


Sexual Harassment Among Chinese Psychiatrists and Its Impact on Quality of Life: A Cross-Sectional Survey

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Objectives: Sexual harassment (SH) is a prevalent issue in various professional fields worldwide. The current study aims to investigate the incidence of SH targeting psychiatrists in China and explore its impact on quality of life (QOL).

Methods: A consecutive recruitment of 1093 psychiatrists was conducted from 6 hospitals in China. The recorded data included participants' socio-demographic characteristics, experiences of workplace SH within the previous year, and their QOL. SH comprised verbal harassment, physical harassment, and displaying of sexual organs. The Chinese version of the World Health Organization Quality of Life Brief Version (WHOQOL-BREF) was employed to assess QOL. We compared the demographic characteristics and QOL between the SH group and the non-SH group. Multiple logistic regression analysis was used to identify independent demographic correlates of SH.

Results: In total, 13.8% ($n = 151$) of the psychiatrists reported SH, with 5.8% reporting it once, 4.4% reporting it twice, and 3.6% reporting it three times or more. Psychiatrists who had encountered SH exhibited lower QOL across social, psychological, physical, and environmental domains. Multiple logistic regression analysis revealed that young physicians and those with shorter work experience had a higher likelihood of experiencing SH.

Conclusion: The high prevalence of SH among Chinese psychiatrists is of concern. Given its detrimental effects on the well-being of physicians and the quality of medical care they provide, it is crucial to develop specialized employee training programs for this population to effectively manage workplace SH.

Keywords: China, psychiatrists, quality of life, mental health professionals, sexual harassment, workplace safety

Introduction

The global attention on the issue of sexual harassment (SH) has been brought about by the #MeToo and Time's Up movements.¹ SH, as defined by the US Equal Employment Opportunity Commission, encompasses unwelcome sexual advances, requests for sexual favors, and other physical or verbal behaviors of a sexual nature that have an explicit or implicit impact on an individual's employment or create a work environment that is intimidating, hostile, or offensive.² In the healthcare industry, particularly among physicians, incidents of offensive behaviors, including SH, are more prevalent compared to other professions.³⁻⁶ Studies indicate that healthcare workers are 16 times more likely to experience workplace violence than individuals in other occupations.⁷ It is not surprising that SH has a range of negative effects on victims, both in terms of their job and their mental and physical wellbeing. Numerous studies have indicated that being subjected to SH can lead to a decline in job satisfaction, organizational commitment, productivity, and

performance, while also increasing levels of stress, turnover, and burnout.^{4,8,9} The psychological impact of SH is significant, with common outcomes including depression, avoidance behaviors, changes in arousal patterns, and hypervigilance.^{10,11} Additionally, physical consequences have been observed in victims, such as headaches, gastrointestinal issues, sleep disturbances, and menstrual irregularities.^{12,13} It is noteworthy that there have also been associations found between SH and suicidal behavior.¹

To effectively address the issue of SH within the physician community, it is imperative to understand its frequency and patterns. To date, several studies conducted in Western countries have revealed a range of SH occurrence rates among physicians, varying from 6.1% to 57.3%.^{5,6,14} Common demographic factors among physicians that are associated with higher levels of SH include divorce, younger age, shift work and less work experience.^{2,6,15} The presence of SH among physicians is also linked to various socio-economic and cultural elements, implying that this phenomenon is influenced by specific cultural and contextual factors.^{16–18} Hence, it is necessary to investigate the patterns and risk factors of SH individually in diverse countries and regions.

A previous meta-analysis revealed an overall prevalence of workplace violence among physicians in China to be 62.4%, with an estimated incidence rate of SH at 6.3%.¹⁹ Additionally, a cross-sectional study indicated that the prevalence of verbal SH among Chinese doctors was 19.2%, while the incidence rate of sexual assault was 6.7%.²⁰ Previous studies conducted in China have been limited in terms of study sites and sample sizes, which may have impacted the validity of their findings. Moreover, these studies often failed to report the prevalence rates and associated factors in different units^{21–23}. Psychiatrists, in particular, are more susceptible to higher levels of SH compared to those working in other medical specialties.^{20,22} This is attributed to their frequent direct contact with psychiatric patients who may present challenging behaviors associated with their illnesses. However, there is a lack of knowledge regarding the prevalence rates of SH among psychiatrists in China, as well as its demographic correlates. Furthermore, the impact of SH on the quality of life (QOL) of psychiatrists remains unknown. In this study, we aim to investigate the prevalence of SH against Chinese psychiatrists and its potential association with QOL.

