

NIH Workplace Climate and Harassment Survey

Summary Findings Report

September 2020

Prepared for the NIH Chief Officer of Scientific Workforce Diversity

Prepared by ICF Next



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EXECUTIVE SUMMARY

The mission of the National Institutes of Health (NIH) is to “seek fundamental knowledge about the nature and behavior of living systems and the application of that knowledge to enhance health, lengthen life, and reduce illness and disability.” Achieving this mission involves a substantial workforce across 27 Institutes, Centers, and Offices (ICOs). Workplace harassment within NIH not only affects individuals, it also inhibits NIH’s mandate of seeking knowledge and improving human lives. To this end, NIH has numerous efforts underway to strengthen its anti-harassment program and tools, including a new reporting system, hotline, and web form where individuals can submit allegations of harassment. In 2019, NIH developed and fielded the *NIH Workplace Climate and Harassment Survey* to better understand employee, trainee, contractor, and volunteer experiences with workplace harassment and inappropriate conduct. **Of the 36,228 NIH federal employees, trainees (including students and fellows), contractors, and volunteers who received the survey email invitation, 15,794 responded, resulting in a survey response rate of 44 percent.** This report describes the goals, methods, and results of the 2019 survey, as well as recommendations for action based on key survey findings.

The *NIH Workplace Climate and Harassment Survey* employed the Sexual Experiences Questionnaire, which has undergone considerable testing in a range of occupational settings, to assess the NIH’s workforce experiences with sexual harassment (Fitzgerald et al., 1999). NIH defined sexual harassment according to a **recent report** from the National Academies of Sciences, Engineering, and Medicine (NASEM): a form of discrimination that is “composed of three categories of behavior: (1) gender harassment (verbal and nonverbal behaviors that convey hostility, objectification, exclusion, or second-class status about members of one gender), (2) unwanted sexual attention (verbal or physical unwelcome sexual advances, which can include assault), and (3) sexual coercion (when favorable professional or educational treatment is conditioned on sexual activity)” (NASEM, 2018, p.28). NIH Policy defines harassment as unwelcome,

deliberate, or repeated unsolicited verbal or physical conduct that is based on protected classes (e.g., race, color, religion, sex, or national origin). The term inappropriate conduct is broader than the definitions of harassment and sexual harassment, and refers to any comments or conduct that disparages or demonstrates hostility or aversion toward any person that could reasonably be perceived as disruptive, disrespectful, offensive, or inappropriate in the workplace. Federal law prohibits harassment, as well as sexual harassment that violates **Title VII of the Civil Rights Act of 1964**. However, since **NIH’s Policy** prohibits all forms of inappropriate conduct or harassment, including sexual and gender harassment, the *NIH Workplace Climate and Harassment Survey* assessed a broader scope of workplace experiences (referred to throughout the report as harassment).¹

Workplace harassment, particularly sexual harassment, has substantial negative implications for individuals and organizations, and for scientific advancement. The NASEM report identified key aspects of academic science workplace culture that may increase the risk of sexual harassment, including a perceived tolerance for harassment, strong hierarchies and dependence on supervisors or mentors for career advancement, and a focus on legal compliance rather than harassment prevention measures (NASEM, 2018). The report, which reviewed decades of social science and legal literature, concluded that in addition to providing adequate support to individuals experiencing harassment, more must be done to change the workplace climate of academic science institutions to ultimately prevent harassment before it begins.

As the premier biomedical research agency in the United States, NIH must play a leadership role in making progress against harassment and ensuring that its workforce feels safe at work. With this in mind, the key findings in this summary and extended report will provide NIH with areas for potential action. NIH intends to use the findings as a quality assurance and quality improvement guide, and to use the survey insights along with peer-reviewed literature to inform future activities to prevent and address harassment at NIH. The key findings below are listed in order of appearance in the report, not in order of importance.

¹An illustration of the relationship between inappropriate conduct, harassment, and sexual harassment can be seen in the **Reporting Continuum** developed by NIH’s Office of Human Resources.

Key Finding 1: Extent of Harassment and Inappropriate Conduct at NIH

One in five survey respondents experienced sexual harassment in the past 12 months. Women, sexual and gender minorities, younger individuals (18–24 years), trainees (including students and fellows), and individuals with a disability were more likely to experience sexual harassment. Individuals in the NIH Intramural Research Program (IRP)—particularly those who were women, sexual and gender minorities, younger (18–24 years), or trainees—were more likely to experience sexual harassment than those not in the IRP. The most significant incidents of sexual harassment were perpetrated by NIH employees who are men. Half of respondents experienced incivility in the past 12 months, while 10 percent experienced bullying and 6 percent were the target of intimidating behaviors. Respondents experiencing sexual harassment were more likely to experience bullying, incivility, and intimidating behaviors in the workplace than those not experiencing sexual harassment. Expectation of future harassment was also assessed for all survey respondents; three percent (516 respondents) indicated that they were extremely or very likely to be harassed within the next 12 months at NIH.

Key Finding 2: Workforce Well-Being

Close to half of the respondents experiencing sexual harassment in the past 12 months indicated that their work conditions worsened as a result of sexual harassment, or that they were the subject of unkind gossip from coworkers; some indicated facing severe repercussions, such as being denied training opportunities. Overall, respondents experiencing sexual harassment had poorer self-rated physical and mental health, and were less satisfied with their jobs, compared with respondents who had not experienced sexual harassment.

Key Finding 3: Awareness of NIH Anti-Harassment Policies and Procedures

The majority of respondents were aware of NIH policies and procedures relating to harassment and report understanding how individuals can get help if they experience harassment. Most positively evaluated NIH's performance at encouraging harassment reporting

in the past 12 months. Many respondents indicated that their supervisors do not consistently speak up or respond appropriately in cases of harassment, and do not universally implement recommended anti-harassment activities, such as providing information or work time dedicated to organizational policies and procedures.

Key Finding 4: Response to Sexual Harassment

Respondents did not frequently talk about or report the sexual harassment experience that had the greatest effect on them with someone within official NIH channels. Instead, they chose to speak to coworkers or supervisors, or they did not talk about the incident at all. Incidents may go undiscussed or unreported due to beliefs that the incident was not serious enough or that nothing helpful would come of a report, or for fear of negative work outcomes. Of respondents who talked about the incident to a supervisor, over one-third felt their complaint was not taken seriously.

Key Finding 5: Preventing Harassment and Inappropriate Conduct

Perceived support is the perception that NIH will intervene in situations in which individuals are subjected to unwanted or offensive experiences, while perceived equity is the perception that supervisors are fair, value work, and consider the opinions of others. An organizational climate with low levels of perceived support may increase the likelihood that harassment occurs. Similarly, a low level of perceived equity may increase the likelihood that non-sexual harassment (incivility) occurs. Respondents who have been sexually harassed in the past 12 months reported lower levels of both these factors.

By using these key findings to guide strategic, evidence-based actions, NIH has the opportunity to address harassment in the workplace, thereby advancing its mission toward improving the health of all Americans.

INTRODUCTION

Achieving the NIH's mission of enhancing health, lengthening life, and reducing illness and disability involves thousands of dedicated staff across 27 ICOs. Workplace harassment within NIH not only affects individuals, it also inhibits NIH's mandate of seeking knowledge and improving human lives. To this end, NIH has numerous efforts underway to strengthen its anti-harassment program and tools, including a new reporting system, hotline, and web form where individuals can submit allegations of harassment. In addition, NIH developed and fielded the *NIH Workplace Climate and Harassment Survey* to better understand employee, trainee, contractor, and volunteer experiences with workplace harassment and inappropriate conduct. This report describes the goals, methods, and results of the 2019 survey, as well as recommendations for action based on key survey findings.

METHODOLOGY

SURVEY OBJECTIVES AND DEVELOPMENT

The *NIH Workplace Climate and Harassment Survey* was developed in 2018, and responses were collected from January 28 to March 25, 2019. The objectives of the survey were to:

1. Understand the landscape of harassment and inappropriate conduct at NIH, including how frequently it occurs, who is most affected, and the surrounding circumstances.
2. Understand if and how respondents talk about or report sexual harassment at NIH.
3. Understand the impact of sexual harassment on the NIH workforce's psychological and physical health.
4. Identify elements of the NIH workplace climate that may be associated with harassment.

The survey asked NIH respondents about their experiences with sexual harassment, including gender harassment, in the past 12 months; the circumstances surrounding the harassment incident that had the greatest effect on them; their perceptions of NIH's workplace climate, including experiences of workplace incivility and bullying; their knowledge and understanding of NIH's anti-harassment policies and procedures; and a number of demographic and diversity characteristics. When possible, survey measures were based on validated survey items or scales. However, some measures were modified or revised based on the NIH target population and the survey objectives.

Prior to fielding the survey, selected measures underwent cognitive testing with NIH staff volunteers to assess understanding and interpretation. Then, response options for key survey items were pilot tested with over 5,000 general population participants (not affiliated with NIH). Survey items were revised based on the findings of these tests before fielding the survey with all NIH employees, trainees, contractors, fellows, and volunteers.

RESPONDENT CONFIDENTIALITY

Since many of the survey questions were related to sensitive topics, NIH implemented measures to ensure that the survey results remained confidential:

- The survey was sent, collected, and analyzed by an independent contractor. No individual-level response data were sent to NIH during or after the survey.
- The contractor deleted all personally identifiable information (e.g., email addresses) immediately after the survey was closed.
- The contractor did not provide NIH with breakdowns of any subgroups with fewer than 15 respondents. For this reason, analyses resulting in fewer than 15 respondents are labeled as Not Reportable (NR) in this report.²

²Suppression of cells with sample sizes under a predetermined threshold is a common approach to preserve respondent confidentiality and prevent any potential re-identification of survey respondents. Best practices supported by [Centers for Disease Control and Prevention WONDER Data Use Restrictions](#) stipulate that demographic data with a count fewer than 10 be suppressed. However, since the *NIH Workplace Climate and Harassment Survey* asked about highly sensitive subject matter that could have substantial personal and professional implications if disclosed, the survey design team increased the threshold to counts fewer than 15 (in accordance with recommendations from the [U.S. National Center for Health Statistics Research Data Center](#)).

SURVEY IMPLEMENTATION AND RESPONSE

Beginning on January 28, 2019, the survey was sent via email to NIH employees, trainees, contractors (if permitted by their employers), fellows (post-baccalaureate and post-doctoral), and volunteers. A link in the email connected respondents to an online survey. A total of 36,228 survey invitations were sent to valid NIH email addresses, and 15,794 individuals completed the survey, resulting in an overall response rate of 44 percent. Based on self-reported appointment type, there were 10,594 NIH employees (including 2,304 fellows or trainees), 3,792 contractors, 325 guest researchers, and 175 volunteers.

SURVEY ANALYSIS

Survey results were analyzed using descriptive statistics and multivariate logistic regression (Appendix A). Multivariate modeling techniques were also used to understand if certain elements of the NIH workplace climate were related to workplace harassment, as well as if workplace harassment experiences were related to negative health or career outcomes. These elements of workplace climate are outlined in the NIH Simplified Conceptual Model of Harassment (figure 1). NIH developed this conceptual model to provide a foundation for survey development and analysis.

Figure 1. NIH Simplified Conceptual Model of Harassment³



SURVEY LIMITATIONS

Surveys containing sensitive information often run the risk of non-response bias; that is, potential differences between those who chose to respond to the survey (or certain questions) and those who chose not to respond. To assess the strength of non-response bias in the *NIH Workplace Climate and Harassment Survey*, survey respondent characteristics were compared to NIH staff characteristics using a human resources database. Federal employee respondents were compared to all NIH federal employees based on gender, age, and the

ICO where they worked. Demographic data for trainees and contractors were not available, so they could not be included in this analysis.

Although the gender, age, and ICO of federal employee respondents were similar to the population of federal employees, given the large sample size, respondents were significantly more likely to be women and younger than all federal NIH staff. As well, ICOs were disproportionately represented in the survey due to varying response rates.⁴ Therefore, survey findings

³The simplified conceptual model of harassment depicts the theorized relationships between organizational climate constructs, sexual and non-sexual harassment (including inappropriate conduct) and negative job and health outcomes. Solid arrows indicate hypothesized relationships that were examined in multivariate analysis; dashed arrows indicate relationships that were not examined. More detail on the multivariate analytic techniques and findings can be found in Appendix A.

