

No Rest for the Stigmatized: A Model of Organizational Health and Workplace Sexism (OHWS)

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Abstract Employee sick attendance at work—presenteeism—poses a significant threat to both employee health and organizational productivity. However, despite the wealth of literature examining organizational predictors of presenteeism, little research has investigated the impact of stigmatized status on employee work attendance when sick. We argue that gender discrimination in the workplace promotes negative job perceptions and poorer health, ultimately contributing to increased rates of presenteeism among female employees. In two studies assessing U.S. women’s perceptions of workplace sexism, job security, job autonomy, job stress, reported health, and workplace sick-related attendance, we develop the framework for the Organizational Health and Workplace Sexism (OHWS) model. Study 1 utilized a large nationally representative dataset to conduct a secondary data analysis that preliminarily investigated the unique impact of perceived workplace discrimination. Results found that women who experienced workplace sexism reported more negative job perceptions and poorer health outcomes, yet they did not

stay home from work more often than non-stigmatized women did—suggesting sick work attendance. Study 2 surveyed employed women through a paid online survey service in a more detailed assessment of the variables. Structural Equation Modeling (SEM) revealed that workplace sexism negatively related to reported health, job security, and job autonomy, which were positively associated with perceived job stress. Job factors also were negatively related to health, which directly correlated with rates of presenteeism. Therefore, the OHWS provides a novel addition to the presenteeism literature by bridging the health, stigma, and organizational literatures.

Keywords Presenteeism · Sexism · Health · Job security · Job autonomy

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Despite social and legal efforts to reduce prejudice, stigmatized individuals continue to experience discrimination during their daily lives. While undoubtedly exerting a considerable toll in numerous aspects of life, perceived discrimination may distinctively impact the health of stigmatized group members (Banks et al. 2006; Pascoe and Smart-Richman 2009; Williams and Mohammed 2010). Mental and physical health detriments for those who experience discrimination arise in response to the uncontrollable and unpredictable nature of prejudice because stigmatized individuals contend with increased psychological and physiological stress reactions in volatile environments (Pascoe and Smart-Richman 2009). Daily discrimination may become a chronic stressor which depletes stigmatized individuals of their self-protective resources over time, thus increasing their vulnerability to illness (Gee et al. 2007). Common self-reported health afflictions associated with perceived discrimination include chronic mental and physical ailments such as depression and

psychological distress, as well as hypertension (Krieger 1999). These chronic health problems may impact daily functioning in the lives of stigmatized individuals, creating additional challenging stressors (e.g., social relationships, employment issues, financial strains) that exacerbate already present health issues (Stenbeck and Hjern 2007; Stewart 1989). Therefore, perceived discrimination presents a potential threat to the health of stigmatized individuals.

Although independently concerning, these negative health outcomes may also impair the ability for stigmatized individuals to function optimally in the workplace. Specifically, these employees may continue to attend work when they become ill rather than take time off to recover, potentially in response to fears over losing their employment (Agudelo-Suárez et al. 2009), which stem from a discriminatory work environment. Employee attendance at work while ill—*presenteeism*—results in impaired employee performance, a pervasive problem across organizations (Aronsson et al. 2000; Johns 2010). Although the antecedents and consequences of worker presenteeism have received considerable attention in recent years, little research has focused on the unique factors facing women who experience sexism in the workplace. For example, U.S. women represent half of all those employed in management and professional occupations (U.S. Bureau of Labor Statistics 2014), yet they are far more likely to encounter sexism than their male counterparts (Swim et al. 2001). Sexist discrimination may lead to increases in anxiety, depression, and other negative psychological symptoms (Foster 2000), which may in turn threaten physical health (Pascoe and Smart-Richman 2009). Therefore, women may experience unique challenges resulting from workplace gender discrimination, not shared by their male colleagues. As an initial venture, we present the Organizational Health and Workplace Sexism (OHWS) model, a preliminary examination of the relationships among workplace sexism, women's job perceptions, and sick-work attendance (i.e., presenteeism). Specifically, we examine how experiences of sexism at work relate to women's physical health, perceptions of job security, job autonomy, job stress, and ultimately presenteeism. In the following, we detail how experienced sexism relates to each of these variables and why they are critical to understanding presenteeism.

Consequences of Presenteeism

The pressure to attend work while ill remains a pervasive problem among employees across organizations. A study of Swedish workers in 2000 found that 37% indicated attending work while ill instead of using a sick day, with estimates rising to 53% of employees after a 3 year follow-up (Aronsson et al. 2000; Aronsson and Gustafsson 2005). A majority (70%) of Danish workers report having gone to work while sick at least once during a 12-month period, with 38% reporting

presenteeism 2–3 times within a year (Hansen and Andersen 2008). Recently, a survey conducted across several European organizations found that 60% of employees indicate instances of working while ill during a 3-month period (Robertson et al. 2012). These trends suggest that workers may substitute presenteeism for absenteeism, choosing to remain present at work despite an illness which would typically warrant staying home to recover (Bergström and Bodin 2009; Caverley et al. 2007; Johns 2011). Although a pervasive trend among general employee populations, stigmatized workers—who may already experience chronic health issues associated with discrimination—may feel additional pressures to attend work during times of illness.

