Sexual harassment of male osteopaths in the workplace: Evidence and effect.

Sexual harassment of male osteopaths in the workplace: Evidence and effect.

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This thesis is submitted as part fulfillment for the degree M.H.Sc (Osteo)

2005

KEYWORDS

Osteopath, sexual harassment, gender harassment, unwanted sexual attention, sexual coercion

ABSTRACT

The aim of this research was to investigate the form, frequency and effect of sexual harassment affecting male osteopaths; to explore education received in dealing with these incidents, and to compare the frequency and impact of any form of sexual harassment effecting male and female osteopaths.

A questionnaire, based on the Female Osteopaths Questionnaire (Willy 2003), was distributed to 288 male osteopaths in Australia. The response rate was 107 (37%).

Eighty percent (80%) of respondents reported having been sexually harassed in some way during their osteopathic career. The most common form of sexual harassment experienced by the respondents was discussion of personal/sex life (73%). Of those who reported sexual harassment, 80% experienced effects on their professional life and 51% experienced effects on their private life. Seventy nine percent (79%) of respondents felt that it is important to incorporate sexual harassment education into osteopathic training courses.

Sexual harassment affects male osteopaths in practice as commonly as female osteopaths. The osteopathic profession, and other health-care professions, should begin to, or continue to, incorporate sexual harassment education for students and practitioners into their curricula.

INTRODUCTION

Interest in the sexual harassment of men has increased as both researchers, and popular media, have challenged the exclusive focus on females in discussion of this topic (Waldo et al. 1998). Although sexual harassment of females, particularly in the health care industry, has been well documented, there is little research focusing on the sexual harassment of males.

A legal definition of sexual harassment accepted by the Australian Human Rights and Equal Opportunity Commission is 'unwelcome sexual conduct which makes a person feel offended, humiliated and/or intimidated where that reaction is reasonable in the circumstances' (Australian Human Rights and Equal Opportunities Commission 2002). Personal distinctions can be 'drawn between sexual advances that are invited, uninvited but welcome, offensive but tolerated, and flatly rejected' (Langslow 1996). By definition, sexual harassment does not include sexual interaction, flirtation, attraction or friendship that is invited, mutual, consensual or reciprocated, and it may vary according to individuals and circumstances. Sexual harassment, as defined above, is a legally recognised form of sex discrimination that is unlawful under the Sex Discrimination Act.

Three major categories of sexual harassment have been identified by O'Hare and O'Donohue (1998). *Gender harassment* is the least severe form and generally involves behaviours that convey degrading and hostile attitudes. Examples include offensive jokes, sexual remarks, suggestive looks and suggestive gestures. *Unwanted sexual attention* is the next level of sexual harassment and involves verbal and nonverbal behaviours that

create an intimidating, hostile and offensive environment. Examples include discussion of personal or sex life, pressure for dates, suggestive exposure of body parts, brushing, grabbing and inappropriate touching. The third and most severe form of sexual harassment is *sexual coercion*. Sexual coercion involves attempting to force sexual compliance and examples include, unwanted attempts for sex, bribery or threats for sexual cooperation and mistreatment for not cooperating sexually (O'Hare & O'Donohue 1998).

A number of studies have found that men and women differ in their perceptions of what is, and what is not, sexual harassment (Lengnich-Hall 1995, Madison & Minichiello 2001). Careful consideration of the responses from men has given rise to an additional and previously unidentified component of *gender harassment,* namely enforcement of the traditional heterosexual male gender role. Participants identified examples of this form of gender harassment as ridiculing men for acting too femininely and pressuring men to engage in stereotypical forms of 'masculine' behavior (Waldo et al. 1998).

Numerous researchers have identified a higher incidence of sexual harassment in health care professions, when compared to other professions (Madison & Minichiello 2001, McComas et al. 1993, deMayo 1997). It has been proposed that the nature of health care practice contributes to a greater occurrence of sexual harassment. Factors identified included the close working proximity, frequent touching of patients and close interpersonal relationships that exist between patients and many health care practitioners, which predispose the latter to increased levels of sexual harassment (McComas et al.

