

General and Sexual Harassment as Predictors of Posttraumatic Stress Symptoms among Female Health Professionals

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Abstract: This research was conducted to explore the role of general and sexual harassment as predictors of posttraumatic stress symptoms. The purposive sample was composed of 300 female healthcare professionals within age range from 20 to 59 years (100 doctors, 100 house-job doctors and 100 certified nurses). The sample was drawn from five different public hospitals of Lahore city. The findings suggested significant positive relationship between general workplace harassment, sexual harassment and posttraumatic stress symptoms. The results further indicated that workplace harassment and sexual harassment are the strongest predictors for posttraumatic stress symptoms. The findings of this research could be beneficial in enhancing awareness about the serious issue of workplace harassment and its negative consequences.

Key words: Sexual Harassment • General Work Harassment • Posttraumatic Stress Symptoms

INTRODUCTION

Workplace harassment is a serious issue these days. Throughout the world, working people are reporting general and sexual harassment at their workplaces. Despite all the efforts for preventive remedies, the problem of workplace harassment is continuing and adversely affecting the mental and physical health of working women across the globe.

Workplace harassment is in fact the mistreatment of a subordinate, a colleague or a supervisor which if continued for a long period may cause severe social, psychological and psychosomatic symptoms in the victim [1]. In fact, workplace harassment is a complex issue with many shapes, multiple factors and many levels [2]. General work harassment is defined as persistent negative actions by one or several persons towards an individual or group of people, who have difficulties in defending themselves [3] whereas, sexual harassment is “Any action occurring within the workplace whereby women are treated as objects of the male sexual prerogative... regardless of whether the victim labels it as problematic or not” [4]. During the initial phases of harassment, the victim has to face discrete and indirect aggressive behaviors that are difficult to mention. However, with passage of time, aggression that is more direct appears

and the target person has to face definite isolation, intimidation and public humiliation. In the end, physical harassment may be used against the victim [5].

Sexual harassment generally reflects the male attitude toward women in a patriarchal society and workplace [6]. Moreover, sexual harassment is not a mutual attraction or understanding between men and women [7], it may include leering, ridiculing, insulting remarks, repeated and unwanted sexual comments, demands for sexual favors and unwanted comments about dress or appearance [8-10]. Harassment of sexual nature affects the psychological integrity of women like other workplace stressors and it has serious health consequences for women [7]. Anila [11] showed positive relationship among different demographic variables and sexual harassment. The findings further suggested that experiences of sexual harassment at workplaces affect working women in terms of vocational, psychological, interpersonal and physical strain. The women who experienced more sexual harassment used more externally focused coping approaches than to internally focused coping strategies.

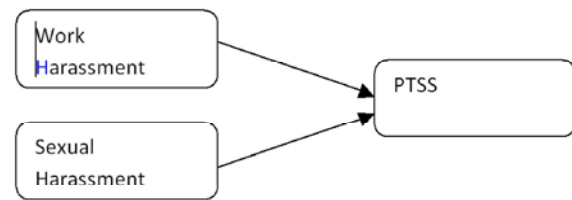
Workplace harassment can have a variety of physical and psychological effects on employees; such as general stress, insomnia, mental stress, self-hatred, suicidal ideation, low self-esteem, lack of concentration and reduced self-confidence [12]. Yildirim and Yildirim [13]

reported that 86.5% of the studied nurses reported mobbing experiences during last 12 months. The nurses in private hospitals reported more harassing behaviors than those work at public hospitals. The results further indicated that the most common behaviors to avoid mobbing were hard work and more organized and careful work behavior to avoid criticism. 10% of the participants reported that they have suicidal ideation.

It has been found that victimized women exhibited common cognitive and emotional after-effects similar to the victims of post-traumatic stress syndrome (PTSD) that include anxiety, depression and headaches, sleep disturbance, gastrointestinal disorders, weight loss or gain, nausea and sexual dysfunction [14]. Furthermore, prior research findings suggested that repeated exposure to several traumas such as workplace harassment increase victims' vulnerability to developing PTSD [15].