Whereas employee presence rather than absence conventionally seems preferable, work attendance while sick results in impairments for both individual and overall workplace productivity, costing employers more financially than absenteeism (Cooper and Dewe 2008), with estimates of up to \$150 billion in yearly losses for U.S. employers (Hemp 2004). Thus, presenteeism represents a tangible threat to employers. Furthermore, as a stronger predictor of health outcomes than absenteeism (Caverley et al. 2007), presenteeism presents a risk factor for future health issues (Bergström et al. 2009; Lu et al. 2013). Indeed, Bergström and Bodin (2009) found that presenteeism predicts later work absenteeism because employees who reported working while sick on more than five occasions missed more than 30 days of work during a second year follow-up. Employees who attend work while sick may inadvertently intensify or prolong their illness, thus extending their period of impaired productivity. Further, continued poor health, coupled with the pressure to remain present at work in spite of illness, may lead to employee burnout (Demerouti et al. 2009). Thus, despite the goal of remaining present at work, presenteeism may ultimately result in extended employee absenteeism and further productivity detriments.

Job Insecurity and Presenteeism

Although employee attendance requirements (i.e. specified number of allotted sick days) may pressure sick employees to continue working (Johansson and Lundberg 2004), organizational research has identified links between perceived job factors with higher rates of presenteeism. Considerable research points to the relationship between job insecurity and frequency of attending work while ill (Caverley et al. 2007). Employees who fear losing their jobs may feel pressure to show visible commitment to their positions, and as a strategy to avoid layoffs, insist on maintaining a presence at work despite illness (Virtanen et al. 2005). Thus, job-insecure employees are less likely to miss work when ill and therefore remain more prone to sick work attendance (Johns 2011; Virtanen et al. 2005).

Following a period of job insecurity (i.e., a series of organizational wide layoffs), women reported higher work attendance than men did, a trend even more pronounced for women identified as high risk for cardiovascular disease (Theorell et al. 2003). Thus, women, and particularly those with ongoing health issues, attended work more often than their male colleagues did, suggesting that they opted for presenteeism over absenteeism. Although not explicitly investigating workplace gender discrimination, these trends may stem from women's unique experiences in the workplace and their greater likelihood of experiencing sexism. Continually exposed to a hostile work environment, stigmatized employees may feel less secure about their jobs, potentially motivating increases in presenteeism. Qualitative research featuring immigrant populations in Spain found that racially stigmatized workers reported feeling pressure to remain present throughout periods of illness instead of taking time off to recover (Agudelo-Suárez et al. 2009). Thus, we propose that stigmatized status and subsequent workplace gender discrimination may exacerbate perceptions of low job security, motivating employees to maintain a presence at work despite ongoing health issues.

Job Stress and Presenteeism

Work stress may also prompt employee presenteeism throughout the course of tenure at a particular organization (Jourdain and Vézina 2014). Whereas both presenteeism and absenteeism correlate with reported job stress, work stress more strongly correlates with presenteeism (Elstad and Vabø 2008). Increases in presenteeism linked specifically to the stress of adverse working conditions, including pervasive harassment, poor team cooperation, and inadequate equipment (Musich et al. 2006), suggests that employees continually exposed to stressful work environments may opt to remain at work even when ill. Although this initial work has identified workplace discrimination as a stressor that leads to higher rates of presenteeism, the focus was on general hostile working conditions rather than on gender discrimination specifically. Despite the observed health consequences for stigmatized individuals, little research has investigated the impact of a sexist work environment and subsequent perceived stress on stigmatized employees' rates of presenteeism.

Job Autonomy and Presenteeism

Additionally, the degree of freedom a worker has in determining how to carry out various aspects of their duties, defined as job autonomy (Hackman and Oldham 1976), may have implications for employees' decisions to attend work while ill. Specifically, employees with low job autonomy report greater frequency of illness and more frequent work absenteeism

(Humphrey et al. 2007; Smulders and Nijhuis 1999; Väänänen et al. 2003), with those indicating a lack of control over their work tasks demonstrating an increased propensity to attend work during periods of illness (Gosselin et al. 2013). Because working while sick may exacerbate illness, these trends align with research demonstrating that presenteeism predicts later absenteeism (Bergström et al. 2009; Gustafsson and Marklund 2011). Therefore, workers with little autonomy may exhibit increases in both presenteeism and absenteeism—a trend predictive of poorer health outcomes within the following year (Gustafsson and Marklund 2014).