1993). When researching specifically on physical therapists, the increased level of sexual harassment reported by them was related to the many elements of physical therapy treatment that require close physical contact (deMayo 1997). Asking a patient to disrobe, for example, may have the potential to stimulate sexual feelings and associated behaviours in patients (deMayo 1997). These examples, as well as manipulative techniques that require intimate, hug-like positions between patient and practitioner, are common to osteopathic practice and may potentially contribute to a higher risk of sexual harassment experienced among osteopaths.

The health care practitioner may experience an array of outcomes as a result of sexual harassment that are extensive and specific to the circumstances. Physical and psychological repercussions of sexual harassment reportedly include irritability, anxiety, tension, depression, deterioration of personal relationships, hostility, sleeplessness, fatigue, headaches, gastrointestinal disorders, weight loss/gain and sexual dysfunction (Forster 1992).

In a study of Australian female osteopaths, of the 102 respondents, 88 (86%) reported having experienced some form of sexual harassment in the course of their career (Willy 2003). Gender harassment was the most common type of behaviour reported, with 75% of respondents reporting this behaviour. Sexual remarks and suggestive looks the most common specific examples of sexual harassment experienced. Although the literature investigating harassment of male health care practitioners is limited, in a study of nurses and nursing students of both sexes, 90% of respondents reported at least one type of

sexual harassment (Bronner et al. 2003). While females reported significantly more experience with mild and moderate forms of sexual harassment than men, 35% of male participants (in comparison to 26% of female participants) experienced severe types of harassment (Bronner et al. 2003).

A relevant study used a differently worded, more accessible form of questioning, namely inappropriate patient sexual behaviour (IPSB), to investigate experiences of physical therapy students and physical therapists. This term IPSB subdivided patient behaviour into the categories of mild, moderate and severe. These categories correspond very closely to gender harassment, unwanted sexual attention and sexual coercion, respectively. McComas et al. (1993) found that IPSB affected both male and female participants, with 83.1% of female participants and 56.3% of male participants reporting experiences of IPSB.

In a United States of America study of physical therapists, 86% of participants reported having experienced at least one type of sexually related patient behaviour, and 63.4% reported being sexually harassed by a patient (deMayo 1997). The researcher considered that the difference in these two figures indicates that therapists do not equate all sexually related patient behaviours as harassment, but rather consider the intrusiveness and context of the event in a psychologically flexible manner (deMayo 1997).

An important aspect of this study investigating male osteopaths is to differentiate between incidents of sexual harassment and incidents that may be sexual in nature, but

are not regarded by the practitioner to be harassment. This distinction is essential to make to allow us to learn how practitioners define the difference and respond to such incidents. Such information can then be used in an educational setting to pass on knowledge and awareness to future and present male osteopaths.

Previous research into male sexual harassment includes three contiguous studies investigating sexual harassment of men in various occupations, but none was in a health care industry. Overall analysis of this research identified that 2% reported having experienced sexual coercion, 11.5-29% reported unwanted sexual attention and 37-44.1% reported experiencing gender harassment. For all types of harassment, and in all three samples, men reported that other men were more likely to target them for sexual harassment (Waldo et al 1998). Research conducted by the United States Merit Systems Protection Board (1995) investigated sexual harassment in the federal workplace. It was found that when males were the subjects of sexual harassment, 65% of the perpetrators were female, 21% were male and 14% were identified both male and female. It is important to identify the gender of the person responsible for the sexual harassment as this may have implications for the type of harassment experienced and optimum educational responses to harassment.

Sexual harassment is detrimental to the health care practitioner-patient relationship and if the practitioner is not prepared for it, or assisted in learning how to deal with the situation, could lead to less than effective health care (White 2000). Information obtained from this current study will provide an indication of the extent of the behaviour, the

severity and impact of it on male osteopaths, and may offer suggestions for more effective educational responses.

AIMS

- To investigate the form and frequency of sexual harassment affecting male osteopaths.
- To investigate the effect of sexual harassment on the personal and professional lives of male osteopaths.
- To explore the views of male osteopaths about the education they received in dealing with these incidents of sexual harassment.

METHOD

Subjects and Procedure

In February 2005, an introductory letter and three-page questionnaire titled "Male Osteopaths Questionnaire" was mailed to 288 male osteopaths practicing in Australia. The addresses were obtained from the Yellow Pages online directory.

