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# Sexual Harassment of Newcomers in Elder Care —An Institutional Practice?

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## ABSTRACT

Sexual harassment is illegal and may have very damaging effects on the people exposed to it. One would expect organizations, employers, and institutions to take very good care to prevent employees from exposure to sexual harassment from anyone in their workplace. And yet, many people, mostly women, are exposed to sexual harassment at work. In care work, such behaviour is often directed toward their female caregiver by elderly citizens in need of care. Contemporary Nordic studies of working life and work environment have primarily investigated the interpersonal dimensions of sexual harassment, thus focusing on the relation between elderly citizens in need of care and their professional caregivers. In this article, we argue that sexual harassment from the elderly toward newcomers in elder care should also be seen as an effect of institutional practices. Based upon a Foucauldian-inspired notion of practice-making, the article carries out a secondary analysis of three different empirical studies in order to explore how sexual harassment is produced and maintained through institutional practices in elder care. The term institution in this perspective includes three dimensions; a political, an educational (educational institutions in health and elder care), and a work organizational dimension. By examining elder care in these different dimensions, we identify how sexual harassment of professional caregivers is produced and maintained through institutional practice-making in elder care. The article thus contributes to our knowledge on working life by expanding and qualifying the understanding of the problematic working environment in care work, and by offering an alternative theoretical and analytical approach to the study of sexual harassment. Together, these insights suggest how elder care institutions might act to prevent sexual harassment toward caregivers.

## KEY WORDS

*Care professions / care work / institution / practice-making / sexual harassment / women's work life / work environment*

## Introduction

**C**ontrary to what one might expect when reading the title of this article, the main issue in the article is not sexual behaviour. The issue we are addressing concerns harassment on the job and the way it is connected to the institution of elder care. Departing from the research question “How is sexual harassment produced and

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maintained through institutional practices in elder care?” we deploy a theoretical concept of practice-making to look at specific forms of harassment. We inquire how these are made possible and liable to happen by exploring the way the institution works and understands itself and the people inside it.

In Denmark (and the rest of Scandinavia), elder care is part of the universal welfare model, which implies that care is a welfare service (often free of charge) provided on the basis of an individual needs assessment. It is administered partly by the state, and partly by local government. Elder care is provided both in nursing and retirement homes and in private homes. During the last decade, elder care work has undergone a professionalization and today a majority of the professionals within elder care in the Nordic countries are educated as social and health care helpers or assistants from the social and health care education program (Fejes 2011).

### **Definition of sexual harassment/offensive sexual behaviour**

The aim of this article is to understand the institutional mechanisms and processes enabling the incidents to occur, not to measure or characterize the severity of the incidents experienced by the female caregivers. Hence, we deploy the term “sexual harassment” defined by the Equal Employment Opportunity Commission guidelines as “unwelcome sexual advances, requests for sexual favours, and other verbal or physical conduct of a sexual nature” (Grieco 1987). In line with Rospenda et al. (1998) we find inspiration in the organizational, sociocultural, and feminist perspectives on sexual harassment that emphasize power dimensions, thus seeing sexual harassment as a potential expression of power. Power is conceived as inspired by, for example, the works of Michel Foucault (1980a, b). This implies that power is not viewed as hierarchical and stable, but as negotiable and productive.

### **Contemporary research on the problem of sexual harassment in care work**

Sexual harassment in elder care is the object of study in statistical/epidemiological working environment studies as well as in qualitative studies of care work. In the following, we highlight elements of the knowledge production within both approaches in order to present an outline of the extent of the problem and of the way the phenomenon is perceived within qualitative work life studies. The aim is to point to the need of a different approach in work life research which provides us with possibilities to indicate solutions to the problem of sexual harassment in elder care. To identify relevant research we deployed three strategies. First we reread the research of elder care known to us (e.g., Dahl 2000, 2004; Glerup 2010; Kamp 2011; Liveng 2007; Wrede 2008) looking specifically for findings on sexual harassment. Apart from an article written by ourselves (Krøjer 2013), this resulted in a single finding (Hansen 2006). Secondly, we contacted the Danish National Research Centre for the Working Environment in order to identify relevant surveys in a Danish and European perspective. This resulted in a number of findings which will be presented here. Thirdly we conducted a systematic literature search using the ISI Web of Knowledge. We searched for topic=(sexual harassment OR sexual abuse OR sexual assault) AND Topic=(care work OR elder\*

