
Emotional Effects and Correlates of Harassment in Female Health Professionals

Abia Nazim¹, Tauqeer Nazim²**Abstract**

Harassment is one of the workplace challenges which leads to multitude of issues for both the victim and work organization. A cross sectional study was conducted on 187 female healthcare professionals working in various private and public hospitals chosen through purposive sampling technique from private and public health facilities of Lahore. Data were gathered using harassment experience survey and detailed demographic questionnaire. The study took into consideration both direct and indirect harassment experiences. Findings showed that female healthcare professionals reported significant rate of both indirect harassment experience (82 %) and direct harassment experience (69%). The rate of sexual harassment was reported to be higher in both indirect (75%) and direct (63%) experience groups. Rate of verbal harassment was reported to be 25% in participants of indirect and 37% for direct experience groups. Most of the participants reported to have experienced various psychological problems after facing harassment. Depression and anger were observed to be most reported psychological reactions to sexual harassment, whereas depression and phobia were significantly related to verbal harassment. Experience of harassment faced at workplace makes victims vulnerable towards many psychological problems.

Keywords: Female Health Professionals, Psychological Problems, Sexual Harassment, Verbal Harassment

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Introduction

Workplace harassment has turned into a significant peril across the world. Although harassment is significantly an underreported issue throughout the world, high reported rates are alarming in general population and health professionals (Spector et al., 2014). In Pakistan, healthcare profession is considered one of the most respectable and suitable profession for females and includes a large

number of females who work at various positions in many specialties. Harassment is reported as a common challenge faced by significant majority of female healthcare professionals across the world (Alobaid et al., 2020). Harassment occurs as a common form of discrimination based on unwanted physical or verbal behavior based on sex, physical characteristics, race, age, color, gender identity, national origin, religion and disability in the form of ridicule, intimidated comments, unwanted unwelcomed attention, use of abusive words, pressure to date or other sexual favors, intimidating jokes etc. (Canadian Human Rights Commission, 2020; US Equal Opportunity Commission, 2020). Although harassment can be of many types, sexual and verbal forms are most commonly experienced at workplace (US Equal Opportunity Commission, 2020).

Female health professionals have work experiences and routines different from other professions, as they have prolonged and odd

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working hours, remain in constant contact with patients and their care providers compared to other organizations and these variations make them more vulnerable to harassment (Jawaid, 2015). Healthcare system is also known for a long history of very conventional authoritative power hierarchy that researches have linked with higher rates of harassment and vulnerability towards it (Kabat-Farr & Crumley, 2019). Harassment experiences disrupt various aspects of work environment, reduces performance efficiency and adversely affects wellbeing of the victims. Victims of workplace harassment have been observed to experience a broad range of physical, psychological and work related problems after getting exposed to harassment (Gabay, & Shafran-Tikva, 2020; Nelson, 2018). The reactions may include but not restricted to significant decline in victims work productivity, negative attitude towards the organization (Ilies et al., 2003), severe sleep problems, difficulties in family relationships and various physical problems (Bum, 2019; Nye et al., 2014). Psychological difficulties commonly reported after harassment includes depression, suicidal ideation, extreme guilt, anxiety, frustration, anger, phobia, loneliness, somatic problems, post traumatic stress disorder, paranoia and other psychotic disorders (Beran et al., 2012; Schenk & Fremouw, 2012). Although evidence suggests that work place harassment leaves long term adverse effects on victims' health and career, only few researches have studied the impact of workplace harassment on victim's health. Research literature in Pakistan revealed that most of the researches on harassment were conducted in corporate sector (Yasmin & Jabeen, 2017) and this area is relatively ignored in health care. Harassment studies conducted in health sector of Pakistan were focused on medical students or nurses and no research explored harassment on female

health professionals working at different positions and across specialties. Other than that, literature at large showed that most of the previous studies ignored psychological and physical health consequences of harassment. It is expected that findings of the present study will be helpful to understand the dynamics of harassment and psychological difficulties experienced in reaction to it which would be helpful to create better work environment and provide effective support to victims.

Therefore, present study was conceptualized to assess different forms of harassment experienced by female healthcare professionals and to identify psychological problems experienced in response to harassment.