⁴Results from chi-square goodness of fit tests indicated that the sample who self-reported as NIH employees was not representative of the NIH federal employee population by gender ($\chi^2 = 61, p < 0.001$), age ($\chi^2 = 1553, p < 0.001$), and ICO distribution ($\chi^2 = 414, p < 0.01$).

should be interpreted to represent respondents. Caution should be exercised in generalizing to the entire population of federal employees, particularly to the population of contractors and trainees for which there are no population data for comparison.

Other factors could also limit interpretation of the survey findings:

- Survey respondents were asked about their experiences of harassment in the past 12 months. This time period was chosen to lay the groundwork for future surveys. However, the assessment may exclude some respondents who experienced harassment more than 12 months ago.
- For survey items about the circumstances of the harassment experience and reporting, respondents were asked to consider the experience in the past 12 months that had the greatest effect on them. Therefore, the findings from these questions should not be generalized to all harassment experienced by respondents in the past 12 months.
- Some questions ask about respondents' perceptions of events (e.g., if respondents knew whether their report of sexual harassment was investigated). However, due to confidentiality during the investigation process, the respondent may not know the true outcome (e.g., whether the report was ultimately investigated and whether the perpetrator was punished).

USING THIS REPORT

The findings in this report are organized based on five key questions related to NIH employee, trainee (including student and fellow), contractor, and volunteer experiences with workplace harassment and inappropriate conduct:

1. **Defining the problem:** What is the extent of harassment, including sexual harassment, bullying, and incivility, and who are the most vulnerable populations at NIH?
2. **Workforce well-being:** Is sexual harassment associated with physical or mental health outcomes, job satisfaction, or negative work outcomes in the NIH workforce?
3. **Current policies and procedures:** How well are current NIH policies and procedures understood by the NIH workforce? How well do supervisors appear to promote NIH policies and procedures?
4. **Response to sexual harassment:** How are respondents talking about or reporting experiences of sexual harassment? How are these experiences seemingly addressed?
5. **Preventing harassment:** Which workplace climate factors are associated with harassment at NIH, and how can these factors be used as targets for harassment prevention?

NIH intends to use the findings as a quality assurance and quality improvement guide, and to leverage the survey insights along with the literature to inform future activities to prevent and address harassment at NIH.

1. DEFINING THE PROBLEM

WHAT IS THE EXTENT OF HARASSMENT, INCLUDING SEXUAL HARASSMENT, BULLYING, AND INCIVILITY, AND WHO ARE THE MOST VULNERABLE POPULATIONS AT NIH?

SEXUAL HARASSMENT

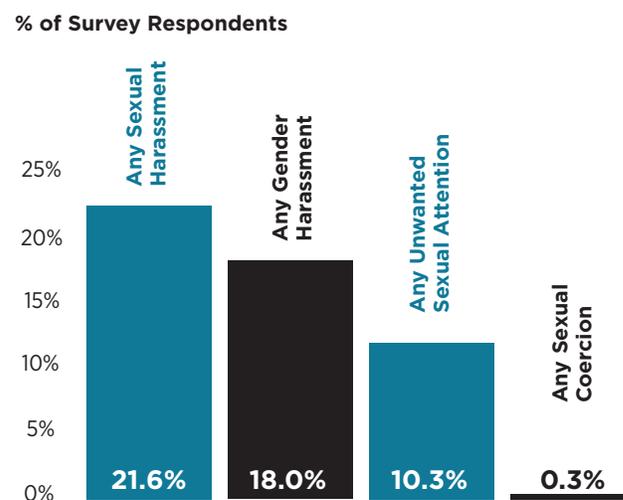
In this section, percentages denote the percentage of respondents indicating that response option, among all survey respondents.

All survey respondents were asked questions about any unwanted or offensive experiences in the last 12 months while working at NIH, in which they interacted with the perpetrator(s) because of their NIH work. These experiences were assessed based on items from a validated tool called the Sexual Experiences Questionnaire (SEQ), which asks respondents to indicate their experience with 25 items (Fitzgerald et al., 1999). The SEQ items are grouped into the three categories listed below. Since respondents could indicate multiple sexual harassment experiences in different categories in the past 12 months, the SEQ categories are not mutually exclusive.

- **Gender harassment:** Behaviors conveying “hostility, exclusion, or second-class status about members of one gender,” such as someone insulting you because of your gender (NASEM, 2018, p.30).
- **Unwanted sexual attention:** “Unwelcome sexual advances, which can include assault,” such as someone making a gesture of a sexual nature that was offensive to you (NASEM, 2018, p.30).
- **Sexual coercion:** Situations in which “favorable professional or educational treatment is conditioned on sexual activity,” such as someone treating you badly because you refused to have sex (NASEM, 2018, p.30).

Among all respondents, 22 percent experienced sexual harassment in the past 12 months (i.e., they answered affirmatively to at least one of the 25 SEQ questions; figure 2). Gender harassment was the most common subtype of harassment, with 18 percent of all respondents experiencing one or more gender harassment incidents in the past 12 months, and 10 percent of all respondents experiencing unwanted sexual attention. Although less than 1 percent of survey respondents (n = 41) experienced sexual coercion and, therefore, were excluded from most analyses due to sample size, the severity of those incidents suggests a need for prevention efforts and consideration.

Figure 2. Percentage of Respondents Experiencing One or More Sexual Harassment Incidents in the Past 12 Months, By SEQ Subscale



GROUPS VULNERABLE TO SEXUAL HARASSMENT

In this section, all percentages denote the percentage of a certain group (e.g., women) who indicated experiencing any sexual harassment in the past 12 months.

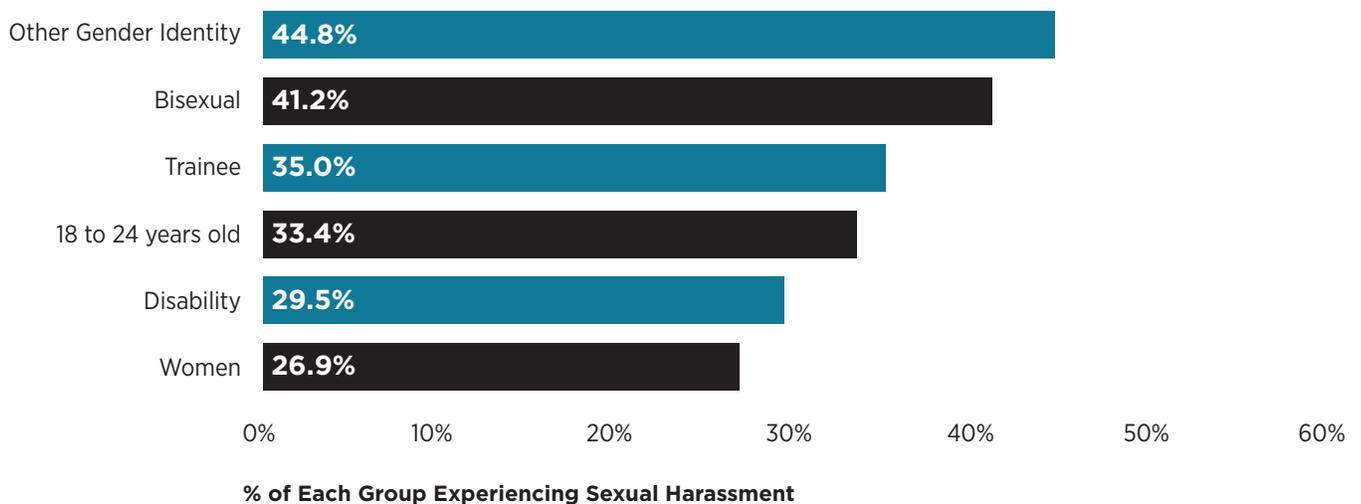
Harassment experiences are not limited to any one group. However, certain populations may be more likely to experience sexual harassment than others.

- **Gender:** Individuals who reported having a gender identity other than man or woman (including transgender man, transgender woman, genderqueer or gender non-conforming, and questioning) were more likely to experience sexual harassment in the past 12 months (45 percent). Women were more likely than men to experience sexual harassment (27 percent; figure 3), gender harassment (22 percent), and unwanted sexual attention (13 percent).
- **Sexual orientation:** Respondents who identified as bisexual were more likely to experience sexual harassment in the past 12 months (41 percent) compared with respondents of other sexual orientations. Twenty-nine percent of respondents identifying as lesbian, gay, or homosexual, and 31 percent of

respondents identifying as asexual, questioning, or something else experienced sexual harassment in the past 12 months, relative to 20 percent of respondents who identified as heterosexual or straight.

- **Appointment type:** Respondents who identified their primary NIH role as a trainee, fellow (post-baccalaureate and post-doctoral), or student were more likely to experience sexual harassment in the past 12 months (35 percent) compared with respondents with other primary appointment types (25 percent of guest researchers, 22 percent of NIH employees, 19 percent of volunteers, and 18 percent of contractors experienced sexual harassment in the past 12 months).
- **Age:** Age was related to the likelihood of experiencing sexual harassment in the past 12 months, with younger respondents being more likely to experience sexual harassment than older respondents. Respondents aged 18–24 of any gender were more likely to experience sexual harassment (33 percent) compared to respondents of all other ages (20 percent).
- **Disability:** Respondents indicating that they have a disability were more likely to experience sexual harassment in the past 12 months (30 percent) relative to respondents without a disability (21 percent).

Figure 3. Percentage of Each Vulnerable Group Experiencing Sexual Harassment in the Past 12 Months



GROUPS VULNERABLE TO SEXUAL HARASSMENT: INTRAMURAL STAFF AND RESEARCHERS

In this section, all percentages denote the percentage of a certain group (e.g., respondents in the Intramural Research Program) who indicated experiencing any sexual harassment in the past 12 months.

NIH has a robust **Intramural Research Program** (IRP), which consists of approximately 1,140 Principal Investigators and 4,000 trainees, including postdocs, graduate students, and post bacs, as well as administrative and support staff. The *NIH Workplace Climate and Harassment Survey* sought to identify differences in sexual harassment experiences between those in the IRP (referred to as ‘intramural respondents’) and those not in the IRP (referred to as ‘non-intramural respondents’). The goal of this analysis, which includes 5,762 intramural and 9,611 non-intramural respondents, was to identify key opportunities for harassment prevention; 421 respondents skipped the survey item related to the IRP and were, therefore, excluded from analysis.

Intramural respondents were more likely to experience sexual harassment in the past 12 months than non-intramural respondents—24 percent of intramural respondents experienced sexual harassment in the past 12 months, compared with 20 percent of non-intramural respondents. Twenty-one percent of intramural respondents experienced any gender harassment (a type of sexual harassment) in the past 12 months, compared with 16 percent of non-intramural respondents.

Within groups most vulnerable to sexual harassment (i.e., women, sexual or gender minorities, younger individuals, those with disabilities, and trainees/students/fellows), differences in sexual harassment experiences between intramural and non-intramural respondents remain:

- **Gender:** Among intramural *women*, 32 percent experienced sexual harassment in the past 12 months, compared with 24 percent of non-intramural women. Fewer than 15 intramural respondents with a gender identity other than man or woman experienced sexual harassment in the past 12 months; therefore, a comparison with non-intramural respondents cannot be reported.
- **Intramural women** represent a group particularly vulnerable to harassment. Forty percent of intramural women respondents under the age of 34 experienced harassment in the past 12 months. Intramural women whose appointment types include leadership, administrative scientists, and trainees were more likely to experience harassment.
- **Sexual Orientation:** Intramural respondents with a *sexual orientation other than heterosexual/straight* were slightly more likely to experience sexual harassment than non-intramural respondents. Among respondents identifying as lesbian, gay, or homosexual, 31 percent of intramural respondents experienced sexual harassment in the past 12 months, compared with 27 percent of non-intramural respondents. Among respondents identifying as bisexual, 42 percent of intramural respondents experienced sexual harassment in the past 12 months, compared with 40 percent of non-intramural respondents.
- **Appointment Type:** Thirty-one percent of intramural *trainees* experienced sexual harassment in the past 12 months, compared with 24 percent of non-intramural trainees (including respondents who self-identified as students or fellows). Twenty-seven percent of intramural respondents in leadership experienced sexual harassment in the past 12 months, relative to 21 percent of non-intramural respondents in leadership.
- **Age:** Thirty-seven percent of intramural *respondents* aged 18–24 experienced sexual harassment in the past 12 months, compared with 23 percent of non-intramural respondents aged 18–24.
- **Disability:** Intramural and non-intramural respondents with disabilities had a similar likelihood of experiencing sexual harassment in the past 12 months (30 percent versus 29 percent).