Alternatively, *high* job autonomy may shield employees from the pressures of presenteeism, allowing them to take time off to recover when necessary, ultimately staving off further sickness-related absence (Irvine 2011). Although high job autonomy may also buffer employees' observed work-related stress (J. Lu 2005), women, on average, report lower job autonomy than do men (Väänänen et al. 2003), leaving women more vulnerable to work stresses, and ultimately, presenteeism. Aligning with reports that low job autonomy increases women's—more so than men's—sick attendance at work (Gustafsson and Marklund 2014), these findings suggest that workplace sexism may result in presenteeism. Female employees already under unique discrimination-related stress may perceive less freedom in conducting their job duties, creating additional perceived job stress. These factors may pressure women to maintain their workplace attendance, further exacerbating ongoing health issues and impairing job performance. Taken together, these findings provide initial evidence that women experiencing gender discrimination may experience lower autonomy in the workplace, increasing their risk for higher perceived job stress and ultimately, sick work attendance. Therefore, the present work seeks to provide initial corollary evidence of workplace gender discrimination's negative impact on job autonomy and subsequent employee sick work attendance.

Although a recent meta-analysis has identified the positive link between discrimination and presenteeism (Miraglia and Johns 2016), no research to our knowledge has examined the direct connection between experienced workplace sexism and presenteeism, despite women's increased prevalence of encountering sexism (Swim et al. 2001) and exhibiting presenteeism (Aronsson and Gustafsson 2005; Robertson et al. 2012). Because the critical factors in preventing presenteeism (i.e., high job autonomy, sense of job security, and lower job stress) are negatively associated with discrimination, women experiencing sexism at work may be especially prone to presenteeism.

Current Research

We propose that women who report greater gender discrimination in the workplace will also report increased job-related

stress, in addition to lower autonomy and job security. Furthermore, concurring with recent research demonstrating that health mediates job conditions and sick work attendance (Pohling et al. 2015); we predict that adverse job factors independently share a relationship with negative employee-reported health. Specifically, we hypothesize that experienced workplace sexism relates to lower perceptions of job security and autonomy while correlating with higher symptoms of poor health. Additionally, lower job security was expected to be associated with higher negative perceptions of job autonomy. Further, low job security and autonomy was expected to relate to higher perceived work stress, which in turn was expected to relate to poorer health symptoms. Finally, we hypothesize that women reporting compromised health associated with these negative job perceptions will report higher rates of sick work attendance (i.e., presenteeism). Additionally, because work stress correlates with presenteeism, we predict that perceived stress will also be associated with presenteeism independent of increased health symptoms.

Therefore, the present research examines the relationships among perceived job security, job stress, and job autonomy as they relate to stigmatized employee health and presenteeism. Study 1 utilized a large, publically available dataset to preliminarily explore the relationships among workplace sexism, health, perceived job security, autonomy, stress, and attendance. Study 2 presents a direct test of the Organizational Health and Workplace Sexism (OHWS) model, depicting the relationships among women's experiences of workplace sexism, job perceptions, and presenteeism.

Although an important topic for both the progress of gender equality and workplace productivity, no research to our knowledge has investigated the impact of experienced workplace sexism on female employees' presenteeism and the factors that influence sick work attendance. The current research is crucial for improving both the health of stigmatized employees and overall organizational productivity. Therefore, the following studies aim to bridge the apparent gap in the literature by developing a model to illustrate the relationship between experiencing sexism in the workplace and attending work while ill.

Study 1

Our initial study aimed to provide preliminary support of the hypothesis that women who encounter workplace sexism report more negative health and job perceptions than those who do not. Another aim of Study 1 was to determine if women experiencing sexism report differences in attending work while sick. Although the ultimate goal of this research is to assess the relationship of experienced sexism and presenteeism, Study 1 first aimed to establish a pattern of experiences unique to stigmatized women.

To test these assumptions, we conducted a secondary data analysis using the General Social Survey 2014 dataset (GSS; Smith et al. 2013). The GSS was created to examine the changing societal attitudes of American respondents. Data are collected via 1.5 h phone interviews during which respondents are asked about their attitudes, behaviors, and demographics in regard to various social and political issues. Several questions in the 2014 GSS allowed us to reasonably assess the constructs of interest for the present study with a representative U.S. sample. However, because the GSS did not measure presenteeism, our analysis examined sick-related work absenteeism as an approximation. Aligning with the substitution hypothesis (Caverley et al. 2007), we predict that stigmatized workers will substitute presence for absence during times of illness at higher rates than non-stigmatized employees. The substitution hypothesis predicts that when facing conditions which discourage absenteeism, ill employees will opt for presenteeism as an alternative to staying home. Therefore, whereas absenteeism rates may not rise for these employees, instances of sick work attendance may increase instead. Although we anticipate that women who experience sexism at work will report more negative job perceptions and poorer health in comparison to women who report no sexism at work, we do not expect their frequency of sick-related absenteeism to reflect their increased rates of illness, because they may continue to attend work throughout these periods of poor health.

Method

Participants

The General Social Survey 2014 dataset surveyed over 2500 respondents; however, for our purposes, we focused only on employed women, resulting in a final sample size of 763 ($M_{\text{age}} = 43.35$, $SD = 13.48$, range = 18–80). The final sample consisted of both full-time (591, 77.5%) and part-time (172, 22.5%) workers, with a reported median annual household income of \$60,000–74,999. Participants identified as White (543, 71.2%), Black (131, 17.1%), Hispanic (37, 4.9%), Asian (30, 3.98%), Native American (16, 2.1%), or some other race/ethnicity (1, .1%). The remaining participants (5, .5%) declined to indicate their race/ethnicity.