Methods

Research Design

A descriptive cross sectional research design was employed for current study.

Participants

187 female professionals working at various positions in different public and private hospitals of Lahore were selected through nonprobability purposive sampling technique. The sample size was determined through g-power analysis with medium effect size. From all female professionals contacted, 32 % declined participation request. The age of participants ranged from 22 to 59 years with mean age of 31 ($SD=17$) years, and all had at least one year of experience working at their respective institute.

Measures

Demographic form - A detailed demographic form was designed specially for the current study and included questions about age, marital status, education, income, nature of job, total duration of job, religion, family system etc.

Brief Symptoms Inventory (BSI) – This scale was developed by Derogatis, a self-report inventory consisted of 53 items

recorded on a 5 point Likert scale from 0 to 4 frequently used to assess various psychological problems (Adawi et al., 2019). It was decided to only use 22 items of BSI to assess the psychological problems participants experienced after being exposed to harassment. They rated the items in retrospect and only those psychological disorders were included that were mentioned in literature as reactions to harassment. Psychological problems included depression (9, from 16 to 18, 35, 50), phobia (item 8, 28, 31, 43, 47), anger (6, 13, 40, 41, 46) anxiety (items 1, 12, 19, 38, 45, 49).

Harassment Experience Questionnaire - Harassment experience questionnaire to record the details of harassment experiences was designed to get detailed information about type of harassment experiences. The instrument was developed using mixed method approach of scale development where 63 % items were generated through deductive method and 37 % items were developed using inductive approach. Content validity was established by calculating item content validity index (ICVI) and construct validity was based on factor analyses. It divided harassment in two basic types of experiences namely direct and indirect. Direct experiences were about harassment faced personally by the victim and indirect experiences were about harassment not experienced personally but witnessing someone else getting harassed. Details of nature of behaviors faced, enlisting and establishing threats of various risk factors, enlisting and establishing safety of different protective factors, details of the perpetrator and their characteristics, most vulnerable times and circumstances for harassment and details of psychological problems experienced in result of harassment. Some of the sample questions were “You are repeatedly told sexual jokes and/or stories that are offensive or make you very uncomfortable” , “Making impolite remarks

on your body type, appearance, sexual activities”, “Repeatedly asking you to go on lunch, tea, dates, to drop you off regardless of your clear rejection”, “Frequently establishing physical contact (like accidentally touching your hands during exchange of files, pens, or other things)”, “Frequently using impolite and rude words with you”, “Making you feel like you were being given special treatment or favor to engage in sexual behavior”, “have you been seriously threatened”, “Calling you names”, “Frequently mocking you and your work”, “Spreading rumors about you”, “yelling at you”. The questionnaire revealed good internal consistency as Cronbach alpha values for individual questions ranged from 0.84 to 0.93 and overall value was 0.91.

Procedure

Study design and all procedures were reviewed and approved by the departmental research review committee of Forman Christian College (A Chartered University) at Lahore through letter number ERRC-179-01-2020 and special attention was paid to ethical aspects of the current study. A small pilot study was conducted on 8 female healthcare professionals (including 4 nurses, 2 clinical psychologists and 2 doctors) mainly to assess the comprehension and content adequacy of research tools. All questions were in English language as the sample was expected to be educated. The results and brief inquiry from the participants did not reveal any significant difficulty comprehending the content. However, the font size was increased for reading ease in the light of participants’ feedback. After taking general permission from the institutes, consent was sought from individual participants. Purpose of the study and ethical rights of the participants were explained to all. All participants filled same set of questions in the same order, starting from demographic form which recorded significant personal information and a specially designed harassment experience

questionnaire that included significant information about the direct and indirect experiences of harassment, specific type of harassment witnessed or experienced, status of the harasser and psychological problems experienced in reaction to harassment.

Ethical Considerations

All participants were particularly told about confidentiality and all measures were taken to ensure the privacy and safety of participants by strictly keeping anonymity. They were also informed about the availability of a clinical psychologist appointed to offer psychological services in case of distress experienced after filling questionnaires. All participants were thanked for their time and participation. The data were then analyzed through Statistical Package for Social Sciences (SPSS version 21.0) and both descriptive and inferential procedures were employed.