CIRCUMSTANCES SURROUNDING SEXUAL HARASSMENT

In this section, percentages denote the percentage of respondents indicating that response option, among all respondents experiencing any sexual harassment in the past 12 months.

Survey respondents who experienced sexual harassment in the past 12 months were asked follow-up questions about the circumstances surrounding the incident that *had the greatest effect on them*. When asked about the perpetrator of that incident, most of those respondents indicated that the perpetrator was an NIH employee and a man (78 percent and 72 percent, respectively), and over half (57 percent) indicated that the perpetrator was in their work unit (figure 4).

Respondents were also asked about the power relationship between themselves and the perpetrator of the incident. Thirty-five percent of respondents indicated that the perpetrator was their supervisor or manager, and 25 percent indicated that the perpetrator could influence their work opportunities at NIH.

When asked about the location of the incident that most affected them, a majority of respondents shared that the incident occurred in a building owned or leased by NIH (88 percent). Few respondents indicated that the

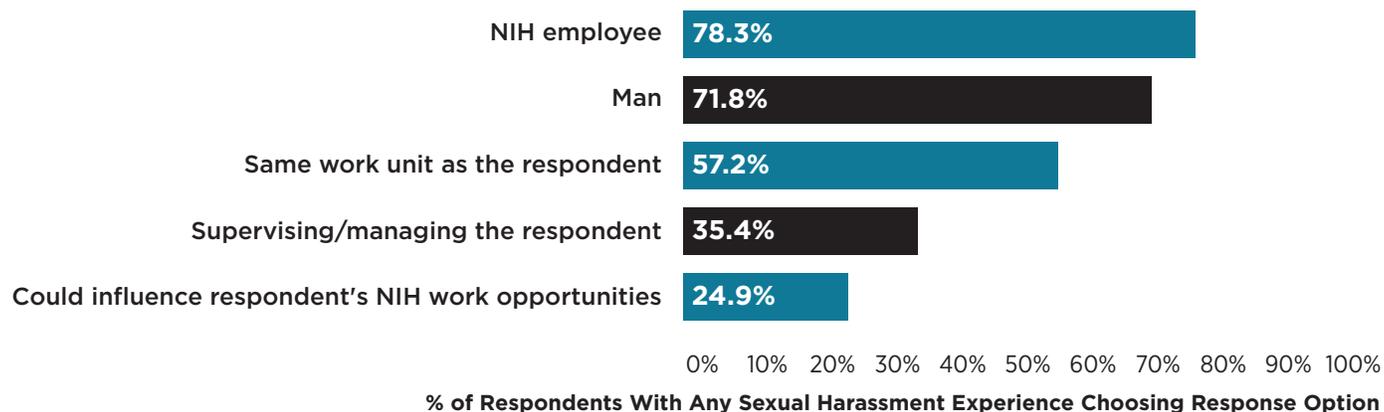
incident took place during a conference (5 percent) or at a social event attended by multiple NIH personnel (13 percent). Since the survey did not assess the overall percentage of time respondents spent in these environments, the percentage of incidents in social gatherings or conferences may be disproportionate to the amount of time spent by respondents in these situations. However, these findings indicate that most incidents of sexual harassment occur in the workplace, not outside of the workplace.

NON-SEXUAL HARASSMENT: BULLYING, INCIVILITY, AND INTIMIDATING BEHAVIORS

In this section, percentages denote the percentage of respondents indicating that response option, among all survey respondents (unless otherwise noted).

To capture the extent of the harassment landscape at NIH and assess if incivility and other non-sexual forms of harassment contribute to sexual harassment, the *NIH Workplace Climate and Harassment Survey* assessed respondents' experiences of non-sexual harassment in the past 12 months. Survey respondents' experiences of rude, disrespectful, or condescending behaviors from supervisors or coworker was assessed using six items from the Workplace Incivility Scale (Cortina et al., 2001).

Figure 4. Perpetrator Characteristics, Among Respondents with Any Sexual Harassment Experience in the Past 12 Months

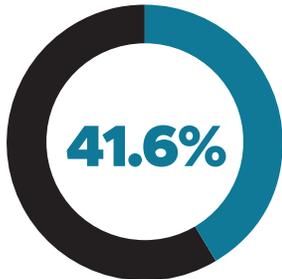


Of respondents who answered all six workplace incivility questions, over 50 percent experienced at least one incident of workplace incivility in the past 12 months, such as having demeaning or derogatory remarks made about them or being ignored or excluded from work activities where they should have been present. Experiences with incivility differed by sexual harassment experience; respondents with sexual harassment experiences in the past 12 months were more likely to experience incivility during the same time frame (figure 5).

Similarly, all respondents were asked if they had experienced bullying in the past 12 months. Ten percent of all survey respondents experienced at least one incident of bullying in the past 12 months. Experiences with bullying also differed by sexual harassment experience; respondents indicating sexual harassment experiences in the past 12 months were more likely to experience bullying during the same time frame (figure 6).

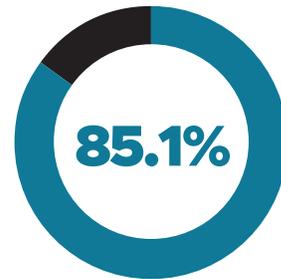
Figure 5. Association Between Sexual Harassment and Incivility in the Past 12 Months

Among respondents not experiencing sexual harassment in the past 12 months...



Experienced Any Incivility

Among respondents experiencing sexual harassment in the past 12 months...



Experienced Any Incivility

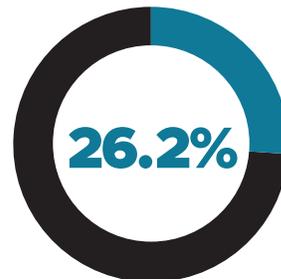
Figure 6. Association Between Sexual Harassment and Bullying in the Past 12 Months

Among respondents not experiencing sexual harassment in the past 12 months...



Experienced Any Bullying

Among respondents experiencing sexual harassment in the past 12 months...



Experienced Any Bullying

All respondents were also asked if they had experienced intimidating behaviors in the past 12 months (e.g., finger pointing, invasion of personal space, shoving, or blocking the respondent’s way). Six percent of all survey respondents experienced at least one incident of intimidating behaviors in the past 12 months. Experiences with intimidating behaviors differed by sexual harassment experience; respondents indicating sexual harassment experiences in the past 12 months were more likely to experience intimidating behaviors during the same time frame (figure 7).

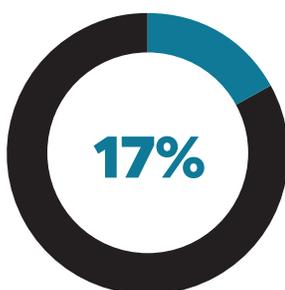
Figure 7. **Association Between Sexual Harassment and Intimidating Behaviors in the Past 12 Months**

Among respondents not experiencing sexual harassment in the past 12 months...



Any Intimidating Behaviors

Among respondents experiencing sexual harassment in the past 12 months...



Any Intimidating Behaviors

LIKELIHOOD OF BEING HARASSED IN THE FUTURE

In this section, percentages denote the percentage of respondents indicating that response option, among all survey respondents.

All respondents were asked about their perceived likelihood of being harassed within the next 12 months while working at NIH. While 93 percent said that they were only slightly or not at all likely to be harassed in the next 12 months, 3 percent (516 respondents) indicated that they were extremely or very likely to be harassed.

SECTION 1 SUMMARY

QUESTION: What is the extent of harassment at NIH, and who are the most vulnerable populations?

FINDING: One in five survey respondents experienced sexual harassment in the past 12 months. Individuals were more likely to experience sexual harassment if they were women, sexual and gender minorities, younger, or trainees (including students or fellows), or if they had a disability. Individuals in the NIH Intramural Research Program—particularly those that were women, sexual and gender minorities, younger, or trainees (including students or fellows)—were more likely to experience sexual harassment than those not in the IRP.

The most significant incidents of sexual harassment were most likely to happen within NIH facilities and to be perpetrated by NIH employees who were men. Half of the respondents experienced incivility in the past 12 months, while 10 percent experienced bullying and 6 percent were the target of intimidating behaviors. Respondents experiencing sexual harassment were more likely to experience bullying, incivility, and intimidating behaviors in the workplace than those not experiencing sexual harassment. Three percent (516 respondents) indicated that they were extremely or very likely to be harassed within the next 12 months at NIH.

2. WORKFORCE WELL-BEING

IS SEXUAL HARASSMENT ASSOCIATED WITH NEGATIVE OUTCOMES FOR TARGETS?

All survey respondents were asked about their self-reported physical health, mental health, and satisfaction with their current job to better understand the connection between sexual harassment and negative health or work outcomes. Because the survey assessed both sexual harassment experiences and health or satisfaction outcomes at the same point in time, it is not possible to know which came first and if the harassment caused any negative outcomes. However, this section of the report includes descriptive data comparing health and work outcomes between respondents experiencing sexual harassment in the past 12 months, relative to respondents not experiencing sexual harassment.

In addition, respondents who experienced sexual harassment in the past 12 months were asked if the experience that had the greatest effect on them resulted in any negative work outcomes. The goal of this question was to gain a deeper understanding of the relationship between sexual harassment and respondents' perception of negative work outcomes.

PHYSICAL HEALTH

In this section, percentages denote the percentage of respondents indicating that response option, among all survey respondents.

The *NIH Workplace Climate and Harassment Survey* used a two-question scale derived from the PROMIS Global Health Items to assess respondents' physical health (Hays et al., 2017). The questions asked all respondents about their general health status and activity level.

Physical health ratings differed by sexual harassment experience. Sixty-six percent of respondents with sexual harassment experiences in the past 12 months rated their health as excellent or good, compared with 72 percent of respondents with no sexual harassment experience.

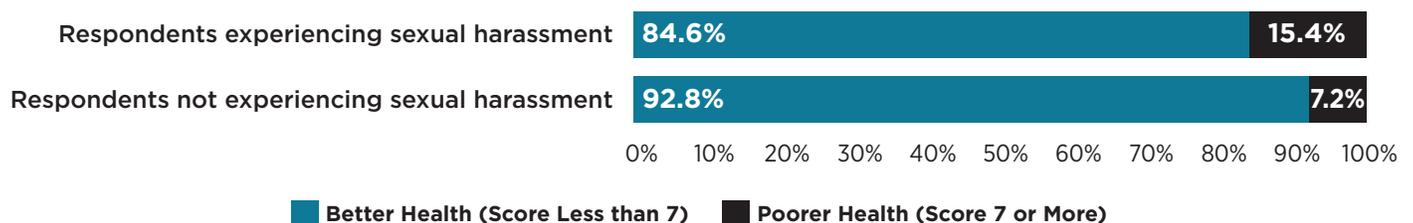
However, respondents' ratings of their physical functioning did not differ by sexual harassment experience; 95 percent of respondents in both groups indicated that they could completely or mostly carry out their everyday physical activities, such as walking, climbing stairs, or carrying groceries.

MENTAL HEALTH

In this section, percentages denote the percentage of respondents indicating that response option, among all survey respondents.

The *NIH Workplace Climate and Harassment Survey* used a two-question scale derived from the PROMIS Global Health Items to assess respondents' mental health (Hays et al., 2017). The questions asked all respondents to rate their mental health, including mood and ability to think, as well as their satisfaction with social activities and relationships, on a five-point scale from Excellent (1) to Poor (5). A single mental health score was obtained for each respondent by adding his/her responses for each of the two items, with a minimum score of 2 and a maximum of 10. Scores of seven or greater indicate poorer health (figure 8).

