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Relationship Between Workplace Aggression and Employee Job Satisfaction

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Walden University
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Abstract

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by

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MHA, Clayton State University, 2009

BS, Clayton State University, 2004

Dissertation Submitted in Partial Fulfillment

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Doctor of Health Leadership

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Abstract

Workplace aggression incidents are increasing and, thus, becoming more difficult to address in the United States. Health care workers in particular are at an increased risk of burnout compared to individuals working in other occupations. The purpose of this quantitative correlational study was to investigate the propensity for workplace aggression among health care professionals and the association between job satisfaction and the propensity for workplace aggression. The conservation of resources theory was used to frame the study. The Work Environment Scale and the Conditional Reasoning Test of Aggression were used to collect data from 89 mental health clinicians, nurses, and technicians employed at 2 metro Atlanta hospitals. Findings indicated no correlation between workplace aggression and job satisfaction among mental health workers. Findings also indicated no higher propensity for workplace aggression among frontline workers (nurses and technicians) than among other mental health workers. However, findings revealed that employees with more years of service had a higher propensity for workplace aggression. Implications for social change include enhancing the capacity of mental health workers to handle the emotional and physical demands of the job.

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Dedication

This dissertation is dedicated to my husband, Ronald Grizzle; my sons, Ronnie and Andre; and my grandson, Devaughn. I could not have accomplished this without you. This has been a long and arduous journey, but you supported, encouraged, and loved me through the many obstacles and setbacks that have led me to this moment. Ronald, words can't express how much your love and support helped me get through this journey. For 28 years, you have been my biggest supporter and fan. You have seen me at my best and worst during this journey. You motivated me with encouraging words and hugs when I thought I was losing my way. I truly appreciate and love you dearly. Ronnie, Andre, and Devaughn, you are without a doubt the reason that I continued this journey when life presented many challenges. Your smiles, encouraging words, and love have always put the reason for this journey back into perspective. I love you all so much.

This dissertation is also dedicated to my deceased father, James Howard, and deceased aunt, Yvonne "Vonya" Dowdy. Both of you were my biggest supporters here on earth, and I continue to feel your love and support as you rest in heaven. Vonya, I did it!

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Chapter 1: Introduction to the Study

Job related stress can affect employees' physical and psychological health

(American Psychological Association, 2016). According to Dollard and McTernan

(2011) workers in the healthcare industry experience significantly higher stressors such

as harassment, workplace bullying, and psychological demands than other industries.

Aftab (2012) found that the primary source of stress for 25% of employees was their job.

Increased stress can directly influence employees' job satisfaction, retention, self-

confidence, and productivity, and may cause workplace aggression (Ladebo et al., 2008).

The purpose of this study was to determine whether mental health professionals

are at an increased risk for engaging in workplace aggression. I also sought to determine

whether job satisfaction was lower among mental health workers who provide direct care

compared to those who do not. In addition, I examined the impact of aggressive

behaviors in the workplace as they relate to perceived job satisfaction among mental

health workers. To test the study hypotheses, I administered several measures including

the Work Environment Scale (WES) to evaluate employees' satisfaction and work

productivity (Mind Garden, 2013), and the Conditional Reasoning Test of Aggression

(CRTA) to measured individuals' propensity to engage in aggressive behavior (James et

al., 2005).

Background

In 2014, the Workplace Bullying Institute (WBI, 2014) conducted a survey that

indicated that 37 million workers in the United States reported being subjected to abusive

behavior, and 65.6 million American workers were affected by bullying. According to

Vega and Comer (2005), workplace bullying receives less attention in the United States

compared to other countries.   According to Morris (2016) American researchers primarily focused on physical aggression in the workplace instead of workplace bullying. According to the WBI (2014), most bullies are men (69%) and most male bullies target women (57%). Conversely, female bullies target other women (WBI, 2014). Workplace bullying typically is not a singular or isolated incident, but is often enacted repetitively and persistently upon one or more employees (O'Moore & Crowley, 2011). Workplace bullying occurs when an individual perceives himself or herself as the recipient of persistent negative actions from one or more individuals within an organization (Nielsen, Hetland, Matthiesen, & Einarsen, 2012). In addition, the recipient considers it difficult to defend himself or herself against these actions (Nielsen et al., 2012). Individuals who experience separate or infrequent negative actions or behaviors by others may find the act offensive but tolerable. However, when the negative actions or behaviors are frequent and repeated, the incidents may create a stressful and/or hostile environment (Nielsen et al., 2012). According to Nielsen et al. (2012), bullying is the "summarized pattern of behaviors that constitute the menace, rather than the particular acts" (p. 38).

Workplace bullying is not the same as abuse or assault (Askew, Schuluter, & Dick, 2013). Abuse or assault can occur only once, whereas bullying occurs repeatedly (Askew et al., 2013). According to Ang and Goh (2010), some bullies who are observed to have participated in antisocial behavior may score high on social intelligence tests. In this study, I examined whether mental health workers had a propensity for workplace bullying. The primary purpose was to determine whether workers with the propensity for bullying had lower job satisfaction compared to other workers.

Problem Statement

Workplace aggression/bullying incidents are increasing at a significant rate and are becoming more difficult to resolve in the United States (Ladebo, Awotunde, &AbdulSalaam-Saghir, 2008). Numerous studies have indicated that content employees are more productive than dissatisfied employees (Ladebo et al., 2008; Modur &Tooksoon, 2011). According to Rossler (2012), health care workers are at an increased risk of burnout compared to individuals working in other occupations. Typical stress factors leading to burnout for health care workers include increased workload; extensive work hours; and frequent demands of patients, family, and coworkers (Rossler, 2012). Further, mental health workers also experience additional stressors of personal safety and environmental concerns (Rossler, 2012; Wood et al., 2011). Aggressive behaviors within the health care industry directly influence patient care, litigation cost, and workplace morale (Yamada, 2009). Given the limited research in this area, the purpose of the current study was to determine the potential associations among job satisfaction, organizational leadership, and workplace aggression in mental health employees.

Purpose of the Study

Numerous researchers have investigated the harmful consequences of workplace bullying; however, the reasons why bullies display such negative behaviors remains relatively unknown (Hills, Joyce, & Humphreys, 2011; Paice & Smith, 2009). Therefore, in this quantitative study I aimed to examine the propensity for frontline mental health care workers to engage in aggressive acts as well as to determine whether job satisfaction was associated with workplace aggression.

Research Questions and Hypotheses

Research Question 1

Is there a significant relationship between propensity for workplace aggression and job satisfaction?

H1$_a$: There is a significant relationship between the propensity for workplace aggression and job satisfaction.

H1$_0$: There is no significant relationship between the propensity for workplace aggression and job satisfaction.

Research Question 2

Do frontline workers (i.e., mental health technicians and nurses) have a higher propensity for workplace aggression than workers in other mental health disciplines?

H2$_a$: Frontline workers have a higher propensity for workplace aggression than workers in other mental health disciplines.

H2$_0$: Frontline workers do not have a higher propensity for workplace aggression than workers in other mental health disciplines.

Theoretical Framework

The conservation of resource (COR) theory was the ideal framework for the study. According to Hobfoll (2012), individuals naturally respond and exhibit behaviors to protect resources they deem valuable, and cultural differences may influence these values. However, certain values such as self-preservation, health, peace, and well-being are universal (Hobfoll, 2012). Researchers have indicated that when stressed, individuals demonstrate aggressive workplace behaviors. In addition, individuals become aggressive in the workplace when they feel they are being treated unfairly (Hickey, 2012).

Individuals react differently to psychological stress by using various coping mechanisms during stressful and high-risk situations (Hickey, 2012). According to Schat and Frone (2011), limited research has been done on the effects that psychological stress and high-risk situations have on people. The COR theory is used to understand why some individuals can cope effectively with stressful situations whereas others cannot. More specifically, the COR theory is used to explain why individuals display various behaviors and psychological responses when exposed to stressful situations (Schat & Frone, 2011).

Nature of the Study

Workplace bullying is a primary cause of stress, impaired health, and decreased well-being (Herchcovis & Barling, 2010), and may also contribute to physiological problems (O'Moore & Crowley, 2011). In addition, workplace bulling may result in the victim experiencing post-traumatic stress and mmajor depression disorder (O'Moore & Crowley, 2011). Leymann (as cited in Rocker, 2012)was one of the first researchers to study workplace bullying. Leymann's landmark study provided suggestions regarding how to treat victimized individuals in the workplace. Consequently, Sweden became the first country to establish an ordinance against workplace violence (Rocker, 2012).

According to Parker, Ceramidas, Forrest, Herath and McRae (2011), mild frustration and anger are common in health care settings. Moreover, Harrell (2011) demonstrated that workplace aggression is more frequently encountered from external sources (i.e., patients, clients, customers) than from coworkers and/or supervisors. The majority of previous studies related to workplace aggression in health care settings has focused on nurses (Hills & Joyce, 2013), and most of these studies were retrospective self-reports (Taylor & Rew, 2011).

Individuals who have been diagnosed with a severe mental illness are often aggressive and impulsive, which requires staff to have procedures in place to cope with the daily stressors associated with treating these patients. In addition, the adverse effects of workplace aggression may negatively affect the health and well-being of individuals (Herchcovis & Barling, 2010). Workplace aggression negatively impacts organizations, both directly and indirectly. According to Hills and Joyce (2013) decreased health and well-being of employees are associated with workplace aggression. Consequently, resulting in difficulty retaining staff (Hills & Joyce, 2013).

According to Rossler (2012), mental health workers experience similar stressors as other health care workers; however, mental health workers also experience stressors that are unique to their profession. For example, mental health workers experience stressors resulting from the challenging and demanding relationships they have with their patients (Rossler, 2012), which include personal threats from violent patients, safety issues, lack of supervision, and inadequate working conditions (Rossler, 2012).

Definition of Terms

Aggression: Any intentional act by the perpetrator that causes harm or damage to another individual; however, these behaviors are not necessarily physically violent acts that harm or damage (Hills & Joyce, 2013).

Bullying behavior: Inappropriate and hostile behaviors that occur repeatedly and regularly (Luparell, 2011). The targeted individual is placed in an inferior position and subjected to negative social acts (Matthiesen & Einarsen, 2010).

Frontline Workers: For the purpose of this research, frontline workers are mental health technicians and nurses.

Incivility: Rudeness, disrespectfulness, and condescension toward another individual, such as the rolling of the eyes (Luparell, 2011). Incivility implies the lack of polite behavior (Rocker, 2012).

Mobbing: Hostile, systematically repeated actions that may lead to violence and insecurity (Chirilă & Constantin, 2013). Mobbing is often used as synonym for bullying (Matthiesen & Einarsen, 2010).

Victimization: The recurrence of adverse actions against individual employees in an offensive manner (Namie & Namie, 2009). Victimization occurs when an individual's psychological and physiological needs are not met within the organization, which negatively impacts his or her well-being (Aquino & Thau, 2009).

Workplace aggression: Any physical or nonphysical aggression directed toward a targeted individual by a perpetrator in the workplace (Hill & Joyce, 2013).

Workplace bullying: Intentional repeated acts or behaviors negatively affecting a person's work, which include harassing, offending, and/or socially excluding someone (Matthiesen & Einarsen, 2010).

Limitations

Limitations of the current study included potential social desirability bias associated with self-reported measures assessing sensitive topics (e.g., workplace aggression). Social desirability bias implies that individuals will choose the perceived socially acceptable response instead of responding truthfully (Krumal, 2013). Also, participants may have been reluctant to express their views and perceptions about their employers and/or coworkers. Another limitation was the use of general instruments that were not specifically developed for use among behavioral health or health care workers.

Significance of the Study

Employers are required to use prudent human resource practices (Cascardo, 2011) and may be liable if their hiring, retention, and supervision of potentially dangerous employees are found to be negligent (Cascardo, 2011). Mental health workers experience a high level of job-related stress (Wood et al., 2011), which may have a direct impact on patient clinical outcomes (Wood et al., 2011). However, research studies addressing mental health workers' job satisfaction propensity for workplace aggression are limited. I sought to address an important gap in the literature by investigating mental health care workers' propensity for aggressive behavior. Results may inform intervention and prevention programs in behavioral health organizations by providing valuable information on how to more effectively identify job-related stress factors, which often contribute to decreased employee satisfaction and aggressive behaviors. Moreover, early identification and intervention by organization leaders may improve health care delivery services and staff retention.

Summary

Workplace bullying is not usually a singular or isolated incident, but is enacted repeatedly and persistently upon one or more employees (O'Moore & Crowley, 2011). According to Nielsen et al. (2012), workplace bullying occurs when an individual perceives himself or herself as the recipient of persistent negative actions from one or more individuals within an organization. Additionally, the victim believes it is difficult to defend himself or herself against these actions (Nielsen et al., 2012). Bullying behaviors vary among individuals. Some individuals may experience separate or infrequent negative actions or behaviors, which are tolerable but offensive. However, when the

negative acts or behaviors become frequent, the incidents often create a stressful and hostile environment (Nielsen et al., 2012). In the current study, I examined the relationship between the propensity for workplace aggression and job satisfaction by administering the WES and CRTA. In Chapter 2, I review literature related to workplace aggression, bullying, and employee job satisfaction. The chapter provides an overview of workplace aggression and ramifications associated with workplace bullying.

