance is an inappropriate and unsafe response to sexual harassment. The sexual harassment of nurses by their patients thus creates a paradox of choice. The uncomfortable choices that nurses face when dealing with patients who sexually harass mirror the studies done by Lanza (1992) with regard to

nurses as victims of violence from their patients. In this dilemma, nurses wrestle with maintaining their role of putting patients first and their own needs as victims of violence second. The same dilemma can be seen in this study as nurses wrestle with the paradoxing of their caregiving roles by the distancing response called for by patients who sexually harass.

Ironically, even if nurses do not respond either verbally or physically with the distancing strategies that sexual harassment calls for, they are in danger of being caught in a paradox, nevertheless. For example, Robbins et al. (1997) argue that in the face of sexual harassment, nurses' commitment to care for patients often leads these nurses to remain in the field where they can continue to be sexually harassed. Such a decision may undermine these nurses' "perception of [their] competence" (p. 6), a consequence that may in turn affect the efficacy of these nurses as caregivers. Being sexually harassed by patients, then, endangers the quality of caregiving, whether nurses use the physical or discursive distancing strategies explicated by the participants in this study, or whether, like the nurses that Robbins et al. reference, they continue to work unabated in the face of such harassment. In either case, patients' sexual harassment of nurses creates untenable paradoxes that potentially compromise nurses' abilities to fully enact their roles as caregivers, thus carrying with it consequences for nurses, patients, and healthcare organizations alike.

These findings have implications for sexual harassment scholars. This study supports the arguments by other scholars that sexual harassment–related power can be enacted in myriad ways (Cleveland & Kerst, 1993). Specifically, patients do not lie within the traditional organizational chart delineating chains of command and levels of authority. They do not represent supervisors, peers, or subordinates; yet by forcing closeness on nurses, they are negotiating a form of power as control. This form of harassment is particularly difficult to manage because standard methods of control (reprimands, demotions, firing) cannot be enacted on this group of people. Consequently, this form of sexual harassment represents a distinctive form of organizational power that deserves further attention. Scholars should also explore more fully the relationship between sexual harassment and paradoxing the dialectic in other organizational settings.

The findings from this study also have important implications for managers in health care organizations. Although the nurses repeatedly indicated that inappropriate sexual behavior from patients was an ongoing problem, only 3 of the participants received any training in how to manage this type of behavior—and then only as it related to psychology patients and maximum security prisoners. Although training may not solve the problem, it would be an appropriate place to start. Previous research suggests that the appropriateness of responses to sexual harassment is situationally and contextually bound (Dougherty & Smythe, 2004). These scholars suggest that instead of criticizing and advocating particular victim responses, the focus should shift to how victims respond to sexual harassment, providing them with multiple process and response options. Consequently, we suggest that both managers and nursing schools should consider a more informal, storytelling type of training in which experienced nurses share instances of sexual harassment by patients, their response to this behavior, and how they wished they had responded. This form of training may help nurses come to an understanding of the options they can negotiate in their role as caregivers with patients who sexually harass. There are two advantages to this type of training. First, it does not mandate how nurses should respond to inappropriate sexual behavior from patients but instead provides a number of options they can draw on depending on the unique situation in which it occurs. Second, this type of training should prepare nurses for the possibility that patients may behave inappropriately. For many of the nurses in this study, the surprise they experienced as the victims of patient-initiated sexual harassment prevented them from responding in a way that they identified as professionally satisfying. Consequently, simply being prepared for the possibility may have aided in their construction of a response they felt was effective. So although the training is unlikely to eliminate the paradox, it may help nurses find ways to transcend the paradox, reclaiming the caregiving dialectic.

The primary strength of this study lies in the diversity of the research participants and the depth of the data collected. The nurse participants were racially diverse, represented a variety of geographical locations, ages, levels and types of experiences. Both men and women were interviewed. Conversely, however, the limitation to this study also lies in the diversity of the participants. Spe-

cifically, given previous research (Dougherty & Smythe, 2004; Keyton, Ferguson, & Rhodes, 2001), it is likely that organizational culture is an important facet of nurses experiences with sexual harassment. This study design did not allow for an understanding of the influence of particular organizational cultures on the participants' experiences with sexual harassment by patients. Future research, then, should explore the relationship between organizational culture and the sexual harassment of nurses by patients by examining the experiences of nurses in a single organization.

This study highlights how important it is for organizational communication scholars to understand the specific nature and effects of tensions and contradictions such as paradoxes and dialectics. Though dialectics and paradoxes are often undifferentiated in the class of organizational contradictions and tensions (e.g., Ashcraft & Trethewey, 2004), a specific understanding and examination of their nuanced qualities may lead scholars to unravel and/or appreciate the complexity afforded by organizational irrationalities; such is the rich promise that these approaches offer. The fluidity and change afforded by dialectical tensions contrasts with the rigidity presented by paradoxical choices. Dialectical tensions promise more agency; paradoxical choices suggest issues of power and control. Dialectics offer the possibilities of accepting both poles of a dualism as positive and constructive (see Werner & Baxter, 1994), although Wood and Conrad (1983) suggest that paradoxes must ultimately be transcended by eliminating the poles altogether (or the impossible choice between the poles). A sustained scholarly focus on the similarities, difference, and linkages between the types of organizational irrationalities may provide important clues for how organizational members can effectively manage the day-to-day tensions and contradictions interwoven into organizational life.

APPENDIX
INTERVIEW PROTOCOL

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 colleague and management?
   What do you think motivates people to behave this way?
   If you had to do it 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?

NOTE

1. The lone exception in this study was a male nurse (Nurse 5) who worked in an intensive care unit. He consistently mentions enjoying the "technical" and "thinking aspect" of his work, but he does not mention the relational component with his patients in the interview.

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