



Editor's Choice

Prevalence of Stranger Harassment of Women Veterans at Veterans Affairs Medical Centers and Impacts on Delayed and Missed Care



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A B S T R A C T

Background: Harassment of servicewomen during military service has been well-documented, but harassment of women veterans in Veterans Affairs (VA) health care settings has not been studied systematically. We assessed the prevalence and impacts of harassment among women veterans who use VA health care.

Methods: From January to March 2015, we conducted computer-assisted telephone interviews of randomly sampled women veterans with three or more primary care and/or women's health visits at 1 of 12 VA medical centers. We asked if patients had experienced inappropriate/unwanted comments or behavior from male veterans at VA in the past year. We measured sociodemographics, health status, perceptions of VA care, delayed/unmet health care need, and care preferences. All analyses were weighted to account for the disproportionate sample design and nonresponse. Brief, open-ended descriptions of harassment were transcribed and coded.

Results: Approximately one in four women veterans (25.2%; $n = 1,395$, response rate 45%) reported inappropriate/unwanted comments or behavior by male veterans on VA grounds. Site prevalence ranged from 10% to 42%. Incident descriptions were wide-ranging (e.g., catcalls, sexual/derogatory remarks, propositioning, stalking, and denigration of veteran status). Reports of harassment were more common among women with histories of military sexual trauma; other trauma exposures (e.g., combat, childhood); positive screens for anxiety, depression, and/or posttraumatic stress disorder; and fair/poor health. Those who reported harassment were significantly less likely to report feeling welcome at VA, and more likely to report not feeling safe, and delaying/missing care.

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Conclusions: One-quarter of women veteran VA users experienced harassment in VA health care settings; these experiences negatively impacted women's health care experiences and use.

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Public harassment is the experience of unwanted and intrusive attention that occurs in public places (Wesselmann & Kelly, 2010). Also referred to as sexual harassment, street harassment, or stranger harassment, public harassment includes a range of verbal and nonverbal behaviors such as comments, catcalls, and staring, as well as noises and gestures (Logan, 2015). Approximately two-thirds of women in recent U.S. national surveys reported ever experiencing sexual harassment in public spaces (Kearl, 2014, 2018). In a Canadian study, stranger harassment was found to be more prevalent than harassment by coworkers or others known to the harassee (Macmillan, Nierobisz, & Welsh, 2000). Reviews demonstrate that public harassment is associated with negative mental and physiological effects (Logan, 2015; Kearl, 2014) and may trigger mental health symptoms, particularly in women with a history of sexual trauma (Miles-McLean et al., 2015).

Public harassment is relatively rare in most medical settings. Only 5% of women respondents in a recent national survey reported that they were sexually harassed in a health care setting (Kearl, 2018). Given that sexual harassment is common in the U.S. military (Harris, McDonald, & Sparks, 2018), we sought to examine whether harassment was also prevalent in the settings where many veterans—including women veterans—receive their health care. Between 2005 and 2015, the number of women veterans using VA health care increased 46%, from 237,952 to 455,875 (National Center for Veterans Analysis and Statistics, 2017). Nonetheless, comprising 7.5% of VA patients, women veterans are still vastly outnumbered by men in almost all VA health care environments, including waiting rooms, hallways, and treatment centers. The numeric minority of women veterans has posed challenges for the health care system (Cheney, Dunn, Booth, Frith, & Curran, 2013), especially considering that many women veteran VA users have complex medical and mental health conditions (Suris & Lind, 2008; Washington, Farmer, Mor, Canning, & Yano, 2015), as well as a high prevalence of trauma exposures, including military sexual trauma (MST, which includes both sexual harassment and sexual assault) among at least one-quarter of this subpopulation (Gundlapalli et al., 2017; Klingensmith, Tsai, Mota, Southwick, & Pietrzak, 2014).

As the number of women veteran VA users has increased, VA has developed policies and care arrangements to achieve high-quality care for women veterans. For example, using proficiency criteria, some VA primary care providers are designated as women's health primary care providers, and all veterans are permitted to specify the preferred gender of their primary care provider (Veterans Health Administration (2010)). VA comprehensive "one-stop-shop" primary care clinics provide integrated gender-specific primary and mental health care (Veterans Health Administration (2010)). Furthermore, important services have been put in place to care for individuals with MST histories: MST screening is mandatory, MST coordinators are required at all VA medical centers, and MST-related conditions are treated for free.

