Research Paper

Women, Sexual Harassment, and Coping Strategies: A Descriptive Analysis

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Citation Mirhosseini Z, Pakdel P, Ebrahimi M. Women, Sexual Harassment, and Coping Strategies: A Descriptive Analysis. Iranian Rehabilitation Journal. 2023; 21(1):117-126. http://dx.doi.org/10.32598/irj.21.1.1797.1

http://dx.doi.org/10.32598/irj.21.1.1797.1

Article info:
Received: 08 May 2022
Accepted: 31 Oct 2022
Available Online: 01 Mar 2023

Keywords:
Coping strategies, Iran, Sexual harassment, Women

ABSTRACT

Objectives: Sexual harassment is one of the most common workplace issues that female employees may experience. The issue is especially severe for women working in a healthcare setting due to factors, such as unequal hierarchical power, night shifts, and a significant volume of visitors, etc. This study sought to characterize and categorize responses to and causes of acute sexual harassment.

Methods: Thirty-nine hospital employees who had experienced sexual harassment were selected for in-depth interviews as part of a qualitative study designed to collect data.

Results: The responses were categorized chronologically as pre-, during-, and post-harassment. Preventive strategies were the most notable pre-harassment responses, whereas, during harassment, diffusion, denial, avoidance, and behavioral changes were the most significant responses. Nonetheless, since diffusion, avoidance, non-disclosure, and non-reporting could result in the persistence of the harassment, the post-harassment strategies shed light on the factors that determined the victims' failure to disclose sexual harassment.

Discussion: Although women experience sexual harassment in healthcare settings, they typically refrain from reporting it and respond passively to such situations. Formal and informal organizational support for the harassed women can empower them to resist harassers and report their conduct in hospital settings.

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Highlights

- The issue of sexual harassment was investigated in a qualitative study using in-depth interviews with activists.
- The responses were chronologically classified into pre-, during-, and post-harassment.
- Harassment prevention strategies were relevant to the pre-harassment stage.
- The during-harassment strategies included dissemination, denial, avoidance, and behavioral changes.

Plain Language Summary

In this paper, we aim to describe and classify the responses and the causes of Sexual harassment in the workplace. this is significant because it is crucial to demonstrate that not a lot of women tend to report or talk about such incidents. However, if they remain silent, they will be victimized for a longer period of time and the process of finding a solution or implementing changes in sexual harassment policies will take more time. Therefore, in addition to the necessity of analyzing women's coping strategies, the researchers need to investigate the reasons for non-reporting.

1. Introduction

The ever-growing presence of women in the labor market has put them at an increased risk of sexual harassment in their workplaces [1, 2]. In 2018, a national survey in Australia with the participation of over 10,000 people revealed that almost two out of every five women (39%) had experienced sexual harassment in the workplace within the last five years [3]. In 2016, Trades Union Congress in partnership with the everyday sexism project conducted a study on 1,553 women and indicated that 52% of them experienced sexual harassment in the workplace [4]. These figures convey the significance of the issue in almost all countries around the world. Women in Iran are no exception; however, there is a paucity of official reports and statistics on the issue in the country. According to the Statistical Center of Iran (SCI) report in 2017, there were four million women in the labor market; thus, there is a great possibility that the number of harassed women in this market is remarkably high.

In addition to the tremendous harm caused by sexual harassment, there are growing concerns about the way victims address such incidents [5, 6]. For example, the fear of being blamed or judged usually forces them not to come forward and file a formal complaint or even open up to others. Such reticent reactions can underrate the significance of sexual harassment in society and as a result, it will not be considered one of women's major problems at work. This might in turn mean that they will be victimized for longer periods [7, 8].

Moreover, regarding sexual harassment in Iran, the majority of the women who are employed in healthcare systems have experienced various forms of sexual harassment. Nevertheless, nurses have reported the highest rate of sexual harassment, which included a wide range of verbal and non-verbal harassment [9-11].

Unwanted sexual advances can occur in any work environment [12]; however, they are more likely to happen in particular environments, such as hospitals. Specific characteristics of healthcare facilities, such as the existence of a power hierarchy, night shifts, break rooms, and frequent interactions with patients and their caregivers expose the female staff to more harassment-related incidents [13-15]. Such incidents not only have devastating effects on the victim's life but also can put patients' lives at risk since the healthcare staff may lose their focus on the process of treating the patients [16, 17].