The potential participants were requested to complete and return the questionnaire. The introductory letter informed potential participants of the aims of the study, the potential risks and benefits associated with participation and that the study was anonymous. The questionnaire and research project had received the approval of the Victorian University Ethics Committee.

Instrument

The Male Osteopaths Questionnaire was based on the Female Osteopaths Questionnaire developed by Willy (2003). The original questionnaire included questions relating to evidence and frequency of sexual harassment, impact of sexual harassment on professional and private life and tactics to reduce the incidence of sexual harassment. Minor adjustments were made to increase the relevance to the current study. These included questions regarding demographics, education, gender of offending patients and incidents of inappropriate patient sexual behaviour. The questionnaire was piloted on three male osteopaths, who were excluded from the subsequent study. At no time were respondents asked to identify themselves, to maintain anonymity.

The questionnaire provided participants with definitions of sexual harassment, inappropriate patient sexual behaviour and gender harassment. Information was sought relating to age, years of experience, place of osteopathic education, views relating to sexual harassment education and training, type and frequency of sexual harassment occurring, impact of sexual harassment on professional and private life and gender of patients responsible for sexual harassment.

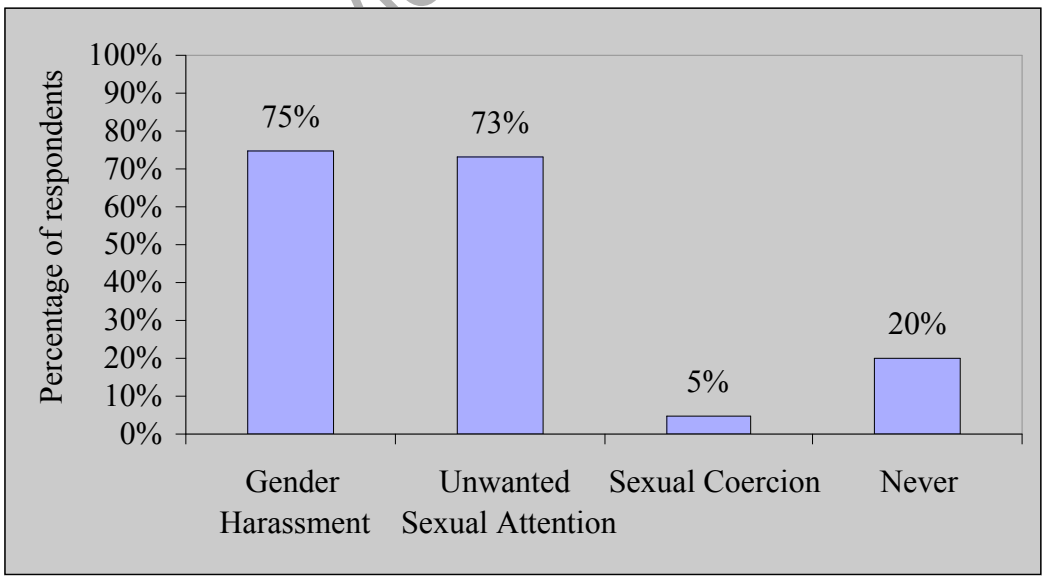
RESULTS

Two hundred and eighty-eight male osteopaths were mailed questionnaires, 107 (37%) responded.