Some qualitative studies have found, however, that women veterans experience discomfort in male-dominated VA health care settings (Cheney et al., 2013; Kehle-Forbes et al., 2017; National Academies of Sciences, 2018). To the best of our knowledge,

no studies to date have attempted to quantify the prevalence of harassment of women veterans in these settings. The objectives of this article were to examine the prevalence of self-reported harassment among women veteran VA users, characterize those who reported experiencing harassment, and describe the associations between harassment and women's perceptions of VA care, delayed or missed care, and care preferences.

Methods

Study Design and Sample

To create the sampling frame, we identified 7,708 female veterans in VA's Corporate Data Warehouse medical records database meeting the following inclusion criteria: living female veterans who had three or more primary care or women's health encounters at 1 of the 12 VA Medical Centers (i.e., main hospitals) in the prior 12 months. Based on power calculations, expected nonresponse, and a goal of recruiting 72 respondents per site, we randomly sampled 4,290 women veterans from the sampling frame. All sites were participating in a cluster randomized trial of an evidence-based quality improvement approach to tailoring VA's medical home model to women veterans' health care needs (Yano et al., 2016). In the baseline wave, we excluded 413 records associated with nonworking telephone numbers and nonveterans, and 82 determined to be ineligible (e.g., deceased, medical/cognitive barriers). We were unable to contact or otherwise confirm eligibility for 693 records. Out of the 3,102 verified as eligible, 1,633 did not participate, including 937 who did not consent to participate and 696 who were unable to complete an interview within the survey period. A total of 1,469 veterans consented to participate. We excluded 74 respondents who completed fewer than one-half of the survey items, for a final sample of 1,395 (Figure 1). Our analyses included 1,387 individuals who answered the harassment question. A table that presents characteristics of individuals included in the sampling frame, those confirmed eligible for the study, those who responded to the study, and the final analytic sample is available as a Supplemental Appendix. The overall response rate was 45%, using the American Association for Public Opinion Research response rate calculation (AAPOR, 2016).

Survey Procedures

After approval by the VA Institutional Review Board, we sent eligible women a prenotification packet, including an introductory letter, VA leadership endorsements, a small refrigerator magnet depicting women veterans, and a study brochure that provided the required elements of informed consent. The survey was fielded by a VA-approved vendor. Interviewers made up to 12 attempts to contact potential respondents at varying days and times, using a computer-assisted telephone interviewing system. After contact, they followed an institutional review board-approved script for obtaining verbal consent and optional permissions to link survey responses to medical record data and use of data for future research.

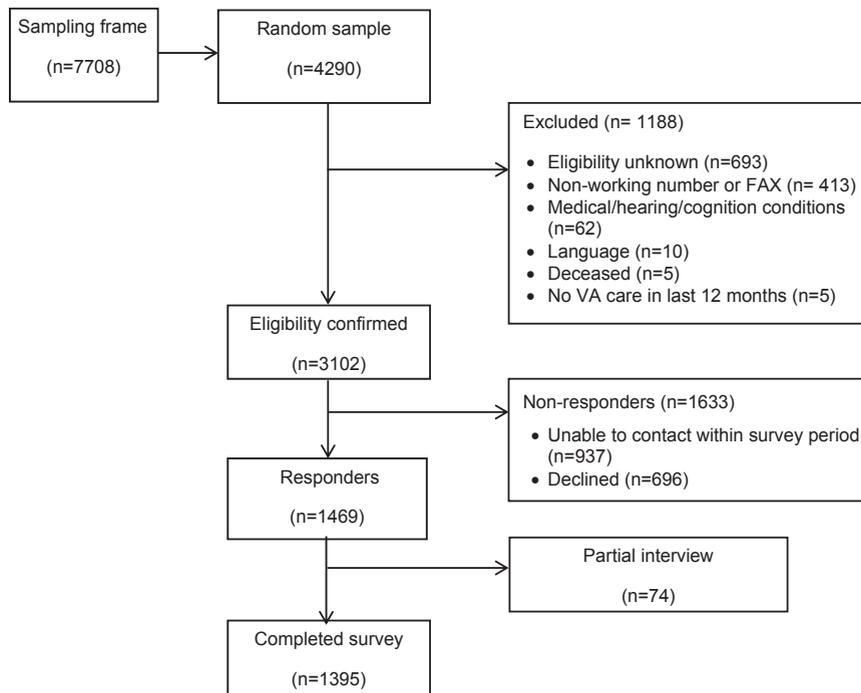


Figure 1. Sample selection.