Figure 8. Respondent Self-Rated Mental Health (2-Item Promis Mental Health Score)



About 15 percent of respondents experiencing sexual harassment in the past 12 months indicated poorer mental health (a score of seven or more), compared with 7 percent of respondents with no sexual harassment experience.

JOB SATISFACTION

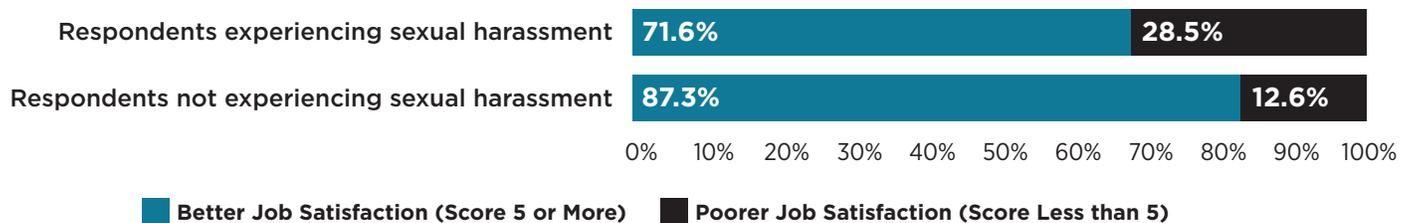
In this section, percentages denote the percentage of respondents indicating that response option, among all survey respondents.

All survey respondents were asked about the degree to which they were satisfied with their current job. The questions were drawn from the Michigan Organizational

Assessment Questionnaire Job Satisfaction Subscale (MOAQ-JSS), which asks respondents the extent to which they agree with statements about being satisfied with their job, not liking their job, and if they like working in their place of employment (Cammann et al., 1979). The overall score is the average of the three questions; lower average scores indicate lower levels of job satisfaction.

Approximately 29 percent of respondents experiencing sexual harassment in the past 12 months experienced low levels of job satisfaction (scores less than five), relative to 13 percent of respondents not experiencing sexual harassment (figure 9).

Figure 9. Respondent Job Satisfaction (MOAQ-JSS Average Score, Cutoff of 5)

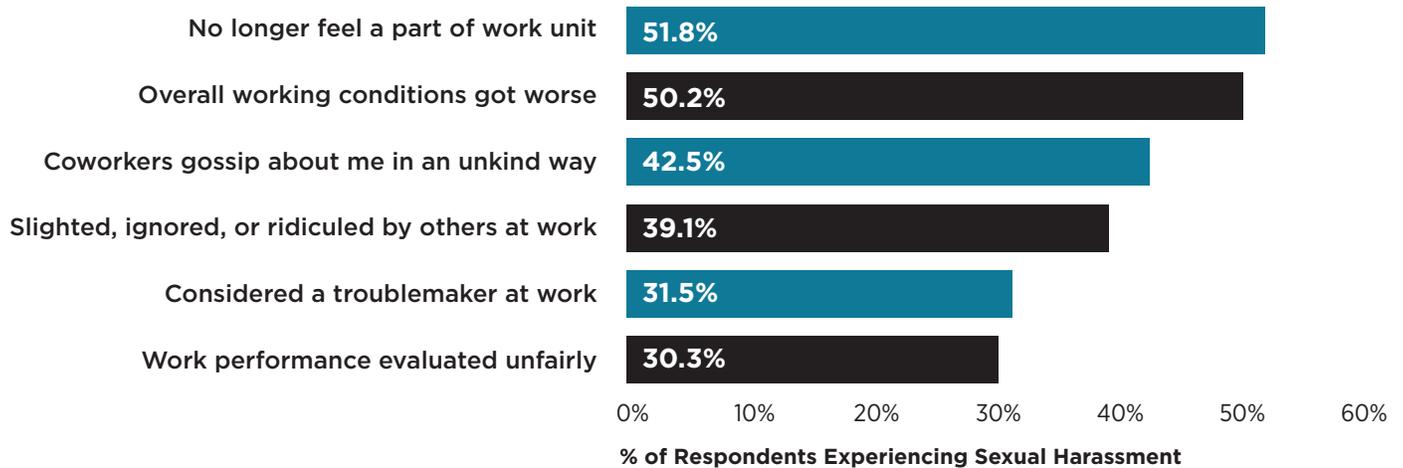


PERCEIVED WORK OUTCOMES

In this section, percentages denote the percentage of respondents indicating that response option, among respondents experiencing any sexual harassment in the past 12 months. Since respondents not experiencing sexual harassment were not asked these survey measures, comparisons cannot be drawn between groups.

For all respondents experiencing sexual harassment in the past 12 months, the survey asked respondents about certain work outcomes as a result of the sexual harassment experience that had the greatest effect on them (figure 10). The most frequently cited outcomes were no longer feeling a part of the work unit (52 percent), feeling that their overall working conditions worsened (50 percent), or experiencing their coworkers gossiping about them in an unkind way (43 percent).⁵ Less common, but more severe consequences, included not receiving a promotion (17 percent), being denied training opportunities (12 percent), or being reassigned or transferred against their wishes (7 percent).

Figure 10. Most Frequently Cited Work Outcomes Resulting from the Sexual Harassment Experience



SECTION 2 SUMMARY

QUESTION: Is sexual harassment associated with negative outcomes for those experiencing harassment?

FINDING: Close to half of respondents experiencing sexual harassment in the past 12 months indicated that their work conditions worsened as a result of the harassment, or that they

were the subject of unkind gossip from coworkers; some indicated severe repercussions such as being denied training opportunities. Overall, respondents experiencing sexual harassment had poorer self-rated physical and mental health and were less satisfied with their jobs, compared with respondents who had not experienced sexual harassment.

⁵Respondents could select more than one response option for this question.

3. CURRENT POLICIES AND PROCEDURES:

HOW WELL ARE CURRENT NIH POLICIES AND PROCEDURES UNDERSTOOD AND PROMOTED BY THE NIH WORKFORCE?

ENTIRE NIH WORKFORCE

In this section, percentages denote the percentage of respondents indicating that response option, among all survey respondents.

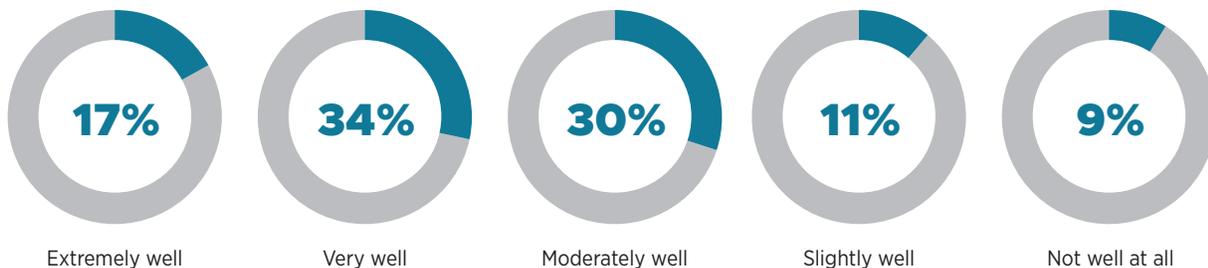
The purpose of NIH’s anti-harassment policies and procedures is to emphasize the organization’s commitment to providing a workplace free of harassment, describe the responsibilities of the workforce and those in people-managing capacities, and designate resources for individuals experiencing or witnessing harassment. For this reason, the *NIH Workplace Climate and Harassment Survey* asked respondents about their awareness and understanding of NIH anti-harassment policies and procedures.⁶

The majority of survey respondents reported that they had read the **NIH Policy Statement: Personal Relationships in the Workplace** (60 percent) and the **NIH Manual Chapter 1311: Preventing and Addressing Harassment and Inappropriate Conduct** (55 percent). About half of all respondents (51 percent) reported understanding those documents extremely well or very well. When asked more broadly if they understood how individuals could get help if they experience harassment, a similar proportion (58 percent) reported understanding the process extremely well or very well (figure 11).

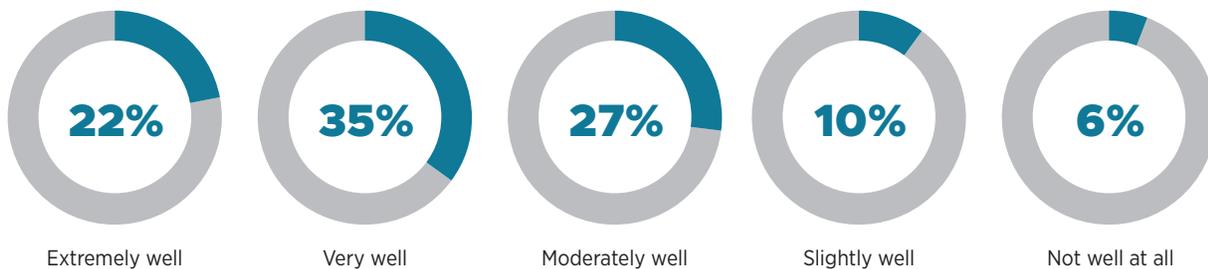
Finally, the survey asked respondents to evaluate NIH’s performance (during the past 12 months) at encouraging people to report any harassment problems they have experienced in the course of their work at NIH. About 78 percent of all survey respondents indicated that NIH has done an excellent or good job of encouraging harassment reporting in the past 12 months.

Figure 11. Level Of Understanding of NIH Harassment Reporting Protocols and How to Get Help

Understanding Policies and Procedures



Understanding How To Get Help From NIH



⁶NIH launched revised policy and procedure documents as part of an anti-harassment effort in 2018; therefore, it is likely that measures of awareness and understanding of these documents will continue to improve beyond the time point of the survey.

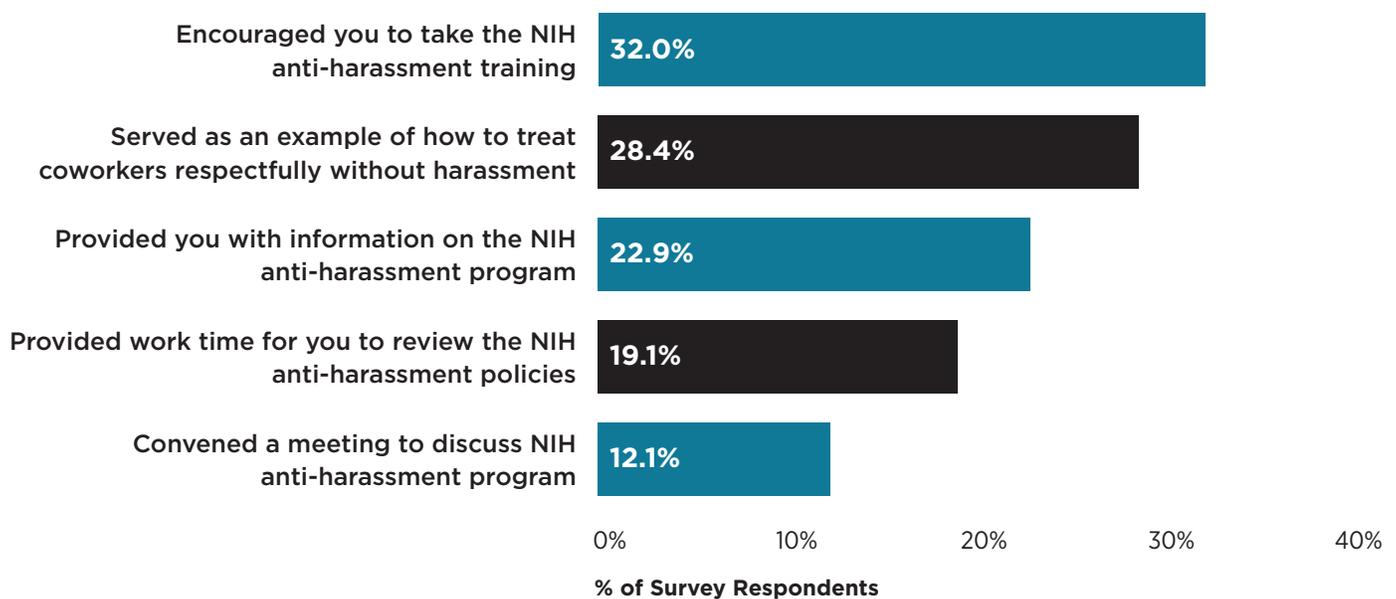
NIH SUPERVISORS

In this section, percentages denote the percentage of respondents indicating that response option, among all survey respondents (unless otherwise indicated).