Materials and Methods

Study Design, Settings and Participants

From March 15 to May 1, 2022, this cross-sectional study targeting psychiatrists was conducted in 6 psychiatric hospitals located in 6 provinces in China. The cross-sectional design was selected due to its suitability for capturing a snapshot of SH prevalence and its correlates among psychiatrists within a specific timeframe. Unlike longitudinal studies, which track changes over time, a cross-sectional design allows us to collect data at a single point in time, providing valuable insights into the prevalence and risk factors associated with SH among psychiatrists. These hospitals were selected based on specific criteria. First, all six hospitals are large tertiary-level medical centers that provide both inpatient and outpatient services to a population exceeding 10 million individuals. Second, to ensure nationwide representation, we specifically selected two hospitals from each of the three major geographic regions in China (East, Central, and West) which are generally recognized as distinct areas in terms of healthcare provision. Additionally, all selected hospitals are government-designated regional medical centers located in different provinces. We invited frontline certified psychiatrists with at least one year of experience working in the participating hospitals to take part in this study. Frontline psychiatrists refer to physicians who are directly involved in providing patient care and have direct contact with patients on a regular basis. We excluded psychiatrists on leave during the study period. Additionally, physicians in high managerial positions that did not directly engage in patient care were also excluded from the study cohort. The medical departments of the collaborative hospitals distributed data collection forms to gather information. Within a week, the completed forms were collected. Participating in the study was completely voluntary and ensured anonymity. The study protocol received approval from the respective ethics committees. All participants were required to provide written informed consent before taking part and were informed that choosing not to participate would not have any adverse effects on their career or relationship with senior staff members. [Figure 1](#) depicts a flowchart outlining the process of questionnaire collection.

