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Amber W. Hunt
Old Dominion University, anwalter@odu.edu

Brenda T. Bradshaw
Old Dominion University, bbradsha@odu.edu

Susan Lynn Tolle
Old Dominion University, ltolle@odu.edu

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Research

Sexual Harassment Issues Among Virginia Dental Hygienists

Amber W. Hunt, RDH, MS; Brenda T. Bradshaw, RDH, MS; Susan Lynn Tolle, RDH, MS

Abstract

Purpose: The "#MeToo" movement has increased awareness of sexual harassment in the workplace and its detrimental effects on the work environment. The purpose of this study was to determine the prevalence of sexual harassment in a convenience sample of dental hygienists in the state of Virginia (VA).

Methods: A cross-sectional research design was used to determine the experiences of VA dental hygienists with sexual harassment in the workplace occurring over the previous twenty-four months. The revised Sexual Experiences Questionnaire (SEQ-W) measured three constructs: gender harassment, unwanted sexual attention, and sexual coercion and was administered electronically to a convenience sample of 238 dental hygienists attending a continuing education conference. Chi-square was used to determine significant associations between survey scores and demographics.

Results: A total of 161 dental hygienists completed the survey (n=161) for a response rate of 68%. A little more than one-quarter of the respondents (27%) reported at least one experience of sexual harassment in the previous 24 months. Of the three constructs measured, 27.3% of participants reported gender harassment, 18.6% unwanted sexual attention, and 6.8% sexual coercion. The most commonly reported items were being told offensive sexual jokes or stories (21%) and hearing someone make crude and offensive sexual remarks (18%). A definition of sexual harassment was provided and participants were asked, "During your career as a dental hygienist, have you experienced sexual harassment?" to which 24.2% (n=39) responded yes.

Conclusion: Sexual harassment is a contemporary problem in dental hygiene employment settings in the state of Virginia. Effective training and policies in sexual harassment is needed to prevent these behaviors from occurring in the workplace.

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Keywords: dental hygienists, employment, sexual harassment, sexual discrimination, workplace issues, occupational health

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Introduction

The "#MeToo" movement has increased awareness of systemic sexism, sexual harassment and sexual assault in the workplace. Sexual harassment involves the interpretation of a verbal, nonverbal, or physical action against another person that is unwanted, not mutually agreed upon or reciprocated by another individual and causes that person to be threatened or humiliated. Sexual harassment is considered to be a form of sex discrimination that violates Title VII of the Civil Rights Act of 1964, this only applies to employers with 15 or more employees.[1] The United States (U.S.) Equal Employment Opportunity Commission further defines sexual harassment as "unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature constitute sexual harassment when this conduct explicitly or implicitly affects an individual's employment, unreasonably interferes with an individual's work performance, or creates an intimidating, hostile, or offensive work environment."[1]

According to the Centers for Disease Control and Prevention (CDC), there are two types of sexual harassment in the workplace.[2] "Quid pro quo" is a form of harassment by a manager/supervisor or person of authority in which an employee's receipt of an employment benefit or the imposition of a tangible job detriment is conditioned on the employee's acceptance or rejection of the harassment.[2] The second type is termed "hostile work environment sexual harassment," which occurs when an employee is subjected to offensive and unwelcome sexual advances, insinuations, or gender-related comments from a co-worker, supervisor, or client that creates an intimidating or offensive place for the employee to work.[2]

Victims of sexual harassment can identify with any gender orientation and the offender can be of the opposite or same gender as the victim. However, sexual harassment is considered a gender phenomenon and as such, women

are most vulnerable and more often experience the hostile environments created by sexual harassment. According to the U.S. Equal Employment Opportunity Commission, as many as 1 in 4 women may have experienced workplace sexual harassment.[3] During 2014, women filed 74% of the sex discrimination charges, which included cases of sexual harassment.[3] The 2016 U.S. Merit Systems Protection Board survey of sexual harassment in the Federal workplace found 18% of women reported experiences of sexual harassment compared to only 6% of men.[4]

Sexual harassment in the workplace is a worldwide problem prevalent in health care settings.[4-15] Research has suggested a variety of health care workers including chiropractors, physical therapists, social workers, nurses and physicians are subjected to sexual harassment during their work.[4-14] For example, one review of the literature combined data from 38 countries and found 28% of nurses reported being sexually harassed,[10] while a survey of U.S. academic medical faculty found that 30% of women reported experiencing sexual harassment.[11] A European study of medical residents revealed 83.8% of females experienced at least one type of sexual harassment,[12] while a study of Japanese medical residents found that over one-half of the female medical residents surveyed (58.3%) reported sexual harassment.[13]

Research has shown a significant positive correlation between sexual harassment and mental health issues such as depression, anxiety, stress, and low self-esteem.[12,16-19] Workplace sexual harassment is costly to victims and studies have found that people who experience frequent workplace sexual harassment have significantly higher depression rates than non-harassed people.[12,18] Vagonis et al. found more severe depression and anxiety and lower quality of life (QOL) scores in sexually harassed medical residents compared to non-harassed residents.[12] Additionally, research by Malik et al. of female physicians and nurses suggests a strong relationship between sexual harassment and post-traumatic stress disorder (PTSD).[20] Similarly, two reviews of the literature and a meta-analysis verified a positive association with sexual harassment and PTSD.[21-23]