Dependent Variables

Experience of harassment at VA

We asked respondents the following questions: “How often, if ever, did you feel you experienced inappropriate or unwanted comments or behavior toward you from male veterans?” Responses were never, sometimes, usually, or always. If respondents answered affirmatively to the previous question, they were asked to provide an open-ended response to the following: “To help us understand your experiences, please briefly describe or give an example of when you experienced unwanted comments or behavior from male veterans at VA.” These items were developed for the survey using cognitive interviewing and pilot tested with women veteran VA users who were not part of the study sample.

Feeling welcome at VA

Using an item from the National Survey of Women Veterans (Washington, Bean-Mayberry, Mitchell, Riopelle, & Yano, 2011), participants were asked for their level of agreement with the statement, “As a woman, I feel welcome at VA,” using a Likert scale response. We dichotomized responses (1 [agree strongly or somewhat] vs. 0 [neither agree nor disagree or disagree somewhat or strongly]).

Feeling safe at VA

We asked if there were any areas at their VA where they felt “particularly unsafe, uneasy or concerned about their safety.” Response options included: yes, within the last 12 months; yes, before the last 12 months; or no. This item was developed based on Operation Enduring Freedom/Operation Iraqi Freedom focus groups and pilot tested for this study. We dichotomized responses into any yes (1) versus no (0).

Delayed or missed care

We asked: “[D]id you ever delay, put off, or go without care that you felt you needed, or that was recommended to you by a provider?” (yes = 1 and no/not sure = 0).

Independent Variables

Sociodemographics

We dichotomized age into two categories (18–44 years = 0 vs. ≥ 45 years = 1). We created a single response race/ethnicity variable from self-identified race/ethnicity measures using U.S. Census classifications (U.S. Census Bureau, 2014) and created dummy variables for non-Hispanic White, non-Hispanic Black, and other, which included Hispanic/Latina, other race, and multiple race. We categorized employment status into employed (1) versus unemployed or not in the labor force (0), and marital status as married/partnered (1) versus not partnered (0).

Health status

We asked a validated global self-reported health item: “In general, would you say your health is: excellent, very good, good, fair, poor?” (DeSalvo, Fan, McDonnell, & Fihn, 2005) and dichotomized global health as fair or poor health (1) versus excellent, very good, or good (0).

Trauma exposure

We measured trauma exposure using three combat stressor items from the Deployment Risk and Resilience Inventory (Vogt et al., 2013). Those reporting no combat exposures were asked if they had ever experienced or witnessed actual or threatened death or serious injury to them or someone else. Our dichotomous (1 [yes]/0 [no]) trauma exposure variable was based on

endorsement of either combat exposure or exposure to traumatic life events.

MST

We used the VA two-item measure of MST exposure, calculating a dichotomous variable based on a positive response to either: 1) “Did you ever receive unwanted, threatening, or repeated sexual attention during your military service? Examples of this are touching, cornering, pressure for sexual favors, or inappropriate verbal remarks,” or 2) “Did you ever have sexual contact against your will, or when you were unable to say no during your military service? For example, after being forced or threatened, or to avoid other consequences?” (Kimerling, Gima, Smith, Street, & Frayne, 2007).

Mental health screens

We used the validated Patient Health Questionnaire depression screener (PHQ-2) to measure probable depression (Kroenke, Spitzer, & Williams, 2003) and the Generalized Anxiety Disorder anxiety screener-2 to measure probable anxiety (Plummer, Manea, Trepel, & McMillan, 2016). We used an abbreviated posttraumatic stress disorder (PTSD) checklist (Lang & Stein, 2005) consisting of two elements that were validated for use with women in primary care to indicate probable PTSD (Lang & Stein, 2005). We dichotomized each as screened positive (1) or negative (0).