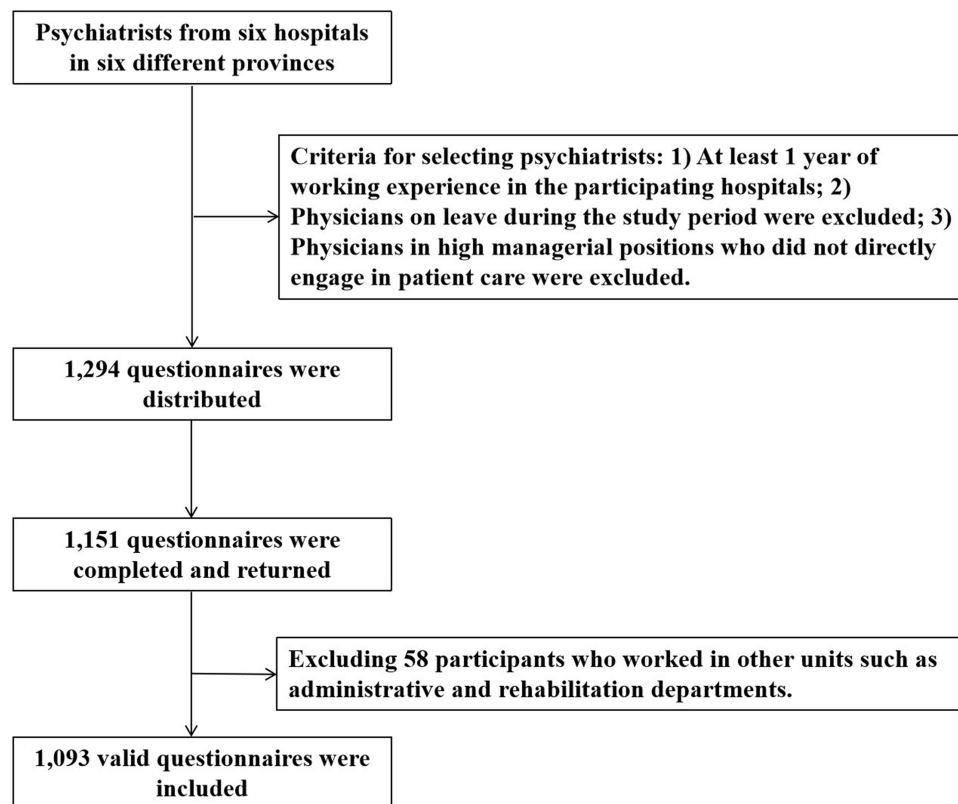


Figure 1 Flow chart of questionnaire collection.

In order to estimate the required sample size, we utilized the following formula:

$$\text{Sample Size} = \frac{(Z^2 * p * (1 - p)) / E^2}{1 + ((Z^2 * p * (1 - p)) / (E^2 * N))}$$

Where:

- Z represents the critical value of the standard normal distribution (which, in this case, is 1.96).
- p is the expected prevalence rate (which, in this case, is 0.11).
- E denotes the margin of error that is acceptable (which, in this case, is 0.05).
- N refers to the total population size (which, in this case, is 40,000).

The expected prevalence rate was chosen based on prior studies and available data indicating the approximate prevalence of the phenomenon under investigation.^{5,6,14,19,20} Regarding the margin of error, this value represents the maximum acceptable deviation from the true population parameter that we are willing to tolerate in our study. A margin of error of 0.05 ensures a high level of precision in our estimates while balancing practical considerations such as feasibility and resource constraints. The total population size (N = 40,000) was derived from previous survey data.²⁴

According to our calculations, a minimum sample size of 150 physicians would be required to ensure sufficient statistical power for conducting general linear modeling to identify risk factors associated with SH.

Assessment Tools

The participants' basic demographic characteristics were collected by the researchers. To assess experiences of SH, the self-reported Workplace Violence (WPV) scale, developed by Chen,²⁵ was used. This validated scale captures various forms of unwelcome words or actions, aiming to intimidate, belittle, or discriminate against an individual. SH can be categorized into three primary forms: 1) physical harassment, 2) verbal harassment, and 3) displaying of sexual organs. The frequency of each type of SH encountered in the previous 12 months was determined using a rating system with four categories: none, once, twice, and three times or more. For the purpose of this study, individuals who had experienced any form of SH at least once in the past 12 months were classified as having suffered from SH.

The Chinese version of the World Health Organization Quality of Life Brief Version (WHOQOL-BREF) was employed to assess QOL. This 26-item self-report scale measures four domains of quality of life: social, psychological, physical, and environmental well-being.²⁶ Out of the 26 items (including two general items), 24 items generate scores for each of the four domains of QOL. The participants were requested to rate each item using a scale that ranged from 1 (not at all) to 5 (completely), resulting in total scores ranging from 24 to 120. Higher scores on the subscales and overall scores indicate better quality of life. The validation process of the Chinese version of the WHOQOL-BREF has been successfully conducted within the Chinese population.²⁷

Statistical Analysis

Data analyses were conducted using SPSS version 22.0. The normality distribution of continuous variables was assessed using the one-sample Kolmogorov–Smirnov test. Independent sample *t*-tests, Mann–Whitney *U*-tests, and chi-squared tests were employed, as appropriate, to compare the demographic characteristics between the groups experiencing SH and no harassment. After controlling for factors including age, gender, marital status, having children, duty shift pattern, job rank, education and working experience using analysis of covariance (ANCOVA), QOL was compared between the group subjected to SH and the group without harassment. Multiple logistic regression analysis was conducted using the “enter” method to identify independent demographic factors associated with SH. SH was entered as the dependent variable, while the aforementioned demographic variables, including age, gender, marital status, having children, work shift, job rank, education and working experience, were included as independent variables. All statistical analyses were performed using two-tailed tests, and a significance level of 0.05 was set.