Type of Harassment

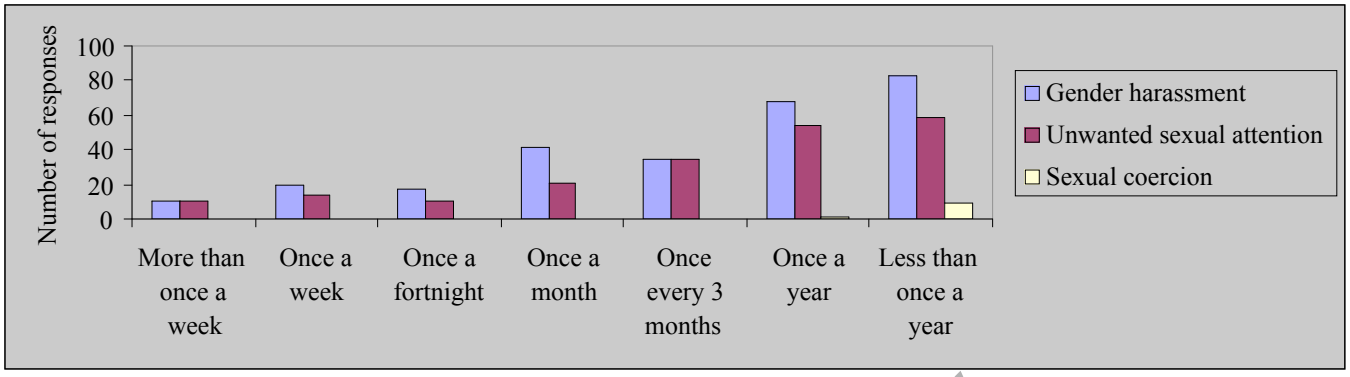
Of the 107 respondents, 86 (80%) reported having been sexually harassed at some stage during their osteopathic career. Using the categories of sexual harassment as defined above, Figure 1 demonstrates that Gender Harassment is the most common form of sexual harassment affecting male osteopaths (75%). Unwanted Sexual Attention follows closely as the second most common form of sexual harassment (73%). The most severe category of sexual harassment, Sexual Coercion, was experienced by 5% of respondents. Twenty percent (20%) of respondents have never experienced any forms of sexual harassment.

Figure 1: Percentage of respondents that have experienced each category of sexual harassment.



There were fewer reports of the greater severity of sexual harassment, sexual coercion (figure 2). The category of gender harassment was reported most frequently.

Figure 2: The frequency of each category of sexual harassment.



The most common form of sexual harassment experienced by the respondents was discussion of personal/sex life (73%), which is included in the category of unwanted sexual attention. Other common forms of sexual harassment experienced are encompassed in the category of gender harassment, and include offensive jokes (68%) and sexual remarks (65%). The more severe forms of sexual harassment were experienced less commonly, with 2% of respondents having experienced being mistreated for refusing to cooperate sexually and 4% having experienced threats for not cooperating sexually and unwanted attempts for sex that resulted in struggling (table 1).

Table 1: The occurrence of specific categories and behaviours associated with sexual harassment.

Category	Behaviour	% of
Gender Harassment	Offensive jokes	68
	Sexual remarks	65
	Suggestive gestures	55
	Suggestive looks	51
	Sexist behaviour	33
Unwanted Sexual Attention	Discussion of personal/sex life	73
	Suggestive exposure of body parts	52
	Brushing, grabbing or inappropriate touching	36
	Pressure for dates despite discouragement	34
Sexual Coercion	Unwanted attempts for sex that resulted in struggling	4
	Threats for not cooperating sexually	4
	Being mistreated for refusing to cooperate sexually	2

Impact on Professional and Private Life

The responses to open-ended questions regarding the impact of experiences of sexual harassment on professional and private lives were analysed and classified according to commonly arising themes. The percentage of responses for each theme was calculated to allow comparison of the frequency of each theme.

Of the 84 responses to the effect of sexual harassment on professional life, the most common outcome was that respondents identified a need for reflection following the incident (24%). Twenty percent (20%) of respondents stated that their experiences had no effect on their professional life and 18% commented that that their experiences had an impact on their patients and future treatments. Other common outcomes were emotional responses to the incident (14%) and modification of future behaviours (12%) (Table 2).

Table 2: Impact of sexual harassment on professional life.

Impact on Professional Life: Most common responses	% of responses
Need for reflection following incident	24
No effect	20
Impact on patients and future treatments	18
Emotional response to incident	14
Modification of future behaviours	12
Part of the job/OK if related to patients physical presenting complaint	8
Seek external assistance	4

Of the 48 responses to the impact of sexual harassment on private life, 49% experienced no effect. Twelve percent (12%) of respondents experienced an emotional response to the incident, 12% stated that they kept work and private life separate and 12% would debrief with other people following these incidents (Table 3).

Table 3: Impact of sexual harassment on private life.

