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Aggression in the Workplace

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Sexual Harassment: A Case of Workplace Aggression

by BARBARA LONG, MD, PhD

Sexual harassment laws, which were implemented under Title VII of the 1964 Civil Rights Act, were intended to protect employees from the adverse consequences of gender-related workplace discrimination. In 1980, the Equal Employment Opportunities Commission (EEOC) defined two actionable types of sexual harassment: quid pro quo and hostile work environment.¹ Briefly, the former means that employees had to submit to unwelcome sexual advances in order to accrue benefits from management (eg, promotions) or avoid adverse employment decisions (eg, termination). The latter means that (1) there was unwelcome gender-based sexual conduct that was pervasive enough to alter the terms and conditions of employment,² and that (2) management knew or should have known about it, but did nothing to eliminate the problem.³

A further legal refinement included the "reasonable woman" standard⁴ for examining the particular workplace environment. This standard asks if a "reasonable woman" would conclude that there was sexual harassment that created a hostile work environment. Importantly, the employee need not prove (1) that the behavior occurred (an allegation suffices), (2) that he or she was the direct object of the behavior, or (3) that he or she suffered any direct injury as a result of the behavior, in order to recover unlimited financial rewards, including punitive damages against the employer if malice is found by the trier-of-fact.

The legal focus, with its political and economic ramifications, has, in some ways, impeded progress in understanding the psychology of

sexual harassment. An educational focus, which seeks knowledge for its own sake, offers an alternative pathway free of such interference. In the sections that follow, the latter approach will be used in exploring three different ways to examine sexual harassment psychologically as a manifestation of inappropriate aggression in the workplace.

AN INTERPERSONAL MODEL

The Interpersonal Model examines sexual harassment within the context of the larger set of relationships linking the individual to others, both inside and outside the workplace. This model describes some of the subtle psychological forces that operate among harasser, harassee, the employer, and others. The case illustrates how both management and employee, when faced with the problem of gender-related aggression at work, can behave in ways that compound rather than relieve the problem.

The Case Of Ms. X:

Ms. X, a 45-year-old white woman, was one of a handful of women employed by a soft drink beverage bottling plant, where she had worked on the packaging line since graduation from high school. Through the years, she sought promotions unsuccessfully, though her performance reviews were always good. The workplace was characterized by sexual jokes, banter, and pranks (spraying each other with syrup, for example), in which Ms. X regularly participated. For the first 25 years of her employment, she had never voiced any complaints about the behavior of coworkers. However, in October of 1993, she was promoted to a lead position over many of her former peers. Unfortunately, she did not enjoy her new responsibilities, which she did not perform well.

Ms. X had known her supervisor, Mr. Y, for her entire tenure with the company. He held traditional views toward women and had reservations about her promotion, but tried unsuccess-

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cessfully to help her by monitoring her closely and giving her performance reviews that emphasized her good efforts and other strengths and avoided documenting deficits.

Meanwhile, some of her previous coworkers, who were now her supervisees, expressed anger and envy about her promotion. Derogatory comments and cartoons referring to Ms. X's age, gender, and physique began to appear. When she complained to Mr. Y about these behaviors, an investigation was begun, but the culprits were never identified. Gradually, Mr. Y noticed that Ms. X became more distant, "cold," and uncommunicative. In his office, Mr. Y inquired about the reason for this change, but Ms. X curtly replied, "Nothing". Mr. Y offered his support and hugged her.

When Mr. Y retired, the company was attempting to reverse longstanding financial losses and hired Mr. Z, a 35-year-old, tough, "hands on" manager. Ms. X's performance did not meet Mr. Z's standards and she was warned that if her performance did not improve, she would be terminated. Ms. X began to call in sick and present herself to her family physician with vague symptoms having no organic basis. Medical notes attributed her symptoms to work and personal stress. When she complained of feeling "sexually harassed," the physician honored her request for short-term disability on the basis of "PTSD caused by sexual harassment at work" and referred her to an attorney.

Through her attorney, she issued a formal complaint to her employer about Mr. Y, Mr. Z, and her coworkers, and began therapy with an "abuse" social worker therapist, on whose intake form Ms. X endorsed every symptom listed from the *Diagnostic and Statistical Manual, Fourth edition* (DSM-IV) diagnostic criteria for PTSD.⁵ The therapist never referred Ms. X for psychological testing or psychiatric medication, but recommended individual and group therapy. Sessions focused on litigation and financial and marital problems, including spousal abuse, drug addiction, and unemployment.