Results

The data revealed two main types of harassment namely verbal and sexual harassment in both indirect and direct experiences.

The descriptive analysis revealed that majority of the participants were living in joint family system (65 %) and most of the participants comprised Muslims (57 %) but also included Christians (38 %) and those following other religions (5 %). The education level ranged from undergraduate degrees till doctorate degrees. Participants included nurses (44 %), doctors (27 %), clinical psychologists (11 %), physiotherapists (5 %), dentists (6%), medical technicians (3%), social workers (2 %), pharmacists (1%) and speech therapists (1%). Majority of the participants were married (49 %) but also included unmarried (42%), divorced (6%) and widowed (3%) females.

Table 1

Descriptives of Harassment Experienced at Workplace (N=187)

Variables	Frequency	Percentage
Never Experienced Harassment	58	31 %
Experienced Harassment	129	69 %
Sexual Harassment	81	63 %
Verbal Harassment	48	37 %
Had not witnessed someone getting harassed	34	18 %
Had witnessed someone getting harassed (Indirect experiences)	153	82 %
Sexual Harassment	115	75 %
Verbal Harassment	38	25 %

In total, 82 percent females reported to witness someone else getting harassed and 69 percent reported to have experienced it directly. Sexual harassment was observed to be significantly high in both direct (63 %) and indirect experiences (75 %) group. Nurses (79 %) were observed to be in majority who faced harassment directly.

Majority of participants (39 %) from direct experiences group reported to be harassed by their senior colleagues, patients harassed 20 % participants, 18 % faced it from their colleagues, 17 % by family member of patients and 6 % got harassed by clerical staff. Common modes of harassment included in-person harassment and through cell phones. Majority of participants faced or

witnessed sexual harassment during evening and night shifts and when they were being called in offices. Sexual harassment reported to be commonly experienced at extremely crowded (47%) or particularly isolated places (41%). However, verbal harassment was not

reported to be specific to such situational conditions. Surprisingly, perpetrators involved in the act of verbal harassment included an almost same representations of males (51%) and females (49%).

Table 2

Psychological Reaction to Harassment among Participants (N=187)

Variables	Direct Experiences (n = 129)		Indirect Experiences (n = 153)	
	Frequency	(%)	Frequency	(%)
Sexual harassment	(n = 81)		(n = 115)	
Depression	28	(35%)	10	(9 %)
Anxiety	8	(10 %)	14	(12 %)
Phobia	17	(21 %)	23	(20 %)
Anger	27	(34%)	68	(59 %)
Verbal harassment	(n = 48)		(n = 38)	
Depression	15	(32 %)	16	(41 %)
Anxiety	10	(20 %)	4	(10 %)
Phobia	15	(32%)	5	(14 %)
Anger	8	(16 %)	13	(35 %)

As far as psychological impact of harassment was concerned, anger and depression were identified as most significant psychological reactions to sexual harassment, while phobia, depression and anger observed to be more common for verbal harassment. Depression turned out to be experienced by majority in direct sexual (35%) and verbal (32%) harassment groups and (41%) for indirect

verbal harassment group. Anger was reported by majority of those who experienced sexual harassment directly (34%) and who witnessed their colleagues getting sexually (59%) and verbally (35%) harassed. Phobia was also observed as a significant emotional reaction against direct verbal harassment (32%) and indirect sexual harassment (20%).

Table 3*Correlation between Psychological Reactions and Demographic Variables (N=187)*

Variables	Direct Experiences (n = 81)				Indirect Experiences (n = 115)			
	Age	Educ	Inc	MS	Age	Educ	Inc	MS
Sexual harassment								
Depression	-.40**	.39*	.24**	.32**	-.16**	.51**	.11**	.33**
Anxiety	.31*	.21*	.55**	-.30*	.12	-.20*	.34*	.18**
Phobia	.47*	.20*	.39**	-.57*	.40*	.36**	.34*	.41*
Anger	-.30*	.46*	.52*	-.55*	-.48*	.57**	.48*	-.36*
Verbal harassment								
Depression	-.36*	.19*	.14	.21*	-.46*	.46**	.33**	.20*
Anxiety	.19*	.33**	-.40*	.28**	.38**	-.11*	-.53*	.10*
Phobia	.41*	-.32*	-.59**	.18*	.19**	-.20*	-.24**	.22*
Anger	-.13*	.20*	.32*	-.21*	-.40**	.44**	.56*	-.27*