Impact on Private Life: Most common responses	% of responses
No effect	49
Emotional response to incident	12
Keep work and private life separate	12
Debrief with others (e.g. Wife, partner, work colleagues)	12
Effect on personal relationships	9
Spark topic of conversation	6

Gender Analysis

When questioned regarding the gender of patients responsible for the sexually harassing behaviour, 52% reported female patients and 9% reported mainly female patients. Thirty four percent (34%) of respondents indicated that both males and females were responsible. Four percent (4%) of respondents indicated that male patients were responsible for sexually harassing behaviour and 1% indicated mainly males.

Education and Training

Eighty five percent (85%) of respondents received their osteopathic training at Australian institutions. A further 14% of respondents received their osteopathic training at non-Australian institutions. One percent (1%) was unspecified.

Thirty-two percent (32%) of respondents reported receiving some training in dealing with incidents of sexual harassment during their osteopathic education. Twenty one (21%) of respondents reported receiving some training in dealing with sexual harassment during their career as an osteopath. Seventy nine percent (79%) of respondents felt that it is important to incorporate sexual harassment education into osteopathic training courses. One practitioner felt that 'osteopaths need not only sexual harassment education, but also education on healthy boundaries'. Another respondent felt that it is important to incorporate such education into osteopathic training courses, and suggested that it also include other religious and political views. He provided the example that 'sexual harassment may be different for a Muslim compared to a Christian'.

DISCUSSION

Of the 37% of male osteopaths that responded to the questionnaire, 80% have had at least one experience with sexual harassment during their career. The work performed by an osteopath with their patients has the potential to remove completely, or at least significantly reduce, the social constraints that may apply to everyday interactions between people. The implications of this are that patients, both female and male, may develop feelings, and pursue actions, that result in increased risks of male osteopaths experiencing sexual harassment. In research based on physical therapists, deMayo (1997) and McComas et al (1993) identified that the particular demands of a physical therapist's role offer an increased opportunity for incidents of sexual harassment to occur. Examples of such demands include the close working proximity, frequent touching of patients and close interpersonal relationships that exist between patients and many health care practitioners. These particular examples are often part of an osteopathic consultation and may contribute towards the high incidence of sexual harassment experienced by male osteopaths.

Gender harassment was the most common form of sexual harassment experienced, with 75% of respondents reporting this behaviour. Unwanted sexual attention was experienced by a similar number of respondents with 'discussion of personal/sex life' the most common example of sexually harassing behaviour reported. In osteopathic practice, it is not uncommon for patients to present with complaints that are related to, or aggravated by, their personal/sex life. It is the interpretation of the practitioner that determines whether these discussions are appropriate or cross the boundaries of sexual harassment. A

number of respondents made side notes on the questionnaire that indicated that 'discussion of personal/sex life is unoffensive if related to the patients' condition'.

An additional component of sexual harassment was incorporated into the current study, specifically sexist behaviour in the form of enforcement of the traditional heterosexual male gender role. This previously unidentified component of gender harassment was first noted by Waldo et al. (1998) and was defined to participants in the current study as 'sexist remarks or behaviour that are based on stereotypes of the sexes'. Sexist behaviour is an important component of sexual harassment of males and may identify a facet of sexual harassment that is otherwise neglected in studies that focus more exclusively on female recipients of sexual harassment. Although 33% of respondents indicated experiences with sexist behaviour, none made specific reference to this form of sexual harassment when describing the impact of sexual harassment. From this information, it can be postulated that sexist behaviour is not a major area of concern for male osteopaths but one worthy of future consideration.

In the current study, respondents were asked to detail the effect of sexual harassment on their professional and private lives, however, it is important to remember that the boundaries between professional and private life are not always clear and easily separated. Of those respondents who answered in the affirmative to experiences of sexual harassment whilst practising as an osteopath, 80% had experienced effects on their professional life as compared to 51% who had experienced effects on their private life.