The present study aimed to examine the strategies employed by the female staff of hospitals in Tehran upon encountering sexual harassers and the reasons for their choice of strategy through in-depth interviews.

2. Materials and Methods

The present study implemented a qualitative methodology, and the data were collected using in-depth interviews with 39 women employed in the hospitals of Tehran, Iran, who had experienced sexual harassment at their workplaces.

The present study was designed to profoundly investigate and understand the experience of sexual harassment in hospital environments by employing a qualitative methodology (conducting in-depth interviews) and making reference to library resources and the research literature. In qualitative studies, studying social phenomena in an in-depth and detailed manner not only provides in-depth descriptions but makes it possible to narrate people's perceptions and lived experiences of those phenomena [18]. Semi-structured in-depth interviews were conducted in the present study to collect the data. The interviews were recorded after gaining the participants" approval and immediately transcribed. Then, the process of data analysis was performed using the thematic analysis method.

Sampling strategy

The sample was selected using the purposive and snowball sampling techniques, and the process of sample selection was continued until achieving theoretical saturation, i.e. when new data and concepts can no longer be extracted from an interview. Care was taken to select the participants of the study from among women employed in various sections of hospitals performing different jobs to observe the maximum variation. Thus, the researcher selected 19 nurses and chief nursing officers, 13 janitors, nursing assistants, and office employees, and seven radiologists, midwives, and surgery technicians.

Data collection

The study was conducted in Tehran, Iran, by performing in-depth interviews with 39 women aged 25-48 years old who were employed in various sections of four public and private hospitals and had experienced sexual harassment at their workplaces (due to the sensitive nature of the study, it was required to obtain a permit. Then, four private and public hospitals in various parts of Tehran were selected for the study). Each interview took about 20-45 minutes. To observe ethical considerations, the examinees were provided with some explanations about the study, its goals, the questions, and process, and they participated in the study with informed consent. They were also made sure that the privacy of their information will be guaranteed by the researchers, and the information will be eliminated immediately after the study. The interviews were performed after working hours outside the hospitals due to the sensitivity of the topic for the interviewees. However, in some cases, particularly during night shifts, when few people were present in the environment, the interviewees preferred their break rooms.

Data analysis

The findings of the study were analyzed using the thematic analysis technique, and special care was taken to extract the implicit and explicit themes and concepts in the texts of the qualitative data [19].

In addition to quoting the interviewees in the conclusion section, the process of coding the interviews was evaluated by comparing the authors' views and was presented after a consensus was reached between them to increase the validity of the study. Moreover, care was taken to accurately understand what the participants were narrating in the process of interviews by employing the member checking method [20], using the examinees' approval, and sharing what they understood from the interviews and the information exchange between them.

3. Results

One of the main purposes of the present study was to describe the responses and strategies stated by the participants. However, given that these responses are shaped by the extent and type of the harassment as well as the status and power of the harasser in the organization, the researchers aimed to investigate the coping strategies in association with different variables, such as the type of harassment and personal characteristics of the victim. Moreover, since sexual harassment is one of the main concerns of female employees, their responses to such behaviors and perpetrators are not restricted to the time of the incident or the following days. These strategies can also determine their behaviors before the incident occurs (predictive strategies). As a result, these women's strategies can be divided into three categories: a) pre-harassment, b) during-harassment, and c) post-harassment.

Predictive strategies

Given that women can be concerned about sexual harassment all the time, one of the behaviors they have been taught is to avoid visiting unsafe places or being around perpetrators. Their workplace is no exception. Preventive strategies include two sets of behaviors that women and harassers show in specific contexts. Regarding women's behaviors, the majority of the participants remarked that they need to have a cold and unwelcoming relationship with men.

According to the interviewees, if a woman does not have a cold and unwelcoming attitude or, as some of them put it, she "does not act like a man" and if she "tries to be more sociable", she is more likely to experience sexual harassment.

One of the focal points in sexual harassment theories is the effect of gender-related stereotypes on the development of such behaviors. However, according to the participants, it seems that the stereotypes regarding women's behaviors are so strongly ingrained in society that any deviation will result in failure in the workplace. Moreover, such approaches toward the causes of sexual harassment can reinforce the aforesaid stereotypes. The significance of this issue is mainly due to the fact that even the victims blame themselves and their own attitude toward men for getting into such trouble. Such viewpoints can make victims feel guilty for not taking the stereotypes more seriously, blame themselves, and finally choose not to talk about the incident.