care OR health profession\*), five years back. This resulted in 418 findings. Hereafter we added NOT Topic=(child\*) thus reducing the result to 195 findings. These findings were examined and articles focusing on elder abuse, immigrant and sex workers, harassment by co-workers, alcohol treatment and professionals in medicine, psychiatry, and social work were discarded. Studies from non-European sources were scrutinized, but considered irrelevant due to the major educational, organizational, cultural, and structural differences. This process resulted in three additional findings: two Danish articles (Clausen et al. 2012, 2013) and one Norwegian (Joa & Morken 2012). These are included in the review below.

### The scale of the problem

Within epidemiological studies of the working environment, sexual harassment is conceived as *one* of many elements in studies of the working environment in health care and more specifically elder care. Such studies provide knowledge about the occurrence of the problem and its relation to the health status of the professionals in the sector. In 2005 The Danish National Research Centre for the Working Environment completed a survey on Mental Health (n: 3500). Here, employees in elder care (home care and nursing homes) were asked if they had been subjected to sexual harassment within the last 12 months. The survey showed that employees in elder care have far more experiences of sexual harassment than the average (The National Research Center for the Working Environment. The COPSOQ-survey, 2005).

In the health care sector, reports from employees of sexual offenses at work are 3.5 times higher than as the average for all jobs, (Anon 2012b). Another recent survey shows that social and health care assistants are exposed to sexual harassment more than the average (13.59% in this job group compared with 2.67% for all occupations). This means that, on average, five times more health care employees than other employees have experienced sexual harassment on the job (Anon 2012a).

Bern et al. examined the percentage of employees in Danish elder care who have been subjected to “abusive behaviour” (violence, threats, harassment, or unwanted sexual attention) at least once a month during the past year. Here it appears that the proportion of employees in elder care in this category remained stable at 4% in 2005, 2006, and 2008. The incidences of abusive behaviour throughout the period were highest in the group of employees performing direct care tasks (social and health care assistants, social and health care helpers, and other caregivers) (Bern et al. 2012). Clausen et al. (2013) found that female care workers exposed to offensive behaviour (threats, violence, bullying, and unwanted sexual attention) have a higher risk of long-term sickness absence in the Danish elder care services and that the risk of leaving care work rises significantly if the worker experiences unwanted sexual attention, thus hindering continuity in health care staffing (Clausen et al. 2012).

In Norway a cross-sectional study of 536 care workers showed that 9% had experienced being sexually harassed during the last 12 months (Joa & Morken 2012). At the European level the measurements are subject to uncertainty. Violence and harassment at the workplace forms a chapter within the “Fourth European Working Conditions Survey” (EWCO 2005). Here it is stated that violence and harassment (including “incidences of sexual harassment” and “unwanted sexual attention”) are becoming increasingly significant issues in the EU public arena. It is also stated that incidents of



sexual harassment, or unwanted sexual attention, are reported by fewer than 2% of all respondents. But the report concludes that the problem is underreported. However, we know that female workers are affected three times as often as male workers and that the group most at risk is women under 30. Here the incidence rises to 6%. Within “health and social work” workers are reporting “higher than average incidences” (ibid).

These findings leave an impression of a problem that is persistent and much too common to be treated as a trivial matter. What the numbers do not reveal is how or why sexual harassment occurs or what the care workers do to avoid or protect themselves from harassment. The reviewed studies do not contribute to an understanding of sexual harassment as a social or complex problem. For these answers we turn to contemporary qualitative research.