The company, aware of her official complaint against Mr. Z and others but unaware that she intended to initiate a lawsuit, offered her a newly vacated position in the laboratory. She initially declined the offer but later changed her mind. By that time, however, the company had already filled the position. The company offered to return her to her old lead position (on probation) or her original position on the line. In either alternative she would not have to report to Mr. Z. Ms. X, paralyzed by indecision, did not respond within the required 30 days and was terminated by the company. She filed her lawsuit with claims including constructive discharge, sexual harassment, retaliation, and hostile work environment. Ms. X and her attorney asked the therapist to testify as a forensic expert while continuing to function as her treater, never realizing the conflict of interest inherent in this role duality.⁷ The therapy notes

became the basis for the "expert opinion," which declared Ms. X to be permanently disabled by PTSD caused by "cumulative stresses associated with sexual harassment in the workplace."

Same Behaviors, Different Viewpoints

Ms. X expressed resentment that she had been denied promotions for 25 years. She felt that the company neither investigated adequately her complaints nor enforced their policies against sexual harassment, which she felt had continued unabated until she left the workplace. She felt that Mr. Y's embrace during her moment of vulnerability was inappropriate and embarrassing and that many of her performance problems related to poor training, although she acknowledged not liking her new job and missing the camaraderie of her old job. She resented Mr. Z's harsh management style, which contrasted boldly with that of Mr. Y, and which she felt further compromised her authority and confidence. Ms. X said that she delayed filing her complaint and leaving the workplace because she needed the job and its benefits and hoped things would change. She admitted that her position was galvanized by input from her attorney, treater, and the legal process itself.

The company was astonished to learn of her longstanding grudges and claim of disability for work-related stress. Management felt angry and betrayed by her lack of communication and abrupt initiation of litigation. From their viewpoint, her promotion was a failure. Ms. X was obviously unhappy, and her performance showed it.

Mr. Y had attempted to support Ms. X but felt awkward in their new relationship. He had intended his hug to be reassuring, and, in the absence of any data to the contrary, assumed that she had experienced it the same way. His investigation of her complaints had yielded nothing specific, so he warned all male subordinates. However, rather than ceasing, the problem intensified and became more covert. Ms. X did not inform anyone that the problem was continuing, and Mr. Y thought that the problem had resolved. Mr. Z acknowledged his uncompromisingly high standards, which he applied to himself and all other employees. He felt that the company's economic survival depended on everyone's performance. Those who did not measure up were terminated.

For Ms. X's peers, initially, the workplace "horseplay" provided an outlet for sexual and aggressive impulses of the employees. The tone and context of such events initially was playful and provided (as is commonly the case) a distraction from tedious, monotonous, and/or dangerous work, as well as a way to communicate affection and acceptance by the group. However, what is tolerable in one context can be intolerable in another. In Ms. X's case, the context changed when she was promoted over her peers. The same pranks became infused with sexual and competitive aggression, such as that seen in

children or adolescents who rebel against parental authority figures or sibling rivals. Complex feelings of envy, jealousy, and loss, along with fear of Ms. X's new power, had changed the meaning of the behaviors. In her new position, Ms. X and her peers worked in isolation. The lack of opportunities for interaction with her new peers intensified her feelings of failure and rejection by her old peers.

Ultimately, Ms. X left the workplace on a medical leave of absence. Such use of the "sick role" is common in sexual harassment cases. This important interpersonal role provides "primary gain" through relief of psychological discomfort and "secondary gain" through compensation and the avoidance of unpleasant job duties or interpersonal interactions. It can be also, in and of itself, an act of aggression toward the employer.

As in Ms. X's case, the employee usually presents to the physician with vague symptoms such as headaches, chest pain, stomach aches, and fatigue. The physician appropriately explores a possible medical basis for these complaints but turns up nothing and does not recognize the aggression beneath the patient's symptoms. The physician on hearing the patient's complaints of workplace stress, grants a medical leave of absence and/or disability. Antidepressants or anxiolytic medications may be prescribed and counseling recommended, often with no referral for psychiatric evaluation or follow-up for medication monitoring. The patient feels better, runs out of medication, and relapses.