Post-traumatic stress disorder (PTSD) is a devastating psychological state caused by a main traumatic event, such as rape, combat, terrorism, a natural disaster, accident or death of a loved one. It is manifested by disturbing memories or thoughts of the suffering, "blunting" of emotions and increased arousal. In the current research posttraumatic stress symptoms (PTSS) are defined in terms of three clusters of symptoms. These are: *re-experience of traumatic event, avoidance of the stimuli and hyper-arousal in the victims* who are exposed to any traumatic events such as workplace harassment. According to the DSM-IV TR criteria for the diagnosis of PTSD; the person must report exposure to an extreme traumatic event (Criterion A1); the person's reaction to any traumatic events must involve extreme fear, vulnerability, or fear (Criterion A2); persistently re-experience the traumatic event (Criterion B); person constantly avoid the associated stimuli (Criterion C); persistent hyper arousal or provocation (Criterion D). Furthermore, persistence of symptoms for more than one month (Criterion E) and significant impairment in functioning of the target person's life (Criterion F) may occur. Thus, PTSS is defined differently from PTSD in the current research; because it does not fulfill all the criteria for PTSD as cited in DSM-IV TR [16].

There is sufficient empirical evidence that suggests similarities between symptoms of PTSD and the after-effects of workplace harassment [17-20]. Research indicated that sexual harassment can produce symptoms of PTSD in almost a third of its targets [21]. In another study it was found that more severe forms of sexual



harassment (sexual or physical attack) clearly meet the diagnostic criteria of PTSD. They further argue that even the less severe forms of sexual harassment may also meet this criterion because sexual harassment affects the person's financial wellbeing, personal limits and control of situation and cause a threat to the physical integrity of the person [22]. Dansky and Kilpatrick [23] argue that the female victims of sexual harassment and workplace harassment are significantly more vulnerable of developing posttraumatic stress disorder.

It may be argued that in a typical Pakistani society women do not feel themselves secure even in boundaries of their home and this feeling of insecurity remains with them throughout their life and in all domains. Especially at workplace, it is a crucial problem because its presence affects the working women's physical and mental health. Health sector is the most suitable setting for the study of workplace harassment in Pakistan. Though the intensity and level of harassment against female healthcare workers is mostly undocumented in Pakistani society, facts from existing literature suggest the occurrence of workplace harassment against working women in healthcare sector. This study was intended to determine the relationship between workplace harassment and PTSS among three types of female healthcare professionals. Furthermore, it aimed to the impact of both general work and sexual harassment on PTSS.

MATERIALS AND METHODS

Hypotheses:

- Higher the general work and sexual harassment higher will be the reported posttraumatic stress symptoms by female doctors, house-job doctors and nurses.
- Workplace harassment (general and sexual) would be the strongest predictor of posttraumatic stress symptoms among female health professionals.

Sample: The sample of 300 females (doctors = 100; house-job doctors = 100; nurses = 100) was drawn from five different public hospitals of Lahore city of Pakistan

(Mayo Hospital, Ganga Ram Hospital, Jinnah Hospital, Lady Willington Hospital and Sheikh Zayed Hospital) met the following inclusion criteria for inclusion in the research sample:

- Age range from 20-59 years.
- At least 1 year working experience as licensed doctors and nurses in a public hospital of Lahore city approved by Pakistan Medical Council.
- At least 1 month working experience for house-job doctors in a public hospital of Lahore city after completion of MBBS degree approved by Pakistan Medical Council.

Instruments: Following instruments were used for data collection:

Demographic Information Form: Demographic Information Form was developed by the researcher in order to gather information about age, education, job status, monthly income, job experience and marital status of the research participants.

Work Harassment Scale (WHS) by Björkqvist *et al.* [24]: Work Harassment Scale (WHS) developed by Björkqvist *et al.* [24] is an instrument to measure the workplace harassment of an individual. WHS consists of 24 items. Each item has five optional responses, which are scored on a 5-point Likert Scale, as follows: 0- Never, 1—Seldom, 2-Occasionally, 3-Often, 5-very often. The respondents can obtain scores from 24-96 on WHS. Written permission was granted by the authors of WHS for its use in the current research). WHS was found to have high internal consistency with Cronbach's $\alpha = .93$ in the current research project. Therefore, it may be argued that WHS is a reliable and valid self-report inventory for assessment of general work place harassment in the Pakistani sample.

