Sexual Harassment and Alcohol Use

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Since the 1990s there has been an increase in research on sexual harassment and its mental health consequences. These researchers discuss the use of alcohol to self-medicate harassment-engendered distress and the need for greater attention to potential alcohol-related consequences of harassment experiences.

Narratives depicting sexual harassment lawsuits have proliferated in the U.S. media ever since the U.S. population eagerly followed the sexual harassment accusations leveled at Supreme Court Justice Clarence Thomas during his Senate Confirmation Hearing in 1991 (Mayer and Abramson, 1994). This case is still referred to whenever sexual harassment is discussed in the media. A corresponding increase in research on sexual harassment and its mental health ramifications has also occurred.

From a legal perspective, sexual harassment represents a form of sex discrimination characterized by "unwelcome sexual advances, requests for sexual favors and other verbal or physical conduct of a sexual nature" that affects the terms, conditions or employment decisions related to an individual's job (quid pro quo harassment) or creates an "intimidating, hostile, or offensive working environment" (hostile environment harassment) (Equal Employment Opportunity Commission, 1980).

Overall prevalence rates of sexual harassment in employed samples have generally ranged from about 30% to 70% for women (Richman et al., 1999; Schneider, 1982; U.S. Merit Systems Protection Board, 1988) and about 27% to 50% for men (Richman et al., 1999; Waldo et al., 1998). Most importantly, sexual harassment is not a purely female problem, and its prevalence differs depending on other social statuses, such as occupation, race/ethnicity or sexual orientation (Nawyn et al., 2000; Richman et al., 1999).

To date, numerous studies have linked the experience of sexual harassment with varied psychological distress outcomes including depression, anxiety, irritability, loss of self-esteem, and a sense of helplessness and vulnerability (Charney and Russell, 1994). It is only recently that researchers shifted their attention to the impact of harassment experiences on increased and problematic drinking patterns.

Our own research has encompassed a five-phase longitudinal survey of a cohort of university workers in four occupational categories: faculty, graduate student/medical resident workers, secretarial/clerical workers and service/maintenance workers. Mailed questionnaires at each phase have addressed experiences of sexual harassment (as well as generalized abusive experiences at work), varied patterns of drinking and use of other substances, and moderating (e.g., social supports, coping behaviors) and mediating (e.g., psychological distress) factors. We have also conducted in-depth interviews with a small subsample of the survey population. We have shown that experiences of sexual harassment are associated with frequency of drinking, escapist motivations for drinking, heavy episodic drinking, drinking to intoxication, and use of prescription drugs (e.g., sedatives, antidepressants) and cigarettes (Richman et al., 1999). Moreover, sexual harassment that continues over time is predictive of increased quantity of alcohol consumption, controlling for prior drinking patterns (Rospenda et al., 2000). This is particularly problematic given that, when it occurs, sexual harassment tends to be chronic in nature.

We have theorized and empirically demonstrated that alcohol functions, in part, as a means to self-medicate distress engendered by sexual harassment. In particular, harassment experiences lead to feelings of depression, anxiety and hostility. Moreover, the associations between harassment experiences and drinking outcomes are partially dependent on whether distressful feelings occur, congruent with the tension-reduction perspective on drinking behaviors (Richman et al., 2002). Moreover, our research has demonstrated that active coping (e.g., reporting these experiences to a supervisor, confronting the person or people involved, or filing a formal complaint or grievance) by the person sexually harassed frequently fails to stop the harassment (Richman et al., 2001). Thus, the fact that active coping often does not produce a cessation of the harassment may both create
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Sexual harassment leads to distressful feelings and leads to maladaptive means of coping such as the self-medication of distress through the use and misuse of alcohol.

An important question for future research involves the extent to which individuals who are already problem drinkers or alcoholics react differently to harassment in contrast to those without pre-existing alcohol problems. In addition, while research has primarily focused on victims of harassment, future research should also examine the drinking behaviors of sexual harassment perpetrators.

When treating people who have been sexually harassed, the focus has been on the high levels of psychological distress generated by such experiences and consequent needs for empathy, validation and empowerment, among other aspects of the therapeutic relationship (Charney and Russell, 1994). By contrast, the potential use of alcohol as a means of coping with harassment-engendered distress has received limited attention. In order to determine the extent to which people who have been sexually harassed may utilize alcohol as a means to cope, clinicians might incorporate a brief alcohol screening tool in their diagnostic assessment. The TWEAK scale (T=tolerance; W=worry about drinking; E=eye-opener; A=amnesia/blackouts; K/C=cut down) consists of five questions (Russell, 1994). It has been shown to exhibit higher sensitivity and specificity compared to other brief measures of problem drinking (Chan et al., 1993) and is a more reliable measure for detecting problem drinking in women (Russell et al., 1997).

In addition to our university workplace study, we have also surveyed a small community sample of employed residents of Chicago. Both samples of workers have shown that individuals who experience sexual harassment are relatively more likely to seek help from the health or mental health care system for work-related stressors compared to workers who have not experienced harassment (Rospenda, 2002). On the other hand, most people who experience sexual harassment do not seek professional help (Rospenda, 2002; Rospenda and Richman, in press). Thus, anti-harassment organizational policies and their enforcement (Richman et al., in press) along with the availability of treatment interventions that consider the full array of potential deleterious outcomes of sexual harassment experiences are needed to address this continuing social problem. Organizational employee assistance programs (EAPs) may be particularly salient for treating individuals with both sexual harassment complaints and related substance use and misuse and can make appropriate referrals for places to file formal grievances as well as receive treatment for psychological distress and substance use and misuse when it accompanies distress. Of particular importance is the need for EAP mental health care professionals (as well as mental health care professionals in general) to recognize and appropriately label sexual harassment when it is brought to the attention of clinicians. However, assurance of confidentiality is critical to the success of EAPs (French et al., 1997) and is of particular importance in the case of stigma-related issues including both sexual harassment experiences and substance use and misuse.

Finally, an exhaustive literature review failed to produce any research on interventions with patients presenting with both sexual harassment experiences and alcohol or other substance use and misuse. Given the high prevalence of sexual harassment experiences and their association with alcohol use and misuse, this constitutes an important area for future attention. It would be useful for residency and continuing education training programs to provide clinicians with the necessary knowledge to diagnose and treat (or make appropriate referrals for) patients who are dealing with the psychological sequelae of sexual harassment as well as manifesting maladaptive coping patterns involving the self-medication of harassment-engendered distress. Courses that integrate current approaches to treating alcohol and drug problems (Allen and Litten, 1999) with the unique issues involved in treating sexual harassment victims such as the avoidance of the secondary victimization of those seeking help (Frazier and Cohen, 1992) and the validation of their feelings (Charney and Russell, 1994) would be of great utility.

Disclosures:

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