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Managers' and Leaders' Perceptions of Sexual and Gender-Based Public Harassment in the Veterans Health Administration

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A B S T R A C T

Purpose: Managers and leaders have a critical role to play in sexual and gender-based harassment prevention within organizations. Although the Veterans Health Administration has committed to eliminating harassment through national directives and training programs, it is unclear how aware local-level managers and leaders are about public harassment at their facilities and how they perceive sexual and gender-based harassment. We examined middle managers' and leaders' views about whether harassment is perceived as a problem locally, and what policies and procedures (if any) are in place to address public harassment.

Methods: We conducted 69 semistructured telephone interviews with middle managers and facility leaders before implementation of an evidence-based quality improvement project designed to improve delivery of comprehensive women's health care. Transcripts were coded using the constant comparative method and analyzed for overarching themes.

Results: Perceptions of the prevalence of sexual and gender-based public harassment varied among middle managers and leaders. A little more than one-half of respondents were unaware of facility-level policies and procedures to address public harassment between patients. To decrease patient-to-patient harassment, both groups generally supported the creation of separate clinical spaces for women. However, middle managers also stated that education was needed to change patient harassing behavior, which they tied to male military culture.

Conclusions: Aligning divergent perspectives of what constitutes sexual and gender-based harassment and how to address it is a necessary step towards tackling harassment at the local level. Managers and leaders should continue to assess environments of care and share findings widely among employees and leadership to improve awareness and inform a unified response.

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Harassment at Veterans Health Administration (VA) health care facilities is common, with one in four women veterans who regularly use VA reporting being harassed by men veterans on VA grounds through, for example, catcalls, stalking, and/or denigration of their veteran status (Klap et al., 2019). Defined as interactions that occur between strangers in public settings, public harassment often targets an individual's gender or gender identity through verbal behaviors and/or non-verbal actions (Logan, 2015; SSH, 2014). The consequences are serious: women veterans who report experiencing harassment on VA grounds are more likely to delay or miss their health care appointments and more likely to feel unsafe or unwelcome at VA (Klap et al., 2019). Feeling unsafe or unwelcome at VA has been associated in prior research with delaying and forgoing health care (Washington, Bean-Mayberry, Riopelle, & Yano, 2011) or even dropping out of VA care entirely (Hamilton, Frayne, Cordasco, & Washington, 2013).

In addition to detrimental effects on health care access, public harassment is associated with multiple negative psychosocial and physical outcomes (e.g., depression, anxiety, trauma symptoms, sleep disorders, decreased feelings of safety, restricted freedom of movement, and relationship difficulties) (Fairchild & Rudman 2008; Logan, 2015; Miles-McLean et al., 2015; SSH, 2014, 2018). Trauma-related symptoms and distress in response to harassment can be heightened in women with trauma histories (Miles-McLean et al., 2015). This is particularly concerning in VA given the high prevalence of trauma, including military sexual trauma (MST), among women veteran patients (Barth et al., 2016; Klingensmith, Tsa Mota, Southwick, Pietrzak, 2014; Sadler, Booth, Nielson, & Doebbeling, 2000; Zinzow, Grubaugh, Monnier, & Suffoletta-Maierie, 2007).

Women are the fastest-growing group of VA users, and this rapid growth has prompted robust efforts over the last several decades to better adapt VA services for women's specific health issues and needs (VA National Center for Veterans Analysis and Statistics, 2017a,b; Yano et al., 2011; Yano, Haskell, & Hayes, 2014). In 2010, the VA established national standards for comprehensive women's health care, enabling women to receive care from designated providers located within women-only or mixed gender clinics. Additionally, women's health managers engage in quality improvement activities such as environment of care rounds to assess and correct environmental barriers to women's high-quality equitable care (e.g., privacy and safety deficiencies) (Veterans Health Administration, 2017).