Sexual Harassment Experience Questionnaire (SHEQ) by Kamal and Tariq [25]: Sexual Harassment Experience Questionnaire (SHEQ) is a self-report instrument to measure the type and frequency of sexual harassment at workplace. SHEQ was developed by Kamal and Tariq [25] and it consists of 35 items. Each item has four optional responses which are scored on a 4-point scale, as follows: 1- Never, 2-Once, 3-A few times, 4- Very frequency. In this research the SHEQ was found to have significantly high internal consistency with Cronbach's $\alpha = .95$.

PTSD Check List-Civilian Version (PCL-C) by Weathers *et al.* [26]: PTSD Checklist-Civilian Version (PCL-C) was developed by Weathers *et al.* [26] which measures level of PTSD of an individual. PCL-C is useful because it can be used with general population including adolescents, adults and elderly. Each item has five optional responses which are scored on a 5-point Likert Scale, as follows: 1-Not at all, 2- A little bit, 3- Moderately, 4- Quite a bit, 5- Extremely. The respondents may obtain scores from 17 to 85. The highest score on this checklist indicates highest level of posttraumatic stress symptoms reported by the respondents. In this study PCL-C was found to have significantly high reliability as supported by the Cronbach's $\alpha = .90$.

Procedure: Official permission was sought from the hospital authorities for data collection from the female doctors, house-job doctors and nurses. Before administration of questionnaires, the participants were briefed about the nature and purpose of the study. Rapport was established by assuring them of the confidentiality of their personal information and its use for research purpose only. Written consent was obtained from all the participants individually. Then questionnaires were used to determine reported workplace harassment and posttraumatic stress symptoms.

RESULTS

The demographic characteristics of the sample are given in Table 1

The results given in Table 2 indicated significant positive correlation between general workplace harassment and posttraumatic stress symptoms ($r = .38$, $*p < .01$); as well as between sexual harassment and posttraumatic stress symptoms ($r = .49$, $*p < .01$) among the sample of the female doctors ($n = 100$). The results further indicated significant positive relationship between general workplace harassment and posttraumatic stress symptoms ($r = .58$, $*p < .01$); and between sexual harassment and posttraumatic stress symptoms ($r = .66$, $*p < .01$) among the sample of the female house-job doctors ($n = 100$). The results given in Table 2 further suggested significant positive correlation between general workplace harassment and posttraumatic stress symptoms ($r = .52$, $*p < .01$); as well as between sexual harassment and posttraumatic stress symptoms ($r = .71$, $*p < .01$) among the sub-sample of the female nurses ($n = 100$) from various public hospitals of Lahore city. The results supported first hypothesis that there would

Table 1: Demographic Characteristics of the Sample (N=300)

Characteristic	Sample (N = 300)	
	F	%
Age		
20 - 29	215	71.7%
30- 39	51	17.0%
40 - 49	34	11.3%
Education		
Matric	20	6.7%
F.A/Nursing	18	6.0%
B/sc/B.A	62	20.7%
M.BBS/FCPS	200	66.7%
Monthly Income		
15000-25000	167	55.7%
26000-35000	133	44.3%
Duration of experience		
< 1 year	101	33.7%
1 - 5 year	121	40.3%
More than 5 years	78	26.0%
Marital Status		
Married	131	43.7%
Unmarried	169	56.3%

Table 2: Relationship between General Harassment, Sexual Harassment and Posttraumatic Stress Symptoms among Doctors, House-Job Doctors and Nurses (N=300).

Variables	Doctors						House-job Doctors						Nurses1					
	M	SD	α	1	2	3	M	SD	α	1	2	3	M	SD	α	1	2	3
1 General Harassment	27.76	13.67	.91	-			34.19	18.74	.95	-			39.86	18.52	.92	-		
2 Sexual Harassment	60.14	12.35	.86	.41*	-		69.03	18.64	.96	.74*	-		67.05	21.22	.94	.65*	-	
3 PTSS	32.44	10.39	.92	.38*	.49*	-	37.46	10.77	.91	.58*	.66*	-	37.26	11.66	.88	.52*	.71*	-

*P<0.05

Table 3: Hierarchical Multiple Regressions Predicting Posttraumatic Stress Symptoms from General Workplace Harassment and Sexual Harassment among the Female Healthcare Professionals (N=300)

Variables	Doctors (100)			House-job Doctors (100)			Nurses(100)		
	B	Δ^2	F	B	Δ^2	F	B	Δ^2	F
1 General Harassment	.21*	.26	18.77	.20*	.45	41.31	.10	.49	50.04
2 Sexual harassment	.40*			.51*			.64*		

*p < .05,

be positive relationship between workplace (both general and sexual) harassment and posttraumatic stress symptoms among the nurses.

