Sexual Harassment in the Virginia Dental Hygiene Profession

Anne Pennington
Old Dominion University

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SEXUAL HARASSMENT IN THE VIRGINIA DENTAL HYGIENE

PROFESSION

by

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A Thesis Submitted to the Faculty of
Old Dominion University in Partial Fulfillment
of the Requirements for the Degree of

MASTER OF SCIENCE

DENTAL HYGIENE

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CHAPTER I

INTRODUCTION

Sexual harassment is prevalent in the healthcare profession and is an issue that causes problems for healthcare personnel. Literature from nursing, physical therapy, dentistry and other health related fields document the prevalence of sexual harassment in the contemporary healthcare environment (Frank, Brogan & Schiffman, 1998; deMayo, 1997; Kaye, 1996). As a result of documented instances of sexual harassment in these disciplines, and since a majority of females are employed in the healthcare professions, many medical, nursing, and physical therapy schools have developed programs to educate students about the problem. Dental hygiene is also a female-dominated occupation that makes sexual harassment in the profession likely. However, few (if any) dental hygiene programs currently educate their students about the problem.

Sexual harassment affects many American industries. In 1993, $25 million were spent on sexual harassment claims settled by United States employers (Decker, 1997). Those costs included investigation, litigation, lower productivity, absenteeism, replacement, and negative publicity. The American Psychological Association (1997) reported that sexual harassment affects victimized employees both emotionally and psychologically, consequently causing an increase in worker attrition. Twenty percent of the women who are sexually harassed leave the workplace where the incident occurred.

Research Questions

The purpose of this investigation was to answer the following questions:

1. What is the prevalence of sexual harassment among Virginia dental hygienists?

2. Is there a relationship between dental hygienists age and their sexual
harassment experience?

3. Is there a relationship between marital status and dental hygienists experiencing sexual harassment?

4. Is there a relationship between the educational level (associate degree and bachelor's degree or higher) and dental hygienists who experience sexual harassment?

5. Do Virginia dental hygienists perceive sexual harassment as a problem in the oral healthcare profession?

6. Do Virginia dental hygienists believe that their dental hygiene education prepared them to manage sexual harassment in the workplace?

7. Do dental hygienists, who have been sexually harassed in the oral healthcare environment, leave their employment?

8. Do dental hygienists in Virginia want the American Dental Hygienists' Association to develop model policies or guidelines on sexual harassment in the workplace?

Significance of the Problem

Sexual harassment is a global problem affecting men and women. The International Labor Organization (ILO) surveyed 23 countries and concluded that 40-60% of women who work are sexually harassed. Because of this high percentage, the ILO suggests that sexual harassment prevention programs be implemented in the workplace environment. The type of sexual harassment varies from physical to emotional incidents, and individuals who are sexually harassed often leave their employment (Webb, 1994).

Frequently, organizations and businesses sponsor employee training programs as a strategy for the prevention of sexual harassment. In an attempt to bridge the communication
gap between employees and employers, businesses have developed written policies and procedures, training and awareness sessions, liaison committees and support groups aimed at reducing sexual harassment (Arvey & Cavahaugh, 1995).

In 1994, a poll taken by the Society for Human Resource Management found that 75% of the 292 companies surveyed have a sexual harassment prevention program within their companies (Sexual Harassment Inc., 1994). Businesses have a legal responsibility to protect their employees and initiate steps to alleviate unwanted sexual encounters between men and women in the workplace (Arvey & Cavahaugh, 1995). The Equal Employment Opportunity Commission stated that between 1990 and 1997, the average sexual harassment claim was settled out of court for $150,000 (Sexual Harassment Seminar, 1998). This illustrates the need for businesses to establish sexual harassment prevention programs. In the past seven years, journal articles have been published alerting dentists to the increase in sexual harassment claims against healthcare professionals (Ladenheim, 1995; Sinkford, 1992; Zarkowski, 1996).

Garvin and Sledge (1992) surveyed 22% of the dental hygienists in Washington State to determine if sexual harassment was a problem in the oral healthcare environment. The pilot study indicated a need for more discussion of the topic and for national research on sexual harassment in the dental hygiene profession. The results from the Garvin and Sledge study revealed a correlation between dental hygienists who were sexually harassed and dental hygienists who left the dental hygiene environment. The authors concluded that 26% of the dental hygienists experienced sexual harassment and that 28% of the harassed hygienists terminated their employment as a result of this illegal behavior.

Unwanted behavior and harassment is a problem among the workforce, and
employees should not be expected to endure that type of emotional stress and humiliation (Zarkowski, 1996). Because intimidating behavior creates emotional stress, and anxiety decreases worker productivity, sexual harassment could lead to employment reduction.

Definition of Terms

For this research, the following terms are defined:

1. **Sexual Harassment**: “Unwanted sexual leers, suggestions, comments, and physical contact that an individual may find objectionable...” (Frazier, Cochran & Olson, 1995); “unwelcome sexual advances, requests for sexual favors, and other verbal or physical sexual conduct...” (“Discrimination Because of Sex..., 1980). As a result, sexual harassment was defined in the *Sexual Harassment in the Dental Hygiene Profession Questionnaire* as: an unwanted sexual behavior which includes: leers, suggestive sexual comments; unwelcome sexual advances; physical contact that you may find objectionable; requests for sexual favors; and/or physical or verbal conduct that affects your work performance creating a hostile, intimidating or fearful work environment.

2. **Dental Hygienist**: “a licensed, professional member of the healthcare team who focuses on the assessment of health and disease in the oral cavity; identification of the dental hygiene problem; and planning, implementing and evaluating dental hygiene care...” (Darby & Walsh, 1995).

3. **Oral Healthcare Setting**: A location where professionals educate and promote oral health wellness and treat oral disease in their clients.

Assumptions

The following assumptions were made for this study:

1. The *Sexual Harassment in the Dental Hygiene Profession Questionnaire* is an
appropriate instrument for obtaining information about sexual harassment in the dental hygiene profession.

2. The dental hygienists randomly sampled are representative of the Virginia dental hygiene population in 1997.

3. Sexual harassment in the workplace is a psychosocial problem that affects the emotions, productivity, and retention of individuals (Garvin & Sledge, 1992).

4. The respondents answered the questionnaire honestly and completely.

5. Sexual harassment against women occurs frequently in the environments where men are in authority positions. Therefore, it is likely to occur in the oral healthcare setting when male dentists are in authority.

Limitations

The following limitations are identified as possible threats to the internal and external validity, and the reliability of this investigation:

1. A questionnaire, designed for this study, *Sexual Harassment in the Dental Hygiene Profession Questionnaire*, was used. To decrease the instrumentation threat to internal validity, a pilot study was performed, and test/re-test reliability and content validity of the questionnaire were established (See Appendix A).

2. Respondents may have preconceived notions and perceptions about what constitutes sexual harassment in the oral healthcare setting. To increase internal validity and prevent misinterpretation, the definition of sexual harassment was included in the questionnaire.

3. The potential for a low response rate existed because of the sensitivity of the subject matter. To encourage responses, anonymity was promised and maintained.
4. The study was limited to dental hygienists currently living in Virginia, but not necessarily to sexual harassment that occurred only in Virginia.

5. The design of the questionnaire measured the relationship between demographic variables and sexual harassment at the time of the survey. However, demographic variables such as age, marital status and level of education, might have differed at the time of the sexual harassment experiences. Therefore, observed relationships between sexual harassment and demographic variables should be interpreted cautiously.

Hypotheses

The following hypotheses were tested at the .05 level of significance:

1. There is no relationship between age and dental hygienists experiencing sexual harassment.

2. There is no relationship between marital status and dental hygienists who experience sexual harassment.

3. There is no relationship between educational level (associate vs. bachelor’s degree or higher) and dental hygienists experiencing sexual harassment.

4. There is a relationship between perception of sexual harassment as a problem and dental hygienists experiencing sexual harassment.

5. There is no relationship between sexual harassment prevention training in the dental hygiene curriculum and dental hygienists experiencing sexual harassment.

Methodology

The total 1997 population of registered dental hygienists in Virginia (2345) was randomly divided for use in two studies. Twenty-five percent, 590 names were randomly
selected for the survey on sexual harassment. A self-designed instrument entitled, *Sexual Harassment in the Dental Hygiene Profession Questionnaire* was submitted to a panel of dental hygiene experts at Old Dominion University to establish content validity (See Appendix A). Prior to administering the questionnaire, a pilot study was performed on 20 registered dental hygienists who were randomly selected from a partial list of registered dental hygienists in the Commonwealth of Virginia. The questionnaire was sent on two separate occasions and each response was analyzed to determine the test-retest reliability (See Appendix B).

Due to the sensitivity of the sexual harassment issue, the correspondence included a cover letter, postcard and questionnaire. The cover letter explained the purpose of the study and ensured confidentiality and anonymity. The respondent indicated on the postcard a willingness to participate or not participate in the survey. The packet also included a stamped envelope to encourage a high response. A second mailing was sent two weeks later to respondents who had not returned the postcard (See Appendix C, D and E).

The questionnaire consisted of four sections: Personal Experience, Management of Sexual Harassment, Personal Opinions and Comments, and Demographics. Various question formats were used: yes/no responses (checking all answers that applied), Likert scale, and an opportunity to write personal comments. Questionnaire data were analyzed using frequency distributions, percentages and the chi-square test of association.
CHAPTER II

REVIEW OF LITERATURE

The purpose of this review of the literature is to discuss sexual harassment in the workplace and its effect on dental hygienists. Definitions of sexual harassment, the legal issues that surround sexual harassment and its prevalence are discussed. In addition, the methods and measurements commonly used to determine the prevalence of sexual harassment, the psychological effect this behavior has on employees, and the occurrence of sexual harassment in the oral healthcare environment are discussed.

Sexual Harassment Defined

Sexual harassment is an unwelcome, deliberate or unintentional action that creates a hostile work environment for the employee (Webb, 1994). Sexually harassing behavior interferes with an individual’s work performance and creates an atmosphere of intimidation and a lack of concentration for the victim (Webb, 1994; McCann & McGinn, 1992). Sexual harassment is not easy to document because it involves the interpretation of a verbal, nonverbal or physical action against another person (Fiske & Glick, 1995).

Unwelcome behavior refers to any action that is not mutually agreed upon between two parties; that is not returned or reciprocated by one or the other. Ignoring a sex-based behavior is a passive action and often is not interpreted as a negative response. The best response to unwelcome sex-based behavior is a tangible negative action. The receiver of the harassment must demonstrate disapproval of the action by verbal rejection or by a physical response such as removing an unwanted hand (Fiske & Glick, 1995).

A hostile work environment can include jokes or innuendoes with sexual
connotations, direct statements about personal sexual matters, or demands for physical favors from another person. A hostile work environment also includes employment decisions that are contingent upon gender or submission to sexual desire as a condition of employment. In an employment setting, it is the responsibility of the employer to provide an emotionally and physically safe environment for employees by monitoring their employee’s activities in the workplace (Decker, 1997).

A sex-based behavior is a behavior directed toward another individual with a sexual implication. There are degrees of sexually harassing behaviors which are socially unacceptable (Webb, 1994). Although these actions overlap, there is a definite progression of severity. As noted in Figure 1, the continuum begins with behaviors considered inappropriate, especially if repeated, but are generally socially acceptable (e.g., jokes that have sexual implication). The next point on the continuum includes subtle remarks or actions that are offensive to most people; these remarks, however, are not so severe that a formal complaint is justifiable. A third point on the continuum is a moderately offensive behavior which is unacceptable and needs to be stopped. Examples of the second and third points include brushing up against someone or directly touching them. At the third point on the continuum, a formal complaint would be necessary. The fourth point, which is the end of the continuum, reflects behaviors which is never acceptable, such as sexual rape or assault. Discipline for severe sexual harassing behavior should be equally severe and legal actions should occur.

The Equal Employment Opportunity Commission (EEOC) provides legal assistance to victims who have encountered harassment in the workforce. Because of the complexity in defining sexual harassment, the United States judicial system uses
the EEOC guideline in sexual discrimination cases (Equal Employment Opportunity Commission, Federal Register, 1980). The EEOC, *Guideline on Discrimination Due to Sex*, is divided into seven major headings (See Table 1). These headings only apply to businesses employing 15 or more employees (Garvin & Sledge, 1992). The EEOC and the judicial system of the United States have attempted to be specific in their definition and interpretation of sexual harassment (See Appendix F).

Table 1. EEOC Final Amendment to Guidelines on Discrimination Due to Sex

| GUIDELINE ON DISCRIMINATION BECAUSE OF SEX |
| SEC. 703 OF TITLE VII                        |
| 1. Unwelcome sexual advances, requests for sexual favors and other verbal or physical conduct of a sexual nature constitutes sexual harassment when submission/rejection to a conduct is a condition of employment; when submission/rejection is used as an employment decision; when submission/rejection interferes with an individual's work performance or creates an intimidating work environment. |
| 2. Commission will look at the record as a whole and at the totality of the circumstances, such as the nature of the sexual advances and the context in which the alleged incident occurred.... |
| 3. Employer, employment agency (etc.) is responsible for its acts and those of its agents and the supervisory employees with respect to sexual harassment regardless of whether the specific acts complained of were authorized or even forbidden by the employer and regardless of whether the employer knew or should have known of their occurrence.... |
| 4. With respect to conduct between fellow employees an employer is responsible for acts of sexual harassment in the workplace.... |
| 5. Employer may also be responsible for the acts of non-employees with respect to sexual harassment of employees in the workplace... |
| 6. Employer should take all steps necessary to prevent sexual harassment from occurring, such as expressing strong disapproval, developing appropriate sanctions... |
| 7. Employer may be held liable for unlawful sex discrimination against other persons who were qualified for but denied that employment opportunity or benefit... |
Sexual harassment is not an easy subject to define because it involves individual perception and interpretation of an action. The perception of an action can differ with gender. Men may not consider sexual jokes harassment, while women, who are more sensitive, might be intimidated and perceive the action as sexual harassment. Because of the difference in the perception of sexual harassing behaviors, it is often necessary to consider the context in which the incident occurred. A one-time occurrence does not necessarily constitute sexual harassment (Fiske & Glick, 1995).

**Legal Aspects of Sexual Harassment**

Sexual harassment is an illegal act of sexual discrimination, and legal actions can result from the incident (Zarkowski, 1996). Prior to 1964, there were no laws pertaining to discrimination and sexual harassment; as a result, sexual harassment incidents were kept within the employment setting. Although many state employment laws restricted the amount of weight a female could lift and the number of hours she could work, the common law failed to protect females from sexual harassment (McCann & McGinn, 1992).

During the 1960’s, with the increase of females in the workforce and concern over social and racial issues, Congress enacted the Civil Rights Act of 1964 to establish guidelines to eliminate race and gender discrimination. The Civil Rights Act began protecting employees from discriminatory actions in areas such as equal pay, handicap and pregnancy, age, religion, race, and national origin. When the United States Congress passed the Civil Right Act, however, Title VII of the Act was designed specifically to protect employees from sexual harassment in the workplace, to prohibit sexual discrimination in the workplace, and to provide equal rights to all employees. Title IX of the Civil Rights Act
prohibits discrimination in educational institutions receiving federal funding (Frazier, Cochran & Olson, 1995).

In July 1965, the Equal Employment Opportunity Commission (EEOC) was established by the federal government, and offered legal protection to employees from discrimination, including sexual harassment in the workplace. Interpreting the Civil Rights Act of 1964, the EEOC maintained definite guidelines about sexual harassment and employer responsibilities to employees. The agency also offered practical advice to victims of sexual harassment on securing witnesses, documenting incidents, and using detailed notes of the time and place of alleged incidents. Another advantage for an employee filing a complaint with the EEOC was that the service was free. If the defendant did not go to court, the intimidation of a federal agency investigating a situation might bring compliance, and behaviors within the company would probably improve (Nicarthy, Gottlieb & Coffman, 1993).

Because the EEOC only accepts sexual harassment cases involving employment settings with 15 or more employees, these services are rarely utilized by employees within the oral healthcare environment. This is because most oral healthcare settings employ fewer than 15 individuals. As a result, any legal action a plaintiff would file against a harasser would be a tort claim. Tort claims usually involve one or more of the following charges: assault, battery, intentional emotional distress, slander, or invasion of privacy. The financial responsibility for hiring a private attorney is ultimately the responsibility of the plaintiff.

Sexual harassment allegations are difficult to prove in court because documentation, including dates and specific incidents, must be recorded and verified. An
eyewitness to the harassment is important in providing the evidence necessary to verify physical assault. Eyewitnesses are also necessary in cases in which the consequence of the harassment is the dismissal of the victim from their job. Most witnesses, however, are reluctant to speak out (Waring & Horne, 1987). For the complaint to qualify as sexual harassment, various criteria must be met by the legal system and federal government, e.g., is the harassment *quid pro quo*; does the harassment create a hostile environment; and is the employer liable for the actions of the employee?

*Quid pro quo* is a Latin term meaning “this for that”. This term is used in judicial situations when an employee’s benefits or punishment is directly associated with the victim submitting to sexual advances or pressures. An example of *quid pro quo* sexual discrimination is the case of *Bundy verses Jackson* (1991). Sandra Bundy received continuous sexual propositions from a fellow employee and she informed her supervisor of the harassment. Her complaints regarding the harassment were ignored and she was later “passed over” for a promotion because of “inadequate work performance”. Ms. Bundy’s performance evaluations, however, never cited deficiencies in her work performance. The court ruled in her behalf stating that she experienced sexual discrimination (Hendrix, 1994).

A *hostile work environment* is defined as an atmosphere where a harassing action is interfering with another employees’ performance and is intimidating to the individual. A harassing action is best exemplified by severe and abusive language, as opposed to merely annoying language (e.g., words which refer to body parts instead of annoying words like *baby* or *sweety*.) The judicial rulings on hostile work environments normally follow the EEOC guidelines of harassment where unwelcome and demeaning sexual
behavior creates a hostile, intimidating and offensive work environment (Webb, 1994).

The employer is liable for the actions of employees and is responsible for illegal behavior within the organization’s guidelines of discrimination. The employer is also liable if sexual harassment is reported to a supervisor and disciplinary action is not taken, or if the disciplinary action is not carried out within a reasonable amount of time (Hendrix, 1994). It is the responsibility of the employer to monitor the activities of employees and provide an emotionally and physically safe environment for all employees (Garvin & Sledge, 1992).

In 1993, a Supreme Court ruling made it difficult to litigate sexual harassment cases because the following must be considered by the jury: 1) the severity of the offense, 2) the work environment (hostile or abusive), and 3) the frequency of the misconduct. A major concern of the court is whether the unacceptable behavior is currently happening and if the incident involves prevalence and severity (Arvey & Cavahaugh, 1995).