The participants referred to some other behaviors, including protective behaviors, such as reluctance to stay alone with the harasser, avoidance, and general unwillingness to acquaint with those who hurt them in the past. Some of the participants pointed out that they tried a lot not to take shifts with a perpetrator.

During-harassment strategies

One of the mains of the present study was the analysis of victims' behavior while they are targeted. Such behaviors can reinforce or prevent further victimization. These responses range from diffusion (reticence, ignoring, etc.) to physical and violent reactions. The type of the victim's response depends on various factors, including the type and extent of sexual harassment, the position of the harasser, and the characteristics of the victim. In the next section, the manner of responding to sexual harassment is investigated based on the above factors.

Type-based analysis of sexual harassment

According to ILO (2002), the behaviors that are regarded to be sexual harassment are as follows:

Non-verbal: Whistling, sexually-suggestive gestures, and displaying sexual materials

Verbal: Commenting and asking questions about the appearance, lifestyle, and sexual orientation, and making offensive phone calls

Physical: Physical violence, touching, and unnecessary close proximity

Given the afore-said definition, the harassments and the subsequent responses fall into three groups: 1) verbal, 2) non-verbal, and 3) physical.

The results of the interviews in the present study suggest that the most common types of sexual harassment that women experience in healthcare environments are verbal and non-verbal. The participants stated that they are more indignant about the recurrence of verbal and non-verbal advances than the intensity of such behaviors.

Non-verbal harassment

According to the participants, non-verbal harassment includes leering, giving the victim phone numbers, and sending offensive messages on social media. Given the fact that this type of harassment can be committed by a wide range of individuals, including doctors, colleagues, supervisors, aides, patients, and caregivers, its frequency is quite high.

The majority of these behaviors have come from patients, caregivers, or those with menial jobs. It is noteworthy that most of the participants did not consider this type of harassment a major issue due to its minor consequences. The participants added that the best or perhaps the easiest solution to combat non-verbal harassment is to simply ignore it because these behaviors are high in frequency and low in intensity. "Zohreh" (assistant nurse in a private hospital) said:

"There is this male service worker who stares at people a lot. When you're having your breakfast or a cup of tea, you find him staring at you. They [the hospital staff] all know him [she laughs.] I try not to go to the staff room when he is in there."

In such cases, the most frequent-cited responses were avoidance, denial, diffusion, or, sometimes, verbal responses. Diffusion includes silence and disregard. Denial, which implies that nothing has happened and there is no consequence for the victim, is to redefine the harasser's advances in order to justify his misconduct. Avoidance includes staying away from the perpetrator or leaving the place. However, a small number of the participants said that they had directly warned the perpetrator to stop their misbehavior.

Verbal harassment

The participants have also experienced verbal harassment, including admiration, repeated sexual requests, lewd jokes, and racist remarks, allusions to private body parts, and crude rumors. It is worth mentioning that because the ramifications of verbal harassment are often not that serious, they tend to occur rather frequently. Moreover, this type of harassment is usually initiated by

coworkers (doctors, aides, supervisors, and caregivers). These reasons often lead victims to view verbal abuse as an inevitable part of their job, something they have to deal with.

Such viewpoints can result in victims' silence and disregard. Responses to verbal harassment depend on its intensity, the status of the harasser, and the location of the harassment. Twenty-seven of the participants, however, said they addressed the incident by avoidance, denial, diffusion, and behavioral change.

The participants stated that verbal harassments in public include sexual comments and jokes and expressing ideas about the female body. These harassments were usually dealt with through avoidance, such as leaving the workplace and refusing to be around the harasser, and diffusion, including remaining silent, ignoring the harasser, and nervous laughing due to the confusion. When a single woman is sexually harassed, especially if she is alone with the harasser, her most probable response is to avoid him. In most cases, it is regarded as the victim's first reaction. Moreover, when the victim and the harasser are in an unavoidable situation (e.g. when the harasser and the likely to be harassed both have to be in the operating room) and the victim is not able to leave the place, she usually displays some other responses, including denial (pretending that nothing has happened or redefining the misconduct, that is, justifying the harasser's advance). "Mehrnoush" (anesthesiologist in a private hospital) said:

"When they are joking about a patient's private parts in the operating room, you have to stay there. It is terrifying; I usually try to make myself busy with files and folders and pretend I'm not listening."