Chapter 2: Literature Review

In Chapter 2, I review peer-reviewed literature related to workplace violence, job satisfaction, and workplace aggression. Most sources were published between 2008 and 2014. I used EBSCOhost and ProQuest Central research databases.

Aggressive behaviors in the workplace are occurring more frequently within U.S. organizations (Schat & Frone, 2011). Specifically, over 41% of U.S. workers reported exposure to some type of workplace aggression (Schat & Frone, 2011). According to Cascardo (2011), over two million employees are victims of some form of workplace violence each year. Approximately 13% of the workers who reported exposure to workplace aggression indicated that it occurred at least weekly (Schat & Frone, 2011). Vessey, Demarco, Gaffney, and Budin (2009) found that 70% of U.S. nurses reported a bullying experience at work. Nurses may engage in bullying behaviors to boost his/her need for power and assist with career advancement (Etienne, 2014). According to Etienne (2014) nurses may bully other nurses to invoke a negative work performance, therefore leading to a better performance review for the perpetrator. Research conducted by Gaffney, Demarco, Hofmeyer, Vessey, and Budin (2012) revealed the lack of nursing support and a culture of indifference by nursing leadership can perpetuate the bullying resulting in staff turnover and compromised patient care.

Workplace aggression involves physical and psychological behaviors that are potentially harmful (Johnson & Rea, 2009; Schat & Frone, 2011). Additionally, workplace bullying can negatively affect individuals by increasing the risk for developing psychiatric disorders such as depression, suicidal ideations, and post-traumatic stress disorders (Morris, 2016). According to Keashly (2010), workplace bullying is a

fundamental "systemic phenomenon" (p. 10) embedded within the organizational culture. Workplace bullying leads to interpersonal conflicts, which ultimately affect patient safety and quality of care (Stagg, Sheridan, Jones, & Speroni, 2013; Yamada, 2009). In 2010, Workplace Bullying Institute-Zogby International (2010) reported that approximately 35% of the U.S. workforce experienced some form of bullying.

Workplace Bullying

Workplace bullying typically is not a singular or isolated incident (Cascardo, 2011; Keashly, 2010). Workplace bullying is inflicted repetitively and persistently upon one or more employees (Cascardo, 2011; Keashly, 2010; O'Moore & Crowley, 2011). According to Nielsen et al. (2012), workplace bullying occurs when an individual is the victim of persistent negative actions from one or more individuals within an organization. Bullying behavior may include persistent, hostile, malicious, or intimidating behaviors. The targeted individual may feel threatened, humiliated, or vulnerable while experiencing separate or infrequent negative actions or behaviors by others, which may be considered offensive, but tolerable (Rhodes, Pullen, Vickers, Clegg, & Pitsis, 2014). When harmful acts or practices are frequent, the events often create a stressful and hostile environment (Nielsen et al., 2012; Rhodes et al., 2014).

Workplace bullying, which has been referred to as workplace aggression, workplace incivility, employee victimization, and interpersonal deviance, was initially known as mobbing (Chirila & Constantin, 2013). Mobbing is defined as hostile actions systematically repeated, which may result in violence and insecurity (Chirila & Constantin, 2013). Previous research indicated that victims of workplace bullying

perceive mobbing as imbalanced power, which escalates to unsolved tension in the workplace (Chirila & Constantin, 2013).

According to Chirila and Constantin (2013), individuals who are harassed, humiliated, and socially excluded are victims of bullying. However, a single act or a conflict between two equally strong parties does not constitute workplace bullying (Chirila & Constantin, 2013). Bullying does not usually involve physical violence and is often passive aggressive, nonphysical, and indirect (Keashly, 2010). Bullying may occur as direct or indirect attacks (Cascardo, 2011). Direct bullying may include physical assaults, verbal abuse, and teasing; indirect bullying involves instigation of rumors, slander, attempting to ostracize another person, or a combination of offensive actions (Cascardo, 2011).

Keashly (2010) categorized the passive aggressive behaviors in five categories: (a) threat to professional status, (b) threat to person, (c) isolation, (d) overwork or unreal expectations, and (e) destabilization. Threat to professional status includes professional humiliation in the presence of colleagues and questioning the targeted individual's job skills competency. Threat to personal standing includes name-calling, verbal abuse, and intimidating behaviors. Isolation involves exclusion of work-related events, withholding pertinent information, preventing promotions, or actively campaigning to get other employees to treat the targeted individually negatively. Overwork and unreal expectation include placing undue pressure or unrealistic and unattainable expectations on the targeted individual. Lastly, destabilization occurs when other individuals take credit for work completed by the targeted individual, including removing responsibilities and assigning futile tasks.

Workplace violence is an occupational hazard that negatively affects the workforce in the United States (Occupational Safety & Health Administration [OSHA], 2011). Public service occupations, which include working with volatile and unstable individuals in isolated areas, contribute to an increased risk of violence at work (OSHA, 2011). Health care and social service workers including physicians, nurses, nursing assistants, social workers, and emergency medical care personnel are at highest risk for exposure to workplace violence (OSHA, 2011). Homicides were one of leading causes of workplace fatalities from 2000 to 2009 (OSHA, 2011). According to OSHA (2011), practicing appropriate safety measures and procedures may prevent or minimize workplace violence.

Workplace Violence

Each year, approximately two million workers in the United States report being victims of workplace violence (OSHA, 2011). There are four types of workplace violence, including criminal intent, customer/client/patient, coworker, and personal (OSHA, 2011). Criminal intent, committed by a current or former employee, involves violent acts with the primary intent to commit a robbery or other crime. Customer/ client/patient workplace violence occurs when customers, clients, patients, or others commit violent acts toward the employee providing the services. Coworker workplace bullying is violence perpetrated against peers, supervisors, or managers. Lastly, personal workplace violence includes actions conducted in the workplace by an individual who does not work in the organization, but has a personal relationship with an employee.

Researchers have identified factors that may increase the risk of violence for particular occupations and worksites. Individuals working in public organizations that

require the exchange of funds are at a higher risk for experiencing workplace violence (OSHA, 2011). Providing services to clients with substance abuse issues and living in high crime areas increase workers' probability of experiencing workplace violence (OSHA, 2011).

Passive Aggressive Behavior

Workplace bullying that involves passive aggressive acts often refers to what people do not do rather than what they do (Keashly, 2010). Passive aggressive behaviors are more psychological than physical, and are difficult to address when victims or others voice concerns (Keashly, 2010). Passive aggressive acts typically include the lack of action by the aggressor; therefore, it is difficult to observe passive aggressive behavior (Keashly, 2010). For example, passive aggressive behaviors may include withholding information, purposely excluding the victim, and preventing victims from gaining access to opportunities.

Workplace bullying includes the impairment of relationships by purposefully harming others via manipulation, passive aggressive behavior, physical abuse, verbal abuse, or other aggressive acts (Keashly, 2010). The type of passive aggressive hostility demonstrated by the aggressor is dependent on the relationship between the victim and the perpetrator (Neuman & Keashly, 2010). According to Rosen and colleague (2011) abused subordinates avoid interacting with the abusive supervisor to reduce anxiety. The victim often limits interaction with the abusive supervisor to avoid any retaliatory actions. This limited interaction may result in the abused subordinate withholding behaviors that benefit the organization (Kacmar et al., 2013).

According to Neuman and Keashly (2010), the availability of means and opportunity may change the relationship between the victim and aggressor. Consequently, bullying can be top-down (e.g., boss-subordinate), horizontal (e.g., peer-peer), or bottom-up (e.g., subordinate-boss). Supervisors may bully subordinates using the means and opportunity to significantly influence the victim's work environment (Neuman & Keashley, 2010). For instance, due to a supervisor's position and authority, he or she may intentionally assign the victim to degrading tasks. Peers have the means and opportunity to demonstrate passive aggressive behaviors by isolating the victim and spreading rumors.

A distinguishing difference between workplace bullying and typical workplace conflict is the existence of a power imbalance that prevents the targeted individual from defending him or herself. In addition, power imbalance allows the aggressor to continue his or her actions for a lengthy amount of time (Keashly & Jagatic, 2010). This imbalance enables covert and indirect aggressive behaviors that gradually increase to overt and directly aggressive acts (Keashly, 2010). Prolonged exposure to workplace aggression has the potential to create a hostile work environment, not just for the targeted victim, but also for other employees within the organization who witness the behavior (Keashly, 2010). Moreover, continued workplace aggression may cause other workers to behave inappropriately (Keashly, 2010). Consequently, this aggressive behavior epitomizes a communal nature of workplace bullying (Namie & Lutgen-Sandvik, 2010).

Economic Cost of Workplace Bullying

The economic effects of workplace bullying are potentially detrimental (Stagg et al., 2013). According to the Workplace Violence Research Institute (WVRI, 2012), the

estimated cost of workplace violence to U.S. businesses is approximately $36 billion per

year. Contributing costs include medical care, loss of productivity, loss of valued

employees, and psychiatric care (WVRI, 2012). The increased prevalence of reported

workplace bullying can significantly increase organizational costs (Stagg et al., 2013).

The estimated cost for each staff bullied in the workplace has been reported to be

between $30,000 and $100,000 (Johnson, Phanhtharath, & Jackson, 2010). Associated

factors related to organizational costs include decreased productivity, low staff morale,

and employee absenteeism (Diakiw, 2009). In addition, workplace aggression directly

affects patient quality of care and safety (Stagg, Sheridan, Jones, & Speroni, 2011).

Organizational leaders often underestimate the economic cost of workplace

violence (Cascardo, 2011; Gumbus & Lyons, 2011). Nontangible factors such as work

not completed while addressing workplace violence affect economic outcomes

(Cascardo, 2011). Factors such as reduced quality of work, poor customer service, and

absenteeism are difficult to calculate (Gumbus & Lyons, 2011). According to Cascardo

(2011), any incident within an organization that results in energy and efforts being

diverted from performing core business functions has a tangible cost to the organization

(e.g., training cost, staff retention). According to Abdullah, Baroto, Ismail, and Tat

(2011), two factors influence employee retention: (a) perceived opportunity for

movement and (b) perceived job satisfaction. Therefore, a balance between the needs of

the organization and employees results in organizational efficiency and reduced staff

turnover (Long, Peruman, & Ajabe, 2012). Moreover, staff turnover and training costs

may directly affect workplace aggression within organizations (Cascardo, 2011).

According to Greenbaum, Mawritz, and Piccolo (2015) documented a significant increase

in staff-reported intentions to leave an organization due to perceived undermining by the supervisor. Further, according to the Workplace Bullying Institute (WBI, 2014), 82% of individuals who are victims of workplace bullying lose their jobs; however, only 18% of bullying perpetrators lose their jobs. Employees often have a difficult time returning to work following a violent workplace incident, and they may require time away from the office to cope with the emotional and physical impact of the workplace aggressive act (Cascardo, 2011).

Workplace bullying influences the recruitment and retention of nurses. A recent study by Houshmand, O'Reilly, Robinson, and Wolff (2012) indicated that nurses who witnessed workplace bullying were affected more by the act than nurses who were victims of bullying. Consequently, these observed acts of aggression negatively affect nursing turnover, recruitment, and retention (Johnson & Rea, 2009; Stagg et al., 2013; Wilson, Diedrich, Phelps, & Choi, 2011). Gumbus and Lyons (2011) investigated the social cost of workplace bullying in a variety of business industries including education, retail, banking, and insurance. Gumbus and Lyons measured the organizational cost of bullying by lost productivity, turnover, emotional health cost, and physical health cost. Study findings indicated that many employers did not have formal policies addressing bullying, therefore resulting in victims leaving the organization.

Physiological and Psychological Effects of Bullying

Numerous studies indicated associations among workplace bullying, physiological problems, and psychological problems (Nielsen et al., 2012; Vie, Glaso, & Einarsen, 2011). The victim of workplace bullying typically perceives the harmful actions as a threat to his or her psychological and physiological needs (Aquino & Thau,

2009). The victimized individual may perceive the bullying behaviors as a reflection of his or her self-worth, sense of belonging, and environmental governance (Aquino & Thau, 2009). Consequently, workplace bullying may cause psychological and physical health problems (Nielsen et al., 2012).

According to Aquino and Thau (2009), individuals who are bullied may perceive and label themselves as a victim. Self-labeling, which reflects the experience of victimization (Keashly, 2010), may lead to an emotional reaction that increases stress and health issues compared to effects of the bullying act alone (Vie et al., 2011). According to Nielsen et al. (2012), the self-labeled victim experiences more psychological distress due to the self-labeling than due to the actual exposure to bullying behavior.

Workplace bullying can cause withdrawal reactions of not only the victims of workplace aggression, but also employees who witness the acts (Tepper, et al., 2009). Workplace violence may lead to increased sick leave, lowered organizational commitment, increased turnover and loss of talent, retaliation behaviors (e.g., theft), and sabotage (Tepper et al., 2009). Moreover, prolonged workplace bullying not addressed may have significant implications both inside and outside of an organization (Keashly, 2010). It is critical for organizations to support and assist employees subjected to workplace bullying (Yamada, 2009). Assistance may include medical treatment, mental health counseling, approved time off from work, and accommodations that separate the victim and the bully.