Results

In this study, a total of 1294 questionnaires were distributed, resulting in a response rate of 88.9% with 1151 completed and returned questionnaires. After excluding 58 participants who worked in other units such as administrative and rehabilitation departments, the analysis included 1093 valid questionnaires. Table 1 presents

Table 1 Comparison of Basic Demographic Characteristics Between Physicians with and without Experience of Sexual Harassment

Variable	Total sample (n = 1093)		Non-sexual harassment (n = 942)		Sexual harassment (n = 151)		Univariate analysis		
	N	%	N	%	N	%	χ^2	D.f.	P ^a
Gender							0.24	1	0.632
Male	258	23.6	220	23.4	38	25.2			
Female	835	76.4	722	76.6	113	74.8			
Marital status							0.90	1	0.345
Married	425	38.9	361	38.3	64	42.4			
Unmarried	668	61.1	581	61.7	87	57.6			
Having children							2.03	1	0.157
Yes	234	21.4	195	20.7	39	25.8			
No	859	78.6	747	79.3	112	74.2			
Work shift							0.01	1	0.904
Rotating	770	70.4	663	70.4	107	70.9			
Fixed day	323	29.6	279	29.6	44	29.1			
Job rank							1.85	2	0.391
Junior physician	416	38.1	366	38.9	50	33.1			
Intermediate physician	397	36.3	337	35.8	60	39.7			
Senior physician	280	25.6	239	25.4	41	27.2			

(Continued)

Table 1 (Continued).

	Mean	S.D.	Mean	S.D.	Mean	S.D.	T	D.f.	P ^a
Age (years)	35.4	8.6	35.5	8.7	34.9	8.2	0.83	1091	0.419
Years of education	17.8	2.7	17.8	2.7	18.1	2.6	-1.47	1091	0.254
Years of working	13.1	9.8	13.2	9.9	12.2	9.2	1.45	1091	0.283
QOL - social	12.8	2.7	12.9	2.7	12.2	2.6	4.32	1091	0.002**
QOL - physical	13.0	2.1	13.1	2.1	12.1	2.3	5.90	1091	<0.001***
QOI - psychology	12.6	2.4	12.8	2.4	11.5	2.2	6.45	1091	<0.001***
QOL - environmental	11.1	2.2	11.3	2.2	10.1	2.0	6.21	1091	<0.001***

Notes: QOL: quality of life; ^aItalicized p-values are significant; **p < 0.001; ***p < 0.0001.

the basic demographic features of the entire sample and separately by exposure to SH. Among the psychiatrists included in the analysis, the majority were female (76.4%), engaged in shift work (70.4%), and nearly 40% were married. The distribution of the respondents' professional ranks showed that junior physicians accounted for 38.1% of the sample, followed by intermediate physicians (36.3%) and senior physicians (25.6%). The age range of the participants was 20 to 62 years, with an average age of 35.4 years (SD = 8.6). Their work experience ranged from 1 to 42 years, with an average of 13.1 years (SD = 9.8).

In the past year, 13.8% (151/1093) of the participants reported experiencing SH. Among them, 5.8% (64/1093) experienced SH once, 4.4% (48/1093) reported experiencing it twice, and 3.6% (39/1093) experienced it three times or more. Compared to psychiatrists who did not experience SH, those who did had lower QOL in social ($F_{(1, 1091)} = 18.50, p = 0.002$), physical ($F_{(1, 1091)} = 36.75, p < 0.001$), psychological ($F_{(1, 091)} = 43.41, p < 0.001$), and environmental ($F_{(1, 1091)} = 40.73, p < 0.001$) domains (see Table 1). Bivariate analysis (Table 1) indicated that gender, marital status, having children, shift work, job rank, and education level were not significantly associated with the occurrence of SH ($p > 0.05$). In Table 2, the results of the multiple logistic regression analyses on the factors associated with SH are presented. The analysis revealed that younger age and shorter clinical experience significantly predicted the occurrence of SH among physicians ($p < 0.05$).