The participants referred to behavioral change as one of the most common responses to verbal harassment. This type of response shows itself mostly when the victim fears the possibility of harassment recurring. The first step that victims usually take is to leave the place and change their attitude toward the harasser. The participants indicated that they address the problem by giving the harasser a cold shoulder or staying away from him. These responses are also due to the fact that the victims have no idea how to deal with the situation. These responses indicate that victims are not ready for such situations or do not know how to address the problem in a less risky way. Generally speaking, the interviewees' responses to verbal and non-verbal harassment reveal the fact that victims refuse to confront the harasser directly and that they prefer passive reactions. The interviewees believed that diffusion, denial, or avoidance result from their fear of the persistence of the harassment or any rise in its intensity if they react negatively and confront the harasser directly.

Moreover, some of the participants suggested that one should not reveal her flaws and weak points at work, because others can take advantage of these flaws to harass them sexually. Some of the interviewees reported that they had an argument with the harassers; however, it usually appeared when the harasser was below them or in the same position as them. There are a few cases where the subjects reported sexual advances to their supervisor due to the persistence of such behaviors, but the supervisor did not act on it or the victims were even criticized. "Samira" (nurse in a public hospital) said:

"He tells me that my uniform looks so good on me or it makes me look so fit. He texts me late at night […] I reported the problem to the head nurse, but she did nothing. I have decided to give him a cold shoulder until he gives up".

Given the results of the interviews, the more powerful the harasser is in the workplace, the less likely it is for the victim to act against him. The power can be given to individuals formally, like having an official position in the institution, or informally, like having more work experience or being a member of the majority in the workplace. Harassers with formal power include doctors or supervisors while those with informal power are colleagues in the same position, but with higher work experience. In such cases, due to the fact that the harasser exercises more power and enjoys higher credibility in the organization, the victim feels that her complaint can bring about her own admonishment. The third type of power pertains to mostly male-dominated workplaces; therefore, women's objections will be ignored or met with harsh criticism. In such circumstances, victims are less likely to file complaints.

Physical harassment

The participants reported several types of physical harassment, including unnecessarily close proximity, unwelcome touching, grabbing private parts of the victim, and raping. Twenty-one of the participants stated that they had experienced physical harassment, with 16 saying that they showed passive reactions (silence, ignoring, or indifference), avoidance, denial, and behavioral change. Most of the reported cases were limited to unnecessarily close proximity, unwelcome touching, and the grabbing of the private parts of the victim, with just a few cases of severe physical advances (raping). The

victims expressed hope that if they had avoided the harasser or changed their attitude toward him, they would have prevented further harassment because the harasser would be aware of their reluctance and spitefulness. majority of the physical harassers are doctors and those in higher positions and victims are so intimidated by the harassers' power that they think they might lose their jobs or face other problems, such as ruining their reputation by causing verbal disputes or physical conflicts or even file a complaint against the victim; therefore, they decide to avoid direct confrontation or formal complaints.

The participants also reported verbal responses, such as warning and asking directly to stop, yelling at the harasser, and asking for support. Although there were few such cases, the victims who found the support of their family or their head nurse could file a formal complaint. "Zohreh" (assistant nurse in a private hospital) said:

"I had to inform my husband; I told him who is calling me that much so that he would not think it was my fault. Finally, he asked me to talk to my supervisor and if she did not do anything about it, I had to quit my job. I told my supervisor everything and she changed my ward".

The number of participants who experienced physical harassment by those in the same or lower positions was not that many; however, such harassment is more likely to be reported or confronted. Although physical harassment is much more severe than other types of harassment and victims are more likely to confront the harasser, the participants revealed that their responses were limited to diffusion, denial, avoidance, and behavioral changes. The importance of avoidance lies in its preventive aspect. The victims believed that they tried not to give a chance to the harasser and chose less risky ways to show them they are not willing to have an intimate relationship. Moreover, given the fact that doctors constituted most of the physical harassers, the victims took no action due to the higher power of the harassers in the organization.

Organizational strategies

Owing to the importance of these strategies, they are discussed in a separate section. These strategies can be employed before, during, and after the incident. The interviewees stated that when a certain person harasses them in the workplace, they warn others against him or ask them to stay away from him. When they share their experiences, colleagues helped each other not to stay alone with the perpetrator. "Zahra" (service worker in a private hospital) said:

"We are all women. If there is a problem, I tell them that I don't wanna go to that specific doctor's office, and they need to send someone else. In other hospitals, it is not like that. Your colleague is not your friend."