Analysis

Statistical analysis

We compared respondents who always/usually ($n = 92$), sometimes ($n = 234$), or never ($n = 1,061$) reported experiencing harassment using χ^2 tests of significance. We used multivariate ordinal logistic regression to test for associations between sociodemographics and health characteristics and harassment. We tested the proportional odds assumption using the *omodel* program for generalized ordered logit models (Wolfe and Gould, 1997). We used multivariate logistic regression to test for associations between harassment and feeling welcome, feeling safe, and delayed/missed care, controlling for sociodemographic and health characteristics that were statistically significant on bivariate analysis. Age, race, and health status categories were collapsed as described to avoid empty cells and enable convergence in the multivariate models. All analyses were weighted to account for the disproportionate sample design and nonresponse. We used Stata Version 15 survey features to account for the complex sample design (StataCorp, 2013).

Qualitative analysis

Brief, open-ended descriptions ($n = 326$) of inappropriate/unwanted comments or behaviors were independently coded for incident types by two team members. After an initial review of the responses, codes were developed and responses were coded independently. The coded segments were compared for consistency. Discrepancies were rare and resolved through discussion. The response categories are described herein.

Results

Respondent Characteristics

Sixty-five percent of respondents were 45 years of age or older. The majority of respondents were non-Hispanic White

(55.8%), with more than one-quarter identifying as non-Hispanic Black (28.4%). Nearly 45% reported being currently employed and 37.6% reported being married or partnered. The majority reported being in excellent, very good, or good health (62.4%). Approximately two-thirds screened positive for probable anxiety (63.1%) and MST (61.5%), and one-half for probable depression (55.2%). The majority reported combat or lifetime exposure to trauma (79.7%). More than one-third screened positive for PTSD (41.5%). Most women veterans (89.6%) said they felt welcome at VA. Ten percent reported feeling unsafe at VA in the last 12 months, and one-third (33.6%) reported delaying or missing care (Table 1).

Prevalence of Harassment

Among the 1,387 women veterans who completed the survey, 25.2% reported inappropriate or unwanted comments or behaviors by male veterans at VA in the past year (17.3% sometimes; 7.9% usually/always). The proportion of women reporting incidents of harassment ranged from 10% to 42% across the 12 study sites.

Descriptions of Harassment Incidents

Respondent descriptions of unwanted comments or behaviors are summarized in Figure 2. Respondents most frequently described harassing behaviors (harassment), such as being cat-called, stared at or watched, propositioned, targeted with sexual or derogatory comments, or told that they were too pretty to be a veteran. For example, when describing her experience, a 37-year-old, non-White veteran noted, “In the parking lot, the cat-calling starts right away. The women’s clinic is a long way, and I am bombarded by sexual attention. It is very threatening.” A few described discomfort that affected their ability to obtain care from VA. A 63-year-old White veteran noted, “I was taking swimming therapy and was the only woman there and it got touchy. I got generalized looks, and stupid comments about women in bathing suits. I quit pool therapy.” Others noted the incongruity of sexualized behavior in a health care setting. A 34-year-old non-White veteran, for instance, said: “Getting hit on when I’m there just to see a doctor. That’s not what I’m there for. They try to get in my business and it gets old. It’s unwanted.”

The next most frequent category of responses (question veteran status) consisted of male veterans questioning or denigrating women’s identities as veterans, or their right to access VA care. A 59-year-old White veteran said: “You get the feeling that you shouldn’t be there, not as much as men, and that your service didn’t matter.” A 56-year-old White veteran said: “Not sexual, but they assume that I am not a veteran, but someone’s spouse, and when I tell them that I am a veteran, they start talking about how women should not be in the military.”

In addition, some veterans described incidents that fell into both of these categories (both harassment and question veteran status). To a lesser extent, respondents also described being followed, threatened, or subjected to unwanted physical contact (threatening/criminal behavior). Some respondents mentioned other issues that did not fall into any of these categories (other not stated).