In July 1998 the Supreme Court established new rules in three areas of sexual harassment. One of the major changes in the Supreme Court ruling is that the harassment is defined by the behavior of the harasser, not the effect it has on the victim. Another new change is the emphasis on enforcing a prevention policy rather than simply establishing guidelines or policies. The third new change in the Supreme Court ruling is the method for reporting sexual harassment. Previously it was sufficient to tell anyone in the workplace about the harassment. Now it is necessary to report the incident to an individual who has authority and makes decisions for the company (Lavelle, 1998). The strongest protection a company has against lawsuits is their initiative to offer prevention programs and their willingness to take disciplinary action against the harasser.
During the past three decades, the judicial system has changed its emphasis from the prosecution of sexual harassment cases to questioning the terminology of sexual harassment policies. As indicated in Table 3, the Supreme Court is emphasizing terminology rather than the unlawful action, which had been previously established by the Civil Rights Act of 1964. The assessment of a harassing action must be within the context in which it occurs (Burns, 1995). Supreme Court rulings in the 1960’s placed a different emphasis on sexual harassment than those in the 1990’s. Confusion has resulted in trying to explain new terminology such as: unreasonable woman, hypersensitive, and reasonable person. The victim must not be accused of wearing improper clothing or making suggestive gestures that would encourage harassment or an unwelcome sexual reaction. In addition, the courts have introduced the concept of the silent tolerater. A silent tolerater is a victim who endures or tolerates unwanted behavior. The judicial courts interpret this silent behavior as compliance or as a willing acceptance of sexually harassing conduct; they assume a ‘real’ sexually-harassed victim will speak out against such behavior (Fitzgerald, Swan & Fischer, 1995).

In Ukarish v. Magnesium Elektron (1983), the District of Columbia Circuit Court ruled that even though the plaintiff reported harassing incidents to her supervisor and kept a diary detailing the abusive behaviors, because her complaints were not voiced to other individuals, the situation implied a willing participation (Fitzgerald, Swan & Fischer, 1995) (See Table 2).

In 1992, the Civil Rights Act created a new law where the private healthcare employer may be liable for damages ranging from $50,000 to $300,000 for each party
involved in a lawsuit. Monetary liability is a strong incentive for employers to control sexual harassment within the healthcare setting. It was the observation of Robinson, Franklin and Fink (1993) that employers who acted quickly and took actions to punish the harasser avoided extensive liability suits. If, however, monetary damages are given, the monetary fine is proportional to the size of the organization and the number of employees. Creating a proactive stand with written policies and guidelines, implementing training sessions, and establishing positive employment relations help administrators avoid liability for the healthcare organization.

The Prevalence of Sexual Harassment

Sexual harassment is more prevalent in healthcare organizations than in other industries because more women are employed in the healthcare workforce in both professional and clerical positions. Numerically, women represent the majority of employees in the healthcare environment and dominate the lower-level positions (Decker, 1997). Healthcare professionals, regardless of their educational training, may be confronted with sexual harassment. Nurses report the largest number of sexual harassment incidents. Sexually
harassed victims are usually younger, divorced or single women. Sexual harassment, however, has no boundaries. Since women represent a high percentage of the workforce, females are disproportionately victimized by sexual harassment (Robinson, Franklin & Fink, 1993). In 1991, 58% of the women with children under the age of six worked outside the home, a large increase from 1960 when only 20% of women were in the workforce outside the home. In 1991, 92% of the sexual harassment incidents reported to the EEOC were reported by women. Seigel (1992) reported that 50-85% of American women will experience some form of sexual harassment during their academic or employment years, and professional women encounter additional problems when voicing a complaint.

Professional employment, in specialized areas, develops networking among colleagues. Voicing a complaint may jeopardize advancement within the profession. A vice president of a radio station filed a suit for sexual harassment and said, “it is career suicide, once you filed a suit, you are known” (Seigel, 1992).

Healthcare professionals develop close-working relationships with clients to divert the patient from the seriousness of an illness or distract them from emotional and physical pain. Off-color humor or physical contact (hugs or touching) with clients is often acceptable behavior in healthcare situations; but this behavior could unintentionally convey sexual overtones (Decker, 1997).

There are other reasons why sexual harassment is prevalent in the healthcare professions. First, the healthcare organizational hierarchy is an environment where males are in prominent positions, and thus have wide-ranging authority over females. There is an uneven distribution of male to female professionals in positions of authority and parity, i.e., male physicians to female; female nurses to male; male physical therapists to female; male
dentists to female; and female dental hygienists to male. Because sexual harassment is essentially a demonstration of power and control, it is possible that this uneven distribution of gender accentuates the prevalence of sexual harassment in the healthcare professions (Decker, 1997).

Healthcare organizations have definite levels of command and power. Administrators are ultimately responsible for the behavior and control of the organization’s employees. This power, however, is sometimes allowed to continue with physicians and administrators in control. Physicians who exhibit offensive sexual behavior to other employees within the workplace, and who are ignored or excused by the administrator, exemplify the informal power and control held by them. The ultimate ‘confusion,’ about who is responsible for the actions of employees accentuates the potential for sexual harassment.

A study to determine the prevalence of violence and sexual harassment of registered nurses in the workplace was performed in Illinois. A mail survey was sent to 1130 randomly selected nurses. The respondents, 30% (N=345), were between 30 and 49 years old and 75% were employed more than 10 years. Sixty-four percent of the nurses experienced sexual harassment and 71% were sexually harassed within the past year (Williams, 1995). The results from this survey, clearly demonstrates that the nursing profession reports frequent incidents of sexual harassment.

At the 1992 national convention, the American Nurses’ Association voted 543 to 3 to denounce sexual harassment in the workplace. It is obvious from this almost unanimous vote that the nursing profession experiences sexual harassment and is aware of the devastating effect it has on the workplace. Since 97% of the registered nurses are
female (Nicathy, Gottlieb & Coffman, 1993), and since sexual harassment occurs most frequently against women in environments where men are in authority, persons in the healthcare environment are extremely susceptible to sexual harassment.

Physical therapy, another healthcare profession, also reports a high rate of sexual harassment. Eighty-six percent of physical therapists report some form of sexual harassment from patients (deMayo, 1997). This profession, like nursing, demands physical closeness and contact with clients.

A computer-generated random sample questionnaire was sent to 750 members of the American Physical Therapy Association regarding patient sexual harassment behavior in their practice. The members were licensed and employed in outpatient clinics, private physical therapy offices, hospitals, nursing facilities and home agencies. Forty-eight percent of the physical therapists in the sample returned the questionnaire; 86% of those who responded experienced mild to severe sexual harassment in their professional practice. Out of the 86% who returned the questionnaire, 81.5% were female. The authors concluded that female therapists were more willing to respond to the questionnaire since a higher percentage of females returned the survey. Sixty-three percent of the physical therapists said they experienced at least one incident of sexual harassment from patients; 84% of the sexual harassment incidents were from men. There was no relationship between the age of the therapist and the occurrence of the harassment; females, however, formally reported more incidents than males. The study documented that physical therapists nationwide frequently experience sexual harassment (deMayo, 1997).

A similar study from a single urban community in Ottawa, Ontario reported 80%
of physical therapists and physical therapy students experienced ‘inappropriate patient
sexual behaviors’. This study represented a smaller number of participants, (N=152)
than the deMayo 1997 study and included licensed therapists and students. The
participants in the McCombes study differentiated between the psychological level and
the intellectual capacity of their clients. An example was “I do not feel harassed if a
senile patient touches me inappropriately, but if a young man does, it is a different story.”
This study did not implicate gender or age as predictors of sexual harassment (deMayo,
1997).

The American Management Association, in the early 1990’s, surveyed 524 of their
firms and reported that 52% of their member companies have dealt with the allegation of
sexual harassment. In 60% of the cases, disciplinary action was taken against the offender.
The following table reflects a regional cross-section of the American Management
Association and the sexual harassment claims reported to them (See Table 3).

Table 3. Sexual Harassment Claims of the American Management Association by
Geographic Region

<table>
<thead>
<tr>
<th>Satellite Locations of the American Management Association</th>
<th>Reported Claims</th>
</tr>
</thead>
<tbody>
<tr>
<td>West Coast States</td>
<td>60%</td>
</tr>
<tr>
<td>North Atlantic States</td>
<td>41%</td>
</tr>
<tr>
<td>New England States</td>
<td>36%</td>
</tr>
</tbody>
</table>

Although the EEOC reports that their claims have increased 150% between
1990-1996 (Sexual Harassment Seminar, 1998), the percentage of victims who actually
file formal complaints is extremely low, usually less than 7% nationally (See Table 4)
(Wolf 1996). This does not reflect those victims who do not report offensive behaviors either
out of fear or because the EEOC is not able to accept their cases.
Table 4. Percentage of Claims Filed with the EEOC from 1980-1995

<table>
<thead>
<tr>
<th>DATE</th>
<th>CLAIMS FILED IN THE UNITED STATES WITH THE EEOC</th>
</tr>
</thead>
<tbody>
<tr>
<td>1980</td>
<td>1,000</td>
</tr>
<tr>
<td>1981</td>
<td>4,272</td>
</tr>
<tr>
<td>1983</td>
<td>5,566</td>
</tr>
<tr>
<td>1995</td>
<td>16,000</td>
</tr>
</tbody>
</table>

Most females do not report sexual harassment because they believe it will be detrimental to their careers. The American Nurses’ Association estimates that more than 50% of the sexually harassed nurses do not report an incident because of fear of retaliation (Sherer, 1995). For example, Dr. Frances Conley, a neurosurgeon and professor at the Stanford University Medical School, after 23 years of enduring sexual harassment in her profession, was forced to resign. Her resignation drew public attention and she had the opportunity to expose the sexual harassment which often occurs in the medical profession. Her frustration is evident in her statement, “Women cannot speak out if they want their jobs because retaliation is definitely a consequence. Speaking out has been a very lonely experience” (Conley, 1998).

Webb (1992) suggested a characteristic profile of individuals who are most likely to be sexually harassed. Support for these profiles varies in the literature. Married or widowed women are less likely to be harassed than single, divorced or separated women (Webb, 1992; deMayo, 1997; Tangri, Burt & Johnson, 1982; McCann & McGinn, 1992). Webb (1992) also states that most female victims are ages 24-34, and earn less than $11,000 a year. In contrast, McCann and McGinn (1992) report that age is not a factor in sexual harassment.

Dentistry is a male-dominated profession in the United States; however, more
females continue to enter this field every year (Rosenberg, Cucchiara & Heplin, 1996). In 1970, only 1% of the dentists were women; in 1994, 36% of the incoming freshman dental students were female. Although there has been a change in dentistry, dental hygiene is still a predominately female profession with only 1% of the profession being male (Worley, 1996). Because the dental hygiene profession is 99% female and the majority of dentists are male, a hierarchy of authority exists. The dental assistant and dental hygienist function in a subordinate position to the dentist (Shuman & Tolle, 1989).

Sexual harassment is a significant problem often experienced within the oral healthcare environment by dental assistants and dental hygienists (Weinstein, 1994). Oral healthcare professionals working in small dental practices are reluctant to report sexual harassment incidents because they do not want to jeopardize their employment status. In many offices, individuals become personally familiar with one another and do not want to damage their collegial relationships. Reducing the prevalence of sexual harassment in the workforce is a major concern for many organizations (Webb, 1992).

Measurement of Sexual Harassment

Surveys are the most common method used to determine the prevalence of sexual harassment. The methods used in a survey are as important as the final result obtained from the survey. Several key concepts are necessary to build a strong survey: a basic definition of the situation, a definition of the problem, and an understanding of the difficulties in gathering unbiased information from a control group (Arvey & Cavahugh, 1995).

One way of surveying individuals and their exposure to sexual harassment is with a Sexual Experience Questionnaire (SEQ). Although a SEQ collects data on the
frequency of a certain type of behavior, the behavior is difficult to determine as it depends on an observer’s perception of the situation. As a result, researchers need to be explicit and detailed with survey questions in order to ensure that all respondents interpret the behavioral terms similarly. Moreover, sexual harassment is usually a continuum of situations that build on one another rather than being a single event (Arvey & Cavahaugh, 1995).

A clear interpretation of the type of sexual harassment is essential to a well-established survey. The definition of sexual harassment involves a variety of actions. It can be narrowly defined as coercion, or broadly defined as subtle, yet consistent gestures. For these reasons, it is important to use behavioral terms with sufficient detail to clarify any personal or bias misinterpretation. Furthermore, the offenses must be assessed by level of severity to assure the validity and reliability of the questionnaire’s results. For example, a respondent’s experience of being exposed to offensive jokes is not an act of sexual harassment at the same level of severity as a respondent who experiences physical contact. Categorizing behaviors and actions that fall within the legal definition provides greater validity and reliability for the survey instrument (Arvey & Cavahaugh, 1995).

Developing survey items that assess behavior and determine frequency of sexual harassment are extremely important. A researcher may categorize a sexual behavior at a particular point along a continuum, (See Figure 1), but the respondent may perceive the situation differently. Fitzgerald and Shullman (1993) analyzed types of behavior (including looks, gestures, and coercion) on a 3-point frequency scale comparing the psychometric and psychological results and averaging the frequency of behavioral actions
to determine a sexual harassment score. They suggest that the phrase ‘sexual harassment’
be avoided in order to differentiate between the action and the perception of an action.
Fitzgerald and Shullman (1993) reported that victims who experienced instances of
uninvited sexual behavior did not label their experiences as sexual harassment.

Most surveys ask respondents to reflect back over three years or longer and report
events that occurred during that time frame. Such a long time period could lead to
memory distortion involving the individual or the context of the event. For instance, an
event could have occurred which, at the particular time, was accepted as normal
behavior. When the norms of society change over a period of time, however, that same
incident might be viewed as sexual harassment. Therefore, to increase reliability of the
data, the important issue in a research questionnaire is to determine if sexual harassment
is currently being experienced (Fitzgerald & Shullman, 1993).

Although there are some insurmountable problems, surveys are still the most
desired method to obtain information about sexual harassment. Due to embarrassment
and intimidation associated with the subject, people are less likely to communicate the
information by methods where they could be identified. Some women may be
embarrassed by the harassing acts and may not even respond to a questionnaire.
Interestingly enough, when the response rate from a survey is low, the reported incidents
of sexual harassment are usually high (Gruber, 1990).

Effects of Sexual Harassment

Sexual harassment is by definition intimidating, and the harasser attempts to
control a situation by using power and authority over the victim. Sexual harassment
usually does not occur because of sexual attraction (Webb, 1994; Livingston, 1982;
Cleveland & Kerst, 1993; Nicarthy, Gottlieb & Coffman, 1993). How a victim responds internally and externally to sexual harassment affects their psychological and physical health, which in turn directly affects their employment.

The word 'power' implies control over another individual and is an important issue in sexual harassment (Cleveland & Kerst 1993). This power may be displayed socially, organizationally or interpersonally. Sexual harassment can be found in each of these three areas and has distinctive characteristics in each. The characteristic behavior of this controlling power may explain why sexual harassment occurs.

'Social power' is an expected and accepted use of authority occurring within the structure of any organization. Cleveland and Kerst (1993) reported on norms in Western society which imply that men have power and control over women, and that men are expected to be goal-oriented, aggressive, and rewarded for their ability to exercise power and influence. Women, therefore, are stereotyped as passive-receptive, interpersonally-oriented and limited in their ability to influence others. Most women do not believe their actions make a significant difference in the organization. The stereotype norms of Western society suggest that women do not attempt to influence men even when they have the authority (Cann, 1979). This may be because women are not supported or encouraged to exercise power, and consequently learn to take a passive role in society.

'Organizational power' is an extension of social power displayed in the workplace. Men usually hold higher-status positions while women have jobs that lack status. Consequently, women usually do not exercise authority within an organization. It is assumed that an individual who occupies a high-status position has the right to exercise authority, and subordinates are expected to comply with that authority. Often, a female
with the same comparable credentials as a male is not given the same status within the organization. Cleveland and Kerst (1993) found that if a woman occupies a position or specialty that is not vital to the survival of the organization, she is less powerful despite her assertiveness.

'Interpersonal power' is the behavior of the power-holder and the reaction of the recipient. Men use strong tactics to demonstrate power such as commanding, demanding or begging a response from an individual. To acquire power, women develop formal networks of coalitions through informal alliances with individuals within the organization (Cleveland & Kerst, 1993). Women tend to use an indirect, nonverbal or helplessness strategy to demonstrate their power and control over other individuals (Cleveland & Kerst, 1993). These different styles of influence are manipulative. Controlling an individual using interpersonal power may be demeaning and effect the emotional stability of the recipient.

Finally, gender is associated with the use of power. Men often use the 'stag effect' (women are excluded) and the 'put down' approach as informal methods of discrimination. When contributions of women are ignored or demeaned within an organization, there is a strong display of gender power. These strategies are informal and passive, but are very powerful means of control especially if a woman has a prominent position (Cleveland & Kerst 1993).

Fitzgerald, Swan and Fischer (1995) studied the responses of sexually harassed victims and classified their responses as internal or external. Individuals who respond with internal strategies try to manage their emotions in association with the event which occurred. This management is done by endurance, denial, detachment and other inward
methods. Individuals who respond with external strategies try to solve the problem directly. Examples of this type of behavior are avoidance, appeasement or seeking social support.

The most common internal response to sexual harassment is endurance. The United States Merit Systems Protection Board (USMSB) is Federal workforce which investigates and studies sexual harassing incidents of federal employees. This agency reported that 26% of harassed workers “did nothing” (Fitzgerald, Swan & Fischer, 1995). Some individuals endure the harassment out of fear because they are uncertain what to do or to whom to report the harassment. Jensen and Glutek (1982) found that 25% of female victim's blame themselves for the harassment because of their behavior. Because victims feel responsible and self-blaming, they are reluctant and afraid to report the incident. Embarrassment, helplessness and the fear of retaliation are the most common psychological reactions. Many victims are reluctant to go back into the same occupation and therefore accept lower economic or opportunity jobs (Gutek & Koss, 1993; Livingston, 1982). In 1981, the USMSB reported that 1 out of 10 women left their jobs after sexual harassment. Ignoring the harassment is a passive action and is not interpreted as a negative response. Nevertheless, pretending nothing happened is a conscious and deliberate decision on the part of the victim. Finally, appeasement and humor are ways some victims cope with harassment. Fifty percent of the sexually harassed victims responded externally by denying and avoiding the issue (Fitzgerald, Swan & Fischer, 1995).

The best response to unwelcome sexual behavior is a tangible negative action. The receiver of the harassment must demonstrate disapproval of the action by verbal
rejection or by a physical response such as removing an unwanted hand. The USMSPB (1982) reported that 44% of victims directly tell the harasser to stop.

Some of the reasons why women are afraid to report sexual harassment are because of social retaliation and the initial effect it might have on their employment status (See Table 5). Loy and Stewart (1984) studied state workers and their response to sexual harassment. Although the study was small (N=86), the pattern was consistent with other studies demonstrating assertive responses and negative outcomes. Sixty-two percent of the state workers reported retaliation for their negative responses to sexual harassment. Some of the retaliation included lower job evaluations, lack of promotion and loss of employment. One-third of the victims who filed formal claims reported that ‘things were worse’, and many were humiliated in front of their peers (Fitzgerald, Swan & Fischer, 1995).