In regards to workplace sexual harassment, victims are not limited to the offender and the one being directly attacked, but can also include anyone else who feels indirectly affected by the offense.[1] Research has suggested that people with indirect exposure to sexual harassment, such as hearing about or witnessing it, termed "co-victimization," can suffer from similar negative psychological effects experienced by victims.[21-23] A study by Miner-Rubino and Cortino found that the sense of well-being of all genders was diminished when working in an environment considered to be hostile towards women, even in the absence of personal experiences with harassment.[24] Additionally, sexual harassment has been linked to withdrawal from the organization, which can present as work withdrawal (tardiness, absenteeism, or neglecting work tasks) or job withdrawal (turnover or intentions to quit).[4,14,21,25] Research by Willness et al. suggested a more positive correlation between sexual harassment and work withdrawal versus job withdrawal due to the reluctance or inability of the victim to quit a job.[22] Work withdrawal behaviors may lead to reduced productivity which may explain why there is a negative relationship between sexual harassment and productivity.[22]

Limited research is available on the prevalence of sexual harassment in dentistry and recent studies have focused on dental students. In a study of dental students from four multinational schools, 34% of female students and 7% of male students reported experiences of sexual harassment.[26] Sexual slurs and advances were the most common harassment experiences reported. Another multinational study of female dental students found 11.2% of participants reported experiencing verbal harassment, 3.1% reported physical assault and almost half said that their school was not vigilant about these issues.[27] Additionally, almost half of the participants reported they would not be comfortable reporting a sexual harassment violation, and 62.8% of the participants indicated they would face consequences if a report was filed.[27] It was suggested that cultural traditions of gender bias in patriarchal societies may explain low reports of violations and perceived inability to report violations without consequences.[27]

Minimal research is available on dental hygiene practitioners and the prevalence of workplace sexual harassment. A 1992 study of 472 dental hygienists in Washington State revealed 26% of respondents reported workplace sexual harassment.[28] In this study, results indicated that the perpetrator of the sexual harassment instances was either the dentist/employer (54%) or patients (37%). In a 1998 survey of dental hygienists in the state of Virginia, over half of the dental hygienists surveyed (54%) indicated having experienced sexual harassment.[29] Of the harassed dental hygiene respondents, 50% indicated the harassment happened more than four years prior while 10% reported harassment in the past year. While one-third of the victims considered leaving their employment, only 16% actually left. A 2017 study of dental hygienists in Korea found 48.7% reported experiencing workplace sexual harassment, with the dentist/employer identified as the offender in 67.3% of the cases.[30]

Sexual harassment has been reported as a common problem by women employed in health care as well as the general workforce.[3-14] Given the predominance of women in the dental hygiene profession, assessing its prevalence is needed. In order for dental hygienists to effectively manage this type of illegal behavior, its occurrence must first be recognized. The purpose of this study was to determine the prevalence of sexual harassment in a convenience sample of dental hygienists in the state of Virginia.

Methods

This study received an exempt status by the Old Dominion University Institutional Review Board. A cross-sectional research design was used to determine the experiences of dental hygienists with workplace sexual harassment occurring over the previous twenty-four months in the state of Virginia (VA). A convenience sample of dental hygienists attending a three-day Continuing Education (CE) event in VA was used for the study population. Each attendee received a cover letter explaining the purpose of the study and an invitation to participate in their CE packets during event registration. The inclusion criteria for the study were dental hygienists licensed in the state of VA. Computers were provided for participants to complete the online survey using a web-based software company (Qualtrics; Provo, UT). Participants were informed of the confidentiality of their responses and consent was understood with the completion and submission of the survey. The survey was made available over the three-day period of the CE event.

Survey Instrument

Fitzgerald's revised *Sexual Experiences Questionnaire* (SEQ-W) was used for this study.[31] The SEQ-W survey is comprised of 17 situational specific items related to workplace sexual harassment and measures three constructs: gender harassment, unwanted sexual attention, and sexual coercion. It should be noted that the SEQ-W survey has limitations when used to measure sexual harassment from a legal perspective. Fitzgerald et al. acknowledges that the SEQ-W survey does not address conditions under which the three constructs become harassment under the sanctionable meaning of the term and advocates that complete circumstances must be evaluated in any particular situation before these experiences can be deemed sexual harassment under the law.[31] The construct of gender or sexual harassment is defined as treating someone unfavorably due to one's gender and does not have to be sexual in nature.[1] Unwanted sexual attention is defined as unwelcomed, non-reciprocated sexual attention such as asking for dates, touching, staring, or making gestures of a sexual nature.[32] Sexual coercion is "quid pro quo" sexual harassment where a job-related benefit or consequence is conditioned on the employee's acceptance or rejection of the harassment. A five-point Likert-type scale ranging from one (never) to five (most of the time) was used to indicate how often participants experienced the listed behaviors over the previous 24 months. In addition to the SEQ-W, five demographic questions (age, gender, highest education, ethnicity, and primary employment setting) were included along with additional questions on whether the participant believed they had ever been a victim of sexual harassment during their dental hygiene career, how long ago, if it was reported, and whether or not their current employment setting had a written anti-sexual harassment policy. The additional questions were reviewed by a panel of experts for face validity and revisions were made to improve clarity based on comments made by the panel.

