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Workplace Sexual Harassment against Female Nurses and Occupational Health Outcomes

Amal A.Hussein [(1)], Sohair M. Mabrouk [(2)], Gehan A. Abed [(3)]
. Community Health Nursing , , Nursing Administration
, Psychiatric Nursing,
Faculty of nursing, Menofyia University

Abstract: *Workplace harassment is attracting in the practitioner and academic literature. Studies showed that sexual harassment against women in Egypt is endemic. It has become an overwhelming experience for most women in the society, even at workplace, and nurses are not immune. Incidence of sexual harassment in nursing is high, with 60 percent of female nurses reporting a sexual harassment incident and 8 percent had taken time off work.* ***So the study aimed to:*** *Assess nurses' awareness, prevalence, forms of sexual harassment, nurses' opinions about factors leading to harassment, how to face it, and identify the effects of harassment on psychological state of nurses (anxiety & depression) and on work` satisfaction.* ***A descriptive design*** *was used for this study.* ***Tools:*** *there were three questionnaires to collect data; 1) Sexual harassment scale. 2) Depression and anxiety scale for women and 3) job satisfaction scale.* ***Setting****: Shibin El-kom University Hospital in Menofiya Governorate, Egypt.* ***Subjects****: A110 female staff nurses.* ***Results****: The majority of the studied sample exposed to sexual harassment in a 6-month period, there was statistical significance between exposure to harassment and anxiety, depression and work satisfaction.* ***Conclusion****: It can be concluded that sexual harassment has negative impact on psychological state of female nurses (depression, anxiety) and work satisfaction.* ***Recommendation****: Further researches aimed at reducing the incidence and severity of sexual harassment and introduction of procedures, policies and practices to alleviate the phenomenon.*

Kew words*: Harassment, Workplace, Nurses, Occupational, outcomes*

I. Introduction

The concept of sexual harassment (SH) is relatively new. It was introduced by the United States and was disseminated via the media and various publications in the latter half of the 1980s **(American Medical Association,2005).** Workplace harassment has become an important issue to be addressed and become a part of daily discourse among nurses in hospitals, regardless of social or economic status or political belief **(Pasqual, Chung and Fernandez ,2008).** In the healthcare settings, it is a feature of the nursing workplace for many nurses. It is defined as unwanted persistent, offensive, abusive, intimidating, malicious and insulting behavior conduct deliberately perpetrated by the harasser resulting in sexual, physical, or psychological abuse of the victim regardless of location. **(Harvill, 2006)**. It can involve a range of unacceptable behaviors including unwanted physical contact, offensive sexual comments and sexual propositions.

A number of studies indicated that nurses are frequently subjected and may be the most vulnerable to (SH) from physicians, patients or their family members, colleagues, and other healthcare professionals. Recent study show that about two in five female nurses and one in six male nurses report at least one episode of (SH) at short duration **(Alderman, 2007).** Workplace harassment is becoming recognized as a management problem for employers. It has become an issue of concern for academician, human resource practitioners, management, employees, governments, and unions. Female nurses may leave as a way of coping, because human resource management and senior management have ineffectively dealt with their complaints and comments **(Slackman, 2008).**

Health care settings were more likely than other employment contexts to have higher than average rates of harassment; however, no rates of harassment among specific health care professionals were reported **(Brittany, 2010).** High SH prevalence rates provide strong justification for strategies such as policy development, grievance handling procedures, and awareness training to be implemented. However, these initiatives are largely reactive and concerned with responding once claims have been made or a SH episode has taken place **(Ellen, 2009).**

There are several reasons why nurses are vulnerable to (SH). One is the hierarchical structure in the healthcare community, in which superior positions are occupied by physicians, and nurses are placed in an inferior position. Additionally, healthcare providers are being placed in a position that is becoming more vulnerable to patients, who are the consumers of medical care **(Street, 2007).** Another reason is the existing gender issue, namely, that the majority of the nurses in hospitals are female. The popular image of a nurse is thus of a female who provides maternal care and emotional care for patients, it can lead to frequent (SH)

Moreover, the worsening economic situation and followed by weak awareness of religious values. Some studies by **Costa, Elbert, Hatfield, Grobler, Marx, & Van De Schyf, 2007)** indicated that particularly blamed the general appearance of some female nurses and their behavior in health setting. Also, attributed to the media, harassers' poor upbringings, lack of a clear law to criminalize the harassment. Additionally, due to the victim's silence, this allows the harasser to escape from the penalty **(Alderman, 2007).** Prevention of sexual harassment.