Table 5. Some Reasons Why Women are Afraid to Report Sexual Harassment

<table>
<thead>
<tr>
<th>STUDY</th>
<th>YEAR</th>
<th>REASONS WOMEN DID NOT REPORT HARASSMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gutek &amp; Koss</td>
<td>1993</td>
<td>Nothing can or will be done</td>
</tr>
<tr>
<td>Martindale</td>
<td>1990</td>
<td>&quot;</td>
</tr>
<tr>
<td>USMSPB</td>
<td>1981</td>
<td>&quot;</td>
</tr>
<tr>
<td>Gutek</td>
<td>1985</td>
<td>Do not want to cause problems for the harasser</td>
</tr>
<tr>
<td>Jensen &amp; Gutek</td>
<td>1982</td>
<td>&quot;</td>
</tr>
<tr>
<td>Martindale</td>
<td>1890</td>
<td>&quot;</td>
</tr>
<tr>
<td>Fitzgerald, Swan &amp; Fischer</td>
<td>1993</td>
<td>Fear of retaliation, not being believed, hurting one’s career</td>
</tr>
<tr>
<td>Gruber &amp; Bjorn</td>
<td>1988</td>
<td>&quot;</td>
</tr>
<tr>
<td>Gutek</td>
<td>1982</td>
<td>&quot;</td>
</tr>
<tr>
<td>Gutek &amp; Koss</td>
<td>1985</td>
<td>Hurting one’s career</td>
</tr>
<tr>
<td>Martindale</td>
<td>1982</td>
<td>&quot;</td>
</tr>
<tr>
<td>Phillips</td>
<td>1990</td>
<td>Shamed and humiliated</td>
</tr>
<tr>
<td>Sanders</td>
<td>1989</td>
<td>&quot;</td>
</tr>
<tr>
<td>USMSPB</td>
<td>1992</td>
<td>&quot;</td>
</tr>
<tr>
<td>&quot;</td>
<td>1981</td>
<td>&quot;</td>
</tr>
<tr>
<td>&quot;</td>
<td>1988</td>
<td>&quot;</td>
</tr>
</tbody>
</table>
Charney and Russell (1994) identified self-doubt as a central issue in sexually-harassed victims. They cautioned therapists to avoid the ‘second injury’, i.e., implying in any way to the victim that the harassment was brought on by their own actions. Charney and Russell reported that sexual harassment produced psychological and physical symptoms in 90% of the victims. Emotional stress affects the victims, but it also affects the entire employment atmosphere. Fellow-workers and colleagues who are aware of the harassment may feel intimidated and afraid for themselves. Kaye (1996) studied the harassment of the nursing profession and found that nurses encountered more sexual harassment than those in many other professions. One explanation is the predominance of females in the nursing occupation with a high number of male physicians. This gender difference combined with an economic status of power and prestige, could promote sexual harassment. Psychological effects, symptoms of stress and somatic symptoms distract nurses from concentrating and performing their jobs adequately (Kaye, 1996) (See Table 6).

Table 6. Some Effects and Symptoms of Sexual Harassment on Nurses

<table>
<thead>
<tr>
<th>PSYCHOLOGICAL EFFECT</th>
<th>SOMATIC SYMPTOMS</th>
<th>STRESS SYMPTOMS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Post-traumatic stress disorder</td>
<td>Nausea</td>
<td>General tension</td>
</tr>
<tr>
<td>Major disorders (depression)</td>
<td>Headaches</td>
<td>Nervousness</td>
</tr>
<tr>
<td>Dysrhythmic disorder</td>
<td>Stomach ache</td>
<td>Persistent anger</td>
</tr>
<tr>
<td>Adjustment disorder</td>
<td>Weight changes</td>
<td>Shame</td>
</tr>
<tr>
<td></td>
<td>Blood pressure changes</td>
<td>Fear</td>
</tr>
<tr>
<td></td>
<td>Chronic fatigue</td>
<td>Helplessness</td>
</tr>
<tr>
<td></td>
<td>Insomnia</td>
<td></td>
</tr>
</tbody>
</table>

Sixty percent of harassed victims are extremely dependent on their jobs (Tangri, Burt & Johnson). This factor explains why few victims report the illegal and offensive behavior. The psychological, self-accusing guilt can create emotional instability
resulting in poor employment productivity, absenteeism from work, and depression (Welzenbach, 1986). The American Psychological Association (1997) states that sexually harassed women have psychological and physical reactions that affect their careers. Sexual harassment can devastate the psychological health, physical stability and vocational development of its victims (See Appendix G).

Training and Prevention of Sexual Harassment

It is essential in any organization to establish written policies and guidelines regarding sexual harassment (Robinson, Franklin & Fink, 1993). Written policies clarify what is expected of employees and employers, and preventive training sessions may stop any harassment.

Taking a proactive stand by developing written policies and guidelines minimizes liability and internal problems for an organization (Robinson, Franklin & Fink, 1993). In 1987, the Bureau of National Affairs reported that 97% of the companies they represented had policies or guidelines regarding sexual harassment (Gutek & Koss, 1993). A general statement regarding harassment, combined with a detailed procedure to investigate the harassing claim, is usually established. Most preventive sexual harassment policies are specific in three areas: the organization’s position on sexual harassment, the rights of the employee to work in a harassment-free environment, and the correct procedures for filing a sexual harassment complaint (Robinson, Franklin & Fink, 1993).

Guidelines and policies, however, are not sufficient in and of themselves. Employees must also be educated on the meaning and implication of these policies. As a result, preventive-training for supervisors and employees is necessary. Training
employees to recognize and avoid aggressive sexual behavior could eliminate many potential problems. Maintaining confidence and emotional control is a developed skill which may combat the fear and intimidation associated with sexual harassment. Training sessions also establish open communication and interaction between supervisors and employees (Robinson, Franklin & Fink, 1993).

Chiodo, Tolle and Labby (1992) suggest a three-step training curriculum for students in the healthcare professions. This curriculum teaches the participant to identify different levels of client aggression using case studies, videos and small group seminars. The first component includes an assessment to identify verbal and nonverbal clues of aggression. It is important for students to identify and recognize the difference between a deliberate action and a misperception or unintentional action. The second component in a training curriculum is the environment where the sexual harassment occurs. For instance, physical contact in a close working environment could be misunderstood as a willing action of sexual harassment. The third recommended component of training focuses on the behavior and behavioral strategy of the student when responding to aggressive clients.

The American Nurses’ Association (ANA) has taken an aggressive role against sexual harassment in the workplace by establishing the ‘Position Statement on Sexual Harassment’. This statement upholds the ANA’s commitment to principles of civil rights and opposition to discrimination. The responsibility to uphold the Position Statement on Sexual Harassment resides with the employees and employers, who should maintain prevention policies and clearly written guidelines outlining sexual harassment issues for all personnel. Policies in themselves, nonetheless, are not sufficient unless the
management endorses and enforces the policies, and educational programs include all staff members (Kaye, 1996).

The American Nurses' Association has employment prevention training sessions that teach transitioning from a victim role into the controlling role by taking immediate and prompt assertive action. The individual is taught to look the harasser in the face and demand that the undesirable behavior stop. This assertive behavior reestablishes a professional relationship and maintains a distance between the victim and the harasser. If the victim is too surprised or humiliated to respond to the harassment, then a letter should be sent to the harasser by registered mail. The letter should include the specific time and date of the action; strong statement that the behavior must stop; request for a professional relationship; examples of the negative impact of the behavior; and intent to seek legal counsel. A formal complaint should be filed in the personnel office within 180 days of the incident and legal counsel should be obtained as soon as possible. If retaliation in form of criticism, or reassignment to another area occurs, then it is important to maintain detailed records of the incident and attempt to get witnesses (Kaye, 1996). If other healthcare professions followed this simple training, individuals would be better prepared to recognize and prevent sexual harassment. Currently, there are no training sessions supported by the American Dental Hygienists' Association. In contrast, the College of Dental Hygienists of Ontario mandates sexual abuse prevention programs (College of Dental Hygienists of Ontario, 1996a).

The College of Dental Hygienists of Ontario governs and regulates the dental hygiene profession in Ontario, Canada. In 1991, the Regulated Health Professions Act (RHPA) of Canada passed new regulations which mandates that healthcare professions
initiate sexual abuse prevention programs. The RHPA justified its actions on behalf of the public interest since the public relies on the ethical decisions of the Council for protection. The members of the Council establish standards of character, skill and knowledge for all dental professionals. The RHPA defines the sexual abuse of a client or professional as an unacceptable action which must be reported. Members of this Council developed a policy of 'zero tolerance' for sexual harassment from clients (College of Dental Hygienists of Ontario, 1996b).

The College of Dental Hygienists of Ontario is aware of the emotional pain sexual harassment has on its victims. The Patient Relations Committee of the College takes a firm stand against the occurrence of sexual harassment in the workplace and uses education as the main defense. An Instructor's Guide was prepared to assist dental hygiene faculty in teaching sexual abuse prevention to dental hygiene students.

This Instructor's Guide, circulated to all dental hygiene coordinators in Ontario, addresses the recognition and prevention of sexual harassment. The three areas of emphasis in the Instructor's Guide are the basics of zero tolerance, language of zero tolerance and oral healthcare encounters which support the standards of dental hygiene practice. The prevention of sexual harassment training methods includes lectures, practical exercises, video recording and peer and instructor coaching (College of Dental Hygienists of Ontario, 1996b).

The philosophy of zero tolerance recognizes the emotional injury sexual harassment creates for the victim. Dental hygienists in Ontario are taught the behaviors and attitudes of cultures different from the Canadian culture. This cultural knowledge eliminates the possibility of dental hygienists being victimized by sexual harassment out
of ignorance. Words, actions or physical behaviors from clients that are demeaning or uncomfortable are neither accepted nor tolerated. According to the Instructor's Guide, sexual harassment is unprofessional and strict standards of professionalism must be maintained.

Dental hygienists in Ontario are taught to understand that clients are often under stress when they receive dental treatment. Because of the stress, a client may show aggression either verbally or non-verbally. Distinguishing between verbal and non-verbal communication, maintaining respect, and eliminating embarrassment or intimidation are important principles of client communication that also are taught to dental hygienists.

The last section of the Instructor's Guide explains which touching behaviors are acceptable, and reasons why speech and touch should occur simultaneously. Students are taught touching behaviors appropriate for eliciting cooperation, such as during an extra or intra oral examination. Teaching students these procedures prepares them to maintain the Standards of Practice established by the College of Dental Hygienists of Ontario (1996b).

**Sexual Harassment in the Oral Healthcare Environment**

Although healthcare professionals are often confronted with sexual harassment (Robinson, Franklin & Fink, 1993), there is little published on the subject in the dental literature (Chiodo, Tolle & Labby, 1992). A few smaller studies have been published regarding dentists and the sexual harassment claims of their patients (Ladenheim, 1995; Sinkford, 1992; Zarkowski, 1996). In the Dental Assistant, the American Dental Assistants' Association included a questionnaire about sexual harassment in the dental office, and asked interested readers to participate in the survey (Gervasi, 1984b). A study by Garvin and Sledge (1992) surveyed dental hygienists in Washington State to assess sexual harassment in
the oral healthcare environment. Chiodo, Tolle and Labby (1992) studied the frequency of patient-initiated sexual harassment toward dental professionals in Oregon.

In 1984, the *Dental Assistant* published a nationwide survey to determine if dental assistants had been sexually harassed at work; 767 dental assistants responded to the survey. The severity of the harassment varied from mild verbal comments to actual physical assault. Of those who responded, 43% said they were sexually harassed while employed in the dental setting; 99% of the dental assistants who were sexually approached were embarrassed, intimidated and demeaned by the experience; 75% believed sexual harassment was a serious problem in the dental office. Ninety-seven of the dental assistants, in the Gervasi study (1984a) who said they were sexually harassed, eventually quit or were fired from their jobs because they did not comply with the demands of the harasser. Over 60% of all dental assistants reported that unwelcome sexual attention was offensive. Ninety-four of the respondents reported that sexual harassment perpetuates the idea of sexism. Although non-representative, many respondents wrote individual letters relating upsetting personal experiences. This reemphasized that offensive behavior and harassment can be emotionally debilitating and affect the productivity of the dental professional.

Garvin and Sledge (1992) surveyed 2,138 dental hygienists in Washington State to determine if sexual harassment was a problem in the oral healthcare environment. Of the 472 who participated in the survey, 26% said they were sexually harassed while employed. Fifty-four percent of the sexual harassment was from the dentist/employer and 37% was from clients. Twenty-three percent of the sexually harassed dental hygienists terminated their employment. Sixty-three percent said the harassment did not affect their work performance. Even though one-fourth of the respondents were victims, most of the respondents did not
consider sexual harassment to be a serious problem for the dental hygiene profession.

Chiodo, Tolle and Labby (1992) used a 16-item questionnaire to survey 300 Oregon dentists and dental hygienists to determine the frequency of sexual harassment from clients toward dental professionals. The questionnaire was returned by 83% of the dentists and 78% of the dental hygienists. This study examined the differences between the types of sexual harassment (verbal or physical) which the healthcare professional received. The dentist received 31% verbal and 15% physical advances from clients. The dental hygienists reported 45% verbal and 23% physical harassment from clients. The dentists felt they were in control of the situation whereas the dental hygienists felt a distinct lack of control over patient advances. The study indicated that the predominant response of sexually harassed dental hygienists was to leave the current dental employment setting and seek employment elsewhere. The findings of this study were similar to other studies of healthcare professions (Gervasi, 1984b; Garvin, 1992; Sherer, 1995; Decker, 1997).

Summary

Seigel (1992) reported to the National Council for Research on Women that 50-85% of American women would probably be sexually harassed during their employment or academic education. Decker (1997) stated that more than 20% of working women will quit their jobs because of sexual harassment. Between 1990 and 1996, the Equal Employment Opportunity Commission (EEOC) reported that sexual harassment complaints increased 150% (Sexual Harassment Seminar, 1998). Most dental offices employ less than 15 employees, and there is no legal assistance from the EEOC. Dental hygienists employed in the oral healthcare environment do not seek legal retribution. Although legal ramifications for
sexual harassment exist, few individuals have the financial capability to procure professional legal assistance. Nonetheless, Charney and Russell, reported in 1994 that 90% of the victims of sexual harassment sought out psychological and emotional counseling because the harassment affected their ability to work.

Three surveys concerning sexual harassment in dental programs were examined: one in 1984 of dental assistants, and two in 1992 of dental hygienists. Ninety-seven percent of the dental assistants who were victims of sexual harassment left their employment; 66% of the dental hygiene victims left their dental office. These surveys suggest the existence of a significant problem for both the victim and the healthcare environment.

The nursing profession in the United States has an aggressive educational program to teach professionals how to manage sexual harassment, and as a direct result nurses feel better equipped to handle such situations (Kaye, 1996). The College of Dental Hygienists of Ontario mandates sexual abuse prevention programs for dental hygienists in their jurisdiction.

The literature suggests that it is essential to prepare dental hygiene students and professionals to recognize and manage this illegal behavior. This preparation could have a direct impact on job retention, career satisfaction and quality of care provided in the oral healthcare environment.
CHAPTER III

METHODS AND MATERIALS

A self-answered questionnaire entitled *Sexual Harassment in the Dental Hygiene Profession Questionnaire* elicited data on the experience, management, and personal opinions relative to sexual harassment. The survey attempted to examine the prevalence of sexual harassment in the oral healthcare environment, the extent to which dental hygienists left the profession due to sexual harassment, and the perception of sexual harassment as a problem in the oral healthcare environment.

**Description of Sample**

Twenty-five percent (N=590) of the population of Virginia registered dental hygienists (N=2345) were randomly selected for the survey on sexual harassment. Fifty questionnaires were returned as undeliverable, which reduced the valid sample population to 540. The final response rate of dental hygienists represented 53% of the sample.

The demographic section (Section IV) of the questionnaire, asked respondents their gender, age, marital status, ethnic background, highest educational level, and year of graduation from dental hygiene school. The demographic profile of the respondents is presented in Table 7. The demographics indicated that 99% of the dental hygienists sampled were female. The mean age was 40, (sd= 8.14). Eighty-six percent of the respondents (n=239) were married and 14% (38) were single, divorced or cohabitating. Caucasian persons accounted for 96% (n=265) of the sample; 4% (10) of the respondents represented various racial groups. Forty-two percent of the respondents held associate degrees and 58% held bachelor’s degrees or higher. Two hundred seventy-two
respondents graduated from dental hygiene school between 1956 and 1997. The median graduation year was 1982 and the average number of years since graduation from dental hygiene school was 17 years.

Table 7. Demographic Profile of Virginia Dental Hygienists Sampled (N=285)

<table>
<thead>
<tr>
<th>CHARACTERISTICS</th>
<th>(N) and % SAMPLED</th>
<th>(N) and % HARASSED FROM THE TOTAL SAMPLE</th>
<th>MEAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender: Male</td>
<td>3 (1%)</td>
<td>2 (67%)</td>
<td>___</td>
</tr>
<tr>
<td>Female</td>
<td>278 (99%)</td>
<td>150 (55%)</td>
<td>___</td>
</tr>
<tr>
<td>Age</td>
<td>21-39</td>
<td>150 (55%)</td>
<td>___</td>
</tr>
<tr>
<td></td>
<td>40-65</td>
<td>124 (45%)</td>
<td>___</td>
</tr>
<tr>
<td>Marital Status: Married</td>
<td>239 (86%)</td>
<td>130 (54%)</td>
<td>___</td>
</tr>
<tr>
<td>Single, Divorced, Cohabitant</td>
<td>38 (14%)</td>
<td>21 (55%)</td>
<td>___</td>
</tr>
<tr>
<td>Ethnic background: Caucasian</td>
<td>265 (96%)</td>
<td>147 (56%)</td>
<td>___</td>
</tr>
<tr>
<td>Other</td>
<td>10 (4%)</td>
<td>4 (40%)</td>
<td>___</td>
</tr>
<tr>
<td>Highest educational level:</td>
<td></td>
<td></td>
<td>___</td>
</tr>
<tr>
<td>Associate</td>
<td>117 (42%)</td>
<td>65 (56%)</td>
<td>___</td>
</tr>
<tr>
<td>Bachelor degree or higher</td>
<td>159 (58%)</td>
<td>87 (55%)</td>
<td>___</td>
</tr>
<tr>
<td>Year of graduation from Dental hygiene school:</td>
<td></td>
<td></td>
<td>1982 (8.90)</td>
</tr>
<tr>
<td>1956-1982</td>
<td>138 (51%)</td>
<td>75 (54%)</td>
<td>___</td>
</tr>
<tr>
<td>1982-1997</td>
<td>134 (49%)</td>
<td>75 (56%)</td>
<td>___</td>
</tr>
</tbody>
</table>

Methodology

The Sexual Harassment in the Dental Hygiene Profession Questionnaire was constructed to determine prevalence, management of, and personal opinions about sexual harassment from Virginia dental hygienists. To improve content validity, the questionnaire was reviewed and critiqued by dental hygiene faculty members of the Old Dominion University School of Dental Hygiene School and a statistician in the Old Dominion University College of Health Sciences.

To establish content validity and test-retest reliability, 20 registered dental hygienists from Virginia were randomly selected for a pilot study and surveyed twice within
a two-week period of time. Two questionnaires were returned with incorrect addresses, reducing the sample size to 18. Therefore, 44% (8) of the respondents returned the pilot study. Reliability data from the pilot study, and a list of changes, are in Appendix B.

A cover letter, postcard, and questionnaire were mailed to the 590 randomly selected dental hygienists in Virginia (See Appendix A, C and D). The cover letter accompanying the questionnaire explained the purpose of the study, assured confidentiality and anonymity, and defined sexual harassment. The postcard allowed respondents to anonymously indicate their participation in the survey and return their completed questionnaire. A self-addressed, stamped envelope and a stamped postcard accompanied the questionnaire to encourage a high participation rate. Two weeks after the initial mailing, a second letter and questionnaire were sent to respondents who had not returned the postcard (See Appendix E).

Protection of Human Subjects

In accordance with Old Dominion University's policy concerning research on human subjects, the proposal was submitted to the Institutional Review Board and approved in February 1998. The subjects were protected by the following methods:

1. Sample Population: Subjects for this research consisted of a sample of registered dental hygienists in the Commonwealth of Virginia. They were selected because of their accessibility and because no research on sexual harassment had been conducted on the population.