Note. Educ= Education; Inc= Income; MS= Marital status

* $p < 0.05$; ** $p < 0.01$

Correlation between demographic variables and psychological reaction to harassment revealed some interesting trends. Age showed a significant positive association ($p < 0.05$, $p < 0.01$) with all types of psychological distress across all groups except depression (direct sexual harassment= $r, -.40$ $p < 0.01$; indirect= $r, -.16$ $p < 0.01$; direct verbal harassment= $r, -.36$ $p < 0.05$; indirect= $r, -.46$ $p < 0.05$) and anger (direct sexual harassment= $r, -.30$ $p < 0.05$; indirect= $r, -.48$ $p < 0.05$; direct verbal harassment= $r, -.13$ $p < 0.05$; indirect= $r, -.40$ $p < 0.01$) among those who faced direct and indirect sexual harassment. Education was positively associated ($p < 0.05$) with all problems in direct sexual harassment group and inversely

associated ($p < 0.05$) with anxiety in indirect group ($r, -.20$ $p < 0.05$). It revealed positive relationship ($p < 0.05$, $p < 0.01$) with all variables but with phobia ($r, -.32$ $p < 0.05$) for direct verbal harassment and with phobia ($r, -.20$ $p < 0.05$) and anxiety in ($r, -.11$ $p < 0.05$) indirect group. Income indicated negative association with anxiety (direct= $r, -.40$ $p < 0.05$; indirect= $r, -.53$ $p < 0.05$) and phobia (direct= $r, -.59$ $p < 0.01$; indirect= $r, -.24$ $p < 0.01$) in verbal harassment groups. Being married was observed to have negative association with anger across all groups ($p < 0.05$). It was also inversely related to phobia ($r, -.57$ $p < 0.05$) and anxiety ($r, -.30$ $p < 0.05$) of direct sexual harassment group.

Discussion

Violence against healthcare professional reported to have increased significantly across the globe, health professionals in Pakistan have also reported to be victims of violence in several studies (Yasmin & Jabeen, 2017) and present findings also support this as most participants reported experiencing harassment directly or

indirectly. Participants of present study were harassed by both their colleagues and patients which got support from findings of previous studies that reported healthcare professionals being harassed by colleagues, patients and their relatives (Kabat-Farr & Crumley, 2019). Nursing in present study was the lowest service rank and nurses were observed to be most vulnerable to harassment with highest

percentage of harassment. This might be due to two reasons, nurses had more frequent direct contact with fellow colleagues, patients and their relatives and secondly, they might be seen as easy targets for having low authority compared to others making them easy targets as reported by other studies that workers having less authority were easy targets of harassment (Kabat-Farr & Crumley, 2019). Studies also concluded that conventional hierarchical system of healthcare likely to encourage higher ups to harass low status workers and this in turn may also give outsiders (patients and their caregivers) impression that it is permissible to harass low status workers (Celik, & Celik, 2007; Kabat-Farr & Crumley, 2019).

Most of the previous research also have agreed that victims of harassment usually experience wide range of emotional difficulties in reaction to harassment from high levels of stress, poor work efficiency and job dissatisfaction to intense fear, frustration, anger, anxiety, depression, post traumatic stress disorder and even psychosis (Reed et al., 2016; Shaikh et al., 2020). Findings of present research revealed that majority of participants experienced some form of psychological disturbance regardless of the fact whether harassment was experienced directly or witnessing someone else being the victim (Lu et al., 2020).