All respondents were asked about their perception of their supervisor's (or NIH point of contact's for contract staff) response to harassment in their work unit. Approximately 41 percent indicated that their supervisor spoke up when a sexist or racist remark was made,⁷ and 57 percent indicated that their supervisor responded appropriately to a report of harassment in their work unit.⁸

Respondents were also asked about the types of anti-harassment activities that their supervisor or NIH point of contact implemented in the work unit during the past 12 months. Approximately one-third of respondents indicated that their supervisors encouraged them to take an anti-harassment training, while 28 percent responded that their supervisors served as an example of how to treat coworkers respectfully without harassment (figure 12).⁹ Less than a quarter of respondents indicated that their supervisors provided information, work time, or a meeting related to the NIH anti-harassment policies and procedures.

Figure 12. **Supervisor Anti-Harassment Activities in the Work Unit**



SECTION 3 SUMMARY

QUESTION: How well are current NIH policies and procedures understood by the NIH workforce?

FINDING: The majority of respondents were aware of the NIH policies and procedures relating to harassment, and they reported understanding how individuals can get help if they experience harassment. Most respondents evaluated NIH's performance at encouraging harassment

reporting in the past 12 months positively. Many respondents indicated that their supervisors do not consistently speak up or respond appropriately in cases of harassment, and that their supervisors do not universally implement recommended anti-harassment activities such as providing information or work time dedicated to organizational policies and procedures.

⁷Percentages exclude 13,323 respondents who skipped the question, responded "I don't know," or indicated that their supervisor had never observed harassment in the work unit.

⁸Percentages exclude 13,845 respondents who skipped the question, responded "I don't know," or indicated that they were not aware of any harassment reported to their supervisor.

⁹Respondents could select more than one response option for this question.

4. RESPONSE TO SEXUAL HARASSMENT:

HOW ARE INCIDENTS OF SEXUAL HARASSMENT TALKED ABOUT, REPORTED, AND/OR ADDRESSED AT NIH?

TALKING ABOUT OR REPORTING SEXUAL HARASSMENT

In this section, percentages denote the percentage of respondents indicating that response option, among respondents experiencing any sexual harassment in the past 12 months.

The *NIH Workplace Climate and Harassment Survey* sought to characterize the degree to which sexual harassment is reported or talked about with others, potential barriers to talking about or reporting an incident, and the perceived outcomes of reporting from the perspective of those experiencing harassment. To this end, survey respondents who experienced sexual harassment in the past 12 months were asked follow-up questions about the incident that had the greatest effect on them.

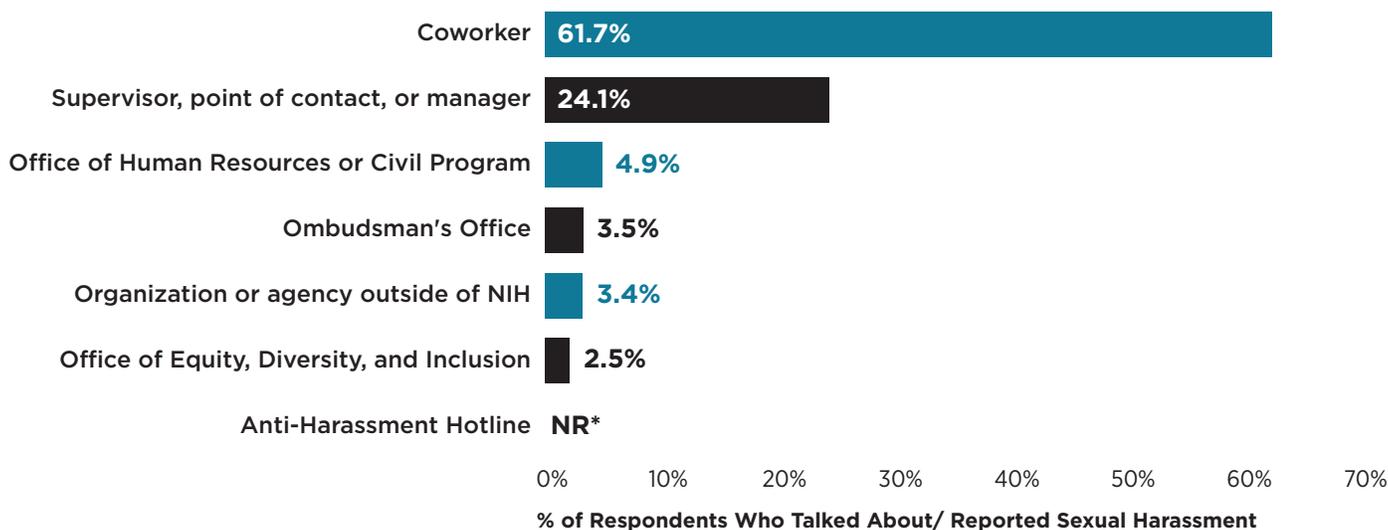
More than half of respondents did not talk about the incident with anyone or with any of the entities listed as response options. Among those who did talk about or report the experience, approximately

14 percent did so using a dedicated NIH channel (e.g., NIH Office of Human Resources; NIH Civil Program; NIH Ombudsman’s Office; NIH Office of Equity, Diversity, and Inclusion; or the NIH Anti-Harassment Hotline).¹⁰

Of respondents who talked about or reported the sexual harassment experience that had the greatest effect on them, the majority (62 percent) talked about the incident with a coworker (figure 13). Of those respondents, 18 percent felt that their coworker did not take the complaint seriously, 11 percent were told by coworkers to drop the complaint, and 4 percent were told by coworkers that they were partly responsible for the incident.

In contrast, 24 percent of respondents who talked about or reported the incident did so with their NIH supervisor, point of contact, or manager. Of those respondents, 34 percent felt that their supervisor did not take the complaint seriously, 17 percent were told by their supervisor to drop the complaint, and 13 percent were told by their supervisor that they were partly responsible for the incident.

Figure 13. Talking About or Reporting the Sexual Harassment Experience, Among Those Who Talked About or Reported It



*Fewer than 15 respondents indicated talking to or reporting the experience to the NIH Anti-Harassment Hotline

¹⁰Respondents could select more than one response option for this question.

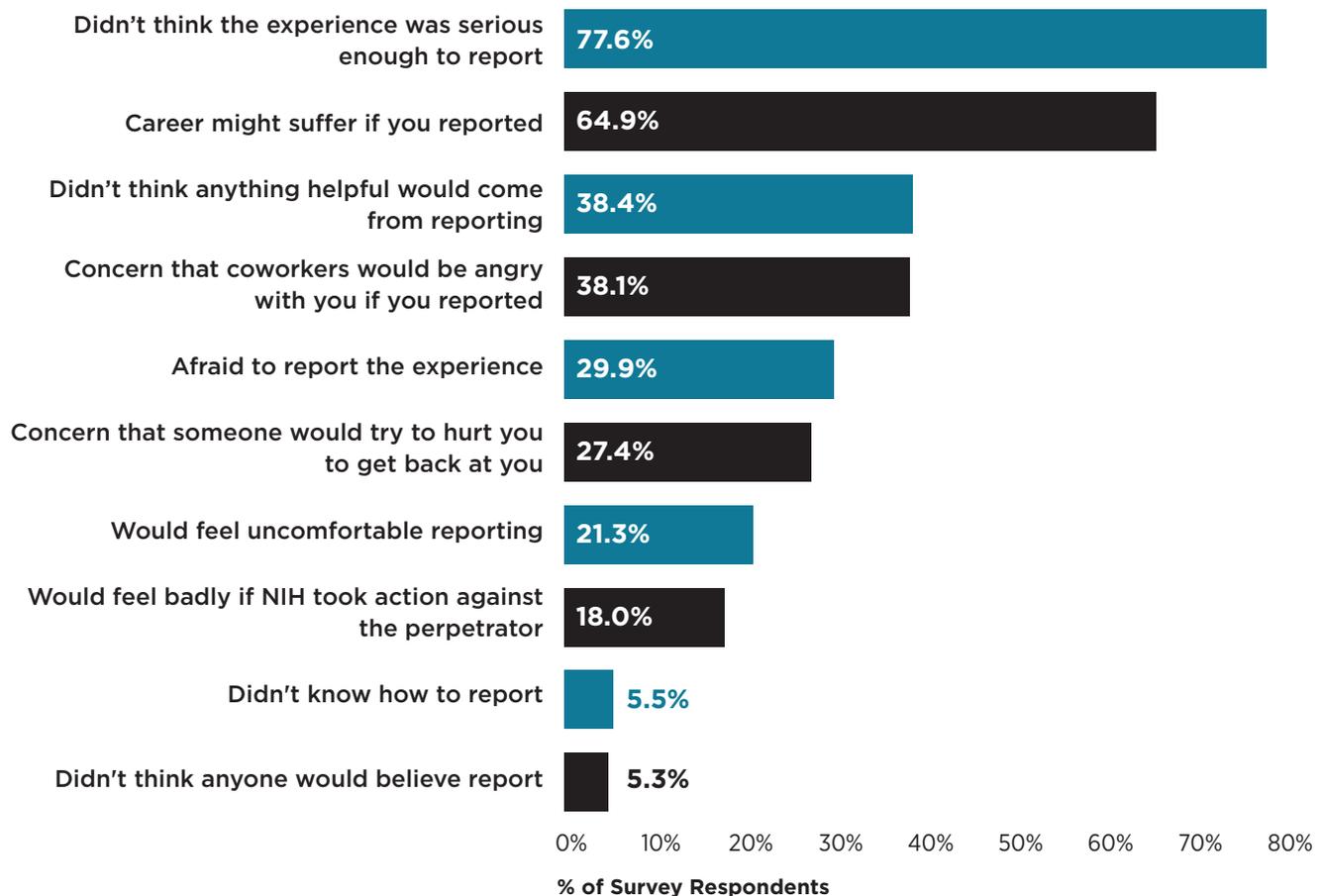
All respondents with sexual harassment experiences in the past 12 months were asked about their knowledge of NIH's response to their claim. Fifteen percent of those respondents indicated that their supervisor talked to the perpetrator, 7 percent said that their complaint of sexual harassment was investigated, and 2 percent said that the perpetrator of their claim was punished. In addition, 22 percent did not know if their supervisor talked to the perpetrator, 16 percent did not know if their complaint was investigated, and 20 percent did not know if the perpetrator of their claim was punished. Much of that uncertainty is likely due to confidentiality during NIH's investigation process.

REASONS FOR NOT TALKING ABOUT OR REPORTING SEXUAL HARASSMENT

In this section, percentages denote the percentage of respondents indicating that response option, among all respondents who experienced any sexual harassment in the past 12 months but did not talk about or report it to any entity listed.

Respondents who indicated that they did not talk about or report the sexual harassment incident of most impact were asked why they did not (figure 14). The most commonly cited reasons for not reporting were that they did not think the experience was serious enough to report to anyone (78 percent), they were concerned their career might suffer if they reported (65 percent), they didn't think anything helpful would come from reporting (38 percent), or they were concerned that coworkers would be angry if they reported (38 percent).¹¹

Figure 14. Most Common Reasons Why the Sexual Harassment Experience Was Not Talked About or Reported



¹¹Respondents could select more than one response option for this question.

SECTION 4 SUMMARY

QUESTION: How are incidents of sexual harassment talked about, reported, and/or addressed at NIH?

FINDING: Respondents did not frequently talk about or report the sexual harassment experience that had the greatest effect on them using official NIH reporting channels. Instead, they chose to speak to coworkers, supervisors, or did not talk about the

incident at all. Incidents may have gone undiscussed or unreported due to beliefs that they were not serious enough or that nothing helpful would come of a report, or for fear of negative work outcomes. Of respondents who talked about the incident to a supervisor, one-third felt their complaint was not taken seriously.

5. PREVENTING HARASSMENT:

WHICH WORKPLACE CLIMATE FACTORS ARE ASSOCIATED WITH HARASSMENT AT NIH?