2. Potential Risks: This descriptive study posed no physical or emotional risks to the participants. Some participants, however, may not define all sex-based behavior as sexual harassment. The survey was anonymous and the results were presented in a collective
form. The investigator assumed all postage expenses with no expense to the participants. Data were kept in a locked file in the home of the principal investigator. Only the principal investigator had direct access to the data.

3. Consent Procedures: Participation in the study was strictly voluntary. Completing and returning the questionnaire was an indication of the participant's comprehension of the subject matter and their willingness to participate voluntarily. A statement in the cover letter reinforced the voluntary nature of the questionnaire. Individuals who did not want to be involved in this survey were asked to return the questionnaire unanswered.

4. Protection of Subjects Rights: To maintain clarity, the cover letter explained the intent of the research, length of time to complete the survey, how the participant's name and address were chosen and how confidentiality and anonymity would be maintained. Only the investigator had access to the questionnaire. Questions or concerns about the questionnaire were channeled to the thesis director whose name, address and phone number were listed on the cover letter. Participants interested in the results were able to request a report from the principal investigator.

5. Potential Benefits: The results from the study provided valuable information about sexual harassment of dental hygienists while employed in the oral healthcare setting. Findings were used to determine whether dental hygienists feel professionally prepared to manage sexual harassment, and are available to dental hygiene schools interested in designing sexual harassment prevention programs for their curricula. Experiencing sexual harassment may be correlated to attrition in the dental hygiene profession.

6. Risk/Benefit Ratio: There were no risks to the participants and the benefits could
potentially aid the career satisfaction and employment retention of dental hygienists.

**Instrumentation**

The self-answered *Sexual Harassment in the Dental Hygiene Profession* Questionnaire was the instrument of choice since the sample population was geographically dispersed across the Commonwealth of Virginia. The anonymous questionnaire was designed to reduce the intimidation factor expected when surveying people on sensitive issues. Anonymity was maintained by having the respondents mail a separate postcard indicating that the questionnaire was completed and returned, without connecting the survey to any names.

The 26-item questionnaire was composed of four sections: Experiences with Sexual Behavior, Management of Sexual Harassment, Personal Opinion and Comments, and Demographics. If the respondent answered 'never' to all items in question 1, Experiences with Sexual Behavior, then they were categorized as 'not being sexually harassed' and were to answer only Sections III and IV of the questionnaire. Only respondents who answered otherwise to question 1 were categorized as 'being sexually harassed' and completed all four sections of the questionnaire. Data were categorized into two groups: sexually harassed and not sexually harassed. Frequency distribution, percentages and chi-square tests of association were performed and reported on the two groups, harassed and not sexually harassed. Section I, Experiences with Sexual Harassment included: when the harassment occurred, who was the harasser, type of practice setting where the harassment occurred, and if harassment occurred in more than one setting. Management of Sexual Harassment, Section II, had three questions about filing formal complaints: one question regarding written policies or guidelines and two
questions about leaving the employment. Personal Opinion and Comment, Section III, included factors on educational training, reluctance to file a formal complaint, perception of sexual harassment as a problem, educational training of sexual harassment in the dental hygiene curricula, American Dental Hygienists’ Association involvement in policies and guidelines, and personal comments. Demographics, Section IV, consisted of six items of personal information.

**Statistical Treatment**

Variables used in the statistical analysis of data were defined as follows:

1. **Gender**
   Nominal (Female/Male)/demographic characteristic.

2. **Age**
   Ratio/demographic characteristic; younger (21-39 years of age) and older (40-64 years of age).

3. **Marital Status**
   Nominal (Married, Single, Divorced, Cohabiting, Widowed)/demographic characteristic; dichotomized into two groups; married was one category and all others were categorized as not married.

4. **Ethnic**
   Nominal (Caucasian, African American, Native American/Alaskan, Hispanic, Asian/Pacific Islander, Middle Eastern)/demographic characteristic; Caucasian was one category and all others were categorized as other.

5. **Educational Level**
   Nominal (Associate/Certificate in Dental Hygiene, Bachelor’s, Degree Master’s Degree, Doctoral Degree)/demographic characteristic; Associate/Certificate was one category and Bachelor’s Master’s Doctoral was the other.
6. Year of Graduation  Ratio /demographic characteristic

7. Sexually Harassed  Sexual harassment for the purpose of this study was measured by Question 1. If the respondents answered *never* to all items, they were categorized as not being sexually harassed. All other categories (seldom, sometimes, often, most of the time) were grouped as being sexually harassed.

The acronym used in the SPSS was HARASS.

8. Filing Formal Complaint  Reluctance to file a formal complaint for the purpose of this study was measured in Question 14. The categories *Strongly Disagree* and *Disagree* were categorized into one category and *Agree* and *Strongly Agree* were grouped into another category.

9. Harassment a Problem  Sexual harassment as a problem in the oral healthcare setting for the purpose of this study was measured in Question 15. The categories *Strongly Disagree* and *Disagree* were categorized into one category and *Agree* and *Strongly Agree* were grouped into another category. The acronym used in the SPSS was SHPROB.

10. Filing is Effective  Filing a formal complaint, an effective strategy in alleviating sexual harassment, was measured in Question 16. The categories *Strongly Disagree* and *Disagree* were grouped into one category and *Agree* and *Strongly Agree* were grouped into another
11. Educationally Prepared

Educationally prepared to manage sexual harassment was measured in Question 17. The categories Strongly Disagree and Disagree were grouped into one category and Agree and Strongly Agree were grouped into another category.

12. Had Sexual Harassment Guidelines and policies discussed in the dental hygiene training in dental curriculum were measured in Question 18. The categories Strongly Disagree and Disagree were grouped into one category and Agree and Strongly Agree were grouped into another category.

13. ADHA’s Should Be Involved in Setting a Good Sexual Harassment Policy

Involving the ADHA in policies and guidelines about sexual harassment was measured in Question 19. The categories Strongly Disagree and Disagree were grouped into one category and Agree and Strongly Agree were grouped into another category.

Data analyses were completed using the computer software SPSS. The data collected using the questionnaire were nominally and ordinally scaled. Both parametric and nonparametric statistics were used to analyze the data. Chi-square test of association was used to determine relationships between demographic characteristics of the sample, prevalence of sexual harassment in the oral care setting, sexual harassment experiences, and employment attrition. Hypotheses were tested at the .05 level of significance.
CHAPTER IV
RESULTS AND DISCUSSION

Results

The data from the questionnaire yielded the following results:

Experiences with Sexual Harassment Behavior: Section I asked respondents to indicate the frequency of sexual harassment in the work environment. Responses, from Question 1, were gathered on a Likert scale with five possible choices: never, seldom, sometimes, often, most of the time. The respondents who answered ‘never’ to all items in Question 1 (45%; 128) were categorized as not being sexually harassed; respondents who chose seldom, sometimes, often, or most of the time to any items in this question, (54%; 155) were categorized as being sexually harassed (See Table 8).

Table 8. Virginia Dental Hygienists’ Experiences with Sexual Harassment

<table>
<thead>
<tr>
<th>EXAMPLES OF SEXUAL HARASSMENT</th>
<th>Number (n)</th>
<th>Never</th>
<th>Seldom</th>
<th>Sometimes/Often/ Most of the Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>1a. Subjected to stories/jokes which were offensive to me</td>
<td>284</td>
<td>56% (155)</td>
<td>23% (64)</td>
<td>23% (65)</td>
</tr>
<tr>
<td>1b. Felt demeaned because of gender</td>
<td>284</td>
<td>64% (183)</td>
<td>19% (53)</td>
<td>17% (48)</td>
</tr>
<tr>
<td>1c. Received unwanted attempt to be drawn into discussion</td>
<td>285</td>
<td>70% (200)</td>
<td>18% (51)</td>
<td>12% (34)</td>
</tr>
<tr>
<td>1d. Continuously asked for dates, dinner…</td>
<td>285</td>
<td>90% (256)</td>
<td>8% (22)</td>
<td>3% (7)</td>
</tr>
<tr>
<td>1e. Felt threatened because I did not comply w/ requests</td>
<td>285</td>
<td>95% (271)</td>
<td>4% (11)</td>
<td>1% (3)</td>
</tr>
<tr>
<td>1f. Touched in more than one way which was uncomfortable</td>
<td>284</td>
<td>80% (228)</td>
<td>13% (37)</td>
<td>7% (19)</td>
</tr>
<tr>
<td>1g. Received unwanted sexual behaviors which were embarrassing</td>
<td>285</td>
<td>81% (230)</td>
<td>11% (32)</td>
<td>8% (23)</td>
</tr>
</tbody>
</table>

Question 2 asked the sexually harassed dental hygienists when the harassment occurred. In the sample, 10% (14) were currently experiencing harassment; 18% (25)
within the past year; 11% (15) were harassed within the past 1-2 years; 12% (17) were harassed 3-4 years ago; and 50% (71) indicated they were harassed more than 4 years ago (See Figure 2).

Question 3 asked the dental hygienists to identify the perpetrator of the harassment. The respondents could select more than one choice. The majority, 75% (103), experienced sexual harassment from male dentists and almost half, 45% (63), from male clients. Other individuals in the healthcare environment were rarely named as offenders: female co-worker (9%; 12); other (8%; 11); male co-worker (4%; 6); female client (3%; 4) and female dentist (1%) (See Figure 3).

Question 4, the type of practice settings where the sexual harassment occurred, offered four choices and the respondents could check more than one choice. Of the sample, 62% of the occurrences were in a solo practice; 22% in a dual partnership; 20% in a group practice setting; and 6% in other dental practice settings (See Table 9).

Table 9. Virginia Dental Hygienists Who Experienced Sexual Harassment in Various Practice Settings (N=141)

<table>
<thead>
<tr>
<th>Practice Settings</th>
<th>Dental Hygienists Who Experienced Sexual Harassment Percentages (Frequencies)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Solo</td>
<td>62% (88)</td>
</tr>
<tr>
<td>Dual Partnership</td>
<td>22% (31)</td>
</tr>
<tr>
<td>Group</td>
<td>20% (28)</td>
</tr>
<tr>
<td>Other</td>
<td>6% (9)</td>
</tr>
</tbody>
</table>

Question 5 asked respondents if they experienced the harassing behavior in more than one healthcare setting. More than two-thirds of the dental hygienists (68%; 96) did not experience harassment in more than one dental environment, and 31% (45) had experienced sexual harassment in more than one healthcare setting.
Figure 2. When Virginia Dental Hygienists Experienced Sexual Harassment (N=142)
Figure 3. Perpetrators Who Sexually Harassed a Sample of Virginia Dental Hygienists in the Oral Healthcare Environment (N=144)

*Percentages total to more than 100%
Management of Sexual Harassment: Section II obtained information about how sexually harassed dental hygienists managed the experience. Question 6 gathered information from sexually harassed dental hygienists who did not file a formal complaint. As Table 10 shows, over half (57%, 80) ignored the harassing behavior, one-third (36%, 50) told a co-worker, one-third (35%, 49) told a friend or family member. Only 29% (41) told the offending person to stop the behavior. Seventeen percent (24) terminated their employment, and 11% (16) did not tell anyone. Documenting the incident (4%, 5) or filing a formal complaint (.07%, 1) were passive responses and not often reported.

Table 10. Responses of Virginia Dental Hygienists Who Were Sexually Harassed in the Oral Healthcare Environment (N=140)

<table>
<thead>
<tr>
<th>Responses to Sexual Harassment</th>
<th>Percentages (frequencies* )</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ignored it</td>
<td>57% (80)</td>
</tr>
<tr>
<td>Told a Co-worker</td>
<td>36% (50)</td>
</tr>
<tr>
<td>Told a friend or family member</td>
<td>35% (49)</td>
</tr>
<tr>
<td>Told the offending person to stop</td>
<td>29% (41)</td>
</tr>
<tr>
<td>Terminated my employment</td>
<td>17% (24)</td>
</tr>
<tr>
<td>Did not tell anyone</td>
<td>11% (16)</td>
</tr>
<tr>
<td>Documented the incident</td>
<td>4% (5)</td>
</tr>
<tr>
<td>Filed formal complaint</td>
<td>0.7% (1)</td>
</tr>
</tbody>
</table>

*Respondents could choose more than one

Question 7 asked to what degree six possible reasons played in the dental hygienist’s decision to not file a formal complaint. Responses were scored on a Likert scale with three choices, very concerned, concerned and not concerned. As Table 11 shows, 33% (43) were very concerned or concerned about losing their jobs. Jeopardizing the possibility of a salary increase was a concern for 31% (39). The majority (63%, 80) were not concerned about receiving a negative employment recommendation. Although the next two questions both related to social acceptance, one within the office and the
other within the dental community, the responses were different. Fifty-four percent (65) of the dental hygienists were concerned that filing a formal complaint would cause social retaliation in the dental office. And one-third (33%; 43) were concerned about receiving a negative retaliation socially within the community.

Table 11. Some Reasons Why Virginia Dental Hygienists Might Not File Formal Complaints Regarding Sexual Harassment

<table>
<thead>
<tr>
<th>REASONS</th>
<th>NUMBER (N)</th>
<th>VERY CONCERNED (Percentages Frequencies)</th>
<th>CONCERNED (Percentages Frequencies)</th>
<th>NOT CONCERNED (Percentages Frequencies)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q7a. Losing my job</td>
<td>128</td>
<td>16% (21)</td>
<td>17% (22)</td>
<td>66% (84)</td>
</tr>
<tr>
<td>Q7b. Jeopardizing the possibility of a salary increase</td>
<td>128</td>
<td>13% (16)</td>
<td>18% (23)</td>
<td>70% (89)</td>
</tr>
<tr>
<td>Q7c. Receiving a negative Employment recommendation</td>
<td>125</td>
<td>16% (21)</td>
<td>21% (27)</td>
<td>63% (80)</td>
</tr>
<tr>
<td>Q7d. Receiving a negative retaliation socially within dental office</td>
<td>131</td>
<td>16% (21)</td>
<td>34% (44)</td>
<td>50% (66)</td>
</tr>
<tr>
<td>Q7e. Receiving a negative retaliation socially within dental profession</td>
<td>129</td>
<td>14% (18)</td>
<td>19% (25)</td>
<td>67% (86)</td>
</tr>
<tr>
<td>Q7f. Receiving a negative retaliation socially within community</td>
<td>127</td>
<td>6% (8)</td>
<td>14% (18)</td>
<td>80% (101)</td>
</tr>
</tbody>
</table>

Question 8 asked respondents to whom they reported the incident if they did not file a formal sexual harassment complaint. Only one-third, 38% of the harassed dental hygienists, answered this question. The majority of dental hygienists (72%, 43) indicated they spoke to no one about the harassing behavior: 20% (12) reported it to a family member: 17% (10) told a co-worker: 14% (8) spoke to a friend: 9% (5) reported it to the dentist: 7% (4) told the office manager: 3% (2) reported to indicated a legal authority; and 2% (1) of the harassed dental hygienists spoke to an unspecified other.
Question 9 asked sexually harassed dental hygienists if they were aware of written guidelines or policies in the oral healthcare setting where they were sexually harassed. Eighty-eight percent (120) were unaware of written sexual harassment policies or guidelines in their work environment.

Question 10 and 11 both related to employment status, but yielded different responses. From question 10, 30% (41) considered leaving their place of employment due to sexual harassment (See Figure 4) and 16% actually did leave.

Personal Opinion and Comment: Section III gathered personal opinions and comments from the entire sample of dental hygienists who responded to the questionnaire. Question 12 asked if the respondents had educational training in their dental hygiene curriculum to manage sexual harassment. The majority (89%, 250) did not receive educational training in their dental hygiene curriculum to manage sexual harassment.

Question 13 asked if the current oral healthcare environment has policies or guidelines regarding sexual harassment. This question yielded a high negative response of 82% (216) indicating there were no policies or guidelines in their current work environment (See Figure 5).

Question 14 listed 6 opinions about filing a formal complaint and was scored on a Likert scale with four choices, *strongly disagree, disagree, agree,* and *strongly agree.* For clarity of analysis, *strongly disagree and disagree* were combined and *agree and strongly agree* also were combined and reported as two categories. As Table 12 shows, 34% (92) were afraid of losing their job if a formal complaint was filed; 36% (97) were afraid their salary would be jeopardized; and 46% (123) did fear negative employment
Figure 4. Virginia Dental Hygienists Who Considered/Did Not Consider Leaving Their Employment Because of Sexual Harassment (N=138)
Figure 5. Virginia Oral Healthcare Settings With and Without Sexual Harassment Policies and Guidelines (N=266)
recommendation. The next two questions related to the filing of a formal complaint.

Sixty-three percent (168) of dental hygienists would be reluctant to file a formal complaint for fear of receiving negative retaliation socially within the dental profession while 82% (219) were not afraid of a negative retaliation socially within the community.

The final sub-question was a statement to which they agreed or disagreed. To the statement, 'I would not be reluctant to file a formal complaint', 61% of the respondents said they would not be reluctant to file a formal sexual harassment complaint.

Table 12. Opinions of All Virginia Dental Hygienists Regarding Filing a Formal Sexual Harassment Complaint (N=267)

<table>
<thead>
<tr>
<th>Hesitations About Filing a Formal Sexual Harassment Complaint</th>
<th>Number (n)</th>
<th>Responses Agree/Strongly Agree Percentages (Frequencies)</th>
<th>Responses Strongly Disagree/Disagree Percentages (Frequencies)</th>
</tr>
</thead>
<tbody>
<tr>
<td>14a. I could lose my job</td>
<td>267</td>
<td>34% (92)</td>
<td>66% (175)</td>
</tr>
<tr>
<td>14b. I could jeopardize the possibility of a salary increase</td>
<td>268</td>
<td>36% (97)</td>
<td>64% (171)</td>
</tr>
<tr>
<td>14c. I could receive negative employment recommendations</td>
<td>269</td>
<td>46% (123)</td>
<td>54% (146)</td>
</tr>
<tr>
<td>14d. I could receive negative retaliation socially within dental profession</td>
<td>268</td>
<td>37% (99)</td>
<td>63% (168)</td>
</tr>
<tr>
<td>14e. I could receive negative retaliation socially within community</td>
<td>267</td>
<td>18% (48)</td>
<td>82% (219)</td>
</tr>
<tr>
<td>14f. I would not be reluctant to file formal complaint</td>
<td>270</td>
<td>61% (165)</td>
<td>39% (105)</td>
</tr>
</tbody>
</table>

Questions 15-19 asked respondents to indicate their responses using a Likert scale with four choices, strongly disagree, disagree, agree, and strongly agree. Again for clarity of analysis, strongly disagree and disagree were combined and agree and strongly agree also were combined and reported as two categories (See Table 13). When asked their opinion as to whether sexual harassment was a problem, slightly over one-third
(36%) indicated it was a problem in the oral healthcare environment.