Although the provision of gender-sensitive care has improved substantially, the VA has served a predominantly male population throughout its history, and women veterans are still vastly outnumbered by men in almost all VA settings (Frayne et al., 2018). Higher levels of sexual harassment have been documented in traditionally male-dominated, hierarchical occupations such as the military (Buchanan, Settles, Hall, & O'Connor, 2014; Fitzgerald, Magley, Drasgow, & Waldo, 1999; Street, Gradus, Stafford, & Kelly, 2007), and by extension the VA (Cheney, Dunn, Booth, Frith, & Curran, 2014). A recent study by our research team revealed that both men and women veterans link harassment at VA to the male-dominated military culture experienced during active duty and later "re-created" by veterans in VA settings (Dyer et al., 2019).

The prevention and elimination of harassment are top VA priorities (Isakson & Roe, 2020 cf. Hayes, 2013). VA leaders are invested in identifying and deploying system-wide solutions to address harassment at VA sites of care (Dyer et al., 2021). For example, the VA Office of Women's Health launched the *End Harassment Campaign* in August 2017, a national social marketing effort composed of staff training initiatives and awareness-raising materials (Hayes 2019).

Although national leaders have launched anti-harassment campaigns, we lack local-level, on-the-ground information about how harassment is understood, perceived, and addressed by VA employees. For instance, to what extent is harassment perceived as a problem, and how do new national directives and initiatives fit into the local context? Understanding how middle managers and leaders perceive harassment prevalence and solutions is important, given their role in implementing and sustaining new, top-down initiatives locally (Birken, Shoou-Yih, & Weiner, 2012; Engle et al., 2017). In this article, we present VA facility leaders' and middle managers' perceptions of sexual and gender-based harassment in their facilities to assist with the local adaptation of national initiatives.

Methods

Study Setting, Sample, and Data Collection

Data were collected as part of a larger VA evaluation of the use of evidence-based quality improvement to improve delivery of comprehensive women's health care (Hamilton et al., 2020). The evaluation included 21 geographically dispersed VA sites of care that were categorized as low-performing based on several standard women's health-related metrics. Detailed information about study design and site selection has been previously described (cf. Hamilton et al., 2020). We conducted a total of 73 semistructured telephone interviews with 50 middle managers and 23 senior leaders.

Interview questions included topics such as structure and delivery of usual care for women veterans, barriers and facilitators to the delivery of comprehensive women's health care, and ongoing improvements in women's health for women veterans. For the purpose of this article, our analytic sample consists of 69 participants who answered questions about 1) the environment of care for women, including public spaces, safety, and gender sensitivity; 2) incidences of public harassment; and 3) policies or procedures in place to address harassment. Given the many topics covered in the semistructured interview guide for the larger study, questions about environment of care and harassment were not asked in some interviews owing to time constraints. However, all participants in our analytic sample answered at least one of these questions. Of the middle managers, 32 discussed #1, 47 discussed #2, and 15 discussed #3. Of the senior leaders, 16 discussed #1, 21 discussed #2, and 5 discussed #3.

Interviews, ranging from 30 to 60 minutes, were conducted between February and October 2017 by a team of trained interviewers. Interviewers provided appropriate confidentiality assurances and verbal consent to audio-record was obtained from participants before the start of each interview. All interviews were recorded and transcribed, except for the one participant who declined, where detailed notes were analyzed.

This project was designed as an evaluation in support of VA quality improvement and therefore not eligible for human subjects review. VA ethics standards for quality improvement studies are comparable to those for research involving human subjects.

Data Analysis

Interview transcripts were imported into ATLAS.ti (v.8). Before formal coding, 21 site summaries were compiled using all interview data from each site. These summaries provided a site-specific "snapshot" of women's health care to guide decision-making about subsequent formal coding. Based on interview guide domains, team members (A.O., A.S., K.D., T.L., T.O.) developed an initial list of top-level codes that was iteratively refined. Next, a four-person team (A.O., K.D., K.F., S.C.) focused on two top-level codes to further analyze participants' perceptions of 1) the environment of care for women veterans, and 2) public harassment, including how harassment may have been addressed at their respective VA sites. All transcripts were coded by a primary coder and reviewed by a secondary coder, and discrepancies were resolved through team discussion and consensus (Harry, Sturges, & Klingner, 2005). The team then reviewed the corresponding quotations for each code by role (middle managers and facility leaders) and created summaries that were used to identify themes within and across roles about whether harassment is a problem and how it was being addressed.