There are forms of (SH), which are: touching, noises (including whistling, hissing noises, kissing sounds. ogling of women's bodies and verbal harassment of a sexually explicit nature, stalking or following, phone harassment, and indecent exposure · Verbal abuse is so prevalent in nursing which included sexually harassing comments **(Sabitha, 2009)**

Those who are sexually harassed display common coping strategies, such as indirect expression of anger, denial or minimization of the incident, and compliance; as well as feelings of powerlessness, aloneness, fright, and humiliation. Finally, it reported that although 50 percent of people who experience SH, they simply try to ignore it **(Bargad, 2005).**

It has been suggested in the literature on occupational health outcomes, such as; anxiety, depression and job satisfaction that having a supportive work environment can act as a coping strategy, helping to moderate the effects of workplace stressors such as harassment and protecting the individual from the harmful effects of it. Depression is a public mental health problem that affects nurses, negatively and impacting their personal, social, and family lives **(Laxman, 2003).**

Job satisfaction defined as the degree to which nurses like their work, is a general attitude toward the job. It is the extent to which nurses satisfy or dissatisfy their work. Job satisfaction is appositive feeling towards one's work controlled mainly by satisfiers such as stable schedules, incentives, and opportunities for professional promotion. If satisfiers existed, the employee would be satisfied with his / her job **Barak, Tangri and Johnson (2005).**

The effects of (SH) vary from person to another person and depend on the duration and severity of the harassing behavior. SH have significant negative consequences that have been widely reported in the literature. Work performance, morale, motivation, confidence and satisfaction have also been widely documented **(Jejeebhoy and Bott, 2003).**

Job performance was affected by harassed nurses, take leave to avoid the harasser and choose to leave their jobs at least in part because of the harassment. Largely through reduced levels of concentration following sexual innuendos. Also, the potential psychological effects of a SH incident include lowered self esteem, insecurity, embarrassment, shame, guilt, self-blame, isolation, difficultly with interpersonal relations, increased stress, depression, frustration, and anxiety **(Harvill, 2006).**

Significance of the study

From the available studies and review of literature, it estimates high occurrence and percentage among nurses on reporting SH, and don't realize the term of SH**.** There is a lack of such studies in developing countries in general. Since limited work on SH in nursing has been undertaken **(Ellis, Barak, and Pinto, 2004)**. So this research paper aimed to:

1- Assess nurse's awareness about concept and forms of SH.
2- Identify occurrence of SH among the studied nurses.
3- Determine nurse's opinions about factors lead to SH and how to face it.
4- Investigate the effect of SH on psychiatric state of nurses (anxiety & depression) and on their work satisfaction

Subjects and methods

Design: - A descriptive a cross-sectional study design was used in this study.

Variables: - The independent variable in this study is (SH); the dependent variables are psychiatric state of nurses and staff nurses' job satisfaction.

Setting:-

The study was conducted at Shibin El-kom University Hospital in Menofiya Governorate, Egypt. The hospital serves all specialties.

ubjects:-

It consisted of 110 female staff nurses .They represent almost ten percent of the total nursing staff at the hospital.

Data collection tools:

Three tools were be used to collect data

Tool (1):- A structured questionnaire was designed by the researcher and consists of two parts. **a**) It was developed to assess the socio- demographic characteristics of studied nurses including:-1) age,2) unit of work, 3) educational qualification, 4) marital status, 5) residence, 6) appearance, 7) previous attendance of educational program about (SH).

b): Sexual harassment scale: It developed by **Sadik (2010)** and modified by the researcher to assess nurses' awareness about concept of harassment and forms, their opinions about factors leading to the sexual harassment. The concept of (SH) was assessed using 4 statements that define the act of (SH). The scale composed of 47 items divided into five sub items. (1) factors related to the nurse (12 items) such as appearance, behavior and attitude ,(2) family factors (9 items) such as family dysfunction and bad breeding (3) factors that attributed to the mass media(12 items) such as sexual program, delayed marriage and internet (4) economic factors (6 items) such as unemployment and poverty(5) Religious factors (8 items) such as poor religious education and instructions, no commitment to ethical and moral, norms and values. Also, the tool included 14 statement related to suggested ways to face the problem such as increase the ethical and moral awareness, criminalization of sexual harassment, and positive image of nurses in media.

