

**THE ROLE OF COPING IN MODERATING THE NEGATIVE
IMPACT OF WORKPLACE AGGRESSION**

A Thesis
Presented to
The Academic Faculty

by

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In Partial Fulfillment
Of the Requirements for the Degree
Master of Science in the
School of Psychology

Georgia Institute of Technology
December 2011

**THE ROLE OF COPING IN MODERATING THE NEGATIVE
IMPACT OF WORKPLACE AGGRESSION**

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ACKNOWLEDGEMENTS

I would like to thank my mother, for her constant support and for always cheering me on and believing in me. I would like to thank Patrick for his unwavering love and support and for always serving as a sounding board. I really appreciate all your help along the way. Special thanks also to Abbie, for motivating me in ways I never thought possible and for giving me the gift of seeing the world in a whole new way. I wouldn't have made it this far without you three.

TABLE OF CONTENTS

	Page
ACKNOWLEDGEMENTS	iii
LIST OF TABLES	vi
LIST OF FIGURES	vii
SUMMARY	viii
<u>CHAPTER</u>	
1 Introduction	1
Stressor-Strain Framework	2
Prevalence of Workplace Aggression	3
Outcomes of Workplace Aggression	4
Coping	7
The Current Study	11
2 Method	12
Focus Group	12
Participants	12
Measures	13
Procedure	15
3 Results	16
4 Discussion	30
Limitations	34
Future Research	35
APPENDIX A: Items added to the Brief COPE measure	38
APPENDIX B: Correlations and descriptive statistics for study variables	39

APPENDIX C: Survey measures	42
REFERENCES	48

LIST OF TABLES

	Page
Table 1: Reliability of JDI subscales.	14
Table 2: Component Correlation Matrix.	16
Table 3: Eigenvalues and variance explained.	17
Table 4: Communalities.	17
Table 5: Structure matrix of factor analysis of coping measure.	18
Table 6: Description of coping factors.	18
Table 7: Regression of well-being on workplace aggression and coping tested within one model.	21
Table 8: Regression of well-being on workplace aggression and coping tested individually.	22
Table 9: Regression of coworker satisfaction on workplace aggression and coping tested with one model.	23
Table 10: Regression of coworker satisfaction on workplace aggression and coping tested individually.	24

LIST OF FIGURES

	Page
Figure 1: Moderation analysis plot (distraction/channeling scale)	25
Figure 2: Moderation analysis plot (support/self-blame scale)	25
Figure 4: Moderation analysis plot (active emotional scale)	26
Figure 4: Moderation analysis plot (accept/suppress scale)	26
Figure 5: Moderation analysis plot (religion scale)	27
Figure 6: Moderation analysis plot (distraction/channeling scale)	27
Figure 7: Moderation analysis plot (support/self-blame scale)	28
Figure 8: Moderation analysis plot (active emotional scale)	28
Figure 9: Moderation analysis plot (accept/suppress scale)	29
Figure 10: Moderation analysis plot (religion scale)	29

SUMMARY

Research has established that workplace aggression leads to a multitude of negative outcomes for individuals and organizations. This study aimed to determine if certain coping strategies could assuage the negative impact of workplace aggression on two outcomes: job satisfaction and psychological well-being. A study of nurses explored their experiences with being the target of verbal, passive, and physical workplace aggression, their job satisfaction, psychological well-being, and their coping strategies. Results indicate that coping style does indeed moderate the relationship between being the target of workplace aggression and negative outcomes. Implications for the workplace are discussed.

CHAPTER 1

INTRODUCTION

Workplace aggression can be defined as any form of behavior intended to harm an individual within an organization or an organization itself (Folger & Baron, 1996). This definition broadly encompasses forms of aggression that are physical (e.g., shoving, hitting, unwanted touching), verbal (e.g., threats, insults), and passive (e.g., withholding information, spreading rumors, being consistently late or absent). It is important to note that this is a psychological definition of aggression that includes a component of intentional harm; therefore, behaviors such as general assertiveness that are not intended to cause harm (e.g., a pushy salesperson) are not considered aggressive under this definition. Extensive previous research has identified workplace aggression as problematic. Here, the focus will be on the victims of aggressive behavior in the workplace, to better understand the impact of workplace aggression for those who experience it. Further, this study will add to the current understanding of workplace aggression by assessing whether certain coping responses can minimize the negative effects of workplace aggression.

A stressor-strain framework is used to outline the problem of workplace aggression. I will discuss workplace aggression as a stressor and review findings related to the types, prevalence, and sources of workplace aggression. I will then summarize the literature on the outcomes of workplace aggression. Additionally, coping style will be discussed as a potential moderator of the relationship between workplace aggression and its negative outcomes. Empirical tests will be utilized to examine the relationships between experiencing workplace aggression, coping methods, job satisfaction, and psychological well-being.

Stressor-Strain Framework

Previous research has focused on identifying stressor-strain relationships in the workplace, often with the goal of finding ways to reduce the impact of stressors. Stressors can be defined as “aspects of one’s work environment that could be harmful to the employee and require adaptive responses” (Bowling & Beehr, 2006, p. 1001). Strains, on the other hand, are the outcomes of a given stressor. Thus, within this framework, workplace aggression can be conceptualized as a stressor, while the specific outcomes of aggression are considered strains.

Traditional workplace stressors that have been studied include role conflict, role ambiguity, role clarity, negative performance related events (e.g., losing a sale), and work overload (Brown, Westbrook, & Challagalla, 2005; Jex, Bliese, Buzzell, & Primeau, 2001). Very little previous research has considered workplace aggression as a stressor (see Bowling & Beehr, 2006, for an exception). This paper will apply a stressor-strain framework to the study of workplace aggression. Being the target of aggression clearly fits the definition of a stressor, as it is an aspect of the work environment that is likely to be harmful for those affected by it. Additionally, very little previous research has considered the role of individual differences in stressor-strain relationships (Jex, Bliese, Buzzell, & Primeau, 2001). Coping style can be conceived of as one such individual difference, which may influence the relationship between workplace stressors and strains. Thus, this study will add to the current literature by applying the stressor-strain framework to workplace aggression and its outcomes, and by assessing individual

differences in coping style as a potential moderator of the relationship between workplace aggression and its associated outcomes.

Prevalence of Workplace Aggression

Although the media tends to concentrate on extreme, severe incidents of physical aggression in the workplace (e.g., homicide, physical attacks), verbal and passive forms of aggression are actually much more prevalent (Neuman & Baron, 1998). In addition, Griffin and Lopez (2005) assert that relatively mild forms aggression can often be enduring because they are tolerated more than physical aggression, which contributes to the problematic nature of verbal and passive aggression. It is also important to note that there is often a pattern of progression with workplace aggression, such that verbal or psychological abuse can escalate to more severe forms of aggression such as physical assault (Barling, 1996; Dupre, Inness, Connelly, Barling, & Hopton, 2006).

In 1999, a study conducted by the U.S. Postal Service found that 1 in 20 U.S. workers were physically assaulted, 1 in 6 were sexually harassed, and 1 in 3 were verbally harassed (Schat & Kelloway, 2003). Homicide is the second leading cause of death in the workplace for men and the leading cause of death in the workplace for women (Miller, 1999; Neuman & Baron, 1998). Additionally, workplace aggression is not a problem unique to the United States. A 1998 study of European countries reported rates of workplace mobbing (i.e., long-lasting non-physical abuse) such as 16.3% in Great Britain, 10.2% in Sweden, and 9.9% in France (Invernizzi, 2000). Based upon a study conducted in Sweden, researchers estimate that 1 in 7 suicides are related to workplace harassment and abuse (Bjorkqvist, Osterman, & Hjelt-Back, 1994).

Additionally, the prevalence of workplace aggression can vary widely based on the field or industry of employment. Certain occupations have extraordinarily high rates of workplace aggression; for example, 90% of emergency medical technicians report that they have been physically assaulted while working (Pozzi, 1998). Barling, Rogers, and Kelloway (2001) found that 32% of health care professionals in their study had been the target of verbal aggression. Additionally, Whittington, Shuttleworth and Hill (1996) found that nurses experienced higher rates of physical aggression, verbal abuse, and threats than did other hospital employees. In a study by Lanza (1992), 16% of nurses reported being physically assaulted while working in the previous year, and the author warns that such assaults often go unreported, so this is likely an underestimation. Because of the high base rate of workplace aggression within the healthcare industry and the fact that these rates are rising (Whittington et al., 1996), this study will focus on nurses' experiences of being the target of workplace aggression.