Materials and Procedure

Data from the 2014 GSS were utilized for a preliminary investigation of the effects of workplace discrimination on health and organizational factors. All variables were weighted using the guidelines suggested in the GSS codebook (Smith et al. 2012).

Workplace Discrimination Participants indicated experiencing sexism in the workplace through one dichotomous “yes” or “no” item which asked: “Do you feel in any way discriminated against on your job because of your gender?” The item received a total of 625 responses from GSS participants in the study sample. GSS female respondents indicated relatively low levels of work discrimination in this one question format with 7% of the sample ($n = 44$) indicating having experienced workplace gender discrimination. Thus, Study 1 represented a conservative test of the hypotheses, but had the advantage of representing a diverse national sample.

Health and Health Impairment Participants were asked to describe their perceived health with a single self-rated health measure: “Would you say that in general your health is ...” on a scale of 1 (*excellent*) to 5 (*poor*). Responses were reverse scored so that higher scores indicate better health ($M = 3.67$, $SD = 1.02$). The self-rated health (SRH) item has been demonstrated to be a valid measure of health because it robustly predicts mortality among respondents in industrialized nations (Idler and Benyamini 1997). Participants reported their daily impairment due to health with a single item: “During the past 30 days, for about how many days did your poor physical or mental health keep you from doing your usual activities, such as self-care, work, or recreation?” ($M = 1.02$, $SD = 3.52$, range of days = 0–30).

Job Security Two items in the GSS evaluated job security. Participants were asked: “With respect to the work you do, the job security is good?” on a scale of 1 (*very true*) to 4 (*not at all true*). Responses were reverse scored such that higher values indicate stronger feelings of security ($M = 3.46$, $SD = .76$). Participants were also asked about the likelihood of being fired: “Thinking about the next 12 months, how likely do you think it is that you will lose your job or be laid off?” on a scale of 1 (*very likely*) to 4 (*not likely*). Responses were reverse scored such that higher values indicate a greater likelihood of being fired ($M = 1.49$, $SD = .74$). Unexpectedly, these items did not correlate strongly, $r(429) = -.31$, $p < .001$, and were thus treated as separate indicators of job security.

Job Stress and Job Autonomy Participants indicated their perceived job stress through a single item: “Do you find your work stressful?” on a scale of 1 (*always*) to 5 (*never*). Responses were reverse scored so greater values reflect higher perceived job stress ($M = 3.08$, $SD = 1.06$). The GSS included a single item related to job autonomy that asked participants how strongly they endorse the statement: “I am given a lot of freedom to decide how to do my own work,” on a scale of 1 (*very true*) to 4 (*not at all true*). Responses were reverse scored such that higher values indicate stronger feelings of autonomy ($M = 3.35$, $SD = .82$).

Absenteeism Participants reported their rate of work absenteeism due to health via one item that asked: “During the past 30 days, about how many days did you miss work due to your mental or physical health?” ($M = .45$, $SD = 1.69$; range = 0–21). Absenteeism was non-normally distributed, with skewness of 6.12 ($SE = .10$) and kurtosis of 45.29 ($SE = .20$). Work absences were transformed via natural log transformation to attain closer normality (skewness = 3.04, $SE = .10$; kurtosis = 10.16, = .20).

Results

To test whether employed women who had experienced workplace discrimination reported less job security, increased job stress, lower job autonomy, worse health outcomes, yet lower sick absenteeism, we conducted a series of ANCOVAs which controlled for participants’ income, age, and race/ethnicity. Income was chosen as a control variable to account for status within an organization. Participants’ age was chosen as a control variable to account for experience in the workplace. Race/ethnicity was chosen as a control variable because sexism experience by White women and Women of Color may differ. See Table 1 for a summary of the results. Consistent with previous literature, women reporting workplace gender discrimination reported higher rates of health problems and health-related daily impairments (Pascoe and Smart-Richman 2009). Despite their poorer health, these women did not indicate a significantly higher frequency of missing work due to illness, suggesting that they attended work while ill, thus substituting workplace presenteeism for absenteeism (Caverley et al. 2007). Furthermore, women who experienced workplace sexism perceived greater job stress and insecurity and felt less autonomous in their place of work.