Although such responses are not useful when the harasser is a doctor or in a higher position, they can minimize the possibility of harassment.

The classification of responses based on the harasser and the type of the harassment

Based on the classifications presented in the literature review section of this article and the responses mentioned by the participants, the responses to sexual harassment are classified as follows:

Diffusion: Remaining silent and doing nothing,

Denial: Reacting as if nothing had happened, pretending not to hear the harasser,

Avoidance: Leaving the place, staying away from the harasser, and confronting the harasser indirectly

Behavioral change: Terminating the relationship and giving the harasser a cold shoulder

Search for support: Sharing the experience with one's family, colleagues, or supervisor

Change of place: Changing wards, shifts, or even jobs

Verbal response: Arguing, calling the harasser names, and insulting

Physical responses: Physical resistance

Reporting: Informing those in higher positions/ the management or the hospital CEO.

Post-harassment strategies

Although some of the participants reported unwanted sexual advances or had a physical confrontation with the harasser, the number of such responses is rather low. The majority of the participants preferred not to have any direct confrontation with the harasser and, in case of any persistent harassment, they usually change their attitude or discontinue the relationship with the harasser and finally report the incident to their supervisor.

Sometimes, if the harassment persisted and victims were left with no other alternative, they even thought of committing suicide or, according to many of the participants, moving to another working environment, changing their job, obtaining higher academic degrees to go to a safer place, or even moving abroad. Sexual harassment often changes the victim's life.

The reasons for diffusion, denial, avoidance, and non-reporting

In addition to certain factors, such as the type of harassment, other factors, including the characteristics of the harasser and the victim can determine the way the latter responds to the harassment, particularly when they show diffusion, denial, or avoidance. Moreover, one of the main responses to sexual harassment is reporting and disclosing the incident. Reporting such behaviors can help prevent the persistence of harassment. It can also reduce the period they are being harassed. As a result, the subjects' reluctance to share, report, or disclose the harassment was analyzed in the present study.

The reasons for diffusion, denial, and avoidance

In the following paragraphs, the factors that can affect some responses, such as diffusion, denial, and avoidance are examined. These factors include the characteristics of the harasser and the victim (micro-level), organizational factors (meso-level), and cultural factors (macro-level). The characteristics of the victims include negative social attitudes, financial needs, the lack of job security, and one's position and age.

1. Negative social attitudes: Some social negative attitudes oblige the victim to ignore the harassment and remain silent. The victims who are judged negatively by society or assume that others think negatively of them are more likely to address sexual harassment by avoidance, diffusion, or non-reporting. If the victim has a specific problem, such as being a divorcee, she fears that others will blame her for the incident; therefore, she is reluctant to share her experience with her colleagues or report the incident. "Sheida" (nurse in a private hospital) said: "As I'm divorced, others think less of me. It's irritating. I don't wanna ruin my reputation. Just because I'm divorced, they might say that it is my fault. I can't tell my colleagues what happened. I won't file a complaint, either."

2. Financial needs and lack of job security: These two factors make the victims with financial needs or insecure status choose to react passively or avoid the harasser. This particularly applies to the victims who have difficulty finding jobs due to their age or the significant number of applicants. This dilemma was mostly mentioned by the participants with lower job status, including the service workers, assistant nurses, and administrative workers.

3. The position of the victim: Regarding the victim's position and her response to sexual harassment, victims in lower positions are more likely to experience harassment because it is easier to find a substitute for them and the management fails to notice their problems. Moreover, due to their financial needs and lower job security, these participants are less willing to file a complaint. Fear of losing jobs or a decent contract was one of the main reasons for the victims' non-disclosure.

4. Age of the victims: According to the participants, age can be one of the most significant factors in sexual harassment in the workplace and the victim's responses to such advances. Younger individuals are more likely to face harassment. Despite its low rate, it is more likely that these individuals seek support and share their experiences with their supervisors, colleagues, or family members. More senior members of the staff are less exposed to sexual advances due to their age or status. These people can report harassment to the management or confront the harasser. However, they act passively when they themselves are the target of sexual harassment by doctors or those in higher positions. "Somayeh" (head nurse in a public hospital) said:

"There is a doctor in our hospital who explains every detail of his operations in the patient's private areas. Well, maybe I don't wanna hear it. It is really irksome, but I can't ask him to stop. You should not show them your weak points, because they can hurt you even more".