Failure to provide adequate support may increase the likelihood that the victim will pursue legal action, by citing Intentional Infliction of Emotional Distress (IIED). (Yamada, 2013). Victims often seek to impose liability against their employers and

alleged perpetrator who caused emotional distress (Yamada, 2013). According to Yamada (2013), it is difficult to establish IIED liability in the judicial system. Specifically, judicial courts often reject workplace related IIED claims due to the inability to demonstrate that the individual suffered severe emotional distress and that the acts conducted were intentional, extreme, and outrageous (Yamada, 2013).

Workplace Bullying and Post Traumatic Stress Disorder

According to O'Moore and Crowley (2011), research has shown that bullying contributes to stress, anxiety, and physical health issues for individuals in the workplace. Post-traumatic Stress Disorder (PTSD) may occur after an individual experiences a traumatic event (O'Moore & Crowley, 2011). Individuals diagnosed with PTSD typically re-live the experiences via dreams or recurrent memories, as well as may become socially withdrawn and emotionally aloof (O'Moore and Crowley, 2011). Victims of workplace aggression often experience psychological, emotional, and physical disruption, which may manifest as PTSD symptoms (Hauge, Skogstad, & Einarsen, 2010; Keashly, 2010). Victims of chronic bullying experience anxiety, depression, and panic attacks; consequently, undermining the individual's self-confidence (Gumbus & Lyons, 2011).

In a study on workplace bullying and its effect on job resources, Law, Dollard, Tuckey, and Dormann (2011) found that employee mental health and engagement was related to bullying and health impairment. Law et al. (2011) sought to ascertain if a Psychosocial Safety Climate (PSC) revealed contributed to mental health and job stress outcomes. According to Dollard and Bakker (2010), a PSC is a shared perceptions that organizational policies, procedures, and managerial practices are in place to protect workers' psychological health and safety. The researchers noted organizations with a low

level of PSC had significantly more reported cases of psychological distress and emotional exhaustion than organizations with high levels of PSC (Law et al., 2011). Low levels of a PSC within an organization consequently results in victims of workplace bullying experiencing decreased cognitive functioning, poor job attitudes, problematic job behaviors, and decreased performance (Keashley, 2010). Low organizational PSC can also influence staff turnover, absence from work due to illness, decreased motivation, and productivity (Law et al., 2011).

Workplace Bullying Antecedents

Psychosocial, cultural, and individual factors influence bullying relationships (Matthiesen & Einarsen, 2010). According to Keashley (2010), individual and work-related experiences influence how employees cope with the challenges created by certain antecedent processes. Baillien, Neyens, De Witte, and De Cuyper (2009) posited that three interrelated antecedent processes influence the development of bullying: intrapersonal, interpersonal, and intragroup/organizational.

Casual factors for bullying vary by ethnicity (Workplace Bullying Institute, 2014). In a recent study, survey response options contributing to workplace bullying included target attributes, perpetrator attributes, employer, and societal. Caucasian and Hispanic participants endorsed perpetrator's attributes as primarily contributing to workplace bullying; whereas, African Americans and Asian Americans reported that the employer was the main cause of workplace bullying (Workplace Bullying Institute, 2014). Further, in the same WBI survey (2014), bullying by peers accounted for 33% of workplace bullying acts; however, 56% of the participants reported a perpetrator in a higher position (e.g., manager, supervisor) conducted the bullying acts (WBI, 2014).

Intrapersonal

Intrapersonal conflicts involve how employees cope with stressors and frustrations within the workplace (Keashly, 2010). Previous research on intrapersonal conflict has focused on characteristics of individuals that may increase vulnerability to be the victim of bully or characteristics that may influence a person's propensity for aggressive behavior (Keashly, 2010). Matthiesen and Einarsen (2010) have identified sensitivity as a characteristic of bullying victims. According to DeCuyper, Baillien and DeWitte (2009), individuals targeted for bullying may provoke sentimental and behavioral reactions perceived as confrontational to others; therefore, making the victim seem as an obvious target for the perpetrator to exhibit displaced aggression.

Victims of bullying have the tendency to experience negative emotional distress such as anger, fear, anxiety, and sadness (Aquino & Thau, 2009; Milam, Spitzmueller & Penney, 2009). Baillien and colleagues (2009) have suggested that ineffective coping mechanisms in response to stressors in the workplace may determine which employees become victims and which ones become aggressors. Moreover, employees become victims of bullying when they respond to stressors and frustrations in passive and inefficient methods, which include decrease productivity, withdrawn, and acting helpless. These behaviors are perceived as a violation of organizational norms (e.g., inability to carry own workload), which results in negative responses by other workers (Keashly, 2010). Similarly, perpetrators of bullying also exhibit anger and anxiety characteristics. However, the perpetrator of bullying also exhibits poor self-control, emotional susceptibility, irritability, fluctuating self-esteem, and dispositional aggressiveness (Keashly, 2010). As posited by Matthiesen and Einarsen (2010), individuals engage in

bullying behaviors to compensate for a lack of social competencies and to buffer against low self-esteem.

Interpersonal

Leadership, role conflict, and bullying have been demonstrated to be significantly associated (Matthiesen & Einarsen, 2010). Moreover, role ambiguity, lack of work control, workload, change in management and interpersonal conflicts are factors shown to contribute to workplace bullying (Matthiesen & Einarsen, 2010). The balance of power determines bullying interaction and outcomes. Specifically, the individual with the most power typically becomes the perpetrator/aggressor of bullying; whereas, the less powerful employee becomes the target/victim (Keashly, 2010).

Interpersonal divergence escalates when individuals ineffectively manage conflicts, often resulting in hostile and destructive behaviors (Keashley, 2010; Matthiesen & Einarsen, 2010). Bullying incidents occur when an individual unsuccessfully attempts to defend him/herself and/or address the conflicts (Keashley, 2010).

Intragroup

Intragroup or organizational culture is a precursor to workplace bullying (Matthiesen & Einarsen, 2010). Shared assumptions, beliefs, values, and expectations are the constructs of organizational cultures. Workplace bullying is a systemic and persistent phenomenon, grounded in the organization's culture, which can escalate by involving more than the victim and aggressor (Keashly, 2010). According to Brodsy (as cited in Matthiesen & Einarsen, 2010), organizations may perceive harassment as necessary by management to achieve increased productivity and acceptable performance by employees.

Employee Job Satisfaction

Employee job satisfaction, interpersonal work, and organizational relations are interrelated (O'Moore & Crowley, 2011). Researchers have demonstrated organizational outcomes and productivity improves when employees are happy. However, studies investigating the relation between employee job satisfaction and workplace aggression are limited. Workplace aggression may directly influence employees' job satisfaction, organizational retention, self-confidence, and work productivity (Ladebo, Awotunde, & AbdulSalaam-Saghir, 2008). Moreover, the employees' perception of fair treatment within the organization is associated with job satisfaction and organizational commitment (Hendrix, Robbins, Miller, & Summers, 1998). Similarly, job dissatisfaction increases the probability of workplace aggression (Ladebo et al., 2008).

Factors associated with organizational success include effective leadership and employee job satisfaction (Voon, Lo, Ngui, & Ayob, 2011). According to Taris and Schreurs (2009), satisfied employees increase work effort and performance. Adam's equity theory (as cited by Taris & Schereurs, 2009), states highly satisfied employees are committed employees secondary to their perception of a positive working environment to include a positive and valued relationship with organizational members. Lack of job satisfaction can occur when an employee perceives that inequity is a factor. Inequity occurs when an individual perceives that they have invested more (or less) but receives less (or more) than another individual invests more (Taris & Schreurs, 2009). Employees' time, effort, and knowledge are measurements of resource investment. Organizations compensate employees for their investments by providing extrinsic rewards such as a

salary, job security, and prestige. Researchers (e.g., Taris & Schereurs, 2009) have shown that employee satisfaction is directly associated with their motivation to perform well.

Not addressing continued job dissatisfaction can led to employees exhibiting aggressive behaviors in the workplace resulting in detrimental outcomes for organizational leaders (Taris & Schereurs, 2009). Ladebo and colleagues (2008) documented that workplace aggression, which may be verbal or physical, occurs when an employee performs acts to harm coworkers and/or the organization. According to Neuman and Baron (as cited in Myburgh, Poggenpoel, & Breetzke, 2011), workplace aggression includes the deliberate action of not performing tasks or providing information with the intent to cause harm to an individual or organization.

Employee Performance

An individual's job design, motivation level, and performance work level are measurements used to determine the contextual nature of employee performance (Boxall & Mackay, 2009). Researchers (e.g., Carter, Murray, & Gray, 2011) have examined relational competence and the effects of enhancing relationships. However, studies investigating the association between relational competency and employee job performance are scarce (Carter et al., 2011). In a study on the effects of interpersonal relational competence as it relates to increasing employee performance, Carter et al. (2011) found that increased job satisfaction results in heightened social respect. In addition, the researchers suggested better organizational retention practices can result in improved management of employee performance, therefore leading to improve staff retention and decreased staff turn-over.

Mental Health Workers

Mental health agencies utilize programs and services that conceptualize a "wellness" approach focusing on a recovery-oriented and holistic model of care for individuals with mental illnesses (Nelson & Shockley, 2013). Wellness coaches collaboratively work with individuals with serious mental illness (SMI) assisting the individuals to develop self-defined goals as it relates to physical health, occupational, and social needs (Nelson & Shockley, 2013). The concept of wellness coaching assists the SMI population with actively facilitating their mental health and recovery goals. Furthermore, the majority of mental health wellness initiatives include employing individuals who have received mental health services in the past to provide peer support and direct care to SMI patients (Nelson & Shockley, 2013).

Frontline Mental Health Workers

Frontline mental health workers provide direct care to patients who have been diagnosed with a SMI. Although limited data exists on mental health frontline workforce, frontline mental health workers have been shown to be less educated and have a lower socioeconomic status than mental health workers in middle and upper level positions (Nelson & Shockley, 2013). Consequently, this socioeconomic difference results in fewer opportunities for career advancement compared to higher level mental health workers (Nelson and Shockley, 2013).

Frontline Healthcare workers comprise fifty percent of the healthcare workforce (Chuang, Dill, Morgan & Konrad, 2012), which includes direct care staff such as nursing assistants, mental health counselors, and respiratory therapy technicians (Schindel et al., 2006). Traditionally, health care organizations' investment in front line workers was

minimal due to the ability to replace the workers easily upon their departure from the organization (Schindel et al., 2006). However, while this paradigm is shifting as the demand for health care workers increase, organizations are relying on front line workers as a cost-effective method of meeting the basic service demands and expanding primary care services (Brownstein et al., 2011).

Legal Implications of Workplace Aggression

Tort law is the civil law that holds employers liable for negligence and motivates them to address workplace violence (Fletcher, Brakel, & Cavanaugh, 2000). The theory is that civil liability or the threat of civil liability will shift employers to improve the safety of the workplace (Fletcher et al., 2000). According to McLaughlin (2014) anti-bullying legislation in America does not exist, despite workplace bullying being four times more predominant than any other form of illegal harassment.

According to Cascardo (2011), court systems are reviewing an increased number of legal cases against employers for violent acts committed by their employees. Employers are required to utilize a logical approach when hiring and retaining potentially dangerous employees (Cascardo, 2011). The Office of Safety and Health Administration (OSHA) provides guidelines to organizations for addressing workplace safety and workplace aggression (Cascardo, 2011). Organizational leaders may incur liability to employees if they fail to provide a safe workplace, conduct negligent hiring practices as it relates to pre-employment testing, and negligent supervision (Cascardo, 2011).

Bullying and Organizational Ethics

Understanding ethical and organizational dimensions is key to addressing workplace bullying (Rhodes et al., 2014). Until recently, research on bullying from an

organizational perspective was limited (Samnani, 2013). Bulutar and Oz (2009) have suggested that researchers are increasing their emphasis on the importance of workplace aggression. Although violent acts garner immediate attention, bullying behaviors are underestimated and less noticeable despite their detrimental effects to both the organization and individuals (Bulutar & Oz, 2009). Previous studies (e.g., Rhodes et al., 2014) have examined bullying and its association with job-related stress, role conflicts, workplace culture, and organizational change process. The balance of power determines bullying interaction and outcomes. Specifically, the individual with the most power typically becomes the aggressor and perpetrator of bullying; whereas, the less powerful employee becomes the target/victim (Keashly, 2010).

Bullying, which is deliberate act to harm another individual, is an unethical behavior (Harvey et al., 2009). Bullying is the product of an individual act of misconduct by a perpetrator, therefore, the relational aspects of bullying and organizational scope is often unobserved (Rhodes et al., 2014). Kumar, Jain, and Kumar (2012) suggest that not all individuals who display aggressive behavior towards others do so deliberately. Kumar et al. (2012) contend that employers, managers, and supervisors typically are not aware that the victim perceives their behavior as bullying (Kumar et al. (2012).

In 2008, a study conducted by Postgraduate Medical Education Training Board indicated that 9.7% of doctors who responded reported that they experienced bullying, with physicians training in specialized care being more likely to report bullying by consultants (Paice & Smith, 2009). Organizations appear to support abusive acts when they do not have any policies in place to address incivility or when management does nothing to punish bullies (Gumbus & Lyons, 2011).