The most common effect of sexual harassment on professional life was that respondents described a need for reflection following the incident. These responses indicate that some male osteopaths have the need to contemplate and reassess their actions and communication skills following incidents of sexual harassment. The ability to acknowledge and identify incidents of sexual harassment is important to allow practitioners to alter their future behaviour to decrease the likelihood of such incidents. Some examples of typical responses included improvement of communication skills by rehearsing responses, and emphasising the importance of clarity of language. Respondents identified an 'increased awareness of [their] responsibility as an osteopath to be professional and ethical [in order] to decrease the incidence of misinterpretation of cues' and the 'necessity of defining and maintaining boundaries'. One respondent expressed awareness that he may have been 'inadvertently leading on or encouraging patients'.

A number of respondents identified constructive actions to modify their behaviour to decrease the occurrence of future incidents. These included increased use of towels to drape patients, asking the patient to remove as few clothes as possible, displays of family photos, use of an observer during treatment and ensuring that they are not left alone in the clinic. Personal experience is a major factor that contributes to the ability of male osteopaths to identify and implement these modifications of future behaviour. Nevertheless, education can assist inexperienced male osteopaths in recognising the possibility of such incidents and constructing effective measures to decrease and prevent the future likelihood of sexual harassment from occurring.

The psychological and economic effect of sexual harassment becomes evident when considering the respondents who had experienced enduring impacts of sexual harassment on subsequent patients and treatments. A number of respondents commented that their experiences with sexual harassment had resulted in them thinking, acting and dealing differently with other patients seen after the event. Some respondents identified that patients may cease further treatment following such incidents of sexual harassment and other practitioners refused to treat the patients in the future, both of which have potential economic consequences.

Forty nine percent (49%) of respondents stated that there was no effect on their private life. A number of respondents indicated an ability to disconnect from events that occurred at work. Others responded that they would discuss events with fellow osteopaths or their wife/partner. The ability to switch off, or openly discuss incidents of sexual harassment that respondents are exposed to, are important mechanisms that male osteopaths can use to dissociate events that occur at work from their private life. This can have the overall benefit of decreasing the stressfulness of these events and assisting the osteopath to maintain objectivity about these incidents.

The data obtained from this study indicates that 20% of respondents have never experienced sexual harassment while up to 49% of respondents stated that they experienced no effect from any incidents that have occurred. At the other extreme, however, the more severe outcomes that respondents provided included being 'unable to treat patients to their full potential', seeking the 'assistance of a psychologist', seeking

legal assistance, 'pressure on marriage' and 'feelings of loneliness and mild depression'. While these situations were much less common, their severity indicates that sexual harassment of male osteopaths is an important topic that is worthy of consideration and action.

The response rate of the current study (37%) is similar to the 42% response rate achieved in research investigating sexual harassment of female osteopaths (Willy 2003). In Willy's study, 86% of female osteopaths reported at least one experience of sexual harassment, as compared to 80% of male osteopaths. The forms of sexual harassment that male and female osteopaths experienced are also very similar. Gender harassment was the most common category of sexual harassment experienced in both studies, followed by the similarly common unwanted sexual attention and much less common sexual coercion. Interestingly, the most common behaviours experienced by female osteopaths were sexual remarks and suggestive looks and the most common behaviours experienced by male osteopaths were discussion of personal/sex life and offensive jokes. The similarity of data in regards to the frequency and type of sexual harassment that male and female osteopaths are experiencing indicates it is equally important for both genders to receive education on this topic. The evidence also indicates that it is unnecessary to alter the education provided to males and females and that both genders can be educated using the same methods.

Other studies that have investigated sexual harassment of health care professionals provide a basis of comparison with the current study, although data investigating sexual

harassment specifically of male health care professionals is lacking. McComas (1993) found that inappropriate patient sexual behaviour (IPSB) affected both male and female physical therapists, with 83.1% of female participants and 56.3% of male participants reporting experiences with IPSB. In a different study, 86% of male and female physical therapists and physical therapy students had experienced at least one type of sexually related patient behaviour (deMayo 1997). In the latter study, the relationship between personal characteristics (age, gender, etc) and experiences of sexual harassment were investigated. It was found that harassment experiences were not limited to a particular group of therapists, such as young women, and gender was not a powerful predictor of sexual harassment. These statistics further reinforce the importance of incorporating males into research regarding sexual harassment, particularly males who are employed in the health care profession.

