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Unraveling the genetic architecture of migraine: exploring the vascular components

Boer, I. de

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CHAPTER 14

Harassment in the headache field: a global web-based cross-sectional survey

Irene de Boer¹, Anna Ambrosini², Rashmi B. Halker Singh³, Betül Baykan⁴, Dawn C. Buse⁵, Cristina Tassorelli^{6,7}, Rigmor H. Jensen⁸, Patricia Pozo-Rosich⁹, Gisela M. Terwindt¹ on behalf of the International Headache Society Women's Leadership Forum

Affiliations:

¹Department of Neurology, Leiden University Medical Center, Leiden, The Netherlands

² Headache Unit, IRCCS Neuromed, Pozzilli (IS), Italy.

³ Department of Neurology, Mayo Clinic, Scottsdale, Arizona, USA.

⁴Department of Neurology, Istanbul University, Istanbul Faculty of Medicine, Istanbul, Turkey.

⁵Department of Neurology, Albert Einstein College of Medicine, Bronx NY, USA

⁶Headache Science & Neurorehabilitation Center, IRCCS C. Mondino Foundation, Pavia, Italy; ⁷Department of Brain and Behavioral Sciences, University of Pavia, Pavia, Italy

⁸Department of Neurology, Danish Headache Centre, University of Copenhagen, Rigshospitalet Glostrup, Glostrup, Denmark.

⁹Headache Unit, Neurology Department, Vall d'Hebron University Hospital, Barcelona, Spain; Headache and Neurological Pain Research Group, Vall d'Hebron Research Institute, Department of Medicine, Universitat Autònoma de Barcelona, Barcelona, Spain.

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Abstract

Background: Matters of workplace harassment are an important issue. This issue needs to be recognized and studied to prevent occurrences. These important sensitive areas of effective workplace management are increasingly gaining more interest. We aimed to identify the prevalence of workplace sexual, verbal and physical harassment among headache professionals.

Methods: We adopted a cross-sectional exploratory survey approach with quantitative design. The survey was distributed electronically among headache healthcare and research professionals globally through the International Headache Society (IHS).

Results: Data were obtained from 579 respondents (55.3% (320/579) women). A large percentage of respondents (46.6%, 270/579) had experienced harassment, specifically, 16.1% (93/578) reported sexual harassment, 40.4% (234/579) verbal harassment and 5.5% (32/579) physical harassment. Women were almost seven times more likely to experience sexual harassment compared to men (Odds ratio: 6.8 [95%CI 3.5-13.2]). While women did also more frequently report other types of harassment, this was not statistically significant (Odds ratio: 1.4 [95%CI 1.0-2.0]).

Conclusion: Lifetime exposure to workplace harassment is prevalent among headache professionals, especially in women. This study uncovers a widespread issue and calls for strategies to be implemented for building a healthy and safe workplace environment.

Introduction

Although not always recognized, healthcare as an industry is predisposed to harassment.¹⁻⁴ In some cases, this may be related to differences in economic status, prestige and power.⁵⁻⁷ Not only can this problematic behavior affect victims severely,^{8,9} but it may also influence patient outcomes. A consistently positive association has indeed been found between a positive workplace environment and positive patient outcome across multiple studies.^{10,11}

Harassment in the workplace can take many forms, including behaviors which affect an individual's employment, cause employee discomfort, impact work environment, or interfere with work performance. Verbal harassment in the workplace includes insults, disrespectful or unpleasant jokes, name calling and unjustified and/or public criticism. Physical harassment encompasses behavior such as damaging property, threats and assaults. Sexual harassment includes requests for sexual favors, and other undesired or unsolicited verbal or physical behavior of a sexual nature.

Excluding quid pro quo cases of sexual coercion and other behavior with obviously bad intent, to a certain degree, the problem of harassment can result from differences in perception. In a proportion of cases, the perpetrator has different beliefs on the offensiveness of their behavior. What is considered innocuous by one individual is not perceived that way by another. This difference in threshold concerning acceptable behavior inevitably leads to disputes. To be deemed unlawful, harassing conduct must objectively be viewed as creating a hostile work environment; however, the perspectives of the person being harassed are still very important and should always be considered. In the American court system, often the 'reasonable person' standard is used. With this standard, in addition to the behavior being unwelcome and affecting the work environment of the victim, an objective reasonable person's perspective would also view the behavior as harassment.¹² Of course, this remains a subjective matter, which is greatly influenced by who this reasonable person is.^{12,13}