If litigation is initiated, the medical intervention becomes a way for the individual and attorney to establish a case of mental and emotional "damages" caused by the workplace. For the employee, seeking help from a physician rather than the employer may be the best or only apparent option at the moment. However, this choice, as in Ms. X's case, preempts any remedial action by the employer. If the choice is even partly a legal manipulation, the employee's psychological and physical problems, whether they are valid, fictitious, or malingered, may be falsely attributed to the employer while other causal factors are ignored or minimized. The physician's leave of absence is used as proof of this causal linkage, and the physician soon becomes drawn into the legal fray. Whenever a treater becomes involved in a patient's legal process, there is risk to the therapeutic relationship. Therefore, the physician is wise to obtain a psychiatric consult for a second opinion about the question of "disability." Moreover, whether or not the leave of absence/disability is deemed appropriate, referral for psychiatric follow-up and treatment can help the patient resolve the anger and other psychological causes of the physical symptoms as well as decrease the overutilization of medical resources for problems whose etiologies are emotional and/or legal.

INTRAPSYCHIC DIMENSIONS OF SEXUAL HARASSMENT

Examining the intrapsychic origins of "sexual harassment" behaviors reveals an internal dynamic tension between oral/nurturance-seeking, aggressive/competitive, and sexual/affiliative drives. Individuals first develop ways of responding to these drives through relationships with mother, father, and siblings (or their surrogates). These patterns are re-enacted later in workplace relationships.⁶ Regardless of position or gender, maladaptive idiosyncratic behaviors and reactions toward the same or opposite sex employees can usually be traced back to relationships with mother, father, or siblings.

Accordingly, individuals, coworkers, supervisors, and management all have different perspectives on the same sequence of events. Usually transference and countertransference reactions form the basis by which earlier developmental problems become re-enacted in workplace relationships.

The supervisor may react to the supervisee as child, sibling, or parent. The supervisee as "child" may evoke parental-like protective and nurturing feelings in the supervisor, or the supervisor may look to the supervisee for such nurturance and support. The supervisor may experience conscious or unconscious feelings of attraction to the supervisee. If this attraction is required, a consensual sexual relationship may develop, with all the attendant risks, including coworker reactions of jealousy, envy, or parental overprotectiveness. If the sexual relationship ends, feelings of loss, rejection, or guilt may result in depression, anxiety, or other symptoms in either party. Attendance or performance may decline along with workplace "morale." The situation may lead to transfers, termination, or probation. Jealousy or a desire for revenge may lead to inappropriate aggression. The supervisor may express this directly through hostile or sarcastic remarks and unrealistically harsh performance reviews, or indirectly through actions designed to evoke jealousy in the supervisee (such as displaying photos of a new girlfriend). The supervisee may express aggression indirectly through tardiness or excessive sick-leave, or directly through excessive or unfounded complaints to management or litigation, which recasts the former love relationship as "sexual harassment" by the "superior."

If the supervisor's feelings are not required, but he or she continues to make advances, the sexual impulses are joined by aggressive competitive drives to master, conquer, or control the supervisee. Often this sadistic turn of events is related to underlying feelings of sexual humiliation and associated rage.

Ambiguous behaviors by either supervisor or supervisee can create awkwardness and tension in the workplace. Misperceptions and misunderstandings can result in inappropriate overtures and negative feelings that may require intervention by management. Because management positions involve authority, man-

agers, and by extension, the employer, are usually viewed as parental figures toward whom subordinates react accordingly—either as submissive children or rebellious adolescents. Managers, in turn, respond to subordinates based on their own family experiences, whether constructive or destructive.

INDIVIDUAL RESPONSES TO SEXUAL HARASSMENT

As discussed in the prior section, sexual harassment may be viewed as inappropriate aggression evoked by competing oral, aggressive, and competitive drives. These same internal drives create psychological responses in the sexual harassment recipient. Psychiatrists, like other physicians, marvel at the capacity of humans to respond and adapt to internal and external forces that threaten health and homeostasis. Such responses, which may be behavioral, affective, and cognitive, may be adaptive (promoting mental health) and maladaptive (promoting mental illness), or neutral (promoting mental health or illness depending on the context and individual).

Individual Defense Mechanisms and Responses to Sexual Harassment

All humans have intrapsychic defense mechanisms that, if successful, protect the individual from emotional symptoms that otherwise might result in mental illness and impairment in social or vocational functioning. Both the nature and resilience of an individual's defense mechanisms are the most important determinants of his or her responses to workplace stress. Just as the responses may be adaptive, maladaptive, or neutral, similarly the defense mechanisms that support the responses may have these same dimensions and consequences for mental health.