Table 2 Multiple Logistic Regression for the Association Between Demographic Factors and Sexual Harassment

Variable	Odds ratio	95% C.I.	p
Female	0.89	0.67–1.23	0.541
Married	1.30	0.91–1.78	0.147
Have children	1.27	0.83–1.72	0.363
Shift work	1.02	0.76–1.45	0.970
Junior physician	1.00	–	–
Intermediate physician	0.52	0.36–1.02	0.108
Senior physician	0.69	0.45–1.14	0.434
Age (years)	0.92	0.63–1.42	0.041*
Years of education	1.03	0.99–1.14	0.513
Years of working	0.85	0.53–1.07	0.022*

Note: *p < 0.05.

Discussion

The Prevalence of SH Among Chinese Psychiatrists

In this study, we investigated the occurrence of SH and its correlation with the QOL among psychiatrists in China. Out of the physicians involved in the study, 13.8% reported experiencing SH within the past year. Additionally, more than half of those (57.6%) who experienced SH indicated that it occurred on two or more occasions. These results indicate that workplace SH is a significant concern in the healthcare industry and may have implications for the well-being and productivity of workers, as well as the provision of optimal patient care.^{2,24,28} Various factors contribute to the prevalence of SH in healthcare organizations, including hierarchical organizational structures, predominantly male-dominated environments, and a culture that tolerates harassment from individuals in positions of authority.² Additionally, the scarcity of training programs and ongoing education regarding the management of SH, coupled with the absence of efficient reporting mechanisms, exacerbate the issue.¹⁰ The high incidence of SH among psychiatrists may be attributed to several potential factors. Firstly, the inadequate provision of community-based psychiatric services in China forces a majority of psychiatric patients to seek treatment in hospitals, resulting in crowded clinical environments that are challenging to supervise. Secondly, psychiatrists often provide direct, face-to-face patient care in their work, increasing the possibility of experiencing SH in the workplace.²²

Comparison with Relevant Studies

Past studies have indicated that the prevalence of SH among physicians varies across different countries and genders. For example, a study conducted in the US involving over 6200 healthcare providers found that approximately 12% of physicians who disclosed instances of SH were women, while 4% were men.²⁸ Another study showed that incidents of SH directed towards physicians by patients were alarmingly prevalent, with approximately 67% reporting episodes of inappropriate behavior.²⁹ Specifically, around 84% of female clinicians disclosed some form of SH by patients, while 40% of male clinicians reported similar experiences. Besides, female physicians in the fields of surgery and emergency medicine have been found to be more vulnerable to experiencing SH.³⁰ According to a multicenter investigation conducted in China, the one-year prevalence rate of SH among healthcare professionals in the mental health sector was found to be 10.2%.²⁰ In our study, the incidence rate of SH among Chinese psychiatrists was close to 14%, and no significant gender difference was found. Different studies may yield different results. Apart from differences in departments and professions, varying definitions and measurements of SH, changes in sampling methods and different characteristics of study locations may all have an impact on the results.^{31–34} Besides, deep-rooted traditional gender norms in Chinese society may influence the perception and tolerance of SH. Female psychiatrists might be more reluctant to report incidents due to fear of backlash, reputation damage, or societal pressure to maintain harmony within the workplace environment. Hence, it is imperative to exercise caution when making direct comparisons.

The Impact of SH on Physician QOL and Its Risk Factors

SH has the potential to result in feelings of disappointment and depression related to one's role, as well as low self-esteem and reduced job satisfaction.^{35–37} Additionally, it can increase the likelihood of burnout. Based on the protection/distress model of QOL, the level of QOL is influenced by the interaction between various distressing and protective factors.³⁸ Given the strong correlation between SH and a range of distressing emotions and experiences, such as anger, depression, fear, sadness, frustration and low self-esteem, it is reasonable to hypothesize that a negative association exists between SH and QOL. As anticipated, physicians who reported experiencing SH exhibited lower QOL across all domains compared to those who did not undergo such experiences. Therefore, it is crucial to address workplace SH in order to improve the well-being and job satisfaction of healthcare professionals.