Data Analysis

Data analyses were conducted to understand the frequency and pervasiveness of sexual harassment among participants using descriptive statistics. Additionally, Pearson's Chi-square test of association was used to determine if statistically significant relationships existed between demographic characteristics and each of the three subscales. Statistical significance was set at α=0.05. Frequency of responses for all 17 situational specific items of the SEQ-W were calculated. Additionally, the percentage of sexual harassment across various demographics was calculated.

Responses were grouped by subscale category and analyzed using Fitzgerald's recommendation to calculate simple percentages at the scale level. Any participant who endorsed at least one item in a subscale with any answer except "never" was counted as having experienced sexual harassment assessed by that subscale, in order to avoid double counting participants who reported multiple behaviors within the same subscale.[33]

Results

Of the 238 dental hygienists invited to participate, 161 completed the survey (n=161) for a response rate of 68%. Most of the respondents were employed in a solo private practice (44.1%), followed by group practices (33.5%). The majority of participants were white (77%) and female (99%). Nearly one-half (46.0%) of the participants reported a bachelor's degree as their highest education and 40.4% reported an associate's degree. Over one-half (60%) of respondents were 40 years of age or older. Complete demographic data is found in Table I. The rates of sexual harassment across various demographics were also calculated and shown in Table II.

Table I. Respondent demographics

Characteristics	Number of Respondents n (%)
Gender	
Male	2 (1.2%)
Female	159 (98.7%)
Ethnicity	
White	124 (77.0%)
Black or African American	14 (8.6%)
Hispanic	6 (3.7%)
Native Hawaiian or other Pacific Islander	2 (1.2%)
Asian	9 (5.5%)
Other	6 (3.7%)
Age Range	
20-29	20 (12.4%)
30-39	43 (26.7%)
40-49	35 (21.7%)
50-59	37 (22.9%)
Over 60	26 (16.1%)
Employment setting	
Solo Private Practice	71 (44.0%)
Group Private Practice	54 (33.5%)
Education	17 (10.5%)
Public Health	3 (1.8%)
Corporate Setting	7 (4.3%)
Other	9 (5.5%)
Highest education	
Associate degree	65 (40.3%)
Bachelor's degree	74 (45.9%)
Master's degree	19 (11.8%)
Doctoral degree	3 (1.8%)

Table II. Comparison of sexual harassment experiences among respondents*

	Sample %	Gender harassment %	Unwanted sexual attention %	Sexual coercion %
Age				
20-39	39.1	28.6	23.8	6.3
40+	60.9	26.5	15.3	7.1
Race/Ethnicity				
White	77.0	27.4	18.5	5.6
Non-White	23.0	27.0	18.9	10.8
Education Level				
Associate's degree	40.4	35.4	26.2	10.8
Bachelor's degree	46.0	20.3	10.8	4.1
Graduate degree (MS/ PhD)	13.7	27.3	22.7	4.5
Employment Setting				
Solo practice	44.1	29.6	16.9	9.9
Education	10.6	29.4	29.4	5.9
Public health	1.9	66.7	33.3	33.3
Other	5.6	11.1	0.0	0.0
Group practice	33.5	20.4	20.4	3.7
Corporatesetting	4.3	57.1	14.3	0.0
Written Policy				
Yes	44.0	28.6	17.1	4.3
No	25.2	27.5	25.0	10.0
Not Sure	30.8	22.4	14.3	6.1

*Percentage of respondents who shared a specific trait (i.e. holding an associates degree) who reported having experienced a specific category of sexual harassment (i.e. sexual coercion).

The prevalence of sexual harassment experienced by participants in each of the three subscales (gender harassment, unwanted sexual attention, and sexual coercion) is shown in Table III. Over one-fourth of the respondents reported gender harassment (27.3%), followed by unwanted sexual attention (18.6%), and sexual coercion 6.8%). Combined, gender harassment

Table III. Sexual harassment prevalence for three subscales

	Yes n	Yes (%)	No n	No (%)	Total n	Total (%)
Gender Harassment	44	(27.3)	117	(72.7)	161	(100)
Unwanted Sexual Attention	30	(18.6)	131	(81.4)	161	(100)
Sexual Coercion	11	(6.8)	150	(93.2)	161	(100)

and unwanted sexual attention were reported by 49.5% of the respondents as compared to 6.8% who reported sexual coercion. The most commonly reported sexual harassment items were: "told sexual stories or jokes that were offensive to you" (21.7%), "made crude or offensive sexual remarks" (18.0%), and "made offensive remarks about your appearance, body, or sexual activities" (13.0%). Every item on the scale was reported by at least one respondent. Frequencies of the SEQ-W sexual harassment items are shown in Table IV.