Results

Participant Characteristics

Our final analytic sample ($N = 69$) included 47 middle managers, composed of women veteran program managers ($n = 20$), women's health medical directors ($n = 12$), primary care chiefs ($n = 11$), women's health coordinators (e.g., maternity care coordinators) ($n = 4$), and 22 facility-level senior leaders, comprised of facility directors/assistant directors ($n = 9$) or chiefs of staff/deputy chiefs of staff ($n = 13$). Sixty-seven percent of the participants were women.

Perceptions of Harassment Prevalence

Perceptions of harassment prevalence varied, even among participants working in the same facility, although we did not detect any systematic differences by gender of leader/manager. Of those who answered the environment of care questions, half of the middle managers (18 of 32) reported no knowledge of harassment, compared with one-quarter (4 of 16) of senior leaders. Moreover, participants in both groups pointed to lack of complaints as indication that harassment was not an issue at their facility. One middle manager explained, "I haven't gotten anything [any reports] lately so I really don't think safety is an issue," and a senior leader simply stated, "I have not heard that here." A few recognized, however, that harassment could be a problem at their facility, even if they had not received complaints or seen it: "I haven't witnessed any of that [harassment] here. That doesn't mean that doesn't happen." (senior leader) (Table 1).

A few middle managers (7 of 32) and senior leaders (4 of 16) reported that harassment happened on occasion at their facility, but they did not perceive it as a major issue. Incidents typically involved patient-to-patient harassment, and to a lesser degree, male patients harassing female staff and harassment between staff. One respondent perceived harassment and feeling unsafe as an individual problem, not shared by women veterans in general.

One-half of the senior leaders in our sample perceived harassment as a prevalent issue in need of attention, whereas one-quarter of middle managers held this view. Generally, respondents described the harassment of women veteran patients by men veteran patients in lobbies and residential programs, including sexual and gender-based harassment such as whistles, inappropriate jokes, questioning one's veteran status, and one report of attempted assault. A few also mentioned staff harassment of women patients, such as one leader who stated, "a female veteran was subjected to some whistles and some inappropriate comments … from one of the EMS [emergency medicine staff] personnel, and that person was disciplined for it." Finally, although not sexual in nature, some participants described gender-based discrimination as harassment, such as one middle manager who remarked, "I feel like depending on sometimes where our women veterans go, they are not always met with a smile and with courteous care…. They are treated like they are a bother, like they shouldn't be here, they should be at the women's care clinic."

Knowledge of Policies and Procedures to Address Harassment

There was general lack of awareness among participants overall about facility-level policies to address public harassment. Most tended to reference general anti-discrimination policies, such as national Equal Employment Opportunity standards, organizational employee training modules, patient rights and responsibilities related to discrimination, and general disruptive behavior policy. One senior leader stated, "I'd say we have sort of the 'no tolerance for that behavior policy.' I don't think it's gender-specific. It's about any type of disruptive behavior."

Formal procedures for responding to harassment varied. One participant noted that in cases involving employees, complaints are escalated to supervisors and police, if necessary. Others mentioned contacting women's health or other services such as mental health when a formal complaint about harassment between patients is reported through a hotline or patient advocate. Only one respondent mentioned intervention as a response to witnessing an incident of harassment:

> Our police are very involved with us so…we try to deal with the situation like right then and there if we can. We're taught to do that…especially if it's like a veteran-on-veteran kind of thing and we're there and we witness it. (middle manager)

Harassment: Perceived Causes and Solutions

Participants characterized the likelihood of patient-to-patient harassment in terms of the physical space. A common perception was that harassment occurred primarily in mixed-gender spaces where intermingling between men and women was inevitable, such as clinic lobbies, emergency rooms, corridors, and domiciliary care. These spaces were viewed as especially problematic for survivors of MST.