Outcomes of Workplace Aggression

Workplace aggression is problematic and has been linked to high costs for organizations and a host of negative psychological, physical, and job-related outcomes for individuals. According to the Bureau of Justice Statistics (1994), workplace victimization (excluding homicide) results in over \$55 million in lost wages annually due to missed days of work, not including days covered by sick and annual leave. Additional costs to organizations include employee medical expenses, legal expenses, expenses associated with increased turnover, decreased productivity and performance, negative publicity (which may result in lost business), and increased costs of security and insurance (Miller, 1999; Vandebos & Bulatao, 1996).

Previous research has established relationships between experiencing workplace aggression and a variety of negative consequences for individuals, with many being job-related. Numerous studies have established a link between being a target of aggression in the workplace and lowered job satisfaction (Bowling & Beehr, 2006; Budd, Arvey, & Lawless, 1996; Glomb, 2002; Keashly, Trott, & MacLean, 1994; Lim & Cortina, 2005; Rowe & Sherlock, 2005; Tepper, 2000). Experiencing workplace aggression has also been linked to increased job stress (Budd, Arvey, & Lawless, 1996; Glomb, 2002; Lim & Cortina, 2005), increased work withdrawal and job neglect (e.g., leaving early, excessive absenteeism) (Cortina & Magley, 2001; Glomb, 2002; Lim & Cortina, 2005; Schat & Kelloway 2000; Schat & Kelloway, 2003), and actual turnover or turnover intentions (Bowling & Beehr, 2006; Budd, Arvey, & Lawless, 1996; Keashly, Trott, & MacLean; Tepper, 2000).

Being the target of workplace aggression also predicts lowered job performance (Glomb, 2002), decreased organizational commitment (Bowling & Beehr, 2006; Leblanc & Kelloway, 2002), burnout (Bowling & Beehr, 2006), and counterproductive work behavior on the part of the target (Bowling & Beehr, 2006). Additionally, several studies have found that being the victim of workplace aggression leads to negative emotions at work and worsened job-related affect (Bowling & Beehr; Schat & Kelloway, 2000; Schat & Kelloway, 2003). Tepper (2000) found that victims of workplace abuse experienced increased conflict between work and family. Budd, Arvey, and Lawless (1996) found that being attacked or threatened in the workplace was related to increased likelihood of bringing a weapon to work (which could lead to more violence).

There are additional outcomes of workplace aggression that are psychological or physical in nature. Rospenda and colleagues conducted a longitudinal study and found that workplace abuse was related to increased odds of illness, injury, and assault in the future (Rospenda, Richman, Ehmke, & Zlatoper, 2005). Employees who have been targets of workplace aggression often experience worsened psychological well-being, increased psychological distress, depression, anxiety, emotional exhaustion, frustration, increased fear of future aggression, and post-traumatic-stress disorder (Bjorkqvist, Osterman, & Hjelt-Back, 1994; Bowling and Beehr, 2006; Cortina and Magley, 2001; Leblanc & Kelloway, 2002; Schat & Kelloway, 2000; Schat & Kelloway, 2003; Tepper, 2000).

Research has also established that both direct violence and vicarious violence (i.e., watching a coworker be abused) in the workplace are related to worsened somatic health (e.g., sleep disturbances, gastrointestinal symptoms, headaches) (Leblanc & Kelloway; Schat & Kelloway, 2000; Schat & Kelloway, 2003). In addition, Bowling and Beehr (2006) established links between experiencing aggression and decreased self-esteem and lowered life satisfaction. Bamberger and Bacharach (2006) found that being the target of workplace aggression predicted problem drinking. Experiencing aggression in the workplace has even been linked to increased problem drinking in retirement (Richman, Zlatoper, Ehmke, & Rospenda, 2006).

Specific to the field of healthcare, Brough (2005) found that paramedics' experiences with verbal and physical aggression predicted poor job satisfaction. Also, nurses' experiences with verbal aggression have been linked to turnover, low morale, decreased job productivity, increased job stress, and lowered job satisfaction (Rowe &

Sherlock, 2005). Lanza (1992) found that nurses experience a multitude of negative effects of physical workplace aggression, including fear, feelings of helplessness and disbelief, irritability, anger, depression, anxiety, shock, self-blame, difficulty returning to work, headaches, sleep problems, body tension, and denial.

This study examines two potential outcomes of workplace aggression: low job satisfaction and poor psychological well-being. These outcomes have important implications for both individuals and organizations. For example, poor psychological well-being is harmful for individuals, and is a meaningful outcome for organizations because it may be related to lowered job performance, as a result of cognitive difficulties and trouble concentrating (Barling, Rogers, & Kelloway, 2001). Job satisfaction is clearly detrimental to individuals in addition to being important to organizations, as it is linked to poor job performance, organizational citizenship behavior, turnover, burnout, and physical health (Spector, 1997). However, it should be noted that many of these relationships are not straightforward and tend to involve other variables as well.

Coping

Minimal research has investigated how to prevent or reduce the negative consequences of workplace aggression (Schat & Kelloway, 2003). Although developing interventions aimed at preventing workplace aggression itself is a worthwhile goal, it is not a complete solution. Thus, researchers should also seek factors that may reduce the harmful impact of aggression when it does occur. Coping strategies are one possible buffer for the negative outcomes of aggression; this relationship has been established in the literature for other workplace stressors, but not for aggression. For example, coping style was found to moderate the negative consequences of job stress relating to loss of a

major sale among sales employees (Brown, Westbrook, & Challagalla, 2005) and the effects of general work stress on psychological well-being (Fortes-Ferreira, Peiro, Gonzalez-Morales, & Martin, 2006). Because of the similarities among the consequences of aggression and other workplace stressors, I suggest that methods of coping would operate in similar ways (e.g., as a moderator) across different types of stressors, including workplace aggression.

Coping strategies are defined as behavioral and cognitive efforts to manage specific external or internal demands that are appraised as taxing or exceeding the resources of the individual (Folkman, Lazarus, Gruen, & DeLongis, 1986). Coping strategies “play an important role in determining the results or consequences of stressors” (Fortes-Ferreira et al., 2006, p. 293). Currently, research is needed to determine the efficacy of various coping methods, specifically in work situations (Fortes-Ferreira et al., 2006). The goals of this study are to determine how nurses cope with workplace aggression and which coping strategies are most efficacious in dealing with workplace aggression.

There are several different models of coping proposed in the literature. Many studies focus on emotion-focused coping (i.e., regulating emotional arousal or tension associated with the situation) and problem-focused coping (i.e., dealing with the problem that is causing distress). Research has typically found that problem-focused coping (e.g., planning, information seeking, taking action) is more advantageous when compared to emotion-focused coping (e.g., seeking emotional support, denial, self-blame) (Jex, Bliese, Buzzell, & Primeau, 2001; Kochenderfer-Ladd, 2004). These studies suggest that emotion-focused coping may be dysfunctional because it does not alter or eradicate the

actual problem. However, to the contrary, Wykes and Whittington (1991) found that nurses most often used palliative, emotion-focused coping strategies to deal with patient assaults, and that this type of coping leads to a reduction in psychological distress over time.

There may be some situations, especially in the workplace, when problem-based strategies cannot realistically be utilized, so emotion-based coping strategies may be the only available strategies. Being the target of workplace aggression can be stressful not only because of any one incident but because ongoing victimization and stress. In these instances, aggression as a chronic work stressor may be resistant to an actual solution, and consequently, emotion-focused strategies are all that are available. Individuals may feel that they do not have control over the actual stressors, but instead feel that they can control the emotional consequences. It is also suggested that some passive/emotional coping strategies may be adaptive while others may be maladaptive, which further complicates the use of this categorization. These equivocal results point to a need for further research on various coping methods and their effectiveness, and suggest that this dichotomization of coping strategies may not be useful when examining workplace stressors.

Furthermore, according to Dewe (1989) there are many other taxonomies used to categorize coping strategies, including active-passive and control-avoidance, among others. Sometimes social support is given as a third dimension for one of the above frameworks (Dewe, 1989). Moos and Billings (1982) describe coping based on three styles: active-cognitive, active-behavioral, and avoidance. Greenglass (1993) adds social coping, which includes social and interpersonal coping strategies, to the typology of

problem-emotion focused coping. Preventative coping is yet another proposed coping style, which focuses on promoting one's well-being and reducing the likelihood of problems in the future (Roskies, 1991). This style includes physical activity, relaxation, good sleeping and eating habits, and planning, time management, and social support skills. Positive affectivity and negative affectivity have also been used to categorize coping strategies (Watson & Clark, 1984). People high in negative affectivity are more likely to use defeatist strategies such as avoidance and disengagement, while those high in positive affectivity are more likely to use active strategies.