Harassment is prevalent in the medical profession.^{5,14-17} In academic and workplace environments in medical institutions and practices, harassment can for instance occur both in teacher–student relationships and in manager–employee relationships, involving students and trainees, medical personnel, managers, and academic faculty. Shockingly, a meta-analysis of 51 studies demonstrated that nearly 60% of medical students and trainees had experienced harassment or discrimination during their training, with female students and trainees being targeted more often than men.¹⁶

In an academic sample of clinician-researchers, one-third of women reported sexual harassment compared to four percent of men.¹⁷

Being subjected to workplace harassment has been associated with many negative effects, such as increase of depressive symptoms, lower levels of vitality, employee discomfort, lower levels of job satisfaction and sense of safety at work, higher ethical or moral distress, increased turnover intentions and suicidal behavior.^{8,9,18-20}

Efforts to curtail this type of behavior are particularly challenging. Perpetrators often hold senior leadership and supervisory positions. This contributes towards the fact that people who experience work-based sexual harassment seldom file complaints or report their experiences.²¹ Moreover, other factors such as stigma, fear of consequences and difficulties in proving allegations all play important roles in this.^{22,23}

Discussing these behaviors in our own field is often uncomfortable. Nonetheless understanding what happens, where, when, and to whom, is essential for efforts to transform culture and to eradicate problematic behaviors. We therefore aimed to determine the prevalence and potential risk factors of workplace sexual, verbal, and physical harassment among headache professionals.

Method

Design and setting

Using a nonexperimental crosssectional exploratory survey approach with a quantitative design, we conducted a global-wide survey aimed at headache professionals, including medical doctors, other healthcare providers, and all those that are involved in the field of headache research. This study was part of a previously published effort to determine relevant career barriers for headache professionals.²⁴ In short, (associate) members of the International Headache Society (IHS), and delegates of the 2019 International Headache Congress (IHC) were sent the web-based survey by email. Additionally, associate national headache societies affiliated with the IHS were requested to send out the survey to their members. The survey was conducted anonymous and voluntary.

Survey development

The survey was developed in English and used previously published surveys,^{25,26} and the experience of authors (IdB, AA, RHS, BB, RHJ, PPR, GMT). Consensus on the content of the questionnaire was reached by online discussion and email communication. The survey collected basic demographic information including country of birth and information on whether respondents had experienced harassment, the severity and perpetrator of harassment, and on if/how they responded as well as other information which has been analyzed and reported separately.²⁴ Finally, participants were asked how they responded to witnessing sexual harassment/being a bystander to sexual harassment. The web-based survey was first sent in September 2019 and closed in June 2020 after three reminders were sent to motivate partaking.

Data Analyses

Data was analyzed using SPSS 25.0 (IBM Corporation, Armonk, NY). All questionnaires were examined for invalid responses as well as inconsistencies, which then were considered missing values. Descriptive statistics were used to capture demographic data. Primary outcomes were reported as percentages. To identify risk factors for experiencing sexual harassment and other types of harassment, we conducted logistic regression analyses on the following demographic characteristics as independent variables: age at time of survey completion, gender, race/ethnicity, region of employment and marital status. Risk factors are reported with odds ratios (ORs) with associated 95% confidence intervals (CIs). Results were considered significant if $p < 0.05$.