Discussion

These results provide an initial demonstration that perceived experiences of sexism in the workplace uniquely affects stigmatized female employees. Women experiencing workplace sexism report more negative job perceptions and poorer health than do women who do not perceive their work environment as sexist. However, despite their increased health impairments, these women report attending work at equal rates to their non-stigmatized counterparts. Women reporting workplace sexism may substitute sick presenteeism for absenteeism—thus maintaining work attendance even during periods of illness. Although limited, our study provides preliminary evidence that workplace gender discrimination may influence employee frequency of presenteeism. Study 2 aimed to examine whether workplace discrimination (using a more detailed assessment) is associated with similar downstream outcomes, as well as was related to presenteeism, utilizing a separate sample of employed women. Therefore, Study 1 served as

Table 1 Results of ANCOVAs controlling for participants' income, age, and race/ethnicity, study 1

Outcomes	Report workplace sexism		Do not report workplace sexism		<i>F</i>	<i>p</i>	η^2
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>			
Health	3.35	.88	3.74	1.00	5.752	.02	.012
Health impairment	2.97	5.96	.71	2.66	19.173	< .001	.039
Job security (good)	3.15	.89	3.51	.70	8.362	.004	.018
Job security (lose)	2.00	1.18	1.48	.71	13.654	< .001	.041
Job stress	3.76	.92	3.04	1.05	14.360	< .001	.030
Job autonomy	2.97	1.09	3.36	.78	8.166	.004	.017
Absenteeism	.27	.47	.15	.43	3.070	.08	.007

the foundation for the development of a model investigating the relationships among workplace gender discrimination, several organizational factors, employee health, and presenteeism.

Because the GSS must limit the number of surveyed items in order to adhere to time constraints and avoid participant fatigue, Study 2 expanded upon the variables of interest by using more extensive measures. In Study 2, we also directly examined participants' reported rates of presenteeism, whereas Study 1 remained limited to an approximation based on work absenteeism. Thus, Study 2 aimed to systematically evaluate the relationships of experienced sexism in the workplace, health, and other organizational factors, in order to develop the OHWS, a comprehensive model that addresses stigma-related factors in female employee presenteeism.

Study 2

Method

Participants

Using a paid online resource of survey respondents (Amazon Mechanical Turk®), 235 female participants were recruited to complete an online survey in exchange for a monetary compensation of \$.40 each. Four participants were removed for failing to finish the survey, and 25 women were removed from analysis for indicating their employment as anything other than "employed for wages," leaving a final sample of 206 participants ($M_{age} = 34.48$, $SD = 10.69$, range = 18–74). Participants identified as White (145, 70.4%), Black (22, 10.7%), Asian (13, 6.3%), biracial (13, 6.3%), Latino (6, 2.9%), Indian (2, 1.0%), and multiracial (1, .5%). The remaining participants (4, 1.9%) declined to indicate their race/ethnicity. On average, participants reported their individual annual income as between \$30,000–39,000. Two participants were excluded for reporting incomes +3 standard deviations above the mean.

Materials and Procedure

Participants completed an online survey that inquired about experience of sexism in the workplace, health, perceived job security, job stress, job autonomy, and rates of presenteeism. All measures were presented in a randomized order.

Workplace Discrimination Participants indicated how frequently they experience sexism in their workplace using 13 items of the Schedule of Sexist Events revised to specifically ask about workplace experiences (SSE; Klonoff and Landrine 1995) on a scale of 1 (*never happened to you*) to 6 (*almost all of the time- more than 70% of the time*). Example items include "How many times have you been treated unfairly by your employer because you are a woman?" and "How many times have people made inappropriate or unwanted sexual advances to you while at your place of employment because you are a woman?" Participants indicated the extent to which they experienced each situation in the past month, in the past year, and during the entirety of their current employment. Only reports regarding entirety of employment were included in the present analyses. Results for all analyses remain unchanged if reports for sexism experienced in the past month or past year were included. The scale was found to be reliable ($\alpha = .94$, $M = 1.82$, $SD = .82$). Comparing to Study 1, 18.6% ($n = 38$) of participants indicated never having experienced sexism in the workplace, that is, responded 1 (*never happened to you*) for all 13 items.

Symptoms of Poor Health As an assessment of physical health, participants completed the Cohen-Hoberman Inventory of Physical Symptoms scale (CHIPS; Cohen and Hoberman 1983) by indicating how much each of 33 physical symptoms of illness bothered them within the past month on a scale of 0 (*not bothered at all*) to 4 (*extremely bothered*). Higher averaged scores indicate greater prevalence of symptoms. Health symptoms included "Sleep problems (can't fall asleep, wake up in middle of night or early in morning)," "Migraine headache," and "Shortness of breath when not

exercising or working hard.” The scale was found to be reliable ($\alpha = .94$, $M = 1.81$, $SD = .66$).

Job Security Based on the Attitudes Toward Work and Job Security survey (Brown 2006), we created six items for participants to indicate how secure they felt at their current jobs on a scale of 1 (*strongly disagree*) to 5 (*strongly agree*). Items were: “I feel that my current job is secure for at least the next year,” “I feel that my current job is secure for at least the next five years,” “I am concerned that my employer will replace me with another worker within the next year” (reverse scored), “I feel that I will be terminated by my employer within the next year” (reverse scored), “I am concerned that my employer will replace me with another worker within the next five years” (reverse scored), and “I feel that I will be terminated by my employer within the next five years” (reverse scored). All items were coded such that higher averaged scores designate more security from being fired ($\alpha = .92$, $M = 3.95$, $SD = .96$).