Dewe & Guest (1990) conducted a qualitative study that was used to create a measure of coping (with work stress) that resulted in six scales of coping: rational task-oriented coping behaviors (e.g., taking some immediate action), emotional relief (e.g., taking one's feelings out on others), use of home resources (e.g., talking things over with spouse), preparation (e.g., take a break and coming back to the problem later), distraction behaviors (e.g., go have a few beers), and passive attempts to tolerate the situation (e.g., trying not to worry or think about it). A study by Dewe (1989b) also looked at coping with work stress, and the analyses resulted in a different set of six factors of coping: problem-oriented behavior (e.g., stand back and try to rationalize the situation), try to unwind and put things in perspective (e.g., distract with a fun activity), express your feelings or frustrations (e.g., expressing your irritation to other colleagues), keeping the problem to yourself (e.g., eat more, have a good cry), accept the job as it is and try not to let it get to you (e.g., just shut off from things going on around you), and passive strategies for handling the situation (e.g., smoking more, drinking more tea and coffee).

These studies illustrate that there is a definite lack of a single taxonomy of coping in the literature, and in fact the structure of coping may vary for different populations, different stressors, or different situations. Thus, this study aimed to determine the structure of coping styles used by nurses when dealing with the specific stressor of workplace aggression.

In addition, this study aims to determine which coping strategies are adaptive (i.e., those that lead to better outcomes) or maladaptive (i.e., those that lead to worsened outcomes) in dealing with workplace aggression. It is hypothesized that the stressor-strain relationship will be weaker when adaptive coping strategies are used and stronger when maladaptive coping strategies are used. In other words, adaptive coping strategies are expected to act as a buffer for the negative consequences of being the target of workplace aggression.

The Current Study

The current study investigates nurses' experiences with workplace aggression and seeks to determine if certain coping strategies may be more efficacious when dealing with aggression in the workplace. The major goals of this study are (1) to establish a taxonomy of coping strategies used for dealing with workplace aggression and (2) to determine if some coping strategies are more efficacious than others.

CHAPTER 2

METHOD

Focus Group

A preliminary focus group was conducted to aid with refinement of the study measures. Seven nurses at a public Southeastern hospital participated in the focus group, which involved piloting the measures and giving feedback. Participants were asked to take the Ways of Coping Questionnaire (Folkman & Lazarus, 1988), the Brief COPE (Carver, 1997), and the Generalized Workplace Abuse (Richman et al., 1999) measures. After completing the measures, they were all discussed. The participants greatly preferred the Brief COPE measure, but made several suggestions for additional items that could be added; thus, the measure was adapted based on the feedback from the focus group. No suggestions were made to change the Generalized Workplace Abuse measure and participants could not think of any aggressive acts that were not included in the measure, so no adaptations to the measure were made.

Participants

Participants for this study included 208 nurses who were employed at the time of the survey. Participants were all female, with an average age of 45 (SD = 13.391, range = 24 to 71). Participants self-reported their race/ethnicity: 69.2% reported being white/Caucasian, 19.2% reported being African American, 7.7% reported being Asian/Pacific Islander, and 3.8% selected “other” for their ethnicity.

Measures

Workplace Aggression

The Generalized Workplace Abuse measure (GWA; Richman et al., 1999) was used to assess experience of workplace aggression. The measure consists of 29 items that compose 5 subscales: verbal aggression (e.g., yelled or screamed at you), disrespectful behavior (e.g., made hostile or offensive gestures at you), isolation/exclusion (e.g., turned others in your work environment against you), threats/bribes (e.g., threatened that they would “get back at you”), and physical aggression (e.g., pushed or grabbed you). Items are rated on a three-point frequency scale as having occurred “never,” “once,” or “more than once” in the current job in the past year. Responses were scored positively only if they occurred more than once. Cronbach’s alpha for the overall measure was found to be .94.

Coping

An adapted version of the Brief COPE (Carver, 1997) was used to assess coping strategies. The measure was adapted with feedback from a focus group of nurses as described previously and the added items can be found in Appendix A. The final measure contained 37 items. Internal consistency reliability was established with Cronbach’s alpha of .88 for the overall measure.

Participants rated on a 4-point Likert scale the extent to which they used each coping strategy when they experienced workplace aggression. Scores for the items were summed to calculate a score for each subscale, with higher scores indicating greater use of the coping behaviors.

Job Satisfaction

Job satisfaction was measured with the Job Descriptive Index (JDI; Smith, Kendall, & Hulin, 1969). The JDI contains 72 items and measures attitudes towards five facets of job satisfaction, including the work itself, pay and benefits, opportunity for promotion, supervision, and coworkers. For each facet, there is a list of adjectives and short phrases (e.g., satisfying, bad, boring), and participants are asked to check “yes,” “no,” or “?” to indicate if the item applies to their job. Positive responses (“yes” to a positively worded item or “no” to a negatively worded item) are given a score of 1, negative responses (“yes” to a negatively worded item or “no” to a positively worded item) are given a score of 0, and “?” responses are not scored. Scores are summed to yield a score for each subscale and an overall job satisfaction score, with higher scores indicating higher job satisfaction. Reliability for each subscale was assessed by Cronbach’s alpha and is described in Table 1. The subscale alphas ranged from .70 to .93.

Table 1. Reliability of JDI subscales.

	Alpha	Number of items
Work	.81	18
Pay	.70	9
Promotion	.87	9
Supervision	.93	18
Coworkers	.82	18

Psychological well-being

Well-being was measured with the General Health Questionnaire (GHQ; Banks et al., 1980). The 12 item measure asks about recent feelings of general well-being (e.g., I

have felt constantly under strain; I have been feeling reasonably happy, all things considered). A 7-point response scale is used, with responses ranging from 1 (*never*) to 7 (*always*), with higher mean scores indicating higher psychological well-being (after reverse-scoring items as appropriate). Internal consistency of the scale was demonstrated with Cronbach's alpha of .83.

Procedure

Participants were members of a nursing organization and were recruited via email to fill out the online survey. The survey consisted of a cover letter explaining the study and asking for participation, a consent form, and the study measures. The participants remained anonymous with no identifying information collected.

CHAPTER 3

RESULTS

Correlations, means, and standard deviations for the main variables in the study can be found in Appendix B. With regards to understanding the prevalence of workplace aggression, 35% of participants endorsed no items (i.e., they didn't experience any of the aggressive behaviors more than once in the past year at their current job). The verbal aggression behaviors were the most commonly endorsed, with 52% of participants endorsing at least one item. For disrespectful behavior, 48% of participants endorsed at least one item. Forty-four percent of participants endorsed at least one isolation/exclusion item, 17% of participants endorsed at least one physical aggression item, and 13% of participants endorsed at least one item from the threats/bribes subscale. In addition, 17% of participants report being hit more than once in the past year, which is arguably the most extreme aggressive behavior included in the survey.

Principal components analysis with Promax rotation was conducted to determine the structure of the coping measure, which resulted in a five-factor solution (these five factors have Eigenvalues greater than one). Correlations among the five factors can be found in Table 2. The five factors accounted for 82.74% of the variance; eigenvalues and variance explained can be found in Table 3. See Table 4 for the communalities.

Table 2. Component Correlation Matrix.

	1	2	3	4	5
1	1	0.41	0.35	0.22	0.08
2	0.41	1	0.20	0.31	0.09
3	0.35	0.20	1	0.34	-0.02
4	0.22	0.31	0.34	1	-0.20
5	0.08	0.09	-0.02	-0.20	1

Table 3. Eigenvalues and variance explained.

	Eigenvalue	% of Variance	Cumulative % of Variance
1	5.28	37.74	37.74
2	2.02	14.45	52.19
3	1.75	12.51	64.70
4	1.51	10.77	75.47
5	1.02	7.27	82.74

Table 4. Communalities.

	Extraction
Self-distraction	.946
Active coping	.811
Emotional support	.695
Venting	.803
Instrumental support	.883
Positive reframing	.842
Self-blame	.841
Planning	.870
Humor	.618
Acceptance	.894
Religion	.925
Health-related behavior	.796
Anti-social behavior	.750
Suppression of feelings	.911

The structure matrix from this analysis can be found in Table 5 and the names of the factors, along with their reliabilities and number of items, can be found in Table 6.

Table 5. Structure matrix of factor analysis of coping measure.

	1	2	3	4	5
Self-distraction	<u>0.870</u>	0.635	0.393	0.178	0.373
Active coping	0.445	0.066	<u>0.822</u>	0.178	-0.237
Emotional support	0.233	<u>0.760</u>	-0.088	-0.030	0.255
Venting	-0.114	0.139	<u>0.779</u>	0.239	0.056
Instrumental support	0.261	<u>0.849</u>	0.355	0.542	-0.190
Positive reframing	0.590	0.248	<u>0.841</u>	0.294	0.182
Self-blame	0.560	<u>0.879</u>	0.356	0.375	0.051
Planning	<u>0.816</u>	0.332	0.692	0.370	0.092
Humor	<u>0.665</u>	0.269	0.195	0.218	-0.362
Acceptance	0.081	0.144	0.375	<u>0.909</u>	-0.375
Religion	0.004	0.038	-0.027	-0.204	<u>0.959</u>
Health-related behavior	<u>0.824</u>	0.587	0.155	0.197	-0.024
Anti-social behavior	<u>0.840</u>	0.171	0.207	0.176	0.067
Suppression of feelings	0.369	0.380	0.177	<u>0.898</u>	0.015

Table 6. Description of coping factors.