Neutral defense mechanisms, which may have adaptive or maladaptive consequences, include denial, encapsulation, intellectualization, rationalization, and reaction formation. These defenses can be adaptive if they protect the employee from the destructive consequences of workplace aggression. For example, through denial, the person may respond with indifference to inappropriate sexual remarks or behaviors. The mechanism of encapsulation compartmentalizes the problem so that it does not overshadow the individual's life. Intellectualization and rationalization may be successful in providing a "perspective" on what occurred. Reaction formation may lead to a religious or "moral" stance toward harasser and offensive behavior. Faith may provide an adaptive coping mechanism such as forgiveness, or may result in a maladaptive "righteous" stance which rationalizes actions, like litigation, in the name of social or political "justice." Adaptive defenses may include humor, sublimation and repression. Maladaptive defense mechanisms may include projection, projective identification, suppression, splitting, psychosis, displacement, idealiza-

tion/devaluation, neurotic symptoms, and compulsions. These defenses may ward off further psychological symptoms, but may compromise the individual's social, vocational, or personal functioning. These defense mechanisms also rarely improve the individual's ability to get along with others and thus may not relieve tensions at work. Harassment may, in fact, increase as both harasser and harassee become increasingly defensive and adversarial, rather than open and conciliatory.

Adaptive responses to harassment may be behavioral, affective, or cognitive in nature. Adaptive behavioral options include conveying cordial but firm limits, reporting the harasser to management, confronting, minimizing contact, and deflecting the comments through humor or repartee. Neutral behavioral responses, which may be adaptive or maladaptive, include returning pranks, ignoring the behavior, and expressing anger. Adaptive affective responses are neutral—ie, they contain an absence of negativity. This means that the interpersonal workplace aggression did not arouse past unresolved psychological conflicts and feelings or evoke defensive or maladaptive reactions that consume psychological energy. There are three major adaptive cognitive responses. These include analysis of one's behavior, analysis of the harasser's behavior and possible motivations, and consideration of personal options and the likely consequences of those options.

As an individual reacts to changing circumstances, there is interaction between the cognitive, affective, and behavioral processes. An individual's responses, if adaptive, can help prevent or decrease psychological or somatic symptoms and possibly diminish the harassing behavior by others. Moreover, self-esteem can be enhanced if the employee has processed feelings and thoughts and has selected behaviors that seek to resolve the workplace tensions in a conciliatory rather than adversarial fashion. If resolution is unlikely or has already failed, conflict avoidance or other measures may be the only practical options.

Maladaptive Responses

Most maladaptive responses reflect problems in constitution or environment. There may be a genetic predisposition to schizophrenia, affective disorders, or other mental disorders. Environmental events can profoundly affect later behavior, feelings, and thoughts. Examples include excessive losses, such as deaths of family members or friends, frequent geographical moves, physical trauma, psychological trauma, such as early life neglect or physical/sexual abuse, chemical dependency in the family, or parental neurosis or psychosis. Within such difficult family circumstances, a child usually has little, if any, ability to change or escape the situation and realistically feels powerless. Later interpersonal problems at work may recapitulate this feeling of helplessness and result in

maladaptive behavioral, affective, cognitive, or somatic responses. Maladaptive behavioral responses include chemical dependency, physical aggression toward others, self-inflicted injury, inappropriate and or destructive sexual activities, or self-defeating behaviors that express anger indirectly such as deliberately being inefficient, obstructing, forgetting to do work, or procrastinating. Maladaptive affective responses include psychotic or non-psychotic depressive episodes, manic episodes, severe anxiety, overgeneralized or excessive anger outbursts, and impotent rage, which may be expressed passive-aggressively. The latter is particularly characteristic of individuals who label themselves "victims." Some of these affective responses have strong genetic determinants. Others, such as inappropriate anger, may reflect problems in personality or early life development. Maladaptive cognitive responses include psychotic thinking, self-depreciation, and obsessions about revenge, self-harm, or homicide. Cognitive behavioral therapy, medications, and hospitalization, if there is a substantial risk of suicide or homicide, can relieve painful emotional symptoms evoked by cognitive disturbances. As discussed in the previous section, reliance on the "sick role" through the development of somatic symptoms or chronic

pain is a common, though maladaptive, pathway for channeling stress from any source.

SUMMARY

This article has examined briefly a number of dimensions of sexual harassment as a manifestation of workplace aggression. The interpersonal and intrapsychic models presented some of the complexities surrounding the behaviors commonly described as sexual harassment, as well as the responses that the behaviors evoke. Further research and education, as an alternative to litigation, offer the best hope of understanding and solving this problem and reducing its economic, mental, medical, and legal costs to society.

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