Table 1. Demographics respondents

	Breakdown by gender		
	Women (n=320)	Men (n=259)	Total (n=579)
Age ^a			
18-30	32 (10.0)	13 (5.0)	45 (7.8)
31-40	100 (31.3)	90 (34.7)	190 (32.8)
41-50	100 (31.3)	64 (24.7)	164 (28.3)
51-60	61 (19.1)	52 (20.1)	113 (19.5)
>60	27 (8.4)	37 (14.3)	64 (11.1)
Gender ^b			
Women	-	-	320 (55.3)
Men			259 (44.7)
Geographic location – birth ^c			
Africa	5 (1.6)	18 (6.9)	23 (4.0)
Eastern Mediterranean	11 (3.4)	8 (3.1)	19 (3.3)
Europe	147 (45.9)	82 (31.7)	229 (39.6)
North America	42 (13.1)	36 (13.9)	78 (13.5)
South America	33 (10.3)	22 (8.5)	55 (9.5)
South East Asia	55 (17.2)	71 (27.4)	126 (21.8)
Western Pacific	27 (8.4)	22 (8.5)	49 (8.5)
Geographic location – workplace			
Africa	1 (0.3)	17 (6.6)	18 (3.1)
Eastern Mediterranean	11 (3.4)	7 (2.7)	18 (3.1)
Europe	145 (45.3)	81 (31.3)	226 (39.0)
North America	46 (14.4)	37 (14.3)	83 (14.3)
South America	34 (10.6)	21 (8.1)	55 (9.5)
South East Asia	51 (15.9)	70 (27.0)	121 (20.9)
Western Pacific	32 (10.0)	26 (10.0)	58 (10.0)
Ethnicity			
Asian/Pacific islander	67 (20.9)	88 (34.0)	155 (26.8)
Black/African American	0 (0)	14 (5.4)	14 (2.4)
Hispanic	12 (3.8)	11 (4.1)	23 (4.0)
White/Caucasian	215 (67.2)	125 (48.3)	340 (58.8)
Multiple ethnicities	13 (4.1)	2 (0.3)	15 (2.6)
Other	13 (4.1)	19 (7.3)	32 (5.5)
Marital status			
Divorced/separated	21 (6.6)	7 (2.7)	28 (4.8)
Married/long-term relationship	248 (77.5)	231 (89.2)	479 (82.7)
Single	46 (14.4)	20 (7.7)	66 (11.4)
Widow(er)	5 (1.6)	1 (0.4)	6 (1.0)
Children			
Yes	211 (65.9)	205 (79.2)	416 (71.8)
Participation in clinical activities			
Yes	305 (95.3)	251 (96.9)	556 (96.0)
Participation in research activities			
Yes	264 (82.5)	216 (83.4)	480 (82.9)
Participation in academic career			
Yes	219 (68.4)	157 (60.6)	376 (64.9)
No longer	41 (12.8)	38 (14.7)	79 (13.6)
Never	60 (18.8)	64 (24.7)	124 (21.4)

^a Three participants preferred not to disclose their age. ^b One participant reported a non-binary gender identity. As results are separately reported based on gender, we had to exclude this participant to ensure anonymity. ^c Participants with difference in location birth and workplace: n=38 (6.6%).

Results

Participant demographics

A total of 580 participants completed the survey. One respondent identified with the non-binary gender identity. To ensure anonymity, this participant was removed from subsequent analyses. Just over half of participants were women (55.3% 320/579). The highest percentage of responders was from Europe (39.6% 229/579), the second most represented region was South East Asia (21.8% 126/579) followed by North America (13.5% 78/579). Only a minority, 4.0% (23/579) and 3.3% (19/579) were born in African and Eastern Mediterranean countries, respectively. In total 556 (96.0%) of the respondents were healthcare providers and 480/579 (82.9%) participated in research. Moreover, the majority of respondents participated in both clinical and research activities (79.1% 458/579). The majority of respondents have or had an academic career path (78.5% 455/579). The majority of participants were in a relationship (82.7% 479/579), and had children (71.8% 416/579). Additional respondents' characteristics can be found Table 1. Almost half of respondents indicated that they had experienced harassment in the workplace (46.6% 270/579). For participants who considered themselves healthcare providers this was 46.6% (259/556), while for those participating in research or academics it was 41.0% (197/480) and 46.8% (213/455) respectively.

Prevalence, severity and perpetrators of sexual harassment

Overall, the prevalence of sexual harassment was 16.1% (93/578) (Figure 1A). In women, the prevalence of sexual harassment was 25.6% (82/320), compared to 4.3% (11/258) in men. For participants working in healthcare, research, and academics the prevalence of sexual harassment was similar, 15.9% (88/555), 14.8% (71/479), and 15.6% (71/454) respectively. Most frequently harassment was subjectively characterized as mild (62.4% 58/93). Nevertheless, 8.6% (8/93) of respondents indicated the harassment as severe. Of note, 18.2% (2/11) of men reported sexual harassment they were subjected to as severe (Figure 1B). The most frequent reported perpetrator was a boss, supervisor, attending or another senior employer (68.8% 64/93), followed by patients (39.8% 37/93) and colleagues (29.0% 27/93). Respondents indicated sexual harassment by subordinates in 8.6% (8/93) of the time and in 2.2% (2/93) the victim did not know the harasser.