Female patients were most commonly responsible for the sexual harassment of male osteopaths (52%). Thirty four percent (34%) of respondents indicated that they had experienced sexual harassment from both male and female patients. Research performed in other workplace environments has found similar results. Research conducted by the United States Merit Systems Protection Board (1995) investigated sexual harassment in the federal workplace. It was found that when males were the subjects of sexual harassment, 65% of the perpetrators were female and 21% were male. Fourteen (14%) of respondents had experienced separate incidents of sexual harassment from male and female patients. In a number of workplace environments, Waldo et al. (1998) found that men were the more likely harassers in the sexual harassment of other men. It is important

for health care practitioners to be aware and prepared for the possibility that sexual harassment may originate from consultation of both female and male patients.

Whilst a number of respondents had received education regarding sexual harassment during their university training or since commencing practice, 79% of respondents believed that it is important to incorporate sexual harassment education into osteopathic training courses. It is necessary to keep in mind that osteopathic education institutes are currently placing a greater emphasis on the subject of sexual harassment. Those practitioners who haven't received any sexual harassment education may have been trained in years prior to institutions identifying a need for sexual harassment education.

In a study of physical therapists, McComas et al. (1993) identified that 'health care workers are often not prepared for the possibility of harassment by patients and react in a manner that increases the likelihood of such behaviour recurring'. This current study demonstrates that male osteopaths have the ability to differentiate between problematic sexual harassment behaviours and non-offensive patient sexual behaviour. For the latter, the impact of incidents is minimal. However, those respondents who report experiencing more flagrant sexual behaviours do need assistance in dealing with these incidents in order to respond in an appropriate manner and one that will decrease future occurrences. In research of female osteopaths, Willy (2003) made the comment that education can restore the power of the practitioner, as well as validate and depersonalise the experience for these future practitioners, and the same applies here.

It is necessary to consider the possibility that the response rate of 37% skewed the results. A limitation of this study may be that the 63% of practitioners who did not respond to the questionnaire have never experienced sexual harassment, or that perhaps some of these practitioners had experienced sexual harassment but did not feel comfortable in raising these issues again, or an indefinable mixture of the two. A further limitation was identified in relation to the question regarding importance of sexual harassment education in osteopathic education courses. This question may have been worded in a loaded manner, and may have encouraged participants to respond in the affirmative because they felt it was the 'correct' response to the question.

A possible suggestion for future study may involve a combined, comparative study using the data obtained from the current study investigating sexual harassment of male osteopaths and the data obtained from Willy's study investigating sexual harassment of female osteopaths.

CONCLUSION

This study demonstrates that sexual harassment of male osteopaths in practice is prevalent. The frequency, type and potentially serious outcomes of sexual harassment affecting male osteopathic practitioners, which have been identified in this study, may raise the awareness of current and future male osteopaths to these potential issues. This research provides additional information which can be incorporated into comprehensive osteopathic educational programs.

Note: The 'Guide for Authors' for the Manual Therapy journal requires that tables/figures be printed on a separate sheet, double spaced and without horizontal lines. For ease of readership and to save paper, this criteria will not be fulfilled for marking purposes. It will be fulfilled for submission of article to the journal.

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APPENDIX A

INFORMATION TO PARTICIPANTS FORM

My name is Melissa Stone and I am currently undertaking a Masters in Osteopathy at Victoria University in Melbourne. My Masters' study is titled "Sexual harassment of male osteopaths in the workplace: evidence and impact".

At present, some research exists that indicates that health care practitioners are experiencing a high rate of inappropriate sexual behaviour and sexual harassment from patients. There is a lack of substantial research conducted to investigate sexual harassment affecting manual therapy practitioners, particularly male practitioners, even though available literature indicates that males are commonly experiencing these events.

The aims of this study are:

- To investigate the forms and frequency of inappropriate sexual behaviour and sexual harassment from patients, affecting male osteopaths
- To investigate the impact of inappropriate sexual behaviour and sexual harassment on the personal and professional lives of male osteopaths.
- To explore the views of male osteopaths on education received in dealing with these incidents.