Table 13. Opinions of Virginia Dental Hygienists Regarding Sexual Harassment Issues

<table>
<thead>
<tr>
<th>OPINIONS ABOUT SEXUAL HARASSMENT</th>
<th>NUMBER (N)</th>
<th>RESPONSES Agree/Strongly Agree Percentages (frequencies)</th>
<th>RESPONSES Strongly Disagree/Disagree Percentages (frequencies)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q 15. Sexual harassment is a problem in the oral healthcare setting</td>
<td>264</td>
<td>36% (96)</td>
<td>64% (168)</td>
</tr>
<tr>
<td>Q 16. Filing a formal complaint is an effective strategy to alleviate sexual harassment</td>
<td>266</td>
<td>70% (186)</td>
<td>30% (80)</td>
</tr>
<tr>
<td>Q 17. Dental hygiene education prepared me to manage sexual harassment in the workplace setting</td>
<td>273</td>
<td>8% (23)</td>
<td>92% (250)</td>
</tr>
<tr>
<td>Q 18. Guidelines and policies regarding sexual harassment should be discussed in the dental hygiene curricula</td>
<td>273</td>
<td>95% (258)</td>
<td>5% (15)</td>
</tr>
<tr>
<td>Q 19. It would benefit the dental hygiene profession if the ADHA developed model policies and guidelines on sexual harassment in the workplace</td>
<td>275</td>
<td>85% (235)</td>
<td>15% (40)</td>
</tr>
</tbody>
</table>

Question 16, related to filing a formal complaint as an effective strategy for alleviating sexual harassment. It was scored on a Likert scale with four choices, *strongly disagree, disagree, agree,* and *strongly agree.* For clarity of analysis, *strongly disagree* and *disagree* were combined and *agree* and *strongly agree* also were combined and reported as two categories. Table 13 shows, the majority (70%, 186) believed that filing a formal complaint was an effective strategy for alleviating sexual harassment.

Question 17 revealed that almost all of the dental hygienists (92%, 250) indicated their education did not prepare them to manage sexual harassment (See Table 13).

Questions 18 and 19 were statements related to guidelines and policies, and were scored on a Likert scale. The four possible responses: *strongly disagree, disagree, agree,* and *strongly agree.*
and strongly agree were combined and reported as two categories; (95%, 258), felt that guidelines and policies regarding sexual harassment should be included in the dental hygiene curriculum as indicated in Table 13. Eighty-five percent (235) of the respondents believed that development of model guidelines and policies by the American Dental Hygienists' Association would benefit the dental hygiene profession.

Research Question 1: What is the prevalence of sexual harassment among Virginia dental hygienists? Analysis by frequency indicated that 54% (155) of the employed dental hygienists experienced sexual harassment sometime during their professional careers and 45% (128) did not experience this behavior (See Figure 6).

Research Question 2 and Hypothesis 1: Is there a relationship between dental hygienists' age and their sexual harassment experience? Hypothesis: There is no relationship between age and dental hygienists experiencing sexual harassment. The ages of the dental hygienists, from 21-64 with a mean of 40 (sd=8.4), were divided into two groups: 21-39, and 40-64. The chi square test of association was used to determine the relationship between sexually harassed dental hygienists and their age. As Table 7 indicates, 55% (82) of the dental hygienists between 21 and 39 years old and 55% (68) of the dental hygienists between 40 and 64 years were harassed. Chi-square analysis revealed no statistically significant relationship and the null hypothesis was retained ($\chi^2 = .001; df=1; p=.977$). Therefore, in this study, age was not associated with sexual harassment (Table 14).

Research Question 3 and Hypothesis 2: Is there a relationship between marital status and dental hygienists experiencing sexual harassment. Hypothesis: There is no relationship between marital status and dental hygienists experiencing sexual harassment. The marital
Figure 6. Prevalence of Virginia Dental Hygienists Experiencing Sexual Harassment (N=285)
status, (married, single, divorced, cohabitating, widowed) was categorized into two
groups married and unmarried. Eighty-six percent (241) of the sample were
married and 14% (38) were single, divorced or cohabiting. Analysis revealed that 54% 
(130) of the married dental hygienists were sexually harassed and 55% (21) of the 
unmarried were also sexually harassed. Statistical analysis revealed no statistically
significant association between marital status and sexual harassment \( \chi^2 = .010; df=1; 
p=.920 \). The hypothesis was retained; therefore, marital status and sexual harassment are
not related in dental hygienists (See Table 14).

Table 14. Chi-square Test Results of Various Factors Which Could Affect Virginia
Dental Hygienists, (N=285) Who Experienced Sexual Harassment

<table>
<thead>
<tr>
<th>Factors Which Could Affect the Virginia Dental Hygienists Who Experienced Sexual Harassment</th>
<th>( \chi^2 )</th>
<th>df</th>
<th>Probability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age of dental hygienists</td>
<td>.001</td>
<td>1</td>
<td>.977</td>
</tr>
<tr>
<td>Marital status</td>
<td>.010</td>
<td>1</td>
<td>.920</td>
</tr>
<tr>
<td>Level of dental hygiene education, associate and bachelor or higher</td>
<td>.019</td>
<td>1</td>
<td>.890</td>
</tr>
<tr>
<td>Perception of sexual harassment as a problem</td>
<td>39.92</td>
<td>1</td>
<td>.000</td>
</tr>
<tr>
<td>Educational prevention training in the dental hygiene educational setting</td>
<td>.647</td>
<td>1</td>
<td>.421</td>
</tr>
</tbody>
</table>

Research Question 4 and Hypothesis 3: Is there a relationship between the educational
level (associate degree and bachelor's degree or higher) of dental hygienists who
experience sexual harassment? Hypothesis: There is no relationship between educational
level (associate and bachelor's or higher) and dental hygienists experiencing sexual
harassment. The educational levels of the dental hygienists were divided into two groups:
associate/certificate and bachelor's degree or higher. Table 7 shows, 42% (117) of the
Virginia dental hygienists sampled hold associate certificate degrees and 58% (159) hold
bachelor's degrees or higher. Of those who hold associate/certificate degrees 56% (65) were
sexually harassed; 55% (87) of the dental hygienists who hold bachelor’s degrees or higher experienced this illegal behavior. The chi-square analysis revealed no significant association between the level of education and sexual harassment ($\chi^2 = .019; \text{df}=1; \text{p}=.890$). Therefore, level of education was not found to be associated with sexual harassment in dental hygienists, and the null hypothesis was retained.

Research Question 5 and Hypothesis 4: Do Virginia dental hygienists perceive sexual harassment as a problem in the oral healthcare profession? Hypothesis: There is a relationship between perception of sexual harassment as a problem and dental hygienists experiencing sexual harassment. Analysis by frequency indicated that the majority of dental hygienists (63%, 166) did not consider sexual harassment a problem in the oral healthcare environment; however, 42% (70) of the sexually harassed dental hygienists, did not believe that sexual harassment was a problem. Chi-square analysis indicated a significant association between sexually harassed dental hygienists and their perception of sexual harassment ($\chi^2 = 39.92; \text{df}=1; \text{p}=.000$), (See Table 14). Therefore the null hypothesis was rejected. Dental hygienists who experience sexual harassment are more likely to perceive this behavior to be a problem in the oral healthcare environment than those who do not experience harassment.

Research Question 6 and Hypothesis 5. Do Virginia dental hygienists believe their dental hygiene education prepared them to manage sexual harassment in the workplace? Hypothesis: There is no relationship between sexual harassment prevention training in the dental hygiene curriculum and dental hygienists experiencing sexual harassment. An analysis of frequency revealed that 92% (250) of the dental hygienists believed they were not educationally prepared to manage sexual harassment. Question 17. The relationship
between sexual harassment prevention training in the dental hygiene curriculum and dental hygienists experiencing sexual harassment, Question 12, revealed that 90% (249) of the dental hygienist did not receive educational training to manage sexual harassment. Of those dental hygienists who did not receive educational training, 54% (135) were sexually harassed, (See Table 15). Chi-square analysis revealed no statistically significant difference and the null hypothesis was retained ($\chi^2 = .647; df=1; p=.421$). Therefore, receiving training about sexual harassment is not associated with the incidence of sexual harassment.

Table 15. Receipt of Sexual Harassment Management Training in the Dental Hygiene Curriculum

<table>
<thead>
<tr>
<th>Question</th>
<th>Percent of Sexually Harassed Dental Hygienists</th>
<th>Percent of Sexually Harassed Dental Hygienists</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q12 Did you receive training in the dental hygiene curriculum to manage sexual harassment</td>
<td>54% (135)</td>
<td>62% (18)</td>
</tr>
</tbody>
</table>

Research Question 7: Do dental hygienists who have been sexually harassed in the oral healthcare environment, leave their employment? Analysis by frequency showed 84% of dental hygienists who were sexually harassed did not leave their employment.

Research Question 8: Do dental hygienists in Virginia want the American Dental Hygienists' Association to develop model policies or guidelines on sexual harassment in the workplace? Eighty-five percent of the dental hygienists wanted model guidelines and policies developed by the American Dental Hygienists' Association (See Table 13).
Figure 7. Virginia Dental Hygienists Sampled and Their Employment Status Because of Sexual Harassment (N=138)
Discussion

Data from the demographic section of the sexual harassment questionnaire are discussed first, followed by each research question and hypothesis as stated in this study. The demographic findings of gender, age and marital status of sexually harassed dental hygienists were compared to those reported by Chiodo, Tolle and Labby (1992) who found that of the 235 Oregon dental hygienists sampled, 100% were female, mean age was 36 years, and 79% were married. The variables of race and educational level were not addressed in this study.

Fifty-four percent of dental hygienists in this study reported experiencing sexual harassment while employed as dental hygienists. These findings are supported by Siegel (1992) who stated that 50-85% of American working women will be sexually harassed, either in their employment setting or academic life. Chiodo, Tolle and Labby (1992) also reported a sexual harassment prevalence of 67% in Oregon dental hygienists. The varying prevalence rates could be due to the population studied or to the way the researchers defined and measured sexual harassment.

Question 1 reflected a continuum of sexual harassment experiences, from mild to severe. Question 1 a-c were examples of verbal harassment, and question 1 d-g were examples of physical harassment. The Equal Employment Opportunity Commission (EEOC) established Interpretive Guidelines, Discrimination Because of Sex Under Title VII of the Civil Right’s Act of 1964, to protect employees from sexual discrimination in the work environment. The Interpretive Guidelines are the Federal rules and regulations used in Supreme Court decisions concerning sexual harassment cases. The EEOC, in
Section 703 of Title VII states "unwelcome... verbal or physical conduct of a sexual nature constitutes sexual harassment... when the conduct has the purpose of creating an intimidating hostile or offensive working environment" (See Appendix F). Many respondents expressed in their personal comments that they did not consider sexual jokes as sexual harassment although the EEOC does classify sexual jokes as sexual harassment (See Appendix H). Decker (1997) reported that healthcare professionals experience more sexual harassment than other occupations. Factors which might contribute to this are the ratio of males to females in the healthcare professions, the stress and anxiety many clients experience during healthcare, and the fact that the human body and sexuality are legitimate foci of attention in some healthcare settings (Decker, 1997; Kaye, 1996; Sherer, 1995). Another factor is the relationship between the dentist, the ultimate authority in the oral healthcare setting, and the employee who have less power (Gervasi 1984; Zarkowski 1996; Weinstein 1994).

The reported occurrence of sexual harassment experienced by Virginia dental hygienists is a concern to the dental hygiene profession. Ten percent of the dental hygienists indicated they currently were experiencing sexual harassment and 18% indicated they had experienced harassment within the past year of the completing the survey. Fifty percent, the largest percentage of sexual harassment reported in this survey, occurred more than four years ago. Asking respondents to recall events more than three years ago might have produced a biased result because the social norms and legal terminology change over time (Arvey & Cavanaugh, 1995; Burns, 1995; Fitzgerald, Swan & Fischer, 1995). Therefore, the results derived from respondents long-term memory should be suspect.
Two-thirds of the sexually harassed respondents (62%) only reported experiencing sexual harassment in one oral healthcare setting. Experiencing a sexual harassing incident in the oral healthcare environment may alert the dental hygienist to be aware of situations which may lead to harassing incidents. Alleviating a particular situation could prevent the recurrence of another harassing occurrence.

The results from Item 3 suggest that the dentist was most frequently implicated (73%) as a harasser in the oral healthcare environment, followed by the male client (45%). Historically, dental hygiene has been a predominately female profession, and is currently 99% female (Worley, 1996). In most dental settings the dentist will be a male and the hygienists will be female. This setting may be a contributing factor to sexual harassment in the oral healthcare environment (Arvey & Cavanaugh, 1995; Decker, 1997).

The type of oral healthcare setting where the sexual harassment occurred was another factor considered. Sixty-two percent of the dental hygienists experienced sexual harassment in the solo practice setting. In a solo practice there is one dentist who is the authority figure as employer, owner and supervisor. The power and authority of the dentist in solo practice has the greatest potential for abuse as indicated by two-thirds of the dental hygienists who experienced sexual harassment in that type of setting. Some dental hygienists felt a strained relationship between themselves and the employer dentist, as indicated in the personal comments: “Our biggest obstacle is the fact that we’re in small offices, we have no boss to complain to if he is the only male in the practice and this is the problem”; “The dentists have the power!”: “So much of this type of thing is ‘your word against mine’” (See Appendix H). From the comments, some dental hygienists appear frustrated and felt they had no where to go for legal recourse and
emotional support. Including information on sexual harassment in the dental hygiene curriculum and at professional meetings might empowered dental hygienists to manage sexual harassment experiences and maximize their sense of control.

The finding that age was not related to sexual harassment differs from those of Garvin and Sledge (1992) who reported that most of the sexually harassed dental hygienists in Washington State were between 20 and 35 years of age. Fitzgerald and Shullman (1993) reported that younger women were more likely to experience sexual harassment. The data from this investigation fail to support an association between age of dental hygienists who experience sexual harassment in the oral healthcare setting. Perhaps one explanation for this is that sexual harassment is not necessarily about physical attraction, but rather power and authority over gender, and therefore, is not confined to the young. Another explanation might be the public acknowledgement and awareness of sexual harassment, which is now openly discussed. The most likely explanation maybe related to the design of the questionnaire. The demographic datum reflects the respondent’s status at the time of the survey, yet the harassment may have taken place at an earlier age. Therefore the relationship between age and sexual harassment are confounded by time, and cannot be confidently interpreted.

The finding of this study showed no statistically significant relationship between Virginia dental hygienists who experienced sexual harassment and their marital status. This conflicts with other studies (Fitzgerald and Shullman, 1993; Frank, Brogan and Schiffman, 1998) which reported that most victims of sexual harassment are “young, single, white women”. Perhaps as the number of married women in the workforce
continues to increase, their likelihood of exposure to harassing behavior also increases. The relationship between sexual harassment and marital status may be spurious. The questionnaire collected data on the marital status of the respondent at the time of the survey, yet the harassment may have taken place when the dental hygienist's marital status was different. Therefore, because of limitations in the survey design, the relationship between sexual harassment and marital status cannot be confidently interpreted.

The analysis of the level of education and sexual harassment revealed no significant difference. Fitzgerald and Shullman (1993) reported that highly educated subjects usually participate in mail surveys, perhaps explaining the higher response from dental hygienist with bachelor's degrees. Wayman (1985) stated that many associate/certificate dental hygiene curricula require credits far beyond the traditional two year degree blurring the difference between associate and baccalaureate level dental hygienists. The minimal credit difference between associate/certificate and bachelor degree dental hygiene programs may explain why no statistically significant association was found between the level of education and sexually harassed dental hygienists. The design of the questionnaire did not specify the level of education at the time of harassment; therefore, the relationship between the level of education and sexual harassment should be interpreted cautiously.

Only 37% of the Virginia dental hygienists considered sexual harassment a problem; however, of the dental hygienists who experienced sexual harassment, 82% agreed it was an issue in the oral healthcare setting. The statistically significant association between the perception of sexual harassment and the occurrence of sexual
harassment can perhaps be explained by some of the respondent’s comments. Some participants commented that they had no opinion on the perception of sexual harassment because they had never personally experienced it, which could explain why some respondents did not answer the question. There is a slight discrepancy between Question 1, dental hygienists who indicated they were sexually harassed (54%), and dental hygienists who indicated sexual harassment is not a problem (63%). This may suggest dental hygienists accept sexual harassment as a normal occurrence in the workplace. Another explanation could be the changing perceptions and definitions of ‘sexual harassment’, once an individual has experienced this harassing behavior.

Eighty-eight percent of the dental hygienists did not believe their dental hygiene education prepared them to manage sexual harassment which could occur in the workplace. A similar question asked participants if they received training in their dental hygiene curriculum to manage sexual harassment. Again a high percentage, 90% (249), indicated they received no training to manage this type of behavior. It is possible that this lack of training is related to half (54%) of the Virginia dental hygienists experiencing sexual harassment. Sexual harassment is usually a progression of events, comments and innuendoes, rather than a single occurrence, (Fitzgerald & Shullman, 1993; Chiodo, Tolle & Labby, 1992). Training in the management of sexual harassment could deter the harassing behavior, prepare practicing professionals for this behavior, and possibly reduce the percentage of dental hygienists leaving the employment setting.

Thirty percent of the dental hygienists who were sexually harassed considered leaving their employment. However, only 16% left the employment environment because of the harassing behavior. The finding that 1 out of 6 dental hygienists left their
employment because of sexual harassment, exceed the ratio found by the United States Merit Protection Board in 1981, which reported that nearly 1 out of 10 women left their employment because of sexual harassment. Like many women, dental hygienists find themselves in environments with male superior figures and no harassment policies to protect them. Another explanation is that many women will leave a situation rather than draw attention to themselves with an assertive or confrontational behavior (Cann, 1979).

In the small oral healthcare environment, with one male dentist, the dental hygienists felt their only recourse was to leave the employment or tolerate the situation. Most choose to tolerate the situation. The 54% sexual harassment prevalence rate in Virginia dental hygienists is consistent with the prevalence rate of 50-85% as reported by the 1992 National Council for Research on Women (Seigel, 1992).

Eighty-five percent of the Virginia dental hygienists sampled wanted the ADHA to develop model policies and guidelines on sexual harassment. Guidelines and policies, directly related to the personnel in the oral healthcare environment, would protect employees from victimizers and encourage the dental hygiene professional to pursue a legal course of action when necessary. Access to guidelines and policies within the healthcare environment might encourage victims to file formal complaints and manage sexual harassment.

Two similar questions about written policies or guidelines in the oral healthcare setting were asked of sexually harassed and not sexually harassed dental hygienists. Unfortunately, 88% of the sexually harassed dental hygienists were unaware of written policies or guidelines in their work environment. Eighty-one percent of the dental hygienists who had not experienced sexual harassment said their current employment
settings did not have written policies and guidelines pertaining to sexual harassment. Too frequently, dental hygienists either lack informed legal knowledge or are unaware of established policies within the oral healthcare setting, allowing the employer dentist to control the work environment unfairly. Lack of knowledge regarding sexual harassment policies could prevent an uninformed victim from seeking legal help. This lack of knowledge is a strong indication of the need to inform dental hygienists of the evolving laws and regulations regarding sexual harassment. If dental hygienists are taught sexual harassment prevention and management strategies, then they would be prepared to identify illegal behaviors and not excuse sexual harassment to maintain their jobs.

Several questionnaire items pertained to filing formal complaints. One question attempted to determine the response of dental hygienists who experienced sexual harassment and did not file a formal complaint. The majority of individuals (57%) ignored the harassing behavior, an action that was also found prevalent by Gutek and Koss (1993). Some victims blame themselves for the sexual harassing behavior they received and this self-effacing attitude diminishes the likelihood of reporting the incident or filing a formal complaint. Moreover, victims might not complain about sexually harassing situations because they feel unable to change the situation themselves or because they fear retaliation. The second and third most frequent responses, telling a co-worker (36%) and telling a friend or family member (35%), implies a close association and trust between co-workers and friends or family, and not with authority figures. Telling a co-worker of an incident, which occurred in the dental environment, allows for other co-workers to validate and report harassment if they also have been
sexually harassed. Only 29% of the victims told the offending person to stop the harassing behavior. This low percentage is a clear indication that the majority of harassed dental hygienists do not know how to confront the victimizer as a strategy for managing sexual harassment. Research suggests that ignoring a harassing behavior will not eliminate or stop the harassment; the harasser must be reported, confronted and told to stop (Livingston, 1982; Gutek & Koss, 1993; Fitzgerald, Swan & Fisher, 1995).