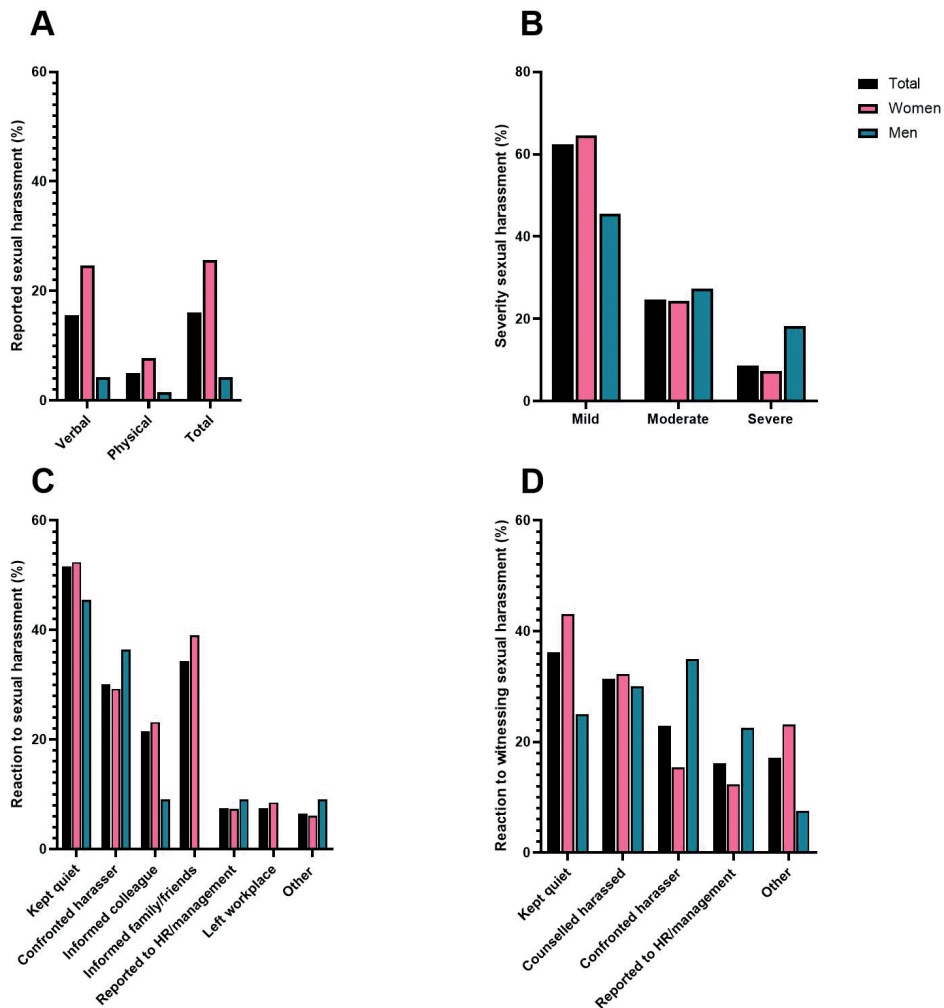


Figure 1. Reported sexual harassment in a work-based setting.

In all questions, multiple responses were allowed. Proportion of respondents reporting at least one experience of work-based sexual harassment (A). Severity of the reported sexual harassment defined as mild, moderate or severe (B). Individuals' reaction to the occurrence of the sexual harassment affecting them in a work-based setting (C). Reaction to witnessing sexual harassment in a work-based setting (D).

Reporting of sexual harassment and bystander behaviour

After incidences of sexual harassment, 51.6% (48/93) of respondents did not report or share information about the incident and only 7.5% (7/93) reported the harassment to human resources or management (Figure 1C). Of all respondents, 18.1% (105/579) indicated that they witnessed sexual harassment in the workplace. Interestingly, when sexual harassment was witnessed, 16.2% (17/105) of respondents indicated that

they reported this to human resources while 36.2% (38/105) kept quiet (Figure 1D). Interestingly, victims reported more frequently that they confronted the harasser compared with what bystanders reported, 30.1% (28/93) vs. 22.9% (24/105) (Figure 1C and 1D).

Risk factors for sexual harassment

Women were more likely than men to have experienced sexual harassment (OR 6.8 [95%CI 3.5-13.2]) (Table 2). Being Caucasian was also associated with an increased risk of experiencing sexual harassment (OR 2.8 [95%CI 1.4-5.6]). Additionally, respondents that were single were more likely to experience sexual harassment (OR 2.3 [95%CI 1.2-4.7]).