The identification of workplace climate factors associated with harassment is a critical step in developing an evidence-based, NIH-wide harassment prevention strategy. The NIH Conceptual Model of Harassment (figure 1) depicts three elements of the NIH workplace climate that may be associated with harassment. Using a multivariate analysis technique called structural equation modeling, two of these factors were found to be significantly associated with different types of harassment—perceived support and perception of equity—and are described in detail in this section. More information about the methods and results of the structural equation model can be found in appendix A.

PERCEIVED ORGANIZATIONAL SUPPORT

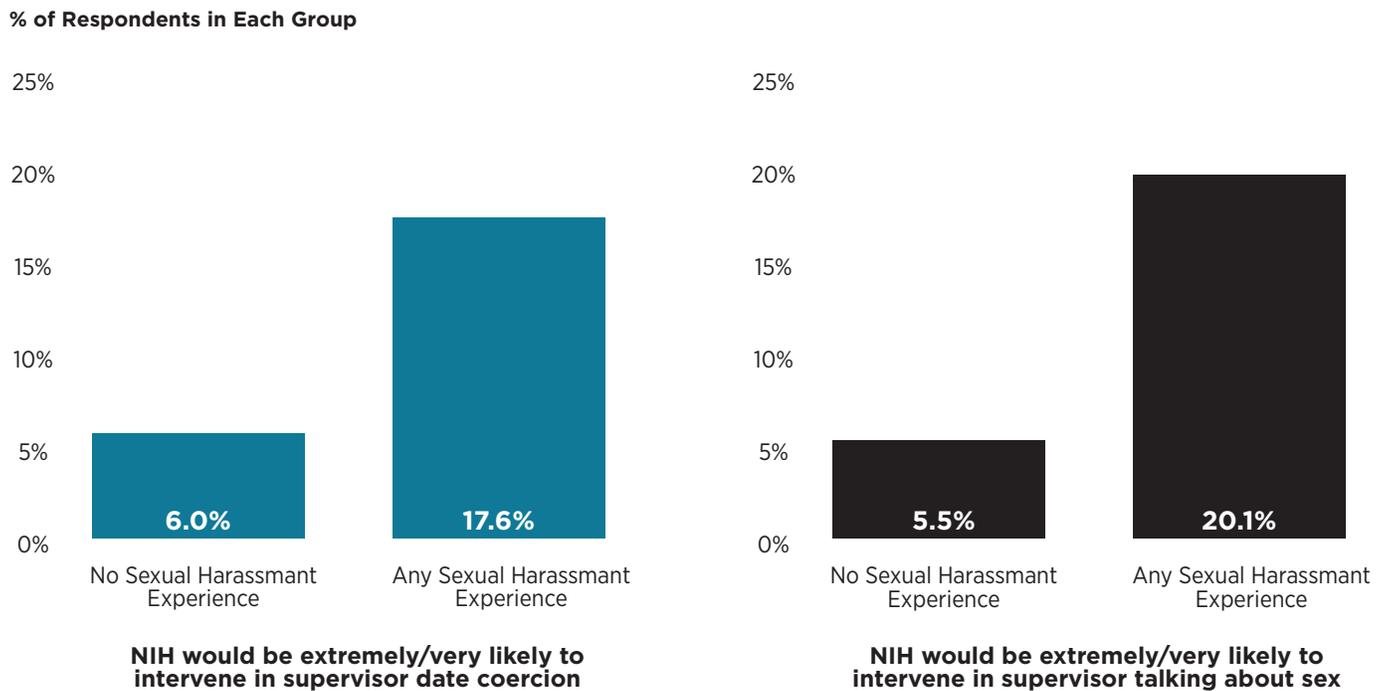
In this section, percentages denote the percentage of respondents indicating that response option, among all survey respondents.

Perceived support in the *NIH Workplace Climate and Harassment Survey* broadly refers to a respondent's perception that NIH will intervene in situations in which they are being subjected to unwanted or offensive experiences in the workplace. In the multivariate model, a lower level of perceived support was significantly associated with a higher likelihood of all types of harassment (sexual and non-sexual). Three individual survey measures represent this factor:

1. **Date coercion:** If a supervisor or NIH point of contact at NIH were to tell someone in his or her work unit that the way to get ahead at work is to date him or her, how likely is it that NIH, once aware, would intervene to stop this behavior?
2. **Talking about sex:** If a supervisor or NIH point of contact were to talk about his or her sex life and try to get employees in his or her work unit to talk about their sex lives, how likely is it that NIH, once aware, would intervene to stop this behavior?
3. **Experience of support:** How would you evaluate the job that NIH has done during the past 12 months at encouraging people to report any harassment problems they have experienced in the course of their work at NIH?

In descriptive analysis, responses to the first two survey measures of support differed by sexual harassment experience (figure 15). Respondents experiencing sexual harassment in the past 12 months were more likely to say that NIH was slightly or not at all likely to intervene if a supervisor was engaging in harassing behavior, relative to respondents not experiencing sexual harassment.

Figure 15. Perception that NIH Will Intervene If a Supervisor Engaged in Harassing Behavior¹²



PERCEPTION OF SUPERVISOR FAIRNESS, EQUITY, AND CONSIDERATION

In this section, percentages denote the percentage of respondents indicating that response option, among all survey respondents.

Perception of equity in the *NIH Workplace Climate and Harassment Survey* refers to the respondents' perception that their supervisor, manager, or NIH point of contact is fair, and values their work and opinions. In the multivariate model, a lower level of perceived equity was significantly associated with a higher likelihood of workplace incivility. Three individual survey measures represent this factor:

1. **Fairness:** When your supervisor or NIH point of contact makes decisions that affect salaries, other professional rewards, evaluations, promotions, and work assignments of people in your work unit, how fair are those decisions?

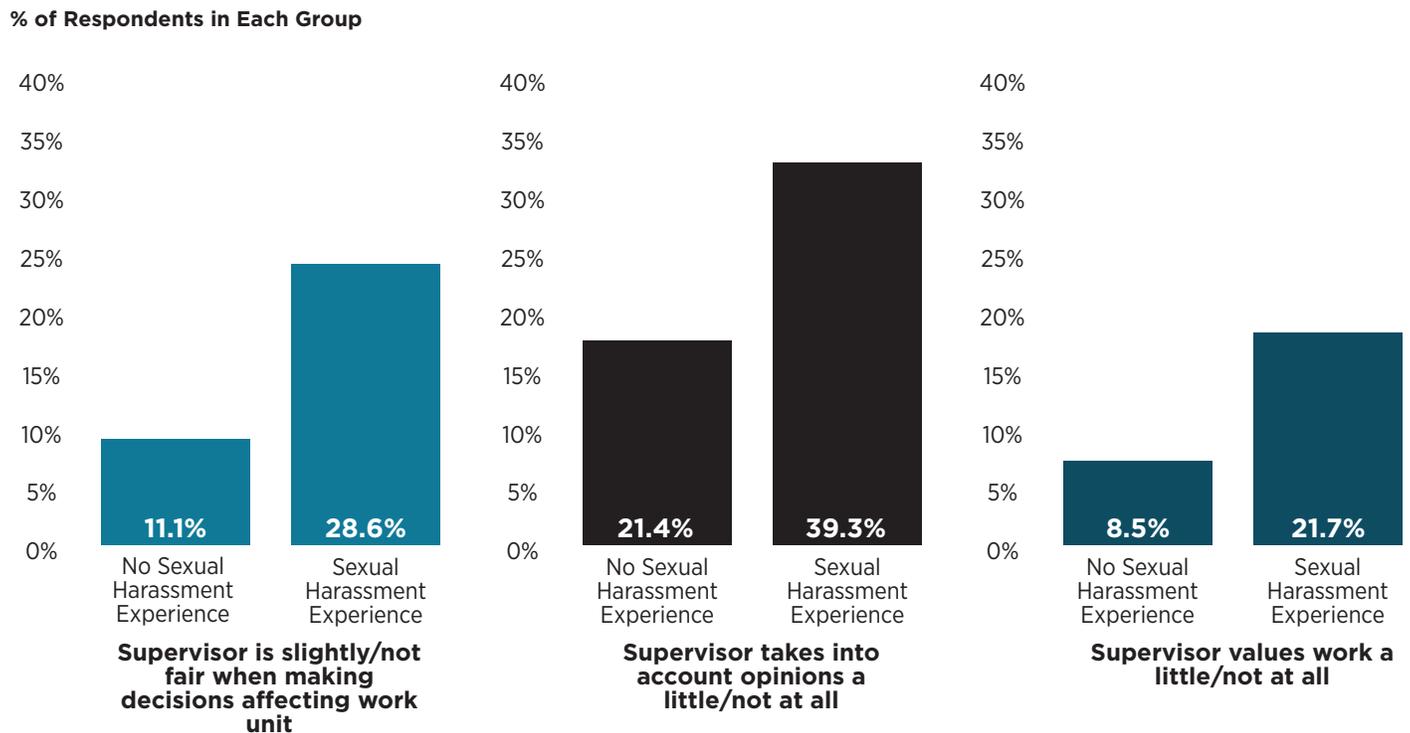
2. **Consideration of opinions:** When your supervisor or NIH point of contact makes decisions that affect salaries, other professional rewards, evaluations, promotions, and work assignments of people in your work unit, how much does he or she take into account the opinions of people in the work unit?

3. **Values work:** During the past 12 months, how much was your work at NIH valued by your supervisor or NIH point of contact?

In descriptive analysis, responses to these three survey measures of equity differed by sexual harassment experience (figure 16). Relative to respondents not experiencing sexual harassment in the past 12 months, respondents experiencing sexual harassment were more likely to say that their supervisor was slightly or not fair, took into account the opinions of others only a little or not at all, and valued their work only a little or not at all.

¹²Survey respondents who did not answer this question or selected the response option "I don't know" were excluded from figure 15.

Figure 16. Perceptions of NIH Supervisor/Point of Contact Fairness, Consideration of Opinions, and Value for Work¹³



SECTION 5 SUMMARY

QUESTION: Which workplace climate factors are associated with harassment at NIH?

FINDING: Perceived support is the perception that NIH will intervene in situations in which individuals are subjected to unwanted or offensive experiences, while perceived equity is the perception that supervisors are fair, value work, and consider the

opinions of others. An organizational climate with low levels of perceived support may increase the likelihood that harassment occurs. Similarly, a low level of perceived equity may increase the likelihood that non-sexual harassment (incivility) occurs. Respondents who have been sexually harassed in the past 12 months report lower levels of both these factors.

¹³Survey respondents who did not answer this question or selected the response option “I don’t know” were excluded from Figure 16.

CONCLUSION

The final section of this report summarizes key findings from the survey alongside key insights for potential action. The section concludes by putting the survey findings in the context of the anti-harassment behavior change literature, to lay the groundwork for potential future activities.

SURVEY INSIGHTS FOR ACTION

Below are the key report questions, associated survey findings, and insights for action:

1. Defining the Problem

Question:

What is the extent of harassment, including sexual harassment, bullying, and incivility, and who are the most vulnerable populations at NIH?

Finding:

One in five survey respondents experienced sexual harassment in the past 12 months. Individuals were more likely to experience sexual harassment if they were women, sexual and gender minorities, younger, trainees (including students and fellows), or if they had a disability. Individuals in the NIH IRP—particularly those that were women, sexual and gender minorities, younger (18–24 years), or trainees (including students and fellows)—were more likely to experience sexual harassment than those not in the IRP.

The most significant incidents of harassment were perpetrated by NIH employees who were men. Half of respondents experienced incivility in the past 12 months, while 10 percent experienced bullying and 6 percent were the target of intimidating behaviors. Respondents experiencing sexual harassment were more likely to experience bullying, incivility, and intimidating behaviors in the workplace than those not experiencing sexual harassment. Three percent (516 respondents) indicated that they were extremely or very likely to be harassed within the next 12 months at NIH.

Insights for Action:

Anti-harassment programs should encourage the **support of all individuals experiencing any form of harassment**, including non-sexual harassment such as bullying or incivility.

2. Workforce Well-Being

Question:

Is sexual harassment associated with physical or mental health outcomes, job satisfaction, or negative work outcomes for the NIH workforce?