Scoring system

The possible response for each item on a three point Likert scale (Yes=3 points / to some extent =2 points/ No=1 point). The scores of the items were computed into numbers and percentage. Scoring for nurses' awareness about concept of (SH)**,** if the nurse select 1 statement she will get 1 point (incomplete answer), if select 2 statements, she will get 2 points (in complete answer). If she select the statement (all of above), she will get 5 points as full mark (complete answer)

Tool (2):-Depression and anxiety scale for women: It was developed by **Rakhaway and Shaheen (1977)** and modified by the researcher **.**This scale includes 90 items divided between anxiety, depression and introversion. Items related to introversion and others were excluded from the scale. (a) Depression scale: - Questions from 1 to 16 to assess the depression state. It includes items as insomnia, anorexia, impatience, mistrust, weakness, lack of concentration and nervousness, (b) Anxiety scale: - Questions from 17 to 36 to assess the anxiety state. It includes items as nervousness, inability to solve problems, lack of concentration, nausea, diarrhea and headache.

Scoring system for depression: the possible response for each item was on a three Likert-point scale. The possible response for each item in the scale, the "never" = 1, "sometimes" = 2, "always" = 3.The total score ranged from 1 to 47. The scores of the items were summed –up and the total divided by the number of the items, giving a mean score, and means and standard deviations were computed.

Scoring system for anxiety:

Using a three Likert-point scale, the possible response for each item in the scale, the "never" = 1, "sometimes" = 2 and "always" = 3 .The total score ranged from 1 to 60. The scores of the items were summed –up and the total divided by the number of the items, giving a mean score, and means and standard deviations were computed.

Tool (3):-Occupational satisfaction scale: The scale was developed **Mith (2002)** to assess nurses work satisfaction. It consisted of 30 items presenting 5 domains based on Herzberge's two –factor theory as the following :-(a) The nature of the work (6 items) such as presence of chance for improvement and acquire new skills,(b) work environment (6 items) such as shared decision making and support from superiors ,(c) salary and benefits (5 items) such as salary is sufficient, (d) promotion(7items) such as chance for promotion and (e) supervision(7items) such as high qualified supervisor for training .

Scoring system for occupational satisfaction scale:- according to the possible response for each item in the scale ,the " yes " response was given a score of 3, "some times" response was given a score of 2 and "no" response was given a score of 1 . The total score ranged from 1 to 90. The scores of the items were summed –up and the total divided by the number of the items, giving a mean score, and means and standard deviations were computed.

Validity of the tool

The validity was measured for content validity by a pannel (jury) of experts in the field of community health nursing, nursing administration, a psychiatrist and sociology professor to ascertain relevance and completeness of the tool.

Reliability of the tool.

Reliability of the tools was done to determine the extent to which items in the tools are related to each other by Cronbach's alpha co-efficiency for tools (**α = 0.0**5). Pearson correlation co-efficiency was done to test the internal consistency (**r =0.02-0.98**) for all items of the tools.

Procedure

Before any attempt to collect data, an official approval to conduct the study was obtained from medical and nursing managers at the study setting. Formal Letters were issued from faculty of nursing, Menoufia University. The letter contained the title, aim of the study, and methods of data collection. Data collection procedures, analysis, and reporting of the finding were undertaken in a manner designed to protect confidentiality of subjects.

Ethical consideration

Before beginning data collection from the nurses. The researcher introduced herself to them, explained the objectives of the study, and informed them that their information will be confidential and will be used only for the purpose of the research. Additionally, each participant was notified about the right to accept or refuse to participate in the study. Their verbal consent was taken.

Data analysis plan

The data collected were tabulated & analyzed by SPSS version 16 on IBM compatible computer. Quantitative data were expressed as mean & standard deviation (X+SD) and analyzed by applying student t-test for comparison of two groups of normally distributed variables. The Mann-Whitney *U* test is used to test the difference between two independent groups when the dependent variable is measured on an ordinal scale. While qualitative data were expressed as number and percentage (No. & %) and analyzed by applying chi-square test. Fisher's exact test**,** To test the difference in proportions nominal and ordinal in a 2×2 contingency table when N=30 All these tests were used as tests of significance at P<0.05.

II. Results

Table 1. Distribution of Socio-demographic characteristics of studied nurses.