Table 2. Multiple logistic regression analysis of risk factors for sexual harassment.

	OR	95% CI	p-value
Age at time of survey completion			
18-30	Ref		
31-40	1.4	0.6 – 3.5	0.45
41-50	1.3	0.5 – 3.4	0.61
51-60	2.5	0.9 – 6.7	0.07
>60	1.2	0.4 – 3.8	0.75
Gender			
Male	Ref		
Female	6.8	3.5-13.2	<0.001
Race/ethnicity			
Non-white/Caucasian	Ref		
White/Caucasian	2.8	1.4 – 5.6	0.003
Marital status			
Married	Ref		
Single	2.3	1.2 – 4.7	0.016
Other	0.4	0.1 – 1.3	0.14
Region of employment			
Other regions Europe and North America	Ref		
	1.5	0.8 – 2.7	0.20

OR: Odds ratio, CI: Confidence interval.

Prevalence and severity of other verbal and physical harassment

Among all headache professionals, the prevalence of verbal harassment was 40.4% (234/579). The prevalence of physical harassment was 5.5% (32/579) (Figure 2A). While harassment was mostly indicated by the respondent to be mild (40.1% 95/237) or moderate (33.3% 79/237), almost one out of ten reports it indicated as severe (9.7% 23/237) (Figure 2B).

Risk factors for other verbal and physical harassment

While women appeared to experience also other verbal and physical harassment more frequently compared with men, this was not statistically significant (OR 1.4 [95%CI 1.0-2.0]) (Table 3). Moreover, no other significant risk factors were identified.

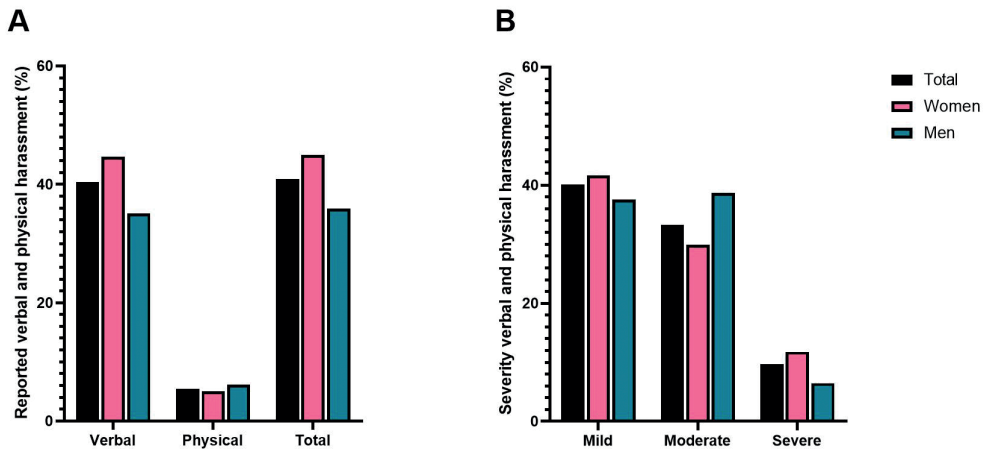


Figure 2. Reported verbal and physical harassment in a work-based setting.

In all questions, multiple responses were allowed. Proportion of respondents reporting at least one experience of work-based harassment that was not sexual in nature (A). Severity of the reported harassment defined as mild, moderate or severe (B).

Table 3. Multiple logistic regression analysis of risk factors for verbal or physical harassment that was not sexual in nature.

	OR	95% CI	p-value
Age at time of survey completion			
18-30	Ref		
31-40	0.9	0.5 – 1.8	0.80
41-50	0.6	0.3 – 1.2	0.13
51-60	0.7	0.3 – 1.4	0.29
>60	1.0	0.4 – 2.3	0.99
Gender			
Male	Ref		
Female	1.4	1.0 – 2.0	0.06
Race/ethnicity			
Non-white/Caucasian	Ref		
White/Caucasian	1.5	0.9 – 2.3	0.10

Marital status			
Married	Ref		
Single	0.9	0.5 – 1.5	0.60
Other	1.0	0.5 – 2.0	0.90
Region of employment			
Other regions Europe and North America	Ref		
	1.1	0.7 – 1.7	0.70

OR: Odds ratio, CI: Confidence interval.