	Name of scale	Alpha	Number of items
Factor 1	Distraction/Channeling	.89	14
Factor 2	Support/Self-blame	.87	8
Factor 3	Active/Emotional	.85	7
Factor 4	Accept/Suppress	.74	5
Factor 5	Religion	.97	2

Factor 1 consisted of subscales for self-distraction, humor, health-related behavior, anti-social behavior, and planning, and was termed the "distraction/channeling scale" because these behaviors represent channeling one's energy into other activities or distractions as a form of coping. Factor 2 consisted of subscales for emotional support, instrumental support, and self-blame, and was termed the "support/self-blame scale". Factor 3 consisted of subscales for active coping, venting, and positive reframing, and was termed the "active emotional scale". Factor 4 contained the acceptance and

suppression of feelings subscales, and was termed the "accept/suppress scale". Factor 5 contained only the religion subscale.

Correlation analysis demonstrated that workplace aggression was indeed related to well-being ($r = -.577, p < .01$), but was not related to overall job satisfaction ($r = -.006, n.s.$). Further analyses revealed that workplace aggression may only be related to certain facets of the job satisfaction measure. Specifically, the coworker subscale was found to be significantly related to workplace aggression ($r = -.286, p < .01$). Thus, further analyses will focus only on the coworker subscale of job satisfaction, which indicates one's satisfaction with the people one works with, rather than the overall measure.

Hierarchical regression (Baron & Kenny, 1986; Cohen, Cohen, West & Aiken, 2003) was then used to determine whether coping style is a moderator of the relationship between workplace aggression and the two dependent variables (well-being and satisfaction with coworkers). Centering procedures were utilized as suggested by Aiken & West (1991). Results (see Table 7 and Table 8) indicate that all five coping styles were significant moderators of the relationship between workplace aggression and well-being. Furthermore, two of the five coping styles were found to be significant moderators of the relationship between workplace aggression and coworker satisfaction when all five coping variables were included as moderators in a single model (see Table 9.). When tested individually, however, all five moderators reached significance (see Table 10). As suggested by Cohen et al. (2003), the relationships were then plotted to further examine the moderating relationships, by plotting lines for the mean and one standard deviation above and below the mean on the coping scales (see Figures 1 through 10). These plots indicate that for the distraction/channeling, support/self-blame, active emotional, and

religion scales, increases in coping behaviors lead to better outcomes for participants. Specifically, there is a strong negative relationship between workplace aggression and the outcomes for individuals who used less of these coping strategies. However, there is only a weak negative relationship for individuals who use more of these coping strategies, indicating that these forms of coping can have a buffering effect. This evidence suggests that these types of coping strategies can be adaptive ways of dealing with workplace aggression.

In contrast, those who tended to use more coping behaviors from the accept/suppress scale experienced worsened outcomes. In this case, there is a strong negative relationship between workplace aggression and well-being for individuals who used more of these coping strategies. On the other hand, there is a weaker negative relationship for those who use less of these types of coping methods. It seems that using these forms of coping actually exacerbates the negative effect of workplace aggression. These results indicate that the acceptance and suppression behaviors may be maladaptive coping behaviors for dealing with workplace aggression, while the other coping behaviors studied here seem to be adaptive in these situations.

Table 7. Regression of well-being on workplace aggression and coping tested within one model.

	β	β
Independent variables		
Workplace aggression (WA)	-.393***	-.203
Coping factor 1	-.596***	-.280***
Coping factor 2	.097	-.087
Coping factor 3	.216***	.035
Coping factor 4	-.102	.160**
Coping factor 5	-.135	-.179***
Interaction		
WA X coping factor 1		-.704**
WA X coping factor 2		.403*
WA X coping factor 3		.716***
WA X coping factor 4		.363***
WA X coping factor 5		.291**
R ²	.579	.902
ΔR^2	.579***	.323***

*Significant at the .05 level

**Significant at the .01 level

*** Significant at the .001 level

Table 8. Regression of well-being on workplace aggression and coping tested individually.

	Standardized coefficient β	ΔR^2
Independent variable		
Workplace aggression (WA)	-.577**	
Interaction		
WA X coping factor 1	.398**	.076**
WA X coping factor 2	.279**	.046**
WA X coping factor 3	.538**	.192**
WA X coping factor 4	-.200*	.020*
WA X coping factor 5	.268**	.054**

*Significant at the .05 level

** Significant at the .01 level

Table 9. Regression of coworker satisfaction on workplace aggression and coping tested with one model.

	β	β
Independent variables		
Workplace aggression (WA)	.349**	-.489
Coping factor 1	-.645***	-.801***
Coping factor 2	-.124	.019
Coping factor 3	.065	.319*
Coping factor 4	.073	.004
Coping factor 5	.472***	.510***
Interaction		
WA X coping factor 1		.951***
WA X coping factor 2		.218
WA X coping factor 3		-.482*
WA X coping factor 4		-.194
WA X coping factor 5		.281
R ²	.415	.661
ΔR^2	.415***	.246***

** Significant at the .05 level

*** Significant at the .01 level

Table 10. Regression of coworker satisfaction on workplace aggression and coping tested individually.

	Standardized coefficient β	ΔR^2
Independent variable		
Workplace aggression (WA)	.286**	
Interaction		
WA X coping factor 1	.386**	.071**
WA X coping factor 2	.482**	.136**
WA X coping factor 3	.681**	.309**
WA X coping factor 4	-.528**	.137**
WA X coping factor 5	.350**	.093**

** Significant at the .01 level

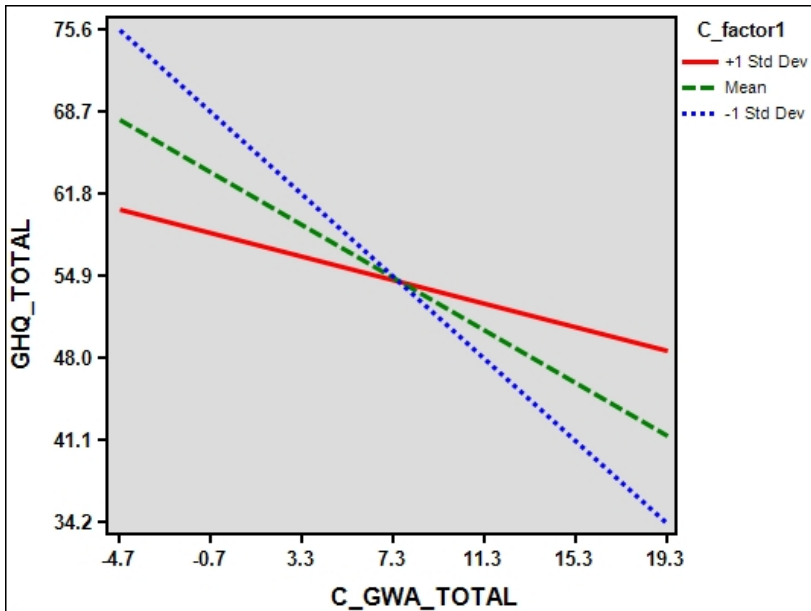


Figure 1. Moderation analysis plot. This figure illustrates that the relationship between workplace aggression and well-being is moderated by coping (distraction/channeling scale).

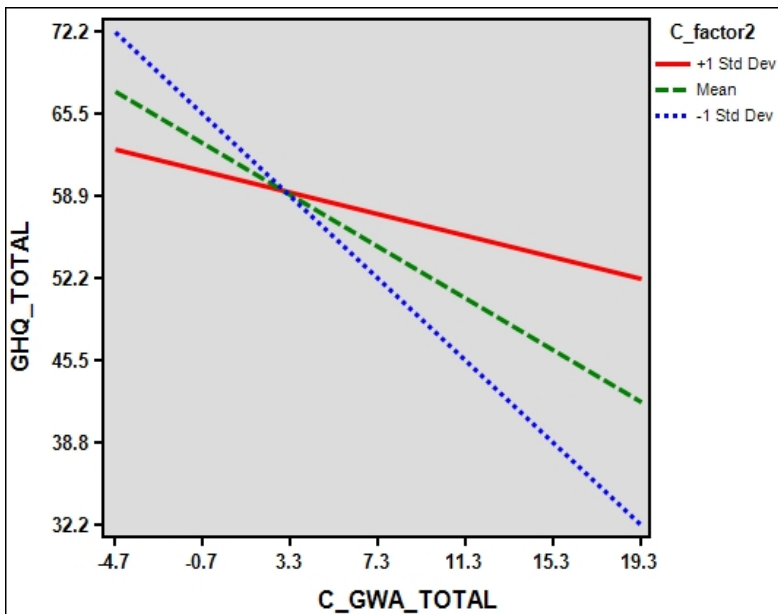


Figure 2. Moderation analysis plot. This figure illustrates that the relationship between workplace aggression and well-being is moderated by coping (support/self-blame scale).