Approximately two-thirds of the respondents indicated that they were not reluctant to file a formal complaint. However, 50% of the dental hygienists were concerned about receiving negative social retaliation within the dental office. Results indicated that while Virginia dental hygienists in this study desired to be socially accepted within the oral healthcare setting, they reported a willingness to jeopardize their jobs and social contacts when necessary, to file a formal complaint.

When asked to whom the dental hygienist spoke to about the harassing incident, 72% reported to no one. However, when a victim confided in someone about the harassing incident, they spoke to a family member, co-worker or friend; not someone with authority in the dental environment. Perhaps a lack of support or lack of trust in the authority figure or the fact that the authority figure (dentist) was the victimizer, explains why the victim spoke to a personal acquaintance. This question was not answered by 96 of the sexually harassed dental hygienists who participated in the survey. The lack of responses could be attributed to the wording in this question “if you filed a formal complaint...” which implied individuals who experienced sexual harassment and filed a formal complaint. Or, the lack of responses to this question could be explained by the fact that almost none of the respondents filed a formal complaint.
Section III, personal opinion and comments, answered by the entire sample listed reasons why a dental hygienist might be reluctant to file a formal complaint against a sexual harasser. Nearly two-thirds of the respondents stated they would not be reluctant to file a formal complaint about sexual harassment. However, nearly one-half of the participants felt some reluctance because it would negatively affect their employment recommendation. The indication was that they would be willing to file formal complaints, and yet 55% were harassed and complaints were not filed. One-third of the dental hygienists were afraid they could lose their job, jeopardize salary increases or receive negative social retaliation within the dental profession. The fear of a negative employment recommendation was indicative of the relatively small dental community where reputations and recommendations are critical to employment. The possibility of employees or employers dropping names into conversations with colleagues, and thus a poor recommendation for a dental hygienist could exist. Some comments from the dental hygienists in the survey were: "Do you go and find another dentist to work for and have that dentist ask why you left your former employer?"; "Our jobs are always on the line and in small communities our employability is at risk as well. Doctors can and will shun a potential employee that has 'blown the whistle'; "On any inappropriate behavior, be it sexual, work quality, billing practice, etc., they [dentists] close ranks quickly" (See Appendix H).

The final question about filing a formal complaint asked if "filing a formal complaint was an effective strategy to alleviate sexual harassment". Seventy percent agreed that filing a formal complaint was an effective strategy. Paradoxically, it was reported that of the 54% sexually harassed dental hygienists, only 1 person out of 145
(0.07%) actually filed a formal complaint. This underscores the chasm between what people say they would do, and what they do when faced with sexual harassment. The literature revealed that it was common for a sexually harassed victim to ‘do nothing’ or to endure the harassment (Fitzgerald, Swan & Fischer, 1995 and; Gutek & Koss, 1993).

The following could be some reasons why a victim might not file a formal complaint: blaming themselves or justifying a sexual harassing incident; lack of emotional support; lack of knowledge about where to go for help and legal assistance; fear of legal expenses; the necessity to remain employed and the fact that the EEOC will only investigate sexual harassment allegation in work settings with 15 or more employees (Fitzgerald, Swan & Fisher, 1995; and Jensen & Glutk, 1982; Gutek & Koss, 1993).

The incidents of sexual harassment and the negative effects could be curtailed through continuing education courses on the illegibility of sexual harassment in the dental hygiene profession. Publishing informative articles on sexual harassment in national dental magazines would also be of benefit. This was suggested by comments from the dental hygienists stating that training on sexual harassment should be included in the dental hygiene curriculum. Ninety-five percent of the respondents agreed that sexual harassment education is important. Many experts also believe that receiving training in the management of sexual harassment is the best prevention for this illegal behavior (Frank, Brogan & Schiffman, 1998; Decker, 1997; Kaye, 1996; Webb, 1994; Burns, 1995; Weinstein, 1994).
CHAPTER V

SUMMARY AND CONCLUSIONS

Summary

In 1964 Congress established a series of laws and regulations which defined and clarified sexual harassment. During the following decades, however, changes in social norms and mores have meant that many of these laws now have new rulings and new interpretations. The Equal Employment Opportunity Commission (EEOC), supported by the Federal government, offers free legal recourse to sexually harassed employees; as long as there are 15 or more employees within the work environment. This limits the potential for sexually harassed dental hygienists to receive help from the EEOC. Between 1990 and 1996, the EEOC reported that complaints formally filed on sexual harassment increased 150%. Sexual harassment complaints, not formally filed, were settled out of court for an average of $150,000 per incident (Sexual Harassment Seminar, 1998).

Employee training on sexual harassment and its prevention is a major concern for many large businesses (Sexual Harassment Inc., 1994). A typical large company, such as a Fortune 500 Company, will lose approximately $6 million dollars annually because of sexual harassment incidents (Sexual Harassment Seminar, 1998). The effects that sexual harassment has on employees include: absenteeism, anxiety attacks, headaches, insomnia, depression, low self-esteem, lack of job satisfaction, and reduction in work performance (Siegel, 1992). The National Council for Research on Women reported in 1992 that 50-85% of American women will experience some form of sexual harassment during their employment or academic life. Since the dental hygiene profession is predominately female, it is important that the dental hygienist know how to file formal complaints and implement
effective sexual harassment management strategies. This study was conducted to determine the prevalence of sexual harassment among Virginia dental hygienists, examine how sexual harassment incidents were managed, and illicit personal opinions on issues related to sexual harassment. Results may be used to understand the extent of the sexual harassment problem among Virginia dental hygienists and spur the development of educational programs for the prevention and management of sexually harassing behaviors.

A self-designed instrument, the *Sexual Harassment in the Dental Hygiene Profession Questionnaire*, was used to collect the information from a sample of 1997 dental hygienists registered in Virginia. To increase the validity and reliability of this investigation, a pilot study of 20 Virginia dental hygienists was performed. Data were analyzed using frequencies and percentages and the chi square test of association to determine relationships between dental hygienists and their experiences.

The data revealed the following information about Virginia dental hygienists:

1. The majority of dental hygienists (54%) admitted they were sexually harassed in the oral healthcare environment. Of the dental hygienists harassed, 50% indicated the harassment occurred more than four years ago; however, 10% reported the harassment was currently occurring and 18% said they were harassed within the past year.

2. The results of this investigation revealed no association between sexually harassed dental hygienists and their age, marital status or level of education.

3. Two thirds of the dental hygienists (64%) did not consider sexual harassment a problem in the oral healthcare setting. Although 70% of the dental hygienists agreed that filing a formal complaint was the correct strategy to alleviate sexual
harassment, in reality, only one individual who experienced sexual harassment (less than 1%) actually filed a formal complaint.

4. The majority of dental hygienists (89%) did not receive formal sexual harassment training in their dental hygiene curriculum and 91% indicated their dental hygiene education did not prepare them to manage sexual harassment. These findings emphasize the importance of employee training on sexual harassment and its prevention.

5. One third of the dental hygienists who experienced sexual harassment considered leaving their employment; however, only 16% actually did.

6. Eighty-five percent of the dental hygienists wanted the ADHA to develop policies and guidelines on sexual harassment. Of the sexually harassed dental hygienists, 88% were unaware of written policies or guidelines within their work environment. Establishing guidelines which are supported by the ADHA would inform and empowered the dental hygienists to manage illegal harassing behaviors.

Conclusions

Based on these findings, the following conclusions are made:

1. Virginia dental hygienists are experiencing sexual harassment in the oral healthcare environment at rates similar to the general population of American working women.

2. Male dentists and male clients perpetrate most sexually harassing incidents experienced by dental hygienists in the oral healthcare environment.

3. Sexual harassment experiences of Virginia dental hygienists are not related to
the victim's age, martial status or level of professional education as measured in this survey.

4. Sexually harassed Virginia dental hygienists know that filing a formal complaint is an effective strategy to alleviate sexual harassment; however, in reality, formal complaints are rarely filed.

5. Sexual harassment in the oral healthcare environment is a problem that often goes unchecked and unreported.

6. Dental hygiene curricula fail to prepare dental hygienists to manage sexual harassment.

7. Most Virginia dental hygienists are unaware of (or unprotected by) written policies or guidelines on sexual harassment in their employment settings.

8. The majority of Virginia dental hygienists who are sexually harassed tend to remain in their employment setting.

9. The dental hygiene profession would benefit from the American Dental Hygienists' Association and the American Dental Association developing model policies and guidelines on sexual harassment in the oral healthcare environment.

Considering the limitations and design of the study, use of a self-designed questionnaire, preconceived ideas and norms regarding sexual harassment, and the sensitivity of a personal experience with sexual harassment, the following recommendations for future study are offered:

1. Replication of this study using populations of dental hygienists from other states is necessary to verify the validity and reliability of the Sexual Harassment
2. Replication of this study using a modification of the questionnaire *Sexual Harassment in the Dental Hygiene Profession Questionnaire* so that the demographic variables of age, marital status and level of education can be measured as they were at the time of the sexual harassment.

3. A comparison of the prevalence of sexual harassment, in the profession of dental hygiene with other female dominated healthcare professions.

The findings of this study suggest a critical need for formal training in the management of sexual harassment in the dental hygiene curriculum. Dental hygiene educators need to instruct students about how to respond to harassing incidents with standards of professionalism, speech and demeanor. An instructional handbook for the prevention of sexual harassment should be designed to include: the definition; prevention-training methods (with examples), emotional and psychological effects of the victim; and procedures for pursuing a legal course of action when necessary. The personal comments from the dental hygienists in this study clearly indicate an interest in continuing education courses on sexual harassment provided by a lecturer experienced in sexual harassment issues. The American Dental Hygienists' Association and the American Dental Association should collaboratively develop guidelines for the prevention of sexual harassment and encourage the subject to be discussed at the national and state levels. Each dental office should have included in their office policies and procedures manual, the Federal Guidelines for the Prevention of Sexual Harassment, a list of area support groups, and the legal course of action if sexual harassment occurs. Educating the dental hygienist to manage sexual harassment situations could promote assertiveness and self-esteem, thus improving dental hygiene.
employee satisfaction and retention in the oral healthcare environment.
BIBLIOGRAPHY


APPENDIX A

SEXUAL HARASSMENT IN THE DENTAL HYGIENE PROFESSION QUESTIONNAIRE
Sexual Harassment In The Dental Hygiene Profession Questionnaire
Dear Registered Dental Hygienist,

A survey is being conducted to determine the prevalence of unwanted sexual behaviors experienced by dental hygienists in Virginia. This research is being conducted in partial fulfillment of the requirements for the degree of Master of Science in Dental Hygiene. Your participation in this survey will help to improve the work environment for dental hygienists.

Due to the sensitive subject matter of this study, I would like to emphasize that your responses are completely anonymous. Please return the postcard indicating your willingness to participate or not participate in the survey. Separately, please return the completed questionnaire in the enclosed self-addressed stamped envelope by April 30, 1998. The questionnaire should take less than 15 minutes to complete.

For the purpose of this research sexual harassment is defined as an unwanted sexual behavior which includes: leers, suggestive sexual comments; unwelcome sexual advances; physical contact that you may find objectionable; requests for sexual favors; and/or physical or verbal conduct that effects your work performance creating a hostile, intimidating or fearful work environment.

There are no risks involved for those who participate in this survey. If you have concerns about sexual harassment, you may contact the EEOC in Virginia 1-800-669-4000. If you have any questions about the survey, you may contact my faculty advisor, Michele Darby, BSDH, MS at 757-683-5232; mdarby@odu.edu. The results of the study will be available upon written request. Thank you for your cooperation and prompt response.

Sincerely,

Anne Pennington, RDH, RBA
Master’s Degree Candidate
School of Dental Hygiene
Old Dominion University
Norfolk, Virginia 23429-0499
e-mail: abassett@odu.edu 757-683-5233

Old Dominion University is an equal opportunity, affirmative action institution.
SEXUAL HARASSMENT IN THE DENTAL HYGIENE PROFESSION QUESTIONNAIRE

Directions: Please complete this questionnaire only if you have worked as a clinical dental hygienist in Virginia; otherwise, please return the questionnaire in the self-addressed, stamped envelope. Thank you very much.

Section I. Experiences with Sexual Behavior
The following are examples of sexual harassment. Please read each statement and circle the number that represents the frequency of workplace experiences you may have had while employed as a dental hygienist.

1. a) Was subjected to sexual stories or jokes which were offense to me.
   1) Never  2) Seldom  3) Sometimes  4) Often  5) Most of the Time
   1  2  3  4  5

   b) Felt demeaned because of my gender.
   1  2  3  4  5

   c) Received unwanted attempts to be drawn into a discussion of personal or sexual matters.
   1  2  3  4  5

   d) Was asked continuously for dates, dinner etc. after repeated refusal.
   1  2  3  4  5

   e) Was threatened because I did not comply with the requests of the offender.
   1  2  3  4  5

   f) Was touched more than once in a way that made me feel uncomfortable.
   1  2  3  4  5

   g) Received 'uninvited sexual behaviors' which embarrassed or upset me.
   1  2  3  4  5

If all answers were “never” please turn to page 3, Section III, Personal Opinion, and Section IV, Demographics, complete and return the questionnaire in the self-addressed, stamped envelope.

2. When did the sexual harassment occur?
   1  2  3  4  5
   1) Currently  3) 1-2 years ago  5) More than 4 years ago
   2) Within the past year  4) 3-4 years ago
3. From whom did you experience sexual harassment while working as a dental hygienist? (Check all that apply)
   a □ Male Dentist   b □ Male Co-worker   c □ Male Client   d □ Female Dentist   e □ Female Co-worker   f □ Female Client   g □ Other

4. In what type of practice setting did you experience sexual harassment? (Check all that apply).
   a □ Solo   b □ Dual Partnership   c □ Group   d □ Other

5. Have you experienced sexual harassment in more than one healthcare setting while employed as a dental hygienist in Virginia?
   1 □ Yes   2 □ No

Section II. Management of Sexual Harassment

6. If you did not file a formal complaint, what did you do in response to the sexual harassment you experienced? (Check all that apply)
   a □ Ignored it   b □ Did not tell anyone   c □ Told a co-worker   d □ Told a friend or family member   e □ Told the offending person to stop   f □ Documented the incident   g □ Terminated my employment   h □ Filed a formal complaint (if you checked this number, please go to #9)

7. The following is a list of reasons why a person might not file a formal complaint regarding sexual harassment. To what degree did these reasons play a role in your decision to not file a formal complaint?

<table>
<thead>
<tr>
<th>Reason</th>
<th>Very Concerned</th>
<th>Concerned</th>
<th>Not Concerned</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Losing my job</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>b) Jeopardize possibility of salary increases</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>c) Receiving a negative employment recommendation</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>d) Negative retaliation socially within the dental office</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>e) Negative retaliation socially within the dental profession</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>f) Negative retaliation socially within the community</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>g) Other</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
8. If you did file a formal sexual harassment complaint, to whom did you report? (Check all that apply).
   a ☐ Dentist        d ☐ Family member        g ☐ None
   b ☐ Office Manager e ☐ Co-worker        h ☐ Other
   c ☐ Friend         f ☐ Legal authorities

9. Were you aware of a written policy or specific guidelines regarding sexual harassment in the oral healthcare setting where you were sexually harassed?
   1 ☐ Yes          2 ☐ No

10. Did you ever consider leaving your employment because of sexual harassment?
    1 ☐ Yes          2 ☐ No

11. Did you ever leave your employment because of sexual harassment?
    1 ☐ Yes          2 ☐ No

Section III. Personal Opinion and Comments

12. Did you receive educational training in your dental hygiene curriculum to manage sexual harassment?
    1 ☐ Yes          2 ☐ No

13. Does your current oral healthcare setting have policies or guidelines regarding sexual harassment?
    1 ☐ Yes          2 ☐ No

For items 14-19, circle the number which most closely represents your opinion regarding each statement.

14. As a dental hygienist I would be reluctant to file a formal complaint because:

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) I could lose my job</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<tr>
<td>b) I could jeopardize the possibility of salary increases</td>
<td>1</td>
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<td>3</td>
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<tr>
<td>c) I could receive negative employment recommendations</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<tr>
<td>d) I could receive negative retaliation socially within the dental profession</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>e) I could receive negative retaliation socially within the community</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>f) I would not be reluctant to file a formal complaint</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>
15. Sexual harassment is a problem in the oral healthcare setting.
   Strongly Disagree | Disagree | Agree | Strongly Agree
   1 | 2 | 3 | 4

16. Filing a formal complaint is an effective strategy in alleviating sexual harassment.
   1 | 2 | 3 | 4

17. Dental hygiene education prepared me for managing sexual harassment which could occur in a workplace setting.
   1 | 2 | 3 | 4

18. Guidelines and policies regarding sexual harassment should be discussed in the dental hygiene curricula.
   1 | 2 | 3 | 4

19. It would benefit the dental hygiene profession if the American Dental Hygienists' Association developed model policies and guidelines on sexual harassment in the workplace.
   1 | 2 | 3 | 4

20. What do you think the dental hygiene profession could do to address sexual harassment in the oral healthcare environment?

______________________________
______________________________
______________________________
______________________________
______________________________

Section IV. Demographics

21. Gender:
   ☐ male      ☐ female

22. Age at last birthday: ______________________

23. Marital status:
   1 ☐ Single       3 ☐ Divorced       5 ☐ Widowed
   2 ☐ Married      4 ☐ Cohabiting
24. What is your ethnic background?
   1 ☐ Caucasian
   2 ☐ African American
   3 ☐ Native American/Alaskan
   4 ☐ Hispanic
   5 ☐ Asian/Pacific Islander
   6 ☐ Middle Easterner

25. What is the highest educational degree you have attained?
   1 ☐ Associate/Certificate in Dental Hygiene
   2 ☐ Bachelor’s Degree
   3 ☐ Master’s Degree
   4 ☐ Doctoral Degree

26. What year did you graduate from entry level dental hygiene school? ________________

This completes the survey. Thank you for your time and participation! Please return the questionnaire in the self-addressed, stamped envelope. If you are interested in the results of the survey or have other questions, please contact: 

Anne Pennington, RDH, RBA
Master’s Degree Candidate
School of Dental Hygiene
Old Dominion University
Norfolk, Virginia 23429-0499
e-mail: abassett@odu.edu  757-683-5233
Table 20. Test-retest Reliability of the Questionnaire Percentage Consistency Between the Two Repeated Questionnaires

<table>
<thead>
<tr>
<th>QUESTIONS</th>
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<tr>
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<td>87.5%</td>
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<td>1d</td>
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<td>1e</td>
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<tr>
<td>1f</td>
<td>87.5%</td>
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<tr>
<td>1g</td>
<td>75%</td>
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<td>2</td>
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Twenty questionnaires were sent out in the 1st mailing of the pilot study. Two were returned with incorrect addresses, thus reducing the sample to 18. Eleven answered questionnaires were returned, which was a 61% return for the 1st mailing. The second mailing was sent two weeks after the initial mailing. Eight answered questionnaires were returned, resulting in a 66% return. Each question was compared and percentage of consistency between the two sets of data computed to establish reliability. Question 6 and 8 had no reliability and were reworded for clarification. Question 6 also had a subsection added and question 8 included ‘check all that apply’.