Discussion

In this survey, workplace harassment emerges as a common incident in the headache field, with almost half of respondents experiencing one or more type of harassment. Weak governance, and an underappreciation of the impact of the misconduct, can all contribute towards an environment in which conductors are not held accountable. As the global demand for equity within the workplace intensifies, it is also crucial to explore the possibility of sexual harassment as a contributor to enduring inequities, and its impact on career progression. We need to understand its occurrence to be able to enact advantageous interventions. We found a high prevalence (16.1%) of sexual harassment in the global headache field. Women were seven times more likely than men to experience sexual harassment. Sexual harassment is a deprivation of fundamental rights, as well as unprofessional and illegal, and should be treated as such. We also found a high prevalence of other types of harassment (40.4%). We could not identify specific risk factors for this type of harassment.

Almost 40% of respondents that experienced harassment indicated to have been harassed by patients. Harassment perpetrated by a patient or their family is a serious problem that the healthcare system has been experiencing for quite some time.²⁷⁻³⁰ Physicians report inadequate training in dealing with sexual harassment by patients and there are barriers for reporting incidents or even discussing this with colleagues or supervisors. We need ways to better address patients' inappropriate behaviors towards healthcare providers.²⁸ Employees should be attended to institutional policies and patients should be educated on behavioral standards. For an overview of suggested recommendations to prevent and address harassment see Table 4. Suggested recommendations could help foster a culture in which headache professionals feel more prepared to address sexual harassment and where they are prepared to prioritize their own safety and wellbeing. However and importantly, the majority of perpetrators were not patients. More than two-third of the respondents that experienced sexual harassment indicated to have been harassed by their boss or

superior. This is especially shocking as we know that perpetrators accused of sexual harassment are rarely held to account. A United States based study of 125 faculty members in biomedical and medicine who had been accused of sexual misconduct and received media attention (affecting at least 1668 individuals) showed that as many as 50 remained in academia, of whom 40% held positions at a different institution.²⁷ As these are cases in which victims reported behavior and there was media attention, this is likely the tip of the iceberg. We need to consider that several factors might impact an employers' response to complaints of sexual harassment. Fear of defamation claims is one of those. Academic employers might find it easier to let harassers leave, resign, or limit their contact with specific groups, in the hope of limiting public scrutiny and reputational damage. In this we need to recognize that human resource departments and other individuals involved often represent the institution and not the individual reporting the harassment. As such, they have other incentives influencing how they respond to the report. This of course only becomes an issue when harassment is reported.

We need to recognize that reporting workplace harassment is incredibly important, but also exceedingly difficult. Often extreme power asymmetries are at work. This means that speaking out and trying to enact change within the profession is extremely hard. Frequently reported reasons for underreporting also include belief that no action will be undertaken, fear of consequences and negative impact on own career, stigma, fear of worsening the situation, and not knowing how to report.^{22,23,28} Another contributing factor is the lack of a clear definition. While some behaviors are obviously harassment (e.g., inappropriate unwanted physical contact), many behaviors are more subtle. This lack of a clear definition has been a barrier for reporting by individuals experiencing sexual harassment.²⁹ It is important to realize that some of these unwanted behaviors have been "normalized". Women in particular may not only downplay harassment, but may feel shame, guilt or stigma themselves and also second guess their own feelings and actions.²⁹ Moreover, the lack of 'evidence' or witnesses may stop victims from reporting harassment, as they might fear a 'their word against mine' situation. In our cohort, more than half of respondents kept quiet after harassment, while more than one-third of witnesses/bystanders did the same. Shockingly, 7.5% of victims felt compelled to leave their workplace. Less than 10% sought assistance from institutional resources to address the harassment. The low utilization rate is very worrisome. It is vital that we create an environment in which victims feel safe and empowered to report harassment. Healthcare and research institutions need policies clearly underlining the unacceptability of these behaviors. They also need to facilitate an appropriate investigation and protection for those who report harassment. They need to ensure accountability and transparent

responses to unprofessional behaviors, including sexual harassment. They should work on fostering a safe and supportive environment that can encourage witnesses to come forward and victims to report incidents of harassment. The bare minimum that all organizations and societies can do is to ask potential hires or committee candidates whether they have violated harassment or any ethics policies or if they left during active investigations. They should demand permission to gather information about such behaviors, investigations, warnings or suspensions from previous employers.³⁰