Socio-Demographic characteristics	No. of nurses (n=110)	Percent %
Age(years):		
• ≤ 20 years	92	83.6
• > 20 years	18	16.3
Mean ±SD **Range**	27.01 ± 6.76 42.00- 18.00	
The nature of working unit:		
Open units • -Gynecology • -Surgical department • -Medical department • -Emergency • -Oncology	 13 12 10 13 14	11.8 10.9 9.1 12.7 11.8
Closed units • -ICU. • -Hemodyalsis • -Operation room • -Pediatric ICU. • Renal dialysis unit	 12 14 14 8 22	10.9 12.7 12.7 7.3 16.7
Qualifications:		
• Bachelor of nursing	46	41.8
• Associated degree	24	21.9
• Diploma of nursing	88	36.3
Place of residence:		
• Urban	83	75.5
• Rural	27	24.5
Marital status:		
• Single	26	23.6
• Married	106	80.3
Attending Sexual health education :		
• Yes	4	3.6
• No	106	96.4
Total	**110**	100

Table 2. Relation between the Socio-Demographic characteristics of studied nurses and exposure to sexual harassment

Socio-Demographic characteristics	Reported exposure		χ^2 test	P value
	Present (n=96) No %	Absent (n=14) No %		
Age:				
• ≤ 20 years	84 87.5	8 57.1	6.16	0.01*
• > 20 years	12 12.5	6 42.9		
Unit of work:				
• Open units	50 52.1	12 85.7	4.33 #	0.03*
• Closed units	46 47.9	2 14.3		
Marital status:				
• Single	44 45.8	2 14.3	3.79 #	0.04*
• Married	52 54.2	12 85.7		
Residence:				
• Rural	85 88.5	6 42.9	14.79	< 0.001*
• Urban	11 11.5	8 57.1		
Qualifications:				
• -Bachelor Degree	30 31.3	2 14.3		
• -Associated degree	24 25	10 71.4	9.33	0.02*
• -Diploma	42 43.7	2 14.3		
Attending Sexual health education:				
• Yes	4 4.2	2 14.3	# 0.86	0.35
• No	92 95.8	12 85.7		

Fisher's exact test**,**
P value**:** *significance at P < 0.05**.**

Table 3:- Nurse's awareness about concept of sexual harassment (n=110)

Nurse's awareness about concept of sexual harassment :	No.	%
Concept of sexual harassment:		
• Complete answer	106	96.3
• Incomplete answer	4	3.7
Total score = 4): **Mean ±SD** **Range**	2.09 ±0.94 1.00 – 4.00	

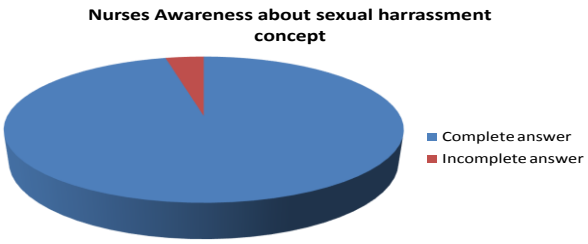

Figure 1: Nurse's awareness about concept of sexual harassment (n=110)

Table 4:- Nurses' distribution according to exposure to sexual harassment (occurrence or prevalence) (n=110)

Exposure to sexual harassment:	No.	%
• **Yes**	96	87.3
• **No**	14	12.7

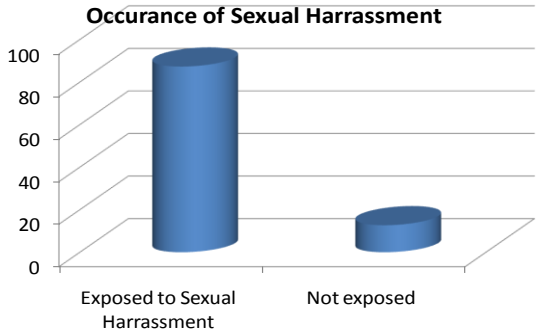

Figure 2: Nurses' distribution according to exposure to sexual harassment (occurrence or prevalence) (n=110)

Table 5. Distribution of verbal forms of sexual harassment and the harasser as reported by the studied nurses.