Characteristics of Women Who Experienced Harassment

Women veterans aged 45 and younger and those in the “other” race category were more likely to report frequent

Table 1
 Characteristics of Women Veterans by Frequency of Harassment Experience

	Total (N = 1,387)*	Frequency of Harassment Experience (Past 12 Months)			n	p Value
		Never (n = 1,061)	Sometimes (n = 234)	Usually/Always (n = 92)		
Age group (y)						
18–44	34.6%	71.9%	16.2%	11.9%	367	.0069
≥45	65.4%	76.6%	17.9%	5.6%	1016	
Race/ethnicity						.0305
Non-Hispanic White	55.8%	77.5%	16.6%	5.9%	848	
Non-Hispanic Black	28.4%	74.4%	18.2%	7.4%	319	
Other	15.8%	67.6%	17.3%	15.0%	202	
Employment						.1961
Employed	44.1%	77.6%	15.5%	6.9%	547	
Unemployed/not in labor force	55.9%	72.5%	19.0%	8.5%	832	
Marital status						.2916
Not married or partnered	62.4%	74.2%	17.1%	8.8%	846	
Married/partnered	37.6%	76.5%	17.3%	6.2%	526	
Self-reported health status						.0001
Fair/poor	37.6%	65.8%	22.4%	11.8%	520	
Excellent/very good/good	62.4%	80.3%	14.2%	5.5%	862	
Anxiety (GAD-2)						<.0001
Positive screen	63.1%	67.8%	21.3%	10.9%	828	
Negative screen	36.9%	86.5%	10.9%	2.6%	517	
Depression (PHQ-2)						<.0001
Positive screen	55.2%	69.8%	20.6%	10.6%	741	
Negative screen	44.8%	82.5%	12.9%	4.6%	611	
Trauma history						.0003
Combat/life exposure, yes	79.7%	70.8%	20.0%	9.2%	1091	
Combat/life exposure, no	20.3%	90.2%	6.8%	3.0%	296	
MST						.0011
Positive screen	61.5%	66.6%	22.1%	11.3%	836	
Negative screen	38.5%	88.4%	9.0%	2.6%	527	
PTSD						.0002
Positive screen	41.5%	66.4%	22.0%	11.6%	556	
Negative screen	58.5%	81.0%	13.8%	5.3%	816	
Felt welcome at VA						>.0001
Yes	89.6%	79.8%	15.2%	5.1%	1244	
No	10.4%	30.8%	36.9%	32.4%	124	
Felt unsafe at VA						>.0001
Yes	10.4%	40.2%	27.6%	32.2%	131	
No	89.6%	78.9%	16.01%	5.1%	1249	
Delayed or missed care						.0006
Yes	33.6%	64.1%	23.0%	12.9%	435	
No	66.4%	80.2%	14.6%	5.2%	936	

Abbreviations: GAD-2, Generalized Anxiety Disorder anxiety screener; MST, military sexual trauma; PHQ-2, Patient Health Questionnaire-2; PTSD, posttraumatic stress disorder; VA, Department of Veterans Affairs.

* Eight respondents who did not respond to the harassment question were excluded.

(usually/always) harassment compared to older women and non-Hispanic White and non-Hispanic Black women veterans, respectively. Women veterans with fair or poor self-reported health status, trauma exposures, MST exposure, positive screens for anxiety (Generalized Anxiety Disorder anxiety screener-2), depression (Patient Health Questionnaire-2) or PTSD were more likely to report harassment. Women who

reported that they felt unwelcome at VA, unsafe at VA, or had delayed or missed care were also more likely to report harassment. Marital status and employment were not associated with reports of harassment (Table 1).

Multivariate Predictors of Harassment Experience

Multivariate ordered logistic regression was conducted to predict harassment experience. Holding the other variables constant, the proportional odds of reporting frequent harassment were less for older women and greater for women with fair/poor health, and those with probable anxiety, MST, or other trauma exposures (Table 2). This model does not violate the proportional odds assumption ($\chi^2, 8 = 12.47; p = .1315$).