One of the main characteristics of harassers that affect the victim most is their power, especially their official power.

5. The harasser's position: The participants admitted that they have witnessed or experienced many harassing behaviors from doctors. There were 21 cases of sexual harassment and 32 cases of witnessing such behaviors committed by doctors. The victims believed that this goes back to the doctors' power in the organization and their high job security. The victims were less willing to confront them or report the harassment. Power and status together with the organization's attitude towards sexual harassment have an effect on the victim's responses. Furthermore, the high status of doctors in society and

the organization confuses the victim and makes them face double standards with regard to sexual harassment. Therefore, sometimes they do not conceive of doctors' advances as a form of sexual harassment.

This section mainly involved passive responses and avoidance, but it also included some of the most significant reasons for non-disclosure and non-reporting of sexual harassment. These reasons are notably associated with cultural and organizational factors.

6. The high cost and unfruitfulness of filing complaints: Most of the participants stated that their complaints will end up in failure and cost them a lot due to the power of the harasser in the organization. The participants stated that one of the main groups of harassers is doctors and they are not reprimanded due to the power dynamics in the hospital; the only possible action can be to change the workplace of the harasser and the victim. "Maryam" (head nurse in a public hospital) said:

"There was a harassment case where the victim didn't want to report it. I myself went to the CEO's office and did it for her. But nothing happened. They just transferred them to different wards."

7. Losing the trust of the management: One of the major concerns of the subjects is that they fear their manager will no longer trust them. Furthermore, some of them even stated that they were harassed by their managers. If one cannot trust the officials who are in charge of addressing sexual misconduct, one will not be willing to file a formal complaint. When a harassed woman hears the story of a victim who got fired after reporting the case to the management, she will feel that the same thing can happen to her.

8. Remaining silent to protect one's dignity: According to the participants, the fear of negative remarks and judgments and losing personal dignity is regarded as one of the main reasons deterring victims from speaking out and forcing them to deal with their problems alone.

9. Victim-shaming attitude: The participants believe that one of the main reasons for non-disclosure is that they may be blamed by their coworkers, and their superiors might think they are guilty. Another significant aspect of the victim-shaming attitude is the victim's "self-blame", which is one of the most-cited obstacles to disclosing sexual harassment and other acute to. There are some reported cases of self-blame even after the victim reported the case to the management.

4. Discussion

The coping strategies used by victims are classified into pre-, during-, and post-harassment ones. The pre-harassment or preventive strategies include staying away from possible harassers and avoiding contact with them in their workplaces. Idås et al. [12] showed that the "avoidance strategy" was among the most prevalent strategies employed by women when they experienced sexual harassment in a way that some women tried to change their jobs or avoid performing their responsibilities after experiencing sexual harassment. Hibino et al. [21] assessed 600 nurses in Japanese hospitals and showed that 55.8% of the nurses had experienced their patients' sexual harassment, but they were more inclined to make passive responses and reported such instances on rare occasions [21].

The participants described verbal and non-verbal harassment, which included a wide range of behaviors, like requests for sex, obscene jokes, offering one's telephone number, and sending insulting and obscene messages, were the most prevalent forms of sexual harassment in the hospitals. Such incidents were typically perpetrated by doctors, nursing officers, assistants, patients, and their attendants, and the examinees' responses to them were typically in the form of avoidance, denial, diffuse, and behavioral changes. In a study titled "sexual harassment against nurses in Turkey", Celik et al. [22] aimed to identify the sources of sexual harassment in eight Turkish hospitals by studying 622 nurses. The findings showed that more than 37% of the participants had experienced sexual harassment. Thus, while the majority of verbal harassment was from the nurses' colleagues, patients and their relatives perpetrated the majority of physical harassment behaviors. Moreover, the nurses did not report such instances to hospital authorities in 80% of the cases.

Moreover, regarding post-harassment strategies, filing a complaint was the most useful response to sexual harassment. Nevertheless, very few subjects reported the incident or opposed the harasser directly. Many of them announced that they could not inform their family members or colleagues of such incidents as they were worried about losing their reputation, being criticized or blamed as women, and being forced to pay large sums of money to sue the harassers. Fallahi Khoshknab et al. [9] showed that many instances of sexual harassment might not be reported for various reasons, like cultural sensitivities or fear [9]. Freedman-Weiss et al. [23] in their study to understand the factors that prevented American surgery residents from reporting sexual harassment showed that above 70% of the female participants had experienced at least one form of sexual harassment during their training period, though

only 7.6% of them had reported such instances. Thus, the majority of the women had decided not to report the cases for various reasons, like the lack of any harm in the harassing action or the uselessness of the report [23].