Organization leaders have normalized the misbehavior of the aggressor, resulting in the creation of organizational cultural practices, in which the bullying becomes both an individual and systemic culture of violence (Rhodes et al., 2014). Organizational changes and the need to compete in a global environment have contributed to the proliferation of workplace bullying (Gumbus & Meglich, 2012). In addition, organizational leaders are experiencing unprecedented stress caused by technological changes, mergers, competitive pressures, and outsourcing. Therefore, workers may experience job insecurity, increased hostility, and incivility in the workplace (Gumbus & Meglich, 2012). Organization leaders are not responsible for individual acts of bullying; however, they are responsible for the presence of bullying acts within the organization. Moreover, organizations have institutional practices in which leaders may include or condone bullying (Rhodes et al., 2014).

Bullying may persist in organizations due to lack of understanding of bullying behavior and its impacts on social and institutional dynamics (Rhodes et al., 2014). Further, bullying may result due to a lack of trust within the organization (Rhodes et al., 2014), as well as the lack of diversity among organizational cultures (Harvey et al., 2009). Workplace bullying may potentially lead to institutional habitual behavior which results in organizational corruption (Hutchinson, 2009). Organizational norms and work demands may result in employees accepting bullying as an acceptable behavior (Harvey et al., 2009). Organizations typically approach all workplace-bullying cases utilizing the same process, placing less emphasis on the needs of the individual (McKay & Fratzl, 2011).

Although individual acts of bullying is typically not condoned in the workplace, organizational systems or practices may coerce the individual to behave in ways in which they normally would not (Rhodes et al., 2014). Samnani (2013) suggested that individuals experience a level of discomfort when inconsistency exists between their values and observed behaviors by others. Consequently, to alleviate the discomfort, the individual may attempt to align their values with the behavior observed (Maertz, Haasan, and Magnusson, 2009; Samnani, 2013). A perpetrator may bully victims because of the difficulty to recognize bullying acts (Hoel et al., 2010). Additionally, individuals within the organization may justify or rationale their bullying behaviors as an attempt to increase productivity. Rhodes et al. (2014) posited that while bullying is considered unethical within organizations, the lack of involvement by organizational leaders perpetuates the violent actions.

According to the WBI study (2014), 72% of participants stated employers either encouraged bullying, defended the bullying acts of managers/executives, rationalized the bullying, denied it happened, failed to investigate, or discounted the abusive act. Currently, the United States does not have a law in place (state or federal) to address abusive conduct within organizations that occurs outside of those defined as illegal discriminatory actions (WBI, 2014).

Traumatization from the process of dealing with bullying incidents may affect both the victim and the aggressor secondary to the organizational process for dealing with bullying (McKay & Fratzl, 2011). Management responds differently to organizational policies and processes due to differing interpretation of policies, management styles, training, and experience (McKay & Fratzl, 2011). Organizations need to develop

processes to effectively determine the severity of the specific situation and the impact on the employee. Moreover, managers should participate in additional training to address the range of victims' responses (McKay & Fratzl, 2011).

Theoretical Framework

The Conservation of Resource (COR) theory's basic tenet is ideal for the proposed research study. According to Hobfoll (2012), individuals strive to protect and retain resources that they perceive are being threatened. Moreover, individuals display aggressive workplace behaviors when they feel stressed and believe they are not being treated fairly (Hickey, 2012). During stressful and high-risk situations, individuals use different coping resources (Hickey, 2012). Research examining the effects of psychological stress and high-risk situations on indivuduals is limited (Rhodes et al., 2014). COR theory explores why some individuals can cope with stressful situations relatively unaffected, whereas other individuals faced with the similar situations become debilitated. Researchers using the COR theory seek to explain the behavioral variances and psychological reactions individuals display during stressful situations (Schat & Frone, 2011).

COR theory attempts to explain characteristics of psychological stress and its consequences (Hickey, 2012; Schat & Frone, 2011). Previous theories related to stress have focused on how individuals view stressful situations and their experiences (Hickey, 2012). COR theory suggests that when people are stressed, they strive to acquire and protect circumstances that impact their well-being, while distancing themselves from circumstances that threaten their well-being (Hickey, 2012).

Further, COR theory utilizes two key principles: 1) Primacy of resource loss and 2) resource investment. The primacy of resource loss principle examines the disproportionality between resource loss and resource gain, and the influence of degree of the loss resources on the speed of the impact of the loss (Hobfoll, 2012). The four resource categories include objects, condition, personal, and energy (Buchwald 2010; Hobfoll, 2012). Object resources provide the basis for coping (e.g., car, house, computer), condition resources facilitate the protection of valued resources (e.g., marriage, job), and personal resources are the individuals' characteristics and individualized skills (e.g. self-esteem, self-efficiency, motivational level). According to Buchwald (2010), self-efficiency is a significant resource that assists individuals in coping with assessment and subsequent stress. Lastly, energy resource includes time, money and knowledge and allows access to additional resources (Buchwald, 2010).

Resource Investment, the second principle of COR theory, implies that in order to protect against resource loss, people must invest in resources (Hobfoll, 2012). Individuals with greater resources are less vulnerable to loss and are capable of gaining more resources; whereas, individuals with less resources are more vulnerable to losing resources and less able to gain resources (Buchwald, 2010; Hobfoll, 2012). In order to adapt, individuals utilize strategies to conserve resources when losses occur (Buchwald, 2010). Moreover, individuals with less resources or coping capabilities take riskier protection strategies as an attempt to gain resources, which often does not yield the desired outcomes (Buchwald, 2010). Unsuccessful attempts to gain resources result in psychological distress and resource loss; consequently resulting in diminished invested resources (Buchwald, 2010).

The COR theory speculates that stress stems from difficulty achieving common cultural goals, expectations or both (Hickey, 2012). Individuals recognize, through personal experience and learning, how to acquire what they perceive are symbolically important based on societal standards, values, and cultural survival (Schat & Frone, 2011). Resources are entities, personal characteristics, or energies acquired and valued by the individual (Hickey, 2012). COR theory outlines a key alignment that determines individuals' behavior to aid in understanding how individuals perform in stressful circumstances (Hobfoll, 2012). Therefore, the COR is the most appropriate theoretical framework to utilize for the proposed study.

Summary

Workplace bullying in healthcare organizations is a significant problem (Carter et al, 2013). Over 41% of American workers are exposed to some type of workplace aggression (Schat & Frone, 2011). Consequently, victims of bullying experience serious ramifications such as mental and physical impairments (Johnson & Rea, 2009; Schat & Frone, 2011). Bullying not only affects victims, but patient care is affected as well. Paice and Smith (2009) documented that physicians who were bullied committed serious medical errors. Further, the cost of bullying is substantial to organizations; staff turnover, absenteeism, and productivity.

I hypothesized that there will be a significant relation between job satisfaction and the propensity for workplace aggression. I also hypothesized that employees with more exposure to workplace aggressive acts will report low job satisfaction. Lastly, I hypothesized that frontline workers (i.e., technicians and nurses) will report more exposure to workplace aggressive acts than workers in other mental health disciplines. In

Chapter 3, I explain the research design and methodology used to test these research

hypotheses.

Chapter 3: Research Method

The purpose of this quantitative correlational study was to investigate the propensity of workplace aggression among health care professionals and the association between job satisfaction and the propensity for workplace aggression. I collected data from various disciplines specializing in mental health. In this chapter, I describe the proposed research methodology, research design and approach, sample size, instruments, and data collection procedures. A primary purpose of the study was to make inferences about perceived antecedents that contribute to workplace aggression.

Research Design

I used a correlational design for the study, which was needed to test theories by investigating the relations among variables (Creswell, 2009). Quantitative research includes instruments that yield measurable data to deductively investigate theories (Creswell, 2009). A quantitative approach was appropriate for the study because I sought to determine whether certain variables contributed to aggressive behavior in the workplace. Researchers using a quantitative approach can make inferences that are generalizable to the targeted population (Creswell, 2009). The purpose of this correlational study was to determine whether there were associations between the propensity for workplace aggression and job satisfaction. The independent variable in this study was propensity for workplace aggression, which included passive aggressive behaviors and psychological, physical and verbal abuse. The dependent variables were work environment, job satisfaction, and organizational leadership.

I used the Work Environment Scale (WES) and Conditional Reasoning Test of Aggression (CRTA) to collect data. The WES was used to evaluate employee satisfaction

and work productivity (Mind Garden, 2013). The CRTA was used to measure individuals' propensity to engage in aggressive behavior (James et al., 2005). To analyze the data, I used Minitab 17 data analysis software. I also collected demographic data including role, gender, service years with the organization, and years of experience at the beginning of the data collection process.

Research Questions and Hypotheses

I sought to answer two research questions (RQs) focusing on mental health workers' propensity for workplace aggression:

RQ1: Is there a significant relationship between propensity for workplace aggression and job satisfaction?

RQ2: Do frontline workers (i.e., mental health technicians and nurses) have a higher propensity for workplace aggression than workers in other mental health disciplines?

Hypotheses are not accepted or rejected until tested by the researcher through a scientific process (Frankfort-Nachmias & Nachmias, 2008). If a hypothesis is accepted, it is considered verified and scientifically proven (Frankfort-Nachmias & Nachmias, 2008). For the proposed study, I sought to determine whether mental health workers had a propensity for workplace aggression. I also explored how job satisfaction influenced employees' perception of workplace aggression. Lastly, I examined whether particular workers (nurses and technicians) had a heightened perception of exposure to workplace aggressive acts.

I hypothesized that there would be a significant relationship between behavioral health workers' propensity for workplace aggression and job satisfaction. Negative

workplace environmental factors such as organizational restructuring, heavy workloads, disparaging management styles, and interpersonal conflicts have been found to be associated with workplace bullying (Matthiesen & Einarsen, 2010). Perpetrators of bullying have demontrated low self-esteem and more aggressive behaviors (Matthiesen & Einarsen, 2010). Individuals may manipulate their interpretation and perceptions of the behaviors to cope with the inconsistency between cultural values and observed behaviors in their environment (Samnani, 2013). Consequently, individuals may allow their perceptions of the behavior to align with cultural expectation and values (Maitlis & Sonenshein, 2010). Moreover, those who exhibit aggressive acts may do so as a way to protect and enhance their self-esteem or compensate for a lack of social competence (Matthiesen & Einarsen, 2010).

Perceived work place stressors can negatively influence physical, psychological, and behavioral changes in employees (Nielsen, Matthiesen & Einarsen, 2012). Further, individuals with low self-confidence and a high degree of anxiety may feel that they are harassed and/or bullied more than others (Matthiesen & Einarsen, 2010). I hypothesized that mental health technicians' and nurses' perceptions of workplace aggression would be more pronounced than those of other behavioral health workers. Based on the research questions, the hypotheses were as follows:

H1$_a$: There is a significant relationship between the propensity for workplace aggression and job satisfaction.

H1$_0$: There is no significant relationship between the propensity for workplace aggression and job satisfaction.

H2$_a$: Frontline workers have a higher propensity for workplace aggression than workers in other mental health disciplines.

H2$_0$: Frontline workers do not have a higher propensity for workplace aggression than workers in other mental health disciplines.

Research Population and Geographic Location

The targeted population for this study included employees working in behavioral health settings (community-based services, -n-patient mental health services, and outpatient mental health clinics) in the metro Atlanta area. Eligible participants included mental health technicians, nurses, social workers, and licensed independent practitioners (psychiatrists, psychologists, counselors, advance practice registered nurses, and therapists). Behavioral health administrative support staff (i.e., unit clerks and financial representatives) were not eligible for the study. Additionally, participants had to be at least 18 years of age and had to have worked in a behavioral health setting for more than 6 months. I obtained a list of all eligible participants and solicited their participation via email with a hyperlink to complete the survey online. The hyperlink included a copy of the consent form, a copy of the CRTA, a copy of the WES, and a short demographic questionnaire. Prior to implementing the data collection surveys, I visited each facility to discuss the research study and establish professional rapport with the organizational leaders to obtain initial approval for employees to participate in the study. Explaining these important details enabled the respondents to understand their roles in the study. I assumed that respondents would be more forthcoming and honest with their responses if they fully understood the importance of the study. I selected the geographic location due

to my knowledge of the area and the close proximities of the selected behavioral health organizations.

Sampling Frame

Choosing the correct sample size is critical to any study. The sample size selected is a major determinant of the risk of reporting false-negative findings (Biau, Kerneis & Porcher, 2008). To ensure validity and reliability for the study, I needed to ensure the sample size represented the targeted population. In addition to using established tools and controlling for biases, researchers should ensure that the sample size is appropriate and indicative of behaviors of the targeted population.

I used a statistical power table to determine the research study sample size (Cohen, 1992). The alpha was 0.05, the beta was 0.20, and power value was 0.80. Based on these sample size determinants, the recommended sample size was 85 (Cohen, 1992).

The participating mental health facilities had approximately 500 direct care workers. To reduce the nonparticipant rate, I invited all 500 potential participants via email notification lists with a website hyperlink to complete the survey. A large participant pool significantly improved the chance of obtaining enough participants to complete the survey, thereby ensuring a sample size that was representative of the targeted population. In addition, I explained the purpose of the study and emphasized participant anonymity in my email invitations.

Informed Consent and Confidentiality

This study required human participants, specifically clinical professionals; therefore, certain ethical issues were addressed. The consideration of these ethical issues is necessary for the purpose of ensuring confidentiality. I obtained approval from Walden

University (IRB approval Number 05-12-16-0337441) and each participating

organizational Institutional Review Board (IRB) prior to the initiation of the data

collection phase. Additionally, I adhered to each facility's process and requests related to

obtaining IRB approval. Further, I advised the respondents that they may withdraw from

the study at any time.