> The problem is the women's clinic is directly off of our main lobby, so there's a lot of traffic right by that door. And directly outside of that door is a bench under the President's picture, and we have a group that I call the Walmart greeters, and these are some very intimidating men that are there every day, very loud, very excitable, and if you don't know them or you have had a negative experience in the past, very intimidating. (senior leader)

> I don't have a single case of any female veteran ever complaining that they have been harassed by a male provider or a

male veteran or a male anybody. But if you allow women veterans to be taken care of their needs everywhere in every clinic, well, you're setting them up for that potential. (middle manager)

I can say though that a lot of the women veterans, particularly the group in MST, do feel uncomfortable in mixed [gender] clinic, mixed reception areas of the clinics. (middle manager)

Consequently, efforts to address harassment often included environment of care changes, with women-only spaces touted as the best solution for preventing harassment between patients. Additional environment of care solutions mentioned by participants included units with all female staffing and staff escorts for women veterans to attend appointments in mixed gender clinics.

I would like to get a women's center because I feel like no matter how much care I provide, we are not very welcoming. (middle manager)

[T]he clerks at the desk, the two clerks there are men so I'm trying to move them. While I am not aware of any rule that says I can't have a man in that position, I recognize that it could be an issue for some of the patients [with MST histories]. (senior leader)

Although reconfiguring space or new construction of a women's clinic was viewed as ideal, participants described significant barriers to achieving this goal. Several discussed spatial limitations since many facilities are in older buildings that were built for an all-male veteran population and/or financial barriers for constructing a dedicated women's clinic.

Additional barriers to addressing harassment included variable leadership support for women-only spaces. Furthermore, despite concerted efforts, some participants felt that striving for a harassment-free facility was an impractical goal due to their belief that no space can be made 100% safe, because "you can't be everywhere" (senior leader).

[S]ome of the discussions we've had is not everything in the US can be segregated and I can't set up an entire podiatry clinic just for women. There are going to be times they have to go to that clinic. (senior leader)

[S]ome of our veterans, especially the veterans that have military sexual trauma, even though they were treated no differently in DoD…in terms of the health care system…it's certainly nice to offer them a private area where they're not sitting there with the men in the waiting room. So I think…for what we have here, would I want to…carve out special space in each of my outlying clinics? No. I would not. We don't see that many [women]. It wouldn't be worth the cost and the effort. (senior leader)

We can't make every environment safe for females. What we do when we get a complaint, we see how we can make it easier and safer. (senior leader)

Notably, middle managers (and not senior leaders) tended to link harassment to both gender-mixing and a permissive organizational climate rooted in male military culture. In addition to women-only spaces, they advocated the need for education, including gender-sensitivity training for staff, veteran education through presentations at new patient and/or volunteer orientations, the creation of workgroups to strategize and implement culture change, and participation in the *End Harassment Campaign*. However, some middle managers were concerned over the perceived lack of leadership support for these initiatives at their facilities.

I've not been allowed to speak to new employees. They pared down their orientation and eliminated the segment on women veterans. I tried doing the new veteran orientation. They're changing it a little bit now. They've got to make it more, you know, veteran friendly and perhaps there'll be another opportunity for me to speak to veterans that way, but it's challenging. (middle manager)

Discussion

Women's health managers and leaders voiced diverse views about harassment prevalence at VA, and most reported not having formal facility-level policies to address public harassment for incidents between patients. To decrease patient-perpetrated harassment, middle managers and senior leaders generally supported the creation of separate clinical spaces for women. However, middle managers also stated that education was needed to change patient harassment behavior, which they tied to male military culture. Yet, some perceived a lack of leadership support for educational initiatives.