Moreover, women with lower-level jobs were more susceptible to experiencing sexual harassment, but they could not report them due to the lack of job security, financial needs, and harassers' power that stopped the harassed party to disclose and report the incidents. This was in line with the findings of Celik et al. [22] where the most significant factors that paved the way for sexual harassment in hospitals were the nurses' lower job positions and power in their workplaces, inconvenient working conditions concerning the employees' health, and the insufficient administrative mechanisms and regulations to stop harassers [22]. Moreover, Idås et al. [12] showed that young women and temporary workers were significantly more prone to sexual harassment [12].

Finally, women's sexual harassment in hospitals and healthcare systems results in their silence, indifference, and anger. This was similar to the findings of Celik et al. [22] where the majority of harassed women experienced issues, like anger, feelings of contempt and helplessness, diminished performance in their jobs, and depression. Thus, it is necessary to train women in the methods of counteracting sexual harassment. Acquiring coping skills and developing educational programs are among the solutions that were mentioned in the study by Zeighami et al. [11], as well. Moreover, psychological therapies are necessary to reduce the consequences of sexual harassment. Such therapies for psychiatric disorders have become prevalent in Iran over the past few years [24-26]. Thus, similar studies should be conducted to evaluate the effectiveness of psychological therapies in treating women who experience sexual harassment.

5. Conclusion

Women who are employed in healthcare systems and hospitals experience a wide range of sexual harassment, but they usually do not report them, stay silent, and make passive reactions to them. Therefore, one of the main policies that an organization can implement is to provide support for the vulnerable group of workers. When there are formal and informal supports, there is a greater possibility for reporting or confrontation with the harasser. Some of the participants pointed out that their head nurses have helped them to report their cases to the management. In spite of the fact that, in most cases, the hospital management does not take any action, such reports can intimidate the harasser and reduce the number of sexual misconduct.

Ethical Considerations

Compliance with ethical guidelines

All ethical principles are considered in this article. The participants were informed of the purpose of the research and its implementation stages. They were also assured about the confidentiality of their information and were free to leave the study whenever they wished, and if desired, the research results would be available to them. A written consent has been obtained from the subjects. principles of the Helsinki Convention was also observed.

Funding

This research did not receive any grant from funding agencies in the public, commercial, or non-profit sectors.

Authors' contributions

All authors equally contributed to preparing this article.

Conflict of interest

The authors declared no conflict of interest.

Acknowledgments

We are grateful to all the women who participated in this research.

References

[1] Hersch J. Sexual harassment in the workplace. Bonn: IZA World of Labor; 2015 [DOI:10.15185/izawol.188]

[2] Di Martino V. Workplace violence in the health sector. Country case studies Brazil, Bulgaria, Lebanon, Portugal, South Africa, Thailand and an additional Australian study. Ginebra: Organización Internacional del Trabajo. 2002; 3-42. [Link]

[3] Australian Human Rights Commission. Everyone's business: Fourth national survey on sexual harassment in Australian workplaces. Sydney: Australian Human Rights Commission; 2018. [Link]

[4] Ross A. Half of women in UK have been sexually harassed at work, study finds. London: The Guardia; 2016. [Link]

[5] Fitzgerald LF, Shullman SL, Bailey N, Richards M, Swecker J, Gold Y, et al. The incidence and dimensions of sexual harassment in academia and the workplace. Journal of Vocational Behavior. 1988; 32(2):152-75. [DOI:10.1016/0001-8791(88)90012-7]

[6] WHO. Violence against women prevalence estimates, 2018 – Executive summary. Geneva: WHO; 2018. [Link]

[7] Smith BL. What it really takes to stop sexual harassment. Monitor on Psychology. 2018; 49(2):36-40. [Link]

[8] Johnson SK, Kirk J, Keplinger K. Why we fail to report sexual harassment. Harvard Business Review. 2016; 1-7. [Link]

[9] Fallahi Khoshknab M, Oskouie F, Ghazanfari N, Najafi F, Tamizi Z, Afshani S, et al. The frequency, contributing and preventive factors of harassment towards health professionals in Iran. International Journal of Community Based Nursing and Midwifery. 2015; 3(3):156-64. [PMCID] [PMID]