Finding:

Close to half of respondents experiencing sexual harassment in the past 12 months indicated that their work conditions worsened as a result of the harassment, or that they were the subject of unkind gossip from coworkers; some indicated severe repercussions such as being denied training opportunities. Overall, respondents experiencing sexual harassment had poorer self-rated physical and mental health, and were less satisfied with their jobs, compared with respondents who had not experienced sexual harassment.

Insights for Action:

Support for all individuals experiencing harassment may benefit from a holistic approach that addresses **the implications of harassment** on a person's health, career trajectories and opportunities, and work satisfaction.

3. Current Policies and Procedures

Question:

How well are current NIH policies and procedures understood and adopted by the NIH workforce?

Finding:

The majority of respondents were aware of the NIH policies and procedures relating to harassment, and reported understanding how individuals could get help if they experience harassment. Most evaluated NIH's performance at encouraging harassment reporting in the past 12 months positively. Many respondents indicated that their supervisors do not consistently speak up or respond appropriately in cases of harassment, and did not universally implement recommended anti-harassment activities such as providing information or work time dedicated to organizational policies and procedures.

Insights for Action:

Current efforts to distribute NIH anti-harassment policies and procedures should be enhanced through

more awareness and education articulated in specific NIH ICO anti-harassment plans. **Enhanced training** should encourage supervisors to implement anti-harassment activities more frequently in the work unit.

4. Response to Sexual Harassment

Question:

How are respondents talking about or reporting experiences of sexual harassment? How are these experiences addressed?

Finding:

Respondents did not frequently talk about or report the sexual harassment experience that had the greatest effect on them using official NIH reporting channels. Instead, they chose to speak to coworkers, supervisors, or did not talk about the incident at all. Incidents may have gone undiscussed or unreported due to beliefs that they aren't serious enough, that nothing helpful will come of a report, or for fear of negative work outcomes. Of respondents who talked about the incident to a supervisor, one-third felt their complaint was not taken seriously.

Insights for Action:

NIH anti-harassment activities should be bolstered by **addressing barriers to talking about or reporting harassment** (e.g., fear of retaliation or career implications, confusion over what constitutes a reportable offense), in addition to making reporting procedures clear and accessible to the entire NIH workforce. **Enhanced training** for supervisors should include skill-building and tools for effective discussion with their staff; knowledge of when and how to elevate informal complaints; and appropriate follow-up on incidents of harassment and official NIH reporting channels. This training could be required as part of supervisors' Performance Management Appraisal Program at NIH. The large number of those experiencing harassment who shared their experience with coworkers is a call to action for more witness and bystander training, such that colleagues are better equipped to address these issues.

5. Preventing Harassment

Question:

Which workplace climate factors are associated with harassment at NIH, and how can these factors be used as targets for harassment prevention?

Finding:

Perceived support—the perception that NIH will intervene in situations in which individuals are subjected to unwanted or offensive experiences—is associated with harassment. In addition, perceived equity—the perception that supervisors are fair, value work, and consider opinions of others—is associated with non-sexual harassment (incivility). Respondents who have been sexually harassed in the past 12 months report lower levels of both these factors.

Insights for Action:

Anti-harassment prevention efforts should include strategies tailored to ensure that the entire workforce **feels supported by both their Institution and the leaders of their work unit**. These efforts should include educating leadership on their legal and moral responsibilities in the context of harassment, as well as holding them accountable for protecting individuals experiencing harassment and preventing or addressing retaliation. Further prevention efforts should be designed, implemented and evaluated to ensure that the entire NIH workforce feels that their supervisors, managers, or points of contact **treat them fairly and value their work**.

IMPLICATIONS

In a recent report from the National Academies of Sciences, Engineering, and Medicine, a committee of experts identified recommendations to address sexual harassment within academic science institutions (National Academies of Sciences, Engineering, and Medicine [NASEM], 2018). Certain recommendations connect to the NIH survey findings described in this report. The NASEM report emphasizes the importance of creating work environments that are “diverse, inclusive, and respectful.” As well, the NASEM committee recommends providing support for individuals experiencing sexual harassment using a “target-led institutional response.” This approach creates and maintains systems in which the targets of harassment can access supportive services or document experiences of harassment without being mandated to file a formal report. Institutions can also develop reporting channels such as an ombudsperson who is responsible for ensuring fairness throughout the process without being a part of the target's management hierarchy or the Institution's human resources unit. Some of the tactics identified in the NASEM report and determined to be consistent with applicable law are currently underway at NIH as part of the multi-faceted anti-harassment effort initiated in 2018.

Research indicates that sexual harassment reports occur less frequently when interventions are tailored to the organization and its staff members (Buchanan et al., 2014). Through the survey, trainees (including fellows and students) were identified as a group particularly vulnerable to experiencing sexual harassment, as were individuals identifying as sexual and gender minorities. Based on the specific context and needs of these groups, NIH is developing and implementing action plans to prevent and address harassment. For trainees, mandatory training is already being delivered featuring information on trainee rights and reporting procedures. This training emphasizes that protecting young scientists and their career trajectories are NIH priorities. The action plan should also include coordinated trainee start dates and mandatory, centralized orientations, with a particular focus on trainees whose primary work unit is not located at the main NIH campus. The proposed action plan to support sexual and gender minorities may involve **Safe Zone** and bystander training for the NIH workforce, engaging with NIH Employee Resource Groups, and conducting an annual symposium on workplace incivility and vulnerable groups.

Another group identified as particularly vulnerable were survey respondents in the NIH IRP, who were more likely to experience sexual harassment in the past 12 months compared with non-intramural respondents. These differences persist when looking within vulnerable groups such as women or trainees. Qualitative assessment as a follow-up to the survey findings, as well as data collected from future surveys, could provide insight into factors that may be driving a more permissive environment for harassment within the IRP, and help identify tailored strategies to prevent harassment at the “sub-cultural” level within the Institution.

Using the survey findings, future qualitative evaluations such as focus groups, and best practices from the literature, NIH is encouraged to develop a comprehensive anti-harassment program featuring the following key components:

1. **Policies mandating deterrents for perpetrators**, such as imposing penalties on perpetrators of harassment and preventing retaliation against individuals reporting harassment, to the extent permitted by law and consistent with agency authorities. These policies, when implemented systematically across the organization, can have the following effects:

- Discouraging perpetrators of harassment from engaging in harassing behavior in the future, and protecting NIH staff from experiencing harassing behavior from that perpetrator in the future (i.e., specific deterrence).
- Reducing the likelihood that others will engage in harassing behaviors due to a widely held perception that perpetrators of such behaviors will be punished (i.e., general deterrence). These effects require NIH to inform staff about penalties that have been imposed on perpetrators at the aggregate level. To do this, NIH may publicize annual anonymized data on intake and adjudication of harassment cases, as well as case studies highlighting the adjudication process and outcome.

2. **Programs that support changes in perceptions, norms, and skills associated with preventing and addressing harassment**, such as communication and training on how senior and junior staff can perform the following key behaviors:

- Treat everyone as equal, regardless of their seniority level, sex, gender identification, sexual orientation, or disability status, before any harassment takes place;
- Act as effective bystanders to mitigate any harassment while it occurs; and
- Support individuals experiencing harassment following the incident(s).

The components outlined above seek to address factors that are associated with preventing and addressing harassment, both at the individual and the environmental level (McAlister et al., 2008). Programs encouraging these behaviors should be accompanied by appropriate incentives and acknowledgements, to promote positive progress and to avoid an overemphasis on deterrents. Appendix B includes a brief review of additional predictors of these desired behaviors.

Evidence-based practice is the foundation of NIH’s biomedical research mandate; as such, those tenets should be applied to the design and implementation of interventions to combat harassment. While there is substantial observational literature on the topic, limited evaluative literature is available for the effectiveness of workplace anti-harassment interventions

(EEOC, 2016). In particular, evidence about the effectiveness and safety of anti-harassment trainings is sparse. NIH has an opportunity to employ a data-driven approach to its anti-harassment programming by using rigorous scientific methods to evaluate and improve its interventions over time.

CLOSING

Findings from the 2019 *NIH Workplace Climate and Harassment Survey* provide crucial insights in the landscape of harassment and organizational climate at NIH, from the perspective of over 15,000 members of the workforce. The objectives of the survey were to provide an evidence base to inform the strategies, interventions, and potential actions put forth across NIH Institutes, Centers, and Offices to affect change in these critical areas, and to establish a baseline such that planned anti-harassment activities could be evaluated over time. **NIH remains dedicated to demonstrating that Harassment Doesn't Work Here (at the NIH), by implementing programs to prevent harassment and sexual harassment of all types, addressing harassment as it occurs, supporting individuals experiencing harassment, and ultimately changing the climate of academic science for the better.**

GLOSSARY OF KEY TERMS

Bullying: Situations in which a respondent is repeatedly and over time exposed to harassment from colleagues, and where the targeted individual cannot defend themselves against the systematic mistreatment (Einarsen & Skogstad, 1996; Nielsen & Einarsen, 2018). In the NIH survey, respondents were not provided with a specific definition of bullying, but were asked if they had experienced bullying in the workplace in the past 12 months.

Disability: The survey asked respondents if they have a targeted and/or reported disability, as listed below:

- **Targeted disability:** Developmental disability, for example, autism spectrum disorder; traumatic brain injury; deaf or serious difficulty hearing, benefiting from, for example, American Sign Language, Communication Access Realtime Translation, hearing aids, a cochlear implant and/or other supports; blind or serious difficulty seeing even when wearing glasses; missing extremities (arm, leg, hand and/or foot); significant mobility impairment, benefiting from the use of a wheelchair, scooter, walker, leg brace(s) and/or other supports; partial or complete paralysis (any cause); epilepsy or other seizure disorders; intellectual disability; significant psychiatric disorder, for example, bipolar disorder, schizophrenia, post-traumatic stress disorder, or major depression; dwarfism; significant disfigurement, for example, disfigurement caused by burns, wounds, accidents, or congenital disorders.
- **Reportable disability:** Speech impairment; spinal abnormalities, for example, spina bifida or scoliosis; non-paralytic orthopedic impairments, for example, chronic pain, stiffness, weakness in bones or joints, some loss of ability to use part or parts of the body; HIV positive/AIDS; morbid obesity; nervous system disorder for example, migraine headaches, Parkinson's disease, or multiple sclerosis; cardiovascular or heart disease; depression, anxiety disorder, or other psychiatric disorder; blood diseases, for example, sickle cell anemia, hemophilia; diabetes; orthopedic impairments or osteo-arthritis; pulmonary or respiratory conditions,

for example, tuberculosis, asthma, emphysema; kidney dysfunction; cancer (present or past history); learning disability or attention deficit/hyperactivity disorder; gastrointestinal disorders, for example, Crohn's disease, irritable bowel syndrome, colitis, celiac disease, dysphexia; autoimmune disorder, for example, lupus, fibromyalgia, rheumatoid arthritis; liver disease, for example, hepatitis or cirrhosis; history of alcoholism or history of drug addiction (but not currently using illegal drugs); endocrine disorder, for example, thyroid dysfunction.

Gender harassment: Behaviors conveying "hostility, exclusion, or second-class status about members or one gender" (NASEM, 2018, p.30).

Gender identity: Refers to a person's basic sense of being a man or boy, a woman or girl, or another gender (such as transgender, bigender, or genderqueer—a rejection of the traditional binary classification of gender). Gender identity can be congruent or incongruent with one's sex assigned at birth based on the appearance of the external genitalia (Institute of Medicine, 2011).

Harassment: Unwelcome, deliberate, or repeated unsolicited verbal or physical conduct based upon race, color, religion, sex, national origin, age, and disability (in other words, a protected class status), including, but not limited to, comments, gestures, graphic materials, physical contact, solicitation of favors, when:

- Submission to or rejection of the conduct by an individual could be used as the basis for employment decisions affecting the individual; or
- The conduct is severe or pervasive enough that it substantially interferes with an individual's work performance or creates a work environment that a reasonable person would consider intimidating, hostile, or abusive.

Inappropriate conduct: Any comments or conduct that disparages or demonstrates hostility or aversion toward any person that could reasonably be perceived as disruptive, disrespectful, offensive, or inappropriate in the workplace.