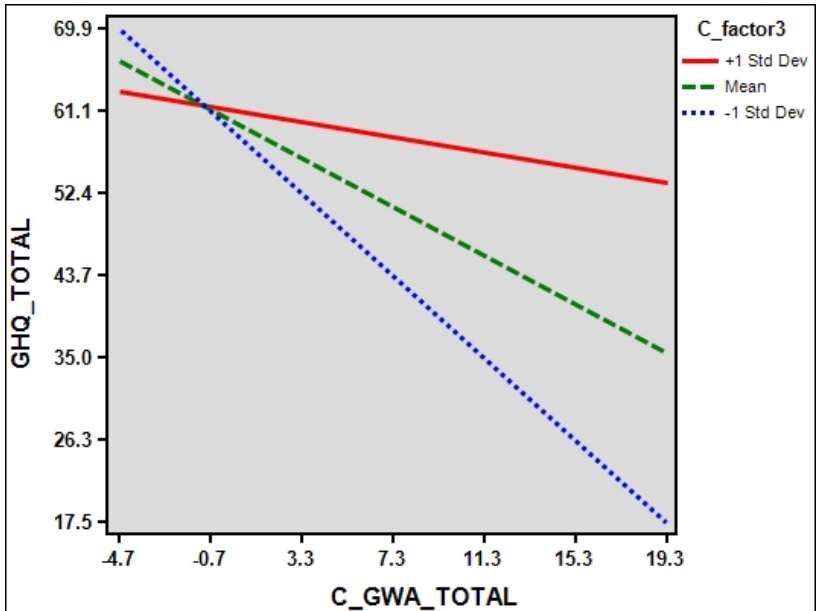


Figure 3. Moderation analysis plot. This figure illustrates that the relationship between workplace aggression and well-being is moderated by coping (active emotional scale).

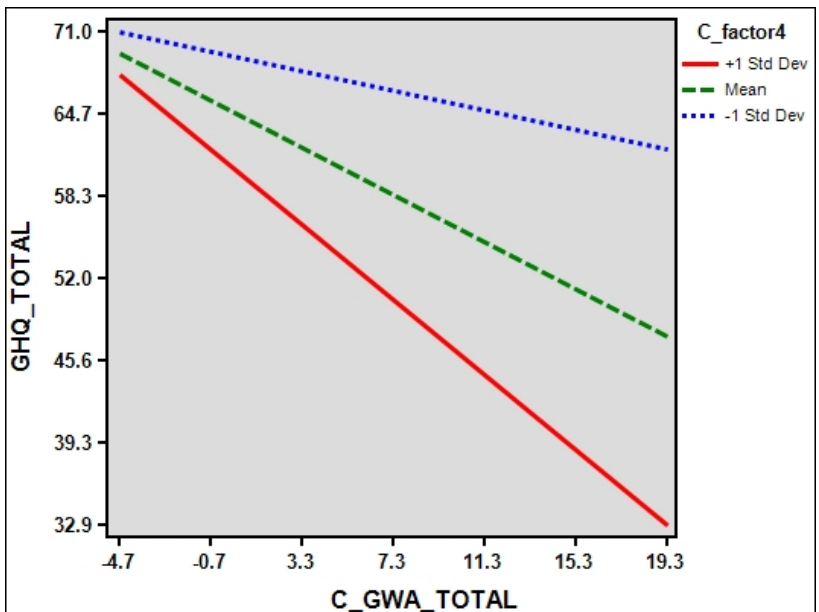


Figure 4. Moderation analysis plot. This figure illustrates that the relationship between workplace aggression and well-being is moderated by coping (accept/suppress scale).

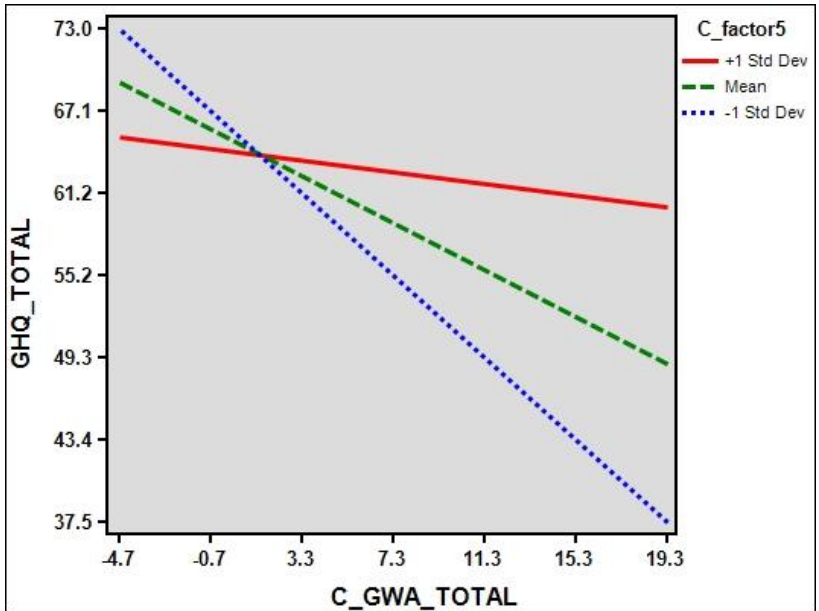


Figure 5. Moderation analysis plot. This figure illustrates that the relationship between workplace aggression and well-being is moderated by coping (religion scale).

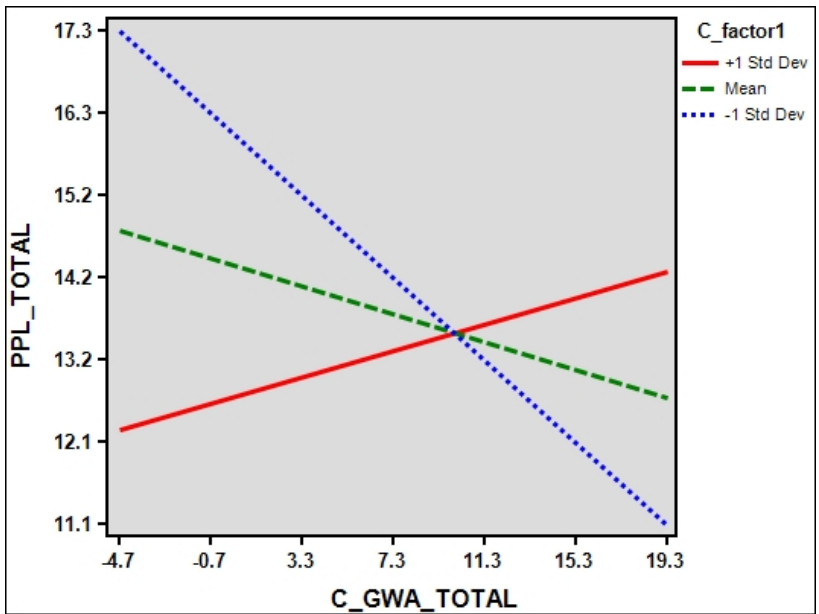


Figure 6. Moderation analysis plot. This figure illustrates that the relationship between workplace aggression and satisfaction with coworkers is moderated by coping (distraction/channeling scale).

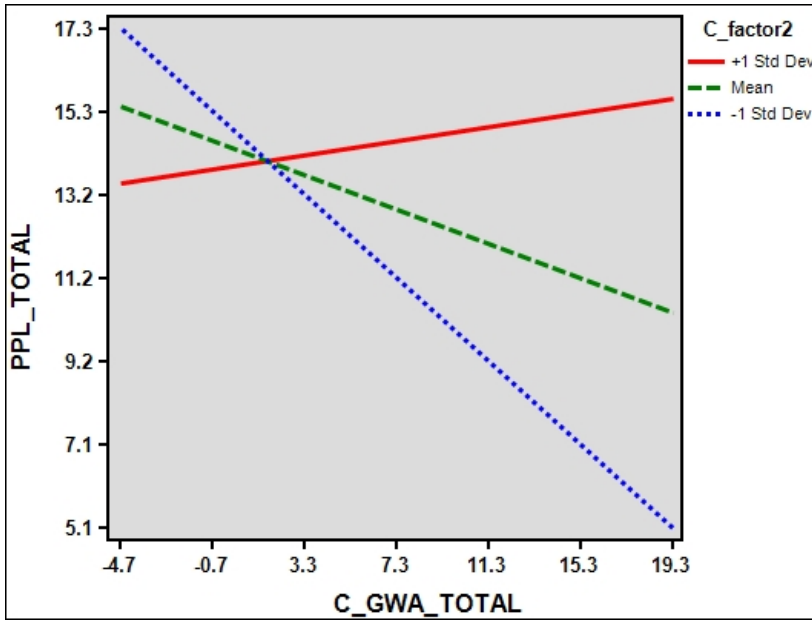


Figure 7. Moderation analysis plot. This figure illustrates that the relationship between workplace aggression and satisfaction with coworkers is moderated by coping (support/self-blame scale).