In addition to the high prevalence of sexual harassment, our data demonstrate that nearly half of headache professionals experience harassment that was not of a sexual nature. Unfortunately, a hostile work environment is frequently reported across different medical and healthcare disciplines.^{16,23,26,31} Nonetheless, these data come at a crucial timepoint, as harassment and the 'toxic hierarchical' culture in medicine are being openly challenged. Our findings indicate the need for a culture change and raise a call to action. A complicating factor is that what may work in one country and culture, may not be relevant elsewhere. The effectiveness of proposed strategies needs to be meticulously evaluated in each environment and results should be communicated.³²

The limitations of the present study include the absence of a response rate. We prioritized giving all headache professionals the chance to participate over calculating a response rate. We therefore allowed national societies and representatives to send out the survey and could as such not calculate a response rate. Additionally, it is important to acknowledge that, due to limitations in our outreach efforts, we were only able to reach out to IHS (associate) members, IHC delegates, and affiliated headache societies. Therefore, we recognize that not all headache professionals may have had the opportunity to participate. Moreover, a possible language barrier, outdated contact information or institutional blockage of emails may have potentially prevented part of the headache professionals from responding. Finally, while we contacted all IHS affiliated national societies (full list to be accessed from the IHS website <https://ihs-headache.org/en/about-ihs/affiliate-member-societies/>), we were unable to determine which representatives actually circulated the survey, as this was on a voluntary basis. While unfortunate, we still consider this an adequate first approach for this sensitive topic. To prevent responder bias we strongly emphasized in our correspondence with prospective respondents that the survey was aimed at all headache professionals. Nonetheless, we cannot exclude that those respondents that strongly emphasized with this topic or the topic of our first manuscript (gender bias and challenges in career achievement) or who had experienced harassment were more likely to participate. While an important result on its own, several ethnic groups were underrepresented, which made it impossible to evaluate to which

extent different ethnicities are a risk factor for sexual harassment. As such, while our finding of a reduced risk of experiencing sexual harassment for non-Caucasian respondents is interesting, this should be interpreted with caution. Moreover, we had an underrepresentation of individuals from African and Eastern Mediterranean countries. In addition, we did not collect data on age, job position, years of experience and workplace culture at the time of harassment incident(s). These may be important predictor variables if we had those data and should be included in future research projects. Furthermore, delving deeper into the circumstances surrounding incidents of harassment is likely to yield crucial insights into this challenging matter. To further investigate this issue, it is important to conduct a more comprehensive analysis to determine the specific types of harassment that occur (such as verbal harassment encompassing bullying, name-calling, criticism). Additionally, it is important to examine the severity and duration of the harassment (whether it is a single occurrence, repetitive behavior by one individual, or involves multiple perpetrators) and its impact (such as increased employee absenteeism, heightened anxiety, diminished self-confidence). Also, determining the role of workplace culture, the organizational culture and leadership, both on the occurrence and attitude towards harassment is likewise important. Finally, we need to consider that recall bias and social desirability bias might have prevented victims from reporting harassment in our survey. By ensuring anonymity we hoped to prevent the second. If these biases occurred, this likely led to an underestimation of the prevalence of harassment. Likewise, individuals that experience severe or traumatic incidents might have been less likely to participate, ensuring a further underestimation of the issue. Another important matter that should be recognized is that we determined how many professionals had dealt with harassment. We did not examine how often victims were harassed. This likely leads to a further underestimation of the problem.

The following approaches, several which were previously discussed in more detail, might significantly reduce (sexual) harassment in the workplace.² Professionals and organizations should strive towards creating a diverse, inclusive, and respectful environment. Institutions should focus on diffusing the power structure, on reducing isolation, on improving transparency and accountability and on having working available supportive structures. If no working supportive structures are available, a system should be developed, afterwards, its effectiveness should be evaluated. Furthermore, they should ensure diverse and accountable leadership that is clear about its dedication to reducing and eliminating all harassment. Institutions and leaders should clearly convey that reporting (sexual) harassment is honorable and courageous. Finally, effective sexual harassment training should be given. Harassment training should not be given out of 'symbolic compliance', as to often its primary aim is to protect from liability.