### **The social and subjective character of sexual harassment**

Qualitative research into sexual harassment of caregivers in elder care is rare. A Danish study (Krøjer 2013) focuses on sexual harassment of social and health care newcomers in relation to the professional ethics of care work. Krøjer states that in order to master professional elder care it is necessary to develop the ability to stop fearing or feeling violated when faced with unwanted sexual attention. This finding is supported by another Danish study, conducted by Hansen in 2006. Hansen studied professional caregivers’ relation to their work and the inherent learning processes. Hansen found that it is more difficult to handle the sexual needs of the demented elderly than it is to handle other matters related to the body of the care receiver. Hansen notes that the caregivers try to avoid sexual advances turning into unpleasant conflict situations, for example, by positioning the harasser as childish and thus defining the incident as not to be taken seriously, but also by avoiding dressing or acting in ways that might be perceived as sexually provocative (Hansen 2006). The latter is also found in the study of Krøjer (2013), where senior caregivers explicitly place the responsibility of sexual harassment on their junior colleagues due to inappropriate dressing.

In addition to this knowledge, three further qualitative studies of sexual harassment in health care are evaluated as highly relevant, even though they do not focus on elder care, but on patients’ sexual harassment of nurses within clinical settings (Madison & Minichiello 2000; Ove et al. 2004). Hellzen et al. focus on nurses working with people with learning disabilities and these nurses’ exposure to sexual harassment. The authors find that frequent exposure to physical violence and/or humiliation severely affects the nurses physically as well as psychologically. As part of the long-term effects of the harassment, nurses feel hatred and aggression toward the harasser, thus finding it difficult for them to maintain a view of caring as meaningful and themselves as good caregivers. This study points to the need to further investigate the meaning of caring with focus on the “dark side of care” (Ove et al. 2004). Madison & Minichiello find that Australian nurses reported several indicators of sexual harassment, including the invasion of space, confirmation from others, lack of respect, the deliberate nature of the behaviour, perceived power or control, overly friendly behaviour, and a sexualized workplace. Nevertheless, nurses rarely labeled harassing behaviour as sex-based or sexual harassment. The study concludes that many forces reduce the likelihood that nurses will recognize and label unwelcome sexualized behaviour as sexual harassment.

## Not just an interpersonal matter

In conclusion, the qualitative research within this field supports and unfolds the findings of quantitative working environment research. The body of qualitative knowledge points to sexual harassment as a problem that has severe consequences for health care professionals. Not only is their health and well-being affected, but their ability and desire to provide care are also at stake. The studies point to the relevance of understanding sexual harassment and its consequences as a social and highly complex phenomenon.

What we can also conclude on the basis of the review above is that the phenomenon of sexual harassment is largely conceived of as an interpersonal matter. Whether the approach is quantitative or qualitative, the focus is primarily on the caregiver/the harassed, and secondarily on the care receiver/the harasser in order to understand the dynamics of sexual harassment and its consequences. Further, current research fails to enlighten us about the emergence of the problem. How and why it is that sexual harassment occurs to the extent that the studies describe?

## Theoretical foundation

To begin to answer this question we shall apply the concept of practice-making (Lehn-Christiansen 2011). In accordance with our research question of how sexual harassment is produced and maintained through institutional practices in elder care, the aim of our efforts is thus to examine the emergence of sexual harassment of care workers in the elderly sector. When exploring practices within elder care, we wish to understand the institutional context and the social, educational, and political conditions in which it is embedded. Instead of seeing “institution” as an end product of these conditions, and understanding the practices carried out within the institution as an institutional effect, we use the concept of practice-making as a means to understanding institutional practice as the social enactment of the way in which the institution is produced by politics, knowledge, and socioeconomics. Practice-making is a concept developed to grasp specific, social practice as a form of materialized power/knowledge relation (Foucault 1979, 1980a, 1994). Hence, practice-making is the complex and proliferated processes which make a certain (type of) institution possible. In this article, the institution at hand is the elder care institution. In a Foucauldian notion, an institution only exists insofar as it is constantly reproduced and sustained in power/knowledge relations. Power/knowledge relations involve every action regarding organized elder care, that is, actions such as educating staff, defining a specific part of the population as (possible) clients for elder care, regulating the tasks and performances to be unfolded within/as the elder care, deciding on salaries and work conditions, organizing care workers in a trade union, designing and building specific buildings for clients of elder care to live in, etc. (Lehn-Christiansen 2011). In a practice-making perspective, any specific situation in which a care worker is caring for a client is entangled in the institution and is at the same time *making* the institution by sustaining and/or perhaps expanding it. Any practice is possible only because it is part of the organized making of the institution.