Verbal forms	From doctor (n=110)		From fellow (n=110)		From patient or his relatives (n=110)		χ^2 test	P value
	NO.	%	NO.	%	NO.	%		
Verbal comments:								
Yes	16	14.5	28	25.5	47	42.7	22.24	
No	94	85.5	82	74.5	63	57.3		< 0.001*
Sending Telephone message:								
Yes	11	10.0	10	9.1	20	18.2	5.07	0.07
No	99	90.0	100	90.9	90	81.8		
Talking sexy words:								
Yes	0	0.0	3	2.7	7	6.4	7.63	0.02*
No	110	100	107	97. 3	103	93.6		
Complement:								
Yes	44	40.0	29	26.4	42	38.1	5.31	0.07
No	66	60.0	81	73.6	68	61.9		
Say Sexy jokes:								
Yes	3	2.7	5	4.5	3	2.7	0.75	0.68
No	107	97.3	105	95.5	107	97.3		

P value: *significance at P<0.05.

Table 6: -Distribution of Non verbal forms of sexual harassment and the harasser as reported by the studied nurses.

Verbal forms	From doctor (n=110) NO.	%	From fellow (n=110) NO.	%	From patient or his relatives (n=110) NO.	%	χ^2 test	P value
Whistling:								
Yes	5	4.5	7	6.4	25	22.7	22.16	< 0.001*
No	105	95.5	103	93.6	85	77.3		
Dirty Sexy Look :								
Yes	31	28.2	38	34.5	57	51.8	13.94	< 0.001*
No	79	71.8	72	65.5	53	48.2		
Sending sex photos:								
Yes	0	0.0	0	0.0	0	0.0	___	____
No	110	100	110	100	110	100		
Waving:								
Yes	5	4.5	5	4.5	7	6.4	0.50	0.78
No	105	95.5	105	95.5	103	93.6		
Increasing working hours:								
Yes	3	2.7	10	9.1	3	2.7	6.44	0.04*
No	107	97.3	100	90.9	107	97.3		
Forced identification:								
Yes	10	9.1	17	15.5	23	20.9	5.99	< 0.001*
No	100	90.9	93	84.5	87	79.1		
Removal of clothes:								
Yes								
No	3	2.7	3	2.7	3	2.7	0.00	1.00
	107	97.3	107	97.3	107	97.3		
Stalking :								
Yes	3	2.7	3	2.7	3	2.7	0.00	1.00
No	107	97.3	107	97.3	107	97.3		
Touching your body:								
Yes								
No	11	10.0	3	2.7	0	0.0	14.47	< 0.001*
	99	90.0	107	97.3	110	100		

Table 7:- Frequencies distribution of the studied nurses by harasser person:-

Harasser person	Frequencies (n =480) No.	%
• From doctor	128	26.7
• From fellow	144	30.0
• From patient or his relatives	208	43.3

Note: Respondents could expose to more than one harasser.

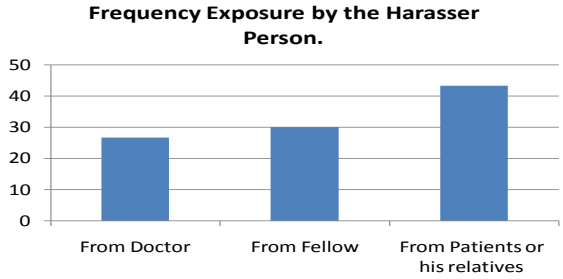

Figure 3: frequencies exposure of the studied nurses by harasser person

Table 8:- Distribution of suggested factors leading to sexual harassment as reported by the studied nurses (n=110):-

Factors leading to sexual harassment	Yes No	%	To some extent No	%	No No	%
• **Factors related the nurse**	67	60.9	14	12.7	29	26.4
• **Family factors** :	77	70.0	10	9.1	23	20.9
• **Factors due to the mass media**:	72	65.5	20	18.2	18	16.3
• **Economic factors**:	59	53.7	26	23.6	25	22.7
• **Moral and ethically factors**:	86	78.2	10	9.1	14	12.7

Table 7:- Distribution of the suggested ways as reported by the studied nurses to face harassment:

Nurses' strategies to face harassment	Yes No	%	To some extent No	%	No No	%
• Increase the moral and ethics awareness	104	94.5			6	5.5
• Criminalization of sexual harassment	98	89.1			12	10.9
• Positive image of nurses in media	96	87.3			14	12.7
• Policy develop	90	81.8	10	9.1	10	9.1
• Reduced communication with the harasser	102	92.7			8	7.3
• Awareness training about stopping the act	96	87.3			14	12.7
• Apply grievance procedures in hospital	96	87.3			14	12.7

. **Table 9. Distribution of Nurses' Occupational Health Outcome According to exposure to harassment** (n=110)**:-**

Nurses' Occupational health outcomes	Reported exposure		Mann-Whitney test	P value
	Exposed (96) group Mean ±SD	Not exposed (14) group Mean ±SD		
• **Anxiety**	41.27 ± 6.12	34.09 ±4.13	3.85	0.000*
• **Depression**	33.40 ± 4.44	30.09 ± 7.30	2.10	0.036*
• **Job satisfaction**	57.92 ± 12.55	70.85 ±15.56	2.70	0.007*

*significance at $P < 0.05$.