Perceived Job Stress Participants reported their perceived job stress on a scale of 1 (*never*) to 5 (*very often*) using four items of the Perceived Stress Scale (Cohen et al. 1983), which were adapted to focus specifically on work-related stress. Items were “In the last month, how often have you felt difficulties at your job were piling up so high that you could not overcome them?”; “In the last month, how often have you felt that you were unable to control the important things at your job?”; “In the last month, how often have you felt confident about your ability to handle your work-related problems?” (reverse scored); and “In the last month, how often have you felt that things were going your way at work?” (reverse scored). All items were coded such that higher averaged scores represent increased perceived stress ($\alpha = .73$, $M = 2.30$, $SD = .77$).

Job Autonomy Participants indicated their feelings of workplace autonomy with three items from the Need Satisfaction Scale (La Guardia et al. 2000) adapted for workplace autonomy. Items were “At work, I have a say in what happens and I can voice my own opinion”; “At work, I feel free to be who I am”; and “At work, I feel pressured and controlled to act certain ways” (reverse scored), on a scale of 1 (*strongly disagree*) to 5 (*strongly agree*). All items were coded such that higher averaged scores indicate stronger job autonomy ($\alpha = .79$, $M = 3.43$, $SD = 1.02$).

Presenteeism Typically when assessing presenteeism (Aronsson et al. 2000; Aronsson and Gustafsson 2005; Bergström and Bodin 2009), frequency of attending work while ill was assessed through one open-ended item: “How many days in the past year did you go into work while you were ill (i.e., did not use an allotted sick day)?” Thus, we also used this item ($M = 4.46$ days, $SD = 5.35$). Presenteeism was

normally distributed, with skewness of 1.86 ($SE = .17$) and kurtosis of 3.90 ($SE = .34$) (Hair et al. 2010).

We performed exploratory principal factor analyses (EFAs) using varimax rotation on the 13-item SSE scale, six-item job security scale, four-item job stress scale, and three-item job autonomy scale independently. Analyses for each scale revealed only one factor with an Eigenvalue >1 (SSE Eigenvalue = 7.89, % of Variance = 65.71; Job Security Eigenvalue = 4.31, % of Variance = 71.83; Job Stress Eigenvalue = 2.22, % of Variance = 55.37; Job Autonomy Eigenvalue = 2.11, % of Variance = 70.36).

Results

Preliminary Analyses

Table 2 reports the partial correlations between each variable of interest. Income, age, and race/ethnicity were included as control variables. Consistent with our hypotheses, workplace sexism was positively related to symptoms of poor health and perceived job stress, whereas negatively related to feelings of job autonomy and job security. Moreover, experienced workplace sexism was positively correlated with presenteeism (see Table 2).

Structural Equation Modeling Results: OHWS Model Evaluation

After initial analyses, an investigation of the proposed OHWS model (see Fig. 1) was performed, including participants’ income, age, and race/ethnicity as covariates. Structural Equation Model (SEM) analyses were conducted using SPSS Amos software. Application of the t-rule, which states that the number of parameters must be equal to or less than the number of independent samples of information in the model (Kline 2010), indicated that the model was identified.

Model fit was assessed through several criteria. Although non-significant Chi-square values suggested good fit, we considered additional fit indicators as suggested by Hu and Bentler (1999) because Chi-square is sensitive to sample size and non-normal data. Therefore, models with good fit should also have a Comparative Fit Index (CFI) value at or greater than .95, a Tucker-Lewis Index (TLI) value at or greater than .90, and a Root Mean Square Error of Approximation (RMSEA) value less than .06 in order to indicate goodness of fit. Path analyses revealed that the hypothesized model fit well to the data, $\chi^2(5, N = 206) = 6.35$, $p = .273$ (CFI = .99; TLI = .95; RMSEA = .04). Moreover, as can be seen in Fig. 1, all paths in the model were significant at $p < .05$. Comparison models were subsequently tested against this model’s AIC = 104.353 and BCC = 109.379 for significant decreases to determine that the proposed model best represents the data.

The model implies several sets of mediation, which we then verified using the PROCESS macro (Hayes 2013) in

Table 2 Partial correlations among primary variables, controlling for participants' income, age, and race/ethnicity, study 2

Study Variables	1	2	3	4	5
1. Workplace discrimination	--				
2. Symptoms of poor health	.399***	--			
3. Job autonomy	-.432***	-.364***	--		
4. Job security	-.272***	-.344***	.339***	--	
5. Perceived job stress	.287***	.382***	-.543***	-.309***	--
6. Presenteeism	.230**	.376***	-.158*	-.047	.272***

SPSS which tests whether indirect effects are significant. Because all 95% confidence intervals do not contain zero (see Table 3), the paths in the model appear to be significantly mediated and thus supportive of the indirect relationships we proposed (MacKinnon et al. 2007).