Michigan Organizational Assessment Questionnaire Job Satisfaction Subscale (MOAQ-JSS):

This subscale assesses respondents' feelings about their job overall (Cammann et al., 1979). Scores for the job satisfaction subscale may be calculated using the average of the three items listed in Q28, with item #2 reverse scored ("In general, I don't like my job"). In this subscale, higher average scores indicate lower levels of global job satisfaction.

Perceived support: Respondent's perception that NIH will intervene in situations in which they are being subjected to unwanted or offensive experiences in the workplace.

Perception of equity: Respondent's perception that their supervisor, manager, or NIH point of contact is fair, and values their work and opinions.

PROMIS Global Health Items: Validated items measuring an individual's physical, mental, and social health using generic (rather than disease-specific) items to obtain an individual's assessment of his or her own health. The two-item measures assess respondents' mental and physical health (Hays et al., 2017).

Sexual coercion: Situations in which "favorable professional or educational treatment is conditioned on sexual activity" (NASEM, 2018, p.30).

Sexual experiences questionnaire: An instrument developed to assess the prevalence of sexual harassment using a psychometrically valid framework (Fitzgerald et al., 1999). The 25-item questionnaire asks respondents about their experiences with sexual harassment, with three subscales (gender harassment, unwanted sexual attention, and sexual coercion).

Sexual harassment: NIH defined sexual harassment as a form of discrimination that is "composed of three categories of behavior: (1) gender harassment (verbal and nonverbal behaviors that convey hostility, objectification, exclusion, or second-class status about members of one gender), (2) unwanted sexual attention (verbal or physical unwelcome sexual advances, which can include assault), and (3) sexual coercion (when favorable professional or educational treatment is conditioned on sexual activity)" (NASEM, 2018, p.28). Sexual harassment can be both targeted at an individual or can be present at the environmental level.

Structural equation modeling: A multivariate statistical analysis technique that is used to analyze the structural relationships between measured or observed variables and latent variables. Latent variables are theoretical constructs inferred through a mathematical model (for example, perceived support).

Unwanted sexual attention: "Unwelcome sexual advances, which can include assault" (NASEM, 2018, p.30).

Workplace incivility: Disrespectful, rude, or condescending behaviors from superiors or coworkers (Cortina et al., 2001).

REPORT CITATIONS

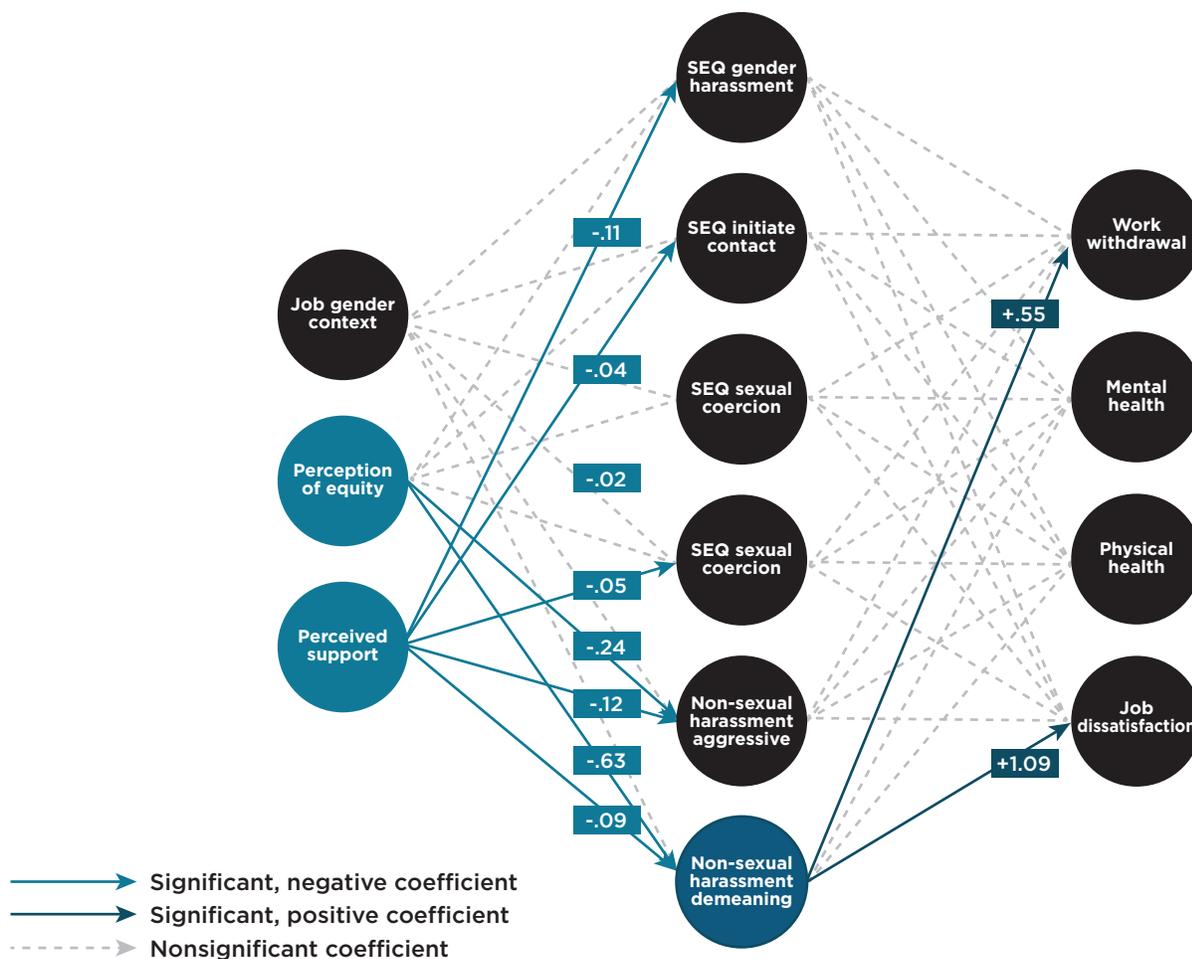
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APPENDIX A: STRUCTURAL EQUATION MODEL OVERVIEW

Structural equation modeling (SEM) is a multivariate statistical analysis technique that is used to analyze the structural relationships between measured or observed variables and latent variables (Hox & Bechger, 1998). Latent variables are theoretical constructs inferred through a mathematical model; in the NIH Conceptual Model, the latent variables are job gender context, workplace climate, the sexual and non-sexual harassment subscales, job outcomes, and health outcomes. Observed variables are the survey responses from the questionnaire. The SEM also takes into consideration person-level covariates, such as race, gender, age, sexual orientation, and marital status. The SEM is depicted in figure 17.

In the SEM, two latent constructs—perceived support and perception of equity—had a significant inverse relationship with harassment. A higher level of perceived support was associated with less sexual and non-sexual harassment,¹⁴ and a higher level of perceived equity was associated with less non-sexual harassment (in other words, incivility).¹⁵ While there was no significant association between harassment and health, the model did show that demeaning or derogatory non-sexual harassment (for example, being condescending) resulted in higher levels of work withdrawal and job dissatisfaction among NIH survey respondents.¹⁶

Figure 17. Final Structural Equation Model, with Model Parameters



¹⁴Gender harassment ($\beta = -0.11, p = 0.00$); sexual coercion ($\beta = -0.02, p = 0.03$); initiate contact ($\beta = -0.04, p = 0.00$); sexual content ($\beta = -0.05, p = 0.00$); aggressive non-sexual harassment ($\beta = -0.12, p = 0.00$); demeaning non-sexual harassment ($\beta = -0.09, p = 0.00$)

¹⁵Aggressive non-sexual harassment ($\beta = -0.24, p = 0.00$); demeaning non-sexual harassment ($\beta = -0.63, p = 0.00$)

¹⁶Work withdrawal ($\beta = 0.55, p = 0.00$); job dissatisfaction ($\beta = 1.09, p = 0.00$)

APPENDIX B: DESIGNING AN EVIDENCE-BASED ANTI-HARASSMENT PROGRAM

Based on the NIH survey findings and the literature, an anti-harassment initiative may feature programs supporting changes in perceptions, norms, and skills associated with preventing and addressing harassment. This may take the form of communications and training on how staff can perform the following key behaviors:

1. Treat everyone, regardless of their seniority level, sex, gender identification, sexual orientation, or disability status, as equal before any harassment takes place;
2. Act as effective bystanders to mitigate any harassment while it occurs; and
3. Support individuals experiencing harassment following the incident(s).

Below is a brief review of the known predictors of these desired behaviors:

Desired Behavior	Known Predictors of Effective Programs
<p>Treat everyone, regardless of their seniority level, sex, gender identification, sexual orientation, or disability status, as equal before any harassment takes place</p>	<p>Certain factors characterize programs that effectively encourage the treatment of everyone within an organization as equal. Results from the NIH survey showed a negative association between an employee’s perception that his or her supervisor is equitable toward individuals in the work unit and experiences of workplace incivility. In 2016, the Equal Employment Opportunity Commission (EEOC) concluded that workplace “civility training” focusing on promoting respect and civility in the workplace rather than just eliminating unwelcome or offensive behavior can help prevent harassment (EEOC, 2016). As well, an estimated one-quarter of U.S. employers have adopted training that aims to reduce unconscious bias by teaching all employees to be aware of and practice challenging ingrained prejudicial perceptions (McCann, 2018). As with the current NIH Safe Zone training, individuals become better at exploring differing opinions and points of view through ongoing exposure to these trainings.</p> <p>An individual’s behavior in this regard may be driven by self-efficacy, or the “belief in one’s ability to perform a given behavior” (McAlister et al., 2008, Self-Efficacy section, para. 1). One evaluation indicated that participants who participated in a team-based game and discussion reported increased self-efficacy to address the problem of sexist beliefs (Zawadzki et al., 2014).</p>

Desired Behavior	Known Predictors of Effective Programs
<p>Act as effective bystanders to mitigate any harassment while it occurs</p>	<p>A number of factors may drive effective programs that encourage action as a bystander of harassment. Crucially, the NIH survey indicates that over 60 percent of respondents who talked about a harassment experience did so with a coworker, indicating that any individual in the work unit (not just leadership) can be an important factor in addressing harassment. As part of bystander training, the EEOC recommends that the program create a sense of responsibility to do something rather than simply stand by when harassment occurs (EEOC, 2016). Bystanders may also be driven to action by identification with the victim in cases of harassment (McDonald et al., 2016). Effective trainings should enhance emotional intelligence, or the ability to direct feelings in a beneficial way (McCann, 2018). Trainings may focus on competencies such as increased empathy, intrapersonal and interpersonal skills, adaptability, and feeling and expressing positive feelings. Training outcomes include enhanced skills supporting collaboration, open communication, and transparency.</p> <p>An individual's behavior with regard to being an effective bystander may be driven by outcome expectancies, or “[b]eliefs about the likelihood and value of the consequences of behavioral choices” (McAlister et al., 2008, Observational Expectations section, para. 1). Observational learning can also be a crucial factor in developing and encouraging all employees to act as effective bystanders. This factor involves watching “similar individuals or role models perform a new behavior” (McAlister et al., 2018, Observational Learning section, para. 1). A recent evaluation demonstrated that undergraduate and graduate college students who viewed an online video in which their peers role modeled bystander action were more likely to intervene across four of seven situations (for example, hazing, intimate partner violence, racial bias, and sexual harassment) than their control group counterparts (Santacrose et al., 2019).</p>
<p>Support individuals experiencing harassment following the incident(s).</p>	<p>Certain factors may predict effective programs that encourage support of victims of harassment. This behavior may be driven by collective efficacy, or an individual’s “belief in a group’s ability to perform actions to bring about desired change” (McAlister et al., 2008, Collective Efficacy section, para. 1). To this end, the <i>NIH Workplace Climate and Harassment Survey</i> found that respondents experiencing sexual or non-sexual harassment were less likely than their counterparts to perceive support from NIH (in other words, that NIH would stop a supervisor from engaging in harassing behaviors). In the literature, social support has been found to be predictive of levels of distress in targets of bullying, such that individuals with high levels of social support experienced lower levels of distress than individual with less support (Nielsen, 2019).</p>



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