I provided a memorandum to all participants indicating that their participation in

the surveys would be voluntary and their responses would be anonymous. Given the

sensitive nature of the study, it was important to protect the rights and anonymity of the

participants.

Before participating in the online survey, the participants acknowledged their

understanding of the research purpose, the criteria for participation, and their voluntary

consent to participate. Once the participants had provided their informed consent, they

were instructed to access a hyperlink that directed them to the survey questions. To

enhance privacy, IP addresses or links to respondents were not noted.

Prior to conducting the study, I obtained clearance (Certification Number 23700)

from The National Institutes of Environment Health Science (NIEHS) certifying that I

had completed the NIH Web-based training course Protecting Human Research

Participants. The certification indicated that I had received formal training in protecting

the rights and welfare of human subjects in a research study (NIEHS, 2013).

Data Collection

To allow for sufficient participation in the least amount of time, I distributed the

surveys using SurveyMonkey, an online survey media. I discussed and received approval

from my dissertation committee members before the survey was administered to the

participants. SurveyMonkey was selected given the ease of access by the user and the user's ability to complete the survey anonymously. I established a private account with SurveyMonkey to collect and store the information gathered from the investigation. Participants' responses were not be transferred to third parties. I exported the data into Minitab, and I was the only person who had access to the data. I will store the data electronically on an encrypted USB data drive secured in a safe deposit box for 5 years at a local bank in Conyers, Georgia. After the 5-year period, the data will be destroyed.

Instrumentation

The survey instrument tool consisted of three parts: demographic data, the Work Environment Scale (WES), and the Conditional Reasoning Test of Aggression (CRTA). The WES is used to measure the perception of work environment and job satisfaction (Moos, 2008). The CRTA is used to measure the propensity for workplace aggression (James et. al, 2005). Demographic data included items such as job title and years of experience. The estimated time to complete the survey was 45 minutes. I obtained permission for use of the WES and CRTA (Appendix A and Appendix B).

Work Environment Scale

The Work Environment Scale (WES) was designed to measure employees' perception of their work environment. The WES has three forms: Real, Ideal, and Expectations. The Real Form is used to measure employees' perception of their current work environment. The Ideal Form is used to measure employees' perception of an ideal work environment. The Expectation Form is used to measure employees' perception of their future work environment (Moos, 2008). I used the Real Form, which focuses on the employees' present-day work environment. The WES Form R is a 90 item true/false

questionnaire, which consists of three dimensions and 10 subscales (Moos, 2008). The three dimensions are Relationship Dimensions, Personal Growth or Goal Orientation Dimensions, and System Maintenance and Change Dimensions (Moos, 2008).

Relationship Dimensions. The Relationship Dimensions are used to assess employees' commitment to their jobs and their perceptions of managerial support and coworkers' friendliness. The Relationship Dimensions include three subscales: Involvement, Peer Cohesion, and Supervisor Support. The Involvement (I) scale is used to assess employees' job commitment. The Peer Cohesion (PC) is used to measure employees' perception of coworkers' supportiveness and friendliness. Supervisor Support (SS) is used to assess supervisor support (Moos, 2008).

Personal Growth or Goal Orientation Dimensions. The Personal Growth or Goal Orientation Dimensions are used to assess employees' perception of job demands, workplace autonomy, and work efficiency. The Personal Growth dimension includes three subscales: Autonomy, Task Orientation, and Work Pressure. The Autonomy (A) subscale is used to measure employees' perception of their ability to be self-sufficient and make decisions within the workplace. The Task Orientation (TO) subscale is used to assess workplace efficiencies. The Work Pressure (WP) subscale is used to assess employees' perception of work demands and time urgency in the workplace (Moos, 2008).

System Maintenance and System Change Dimensions. The System Maintenance and System Change Dimensions are used to measure employees' perception of organizational rules, policies, innovation, and the physical setting in the workplace. System Maintenance and System Change Dimensions consist of four subscales: Clarity,

Control, Innovation, and Physical Comfort. The Clarity (C) subscale is used to assess

employees' perception of communication within the organization related to sharing

policies and protocols and the extent to which employees know their job expectations.

The Control (Ctl) subscale is used to assess employees' perception of managerial efforts

to control employees. The Innovation (Inn) subscale is used to measure employees'

perception of new approaches and changes within the organization. The Physical Comfort

(Com) subscale is used to assess employees' perception of their physical surroundings.

Conditional Reasoning Test of Aggression

Conditional Reasoning Test of Aggression (CRTA) personality-based assessment

measures individuals' propensity for aggressive behaviors (James et al., 2005). The

CRTA is 25 item multiple choice reasoning test consisting of scenario questions. The

participants must select the answer that is most logical based on the information

presented (James et al., 2005). The CRTA is a predictor for employees' potential for

absenteeism, performance problems and rule violations (James et al., 2005).

The CRTA reasoning problems are constructed based on a justification

mechanism for aggression (James et al., 2005). Each reasoning problem has a one logical

response and 2 illogical responses. A high justification mechanism for aggression score,

the higher probability that the individual may engage in behavior that could indirectly or

directly cause harm to others (James et al., 2005). CRTA aggression scores can range

from 0-22 based on the number of aggressive answers that could be selected. James et al

(2005) state that a score of 0 to 12 is the typical range for respondents because aggressive

respondents rarely choose more than half of the aggressive choices. An aggressive score

greater than eight indicates a high probability for aggression (James et al., 2005).

Validity and Reliability

The goal of validity and reliability is to provide evidence that the information/data is trustworthy and represents accurate outcomes (Creswell, 2009). In order to determine the validity of a proposed study, the researcher must ensure that the measurements they are obtaining are actually assessing what they intended to measure (Frankfort-Nachmias & Nachmias, 2008). According to Fields (2009), the Cronbach's alpha is frequently used assess the reliability for continuous measures. A Cronbach's alpha reliability coefficient ranges from 0 to 1. The closer the Cronbach's alpha coefficient is to 1.0, the greater the internal consistency reliability of the items in the scale (Fields, 2009).

Limitations associated with using surveys include the validity and reliability of survey questions (Mora, 2011). Generalized survey questions should be asked to ensure the highest probability of validity and reliability. In addition, the research questions should reflect the problem the research is attempting to explore (Mora, 2011). Previous studies (e.g., Moos & Insel, 2008) have demonstrated good internal consistency reliability for the WES, with Cronbach's alphas for the subscales ranging from 0.69 (Clarity) to 0.83 (Innovation). Research (e.g., James et al., 2005) has also shown the CRTA to be a valid and reliable instrument, with criterion related validity of 0.44.

Data Analysis

The data was analyzed using the Minitab 17.0 data software. The data was downloaded into an Excel spreadsheet to review and categorize the data. All mental health workers received an email invitation with a hyperlink to the online survey to improve participation opportunities amongst all mental health disciplines. Surveys not

completed were excluded from the data analysis. Upon ensuring that the data was "clean", the data was uploaded to the Minitab software for data analysis.

Utilizing Minitab, I tested my research hypotheses o determine (1) Is there a significant relationship between propensity for workplace aggression and job satisfaction? (2) Do frontline workers (i.e., mental health technicians and nurses) have a higher propensity for workplace aggression than workers in other mental health disciplines? A confidence interval of 90% was defined as having a statistical significant relationship.

To analyze the data, I used several statistical tests to analyze the dependent and independent variables, which are shown in Table 1.

Table 1

Variables and Statistical Measurements

Research Question	Independent Variable	Dependent Variable	Confounding Variable	Statistical Measurement
1	Propensity for aggression	Job satisfaction	Years of Service; gender	Multiple Regression; Linear Regression; Pearson Correlation
2	Frontline Workers employee position	Propensity for aggression	Years of Service; gender	t Test ; ANOVA; Pearson correlation
1 &2	Years of service, gender, job title	Propensity for aggression; job satisfaction	N/A	Standard deviation; mean, median, and mode

Initially, univariate descriptive statistics were used to determine the ratio of participants with a propensity for aggression in relation to participants without a

propensity for aggression categorized by job title. Univariate data analysis allows for the researcher to statistically review the frequency distribution of responses per individual variable (Fielding & Gilbert, 2006). Utilizing univariate data statistics, I also examined the participants' length of employment, the number of participants categorized by job titles, and the participants gender. The univariate analysis assisted with making inference related to the research study, therefore providing guidance with selecting further statistical tests required to analysis the research data (Fielding & Gilbert, 2006). I further assessed the correlation of the participants' propensity for aggression and job satisfaction, utilizing the following statistical tests: multiple regression, linear regression, and ANOVA tests. In an effort to control confounding variables in this proposed research study, during the pre-research phase, selection of participants is based on their employment in a mental health department/unit. Therefore, the confounding variables (participants' years of service and gender) is a randomized selection.

Confounders are variables that has the ability to affect the dependent and independent variables relationship (Pourhoseingholi, Baghestani, & Vahedi, 2012). Confounding variables can show a negative or positive correlation with the independent or dependent variables, therefore, affecting the actual relationship between the variables in the research study (Pourhoseingholi, Baghestani, & Vahedi, 2012). To further control confounders, I utilized the linear aggression model to statistically interpret the data when analyzing the results. Utilizing the linear regression model assist with determining the relationship of the covariates and the research outcomes (Pourhoseingholi, Baghestani, & Vahedi, 2012).

Upon controlling the confounders, I used ANOVA tests to examine if Frontline Workers propensity for aggression higher than other mental health workers. In addition, I examined if Frontline Workers position has an impact on their propensity for workplace aggression using the t-test and Pearson correlation statistical analysis. Utilizing the Pearson correlation test assisted with identifying the degree in which mental health workers job position (independent variable) and their propensity for aggression (dependent variable) correlates.

Summary

This quantitative research study utilized the WES and CRTA to investigate mental health workers' propensity for workplace aggression, as well as the association between job satisfaction and workplace aggression. After providing informed consent, mental health workers in the metro Atlanta area participated in the online study conducted electronically via SurveyMonkey. In Chapter 4, I will present the data analysis based on the stated hypotheses.

Chapter 4: Results

The purpose of this chapter is to provide the results of the study. I sought to determine whether mental health workers had aggressive propensities and if job satisfaction was a relational outcome. I used two survey instruments: the Conditional Reasoning Test of Aggression (CRTA) and the Work Environment Scale (WES). The CRTA is a 25-question test to determine a person's probability to engage in aggressive behavior. The WES was used to examine individuals' satisfaction with their work/job environment. The WES consists of 90 true-and-false questions. Primary demographic information was obtained to categorize the participants based on gender, years of service, and job title. The participants' responses to the CRTA questions and WES statements provided the necessary data to answer the following research questions and address their corresponding hypotheses:

Research Question 1

Is there a significant relationship between propensity for workplace aggression and job satisfaction?

H1$_a$: There is a significant relationship between the propensity for workplace aggression and job satisfaction.

H1$_0$: There is no significant relationship between the propensity for workplace aggression and job satisfaction.

Research Question 2

Do frontline workers (i.e., mental health technicians and nurses) have a higher propensity for workplace aggression than workers in other mental health disciplines?

H2$_a$: Frontline workers have a higher propensity for workplace aggression than workers in other mental health disciplines.

H2$_0$: Frontline workers do not have a higher propensity for workplace aggression than workers in other mental health disciplines.

Recruitment and Data Collection

The targeted participants consisted of mental health workers employed at two metro Atlanta hospitals. Recruitment for participants to take the survey was conducted via email. An initial email was sent to targeted participants. A subsequent email was sent to targeted participants at both organizations approximately two weeks after the initial recruitment effort. A total of 89 mental health workers participated in the study. The survey was conducted online via SurveyMonkey. The survey was accessible to participants from June 13, 2016 through July 15, 2016. All potential participants were provided with the purpose of the study, a copy of the consent form, and a hyperlink to the survey. Respondents' participation was voluntary and anonymous.

Demographics

For the purpose of this study, frontline mental health employees included mental health technicians, nurses, clinicians, and physicians. Ancillary and administrative staff were not eligible to participate in the study. The research pool consisted of approximately 350 mental health workers; 96 mental health workers agreed to take the survey, but only 89 completed the survey. Table 2 and Table 3 contain the demographic information including gender, job title, and length of employment. The respondents ($N = 89$) consisted of 78 (88%) females and 11 (12%) males. Most respondents (41.6%) were

clinicians. Mental health technicians represented 33.7% of the same, and 24.7% of the

respondents were nurses. No physicians participated in this study.