Association of Harassment With Women Veterans' Health Care Experiences

Multivariate logistic regression models demonstrated that, compared with women veterans who reported that they were

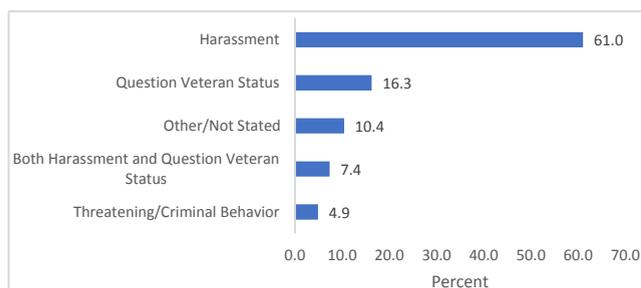


Figure 2. Incident descriptions, percent by category.

Table 2
Multivariate Analyses Predicting Harassment, Feeling Welcome or Unsafe at VA, and Delaying/Missing Care (Adjusted Odds Ratios and 95% Confidence Intervals)

	Model 1 [*]	Model 2 [†]	Model 3 [‡]	Model 4 [§]
	Harassment	Felt Welcome at VA	Felt Unsafe at VA	Delayed or Missed Care
Harassment experience (past 12 months; reference = never)				
Harassment [†]				
Sometimes	— [*]	0.23 (0.12–0.46) [¶]	2.24 (1.67–3.01)	1.45 (0.96–2.17)
Always/usually harassed	— [*]	0.08 (0.04–0.18)	8.04 (4.72–13.69)	1.79 (1.12–2.86) [*]
Age group (reference = ages 18–44)				
≥45	0.84 (0.71–0.99) [#]	1.28 (0.79–2.07)	0.94 (0.58–1.50)	0.62 (0.40–0.97) [#]
Race/ethnicity (reference = other)				
Race/ethnicity [†]			¶	
Non-Hispanic White	0.71 (0.48–1.05)	0.69 (0.32–1.50)	1.11 (0.64–1.90)	0.81 (0.58–1.14)
Non-Hispanic Black	0.88 (0.54–1.42)	1.11 (0.51–2.34)	1.47 (1.04–2.10) [#]	0.87 (0.49–1.56)
Self-reported health (reference = excellent, very good, good)				
Fair/poor	1.63 (1.24–2.14) [¶]	0.71 (0.39–1.28)	0.82 (0.65–1.05)	1.12 (0.81–1.53)
Anxiety (reference = negative screen)				
Positive screen	2.05 (1.44–2.92) [¶]	0.69 (0.35–1.38)	0.89 (0.46–1.70)	1.30 (0.86–1.97)
Depression (reference = negative screen)				
Positive screen	0.99 (0.78–1.27)	0.89 (0.42–1.85)	2.12 (1.06–4.25) [#]	1.47 (0.98–2.21)
Trauma history (reference = negative screens)				
Combat or other life exposures	2.72 (1.78–4.17)	0.48 (0.19–1.19)	1.37 (0.71–2.64)	0.81 (0.60–1.11)
MST positive screen	2.99 (1.73–5.16)	0.59 (0.26–1.35)	2.12 (1.41–3.18) [¶]	2.42 (1.66–3.53)
PTSD positive screen	0.97 (0.63–1.51)	0.77 (0.39–1.28)	2.02 (1.25–3.26) [¶]	1.72 (1.14–2.61) [#]

Abbreviations: MST, military sexual trauma; PHQ-2, Patient Health Questionnaire-2; PTSD, posttraumatic stress disorder; VA, Department of Veterans Affairs.

* Harassment is the dependent variable in Model 1 and thus not included in this regression.

† Adjusted Wald test for overall effect of race and harassment categorical variables.

‡ Multivariate ordered logistic regression analysis.

§ Multivariate logistic regression analysis.

|| $p < .001$.

¶ $p < .01$.

$p < .05$.

never harassed, those who reported harassment were less likely to report feeling welcome at VA, more likely to report feeling unsafe at VA, and more likely to report delayed or missed care (Table 2). In addition, women veterans who screened positive for PTSD, depression, or MST were more likely to report feeling unsafe at VA. Similarly, African American women veterans were more likely to report feeling unsafe at VA than women veterans in the other race category. Finally, older women were less likely to report delayed or missed care, and women who screened positive for MST or PTSD were more likely to report delayed or missed care.