Pearson's chi-square tests were used to check the relationships between the variables. No statistically significant differences were identified between demographic characteristics of age, ethnicity, education, employment setting, or written policy on sexual harassment with any of the gender harassment, unwanted sexual attention and sexual coercion. The results of the Pearson chi-square tests of potential factors correlating with sexual harassment are shown in Table V.

Following the 17 situational specific SEQ-W items and demographic questions, a definition of sexual harassment was provided. Participants were asked the question, "During your career as a dental hygienist, have you experienced sexual harassment? Nearly one-fourth of the respondents (n=39, 24.2%) replied "yes." Respondents indicating "yes" were asked how long ago the sexual harassment occurred with 42% reporting over 10 years ago, and 18.4% reporting an occurrence within the past year (Figure 1). These respondents were also asked about reporting of the sexual harassment incident. A little over one-third (34.2%) responded "no reporting" while nearly one-third (31.5%) responded "employing dentist", and 31.5% responded "friend" or "other" while 2.6% indicated the "office manager" (Table VI). Respondents were also asked whether they had ever left their place of employment due to sexual harassment with the majority indicating "no" (76.9%). In regards to a written policy on sexual harassment, under one-half (44.0%) of all respondents indicated having an office policy, while one-fourth had no policy and nearly one-third (30.8%) were unsure if a policy existed.

Discussion

Workplace sexual harassment is a serious stressor, negatively affecting physical and emotional health, contributing to absenteeism and high employment turnover rates. Sexual harassment fosters an ineffective work environment due to continued destruction of the victim's confidence and skills, and may cultivate negative attitudes toward a chosen profession including dental hygiene.[15-17,25,34] While the legal definition of sexual harassment focuses on patterns of repeated offenses, a single incident can be interpreted by the victim as being so severe that it fosters a negative work culture causing psychological harm to the victim.[31] Moreover, due to "co- victimization", the damaging psychological effects of sexual harassment may impact anyone in the workplace witnessing or hearing about the harassment;[21-23] making sexual harassment prevention a priority to promote a healthy and productive work environment for all.

Results from this study suggest at least one out of four participants experienced workplace sexual harassment in the past 24 months as measured by the SEQ-W. These findings are similar to national employment data reporting 21% of Americans have experienced workplace sexual harassment.[35] In the 1998 study conducted by Pennington et al., over one-half of VA dental hygienists (54%) indicated having experienced sexual harassment.[29] In comparison to the previous study, prevalence of sexual harassment among VA dental hygienists appears to have decreased; however, sexual harassment still remains a serious and prevalent problem among VA dental hygienists. The assessment tools used in the two studies may explain the variation in the results. This study used the SEQ-W survey in contrast to the self-designed survey instrument used by Pennington et al.

When compared to recent data from other healthcare professions, results from this study are similar to those of Spector who found 28% of nurses reported sexual harassment[10] and Jagsi et al. who found 30% of medical faculty experienced sexual harassment.[11] Data from this study and others suggest workplace sexual harassment continues to be a problem for many women in the current healthcare workforce. Increased, high-quality education is needed to facilitate workplaces that feel safe to all. No amount of sexual harassment is acceptable or should be tolerated, and all healthcare settings should strive to promote an atmosphere of prevention especially considering the negative consequences associated with sexual harassment.

When comparing results of this study to sexual harassment experienced by dental students, findings are similar to those of Quick et al. who found 34% of female dental students reported experiencing sexual harassment.[26] According to Kabatt-Farr et al., unaddressed sexual harassment in healthcare education settings may actually increase acceptance of the ideology that harassment is an innate part of the job.[36] Dental hygiene students could benefit from sexual harassment education to help recognize the behavior and learn about resources to help victims.[6]

Sexual harassment is often associated with power in settings where males dominate over female employees. Research has shown that sexual harassment is more about maintaining