To us, institution means not only the nursing home or the retirement home and the practices that unfold within them. The view of institutions put forward is broader. Institutions are conceived as institutional logics and norms which are maintained if and when individuals act as if these norms and logics are real and necessary. Thus, institutions



represent patterns and regularities that are rarely questioned or even spoken of, but carried out on a day-to-day basis (Gulløv 2004). Importantly, we do not conceive institutions to be constructed solely at an individual level, but in interaction on the basis of an objective reality. In other words, we conceive institutions as socially constructed as well as materially and structurally embedded. They regulate practice by defining order and normality, thus making some actions “natural” or inevitable. This implies that our theoretical approach differs from an analysis focusing on how specific work life practices are constructed. Constructionist approaches have contributed substantially to knowledge on working life in many different areas of modern work life (Ellehave 2004, 2005; Kofoed & Krøjer 2004; Petersen 2004, 2007; Shamai 2003; Weerahannadige 2012). However, practice-making is a concept which directs the analytical attention not only toward the way practice is constructed in language and (spoken) social interaction, but also toward material and bodily aspects of work life. The advantage of using practice-making as our analytical concept is that it enables an analysis which includes more than language.

In the analysis of care work, we find it productive to operate with three analytical dimensions, much along the lines of another Danish study of the work environment in elder care (Tufte et al. 2008). In our analysis we choose one dimension to be the political one governing elder care, another comprises education (provided by educational institutions in health and elder care), and lastly we focus on the organizational dimension of the work in elder care. By examining elder care in these three different dimensions, we explore institutional practice-making in elder care and how it produces and maintains sexual harassment of professional caregivers.

## Method

The empirical data in this article were produced in three different research projects carried out in 2004, 2009, and 2011, respectively. None of the research designs were produced to focus on sexual harassment. Yet sexual harassment turned out to be a central issue in each of the studies when producing the data. Different kinds of data were collected in the three studies, called X, Y, and Z.

## Secondary analysis

The three different studies, X, Y, and Z, were of course all subjected to thorough analysis when originally carried out. However, no matter how thorough, detailed, and systematic the analysis may be, qualitative data material is never fully exhausted (Hinds & Vogel 1997). And in all of the studies the case of sexual harassment was not the main topic/interest of the stakeholders and the research design. But when sexual harassment and unwanted sexual attention occurred across the three different studies, it should not be ignored. This is the reason why we wish to return to the material in order to carry out a secondary analysis.

## Data collapse—triangulation of data

As stated above, the current study uses data from studies X, Y, and Z. The research question and findings have emerged by means of a specific comparisons method (Kofoed