The following are a list of changes to the pilot study questionnaire:

Comment after #1, now includes ‘Personal Opinion’

#6 added: b ‘Did not tell anyone

#8 added: check all that apply

#9 moved to Personal Opinion and comments to #13

added #11 ‘did you ever consider leaving employment

#13 moved to Personal Opinion and Comments to #12

#14 changed to #15 and removed ‘do you as a dental hygienists perceive’

added #14 ‘to obtain the personal opinion of respondent’

added #20 ‘to obtain comments from respondent’

#22 changed to a blank response

#26 changed to a blank response
April 15, 1998

Dear Registered Dental Hygienist,

A survey is being conducted to determine the prevalence of unwanted sexual behaviors experienced by dental hygienists in Virginia. This research is being conducted in partial fulfillment of the requirements for the degree of Master of Science in Dental Hygiene. Your participation in this survey will help to improve the work environment for dental hygienists.

Due to the sensitive subject matter of this study, I would like to emphasize that your responses are completely anonymous. Please return the postcard indicating your willingness to participate or not participate in the survey. Separately, please return the completed questionnaire in the enclosed self-addressed stamped envelope by April 30, 1998. The questionnaire should take less than 15 minutes to complete.

For the purpose of this research sexual harassment is defined as an unwanted sexual behavior which includes: leers, suggestive sexual comments; unwelcome sexual advances; physical contact that you may find objectionable; requests for sexual favors; and/or physical or verbal conduct that affects your work performance creating a hostile, intimidating or fearful work environment.

There are no risks involved for those who participate in this survey. If you have concerns about sexual harassment, you may contact the EEOC in Virginia 1-800-669-4000. If you have any questions about the survey, you may contact my faculty advisor, Michele Darby, BSDH, MS at 757-683-5232; mdarby@odu.edu. The results of the study will be available upon written request. Thank you for your cooperation and prompt response.

Sincerely,

Anne Pennington, RDH, RBA

Master’s Degree Candidate
School of Dental Hygiene
Old Dominion University
Norfolk, Virginia 23429-0499
e-mail: abassett@odu.edu 757-683-5233
APPENDIX D

Postcard to Maintain Anonymity
☐ I would not like to participate in this survey.

☐ I have completed this survey and returned it to you.

My name and address is:

________________________________________

________________________________________

________________________________________
APPENDIX E

Cover Letter for Second Mailing
May 10, 1998

Dear Registered Dental Hygienist;

Recently you received a questionnaire on the prevalence of unwanted sexual behaviors experienced by dental hygienists in Virginia. In order for this study to represent the target population of dental hygienists in Virginia and improve the work environment for dental hygienists, it is important that I receive as many responses as possible.

If you have already returned the questionnaire, thank you very much and please disregard this letter. If however, you have not filled out questionnaire, I have included a copy for your convenience. Please return the completed questionnaire by May 25, 1998, in the enclosed self-addressed, stamped envelope. Thank you for your cooperation and participation in this study.

Sincerely,

Anne Pennington, RDH
Dental Hygiene Graduate Student
Old Dominion University
Norfolk, VA 23529-0499
APPENDIX F

Equal Employment Opportunity Commission Guideline
EQUAL EMPLOYMENT OPPORTUNITY COMMISSION

29 CFR Part 1604

Discrimination Because of Sex Under Title VII of the Civil Rights Act of 1964, as Amended; Adoption of Final Interpretive Guidelines


ACTION: Final Amendment to Guidelines on Discrimination Because of Sex.

SUMMARY: On April 11, 1980, the Equal Employment Opportunity Commission published the Interim Guidelines on sexual harassment as an amendment to the Guidelines on Discrimination Because of Sex, 29 CFR Part 1604.11. 45 FR 25624. This amendment will reaffirm that sexual harassment is an unlawful employment practice. The EEOC received public comments for 60 days subsequent to the date of publication of the Interim Guidelines. As a result of the comments and the analysis of them, these Final Guidelines were drafted.

EFFECTIVE DATE: November 10, 1980.


SUPPLEMENTARY INFORMATION: During the 60-day public comment period which ended on June 10, 1980, the Commission received over 160 letters regarding the Guidelines on sexual harassment. These comments came from all sectors of the public, including employers, private individuals, women’s groups, and local, state, and federal government agencies.

The greatest number of comments, including many from employers, were those recommending the Commission for publishing guidelines on the issue of sexual harassment, as well as for the content of the guidelines.

The second highest number of comments specifically referred to § 1604.11(c) which defines employer liability with respect to acts of supervisors and agents. Many commenters, especially employers, expressed the view that the liability of employers under this section is too broad and unsupported by case law. However, the strict liability imposed in § 1604.11(c) is in keeping with the general standard of employer liability with respect to agents and supervisory employees. Similarly, the Commission and the courts have held for years that an employer is liable if a supervisor or an agent violates the Title VII, regardless of knowledge or any other mitigating factor. Anderson v. Methodist Evangelical Hospital, Inc. — F.Supp. 1032 (D.C. Ky. 1971), aff’d 464 F.2d 732, 4 EPD ¶7901 (6th Cir. 1972); Commission Decision No. 71–969, CCH EEOC Decisions (1973) ¶9193; Commission Decision No. 71–1425, CCH EEOC Decisions (1973) ¶9216. Furthermore, a recent 9th Circuit case on sexual harassment imposed strict liability on the employer where a supervisor harassed an employee without the knowledge of the employer. Miller v. Bank of America, 600 F.2d 211, 20 EPD ¶50,080 (9th Cir. 1979). In keeping with this standard, the Commission, after full consideration of the comments and the accompanying concerns, will let § 1604.11(c) stand as it is now worded.

A number of people asked the Commission to clarify the use of the term “agent” in § 1604.11(c). “Agent” is used in the same way here as it is used in § 701(b) of Title VII where “agent” is included in the definition of “employer.” A large number of comments referred to § 1604.11(a) in which the Commission defines sexual harassment. These comments generally suggested that the section is too vague and needs more clarification. More specifically, the comments referred to subsection (3) of § 1604.11(a) as presenting the most troublesome definition of what constitutes sexual harassment. The Commission has considered these comments and has decided that subsection (3) is a necessary part of the definition of sexual harassment. The courts have found sexual harassment both in cases where there is concrete economic detriment to the plaintiff. Hooten v. Johns-Manville Corp., 451 F.Supp. 1382, 16 EPD ¶5030 (D. Colo. 1978); Barnes v. Castle, 561 F.2d 983, 14 EPD ¶7755 (D.C. Cir. 1977); Garber v. Saxum Business Products, 552 F.2d 1032, 14 EPD ¶7927 (4th Cir. 1977), and where unlawful conduct results in creating an unproductive or an offensive working atmosphere. Kyriazis v. Western Electric Co., 461 F.Supp. 189, 18 EPD ¶5070 (D.N.J. 1978). For analogous cases with respect to racial harassment see Rogers v. EEOC, 454 F.2d 234, 4 EPD ¶7597 (5th Cir. 1971); FEOC v. Murphy Motor Freight Lines, Inc., 488 F.Supp. 381, 22 EPD ¶50,888 (D. Minn. 1980).

The word “substantially” in § 1604.11(a)(3) has been changed to “unreasonably.” Many commenters raised questions as to the meaning of the word “substantially.” The word “unreasonably” more accurately states the intent of the Commission and was, therefore, substituted to clarify that intent.

It should be emphasized that the appropriate course for further clarification and guidance on the meaning of § 1604.11(a)(3) is through future Commission decisions which will deal with specific fact situations. Since sexual harassment allegations are reviewed on a case-by-case basis, any further questions will be answered through Commission decisions which will be fact specific.

A fair number of comments were received on § 1604.11(d) which defined employer liability with respect to acts of persons other than supervisors or agents. Again, as in § 1604.11(c), the traditional Title VII concept prevails regarding employer liability with respect to these people other than agents and supervisory employees. Many commenters asked the Commission to clarify the meaning of “others.” As a result, § 1604.11(d) has been separated into two subsections. The new § 1604.11(d) refers to sexual harassment among fellow employees and the liability of an employer in such a situation.

The new § 1604.11(c) refers to the possible liability of employers for acts of non-employees towards employees. Such liability will be determined on a case-by-case basis, taking all facts into consideration, including whether the employer knew or should have known of the contact, the extent of the employer’s control and other legal responsibility with respect to such individuals.

A number of people also raised the question of what an “appropriate action” might be under § 1604.11(d). What is considered to be “appropriate” will be seen in the context of specific cases through Commission decisions.

Section 1604.11(e) of the Interim Guidelines, which sets out suggestions for programs to be developed by employers to prevent sexual harassment, now becomes § 1604.11(f).

The Commission has received many comments which state that this section is not specific enough. The Commission has decided that the provisions of this section should illustrate several kinds of action which might be appropriate, depending on the employer’s circumstances. The emphasis is on preventing sexual harassment, and § 1604.11(f) intends only to offer illustrative suggestions with respect to possible components of a prevention program. Since each workplace requires its own individualized program to prevent sexual harassment, the specific steps to be included in the program should be developed by each employer.

Several commenters raised the question of whether a third party who was denied an employment benefit would have a charge cognizable under Title VII where the benefit was received...
Final Guidelines on Sexual Harassment

by a person who was granting sexual favors to their mutual supervisor. Even though the Commission does not consider this to be an issue of sexual harassment in the strict sense, the Commission does recognize it as a related issue which would be governed by general Title VII principles. Subsection (g) has been added to recognize this as a Title VII issue. After carefully considering the numerous comments it received, the EEOC made the above changes to the Interim Guidelines and, at its meeting of September 23, 1980, adopted them as the Final Guidelines on sexual harassment, subject to formal interagency coordination. Formal interagency coordination has been completed, and coordination. Final Guidelines on sexual harassment, subject to formal interagency coordination. Formal interagency coordination has been completed, and none of the affected agencies had additional comments. Therefore, these Guidelines become final as adopted at the Commission meeting of September 23, 1980.

Signed at Washington, D.C., this 3rd day of November 1980.

Eleanor Holmes Norton,
Chair, Equal Employment Opportunity Commission.

Accordingly, 29 CFR Chapter XIV, Part 1604 is amended by adding § 1604.11 to read as follows:

PART 1604—GUIDELINES ON DISCRIMINATION BECAUSE OF SEX

§ 1604.11 Sexual harassment.

(a) Harassment on the basis of sex is a violation of Sec. 703 of Title VII. Unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature constitute sexual harassment when (1) submission to such conduct is made either explicitly or implicitly a term or condition of an individual’s employment, (2) submission to or rejection of such conduct by an individual is used as the basis for employment decisions affecting such individual, or (3) such conduct has the purpose or effect of unreasonably interfering with an individual’s work performance or creating an intimidating, hostile, or offensive working environment.

(b) In determining whether alleged conduct constitutes sexual harassment, the Commission will look at the record as a whole and at the totality of the circumstances, such as the nature of the sexual advances and the context in which the alleged incidents occurred. The determination of the legality of a particular action will be made from the facts, on a case by case basis.

(c) Applying general Title VII principles, an employer, employment agency, joint apprenticeship committee or labor organization (hereinafter collectively referred to as “employer”) is responsible for its acts and those of its agents and supervisory employees with respect to sexual harassment regardless of whether the specific acts complained of were authorized or even forbidden by the employer and regardless of whether the employer knew or should have known of their occurrence. The Commission will examine the circumstances of the particular employment relationship and the job functions performed by the individual in determining whether an individual acts in either a supervisory or agency capacity.

(d) With respect to conduct between fellow employees, an employer is responsible for acts of sexual harassment in the workplace where the employer (or its agents or supervisory employees) knows or should have known of the conduct, unless it can show that it took immediate and appropriate corrective action.

(e) An employer may also be responsible for the acts of non-employees, with respect to sexual harassment of employees in the workplace, where the employer (or its agents or supervisory employees) knows or should have known of the conduct and fails to take immediate and appropriate corrective action. In reviewing these cases the Commission will consider the extent of the employer’s control and any other legal responsibility which the employer may have with respect to the conduct of such non-employees.

(f) Prevention is the best tool for the elimination of sexual harassment. An employer should take all steps necessary to prevent sexual harassment from occurring, such as affirmatively raising the subject, expressing strong disapproval, developing appropriate sanctions, informing employees of their right to raise and how to raise the issue of harassment under Title VII, and developing methods to sensitize all concerned.

(g) Other related practices: Where employment opportunities or benefits are granted because of an individual’s submission to the employer’s sexual advances or requests for sexual favors, the employer may be held liable for unlawful sex discrimination against other persons who were qualified for but denied that employment opportunity or benefit.
APPENDIX G

The Effects of Sexual Harassment
EFFECTS OF SEXUAL HARASSMENT

Being sexually harassed can devastate your psychological health, physical well-being and vocational development. Women who have been harassed often change their jobs, career goals, job assignments, educational programs or academic majors. In addition, women have reported psychological and physical reaction to being harassed that are similar to reactions to other forms of stress. They include:

Psychological Reactions
■ Depression, anxiety, shock, denial
■ Anger, fear, frustration, irritability
■ Insecurity, embarrassment, feelings of betrayal
■ Confusion, feelings of being powerless
■ Shame, self-consciousness, low self-esteem
■ Guilt, self-blame, isolation

Physiological Reactions
■ Headaches
■ Lethargy
■ Gastrointestinal distress
■ Dermatological reactions
■ Weight fluctuations
■ Sleep disturbances, nightmares
■ Phobias, panic reactions
■ Sexual problems

Career-Related Effects
■ Decreased job satisfaction
■ Unfavorable performance evaluations
■ Loss of job or promotion
■ Drop in academic or work performance due to stress
■ Absenteeism
■ Withdrawal from work or school
■ Change in career goals

Question 3-g OTHER

1. Male DDS, not my employer. He was filling in for several weeks while my boss was out ill.

2. Mostly from male clients age 30-40

3. Patient

4. Sales representative

5. Patient

6. Patient

7. Not serious enough

8. I knew about his reputation, but felt I couldn’t comment unless I found out first hand. I didn’t believe in gossip… but it wasn’t gossip!!

9. Dental consultant

10. Patient
Question 7-g OTHER

1. I don't believe the individuals were intending to harass, I think they exhibited poor judgement and poor tasks (jokes) (my potential receptivity, which was non-existent)

2. I knew he was only working with us on a temporary basis.

3. I did nothing because under the circumstance of the incidents, I really was not offended. The jokes were cute not vulgar.

4. It stopped when I talked to the person involved.

5. Liked my other employer (dual partnership) very much.

6. I was much younger and inexperienced at the time. Approx. 13 years ago. I would react differently to the same situation at this point in my life.

7. Was not that big a deal.

8. Difficult to pinpoint would have been seen as 'complaining about nothing'.

9. It was several off color jokes over a period of several years. I just ignored it. I didn’t think it warranted action.

10. Did not feel sexually harassed-just disgusted. I'm able to tell my employer to 'be quite' and he usually listens and apologizes for being rude.

11. The comment that made me feel demeaned b/c of my gender always refers to the 'women at VMl issue' and isn’t dental related (although it’s mentioned almost weekly).

12. Try to become self regulated so we are not so dependant upon the dentist and dentistry in general.

13. One off color joke was told, I asked them to stop and they did.


15. They were Bill Clinton jokes.

16. Was not out of hand or serious.

17. Easier to ignore than to cause conflict.
18. Happened in 1971- sexual harassment not recognized as such then.

19. Didn't feel it warranted formal complaint.

20. Did not want to offend the client.

21. I just didn't consider the bad jokes to be intended to be offensive. Just poor taste. I didn't feel my job was threatened. I have had dentists make 'flirtatious passes, but they didn't continue if I didn't respond.

22. Not as hot a topic as it is now; no one to complain to.

23. Only happened once each time and ignoring and drawing away, terminated the problem.

24. Inherent in such a female profession.

25. The harassment was on so seldom an occasion that I did not have to deal with it regularly so when something better came along I terminated my employment.

26. Intimidated
Question 20 – Comments:

1. Prepare the “young pretty” graduates for entering and working with other more brazen employers. I’ve turned down jobs because of certain evident attitudes. I’ve witnessed Drs. stating comments about potential employees. My instructors tried to prepare us for different situations and at the time I didn’t know why. 20 years later I appreciate it and realize it’s all over.

2. We’re women, we have to deal with it as we would in any profession, it’s not specifically related to hygiene and need not be addressed in the curriculum. We have to keep ourselves informed and be assertive of our rights in all settings. Our biggest obstacle is the fact that we’re in small offices; we have no boss to complain to if he is the only male in the practice and this is the problem.

3. Our jobs are always on the line and in small communities our employability is at risk as well. DR’s can and will shun a potential employee that has ‘blown the whistle’; on any inappropriate behavior, be it sexual, work quality, billing practice, etc. They close ranks quickly.

4. Guidelines and policies are a must for the entire office to understand and discuss. I also had the support of my doctor-employer when harassed by a male patient. A male dentists that I was temporary working for demeaned me due to gender and occupational title. I reported to the placement agency. We need to encourage our women to speak up and not allow anyone to harass us.

5. Quick note.... like the fact you are addressing/studying this often unnoticed problem I believe there would be mush less sexual harassment and pressure from Dentist (especially male) if hygienist were able to practice independently. They almost feel too comfortable ‘owning us’, so they think. Reality, without us, where would they be? oh very busy!

6. It’s an individual situation for each office/DDS and the hygienist. An ‘across the board’ policy may not be necessary just for hygienist. Sexual harassment occurs in various jobs/careers- it’s a personal thing that each person should handle the way she feels necessary. A policy doesn’t” mean it will rid sexual harassment from dental offices. Personally, I’m not embarrassed easily and enjoy a dirty joke and flirting. One of my employers and his friends tell me jokes and flirt w/me all the time and I enjoy it! If it went too far, I’d be able to end it tactfully w/o a problem.

7. I have been in the DH field since 1973 private practice as well as state job and I have never had a problem w/ sexual harassment. I have always been straightforward on job interviews, so there are no surprises if I am hired by a doctor where I stand on numerous issues-not just the subject of sexual harassment.
8. First, they might define true sexual harassment. Is a ‘leer’ really harassment? Is an off-color joke that offensive? Where should we draw the line between poor taste and a truly objectionable act?

9. I don’t think many offices would have this problem for hygienist, as most dentist wish to retain one when they can find one they work well with. It’s hard to see it as big problem in dentistry. Our office for instance consists of one male doctor amidst 6 female employees! Poor guy wouldn’t stand a chance. Perhaps in larger groups where individuals are not as important it would be a problem. It also helps to be selective when interviewing for jobs.

10. This issue regarding sexual harassment has never arisen in my 15 years of practice. I have worked for 4 different dentists over the years. Sexual harassment legal ramifications may be strongly reiterated in the various dental newsletters just to keep it in the forefront.

11. I do not know because this has never been a problem for me. I guess how to identify a problem, how to handle a situation that is sexual harassment. To try to stop the problem before things get out of hand.

12. I do not feel that sexual harassment in the oral healthcare environment is any different from any other environment. If it is a problem, it should definitely be addressed by the hygienists. However, I do not think the ADHA needs to make a big issue out of this. In my opinion, many women are crying ‘sexual harassment’ today because they can, not because it’s happening. I am just about sick of hearing the two words sexual harassment.