III. Discussion

In recent years, the problem of sexual harassment has gained increasing attention by researcher**.** Although both female and male nurses may experience sexual harassment, researches showed that female nurses are more likely to be sexually harassed. Moreover, women are more likely to expose to various forms of sexual harassment in different places as work place, educational institution and even in the street. The female nurses may experience many negative effects from sexual harassment such as psychological and physical effects **(Indian Centre for Equity and Inclusion, 2009).**

Therefore, the present study was conducted to assess nurses' awareness, occurrence, forms of sexual harassment, nurses' opinions about factors leading to harassment, how to face it, and identify the effects of harassment on psychological state of nurses (anxiety and depression) and on work` satisfaction against female nurses at Menofiya University Hospital.

According to the relation between socio-demographic characteristics and exposure to harassment. The results showed statistical significant relations between all socio-demographic variables except "attending sexual health education". Also, It can be noticed that the highest percentage of the exposed nurses to sexual harassment were in the age group ≤ 20. However, in contradiction with these results, on a comparative analysis of the United States and Japan **(Fitzgerald and Ormerod, (2003)** documented that more than one fifth from 20-25 years experienced sexual harassment. No specific group of women is prone to be victimized by the harasser **(Abou Zeid, and Somach, 2009).** This discrepancy could be because the harasser does not differentiate between categories of victims nor is he limited to a specific type of woman, whether a young girl or even a woman in old age, nor are victims limited to a specific social or economic class. All women can be victims of sexual harassment.

Regarding to the unit of the work, the exposure was high against nurses working at closed unit; these findings are in agreement with a number of previous studies **(Kasim et al., 2001, Ismail et al., 2007and Douki**

et al., 2007). Violence from patients to health professionals is a major workplace issue in mental health and psychiatry. It is generally known that nurses in certain clinical areas, as accident and emergency and psychiatry, encounter high levels of harassment **(Hassan et al., 2008)**

Contradictory, the findings of a study of 209 nurses employed in a large Australian metropolitan teaching hospital at psychiatry and emergency departments revealed that general wards were equally as hazardous as in specialized wards **(Bastian and Anita ,2005)**. Also, it was reported that nurses in all specialties, at all levels, in both public and private sectors are susceptible to violence in the form of harassment **(Terpstra et al., 1986).**

The results of the present study showed that exposure was high against single nurses and less against married. This finding was in accordance with **Mohamed (2000)** who reported that the married women able to recognize forms of sexual harassment than singles. This discrepancy may be because single woman ignore and deny the truth and fell ashamed to speak because of embarrassment.

Regarding the occurrence of sexual harassment, the current study showed that the majority of studied nurses reported exposure to sexual harassment. The result was in congruent with **Amin (2006)** who revealed that the majority of the studied nurses were exposed to sexual harassment. In the same vein, a study undertaken by **Jalal et al (2011)** on surveyed 1,000 Egyptian men and women in Cairo, Giza, and Qalubiya, the results showed that eighty three percent of Egyptian women reported being harassed.

International Labour Organisation (2004) reported that fourth three of the respondents reported having been sexually harassed during their nursing practice. Additionally, a field study conducted by **Ebada and Abu Douh (2007)** on female nurses in the Governorate of Sohag, revealed that more than half of the respondents were sexually harassed at work. On the other hand, it was reported that one fifth of working-women were subjected to sexual harassment in their work places. One fifth of young girls revealed their vulnerability to the same thing and 22.7% of children face the same matter, as well official reports and statistics showed that in 2002, 9580 ethical incidents included 997 crimes of harassment **(Douki et al., 2007)**.