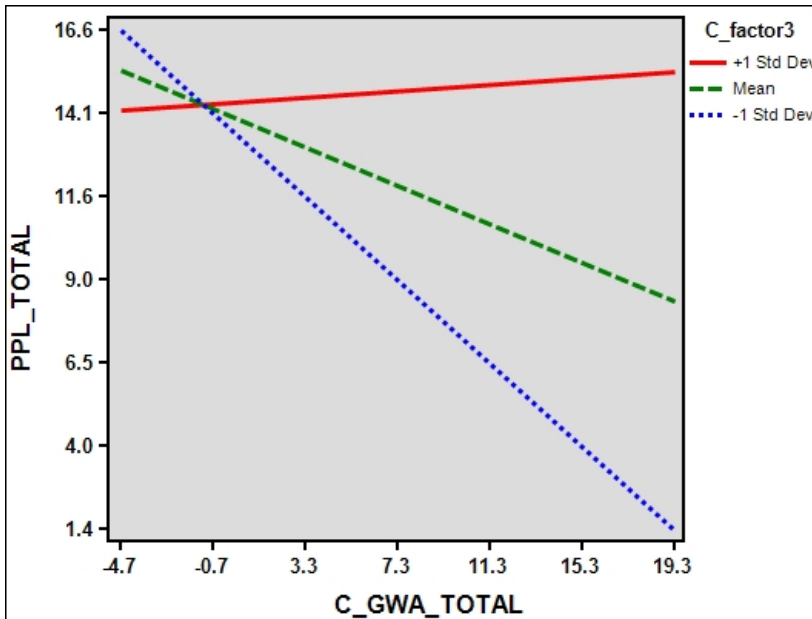


Figure 8. Moderation analysis plot. This figure illustrates that the relationship between workplace aggression and satisfaction with coworkers is moderated by coping (active emotional scale).

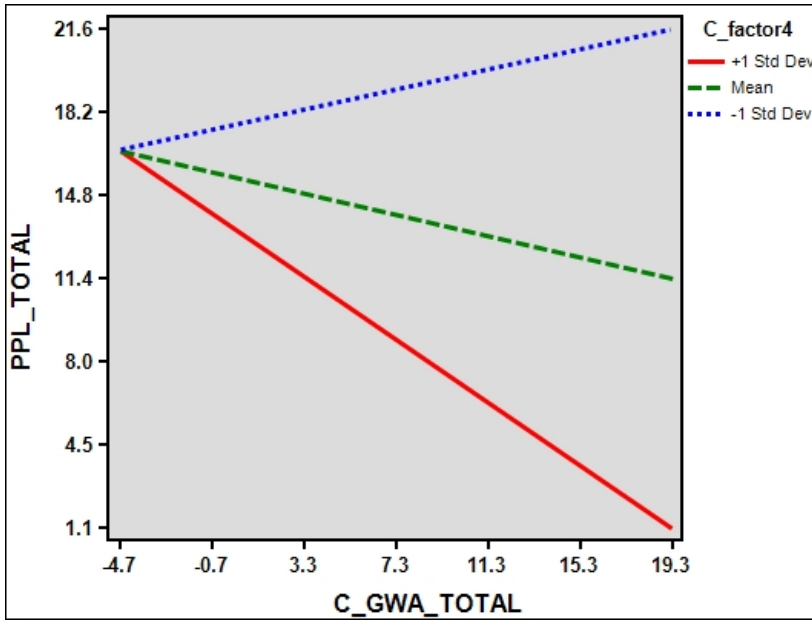


Figure 9. Moderation analysis plot. This figure illustrates that the relationship between workplace aggression and satisfaction with coworkers is moderated by coping (accept/suppress scale).

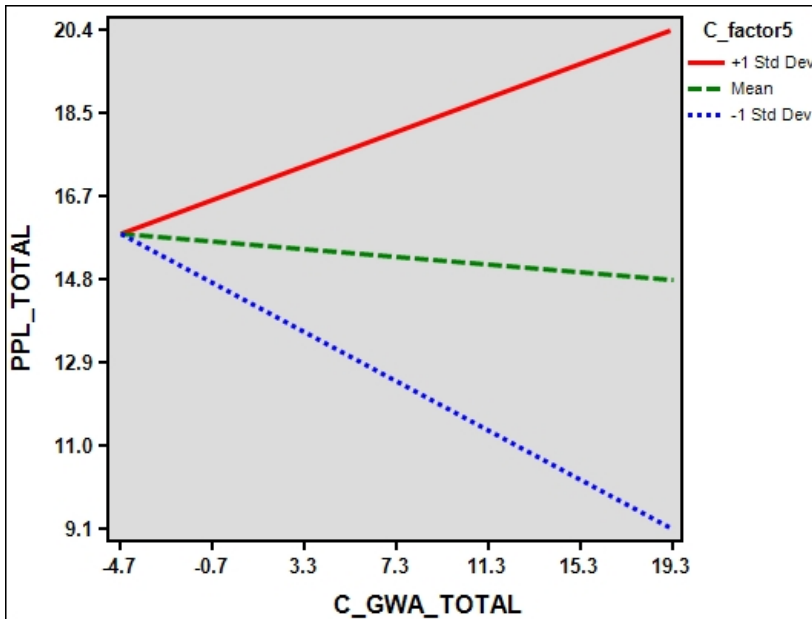


Figure 10. Moderation analysis plot. This figure illustrates that the relationship between workplace aggression and satisfaction with coworkers is moderated by coping (religion scale).

CHAPTER 4

DISCUSSION

Comparing the results regarding prevalence of aggression endured by nurses to rates found in prior research does not provide a clear indication of the trends over time. Because previous research by Whittington et al. (1996) only looked at patient aggression, it would be expected the rates from the current study would be higher because these rates include aggression from all sources. The current study found that 17% of participants had been physically assaulted, 13% had been threatened or bribed, and 52% had been verbally abused. On the other hand, Whittington et al. found that 27% of nurses had been physically assaulted, 25% had been threatened, and 50% had been verbally abused. Thus, the comparison of these rates initially seems to indicate that the prevalence of workplace aggression targeted at nurses is actually decreasing. However, this difference in rates could also be due to how prevalence was determined. In the present study, items are only endorsed if the participant was subject to that aggressive act more than once in the past year. However, Whittington et al. included items that participants reported experiencing only one time. Thus, their generally higher rates of aggression could be due to the fact that they included behaviors even when the participant reported experiencing that behavior only one time. Overall, the rates of aggression found in this study are not negligible and suggest that workplace aggression is an important problem within the healthcare industry.

As previous studies have done for general work stress (e.g., Dewe, 1989), this study aimed to develop a taxonomy of coping strategies used in response to being the target of workplace aggression. Factor analysis was conducted to delineate a

categorization of coping strategies, and a five-factor solution resulted. Factor 1 consisted of coping scales for self-distraction (e.g., I've been turning to work or other activities to take my mind off things), humor (I've been joking or laughing to make myself feel better), health-related behavior (I've been trying to make myself feel better by eating, drinking, smoking, using drugs or medication, etc.), anti-social behavior (I've been taking it out on other people), and planning (I've been trying to come up with a strategy about what to do), and was termed the distraction/channeling scale because these behaviors represent channeling one's energy into other activities or distractions as a form of coping. In addition, these types of strategies largely represent ways for the individuals to make themselves feel better.

Factor 2 consisted of scales for emotional support (e.g., I've been getting emotional support from others), instrumental support (e.g., I've been getting help and advice from other people), and self-blame (e.g., I've been blaming myself for things that happened), and was termed the support/self-blame scale. This finding suggests that people who use self-blame as a coping strategy may be unable to really help themselves cope, which may be why they tend to turn to others for support and help as a form of coping.

Factor 3 consisted of scales for active coping (e.g., I've been taking action to try to make the situation better), venting (e.g., I've been expressing my negative feelings), and positive reframing (e.g., I've been looking for something good in what is happening), and was termed the active emotional scale. Although venting and positive reframing are emotion-focused coping strategies, they are also active strategies because they represent

active attempts to express one's feelings or reframe one's feelings in a more positive way.