Discussion

Although most women veterans in this study did not report harassment (i.e., inappropriate or unwelcome comments or behavior), approximately one in four reported harassment from male veterans in VA health care settings in the past year. These negative interactions included sexual/derogatory comments and questions about women veterans' identity and their right to use VA care. VA facilities varied widely in the prevalence of reported harassment. Younger women were more likely to report harassment, as were women veterans with self-reported fair or poor health status, those with MST and/or other trauma exposures, and those who screened positive for anxiety. Reported harassment was associated with other problematic health care experiences, including not feeling welcome or safe at VA and delaying or missing care. Although public harassment is a common experience for women in public spaces (Kearl, 2014, 2018), it occurs relatively rarely in medical settings outside VA (Kearl, 2018).

The goal of VA Women's Health Services, the national program office that oversees care for women veterans, is to provide

the "best care anywhere" for women veterans (Hayes, 2011). Specifically, its mission is to make sure that equitable, high-quality, and comprehensive health care in a sensitive and safe environment is available to all women veterans at all VA facilities (Hayes, 2011). Consistent with this goal, VA policy requires care delivery in settings where women veterans can be assured of feeling safe and secure and where they are treated with dignity (Veterans Health Administration (2010)). In addition, Women's Health Services notes the importance of addressing VA culture: "My overarching goal has been to enhance the language, the practice and the culture of VA to be more inclusive of Women Veterans" (Hayes, 2013, p. s495).

Exposure to harassment from fellow patients is not consonant with the goals and policy mandates for delivering care in safe and secure environments. In fact, being harassed in one's health care setting presents a potentially serious concern. Harassment is known to be associated with negative mental and physiologic effects (Logan, 2015; Kearl, 2014) and may trigger mental health symptoms, particularly among those with a history of sexual trauma (Miles-McLean et al., 2015). Furthermore, because public harassment is both unpredictable and unavoidable, its negative impact is believed to be more serious than that of harassment that occurs in situations where the harasser is known to the victim (Macmillan et al., 2000). Harassment that takes place in VA settings therefore may adversely affect the conditions for which women veterans are seeking treatment and may contribute to negative health outcomes, especially for women with high rates of trauma, who in our study were more likely to report harassment. Additionally, research has demonstrated that harassing behaviors, including the use of sexually degrading language, are part of a continuum of behaviors that can contribute to an increased risk of sexual violence (McMahon & Banyard, 2012). Thus, the failure to set behavior boundaries

around verbal aggression can create an environment where physical aggression is more likely to occur (Purcell, Shovein, Hebenstreit, & Drexler, 2017).

VA has made substantial progress in providing high-quality and comprehensive care for women veterans. It has been a leader in the reduction of many if not most gender disparities in clinical processes of care (e.g., depression and PTSD screening rates; Whitehead, Czarnogorski, Wright, Hayes, & Haskell, 2014), and access to care has markedly improved. For example, most women veterans who perceive need for mental health services receive these services (Kimerling et al., 2015). The goal of providing a safe and sensitive environment, however, has been more challenging to address (Hayes, 2013). Characteristics of the VA patient population and settings likely contribute to the variation in prevalence of harassment by VA site and difficulties in addressing public harassment more generally. In addition to the male-dominated nature of VA inpatient and outpatient services, some VA Medical Centers provide residential care for segments of the mostly male veteran population, resulting in men veterans residing on-site at some VA or VA-contracted facilities. Some of these residential patients may be complex, with a high prevalence of PTSD, substance use disorders, and other mental health problems (Purcell et al., 2017). Furthermore, for many men veterans, VA serves as a social setting where they spend time for nonmedical reasons. Elements of a masculine military culture may linger at VA, and this culture may be highly resistant to change (Buchanan, Settles, Hall, & O'Connor, 2014). In addition, legislation that prohibits banning disruptive VA patients was enacted in 2011 (Hodgson, Mohr, Drummond, Bell, & Van Male, 2012).