Table IV. Frequency of sexual harassment

Sexual Harassment	Never n	Never (%)	Once or Twice n	Once or Twice (%)	Sometimes n	Sometimes (%)	Often n	Often (%)	Most of the time n	Most of the time (%)
Gender Harassment										
Told sexual stories or jokes that were offensive to you	126	(78.3)	24	(14.9)	8	(5.0)	0	(0.0)	3	(1.9)
Made crude or offensive sexual remarks	132	(82.0)	18	(11.2)	7	(4.3)	3	(1.9)	1	(0.6)
Made offensive remarks about your appearance, body, or sexual activities	140	(87.0)	13	(8.1)	7	(4.3)	1	(0.6)	0	(0.0)
Displayed, used, or distributed sexist or suggestive materials (for example, pictures, stories, or pornography which you found offensive)	150	(93.2)	4	(2.5)	6	(3.7)	0	(0.0)	1	(0.6)
Made offensive sexist remarks (for example, suggesting that people of your sex are not suited for the kind of work you do)	149	(92.5)	9	(5.6)	3	(1.9)	0	(0.0)	0	(0.0)
Unwanted Sexual Attention										
Made unwelcome attempts to draw you into a discussion of sexual matters (for example, attempted to discuss or comment on your sex life)	144	(89.4)	9	(5.6)	5	(3.1)	2	(1.2)	1	(0.6)
Made gestures or used body language of a sexual nature which embarrassed or offended you	147	(91.3)	9	(5.6)	4	(2.5)	0	(0.0)	1	(0.6)
Stared, leered, or ogled you in a way that made you feel uncomfortable	142	(88.2)	15	(9.3)	2	(1.2)	0	(0.0)	2	(1.2)
Made unwanted attempts to establish a romantic sexual relationship with you despite your efforts to discourage it	149	(92.5)	7	(4.3)	4	(2.5)	0	(0.0)	1	(0.6)
Continued to ask you for dates, drinks, dinner, etc., even though you said "No"	149	(92.5)	8	(5.0)	3	(1.9)	0	(0.0)	1	(0.6)
Touched you in a way that made you feel uncomfortable	146	(90.7)	12	(7.5)	1	(0.6)	1	(0.6)	1	(0.6)
Made unwanted attempts to stroke, fondle, or kiss you	151	(93.8)	6	(3.7)	2	(1.2)	1	(0.6)	1	(0.6)
Sexual Coercion										
Made you feel you were being bribed with some sort of reward or special treatment to engage in sexual behavior	152	(94.4)	4	(2.5)	3	(1.9)	1	(0.6)	1	(0.6)
Made you feel threatened with some sort of retaliation for not being sexually cooperative	152	(94.4)	4	(2.5)	3	(1.9)	1	(0.6)	1	(0.6)
Implied faster promotions or better treatment if you were sexually active	154	(95.7)	2	(1.2)	4	(2.5)	0	(0.0)	1	(0.6)
Made you feel afraid you would be treated poorly if you didn't cooperate sexually	155	(96.3)	2	(1.2)	3	(1.9)	0	(0.0)	1	(0.6)
Treated you badly for refusing to have sex	155	(96.3)	0	(0.0)	4	(2.5)	0	(0.0)	2	(1.2)

Table V. Pearson's Chi-square results of potential sexual harassment correlations

Potential correlations with sexual harassment	X^2	df	P value
Age (n=161)			
Gender harassment	0.08	1	.777
Unwanted sexual attention	1.83	1	.176
Sexual coercion	0.04	1	.846
Ethnicity (n=161)			
Gender harassment	.002	1	.963
Unwanted sexual attention	.003	1	.959
Sexual coercion	1.195	1	.274
Education (n=161)			
Gender harassment	3.980	1	.137
Unwanted sexual attention	5.655	1	.059
Sexual coercion	2.661	1	.264
Employment Setting (n=161)			
Gender harassment	8.197	1	.146
Unwanted sexual attention	4.126	1	.531
Sexual coercion	6.360	1	.273
Existence of written policy (n=159)			
Gender harassment	1.588	1	.745
Unwanted sexual attention	1.796	1	.407
Sexual coercion	1.414	1	.493

Statistical significance was set at α=0.05.

power and excluding others from full participation in the work environment as opposed to actual sexual attraction.[36] The predominately female dental hygiene profession with male dentist employers could be conducive to this type of dynamic due to the traditional male hierarchical structure. Additionally, dental hygienists frequently work in isolated rooms and in close proximity with male employers, factors which could contribute to sexual harassment. However, dental hygienists should not feel obligated to tolerate these behaviors as "normal," but instead feel empowered to object this mistreatment. Dental hygienists need to be aware of sexual harassment and know how to handle it if it occurs to help prevent it from being a work stressor that negatively affects their job and health.

Of the three constructs, gender harassment was reported most frequently, followed by unwanted sexual attention. Previous studies measuring these constructs also found highest incidences of gender harassment, followed by

Table VI. Sexual harassment reporting (n=38).

Individual receiving the sexual harassment report	% (n)
Office manager	2.6% (1)
Hygiene manager	0
Employing dentist	31.5% (12)
Corporate administrator	0
No reporting	34.2% (13)
Friend	15.8% (6)
Other	15.8% (6)

unwanted sexual attention, then sexual coercion.[6,12] The most commonly reported items from this study were: "told sexual stories or jokes that were offensive to you", "made crude or offensive sexual remarks," and "made offensive remarks about your appearance, body, or sexual activities." This finding is similar to other studies who also found sexual jokes and crude and offensive sexual remarks to be among the most commonly reported items of the SEQ.[6,37] Counteractions to these behaviors should focus on awareness, tips for identifying such offenses, and ways to handle these offenses. Sexual harassment training in dental hygiene employment settings as well as continuing education seminars could promote a better understanding of how to identify sexual harassment and support the development of proactive action plans to prevent or counteract these behaviors.