Factor 4 contained the scales for acceptance (e.g., I've accepted it, since nothing could be done) and suppression of feelings (e.g., I've been trying to keep my feelings from interfering with other things too much), and was termed the accept/suppress scale. These strategies seem to be avoidant in nature, in that the person using these strategies is not really trying to change the situation or the way they feel about it. Instead, they are accepting the situation for what it is and trying to suppress the emotional consequences they are encountering.

Interestingly, Factor 5 contained only the scale for religion (e.g., I've been trying to find comfort in my religion or spiritual beliefs). This finding suggests that future research may want to consider religion/spirituality as a unique coping style.

Through factor analysis, five general coping styles were identified, and interestingly, four of the five seem to be adaptive coping styles in response to workplace aggression. The only coping style that was found to be maladaptive was the accept/suppress scale (Factor 4). The items from this scale include statements such as "I've accepted it, since nothing could be done" and "I've been trying to keep my feelings from interfering with other things too much." These types of coping behaviors may indicate an avoidance of dealing with the problem and its emotional consequences. Thus, the results of this study indicate that almost all types of coping behaviors are helpful (i.e., they lead to better outcomes) in terms of dealing with workplace aggression, with the exception of these types of avoidance behaviors.

Results of this study indicate that workplace aggression leads to lowered psychological well-being; therefore, organizations have an additional reason to attempt to prevent aggressive acts from occurring. In addition to being a negative outcome for individuals, well-being has been found to significantly correlate with work neglect, which is important to organizational success (Lapierre, Spector, & Leck, 2005; Schat & Kelloway, 2000). Although workplace aggression was not related to overall job satisfaction, it was related to lowered satisfaction with one's coworkers. This finding indicates that lateral workplace aggression may be a problem among nurses.

Correlation analysis also showed that coping was negatively related to well-being, suggesting that increased use of coping is related to lowered well-being. However, when looking at the partial correlations between the coping factors and well-being, while controlling for workplace aggression, the strength of the correlations are reduced and two of them lose significance. This provides evidence that it is really the relationship between aggression and well-being that is carrying the relationship between coping and well-being. In other words, the fact that one even has anything to cope with (aggression in this case) is going to lead to negative well-being. Looking at the interactions allows for a greater understanding of the whole picture, in which coping moderates this relationship between aggression and well-being. In this case, only looking at the correlations fails to provide a complete picture of these relationships.

Results indicate that coping does in fact moderate the relationship between workplace aggression and two outcomes (well-being and satisfaction with coworkers). Results indicate that coping is a more consistent moderator of the relationship between workplace aggression and well-being, while there is only some evidence that coping

moderates the relationship between workplace aggression and coworker satisfaction. This finding makes sense, as the goal of coping may be to improve psychological well-being, so these are more proximal variables. Coworker satisfaction, however, is more removed from the coping process and there are many more variables that influence one's coworker satisfaction.

Four of the five coping style factors were found to buffer, or lessen, the negative impact of being the target of workplace aggression on these outcomes. This finding is extremely important because it demonstrates that although there are many negative effects of workplace aggression, there is at least one method to help diminish these negative consequences. In other words, individuals can be protected from the negative outcomes of aggression if they use adaptive coping methods.

These findings would suggest that secondary interventions could be developed in order to lessen the negative impact of aggressive behaviors in the workplace in the case that they cannot be prevented. Employees could be educated about the beneficial impact of using certain coping behaviors, which may cause them to be more likely to use these strategies when faced with workplace aggression, or other stressors, in the future. In addition, the maladaptive nature of avoidance coping behaviors could be highlighted, so that employees might be discouraged from using these types of unhelpful coping methods (e.g., suppressing one's feelings).

Limitations

This study is not without potential limitations. Common method bias is a possible limitation of this study, because all data were collected at one time and with one questionnaire. Additionally, because the measures are all self-report, response bias (e.g.,

bias due to social desirability) is another possible limitation within this study. However, due to the nature of studying workplace aggression, it is not possible to conduct an experimental study because it would be unethical to purposefully expose individuals to aggression. The goal of this study was to understand how individuals cope with aggression that they actually experience in the workplace, so self-report measures were the best way to obtain this data. However, now that coping methods are more clearly explicated, future research could look at this same moderation model using objective criteria as outcomes, such as turnover or grievances filed.

Another potential limitation of this study is that it is cross-sectional in design. Although this is a good starting point for research on this specific problem, future research that is longitudinal in design could greatly elucidate the time course and persistence of negative consequences of workplace aggression. The negative consequences of aggression may differ depending on whether the aggression is a chronic, ongoing problem. Additionally, because coping is conceptualized as a process that unfolds over time, longitudinal research could be utilized to better examine this as well (Folkman, Lazarus, Gruen, & DeLongis, 1986).

Future Research

Although this study focuses on one specific occupation, future research should determine whether these results would generalize to other occupations. In addition, this study looks at two specific outcomes of aggression; future research should examine whether certain coping strategies could help buffer other important negative consequences of workplace aggression, such as somatic symptoms or lowered organizational commitment. Further, because nurses are exposed to workplace aggression

from several sources, future research should explore whether aggression from different sources leads to differential outcomes for nurses, or whether the effectiveness of various coping strategies varies depending on the source of aggression. Future research that looks at sources of aggression as being internal or external to the work organization would be especially interesting. For example, it could be the case that aggression from internal sources (e.g., coworkers, supervisors) and aggression from external sources (e.g., patients, patients' family members) could lead to different outcomes or even require different coping methods. For example, aggression from patients might be more closely linked to well-being, while aggression from coworkers might be more closely linked to job satisfaction or coworker satisfaction. Nurses may feel especially helpless to use active forms of coping when the aggressor is a patient or a relative of a patient or the nurse may feel that enduring this aggression is simply part of the job. Future research could elucidate these relationships and make recommendations about specific coping strategies that can be employed depending on the source of the aggressive behavior.

This study can contribute to the current literature that seeks to understand the coping processes of employees and the problem of workplace aggression. Understanding coping reactions to workplace aggression can help to explicate a process that can lead to a wide range of negative organizational and personal outcomes, including psychological difficulties among employees. With a better understanding of this process, organizations may be more prepared to develop preventative programs. In addition, this study can provide useful information about one possible way to lessen the negative outcomes of aggression in the workplace. In terms of application, training programs within the workplace could be developed as a secondary intervention tool for dealing with

aggression. For example, employees could be taught about adaptive methods for coping with workplace aggression. In addition, counselors or clinical psychologists who understand the psychological and occupational consequences of experiencing workplace aggression could be made available by organizations to help employees learn to cope in advantageous ways.

Knowledge about the relationships between workplace aggression, psychological well-being, job and coworker satisfaction, and coping mechanisms would be important for psychologists and psychiatrists who treat individuals who may be subjected to workplace aggression. Findings related to psychological well-being in particular could give new insight to psychologists who treat individuals who are victimized at work. Given the prevalence of aggression in the workplace, especially among healthcare employees, effective training, education, and counseling regarding coping could be extremely advantageous for those who are at risk of being victims.

APPENDIX A

ITEMS ADDED TO THE BRIEF COPE MEASURE

I've been sleeping more than usual

I've been seeking professional help

I've been trying to get away from it for a while - to rest or take a vacation

I've been taking it out on other people

I've been avoiding people in general

I've been asking a relative or friend I respected for advice

I've been making light of the situation; refusing to get too serious about it

I've been eating poorly or over-eating

I've accepted it, since nothing could be done

I've been trying to keep my feelings from interfering with other things too much

I've been wishing that I could change what had happened or how I felt

I've been trying to see things from the other person's point of view

I've been jogging or exercising to distract myself or make myself feel better

APPENDIX B
CORRELATIONS AND DESCRIPTIVE STATISTICS FOR STUDY
VARIABLES

		GHQ_TOTAL	PPL_TOTAL	GWA_TOTAL	factor1	factor2	factor3	factor4	factor5
GHQ_TOTAL	Pearson Correlation	1	.516**	-.577**	-.719**	-.516**	-.378**	-.387**	-.029
	Sig. (2-tailed)		.000	.000	.000	.000	.000	.000	.709
	N	184	176	184	144	168	152	160	168
PPL_TOTAL	Pearson Correlation	.516**	1	-.286**	-.547**	-.450**	-.217**	-.431**	.313**
	Sig. (2-tailed)	.000		.000	.000	.000	.007	.000	.000
	N	176	176	176	144	168	152	160	168
GWA_TOTAL	Pearson Correlation	-.577**	-.286**	1	.599**	.453**	.515**	.162*	-.242**
	Sig. (2-tailed)	.000	.000		.000	.000	.000	.041	.002
	N	184	176	184	144	168	152	160	168
factor1	Pearson Correlation	-.719**	-.547**	.599**	1	.624**	.481**	.495**	.087
	Sig. (2-tailed)	.000	.000	.000		.000	.000	.000	.300
	N	144	144	144	144	144	128	136	144
factor2	Pearson Correlation	-.516**	-.450**	.453**	.624**	1	.541**	.627**	-.036
	Sig. (2-tailed)	.000	.000	.000	.000		.000	.000	.646
	N	168	168	168	144	168	152	160	168
factor3	Pearson Correlation	-.378**	-.217**	.515**	.481**	.541**	1	.445**	-.133
	Sig. (2-tailed)	.000	.007	.000	.000	.000		.000	.102
	N	152	152	152	128	152	152	144	152
factor4	Pearson Correlation	-.387**	-.431**	.162*	.495**	.627**	.445**	1	-.187*
	Sig. (2-tailed)	.000	.000	.041	.000	.000	.000		.018
	N	160	160	160	136	160	144	160	160
factor5	Pearson Correlation	-.029	.313**	-.242**	.087	-.036	-.133	-.187*	1
	Sig. (2-tailed)	.709	.000	.002	.300	.646	.102	.018	
	N	168	168	168	144	168	152	160	168