Table 2

Demographics of Respondents by Job Title and Gender

Respondents Demographics	Job Title			
Gender	Clinician	MHT	Nurse	Grand Total
Female	**30**	**28**	**20**	**78**
>10 years	6	5	4	15
0- 6 months	2			2
1 yr- 2 years	1	4	2	7
2 years-5 years	14	14	12	40
5 years-10 years	6	5	2	13
6 months - 12 months	1			1
Male	7	2	2	11
>10 years		2	2	4
2 years-5 years	4			4
5 years-10 years	3			3
Grand Total	37	30	22	89

Table 3

Demographics of Respondents by Job Title and Gender by percentages

Respondents Demographic	Job Title			
Gender by Percentage	Clinician	Mental Health Tech	Nurse	Grand Total
Female	33.7**%**	31.46**%**	22.5**%**	87.6**%**
>10 years	6.7%	5.6%	4.5%	16.9%
0- 6 months	2.3%	0.0%	0.0%	2.3%
1 yr- 2 years	1.1%	4.5%	2.3%	7.9%
2 years-5 years	15.7%	15.7%	13.5%	44.9%
5 years-10 years	6.7%	5.6%	2.3%	14.6%
6 months - 12 months	1.1%	0.0%	0.0%	1.1%
Male	7.9**%**	2.3**%**	2.23**%**	12.4**%**
>10 years	0.0%	2.3%	2.3%	4.5%
2 years-5 years	4.5%	0.0%	0.0%	4.5%
5 years-10 years	3.4%	0.0%	0.0%	3.4%
Grand Total	41.6**%**	33.7**%**	24.7**%**	100.0**%**

Research Instruments and Sample Questions

Validated instruments are critical in conducting a research study. For this

quantitative study, I used the Conditional Reasoning Test of Aggression (CRTA) and the

Work Environment Scale (WES). Demographic information included the respondents'

job title, length of employment, and gender. The CRTA is a 25-question test used to

determine a person's probability to engage in aggressive behavior. The WES was used to

examine individuals' satisfaction with their work/job environment. The WES consists of

90 true-and-false questions. The CRTA is an indirect measure of an individual's

aggression tendency. The CRTA is used to measure the extent to which individuals are

cognitively prepared to use aggressive behavior (James & Intyre, 2000). The CRTA

consists of four factors that underlie conditional reasoning problems and are based on

eight previous studies used to determine reliability. The alpha coefficients of the CRTA

factors were 0.86, 0.85, 0.85, and 0.84 respectively (James & Intyre, 2000). The

Cronbach's alpha coefficient for the WES subscales ranged from 0.69 to 0.83 (Moos,

2008).

Scoring

Each respondent's score for the WES (Form R) was calculated based on the

number of correct responses given based on the scoring key provided with the WES

testing material. The individual's correct responses were then categorized by the

subscales and the number of correct responses for each subscale established the raw

score. The mean of all subsections was used to determine the overall job satisfaction

score. Similarly, the CRTA scoring was determined by calculating the number of

aggressive responses by each respondent.

Conditional Reasoning Test of Aggression

The Conditional Reasoning Test of Aggression (CRTA) personality-based assessment is used to measure individuals' probability for aggressive behaviors (James et al., 2005). The CRTA is 25-item multiple choice reasoning test consisting of scenario questions. The participants selected answers that they felt were the most logical based on the information presented (James et al., 2005). The CRTA reasoning problems are constructed based on a justification mechanism for aggression (James et al., 2005). Each reasoning problem has one logical response, one aggressive response, and two illogical responses. Three questions (Questions 1, 2, and 6) were critical reasoning problems; therefore, they were not scored as measurements for aggression.

CRTA Sample Questions

The CRTA scoring is based on the number of questions for which the respondents chose the "aggressive" response. Table 4 provides the scoring interpretation for the CRTA. According to James and McIntyre (2000), a score of 0 to 12 is the practical range for respondents. The higher aggression score indicates that a person has a higher probability to engage in aggressive behaviors (James & McIntyre, 2000). Individuals with high aggression scores have an inclination to cognitively justify the aggressive behavior (James & McIntyre, 2000).

According to James and McIntyre (2000), there are certain justification mechanisms that guide individual reasoning. Individuals with a higher propensity for aggressive behavior have a strong inclination to use justification mechanisms (James & McIntyre, 2000). There are six primary justification mechanisms for aggression: victimization by powerful others bias, potency bias, hostile attribution bias, retribution

bias, social discounting bias, and derogation of target bias (James & McIntyre, 2000).

Table 4 presents the participants' choices categorized by illogical, nonaggressive, and

aggressive responses.

Table 4

Participants CRTA Responses per Question

CRTA Question	Justification Mechanism	Number of Respondents with Illogical Response	Number of Respondents with Non-Aggression Response	Number of Respondents with Aggression Response
3	Victimization	3.4% (n=3)	49.4%(n=44)	47.2%(n=42)
4	Potency	3.4% (n=3)	77.5%(n=69)	19.1%(n=17)
5	Hostile Attribution	0.0%(n=0)	94.4%(n=84)	5.6%(n=5)
7	Retribution	3.4%(n=3)	96.6%(n=86)	0.0%(n=0)
8	Potency	4.5%(n=4)	82.0%(n=73)	13.5%(n=12)
9	Social Discounting	0.0%(n=0)	51.7%(n=46)	48.3%(n=43)
10	Social Discounting	0.0%(n=0)	97.8%(n=87)	2.2%(n=2)
11	Potency	0.0%(n=0)	74.2%(n=66)	25.8%(n=23)
12	Victimization	3.4%(n=3)	61.8%(n=55)	34.8%(n=31)
13	Retribution	1.1%(n=1)	61.8%(n=55)	37.1%(n=33)
14	Potency	2.2%(n=2)	80.9%(n=72)	16.9%(n=15)
15	Social Discounting	0.0%(n=0)	78.7%(n=70)	21.3%(n=19)
16	Hostile Attribution	4.5%(n=4)	82.0%(n=73)	13.5%(n=12)
17	Social Discounting	0.0%(n=0)	58.4%(n=52)	41.6%(n=37)
18	Potency	3.4%(n=3)	88.8%(n=79)	7.9%(n=7)
19	Social Discounting	2.2%(n=2)	76.4%(n=68)	21.3%(n=19)
20	Social Discounting	3.4%(n=3)	31.5%(n=28)	65.2%(n=58)
21	Potency	3.4%(n=3)	64.0%(n=57)	32.6%(n=29)
22	Derogation	6.7%(n=6)	80.9%(n=72)	12.4%(n=11)
23	Hostile Attribution	3.4%(n=3)	49.4%(n=44)	47.2%(n=42)
24	Retribution	0.0%(n=0)	97.8%(n=87)	2.2%(n=2)
25	(Potency)	0.0%(n=0)	95.5%(n=85)	4.5%(n=4)

Table 5 summarizes participants' responses based on the six justification

mechanisms. Victimization bias was the largest justification mechanism used by the

respondents. On average, 41% of respondents selected the aggressive choice. Social

discounting bias was second with 33% of the respondents selecting the aggressive choice, and hostile attribution bias was third with 22% of the respondents using this mechanism to justify their aggressive choice.

Table 5

Participants' CRTA Aggressive Responses and Justification Mechanisms

Justification Mechanism	Mean Percentages
Derogation	12.4%
Hostile Attribution	22.1%
Potency	17.2%
Retribution	13.1%
Social Discounting	33.3%
Victimization	41.0%

Justification Mechanism Sample Questions

Victimization

According to James and McIntyre (2000), aggressive individuals typically perceive themselves as the victims and therefore see their aggressive acts as justifiable (e.g., bravery, retaliation, self-defense). Of the victimization questions, the average aggressive response by respondents was 41%, the largest justification mechanism used by the respondents. An example of one of the CRTA questions that reflects victimization is "Joe is usually on time for work and for meetings with his boss and clients. He is also on time for appointments with his doctor, dentist, and priest. However, Joe is always five or more minutes late for meetings with Bill. Which of the following is the most logical explanation for Joe being late for meetings with Bill?" The aggressive response is "Joe is usually on time for people he respects, so he must not respect Bill." The nonaggressive response is "Joe and Bill are friends, so they don't care about being on time for each

other." One of the illogical choices is "Bill gets up later than Joe." Of the 89 participants, 47% chose the aggressive choice, 49% chose the nonaggressive choice, and 3% chose one of the illogical choices.

Retribution

Retribution bias indicates that respondents believe that an aggressive response is justified if they feel they were disrespected. Individuals with retribution biases feel that the aggressive response is warranted to regain respect or to correct a perceived wrong (James & McIntyre, 2000). Individuals who exhibit retribution biases typically do not accept or forgive the perceived wrongful act; they prefer retaliating or seeking revenge (James & McIntyre, 2000). One CRTA question associated with retribution bias states "The old saying, 'an eye for an eye,' means that if someone hurts you, then you should hurt that person back. If you are hit, then you should hit back. If someone burns your house, then you should burn that person's house. Which of the following is the biggest problem with the 'eye for an eye' plan?" The aggressive choice is "People have to wait until they are attacked before they can strike." The nonaggressive choice is "It offers no way to settle a conflict in a friendly manner." One of the illogical choices is "It tells people to 'turn the other cheek.'" Of the 89 participants, 0% chose the aggressive choice, 99.6% chose the nonaggressive choice, and 3.4% chose one of the illogical choices.

Potency

Individuals who use the potency bias justification typically perceive people as either strong or weak. Therefore, to individuals using potency bias, their aggressive behavior is justified because they are being brave or a leader to others (James & McIntyre, 2000). An example of a CRTA question that related to the potency bias states

"People in a rich neighborhood in New York were pushed around for years by a homeless man. This man slept in alleys, stayed drunk or high on drugs, and cursed and threatened to hurt many of the residents. The police were called many times. But the homeless man always got a lawyer and returned to the neighborhood and caused trouble. Which of the following is the most logical conclusion regarding the people who lived in this neighborhood?" The aggressive choice is "They were afraid of the man, and would not fight back." The nonaggressive choice is "They did all they could do within the law." Of the 89 participants, 25.8% chose the aggressive choice, and 74.2% chose the nonaggressive choice. No illogical responses were selected.

Social Discounting

Social Discounting Bias received the 2nd largest justification mechanism with the average aggressive response of 33.33%. Social Discounting implies that individuals typically utilized antisocial and/or unorthodox beliefs to understand social events (James & McIntyre, 2000). An example of a CRTA Social Discounting questions states "Gangs have formed in many large cities. Gangs often fight over territory, selling drugs, and insults. Gang members are often killed in these fights. Few murders of gang members are solved. Which of the following is the most logical conclusion based on the above?" The aggressive response is "The police don't really care about the deaths of a few gang members." The non-aggressive response is "Too many people are in gang fights to know who committed the murders." Of the 89 responses, 65.2% chose the aggressive option; 31.5% chose the non-aggressive choice, 3.4% chose one of the illogical choices.

Derogation

A Derogation CRTA question states "Many hold-ups take place on city streets. Hold-up victims are usually not hurt if they do everything a robber wants. Which of the following is the most logical conclusion regarding hold-up victims who do get hurt?" The aggressive choice is "They met a robber with a taste for violence." The non-aggressive choice is "They resisted, refused to turn over money, or started a fight." One of the two illogical choices were "They were able to outrun their attacker." Of the 89 responses, 12.4% chose the aggressive selection, 80.9% chose the non-aggressive choice, and 6.7% chose one of the illogical selections. Typically individuals who utilize the Derogation bias justify the aggressive behavior by perceiving that the targeted individual having negative characteristics (e.g. corrupt, dishonest, etc.) therefore, the recipient of the aggressive behavior was deserving of the aggressive act (James & McIntyre, 2000).

Hostile Attributes

The final Justification Mechanism is Hostile Attribution Bias. Individual who use the Hostile Attribution bias often perceive others with having malevolent intentions. An example of this is the CRTA question which states "Half of all marriages end in divorce. One reason for the large number of divorces is that getting a divorce is quick and easy. If a couple can agree on how to split their property fairly, then they can get a divorce simply by filling out forms and taking them to court. They do not need lawyers. Which of the following is the most logical conclusion based on the above?" The aggressive choice is "If one's husband or wife hires a lawyer, then he or she is not planning to play fair." The non-aggressive choice is "Couples might get back together if getting a divorce took longer." One of the illogical options were "More men than women get divorced." Of the

89 responses, 47.2 % chose the aggressive choice, 49.4%% chose the non-aggressive choice and 3.4% chose one of the illogical choices.

Work Environment Scale

The WES Form R consists of 90 true/false statements with three dimensions and ten subscales (Moos, 2008). The Work Environment Scale conceptual framework encompasses three major perspectives in the workplace: the human relations approach, the socio-technical perspective, and a social information processing orientation (Moos, 2008). According to Moos (2008) "Work stressors stem from the nature of the tasks employees perform and how work groups are organized (socio-technical characteristics). In addition, it emphasizes the quality of relationships among employees and supervisors, human relations, and employee appraisal of the workplace, social information processing" (pg 49).

WES Dimensions and Sample Questions

There are three dimensions of the Work Environment Scales: Relationship Dimension, Personal Growth or Goal Orientation Dimension, and System Maintenance and Change Dimension (Moos, 2008). Each dimension has associated sub-scales. Table 6 provides a brief explanation of the three dimensions and the 10 sub-sections for WES (Moos, 2008). Sample questions related to each Dimension is discussed later in this chapter.