Overview of our different studies and the methods

	Study X	Study Y	Study Z
<b>Author and year</b>	Kofoed & Krøjer (2004)	Lehn-Christiansen (2011)	Nielsen (2008)
<b>Focus of study</b>	The working conditions of new employees within Danish elder care and their learning processes	A study of how health promotion is practice-made in the theoretical part of the Social and Health Education Program. The purpose of the study was to gain insight into the phenomenon of health promotion as a professional competence and an element of professional identity for the students	Youth and work accidents. The objective of the study was to produce knowledge about the informants' own perspectives and attitudes toward work environment issues, safety, and precautions
<b>Type of study</b>	Researchers carried out the study on behalf of stakeholders in elder care (e.g., trade unions).	PhD thesis	Carried out for the Danish Working Environment Authority
<b>Methods</b>	Focus group interviews	Semistructured, individual interviews, group interviews, ethnographic observations	Five focus group interviews, one of them relevant for this study
<b>Informants</b>	17 students from The Social and Health Care Education (SHCE) Study Program during their internship, and 27 supervisors responsible for the internship of Social and Health Care students	The data material consisted of participant observations and 23 qualitative interviews. The observations took place at three different Social and Health Education schools. The author made observations for 24 days in six different classes with around 25 students in each class	Young women and men between 15 and 25 years of age, working within five different professions. All of them were enrolled in their first year of the same Social and Health Care Study Program. They all had workplace experience in elder care
<b>Main results</b>	Newcomers often work alone and feel left alone. Relations between newcomers in elder care and their supervisors (senior colleagues) are vital for the newcomers' learning processes in relation to professional caregivers	Health promotion has significant importance as a discursive resource within the educational institution and in relation to the identity work of the student	Young workers in service jobs have a working life full of stresses and strains. They experience a range of different offenses and abuse in their workplaces. They often do not know where and how to seek support
<b>Data used in this article</b>	Eight group interviews	Field notes from ethnographic observation studies	One focus group interview with five female students aged 19–25 years





2007). These comparisons bring together data which are produced with “parallel ambitions of knowledge production” in different studies. In this case the research question was formulated as result of a curiosity toward the problem of sexual harassment that turned out to be a core issue in the data of studies X and Z, and a subtheme in study Y. The empirical material from all studies was systematically reread to find elements and traces with relevance to the theme.

In our perspective, documents from different settings and actors in elder care institutions are part of the practice-making of elder care. In order to further qualify the secondary analysis of qualitative, empirical material, we produced additional data: documents were drawn into the analysis in order to sustain and further unfold the relevance of the subthemes in other dimensions of elder care. The theme of unwanted sexual attention and sexual harassment was traced in study programs, textbooks, working environment texts, and professional documents from organizations with close links to elder care (e.g., the trade union FOA, where social and health care workers can be organized, and Dane Age Association). Of course, all of these texts are part of the entire empirical body which we produced. The reason to add complementary material to our secondary analysis is that we need it in order to cover empirically our insight into the total institution of elder care. The documents present an important part of the institutional framework that caregivers work within and which is shaping care work.

## Findings

We present the findings we have identified through our analysis of the three different dimensions of practice-making. In the political and educational dimensions, we identify how and why sexual harassment is marginalized by ideals of professional caregiving. In the organizational dimension, we identify how and why the individual handling and acceptance of sexual harassment is institutionally understood as a successful performance of the profession. And we find this to be connected to yet another practice-making, where exposure to sexually offensive behaviour is seen as a rite de passage into the profession.

### The political dimension

In 2001, the Danish National Board of Social Services issued a handbook addressing how sexuality is to be handled in relations between care professionals and adult citizens with physical or mental disabilities. In order to receive elder care in Denmark, a citizen has to be physically or mentally disabled, for example, by old age. Thus, the handbook also applies to the practice of elder care. This handbook was revised and reissued in 2012:

‘It is of great importance for professionals to relate professionally to others’ sexuality. Questions or signals about sexuality should not be ignored or rejected. If a citizen has once been ignored or rejected, it will probably be difficult for them to ask for help another time’ (Holmskov & Skov 2012: 8).

‘It is vital to be careful to use only words and phrases which are familiar to citizens, so as to not be offensive to them’ (ibid: 11).

Hereby a specific practice is made in which older people in need of care are to be known and related to as people who hold legitimate claims to have their sexual needs cared for by professional caregivers. From the highest authority in elder care, care professionals are guided toward attention to any signal of sexual need from (elderly) citizens in need of care. And professionals are thoroughly instructed never to neglect any such signal; neglect does not qualify as the practice professionals should be committed to in elder care. The practice-making in this document establishes a practice where the professional is seemingly the one who may cause harm to the (elderly) citizen—by neglect or by the use of offensive or inadequate language. This calls for a professional practice where caregivers are indeed very open (minded) toward sexual utterances from elderly citizens. The National Board of Social Services upholds this practice by referring to the UN Convention on the Rights of Persons with Disabilities (Disability Convention), which is based on a number of fundamental principles of everyone's right to make their own choices, on participation and inclusion, equal opportunities, etc. (Ibid: 4). In shaping the practice of relating to elderly citizens and their sexual needs, the National Board of Social Services establishes elderly peoples' sexuality as fragile and almost sacred: a delicate matter not to be wronged or offended by careless professionals. Interestingly, it renders the professional caregiver as the potential offender, and the elderly citizen as the person to be subjected to possible offense. The opposite is hardly fathomable in this practice-making of the Danish National Board of Social Services:

'In rare cases, illegitimate/illegal, sexual conduct may occur. Problems concerning illegitimate/illegal, sexual conduct, e.g. sexual harassment, are outside the scope of this handbook' (Holmskov & Skov 2012: 31).

### **The educational dimension**

Moving further to explore another institutional dimension we turn toward a textbook used in the education of social and health care students enrolled in their first year of the Social and Health Care Study Program. Here sexuality is also part of the curriculum. The textbook states that sexual life has a major impact on life quality and that "sexuality is a very private part of life and usually not something which care professionals are involved in" (Møller et al. 2007: 75). But at the same time the textbook puts forward this example:

'If a citizen<sup>1</sup> feels confident to ask for help e.g. to buy porn, be careful not to act judgementally. You have the right to say no, if you think it oversteps your personal boundaries. Then you must try to end the conversation politely' (ibid: 76).

This advice is in line with the political argument that the sexuality of the elderly needs to be accepted and handled politely. The successful professional performance is to be able to accept and assist the elderly in his or her search for sexual remedies. The student is given the option to reject, but is reminded to "end the conversation politely." Unlike the handbook from the National Board of Social Services, the textbook takes into consideration the topic of sexual harassment:



‘(...) some [professionals] have difficulties and find it hard to set boundaries. This may manifest itself when a citizen recurrently talks about sexual topics, uses obscene language or possibly in connection with assaults against personnel, e.g. if they grope the caregiver, expose themselves or the like. Such experiences can be very unpleasant, and if you encounter this problem it is important to reject it by clearly marking your boundaries. If that does not help, you should discuss the problem with your manager. For a period of time, it may be helpful if two employees perform the care task together’ (ibid: 77).

What is remarkable is the manner that sexuality and the potential risk of sexual harassment are practice-made within this textbook as if they were gender neutral, thus obscuring the fact that sexual harassment is most often conducted by men against women. Furthermore, the example illustrates a very common notion of the problem: the solution is conceived as a matter of “setting a boundary.”

‘In class a documentary is put on. It tells the story of an older, clearly alcoholic man who receives care from a female caregiver. She tells him that he will end up killing himself if he continues to smoke and drink so much. The old man loudly asserts that he “doesn’t want to go on any more.” The only thing that could give him the desire to go on living would be if he could experience something that he had not experienced before. “It would be being with a couple of Thai girls,” he says laughing. The class laughs out loud. From where I sit I cannot see if the female Thai student is laughing. Afterwards I join a group of students talking about the man from the documentary as “a good citizen.” They agree that they would like to have him as one of their clients. They find him quick-witted. My own reaction, however, is completely the opposite. The old man reminds me of an episode from when I worked as an untrained holiday replacement in home care at the age of 22. Twice a week I went to clean the house of an elderly, alcoholic man. In addition to telling me about the porn movies he watched on TV every night, he wanted to hold me. A little too long and a little too close. I felt uncomfortable, but also sorry for this man’ (Study Y).

This example tells how “setting your personal boundary” is not always as simple as it sounds. In the classroom situation and in the experienced work situation alike, sexualization of the care relation is intertwined with a multitude of other aspects. Both examples show how limits are blurry between jolly, caring, harmless, and offensive care work relations, which are exactly the reason why it is hard to “say when.” When does someone have to stop, because someone else is not comfortable any longer? It is not necessarily clear when boundaries are crossed. As sexualization of care relations in the documentary are not spoken of in class, it seems as if the educational practice contributes to making sexual harassment likely to be part of the professional care practices carried out in elderly (male) persons’ homes. When boundaries between the newcomers’ professional care and their response to elderly citizens’ sexual expressions are blurred, and when this is not addressed as problematic in class, newcomers are left to their own, individual boundaries instead of being helped by information or other institutional practices to maintain necessary boundaries.