** . Correlation is significant at the 0.01 level (2-tailed).

* . Correlation is significant at the 0.05 level (2-tailed).

	Mean	SD
Well-being	64.0	10.5
Coworker satisfaction	15.1	2.9
Workplace aggression	4.7	6.3
Coping factor 1	26.4	7.7
Coping factor 2	17.4	5.0
Coping factor 3	16.6	4.9
Coping factor 4	10.4	3.1
Coping factor 5	4.5	2.1

APPENDIX C

SURVEY MEASURES

Participation in this survey is voluntary. Some of these questions may make you feel uncomfortable. You may skip over or not answer any question that you do not want to. You may quit at any time.

First we will ask a few demographic questions, just so we can understand the characteristics of the people in our sample.

What is your current age?

What is your gender?

What is your ethnicity?

What is your current job title?

What type of unit do you work in?

How long have you been in your current job?

Have you recently (over the past few weeks)...[7-point scale from 1 (never) to 7(always)]

1. Been able to concentrate on whatever you're doing?
2. Lost much sleep over worry?
3. Felt that you are playing a useful part in things?
4. Felt capable of making decisions about things?
5. Felt constantly under strain?
6. Felt you couldn't overcome your difficulties?
7. Been able to enjoy your normal day-to-day activities?
8. Been able to face up to your problems?
9. Been feeling unhappy and depressed?
10. Been losing confidence in yourself?
11. Been thinking of yourself as a worthless person?
12. Been feeling reasonable happy, all things considered?

Please put a "Y" beside each item if it describes the feature in question, "N" if the item does not describe the that feature, or "?" if you cannot decide.

Work on present job:

1. Fascinating
2. Routine
3. Satisfying
4. Boring
5. Creative
6. Respected

7. Pleasant
8. Useful
9. Tiresome
10. Challenging
11. Frustrating
12. Simple
13. Gives sense of accomplishment
14. A source of pleasure
15. Dull
16. Interesting
17. Awful
18. Important

Present pay:

1. Income adequate for normal expenses
2. Barely live on income
3. Bad
4. Insecure
5. Less than I deserve
6. Underpaid
7. Well paid
8. Unfair
9. Enough for what I need

Opportunities for promotion:

1. Good opportunity for promotion
2. Opportunity somewhat limited
3. Promotion on ability
4. Dead-end job
5. Good chance for promotion
6. Infrequent promotions
7. Regular promotions
8. Fairly good chance for promotion
9. Easy to get ahead

Supervision on present job:

1. Hard to please
2. Impolite
3. Praises good work
4. Tactful
5. Up-to-date
6. Quick-tempered
7. Tells me where I stand
8. Annoying
9. Stubborn
10. Knows job well

11. Bad
12. Intelligent
13. Around when needed
14. Lazy
15. Interferes with my work
16. Gives confusing directions
17. Knows how to supervise
18. Cannot be trusted

People on your present job:

1. Stimulating
2. Boring
3. Slow
4. Ambitious
5. Stupid
6. Responsible
7. Intelligent
8. Easy to make enemies
9. Talk too much
10. Smart
11. Lazy
12. Unpleasant
13. Active
14. Narrow interests
15. Loyal
16. Work well together
17. Bother me
18. Waste of time

Survey on work experiences and coping

During the last 12 months at your workplace, have you ever been in a situation where anyone in your work setting did any of the following? Please circle the number which most closely describes your own experiences the past 12 months.

During the last 12 months at your workplace, how often have you been in a situation where someone in your work setting....

	<u>Never</u>	<u>Once</u>	<u>More than once</u>
a. Expected less of you than others in your position?	1	2	3
b. Pushed you or grabbed you?	1	2	3
c. Offered you a subtle or obvious bribe to do something you did not agree with?	1	2	3
d. Told you insulting jokes?	1	2	3
e. Tried to control your non-work related time or activities?	1	2	3
f. Left notes, signs, or other materials that were meant to embarrass you?	1	2	3
g. Treated you unfairly compared to others in your same position (e.g., in terms of tasks or assignments, salary, promotions, resources, reprimands)?	1	2	3
h. Made negative comments to you about your appearance?	1	2	3
i. Threw something at you?	1	2	3
j. Asked you to do work that really wasn't part of your job?	1	2	3
k. Excluded you from important work activities or meetings .	1	2	3
l. Threatened that they would "get back at you" if you resisted doing something that you thought was wrong, or if you challenged things about the workplace?	1	2	3
m. Hit you physically?	1	2	3

These items deal with ways you've been coping with the work situations from the previous X pages. There are many ways to try to deal with problems, and these items ask what you've been doing to cope with these types of work problems. I would like to know to what extent you've been doing what the item says - how much or how frequently. Don't answer on the basis of whether it seems to be working or not—just whether or not you're doing it. Please make your answers as true FOR YOU as you can. Please rate each item with the response options given. Use the blank to the left of the item to write in the number (1, 2, 3 or 4) that corresponds with how often you have used that particular coping method.

1 = I haven't been doing this at all

2 = I've been doing this a little bit

3 = I've been doing this a medium amount

4 = I've been doing this a lot

- 1. I've been turning to work or other activities to take my mind off things.
- 2. I've been concentrating my efforts on doing something about the situation I'm in.
- 3. I've been saying to myself "this isn't real."
- 4. I've been getting emotional support from others.
- 5. I've been giving up trying to deal with it.
- 6. I've been taking action to try to make the situation better.
- 7. I've been refusing to believe that it has happened.
- 8. I've been saying things to let my unpleasant feelings escape.
- 9. I've been getting help and advice from other people.
- 10. I've been using alcohol or other drugs to help me get through it.
- 11. I've been trying to see it in a different light, to make it seem more positive.
- 12. I've been criticizing myself.
- 13. I've been trying to come up with a strategy about what to do.
- 14. I've been getting comfort and understanding from someone.
- 15. I've been giving up the attempt to cope.
- 16. I've been looking for something good in what is happening.
- 17. I've been joking or laughing to make myself feel better.
- 18. I've been doing something to think about it less, such as going to movies, watching TV, reading, daydreaming, sleeping, or shopping.
- 19. I've been accepting the reality of the fact that it has happened.
- 20. I've been expressing my negative feelings.
- 21. I've been trying to find comfort in my religion or spiritual beliefs.
- 22. I've been trying to get advice or help from other people about what to do.
- 23. I've been learning to live with it.
- 24. I've been thinking hard about what steps to take.
- 25. I've been blaming myself for things that happened.
- 26. I've been praying or meditating.
- 27. I've been making fun of the situation.
- 28. I've been sleeping more than usual.
- 29. I've been seeking professional help.
- 30. I've been trying to get away from it for a while - to rest or take a vacation.
- 31. I've been taking it out on other people.
- 32. I've been trying to make myself feel better by eating, drinking, smoking, using drugs or medication, etc.
- 33. I've been avoiding people in general.
- 34. I've been asking a relative or friend I respected for advice.
- 35. I've been making light of the situation; refusing to get too serious about it.
- 36. I've been eating poorly or over-eating.
- 37. I've accepted it, since nothing could be done.
- 38. I've been trying to keep my feelings from interfering with other things too much.
- 39. I've been wishing that I could change what had happened or how I felt.
- 40. I've been trying to see things from the other person's point of view.
- 41. I've been jogging or exercising to distract myself or make myself feel better.

Lastly, we have a few open-ended questions for you.

Have you had any training about coping at work?

Have you had any training about workplace aggression?

Would you be interested in training on these topics?

If you have any other comments, feel free to share them in the space below.

Thanks so much for your time and participation!

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