To explore these issues, a questionnaire entitled the 'Male Osteopath Questionnaire', has been developed and can be found attached to this letter. It would be greatly appreciated if you could answer this brief questionnaire and return it to me. Return of a completed questionnaire indicates consent to become a participant in this study. All information obtained is completely anonymous and confidential, as there is no requirement to identify yourself at any time throughout the questionnaire.

Gaining insight into this area will be of benefit to both the osteopathic profession and the educational institutions responsible for the education of osteopathic graduates. Information obtained from this study will be used to shed light on this area and identify if a need exists to incorporate education for students into university courses regarding the appropriate prevention and handling of incidents of patient sexual behaviour and sexual harassment.

Potential psychological risks associated with participation in this study may result in feelings of anxiety and stress in participants that have experienced incidents of sexual harassment in the past. In the event that you experience any anxiety or stress during the completion of this questionnaire, please contact Dr Mark Andersen on Ph. 99195413 who will be available to provide counselling and support.

The following terms define sexual harassment, inappropriate patient sexual behaviour and gender harassment. Please keep these definitions in mind when answering the questionnaire.

- Sexual harassment: To constitute sexual harassment, the conduct has to be unwelcome. Conduct becomes unwelcome when it is not invited or solicited and when the person regards the conduct as undesirable or offensive.
- Inappropriate sexual behaviour: Behaviour on the part of the patient that, whilst not being deemed sexually harassing by the practitioner, can be classified as sexual. May include requests for dates, sexual comments, etc.
- Gender harassment: Sexist remarks or behaviour that are based on stereotypes of the sexes. Biased behaviour that intends to demean a gender.

Your participation is vital to this study. Even if you have never experienced any incidents of patient sexual behaviour or sexual harassment, your answers will assist in providing the most accurate information available. A self-addressed and stamped envelope has been included to assist in speedy return of the completed questionnaire. Thank-you in anticipation for your time and effort.

Any queries about your participation in this project may be directed to the researcher (Name: Melissa Stone: Ph. 92481111). If you have any queries or complaints about the way you have been treated, you may contact the Secretary, University Human Research Ethics Committee, Victoria University of Technology, PO Box 14428 MCMC, Melbourne, 8001 (telephone no: 03-9688 4710).

If you would like more information on the anti-discrimination policy and procedures, please contact the:

Australian Osteopathic Association
Federal Office
PO Box 5044
CHATSWOOD WEST NSW 1515
Ph: 1800 4 OSTEO Fax: 61 2 9410 1699
If calling from overseas phone 61 2 9410 0099
Email: **aoa@osteopathic.com.au**

APPENDIX B

Section 1: Please complete all questions.

1. Age: …….
2. Years of practise: …….
3. Location of practice (Rural or Metro, and State) :…….
4. Osteopathic training institution: …….

5. Using the previously defined terminology, have you ever experienced: (please tick)
   a) Sexual harassment from a patient? ☐ YES ☐ NO
   b) Inappropriate sexual behaviour from a patient? ☐ YES ☐ NO

6. Have you received any training in dealing effectively with patient sexual harassment? (please tick)
   a) During osteopathic training: ☐ YES ☐ NO
   b) Whilst practising: ☐ YES ☐ NO

7. Do you feel that it is important to incorporate sexual harassment education in osteopathic training courses? (please tick) ☐ YES ☐ NO

Section 2: Indicate, by ticking the box, your experiences with the following behaviours.

Incident	More than once a week	Once a week	Once a fortnight	Once a month	Once every 3 months	Once a year	Less than once a year	Never
Offensive jokes								
Suggestive gestures								
Sexual remarks								
Suggestive looks								
Discussion of personal/sex life								
Pressure for dates despite discouragement								
Suggestive exposure of body parts								
Brushing, grabbing or inappropriate touching								
Unwanted attempts for sex that resulted in struggling								
Threats for not cooperating								
Being mistreated for refusing to cooperate sexually								
Gender harassment								

Section 3: If you indicated anything other than 'never' in section 2, please answer the following questions.

8. Please indicate the effect of your experiences of inappropriate patient sexual behaviour and sexual harassment on:
   a) Your professional life:
   ……
   ……
   ……
   ……

   b) Your private life:
   ……
   ……
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9. Please indicate the gender/s of patients responsible for inappropriate sexual behaviour and sexual harassment:
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