The effectiveness of training aimed at preventing sexual harassment is often not evaluated. Many training programs are aimed at providing information (for instance about anti-harassment policies) and on changing attitudes.^{2,33} Research, however sparsely, has often demonstrated that a person's beliefs and attitude are very resistant to change. It is important to realize that thoughts are in the end not harmful. The actions and behaviors of a person lead to harm of the victim. Given this, targeting behavior (even amongst those with sexist attitudes and those that do not see the harmful nature of their actions) seems better justified.² Another important type of training is bystander intervention training.^{2,33} Bystander intervention training has long been used, especially in colleges and high schools. It focuses on creating awareness (recognizing problematic behavior), creating a sense of collective responsibility, providing bystanders with the skills and confidence needed to intervene (direct or indirect) and on educating where available resources can be found. Simply put, bystander education equips bystanders with the skills necessary to recognize and take actions when problematic behavior occurs.³³ Evaluating the effectiveness of these trainings is important and one should realize that what is helpful in one setting, might not necessarily be part of the solution in another setting.

We are not the only medical field facing these challenges. Among emergency medicine residents, mistreatment was reported to occur in 29.9% a few times per year.³⁴ While in the vascular workplace, with a vast majority working in vascular surgery, the 43% of responders indicated bullying, undermining behavior or harassment to have occurred in the last 12 months.³⁵ Another example comes from the field of cardiology. Here, 44% of responders indicated that they worked in a hostile work environment.³¹ While these types of studies are difficult to compare due to different endpoints and differences in study population, they do indicate that this issue is widespread in the medical community and that we might learn from one another when facing these challenges.

The prevalence of sexual harassment and other harassment is high in the headache field and women are more likely to experience sexual harassment than men. Understanding mistreatment within our professional field is an important first step in creating and maintaining a safe work environment. Our leadership can help create a culture in which everyone can speak out when perceiving or experiencing harassment. Our efforts might provoke other specialties and societies to also put this issue on their agendas. Moreover, our results may provide the impetus for headache societies, headache research groups and hospitals to develop action plans and to re-examine and enforce policies addressing these damaging behaviors. We owe it to our (future) colleagues, ourselves, and our patients that we all strive towards implementing such policies.

Key findings:

- Workplace harassment is common in the headache field, with almost half of respondents experiencing some type of harassment.
- Sexual harassment was reported by 16% of respondents, and women are seven times more likely to experience this.
- The Women's Leadership Forum of the IHS recommends anti-sexual harassment training programs that focus on changing behavior, not on changing beliefs.

Table 4. Recommendations for preventing and/or dealing with incidents of harassment.

Target of recommendations	Recommendations
Head of department/ Principle investigator/ Supervisor	- Review institutional policies with employees. - Remind employees that experiencing harassment does not reflect on work performance. - Support employees after an incident. - Present the topic to leadership to increase awareness. - Normalize harassment, also sexual harassment, as a topic for supervision. - Be mindful of power dynamics when discussing sensitive issues with employees. - Instruct employees to seek safety if they do not feel safe. - When an incident occurs, first ensure the victims safety. - Carefully take on a non-judgmental stance to help victims and alleged perpetrators.
Hospitals/ Organizations/ Institutions	- Create clear, visible, usable policies for reporting and dealing with harassment. - Create harassment reporting procedures that are clear, visible, usable, and not overly time-consuming - Create harassment procedures where victims are protected. - Review policies often to ensure they are up-to-date. Collect feedback from employees. - Educate professionals, students and patients about behavioral standards. - Provide training on harassment, power differentials and implicit bias. - Train supervisors/leaders on the importance of addressing harassment. - Provide bystander intervention training. These equip bystanders with the skills necessary to recognize and take actions when problematic behavior occurs. - Healthcare providers should be able to transfer patients after incidents or if they do not feel safe. - Phone numbers for security, supervisors, colleagues and the human relations office should be easily accessible. - Results of reported incidents should be transparent. Methods to prevent future incidents should also be reported. - Create taskforces/working groups to address harassment and collect employee feedback. - Ensure diverse and accountable leadership that is clearly dedicated to reducing and eliminating harassment.
Individual leaders/ leadership of institutions/societies	- Clearly convey that reporting harassment is honorable and courageous. - Strive towards creating a diverse, inclusive and respectful environment - Ask potential hires whether they have violated harassment or any ethics policies. - Build a safe culture where harassment is addressed and taken seriously. - Increase awareness and advocate addressing systemic issues. - Encourage team debriefing and (personal) reflection after an incident. - Diffuse power structure and reduce isolation of employees.

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Conflict of Interest

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Research ethics and patient consent:

All responses were kept anonymous and no personal identifying information was collected. No ethical approval was required.

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