### **The organizational dimension**

Newcomers are often left alone when carrying out elder care. In a recurring type of situation for newcomers in elder care, they experience being left alone in a difficult work situation. And among these are situations which include sexual harassment.

Female student: ‘One must also overcome it oneself in one way or another. For example, when I was to see my client for the first time ... he’s a very big and nasty guy. He doesn’t talk about anything but genitals and he touches you and hits you [...]. In the beginning it was very hard, very hard mentally, and it still is. He’s very big, both tall and heavy, and he’s actually strong’ (Study X).

Being alone in that type of situation seems to this student as a condition within the practice-making of elder care that she has to manage in the best possible way. To her, this means to “*overcome it*.” It never occurs to her that it may be wrong to put her in the situation where she is to see him alone on her first visit. This constitutes an institutional practice-making in which newcomers are to overcome any difficult situation, and to manage by themselves the feelings of fear and intimidation it causes. We argue that a particular institutional practice is cited and constituted in the example above. When the institution is maintained by such practices, it can be understood as a way of including newcomers in the institution by a certain rite of passage: a rite that enables the newcomer to commit herself to the institutional ethics of care, which does not leave her with the option to not tend for a citizen, however offensive he might be. Therefore, she just has to accept that he is “*a nasty guy*.” Another female student gives a similar example:

Female student: “I’ve often been called a bitch.”

Interviewer [to the other interviewees]: “Okay. Have you also been called that?”

All: “Yes, yes” (laughs).

Female student: ‘There was one morning where I was to give one of the citizens his breakfast. I bowed my head down to his, and then he touched me on the breast. I said to him “*Stop, please stop*,” and I was the only one there. And he was in a wheelchair. Then he hit me on the head and said “*You bitch!*” So I just had to leave. I just went and then was allowed to go home. And I quit, it was just too much. Well, I couldn’t cope with it’ (Study Z).

In this example it turns out to be commonplace to be called a bitch; they have all experienced this type of harassment, even though they are all newcomers in the practice. As in the previous example, this interpersonal dimension of practice-making shows how students are left alone with elderly citizens who are likely to harass them. And the mutual recognition of such harassment is practiced interpersonally between newcomers as a matter of inevitability and even normality. And so, if someone, like the young female student, is not able to stand such harassment, she thinks that she has to leave the organization. She did not pass the rite of passage. Another female student states the following:

‘Now I kind of got used to him, and sometimes he also behaves himself. In the beginning I felt: “No, I must damn well be able to handle him ... It was hard. It still is very hard ... I was scared’ (Study X).

In order to make it as a newcomer when facing the rite de passage of sexual harassment, students need to engage in as well as accept the practice-making by staying alone when handling the harassment. But it is not only the newcomers in elder care who are contributing to this organizational practice-making. When discussing the challenges of their newcomer colleagues, experienced elder care professionals maintain the very same practice of sexual harassment as a rite de passage for the newcomer to face on their own:



‘One should be very attentive to students signalling that they’ve had their limits violated by a citizen in one way or another ... Those students we had back at that time, they were experiencing so many things, and yet, I do feel sorry for them. I really felt sorry for them for having to be students at our place’ (a retirement home with many elderly citizens harassing the employees)

‘And it varies a lot where your own limit is. So that’s why it’s so hard to explain: What do you *do* in that situation ... well, let’s see about it, when it happens.’

‘One can only hope that the students are strong enough to handle all that. I’ve sometimes heard them say that they’d had too much of an experience, so that they just couldn’t take it. We did have one who actually stopped’ (Study X).