Middle managers and senior leaders working in the same clinic often had different perceptions of harassment prevalence, which may reflect differences in how participants define harassment. For example, some referred to instances of unwanted physical contact whereas others considered additional types of harassment at VA such as questioning a woman's veteran status. Interviewers did not pre-define terms, but instead allowed participants to answer open-ended questions from their own perspectives. Interpretations of harassment often vary along gender and age lines, and VA patients and employees often show a lack of consensus and certainty over what constitutes harassing behavior, especially its less overt forms (Dyer et al., 2019; Purcell, Shovein, Hebenstreit, & Drexler, 2017). Another possible explanation for the variation in the prevalence perceptions is that information about harassment incidents is not evenly or systematically shared among VA employees. Relative awareness may be a function of one's position and access to patient and employee complaints. For example, senior leaders may receive communications from members of Congress who have received complaints from veteran constituents or reports of harassment made in departments outside of primary care (e.g., cardiology) that middle managers in women's health or primary care might not.

Differences in perceptions of harassment prevalence could also stem from assumptions about the absence of formal complaints. Some assumed that an absence of formal complaints signaled a lack of harassment, whereas others were hesitant to draw this conclusion. However, women rarely formally report harassment to organizations, owing to the realities of victim blaming and retaliation (National Academies of Sciences, Engineering, and Medicine, 2018; Fitzgerald & Cortina, 2018). At the VA, women veterans may be unsure about how or with whom to lodge harassment complaints and skeptical that management will take their reports seriously (Dyer et al., 2019). For this reason, it is important to measure prevalence through regular climate surveys and a systematic reporting process to enable organizations to track incidents and assess anti-harassment efforts (Buchanan et al., 2014; National Academies of Sciences, Engineering, and Medicine, 2018; Viglianti, Oliverio, Cascino, & Meeks, 2019).

Table 1
Themes and Example Quotes Regarding Perceptions and Prevalence of Public Harassment

Themes	Example Quotes in Support of Overarching Themes
Perceptions of harassment prevalence	
Harassment not an issue at facility	"I haven't gotten anything [reports] lately so I really don't think safety is an issue."
Harassment happens on occasion	"I hear an occasional complaint that is kind of shocking to me."
Harassment is a prevalent issue	"It's an issue and I'm sure it's an issue with many, many different places."
Public harassment policies, procedures	
Knowledge of facility-level policies	"We don't have specific [public harassment] policy"
	"I don't think it's [the policy] gender-specific. It's about any type of disruptive behavior."
Formal procedures vary by facility	"Our police are very involved with us so…we try to deal with the situation like right then and there if we can."
	"Usually what happens is…I go to mental health and explain [about a harassment incident]."
Perceived facilitators of public harassment	
Gender mixing	Harassment usually happens "when you have a large residential program. Obviously, in the residential program, you've got a mix, right? You have female veterans, male veterans."
Male military culture	"We still have quite a few men from generations when they were in the military that they did not treat women well and it's been allowed to continue."
Solutions for public harassment	
Creating women-only spaces	"I would like to get a women's center…"
	"Units with all female staffing "…the two clerks…are men so I'm trying to move them."
Staff escorts for women veterans	"If a veteran needs to see her [mental health provider] while they're here in primary care, I will either escort them over to her clinic or she'll walk over here and see them."
Employee and patient education	"…we're going to educate staff but we also need to educate others as well."
Improve safety when concerns arise	"What we do when we get a complaint, we see how we can make it easier and safer."

Despite evidence that, on average, one-quarter of women veterans who regularly use the VA experience harassment at VA facilities, most senior leaders and middle managers were unaware of any facility-level public harassment policies, which were not nationally required to be in place at the time of interviews. The apparent lack of clear guidance on reporting could explain why participants' insight into harassment prevalence tended to be anecdotal, and responses were ad hoc. Our data suggest that at the time of data collection, which largely took place before the start of the *End Harassment Campaign*, respondents lacked the necessary knowledge and training to systematically recognize and respond to gender-based and sexual harassment, with facility-level guidance nonexistent, hard to find, or poorly understood.

Both middle managers and senior leaders tended to associate harassment between patients with shared physical spaces. Thus, they advocated the creation of separate clinics for women as the best solution to harassment. However, in line with Brunner, Cain, Yano, and Hamilton (2019), our findings indicate that it poses significant financial and resource barriers for some facilities and is not supported by VA policy. Moreover, addressing harassment through the creation of separate clinics for women (which are chiefly primary care clinics) overlooks other spaces that women must access where harassment is present, such as lobbies, parking lots, hospitals, nursing homes, and pharmacies. Ultimately, this solution compromises women's access to care by failing to address the root problem: harassing behavior.