Multiple regression analysis was performed to determine the impact of general workplace harassment and sexual harassment on posttraumatic stress symptoms. The results given in Table 3 indicated that in the sub-sample of doctors, sexual harassment and general work harassment were found to be the strongest predictors for posttraumatic stress symptoms ($\beta = .40$, $p < .001$; and $\beta = .21$, $p < .05$, respectively) and accounted for 26 % of the variance in posttraumatic stress symptoms. In the sample of house job doctors, results of

the analysis also indicated that both type of harassment (general harassment and sexual harassment) have strong impact on PTSS ($\beta = .20$, $p < .05$; and $\beta = .51$, $p < .001$, respectively) and it explained 45 % variability. The findings of the regression analysis carried out on the sub sample of nurses also revealed sexual harassment is the strongest predictors of posttraumatic stress symptoms among nurses ($\beta = .64$, $p < .001$, respectively) These results supported the second hypothesis that workplace harassment (general and sexual) will be the strongest predictor of posttraumatic stress symptoms among female health professionals.

DISCUSSION

The main finding of the current research was that there is a statistically significant positive relationship between workplace harassment (general and sexual harassment) and posttraumatic stress symptoms reported by all the female doctors, house-job doctors and nurses. Thus, it supported the first hypothesis that more the workplace harassment (general and sexual harassment) greater the posttraumatic stress symptoms would be. Current research findings are consistent with several investigators [21, 23,27-29] who found significant positive relationship between workplace harassment and posttraumatic stress symptoms. There is sufficient empirical evidence, which suggest that being harassed in the workplace setting is associated with mental distress [30-32]. The previous research findings suggested that victimization and unfair treatment caused by the hostile and violent behavior of colleagues and other individuals may produce high level of distress and symptoms of PTSD [33]. Moreover, even slight and subtle type of psychological mistreatment may produce clear symptoms of PTSD [21].

The findings of the current research are further supported by Nolfé *et al.* [34] who found greatest subjective perception of mobbing among 733 workers of high and medium positions. They further reported that adjustment disorders, mood disorders especially major depression and anxiety disorder particularly PTSD are the most frequent diagnosis. The authors concluded that depression and PTSD are the most frequent psychiatric diseases related to workplace harassment at workplace. Stockdale, Logan and Weston [35] found positive correlation between sexual harassment experiences and PTSD symptoms controlling for prior abuse, trauma, prior psychological history and prior PTSD among 445 women. Their findings indicated that sexual harassment experiences are positively correlated with PTSD symptoms controlling for previous abuse, trauma, past psychological history and earlier PTSD. They further discussed that sexual harassment experiences are autonomously related with PTSD symptoms and are sufficient for the diagnosis of PTSD despite of history of trauma or abuse.

The second major finding of this research project was that general workplace harassment and sexual harassment turned out to be the strongest predictor for PTSS among doctors, house-job doctors and nurses. This finding supported the second hypothesis which proposes that workplace harassment (general and sexual)

will be the strongest predictor of posttraumatic stress symptoms. Several research findings [22, 36-38] suggested that bullying and sexual harassment at workplace can produce posttraumatic stress symptoms in the employees.

The main limitation of the current research was use of self report questionnaire/scale/checklist which might have resulted in under reporting of general and sexual harassment and posttraumatic stress symptoms due to the socially tabooed nature of the problem under study. Therefore, it is strongly recommended that in future researches focus group and interview techniques must be used in addition to self report questionnaire in order to gather more comprehensive information. It is further recommended that qualitative analysis in addition to the quantitative analysis must be carried out. The findings of the current research cannot be generalized to the private sector. Therefore, it is strongly recommended that the future researches must include larger samples of male and female participants from both the public and the private hospitals of different cities of Pakistan in order to generalize the findings to the overall Pakistani healthcare system.

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