Present results also showed that most victims of both direct and indirect harassment experienced anger, depression and phobia. This differs slightly from most studies conducted in western countries reporting that large majority of victims rather only experienced depression (Jamshed & Kamal, 2020). One possibility might be that many victims were reported to be afraid of sharing the experience of harassment for the fear of being blamed, judged negatively, fear of facing serious consequences at work for reporting the incident, fear of not believed and receiving negative social attention

(Kabat-Farr & Crumley, 2019; Marsh et al., 2009). All these factors were likely to develop strong feelings of helplessness which could easily transformed into frustration and anger (Lu et al., 2020). Another significant reason might be negative sociocultural connotations attached with harassment victims in Pakistani society. As women reporting harassment are likely to be looked down upon and blamed for it (Lu et al., 2020), this can potentially lead to repression leading towards frustration and anger.

Depression was reported by majority in all groups except those who witnessed others getting sexually harassed, this was supported by findings of research conducted previously in Pakistan (Jamshed & Kamal, 2020) and abroad (Fitzgerald & Cortina, 2018). Depression is a common emotional reaction observed in people after experiencing negative life experiences. Harassment makes victims feel extremely violated, experience distress which can easily lead to various symptoms that characterize clinical depression. Furthermore, many victims reported helplessness and lack of control over the situation and could not do anything against harassment, could not even leave jobs nor avoid the perpetrator which might also contribute to strong feelings of depression.

Phobia emerged as yet another common emotional reaction reported by many participants in response to harassment in present study. Phobia was observed to be highest in those who experienced direct verbal harassment. Ironically, many people do not regard verbal harassment a serious issue compared to physical and sexual harassment. But contrary to this, research has reported that exposure to verbal harassment can also leave a strong adverse effect on psychological well being of victims (Mushtaq et al., 2015). Findings of present study indicated depression, anger and phobia as three most significant psychological reactions to verbal harassment. This finding

can be supported by other studies which reported phobias as one of the significant emotional reactions to verbal harassment (Ali et al., 2002). Though no physical harm is reported along with verbal harassment, the impact is reported to be nothing less than physical harm in any way. Victims are likely to be afraid that the verbal threats could be transformed into physical and sexual harm, and there is still lots of social embarrassment attached to verbal harassment, they may also think that others would also start finding faults in them and would be encouraged to harass them. All these factors are likely to make it an extremely unpleasant experience for victims and trigger anticipatory anxiety which may easily lead to a state of constant fear.

Present study also studied the association between psychological reaction to harassment and different personal variables which revealed interesting trends. Depression showed strongest association with age and education across all groups. Depression was observed to lessen with age that was in line with another study reporting more psychological difficulties in younger age groups particularly in 30s and 40s compared to older harassment victims (Rodriguez & Benton, 2004). Education on the other hand revealed to have positive association with depression, education brings more awareness about one's rights and violation of these rights is likely to be more upsetting than people who do not have this awareness which might have increased depression in present sample. Anxiety observed to decrease with increase in income, this might be because individuals with low income might have considered themselves more vulnerable towards harassment and other negative experiences and were twice as unlikely to report harassment as others (Houle et al., 2011; Runarsdottir et al., 2019). Phobia revealed to be increased with age progression contrary to common assumption that younger

victims would be more afraid than older victims of harassment. This might be due to the fact that females generally believe themselves to be less attractive for perpetrator and less vulnerable to harassment as they age. However, losing this perceived safety might have made them vulnerable consequently making them more petrified. Anger observed to have consistently strong pattern of association with income and education. This might be because these two factors are believed to be strongly associated with empowerment (Runarsdottir et al., 2019). Getting violated despite these two strong empowering factors is more threatening resulting in more distress and frustration. Present findings should be considered in the light of some limitations. Our cohort was selected through nonprobability sampling, it would have been more adequate to get random sample to improve generalizability of findings. Present study only employed quantitative research design whereas, qualitative design or the mixed method design would give more insight and much better understanding of this very significant issue.

Findings of the present study conclude that female healthcare professionals remain vulnerable to sexual and verbal harassment at their workplace and are likely to experience significant psychological disturbances in response to experience of harassment.

Contribution of Authors

Abia Nazim: Conceptualization, Methodology, Validation, Investigation, Data Curation, Formal Analysis, Writing-Original draft, Writing- Review & Editing, Supervision

Tauqeer Nazim: Investigation, Data Curation, Writing- Original Draft, Writing- Review & Editing

Conflict of Interest

There is no conflict of interest declared by authors.

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