Table 6

Definitions for WES Dimensions and Subscales

WES Relationship Dimension Subgroups	Definition
1. Involvement	the extent to which employees are concerned about and committed to their jobs
2. Coworker Cohesion	how much employees are friendly and supportive of each other
3. Supervisor Support	the extent to which management is supportive of employees and encourages employees to be supportive of one another
WES Personal Growth Dimension Subgroups	
1. Autonomy	how much employees are encouraged to be self-sufficient and to make their own decisions
2. Task Orientation	the emphasis on good planning, efficiency, and getting the job done
3.Work Pressure	the degree to which high work demands and time pressure dominate the job milieu
WES System Maintenance and Change Dimension Subgroups	
1. Clarity	whether employees know what to expect in their daily routine and how explicitly rules and policies are communicated
2. Managerial Control	how much management used rules and procedures to keep employees under control
3. Innovation	the emphasis on variety, change, and new approaches
4. Physical Comfort	the extent to which the physical surroundings contribute to a pleasant work environment

Relationship Dimensions

The Relationship Dimension of WES consist of three sub-scales which assess job

commitment, perception of co-workers friendliness, and the supportiveness of co-workers

and supervisors. A question used to assess participants response to the Relationship

Dimension states" Employees who differ greatly from the others in the organization don't

get on well". This question assess the sub-scale Co-Worker Cohesion. Of the 89

respondents, 42% chose the "False" option, whereas, 58% chose the "True" option. This

indicates that 58% of the respondents did not feel that employees who differ from others

got along well. The desired response was the "False" option. Another statement to assess

Relationship Dimension states "Supervisors really stand up for their people". This

statement assesses respondents' perception of Supervisor Support. The preferred response

is "True". Sixty-one percent of the 89 respondents selected the "True" option; 39% chose

the "False" option.

Personal Growth Dimensions

The Personal Growth Dimension assesses employees perception of their

autonomy to make their own work related decisions, job efficiency to complete tasks, and

work demands. The sub-scales are Autonomy, Task Orientation, and Work Pressure.

"Employees function fairly independently of supervisors" is an example of the Autonomy

sub-scale. Eighty-one percent of the 89 respondent selected "true" option, which is the

desired option; 19% of the respondents selected the "false" option.

System Maintenance and Change Dimensions

The third dimension of the WES is the System Maintenance and Change

Dimensions. It consists of four sub-scales-Clarity, Managerial Control, Innovation and

Physical Comfort. One of the Clarity sub-scale questions states "Things are sometimes

pretty disorganized". The desired choice is "False". 72 out of 89 (81%) respondents

selected the "True" option. Only 19% of the respondents selected "False". The Clarity

sub-scale assesses employees' perception of knowing what is expected of them to

complete their job during their daily routine. Employees' perception of how managers

use rules to keep employees under control, the organization of change and embracing new approaches, and the workplace physical surrounding is assessed under the System Maintenance and Change Dimension.

'Supervisor Support' and 'Work Pressure received the highest job satisfaction ranking with a score of 7. The lowest sub-scales for Clinicians were 'Physical Comfort', 'Managerial Control', and 'Innovation' with a score of 4. Mental Health Technicians (MHT) highest scoring sub-scale was 'Autonomy', with a score of 9. The lowest scoring sub-scales for MHT was 'Work Pressure' and 'Innovation'. Nurses' highest scoring sub-scale was 'Managerial Control', scoring a 9. Nurses' lowest scoring sub-scale was 'Physical Comfort' with a score of 1. Overall for all respondents, the highest scoring sub-scales were Autonomy, Managerial Control, Task Orientation and Work Pressure; each with a mean score of 6. The least scoring sub-sets for all respondents were Physical Comfort with a mean score of 3. Amongst the groups of respondents, the Clinicians had the highest job satisfaction with a mean score of 5.3. MHT job satisfaction score was 5. Nurses had the lowest job satisfaction score of 4.6. Table 7 summarizes the average respondents' job satisfaction scores related to the WES 10 sub-scales and categorized by the respondents' job titles.

Table 7

Respondents Job Satisfaction Score by WES Sub-scales

WES Sub-Scale	Clinician Job Satisfaction Score	Mental health Technician Job Satisfaction Score	Nurse Job Satisfaction Score	Overall Job Satisfaction Score (All Respondents)
Autonomy	6	9	4	6
Clarity	5	4	4	4
Physical Comfort	4	5	1	3
Managerial Control	4	5	9	6
Involvement	5	5	5	5
Innovation	4	3	4	4
Coworker Cohesion	5	5	3	4
Supervisor Support	7	4	4	5
Task Orientation	6	7	5	6
Work Pressure	7	3	7	6
OVERALL SCORE	5.3	5	4.6	4.9

Note. Job satisfaction scale range from 0 (low satisfaction) through 9 (high satisfaction)

Results of the Data Analysis

In this section, each research question is addressed to ascertain if there is a relationship between job satisfaction and the propensity for workplace aggression amongst mental health workers. To determine any relational scientific significance, I utilized Minitab 17.0 software program. Analyzation of the data was performed by using the 2 sample t-test, One Way ANOVA, Multiple Regression, and Pearson Correlation. Before conducting any data analysis, the responses by each participant was exported from SurveyMonkey into an Excel Spreadsheet. Secondly, the exported data was coded from text responses into a numerical response. Subsequently, the data was imported to Minitab

17.0 for data analysis. The research results are presented using utilizing graphs and tables with summaries of the data analysis for each of the statistical measurement tests.

Research Question 1

Is there a significant relationship between propensity for workplace aggression and job satisfaction?

H1$_a$: There is a significant relationship between the propensity for workplace aggression and job satisfaction.

H1$_0$: There is no significant relationship between the propensity for workplace aggression and job satisfaction.

To investigate the first research question, initial statistical analysis test included conducting multiple One Way ANOVA test to investigate if a statistical difference is present related to job satisfaction and the probability of aggression. The respondents' job title was the independent variable and their job satisfaction and aggression scores represented the dependent variable. As shown in Table 8 and Figures 1 and 2 the mean for Clinicians, MHT, and Nurses were 4.676, 4.367, and 4.545 respectively; thus yielding a p-value of 0.837 which indicates that there was not a significant difference between aggression scores based on job title.

Table 8

One-way ANOVA: Aggression by Position

Position	N	Mean	StDev	95% CI
Clinician	37	4.676	2.186	(3.988, 5.363)
MHT	30	4.367	2.236	(3.603, 5.130)
Nurse	22	4.545	1.738	(3.654, 5.437)

Note. Analysis of variance→ *p*-value 0.837.
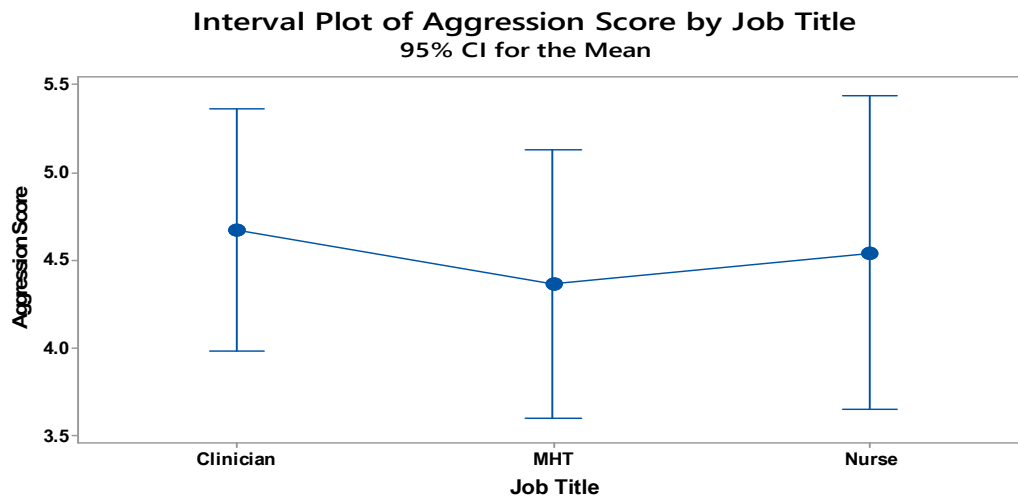
The pooled standard deviation was used to calculate the intervals.

Figure 1. *Aggression score by job title.*
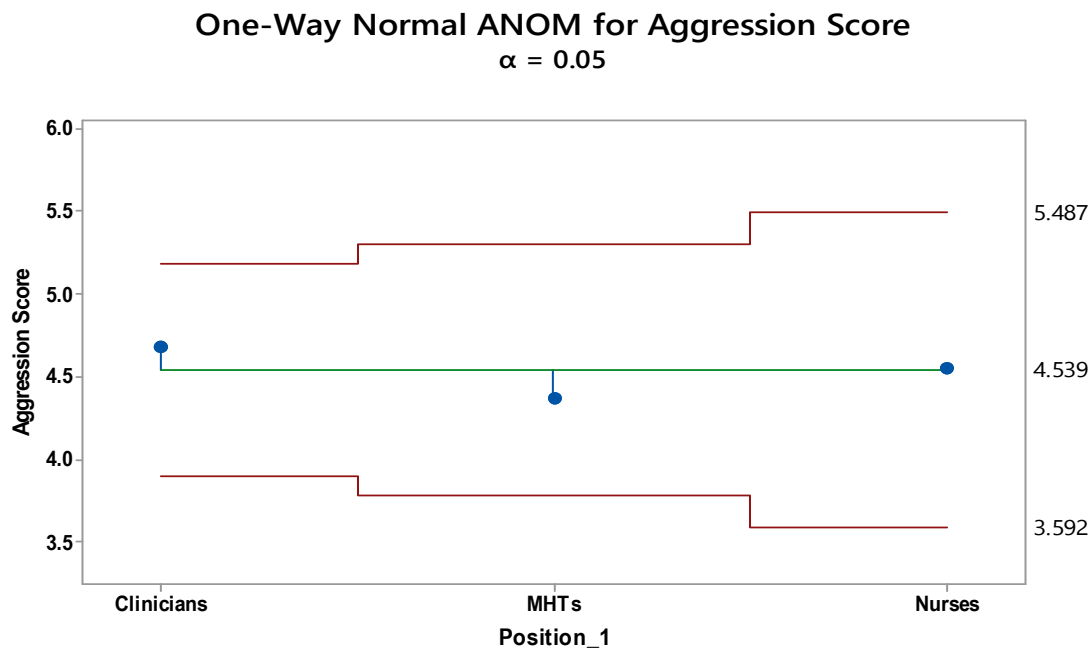
Figure 2. *Aggression score by job title.*

The one-way ANOVA testing for job satisfaction resulted in a *p*-value of 0.053 (see Table 9 and Figure 3). The mean job satisfaction scores for clinicians was 4.797; MHTs mean score was 5.58; and nurses was 4.664. Based on the one-way ANOVA for job satisfaction by position indicates that MHTs were more satisfied in their current job environment.

Table 9

One-Way ANOVA: Job Satisfaction by Position

Position	*n*	Mean	StDev	95% CI
Clinician	37	4.797	1.469	(4.301, 5.294)
MHT	30	5.580	1.731	(5.028, 6.132)
Nurse	22	4.664	1.272	(4.020, 5.308)

Note. Analysis of Variance→ *p*-value 0.053

Interval Plot of Job Satisfaction by Job Title
95% CI for the Mean

The pooled standard deviation was used to calculate the intervals.
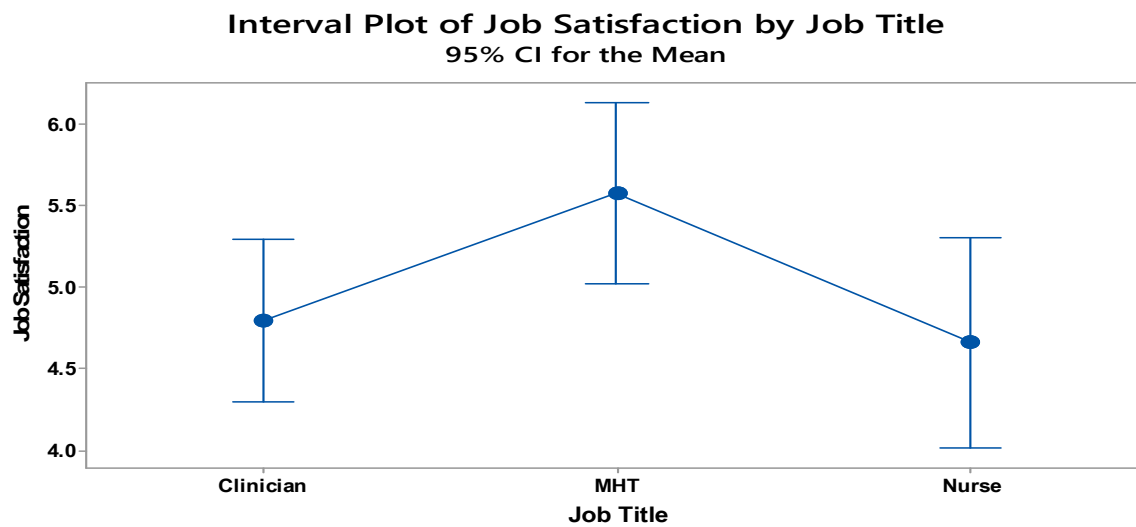
Figure 3. *Job satisfaction score by job title.*

Additional one-way ANOVA tests (see Tables 10 &11, Figures 4 & 5) were conducting using respondents' length of employment as the independent variable and the respondents' job satisfaction and aggression score as dependent variables. The length of employment was categorized in 3 categories (0-2 years employment; 2-5 years employment; >5 years employment) neither tests revealed a significant difference between length of employment in relation to job satisfaction scores or aggression scores.