Model Comparison

In order to ensure that the proposed model best depicts the data, we tested a comparison model which offered an alternative explanation for the relationships present in the data. We tested the counter hypothesis that poor health symptoms (as influenced by workplace sexism) drive subsequent job outcomes, suggesting that impaired health directly affects perceptions of job security, autonomy, and stress. Previous research has noted the impact of a sexist environment on health (Pascoe and Smart-Richman 2009). The rise in problematic health symptoms could fuel employee perceived threats to job security and autonomy. Therefore this alternative model tests the assumption that experienced workplace sexism only directly affects health, whereas poor health then predicts negative job perceptions, and eventually presenteeism.

A comparison model will be considered better than the proposed model if it demonstrates significantly lower AIC

and BCC (a decrease of at least 10) than the hypothesized model (Burnham 2004). Analyses revealed that the comparison model performed significantly worse than the hypothesized model, $\chi^2(5, N = 206) = 23.23, p < .001$ (CFI = .92; TLI = .30; RMSEA = .13; AIC = 121.233; BCC = 126.259), suggesting that the OHWS model better represents the relationships present in the data. (This comparison model is available in an [online supplement](#).)

Discussion

Study 2 expanded upon the findings in Study 1 by examining direct relationships between the variables of interest in order to develop the OHWS model, depicting the relationship between experienced workplace sexism and women's frequency of presenteeism. Supporting our hypotheses, experiences of sexism in the workplace negatively relates to women's perceptions of job security and job autonomy (see Fig. 1; paths A and C), as well as their self-reported health (path B). Job security also has an independent positive correlation with autonomy (path D). In turn, feelings of job security and autonomy share a negative relationship with perceived job stress (paths F and G), which, along with workplace sexism and job security, also relate to self-reported health (paths H, B, and E). Perceived job stress and self-

Fig. 1 Model of Organizational Health and Workplace Sexism. Model controlled for participants' income, age, and race/ethnicity. Standardized estimates are reported for each pathway. * $p < .05$. ** $p < .01$, *** $p < .001$

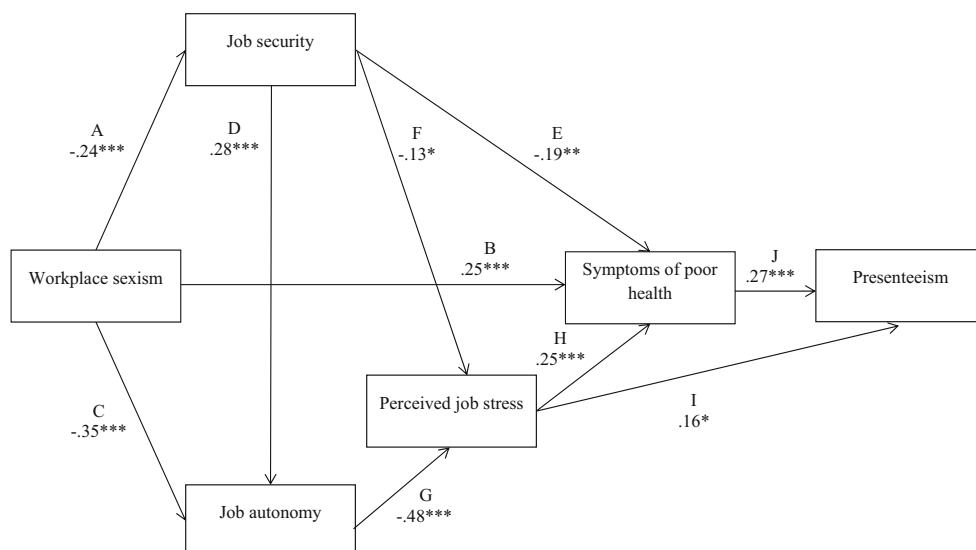


Table 3 Indirect effects, controlling for participants' income, age, and race/ethnicity, study 2

Pathways	<i>B</i>	<i>SE</i>	95% CI
Workplace sexism → Job security → Job autonomy	-.09	.03	[-.16, -.03]
Workplace sexism → Job security → Perceived job stress	.06	.03	[.20, .14]
Workplace sexism → Job security → Poor health symptoms	.06	.02	[.02, .11]
Workplace sexism → Job autonomy → Perceived job stress	.19	.04	[.12, .28]
Workplace sexism → Poor health symptoms → Presenteeism	.76	.26	[.37, 1.40]
Job security → Job autonomy → Perceived job stress	-.13	.03	[-.21, -.08]
Job security → Perceived job stress → Poor health symptoms	-.06	.02	[-.10, -.03]
Job security → Poor health symptoms → Presenteeism	-.80	.25	[-1.39, -.42]
Job autonomy → Perceived job stress → Poor health symptoms	-.09	.02	[-.14, -.04]
Job autonomy → Perceived job stress → Presenteeism	-.76	.27	[-1.34, -.30]
Perceived job stress → Poor health symptoms → Presenteeism	.85	.27	[.43, 1.51]

reported health are then ultimately associated with employee rates of presenteeism (paths I and J). Therefore, the model predicts that women who encounter frequent sexism in the workplace will report lower feelings of job security and job autonomy, along with increased perceived job stress and symptoms of poor health. These women also demonstrate increased rates of working during periods of illness. Thus, the OHWS suggests that experiences of workplace sexism and other perceptions of work-related outcomes may relate to higher rates of sick-work attendance among female employees, a trend that may damage both individual and organizational long-term productivity.