Concerning the frequency of exposure from the same harasser person, the present study findings indicated that more than two fifths of the studied nurses reported their exposures to sexual harassment from patient or his relatives frequently, followed by fellows, then doctor. In agreement with the present findings **Farley (2009)** found that the most likely perpetrator of SH against female nurses to be patients followed by physicians (27 percent), work colleagues (13 percent) and visitors to the hospital (3 percent). Also, **Amin (2006)** indicated that nurses are more frequently subjected to sexual harassment from, patients or their family members, physicians, colleagues, and other healthcare professionals. Also, in a study of emergency department nurses (n = 55) revealed that the majority of participated nurses experienced physical assault by a patient at some time in their career within the preceding 12-month period **(Harvill, 2006)**

Likewise, it was indicated that nurses suffered at the hands of violent patients and visitors for a long time, and incidents are on the increase and reported that the most common perpetrators to nurses are other nurses **United Nations General Assembly (2006).** The literature pointed to nurses as major perpetrators of some forms of workplace violence to other nurses. **Brage (2003)** suggested that doctors were responsible for the workplace harassment they encountered. Also, about three fourth of female nurses as victims were subjected to unwanted behaviors by people they identified as coworkers or other employees.

Concerning the forms of sexual harassment, the current study showed that the most common verbal form reported by the studied nurses was from the doctor was complement (two fifth of the studied nurses), the most common forms from patients or his relatives were verbal comment (around two fifth of the studied nurses) and telephone message (approximately, one fifth of the studied nurses). The result was consistent with **Slackman (2008)** who reported that the high percent were form of verbal hazing and comments 70.6 % and the less common form was show sexy images 13.11%. Also**, Ellen (2009).** reported that the verbal hazing was the high percent of forms and sexually signal way low percent .On the opposite, this finding contradicted with **Ilahi (2008)** who reported that sexual remarks and employees pressuring coworkers for dates were the most frequently reported forms of sexual harassment.

Regarding the suggested factors leading to sexual harassment as reported by the studied nurses, the result of the current study showed that more than three fourth of nurses reported that the most common factors leading to sexual harassment were factors related to lack of ethics and moral, then family factors, factors due to the mass media. This result was in the same vein with **Bastian and Anita (2005)** who reported that the media play an important role in the spread of the phenomenon of sexual harassment where the multiplicity of forms of sexual harassment educated from the media, whether through sexual comments, sexual programs and jokes and use via e – mail and the internet.

Regarding the suggested ways to face sexual harassment, the most common way as reported by the studied nurses were improve moral and ethics, then develop policy in the hospital, the less common suggested ways was reduced communication with the harasser. The present finding was in the same line with those found that the majority of the nurses agreed with good religious education, followed by giving courses to increase awareness of this phenomenon **Laxman, Mohamed, and Heng (2003)**.

This could mean that prevention is the best tool to eliminate harassment in the workplace. Employers are encouraged to take appropriate steps to prevent and correct unlawful harassment. They should clearly communicate to employees that unwelcome harassing conduct will not be tolerated. They can do this by establishing an effective complaint or grievance process, providing anti-harassment training to their managers and employees, and taking immediate and appropriate action when an employee complains **(The E C W R ,2007)**

Moreover, the importance of spreading awareness of the concept of sexual harassment and the need to intensify the studies and research on this phenomenon. As recommended by **Amin (2006**) to increase the moral and ethical awareness and sticking to the values, culture, and principles in the society. This finding is in accordance with **Farley(2009).** who mentioned that good moral and ethical education and raising awareness among citizens was the very important point that should be stressed to reduce this phenomenon.

Likewise, it was reported by **Hassan et al., (2008)** that establish and publicize policies, provide training for all employees, publicize penalties that can be imposed, publicize complaint channels and enforce strong penalties were mechanisms to face (SH)**. The E C W R (2007)** reported that of the 2,500 women who had cases of sexual harassment, only ten percent had made a complaint to the police, formal responses, such as filing grievances or discrimination complaints were rare. Only about six percent of respondents who had experienced sexually harassing behaviors indicated that they took formal action in response to the harassment.

Approximately two - fifths of the victims who said in the 1994 survey that they had ignored the behavior or done nothing about it, only one fifth of the studied nurses reported that this had made things better actions stood out as likely to be the most effective in stopping harassing behaviors. In the same vein **Alderman (2007)** mentioned that more assertive actions is asking or telling the person to stop, then reporting the behavior, filing a formal complaint, threatening to tell or telling others, avoiding the person, ignoring the behavior, one of the more assertive responses available to employees who experience harassment is that of taking some type of formal action. But not many victims actually do this.