Women who reported harassment in the current study were more likely to feel unwelcome at VA, a measure that has been associated in prior research with unmet health care need (Washington, Bean-Mayberry, Riopelle, & Yano, 2011), increased reliance on non-VA care (Washington, Yano, Simon, & Sun, 2006), attrition from VA care altogether (Hamilton, Frayne, Cordasco, & Washington, 2013), and a sense of not belonging at VA (Washington et al., 2015). Our study extends these results by demonstrating that harassment is directly associated with delaying/missing care, consistent with research that shows that harassment is associated with avoidance of locations where it occurs (Kearl, 2014). Delaying or missing needed health care services may place women veterans at risk of poorer health outcomes. If a subset of women veterans is not accessing services in a timely way, the quality gains VA has achieved to date are potentially at risk of not being sustained over time.

This study is subject to several limitations. First, limitations are inherent in survey research and use of cross-sectional data. To mitigate potentially biasing effects from over- or under-reporting that apply to survey research in general (Tourangeau, Rips, & Rasinski, 2000), we followed established best practices for encouraging unbiased and honest recall (Biemer, 2010; Tourangeau et al., 2000), yet we lack any way to verify reported experiences. Second, perceptions of what constitutes negative interactions may vary. It is possible that women with trauma histories, including MST, may be more likely to experience an incident as negative and to later remember and report the incident. Third, to ensure familiarity with the VA primary care environment, we sampled patients with three or more visits, which may have skewed the sample toward higher users, but studies have found that this frequency of use is average among women veterans seen in VA (Frayne et al., 2012). Fourth, our response rate was moderate. Although we used data from the

sampling frame to adjust for nonresponse, our nonresponse weights may only partially account for nonresponse bias. Fifth, it was necessary to rely on collapsed indicators for age, race/ethnicity, and health status to enable convergence of the multivariate model. Finally, our sample was drawn from 12 diverse urban and rural VA Medical Centers across 9 states, and thus our findings may not be generalizable to other locales or patients who obtain VA care less often. In addition, although there was considerable variation in harassment rates across sites, this study was not powered for site-level comparisons. Despite these limitations, this study substantially extends prior research on the topic of public harassment by examining the prevalence of harassment in health care settings (Fairchild & Rudman, 2008; Logan, 2015; Kearl, 2014).

Implications for Practice and/or Policy

Because this study was part of a larger partnered research initiative—the Women Veterans' Healthcare CREATE Initiative, funded by VA (Yano, 2015)—these findings were presented to VA health care leaders as soon as they were discovered. VA Women's Health Services has an ongoing campaign to change the environment and culture of VA to be more inclusive, welcoming, and respectful of women veterans. In response to these findings, VA Women's Health Services enhanced this work by establishing a national workgroup, gauging effective harassment reduction programs outside VA, convening an expert panel, and piloting and evaluating harassment interventions. This work is ongoing. Guidance on how to combat public harassment in health care settings, however, is limited. There is an extensive literature that addresses sexual harassment of women in the workplace (Ilies, Hauserman, Schwochau, & Stibal, 2003; Willness, Steel, & Lee, 2007) and a growing literature on public harassment (Lennox & Jurdi-Hage, 2017; Logan, 2015; Macmillan et al., 2000; Kearl, 2014; Wesselmann & Kelly, 2010). Research has also addressed sexual harassment of women in service industries (Yagil, 2008), and violence and sexual harassment of staff in medical settings (Blando, Ridenour, Hartley, & Casteel, 2015; Hesketh et al., 2003). Nonetheless, rates of harassment remain high, perhaps because effective programs have not been identified (Blando et al., 2015; Phillips, 2016; Schindeler & Reynald, 2017). Additional guidance on how to address patient-on-patient harassment needs to be developed.

VA has a special obligation in this arena, given the potential for symptom exacerbation and retraumatization of women in its own corridors and canteens, in addition to the importance of creating a welcoming and healing environment for all its veterans. Additional research on the extent and frequency of various types of harassment, whether specific subgroups of veterans disproportionately experience harassment (e.g., racial, sexual, cultural, or gender minorities), factors that contribute to the variation in harassment by site, and the role that VA staff and volunteers may play in addressing the problem is needed.

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Supplementary Data

Supplementary data related to this article can be found at <https://doi.org/10.1016/j.whi.2018.12.002>.

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