No statistically significant differences were found between demographic characteristics in any of the three subscales in this study. This differs from research by Moylan and Wood who found a statistically significant difference among ethnicity and sexual harassment with Latina/Hispanic respondents reporting the highest prevalence of sexual harassment.[6] The predominately white sample of the current study (77%) may explain the lack of significant differences in ethnicity and harassment. A sample with more non-white participants may provide more accurate information on this relationship. No significant relationships were found between education level and sexual harassment, which is similar to a previous study of sexual harassment prevalence between bachelor's degree and master's degree students[6] and a second study where no significant differences in reported sexual harassment were found between medical residency training years.[12] This differs another study where sexual harassment prevalence was higher among nurses with bachelor's degrees when compared to nurses who graduated from vocational programs.[14] Conflicting data has also been found regarding age and sexual harassment prevalence. While results of this study and those of Vagonis et al. found no significant

correlation between age and sexual harassment experiences,[12] Moylan and Wood found younger respondents reported higher a prevalence.[6] More research is needed to determine the relationship between age and sexual harassment.

In this study, over one-third of the respondents identifying with sexual harassment (34.2%) did not report the incident. In a study of sexually harassed nurses, over one-half of the victims did nothing regarding the sexual harassment (59.3%).[14] Similarly, in a 2017 study of sexually harassed dental hygienists, 36.4% reported "I did not say anything special or take any special action" and about half reported coping in this manner because "It was no use to counter the offense."[30] Similarly, another study found that only 7% of sexually harassed respondents acknowledged reporting the incident.[37] These findings support suggestions from Kabat-Farr et al. that current reporting mechanisms are flawed and in need of change.[36] Updated safeguards are needed for victims who are brave enough to come forward should include a means of leveling out power disparities.[30,36] It has also been suggested to include an outside investigator to assist with documentation and mitigation of complaints.[36] A lack of reporting resources, unawareness of how to report sexual harassment, or being afraid of the consequences, can be hindrances to reporting. Research by Ivanoff et al. supports this finding with nearly one-half of the participants who experienced sexual harassment stating that they would not be comfortable reporting a violation, and over one-half stating that they would face consequences if they filed a report.[27] Another possibility for lack of reporting, is the doubt that a formal grievance will be effective in remediating the behavior, along with fear of additional harassment and stress.[36] It is important for victims to report sexual harassment to their employer because an employer who has not been informed of the sexual harassment issue may not be held accountable.[38] Employers have a responsibility to prevent and stop sexual harassment in the workplace.[38]

One-fourth of the respondents reported no written policy on sexual harassment, and nearly one-third were unsure whether a policy existed indicating a need for many dental employment settings to implement and disseminate a anti-sexual harassment policy and provide the appropriate staff training. Policies should include a description of prohibited behavior, a reporting system, a promise of immediate action including an impartial investigation, assurance of confidentiality, and protection against retaliation for the reporter and witnesses.[39,40] Furthermore, established policies should be made known to existing employees and new hires, and employers should review the policy annually.[40] The policy should be located in place that allows for direct, easy, and confidential access for anyone at any time.[39] While sexual harassment is a form of sex discrimination in violation of Title VII of the Civil Rights Act of 1964, it only applies to employers with 15 or more employees. A sexual harassment policy could be a resource dental personnel could rely on in any employment setting.

Unfortunately, the existence of a written policy may not be adequate to prevent sexual harassment in the workplace. Results from this study show that of the participants who were aware of a written policy, only one-half reported having experienced gender harassment, unwanted sexual attention, or sexual coercion. Additional measures to prevent workplace sexual harassment include training all employees and modeling appropriate behavior.[40] Training should be required annually for all dental personnel including management as they have a responsibility to represent the practice and handle complaints. In addition to attending training, those in hierarchical positions of leadership such as dentists (both male and female) need to model appropriate behavior and set an example for all in the workplace[40] particularly since harassers often hold positions of power.[12,14,30]

Sexual harassment is a global concern in health care, and there likely is no single solution for this problem. Findings from this study suggest that sexual harassment is occurring within the dental hygiene profession and needs to be effectively addressed. The current #MeToo movement has served to highlight the issue and brought the necessary attention to sexual harassment in the workplace. Increased awareness, training and a workplace culture where such behavior is negatively viewed, may have a stronger impact than a stand-alone written policy.

This study has several limitations. The SEQ-W survey has a low Cronbach alpha (.42) in the area of sexual coercion, meaning that this portion of the survey tool may not be reliable as compared to the gender harassment (.82) and unwanted sexual attention (.85) portions of the survey which have acceptable Cronbach alpha levels.[31,41] Additionally, the definition of sexual harassment used[1] were plural such as "advances" and "requests" indicating that some incidents needed to occur more than once to be considered sexual harassment. However, Fitzgerald at al. argued that the experiences described in the survey pertained to work conditions that facilitate or hinder harassment versus the legal definition of sexual harassment.[31] The survey questions were stated in the plural tense and participants were given the option to choose the Likert response "once or twice" which may have resulted in an over estimation of true sexual harassment experiences.