Research shows that interventions focused on organizational culture change may help to decrease public harassment (Wesselman & Kelly, 2010). In addition, there are demonstrated ramifications of organizational cultures that may be more tolerant of harassment (Dyer et al., 2019). Specifically, women veterans doubted that management would respond to reports of harassment offenses. These participants viewed harassment at VA as a continuation of military behavioral norms, consistent with research on male-dominated occupations (Buchanan et al., 2014; Cheney et al., 2014; Fitzgerald et al., 1999; Street et al., 2007) and our findings with middle managers. To address harassment and in line with the literature, some middle managers advocated for education of staff and veterans, including sensitivity training for staff and presentations for veterans during new patient orientation.

As Best et al. (2012) note, large-scale systems change requires stakeholders at all levels to have a common understanding of the problem and their organization's action plan to implement change. Moreover, harassment research suggests that leaders must disseminate, endorse, and facilitate anti-harassment policies and procedures for them to be effective (Fenwick et al., 2021; National Academies of Sciences, Engineering, and Medicine, 2018). As low-performing sites, the sites in our sample were less likely to report having sufficient quality improvement personnel. This gap, in addition to not having a systematic way to communicate harassment incidents, may have contributed to overlooking harassment at the facilities in our sample and should be explored with further research.

Limitations

This study has several limitations. First, participants were recruited from VAs that had low-performing indicators in women's health care; their perspectives may differ in important ways from employees at higher functioning facilities with, for example, stronger leadership support for women veterans' health initiatives. Furthermore, we did not capture perceptions of prevalence from front-line staff, who may witness or experience instances of harassment that are not formally or informally reported to middle managers or senior leaders. Third, questions about harassment prevalence and policy were of lower priority for the larger evaluation and so were not always asked owing to time limitations during some interviews, thereby limiting responses. However, all participants in our analytic sample answered at least one of these questions. In addition, we did not directly ask questions about causes or solutions of harassment, so findings may not fully represent the range of participant views on that topic. We were also unable to compare participants' perceptions about harassment with the actual prevalence rates and existence of local-level harassment policies and procedures at their respective sites, given that the data do not exist; this limits our triangulation of findings. Finally, interviewers did not define terms such as "harassment" for participants. This enabled us to capture subjective interpretations, but could have obscured nuances in meaning, which should be explored in future research.

Implications for Practice and/or Policy

Differing perceptions of harassment prevalence within facilities signal a need for systematic harassment-reporting mechanisms and the dissemination of facility harassment event rates among leaders, middle managers, and other staff. In addition, respondents' lack of awareness about facility-level policies and procedures to address patient-perpetrated harassment indicates how important it is for senior leaders to interpret and communicate national harassment policies at the facility level to contribute to clear and widely disseminated policies and procedures on the ground.

The VA is currently working to address these gaps. The Deborah Sampson Act of 2020 establishes a comprehensive policy to end sexual- and gender-based harassment and assault throughout the VA. This legislation mandates clear reporting mechanisms for staff and non-staff; training for employees and contractors, as well as the dissemination of policy and educational material to patients; and the prominent display of anti-harassment and anti-sexual assault messages in each facility and on websites (Isakson & Roe, 2020). Indeed, VA is laying the groundwork for large-scale cultural transformation centered on no tolerance for sexual and gender-based harassment by implementing, for example, bystander intervention training for health care staff (Relyea et al., 2020). It will be important for future research to examine the impacts of the Sampson Act and anti-harassment initiatives at the local level, and to include data on harassment rates at VA facilities.

Conclusions

Aligning the divergent perspectives of what constitutes harassment and how to address it is a necessary step toward addressing harassment at the local level. In addition, there is need for ongoing assessments of harassment prevalence at the facility level that are shared widely among employees and leadership so that they are aware of incidents and how to respond.

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