13. In my experience, sexual harassment in the workplace has not been a major concern for me.

14. My experience with sexual harassment in the DH practice is limited to exposure to offensive jokes between dentist and clients, dentist and staff; and knowledge of multiple sexual relationships among dental staff and dentist while working in a certain practices.... which I found offensive and distracting.

15. I have never had to deal with this, thankfully, but believe both dental hygienists and employers could greatly benefit all involved in education on the matter.

16. This situation is not as common in dental offices. I say this because I have worked in many solo/group practices and only once experienced true harassment. I simply said that if he said the word sex one more time I would walk out and the entire staff would go with me. Basically, just saying no and not discussion in a provocative manner makes the situation less likely to occur.
17. All of the rules and policies that are made are not going to stop some males from sexual harassment. It may make them stop and think but it will never end completely.

18. I work in another profession full-time now and only substitute occasionally in the dental practice in which I am a patient. From 1985-87 I worked as a hygienist full-time and never experienced sexual harassment. I think the dental hygiene education environment should provide training on how to avoid serious problems before they start (e.g.-learn to tell the offender that you feel uncomfortable at the onset and that you will not tolerate advances). The can also provide this type of training. Good luck!

19. I would have to know how much of a problem this really is.

20. Fortunately, I have not had a problem but I have heard of others who have. Hopefully people going through this will be able to stand.

21. I feel sexual harassment in dental assistants is more prevalent. As a dental hygienist there's a high level of respect. Sexual harassment works both ways.

22. In my 3-yr. experience I have not found sexual harassment to be a problem in the workplace I feel that many times individuals feed into the jokes and flirting and then when it is convenient, they turn it into an issue of sexual harassment.

23. Not much since our profession is regulated by dentists. Unless the ADA had policies regarding this I don’t feel that anything the ADHA would do could help. The dentists have the power!

24. In all my 20 years as a hygienist I have only had one situation that I would deem close to sexual harassment. I don’t feel that it is that much of a problem that the ADHA needs to develop a curriculum for hygiene schools.

25. Perhaps members of the ADA would make it mandatory that students (dental and hygiene) be required to include a course just on this issue alone: sexual harassment. The more aware the public is on this issue of sexual harassment, would probably deter many employers to engage themselves from becoming involved in the first place.

26. Those of us who were raised with strong moral and Christian values and aren’t afraid to show those in any office setting don’t have problems with those spoken of in this survey. Get real- no matter how attractive we may be strong Christian moral and values when demonstrated- close away any of the weak, wimpy people who do those things.
27. I truly feel if we, from interview day one, explain who we are, how we feel about our job, family and faith, the employer is crystal clear and he or she will respect our position. In my 30 years of practicing dental hygiene I never worked for sleazy, self-centered people. I chose wisely- it make a huge difference. I loved dental hygiene.

28. A sexual harassment situation should be confronted. If that doesn’t change then it should certainly be reported.

29. I think pushing the ADA profession to educate themselves would be a good step. Generally they would be the ones doing the harassing, and most hygienists I know would be unwilling to file any formal complaints due to the repercussions.

30. I think there is no reason that the dental hygiene profession needs to get involved with sexual harassment in the oral healthcare environment. I am not aware that there is a problem and I think that should be left up to the individuals unless it becomes a major issue.

31. I think that legally, standpoints were covered in DH curriculum, but in the ‘real world’ things aren’t that easy. There is the chance that the doctor would ‘threaten you’ with repercussion of loss of employment etc. because the pt was a ‘patient for years’. How do you tactfully address this situation without other considerations? Do you go and find another dentist to work for and have that dentist ask why you left your former employer? So much of this type of thing is ‘your word against mine’.

32. If you act as a professional it doesn’t occur. Besides you have sharp instruments in your hand in somebody’s mouth. What fool (patient) would try to sexually harass you. If the doctor you work for does, then would you work there? Too many quality dentist to work for, to stay with a jerk.

33. Make it aware that it exists.

34. I think it is a problem and needs to be addressed in dental school as well as hygiene school. I have seen it take place, but never felt it was directed to me. I think married employees are less likely to receive ‘harassment’ I feel simple bad jokes are tasteless, but not considered to be harassment unless there is involvement of salary or job security. I also did not work for 8 yr. while raising children during 1983-1991. These were probably pretty bad years.

35. I don’t feel sexual harassment in the oral healthcare environment is a problem in the area in which I work.

36. Women in general need to be more self-confident. This would ward off some aggressive co-workers. In addition it would leave you unaffected by mild advances and or comments that are sometimes meant innocently.
37. I wish I knew then all the avenues to stop the harassment I received. I now work in an all-female practice where there is no sexual harassment. My issue happened in the early 80's. Now people are more aware of this issue and there are ways of dealing with it.

38. This is a personal issue. Handling ‘sexual harassment’ is dependent upon one’s own definition of the item. Mostly, it all builds down to how well you are able to ‘win friends and influence people’—i.e. getting along with other people in society.

39. I am not sure what the dental hygiene profession as a whole could do. I have had experiences with clients and sexual harassment and continuing to act in a professional manner and tell the client that I am not interested in that type of relationship with them has taken care of the harassment problems that I have had with those particular clients.

40. If I face such internal difficulty defending myself about working in a 75-80 room would I defend myself against sexual harassment? My heart goes out to all who face sexual harassment. If I have experienced stress, anxiety and stomach pain confronting my employer about this battle alone, I can only imagine the difficulty and pain one faces in sexual harassment. I think I would quit rather than experience the continued emotional pain.

41. I don’t think sexual harassment is a problem in the dental hygiene profession, however I think it’s a great idea to add it to the hygiene curricula. It never hurts to be prepared for uncomfortable situations that may arise. Also as part of the dental hygiene curriculum, I feel martial arts could be very beneficial. I swift kick in the groin of an individual making unwanted sexual advances would most definitely nip the problem in the bud!

42. I feel it would help to address sexual harassment in d.h. curriculum! My only ‘forward advances’ occurred right after graduation while working in New Jersey. Other subtle problems occurred in VA but never progressed or threatened my position and also they stopped.

43. I think healthcare settings should have polices regarding sexual harassment that is signed by both employer and employees then one would feel the ‘right’ in filing a complaint. A course offered in school, regarding this subject would be wonderful!

44. I believe nothing that the ADHA could do would alleviate the problem. Very little respect is given to the ADHA by the ADA and/or practicing dentists. The dental community is still ‘the good ole boy’ system and any hygienist would ruin any career advancement by pursuing any complaint.
45. I feel the main conflict occurs between patient and hygienist. Guidelines and policies should be written if and when a situation occurs so that the employer, dentist, stands behind the hygienists.

46. That is such a hard questions to answer - but I definitely think something should be done! It seems as if dental hygiene as a profession has to fight for everything, especially respect and we seems to loose it over our stand on sexual harassment in the workplace.

47. This is not something that would ever come up in our office! I work for my husband of 35 years and we have 2 other employees our age. Happy to say, not a problem. Many years ago I worked where this was a problem and I know it is very prevalent. I simply told the person off and went to the president. End of that episode.

48. By boasting women's self esteem and empowering them to not fall victims, will eliminate a lot of harassment in the workplace. By not allowing it to happen and having the power to take action if it does, will help all women. We are always in control!

49. I have worked for the same DDS for 11 years who has never made any sexual advances toward myself or other staff members. It's hard for myself to say or comment on how often it happens or what to do about it.

50. If our profession could do something, I'd love to see their license be suspended or fines for their behaviors.

51. The dentist in VA that I worked for loved to pull down his zipper to his pants when I would walk in his office. I know he was ticked that he couldn't ruffle my feathers; I'd just turn my back to him and talk to him that way, while I was laughing to myself. He's quite handsome and when we run into each other at conventions we still smile that knowing smile. He used to comment about how thin and shapely I was, but now he asks me about my back!

When I use to work in PA I was harassed by a — DDS who practiced in his home. He had a beautiful wife and adorable son, but he'd breathe very and ask me to wear the uniforms that were short! He would always want to come into the dark room to see if I knew how to develop x-rays properly and breathe heavy. I was never scared because if he tried anything I'd kick him where it hurt (at that time I was a student in hygiene school). Then one night he chased me around and cornered me for that big wet sloppy kiss and I escaped under his arm,. He thought that was funny and then our next patient arrived. I was to assist him with a rubber base impression. I know I'd get him now where it hurt the most (in his pocket) I mixed the rubber base very slowly and he yelled '— mix it faster, faster!' I mixed it slower... then I stuck the spatula in it and I promptly walked out the front door! He called me at home and said '— what does this mean?' 'It means I QUIT!', I yelled.
After I graduated I worked for the 'sweat hog' in PA and he took me out to lunch on a Friday then we went back to the office for me to clean his teeth. He wanted N20.02 so during the procedure he grabs me (about 250 lbs. of body weight lunges at me) to kiss me and I was so shocked I grabbed onto the faucet at the sink and I almost pulled it out of the wall, then I ran out. Over the weekend I became engaged and when I went back on Monday I flashed my right around and of course he was so apologetic and said it would never happen again and it didn’t. I stayed for a year, he came to my wedding and still tells people I was the best hygienist he ever had!

I don’t pity any ‘harassed’ employee – GET OUT- but we need to yell and scream to wreck their reputations. Don’t let it overwhelm you. BE clever, it’s a damn good feeling to see them look so pathetic! The zipper DDS is now divorced after his own daughter caught him with another woman on the highway. These ‘penis men’ have many problems and it crosses all professions. From Clarence Thomas to my daughter’s American History teacher it’s a shame that his happens. But when her teacher started harassing her I verbally tore him up and he was brought before the school board. He’s afraid of me and the treats to his job from his boss! I demanded that my daughter be transferred immediately and the principals bent over backward for us!

I hope you don’t have too many positive responses about this survey. It will be sad to hear that other hygienists have had these types of experiences. I will definitely want to hear these results! Good luck!

52. How do you inform patients that it is not acceptable? Can I refuse to terminate my professional services to patients?

53. Since I’ve never been exposed to this problem I don’t really have an opinion.

54. I have not had a problem with sexual harassment as I think that most employers have know better. However; I do think that in a profession such as ours where there is no autonomy and we are employed or not employed only at the discretion of the dentist, it could certainly be a problem. I was divorced for eleven years and I had to work. My employer knew that and I had to tolerate a great deal of questionable behavior. Our professional esteem does not seem to be on the rise with an ADA president who wants to bring in assisting to do our job. When you are not held in high regard; sexual harassment might be more of an issue!!
Question 20- Positive suggestions

1. Education in school and as CEU credit.

2. Increase awareness in the dental community and promote discussion between dental health care professionals.

3. Offer continuing education courses.

4. I think the curriculum should include at least one section on sexual harassment within the work environment. Most of my experiences have been with male clients. The dentist I currently work for gets quite upset when male clients get out of hand.

5. Make sure the policy is clear and spelled out for employees at the office which you work-especially if it involves a client and not an employer.

6. Add guidelines in refer to sexual harassment to Dental Hygiene curricula.

7. Have continuing ed. classes in the office for the staff.

8. Short term: I think it should be mandatory for the entire office to fill out a questionnaire once a year on subjects such as sexual harassment. Office conditions (how well you think it meets OSHA guidelines) etc. and have it sent to a separate group to discuss any major problems and address the doctors.

   Long term: Because hygienist can only practice under a supervising dentist I feel we can never get true respect owed to us either by the dentist who we need and they know it) or by the public. They are aware we are not allowed to make decisions therefore they don’t believe we are worthy of their self-respect. We need freedom!

9. Education of the hygienist/dentist through CE certification programs. However, I don’t feel it is a big issue or problem in the healthcare setting.

10. Teach the students about it. Consider putting offenders on a list to avoid.

11. Incorporate a special segment of hygiene classed devoted to role-playing sexual harassment and overcoming fear of taking action against dentist we feel pressured against in the first place.

12. Add possible scenarios and solution within the curriculum. I have never had a problem personally.

13. Recognize acceptable standards/guidelines as established by related communities federal and state agencies. Research other professional associations’ guidelines. Possibly create an ADHA Library Reference Manual composed of the above. The need not re-invent the wheel nor devote extensive energy or $ toward this agenda,
which doubt is needed by the majority of our dues paying members and national association does not need to attract attention in this area for the few having this isolated problem.


15. Possibly have one of the Access magazine attend to this matter. Also maybe an education weekend on this subject at state level.

16. I feel if you are taught in school how to handle sexual harassment, hygienists would feel more comfortable and have more knowledge on how to handle it. I think legal guidelines should be in every office (mandatory by law) for display; that way it is acknowledgeable by all in the office.

17. Set up guidelines to follow if one experiences harassment.

18. Have a CE for dental Prof. and offer it @ know cost so that all professionals can attend. Be tactful about the situation when it occurs @ that time with the guilty party. Send out ways to prevent and address sexual harassment in the office so we can post it so every employee will see it. My former boss does not even know that there is such a thing as sexual harassment laws and that it can be reputed.

19. Support groups would be beneficial to the individual hygienist. Guidelines and policies regarding sexual harassment should be distributed to all oral healthcare participants. 1. File complaints w/Board of Dentistry 2. File complaint with local hygiene organization referral committees 3. File complaint with all local hygiene temp. services 4. File complaint with local dental association. Basically get the word out to other hygienist not to work for this guy.

20. Education for dentists in dental schools and dental hygienists in dental hygiene school.

21. Have a continuing Education Course on it.

22. Set up support groups. Set up guideline defining sexual harassment.


24. Educate and get the word out. - to counsel w/ people and let them know that it is OK to file a complaint and to work w/ them so they will know how and what to do next. Also to let the ‘victim’ know it is not their fault.

25. Through lectures or possibly ADHA newsletter.
26. Have seminars for the dental staff or include the information in other seminars/CE’s to raise awareness and educate the assistants also. If the staff were to hear the information together they may be more likely to follow guidelines.

27. Define it, do survey such as this and talk about it.

28. Add to dental hygiene curriculum.


30. Discuss it and help especially younger women understand there is no reason to accept this behavior.

31. Education! To prepare hygienists in the work place would help.

32. Follow guidelines and policies that have been developed by large corporations.

33. Set guidelines, policies define sexual harassment.

34. I believe there are guidelines on a legal level in regard to this matter. The dental hygiene education faculty should inform our field as other professional groups are doing. I also believe that individual offices/personnel should address these issues before the sexual harassment occurs.

35. Education, guidelines, steps to take in case of sexual harassment occur! Punishment of the offender!

36. Educate hygienists as well as dentists.

37. Awareness and eliminating negative options until a full story is told.
38. Maintain professional report with co-workers.

39. Make a video training tape for students as well as graduates.

40. Written guidelines.

41. Explain the ‘closeness’ when you work in a dental office-small numbers of employees, men to women ratio.

42. Incorporate this topic in a continuing education course.

43. Continuing ed. courses.

44. Have seminars re: sexual harassment w/ hygienists who have experienced harassment.
45. Have the ADA and ADHA adopt guidelines on models which every dental office should review all their staff and have meetings and discussions to alleviate any concerns or misconceptions on any staff member's mind.

46. Develop guidelines. DH schools need to train candidates about sexual harassment.

47. Continuing Education programs.

48. Come up with a tactful way to tell clients that we do not appreciate their dirty jokes! (without offending the client).

49. Offer CE on subject. Teach in curriculum. Recommend through ADHA guideline for office use.

50. Course supplements should be taught during one of the lecture series. Hygienist needs to be taught self-respect for themselves and their profession. If they need to be taught how to handle a bad situation so be it, and what degrees there should be warnings, then filings of formal complaints. Not every action or work, or story deserves a formal complain and then again some do. The adult dental hygienist needs to also conduct herself as an adult professional.

51. Define sexual harassment- make sure students are clear on what is and isn't acceptable behavior on part of fellow worker, dentist etc.

52. ADA and ADHA should work together in education and guideline and policies regarding sexual harassment in the workplace.

53. Cont. education classes on sexual harassment.

54. Create guidelines and policies regarding sexual harassment. Informal hot line available to discuss situations and issues, as they occur to assist the hygienist.

55. Education and/or training on how to deal with the situation is very important, but ultimately, it is up to the hygienists whether he/she handles it the best way he/she can. Policies and guidelines can help, but each individual will react differently in a harassment situation. My fellow experience w/ this issue in the workplace have been with male patients only, never a dentist.

56. Incorporate curriculum, ADHA policy statement information sharing with ads/and offer classes which teach the healthcare provider how to be assertive in sexual harassment type settings.

57. Be professional at all time. It is the place where you work-not your friends.

58. Include it in curriculum. Have CE classes dealing w/ issue for hygienist and dentists.
59. Best to ignore it and usually it does not go any further.

60. Offer EC course regarding proper office behavior and sensitivity training for hygienist as well as other office staff.

61. Educate students regarding the nature of harassment and how it should be handled with dignity.

62. Guidelines and policies regarding sexual harassment should be discussed in the dental school curricula.

63. Discuss the topic of sexual harassment at local ADHA meetings. It would be an interesting subject to discuss the principles of the subject – not the personalities of specific individuals. Care would have to be taken to present the material in a non-threatening and non-emotional manner. Topics I suggest are: How to handle situations where you are uncomfortable. What to do? What to say? Write down exactly what is difficult. How to do the ‘right things’ for all people concerned. How to be more sensitive to large and small episodes of harassment. How to avoid situations before they become problems. What is appropriate? How to see things in a new way – is an opportunity for personal growth and a chance to cooperate with others for a better outcome to problem situations. Quality responses

64. Just confront it.

65. I think the hygiene association should set policies regarding this matter and have people to contact for advice to deal with individual circumstances of sexual harassment.

66. Include it in all RDH curriculum.

67. It would be best if this subject was incorporated during the dental hygiene program. In order for dental hygiene students to be better prepared if this situation would arise in their future. Hopefully the student then would feel much more confident if this situation development without a lot of damage for the employer and the employee. He or she would know how to act and handle the steps in filing a formal complaint.

68. Bring hygienists together who have been in private practice for ten years or more and have a confidential yet open round table discussion on incidents that they have encountered (sexual harassment) during their career. Then set guidelines for dental hygiene curricula.

69. Provide education for managing sexual harassment.
70. I feel a lot of this is over done, if a hygienist knows how to handle herself in a professional manner.

71. All hygienists should be well informed on their rights. Perhaps the ADHA should have an investigation body.

72. Continuing education course by professionals on this area.

73. I don't feel the ADHA needs to develop guideline on sexual harassment the Federal guidelines on sexual harassment are quite clear.

74. Should be at least addressed in school.

75. Promote groups that would help those in the situations. I don't think formal guidelines w/in the RDH community would make a difference, but helping those affected w/ obtaining the proper legal help/emotional support would be helpful. Hopefully women today are aware/ intelligent enough to know if they're being harassed, but they may not always know where to start to correct the problem.

76. Eliminate it first in the 'School of Dental Hygiene' among faculty and peers. This aspect was missing from your survey.

77. Needs to be strict, solid rules of conduct which should be endorsed by the ADA and the State Board of Dentistry. There should be mandatory CE courses like the OSHA requirements on sexual harassment.

78. Discuss subject in professional publications, newsletters and local chapter meetings.

79. Training would also be necessary for Dental Students.

80. Prepare students entering the work place with guideline about what is sexual harassment and what to do about it.

81. Yearly presentations on this subject could be very informative - review how to file complaints etc.

82. Prepare these young girls for the kind of perverts they'll encounter and teach mature appropriate responses to offenses, most of all help girls develop a sense of self respect.