Incidences of sexual harassment were measured through self-report, which might have impacted findings causing one to assume a corresponding bias in the key variables. The convenience sample of VA dental hygienists from the same geographic location, may not represent the occurrence of sexual harassment nationally. The overwhelming majority of participants were Caucasian females and therefore the results cannot be generalized to male dental hygienists or those of other ethnic races. Response bias may have been an issue as those who experienced sexual harassment may have been more likely to complete the survey. Study replication with a national sample of dental hygienists is suggested to enhance generality of findings. Future studies should also evaluate best practices to reduce sexual harassment in dental hygiene employment settings, causes for the occurrence of sexual harassment and the impact of culture on prevalence.

Conclusion

Sexual harassment is a contemporary problem in dental hygiene employment settings in the state of Virginia. Approximately 27% of the study participants reported experiencing sexual harassment behaviors in the past 24 months. The most commonly reported behaviors were being told offensive sexual stories or jokes, crude or offensive sexual remarks, and offensive remarks about physical appearances, body, or sexual activities. Findings from this study support the need for additional research on the prevalence and impact of sexual harassment at the national level, as well as the need to develop effective sexual harassment policies to prevent these behaviors from occurring in the workplace.

Amber W. Hunt, RDH, MS is a lecturer; ***Brenda T. Bradshaw, RDH, MS*** is an assistant professor; ***Susan Lynn Tolle, RDH, MS*** is a professor; all at the Gene Hirschfeld School of Dental Hygiene, Old Dominion University, Norfolk, VA.

References

1. Equal Employment Opportunity Commission. Facts about sexual harassment [Internet]. Washington (DC); Equal Employment Opportunity Commission: 2019 [cited 2019 Jan 1]. Available from: https://www.eeoc.gov/eeoc/publications/fs- sex.cfm
2. Centers for Disease Control and Prevention. Frequently asked questions: Types of discrimination [Internet]. Atlanta (GA); Centers for Disease Control and Prevention: 2018 [updated 2017 Nov 16; cited 2018 Dec 5]. Available from: https://www.cdc.gov/eeo/faqs/discrimination.htm#8
3. Equal Employment Opportunity Commission. Women in the American workforce [Internet]. Washington (DC); Equal Employment Opportunity Commission: 2018 [cited 2018 Dec 5]. Available from: https://www.eeoc.gov/eeoc/statistics/reports/american_experiences/women.cfm
4. U.S. Merit Systems Protection Board. Sexual harassment in the federal workplace [Internet]. Washington (DC); U.S. Merit Systems Protection Board: 2019 [updated 2017; cited 2019 Jul 19]. Available from: https://www.mspb.gov/MSPBSEARCH/viewdocs.aspx?docnumber=1442317&version=1447804&application=ACROBAT
5. Gleber B, Statz R, Pym M. Sexual harassment of female chiropractors by their patients: a pilot survey of faculty at the Canadian Memorial Chiropractic College. J Can Chiropr Assoc. 2015 Jun;59(2):111–21.
6. Moylan C, Wood L. Sexual harassment in social work field placements: prevalence and characteristics. Affilia. 2016 Apr;31(4):405-17.
7. DeMayo RA. Patient sexual behaviors and sexual harassment: a national survey of physical therapists. Phys Ther. 1997 Jul;77(7):739–44.
8. Nelson R. Sexual harassment in nursing: a long-standing, but rarely studied problem. Am J Nurs. 2018 May;118(5):19-20.
9. Bratuskins PE, McGarry JA, Wilkinson SJ. Sexual harassment of Australian female general practitioners by patients. Med J Aust. 2013 Oct;199(7):454.
10. Spector PE, Zhou ZE, Che XX. Nurse exposure to physical and nonphysical violence, bullying, and sexual harassment: a quantitative review. Int J Nurs Stud. 2014 Jan;51(1):72-84.
11. Jagsi R, Griffith KA, Jones R. Sexual harassment and discrimination experiences of academic medical faculty. JAMA. 2016 May;315(19):2120-21.
12. Vagonis A, Geciene A, Steibliene V. Perceptions of sexual harassment experience during residency training: relations with gender, marital status, anxiety and depressive symptoms and quality of life. Biol Psychiatry Psychopharmacol. 2015 Dec;17(2):47-52.
13. Nagata-Kobayashi S, Maeno T, Yoshizu M, et al. Universal problems during residency: abuse and harassment. Medical Education. 2009 Jun;43(7):628-36.

14. Celik Y, Celik S. Sexual harassment against nurses in Turkey. J Nurs Sch. 2007 May;39(2):200-6.

15. Tudor T. Global issues of sexual harassment in the workplace. Franklin Bus Law J. 2010 Dec;(4):51-7.

16. Schneider KT, Swan S, Fitzgerald LF. Job-related and psychological effects of sexual harassment in the workplace: empirical evidence from two organizations. J Appl Psychol. 1997 Jun;82(3):401-15.