Our study also revealed that there is a significantly higher risk of experiencing SH among young physicians and those with less clinical experience, which is consistent with prior research findings.^{2,6,15,39} The variation among different age groups could be attributed to the differences in perceptions of workplace SH and violence across generations.³⁹ The emergence of the #MeToo movement has facilitated open conversations about violence against women, particularly among young adults. This may have influenced how young physicians participating in the study understood and identified

instances of SH and violence in the workplace, leading them to be more inclined to acknowledge and report such experiences.³⁹ Notably, it is plausible that recall bias played a role in older physicians underestimating their lifetime exposure to workplace SH or violence, contributing to their under-reporting. Furthermore, doctors with limited clinical experience may have received insufficient education and training on effectively handling emotional and behavioral reactions exhibited by psychiatric patients. Consequently, this could potentially increase the likelihood of occurrences related to SH.

Limitations of This Study

There are some limitations that should be acknowledged in this study. First, the assessment of SH relied on self-reported measures, which may introduce recall bias into the participants' data. Some participants were unable to accurately recall whether they had experienced multiple types of sexual harassment during a single event, or could not confirm the specific type of harassment experienced, which limited our ability to conduct sub-group analysis of different types of sexual harassment. Second, the cross-sectional design of this study prevents the establishment of causal relationships between SH and QOL. Furthermore, certain factors commonly linked to SH, such as social support and work pressure, were not measured in this study. Finally, the reasons behind the refusal of some physicians to participate were not recorded. These limitations provide important considerations for future research in this field.

Recommendation and Conclusion

Prevention plays a crucial role in eradicating SH. The implementation of effective measures against SH requires the active involvement of top leadership and all team members.² It is important for every mental health worker, regardless of their position, to be dedicated to creating an inclusive and respectful environment. To effectively combat these unacceptable behaviors, a coordinated and interdisciplinary management approach with an integrated strategic plan is necessary.²⁸ The development of a code of conduct that outlines rights, responsibilities, policies, and access to counseling services is critical in preventing SH. All physicians should receive education on identifying and promoting a culture of zero tolerance within the institution. Instances of harassment must be promptly reported, and appropriate disciplinary action should be taken against those responsible, based on the severity of the harassment.⁴⁰ Leadership at all levels need to actively engage in implementing best practices and safeguarding victims from any form of retaliation.^{41–44} In addition, well-trained designated personnel are essential for conducting thorough investigations.²⁸ In summary, threatening situations can arise from colleagues, patients and superiors in the healthcare field, and teamwork is the most effective strategy.⁴⁵

To sum up, 13.8% of psychiatrists in China reported SH, of which 5.8% reporting it once and 8.0% reporting it twice or more. Young physicians and those with shorter work experience had a higher likelihood of experiencing SH. Psychiatrists who had encountered SH exhibited lower QOL across social, psychological, physical, and environmental domains. Given its detrimental effects on the well-being of physicians and the quality of medical care they provide, it is crucial to develop specialized employee training programs for this population to effectively manage workplace SH.

Abbreviations

QOL, Quality of Life; SH, Sexual Harassment; WHOQOL-BREF, World Health Organization Quality of Life Brief Version.

Data Sharing Statement

The data analyzed in this study is subject to the following licenses/restrictions: If necessary, the data can be obtained by contacting the corresponding author.

Ethics Statement

This study was reviewed and approved by the Ethics Committee of the Fourth People's Hospital of Chengdu. All participants were required to provide written informed consent before taking part and were informed that choosing not to

participate would not have any adverse effects on their career or relationship with senior staff members. All procedures in our study were carried out following the principles of the Declaration of Helsinki.

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Author Contributions

All authors made a significant contribution to the work reported, whether that is in the conception, study design, execution, acquisition of data, analysis and interpretation, or in all these areas; took part in drafting, revising or critically reviewing the article; gave final approval of the version to be published; have agreed on the journal to which the article has been submitted; and agree to be accountable for all aspects of the work.

Disclosure

The authors declare that they have no competing interests in this work.

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