General Discussion

The current U.S.-based studies investigated the relationship of experienced workplace sexism on women's health, perceived job factors, and subsequent rates of attending work while sick (presenteeism). Consistent with recent presenteeism models, adverse work perceptions are associated with negative health outcomes (Pohling et al. 2015) which then correlate with increases in the rate of employee sick work attendance. Additionally, the OHWS model includes the overarching influence of a sexist work environment on sick work attendance, making a novel contribution to the presenteeism literature. Aligning with previous findings that stigmatized individuals develop increased health impairments (Gee et al. 2007; Pascoe and Smart-Richman 2009; Williams and Mohammed 2010), women who report more sexism at their jobs indicate poorer health than those encountering little to no workplace sexism. Furthermore, stigmatized women report higher sick work attendance, corroborating more general findings that stressed employees counterintuitively exhibit greater presence at work, particularly while ill (Elstad and Vabø 2008; Robertson et al. 2012). Thus the OHWS model supports previous findings in the organizational, health, and stigma literatures, while bridging these areas to demonstrate the damaging impact of a discriminatory work environment.

Limitations and Directions for Future Research

The current research provides a novel examination of a discriminatory work environment as a potential motivator of presenteeism for stigmatized workers. However, because individuals experience discrimination resulting from a multitude of biases, future research should investigate the role of workplace discrimination for employees of other stigmatized groups, such as racial or sexual orientation minorities. Moreover, the current studies remained limited to a single assessment of each factor, and so additional work should investigate these trends over time to examine the longitudinal effects of a discriminatory work environment on presenteeism, as well as ensuing employee productivity. Although SEM techniques allow for an examination of the complex relationships among multiple variables, the findings still remain correlational. The strength of the OHWS in comparison to the alternative model supports the directionality of the observed relationships; however, future research should directly test the causality implied by the proposed model.

Additionally, these current studies reflect the measures used. Although the GSS is a nationally representative dataset in the United States, the measurement of its variables was not designed with the current study in mind. Alternatively, the measures for Study 2 were created to assess the hypotheses of the OHWS. This difference may account for the disparity between women indicating experiences of workplace sexism in the two studies. Study 2 was framed as a survey of workplace experiences and asked women to consider their encounters of sexism using multiple items, perhaps prompting them to more deeply reflect on sexist and discriminatory interactions at their place of employment. Due to the nature of the GSS, Study 1 was limited to a one-item assessment of experienced workplace sexism within a large, general survey. Women responding to the GSS may have only cursorily considered their recent work experiences, resulting in lower rates of reported sexism.

Whereas Study 2 directly tested the OHWS, data were collected through Amazon Mechanical Turk (MTurk). However, despite concerns related to online samples (e.g. representativeness, attention, self-selection), evaluations of the MTurk subject pool suggest similar performance to typical convenience samples recruited through traditional means (Berinsky et al. 2012). Regarding the particular aim of assessing employed women's experiences of workplace sexism, MTurk samples may be preferable to traditional student subject pools because MTurk participants are typically older and have more employment experience. Yet even with precedence for representativeness, the sample recruited for Study 2 reportedly earned less annual income than the national average of \$47,230 (Bureau of Labor Statistics 2014). Therefore, future research should test the application of the OHWS for samples representing both the average national income, as well as lower socio-economic status, because financially disadvantaged individuals may face unique experiences of discrimination, health, and job perceptions—potentially contributing to distinct patterns of work attendance.

Practice Implications

Sick employees at work may be less productive, prolong or exacerbate their illness, and endanger co-workers through contagion. With the substantial monetary losses presenteeism poses for organizations (Hemp 2004), understanding the risk factors associated with an employee's decision to attend work while sick remains crucial for employers in order to maintain optimal organizational efficiency. Although managers may seek to alleviate many of the already established antecedents of presenteeism (e.g., job security, job autonomy, work stress), our research suggests that a discriminatory work environment may underlie, or at least intensify, these factors. Without aiming policies toward minority and stigmatized workers, employers may predispose these already vulnerable employees to the pressures associated with sick-work attendance.

As many organizations seek to implement non-discrimination policies and norms, future research may aim to investigate how such initiatives affect stigmatized employees' perceptions of discrimination, health, and attendance behaviors. Acknowledging the links between workplace discrimination, health, and job perceptions may allow both employers and employees to consider the unique burden felt by minority and female workers. Additionally, organizations may wish to consider how attendance policies may disproportionately pressure affected employees to attend work during periods of illness. Including concerns regarding health and attendance in non-discrimination policies may benefit stigmatized employees, decreasing rates of illness, job dissatisfaction, and employee burnout.

Conclusions

Although undoubtedly a portion of a larger, more complex system, our initial model provides an explanation for the seemingly counterintuitive increased work attendance by stigmatized employees experiencing greater health complications. The current research bridges the stigma, health, and organizational literatures as a first endeavor to address a pervasive issue faced by both employers and employees alike.

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