Regarding to psychological impact of sexual harassment, the present study showed a statistical significant increase mean depression and anxiety score among exposed nurse. Also, work satisfaction was higher among non exposed nurses. The current results were on the same line with **Perera (2008)** who reached to the presence of raised negative psychological impact for women as a result of sexual harassment, including shock, depression, lack of self-esteem and lack of psychological satisfaction of the sexual and other psychological effects. The aftermath of sexual harassment is an emotional time, with emotions such as anger, demoralization, feelings of vulnerability and a negatively changed attitude to work were also reported, as was impaired work performance.

This result indicated that the sexual harassment is offensive, illegal and unacceptable behavior against the women lead to all of negative and bad effects. The result was in agreement with **Adams (2007)** who reported that nurses who had experienced one or more form of harassment in the last year reported significantly lower levels of job satisfaction at the time of response than nurses who were not exposed. Additionally they had higher scores on the propensity to leave scale, showing that they were more likely to contemplate leaving than nurses who were not exposed. They were significantly more likely to suffer clinical levels of anxiety as measured by the cut-off point of the Hospital Anxiety and Depression Scale.

Similarly, **Sabitha (2009)** found that there is a strong relationship between sexual harassment of girls and between the occurrences of some variables of psychological, such as a sense of shame, anger, feeling of guilt and self blaming, depression, anxiety, low self esteem and disgrace of objection silent.

Results

Figure 1 presents the distribution of the studied nurses' awareness about sexual harassment. it is clear from the figure that the majority of nurses (96.3 %) gave complete definition about the concept of sexual harassment.

Figure 2 illustrates the distribution of the studied nurses according to their exposure to sexual harassment as reported. As evident from the figure, most of nurses (87.3%) report episode of sexual harassment.

Figure 3 show the distribution of studied nurses as exposed to sexual harassment by harasser as reported .The table reveals that nurses exposed more frequently from patient or his relatives (43.3%) then from fellow (30.0%) lastly from doctor (26.7%).

Table 1 presents socio-demographic characteristics of the studied nurses. The table reveals that the majority (83.6%) of nurses are less than 20 years, (Mean ±SD 27.01 ± 6.76). Also, 41.8% of the studied nurses have Bachelor degree. In addition (75.5%) live in rural area. Eighty percent are married. Most of the studied nurses (96.4%) did not attend (SH) course.

Table 3 show the distribution of verbal forms of sexual harassment and the harasser as reported by the studied nurses. As evident from the table, the most common form that the studied nurses reported was complement from doctor (40%) followed by patient or his relatives(38.1%) then fellow(26.4%). Also, there was statistical significant relation between verbal comments and talking sexy as verbal forms and the same harasser.

Table 4 displays the distribution of nonverbal (behavioral) forms of sexual harassment and the harasser as reported by the studied nurses. The table demonstrates, whistling, dirty sexy look and forced identification were highly reported by studied nurses from patient or his relatives then from fellow, lastly from doctor respectively. .Additionally, the table indicates statistically significant relation between all the harassers and these forms where p value < 0.001

Table 5 describes the factors leading to sexual harassment as reported by studied nurses. As evident from the table, the studied nurses reported that the most common factor leading to sexual harassment was related to religious factors (78.2 %), family factors (70 %), factors related to the mass media (65.5 %), and economic factors (54.7%).

Table 6 presents suggested mechanism as reported by studied nurses to face sexual harassment. It is clear from the table that, the most common suggested way reported by the studied nurses was a "increase religious awareness" (94.5%), then policy development (92.7%), and criminalization (89.1%). Conversely; awareness training to stop the act is the least common suggested way (81.1%).

Table 7 displays nurses' occupational health outcomes according to the exposure to sexual harassment. It points statistical significance relation between exposure to harassment and anxiety, depression and work satisfaction where, P- value (0.000-0.036 and- 0.007 respectively).

IV. Conclusion

In the light of the study findings, it can be concluded that the majority of the studied nurses exposed to SH and more than two- fifths of the studied nurses were perpetrated by patient or his relatives. Also, the most common suggested way to face SH as reported by the studied nurses was an "increase ethical and moral awareness". SH has negative impact on psychological state of nurses as depression and anxiety then work satisfaction

Recommendation

- Further researches aimed at reducing the occurrence of sexual harassment.
- The need to develop training sessions on how to face sexual harassment.
- A suitable reporting mechanism to be established in workplace.
- Introduction of procedures, policies and practices to alleviate workplace sexual harassment

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