17. Mushtaq M, Sultana S, Imiatz I. The trauma of sexual harassment and its mental health consequences among nurses. J Coll Physicians Surg Pak. 2015 Sep;25(9):675-9.

18. Houle JN, Staff J, Mortimer JT, et al. The impact of sexual harassment on depressive symptoms during the early occupational career. Soc Ment Health. 2011 Aug;1(2):89-105.

19. Malik NI, Malik S, Qureshi N, et al. Sexual harassment as predictor of low self-esteem and job satisfaction among in-training nurses. FWU J Soc Sci. 2014 Dec;8(2):107-16.

20. Malik S, Farooqi YN. General and sexual harassment as predictors of posttraumatic stress symptoms among female health professionals. World J Med Sci. 2014;10(1): 43- 9.

21. Pina A, Gannon TA. An overview of the literature on antecedents, perceptions and behavioral consequences of sexual harassment. J Sex Aggress. 2012 Sep;18(2):209-32.

22. Willness CR, Steel P, Lee K. A meta-analysis of the antecedents and consequences of workplace sexual harassment. Pers Psychol. 2007 Feb;60(1):127-62.

23. McDonald P. Workplace sexual harassment 30 years on: a review of the literature. Int J Manag Rev. 2012 Mar;14(1):1-17.

24. Miner-Rubino K, Cortina LM. Beyond targets: consequences of vicarious exposures to misogyny at work. J Appl Psychol. 2007 Sep;92(5):1254-69.

25. Merkin R, Shah M. The impact of sexual harassment on job satisfaction, turnover intentions, and absenteeism: findings from Pakistan compared to the United States. Springerplus. 2014 May;3(215):1-13.

26. Quick KK. A humanistic environment for dental schools: what are dental students experiencing? J Dent Educ. 2014 Dec;78(12):1629-35.

27. Ivanoff CS, Luan DM, Hottel TL, et al. An international survey of female dental students' perceptions about gender bias and sexual misconduct at four dental schools. J Dent Educ. 2018 Oct;82(10):1022-35.

28. Garvin C, Sledge SH. Sexual harassment within dental offices in Washington state. J Dent Hyg. 1992 May;66(4):178-84.

29. Pennington A, Darby M, Bauman D. Sexual harassment in dentistry: experiences of Virginia dental hygienists. J Dent Hyg. 2000 Jan;74(4):288-95.

30. Kim, S. The actual condition among clinical dental hygienists of bullying experience and sexual harassment within the workplace. Int Info Inst. 2017 Nov;20(11): 8245-54.

31. Fitzgerald LF, Gelfand MJ, Drasgow F. Measuring sexual harassment: theoretical and psychometric advances. Basic Appl Soc Psychol. 1995 Jun; 17: 425-27.

32. Gelfand MJ, Fitzgerald LF, Drasgow F. The structure of sexual harassment: a confirmatory analysis across cultures and settings. J Vocat Behav. 1995 Oct;47:164- 77.

33. Fitzgerald LF, Magley VJ, Drasgow F, et al. Measuring sexual harassment in the military: the sexual experiences questionnaire (SEQ-DoD). Mil Psychol. 1999 Nov;11(3):243-63.

34. Hershcovis MS, Barling J. Comparing victim attributions and outcomes for workplace aggression and sexual harassment. J Appl Psychol. 2010 Sep;95(5):874.

35. Edison Research. Sexual harassment in the workplace: #metoo, women, men, and the gig economy. [Internet]. Somerville (NJ); Edison Research:2019 [updated 2018 Jun; cited 2019 Jul 5]. Available from: http://www.edisonresearch.com/wp-content/uploads/2018/06/Sexual-Harassment-in-the- Workplace-metoo-Women-Men-and-the-Gig-Economy-6.20.18-1.pdf

36. Kabat-Farr D, Crumley ET. Sexual harassment in healthcare: a psychological perspective. Online J Issues Nurs. 2019 Jan;24(1):1-12.

37. Dhlomo T, Mugweni R, Shoniwa G, et al. Perceived sexual harassment among female students at a Zimbabwean institution of higher learning. J Psychol Afr. 2012 May;22(2):269-72.

38. Equal Rights Advocates. Sexual harassment at work: What is workplace sexual harassment? [Internet]. San Francisco (CA); Equal Rights Advocates: 2019 [updated 2019; cited 2019 Sept 2019]. Available from: https://www.equalrights.org/issue/economic-workplace-equality/sexual-harassment/

39. Equal Employment Opportunity Commission. Checklist two: an antiharassment policy [Internet]. Washington (DC); Equal Employment Opportunity Commission: 2019 [cited 2019 Jun 14]. Available from: https://www.eeoc.gov/eeoc/task_force/harassment/checklist2.cfm

40. Ross S, Naumann P, Hinds-Jackson D, et al. Sexual harassment in nursing: ethical considerations and recommendations. Online J Issues Nurs. 2019 Jan;24(1):11.

41. Field A. Discovering statistics using IBM SPSS statistics. 4th ed. London: SAGE Publications; 2013. 952p.