[10] Najafi F, Fallahi-Khoshknab M, Ahmadi F, Dalvandi A, Rahgozar M. Human dignity and professional reputation under threat: Iranian nurses' experiences of workplace violence. Nursing & Health Sciences. 2017; 19(1):44-50. [DOI:10.1111/nhs.12297] [PMID]

[11] Zeighami M, Mangolian Shahrbabaki P, Dehghan M. Iranian nurses' experiences with sexual harassment in workplace: A qualitative study. Sexuality Research and Social Policy. 2022; 1-14. [DOI:10.1007/s13178-022-00688-w] [PMID] [PMCID]

[12] Idås T, Orgeret K, Backholm K. #MeToo, Sexual harassment and coping strategies in norwegian newsrooms. Media and Communication. 2020; 8:57-67. [DOI:10.17645/mac.v8i1.2529]

[13] Ramsay MA. Conflict in the health care workplace. Archive of "Proceedings (Baylor University. Medical Center). 2001; 14(2):138-9. [DOI:10.1080/08998280.2001.11927749] [PMID] [PMCID]

[14] Bernardes MLG, Karino ME, Martins JT, Okubo CVC, Galdino MJQ, Moreira AAO. Workplace violence among nursing professionals. Revista Brasileira de Medicina do Trabalho. 2021; 18(3):250-7. [DOI:10.47626/1679-4435-2020-531] [PMID] [PMCID]

[15] Fernandes H, Sala DCP, Horta ALdM. Violence in health care settings: Rethinking actions. Revista Brasileira de Enfermagem. 2018; 71:2599-601. [DOI:10.1590/0034-7167-2017-0882] [PMID]

[16] Bordignon M, Monteiro MI. Violência no trabalho da enfermagem: um olhar às consequências. Revista Brasileira de Enfermagem. 2016; 69:996-9. [DOI:10.1590/0034-7167-2015-0133] [PMID]

[17] Pai DD, Lautert L, Souza SBCd, Marziale MHP, Tavares JP. Violence, burnout and minor psychiatric disorders in hospital work. Revista da Escola de Enfermagem da USP. 2015; 49:457-64. [DOI:10.1590/S0080-623420150000300014] [PMID]

[18] Patton MQ. Two decades of developments in qualitative inquiry: A personal, experiential perspective. Qualitative Social Work. 2002; 1(3):261-83. [DOI:10.1177/1473325002001003636]

[19] Braun V, Clarke V. Using thematic analysis in psychology. Qualitative Research in Psychology. 2006; 3:77-101. [DOI:10.1191/1478088706qp063oa]

[20] Creswell JW, Poth CN. Qualitative inquiry and research design: Choosing among five approaches. California: Sage Publications; 2016. [Link]

[21] Hibino Y, Ogino K, Inagaki M. Sexual harassment of female nurses by patients in Japan. Journal of Nursing Scholarship. 2006; 38(4):400-5. [DOI:10.1111/j.1547-5069.2006.00134.x] [PMID]

[22] Celik SS, Celik Y, Ağirbaş I, Uğurluoğlu O. Verbal and physical abuse against nurses in Turkey. International Nursing Review. 2007; 54(4):359-66. [DOI:10.1111/j.1466-7657.2007.00548.x] [PMID]

[23] Freedman-Weiss MR, Chiu AS, Heller DR, Cutler AS, Longo WE, Ahuja N, et al. Understanding the barriers to reporting sexual harassment in surgical training. Annals of Surgery. 2020; 271(4):608-13. [DOI:10.1097/SLA.0000000000003295] [PMID]

[24] Dana S, Effatpanah M, Mahjoub A. The new epidemic problem of psychoactive drugs at drug treatment centers of Iran: Implications for education, prevention and treatment. Iranian Journal of Psychiatry and Behavioral Sciences. 2018; 12(2):e63555. [DOI:10.5812/ijpbs.63555]

[25] Effatpanah M, Moradi A. Methamphetamine dependence and technology-based interventions in Iran. Iranian Journal of Psychiatry and Behavioral Sciences. 2018; 12(2):e62935. [DOI:10.5812/ijpbs.62935]

[26] Sami S, Effatpanah M, Moradi A, Massah O. Matrix model as an intensive rehabilitation in three methadone services in Iran. Iranian Rehabilitation Journal. 2017; 15(3):293-8. [DOI:10.29252/nrip.irj.15.3.293]