Experienced caregivers are very well aware of the risk of sexual harassment toward newcomers. In the practice-making, it is deemed necessary to leave such situations to the newcomers to handle because that is the path one needs to walk in order to make it in(to) professional elder care. It does not occur to experienced professionals that there might be another, less perilous and unpleasant, way to qualify newcomers. In the interpersonal dimension, experienced and new elder care professionals are mutually making the practice that exposes newcomers to sexual harassment and leaves them on their own. This practice-making acknowledges the need to care for citizens regardless of their harassment toward the caregiver. And thus, by merely enacting this through insisting on their capacity to do it on their own, newcomers engage in the practice-making of the elder care institution. A female student puts it like this:

‘One way or another, when you’re a student, it just has to look good—or how should I put it—that you’re able to manage. And still deep down, you’re just feeling so bad. Even though we’ve been told by our nice teacher at school, that if it feels like a lump in your stomach, and there’s something you don’t like to do ... well, then you should say no. But that’s damn well easier said than done!’ (Study X)

## Conclusion

Our analysis of institutional practice-making examines elder care in three institutional dimensions: the political, the educational, and the organizational dimensions. We have identified vital practices in all dimensions which maintain sexual harassment of newcomers in the care profession as a part of the institution that newcomers are introduced to, and thus are expected to acknowledge and undertake. On this basis we draw these conclusions:

Firstly, the practice-making produces sexual harassment of female caregivers as part of work and of the care profession. This practice-making shows in all of the dimensions of elder care. This implies that the phenomenon of sexual harassment of care workers in elder care cannot solely be viewed and understood in terms of interpersonal dynamics. We fully acknowledge that sexual harassment happens between persons, causing individual women distress and strains in work life, and yet it is necessary to stop looking only for the individual stories of ill-treatment and abuse in order to grasp the scope and the causes of the problem. Of course newcomers should be invited to refuse and report all kinds of abusive behaviour, but this is likely not

to eliminate sexual harassment of caregivers in elder care institutions. First of all our analysis shows that it is often very difficult to actually put one's foot down, even though one is fully aware that this would be the appropriate reaction to sexually offensive behaviour.

Secondly, our empirical research shows how sometimes, when harassment occurs, saying "no" does not make any difference. Once a person has been abused, for example, slapped or called a bitch, the offense and damaging effect to the caregiver's sense of integrity is a reality. And unfortunately, saying "no" does not make sure it will not happen again—either with the same citizen or with a different one. This is partly why we point to the insufficiency of the individualized perspective of an interpersonal relations notion of sexual harassment. The way sexuality is portrayed in institutional documents shows us another consequence of what can be understood as a personalized gaze: it allows for the problem of sexual harassment to be intertwined with the question of sexuality and the role of care professionals in the desire to enable a lifelong sexuality to thrive, despite the loss of bodily functions or sexual relations. It seems that the discourse of the inherent, lifelong sexuality blurs the lines and makes it even harder for female care workers to protect themselves against unwanted sexual attention.

The analysis has shown that the concept of practice-making provides an opportunity to highlight a different kind of complexity than the one following the personalized gaze. It calls for a different dimension of institutional practice-making, making it clear that the problem is produced and sustained by the concurrent effects of the dimensions mentioned. No politicians, teachers, coworkers, or other advocates of a lifelong active sexuality are in favour of sexual harassment. No single person other than the offender can be held responsible for sexual harassment. But by exploring the institutional weave of the political, educational, and organizational dimensions of the practice-making of elderly care, it becomes clear that much more can be done in order to reduce the prevalence of sexual harassment in elder care. Institutions tend to reproduce themselves by supporting certain ways of behaving, while making other paths less accessible. Sexual harassment seems to have become a pattern in the practice-making which is hard for newcomers to escape.

If elder care institutions are to prevent newcomers from experiencing sexual harassment, it calls for a change of institutional practice-making in all dimensions of elder care: the political, educational, and organizational dimensions. Hence, if the problem is not addressed as a serious, institutional issue, sexual harassment of female care workers will persist.

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## End notes

- <sup>1</sup> “Citizen” is the term used within the educational framework.