Table 10

One-Way ANOVA: Aggression by Length of Employment

Length of Employment	N	Mean	StDev	95% CI
0-2 years	10	5.500	2.014	(4.193, 6.807)
2-5 years	44	4.386	2.264	(3.763, 5.009)
>5 years	35	4.457	1.837	(3.759, 5.156)

Note. Analysis of Variance→ *p*-value 0.302

Table 11

One-Way ANOVA: Job Satisfaction by Length of Employment

Length of Employment	N	Mean	StDev	95% CI
0-2 years	10	5.340	1.239	(4.354, 6.326)
2-5 years	44	5.014	1.510	(4.544, 5.484)
>5 years	35	4.957	1.712	(4.430, 5.484)

Note. Analysis of Variance→ *p*-value 0.791

Figure 4. *Aggression score by length of employment.*

Interval Plot of Job Satisfaction by Length of Employment
95% CI for the Mean

The pooled standard deviation was used to calculate the intervals.

Figure 5. *Job satisfaction score by length of employment.*

Consequently, I conducted a Pearson correlation test (see Figure 6) and a multiple

aggression test (see Figure 7) using the aggression score as the independent variable and

the job satisfaction score as the dependent variable. Statistical analysis based on the

Pearson Correlation *p*-value of 0.589 indicates that there is not a significant difference

between job satisfaction and the propensity for aggression. The R^2 of the linear regression

was 0.3% which implies that the variance relative to predicting job satisfaction based on

the propensity for aggression was only 30%. A linear value closer to one (1) would

support a significant relationship.

Boxplot of Aggessive score, Job Satisfaction (All Respondents)
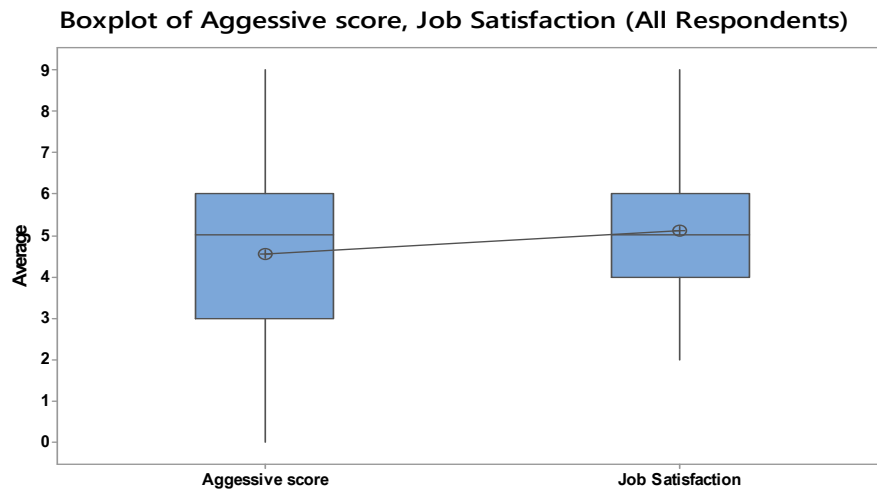
Figure 6. *Aggression score compared to job satisfaction score.*

Fitted Line Plot
Job Satisfaction = 5.301 - 0.04411 Aggessive score

S	1.58784
R-Sq	0.3%
R-Sq(adj)	0.0%

Figure 7. *Fitted Line plot of aggression score in relation to job satisfaction score.*

     The first research question investigated if there was a significant relationship between propensity for workplace aggression and job satisfaction. The alternate hypothesis states that there is a significant relationship between the propensity for workplace violence and job satisfaction. The null hypothesis states that there is no

significant relation between the propensity for workplace aggression and job satisfaction. Based on the findings, RQ1 the null hypothesis is not rejected.

Research Question 2

Do frontline workers (i.e., mental health technicians and nurses) have a higher propensity for workplace aggression than workers in other mental health disciplines?

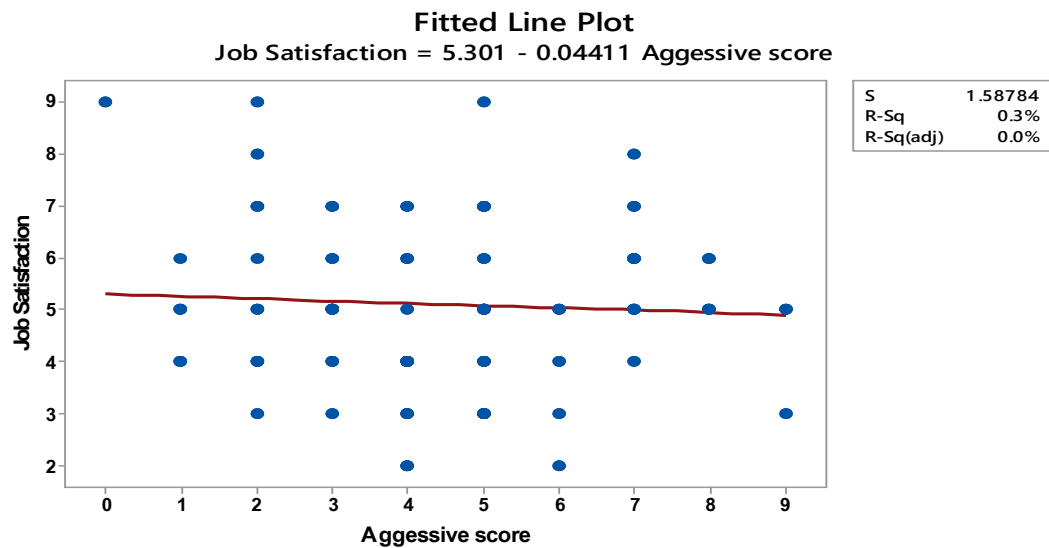**H2$_a$**: Frontline workers have a higher propensity for workplace aggression than workers in other mental health disciplines.

H2$_0$: Frontline workers do not have a higher propensity for workplace aggression than workers in other mental health disciplines.

For the purpose of this research study, frontline workers are MHTs and Nurses. The primary statistical analysis test conducted were the 2 sample *t*-test. Similar to the approach taken to investigate the first research question, I conducted 2 sample *t*-tests extrapolated by length of employment in 3 categories (0-2 years employment; 2-5 years employment; >5 years employment). The aggression scores for Clinician (n=4) was 5.750 and the aggression score for MHT and Nurses (n=6) was 5.33. The Aggression score *p*-value for 0-2 year employment respondents was 0.731 (see Table 12 and Figure 8).

Table 12

Two-Sample T-Test: Aggression by Position (Clinician vs MHT&Nurse; 0-2yr Employment)

Position	N	Mean	StDev
Clinician	4	5.750	0.957
MHT & Nurse	6	5.33	2.58

Note. p-value→0.731

Interval Plot of Clinicians s MHT & Nurses with 0-2 yrs Employment
95% CI for the Mean
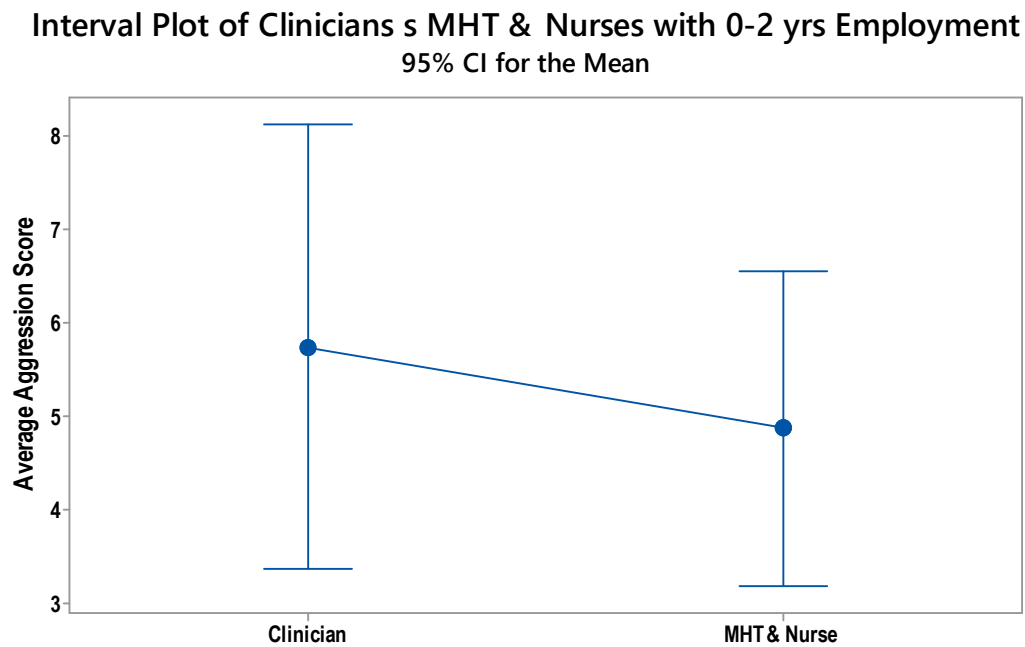
The pooled standard deviation was used to calculate the intervals.

Figure 8. *Aggression score for clinician and MHT & Nurses..*

As shown in Tables 12 and 13 and Figure 9, the 2 sample t-test for 2-5 year and >5 year employment respondents resulted in a significant findings. Clinicians (n= 18) employed for 2-5 years aggression score was 5.5 as opposed to a 3.62 aggressive score for MHT and Nurses (n=26) with a p-value of 0.012 (see Table 11 and Graph 9); which implies that clinicians employed with an organization between 2-5 years have a statistically higher propensity for aggression. A statistically significant difference was noted between respondents employed >5years. Based on the aggression score, MHT and Nurses had a higher propensity for aggression (see Table 12). Clinician (n=15) aggression score was 3.4, whereas the MHT and Nurses (n=20) aggression score was 5.25 which yielded a p-value of 0.001.

Table 12

Two-Sample T-Test: Aggression by Position (Clinician vs MHT&Nurse; 2-5yr Employment)

Position	N	Mean	StDev
Clinician	18	5.50	2.64
MHT & Nurse	26	3.62	1.60

Note. p-value→ 0.012

Table 13

Two-Sample T-Test: Aggression by Position (Clinician vs MHT&Nurse; 5yr Employment)

Position	N	Mean	StDev
Clinician	15	3.40	0.828
MHT & Nurse	20	5.25	2.00

Note. p-Value→0.001

The pooled standard deviation was used to calculate the intervals.

Figure 9. *Aggression score by length of employment for Clinicians and MHT& Nurses*

A final 2 sample *t*-test was conducted to compare the overall aggression score for all clinicians versus all MHTs and nurses. The respondents' length of employment was not factored into the final 2 sample *t*-test. The aggression score for clinicians (n=37) was 4.68 compared to MHTs and Nurses (n=52) aggression score of 4.44. The aggression score *p*-value for all respondents was 0.610 (see Table 14); which does not indicate a significant difference. Although the 2 sample t-test yield significant difference for 2 out of 3 length of employment categories, the overall statistical analysis did not result in a significant relationship. Based on the findings I cannot reject the null hypothesis.

Table 14

Two-Sample T-Test: Aggression (Clinician vs MHT/Nurse; All Respondents)

Position	N	Mean	StDev
Clinician	37	4.68	2.19
MHT & Nurse	52	4.44	2.02

Note. p-Value→ 0.610

Summary

Chapter 4 presented statistical analysis to address the two research questions and the associated hypotheses. Various statistical tests were utilized to include Pearson correlation, Multiple Regression, One-Way ANOVA, 2 sample *t*-test and Descriptive Statistics. The results of the statistical test showed that statistically there was not a significant relationship between mental health workers job satisfaction and a propensity for workplace aggression. The statistical analysis did not support the hypothesis that

Frontline workers have a higher propensity for aggression. In Chapter Five I will discuss

the significance of the results and next steps.

Chapter 5: Discussion, Conclusions, and Recommendations

Recent studies indicate that the probability for health care workers to experience workplace aggression increases when workers are unsatisfied with their work conditions (Ariza-Montes, Muniz, Montero-Simó, & Araque-Padilla, 2013). Factors such as performing repetitive tasks, work stress, work overload, or having a shift schedule can also increase the probability of workplace aggression (Ariza-Montes et al., 2013). The purpose of this quantitative correlational study was to determine whether mental health workers' job satisfaction was related to their propensity for workplace aggression. I also sought to determine whether frontline workers had a higher propensity for aggression than other mental health care workers.

I examined the job satisfaction and propensity for aggression of mental health nurses, mental health technicians, and mental health clinicians. I also investigated whether frontline workers had a higher propensity for aggression compared to other workers. In this Chapter, I summarize the research findings and discuss implications and recommendations for future research.

Interpretation of the Findings

To answer the research questions, I used the Conditional Reasoning Test for Aggression (CRTA) and the Work Environment Scale (WES). Several data analysis tests were conducted to analyze the participants' responses and to answer the following research questions:

Research Question 1

Is there a significant relationship between propensity for workplace aggression and job satisfaction?

H1$_a$: There is a significant relationship between the propensity for workplace aggression and job satisfaction.

H1$_0$: There is no significant relationship between the propensity for workplace aggression and job satisfaction.

Research Question 2

Do frontline workers (i.e., mental health technicians and nurses) have a higher propensity for workplace aggression than workers in other mental health disciplines?

H2$_a$: Frontline workers have a higher propensity for workplace aggression than workers in other mental health disciplines.

H2$_0$: Frontline workers do not have a higher propensity for workplace aggression than workers in other mental health disciplines.

Eighty-nine mental health workers in metro Atlanta hospitals participated in the survey. Participants consisted of health nurses, mental health technicians, and mental health clinicians.

Research Question 1

Is there a significant relationship between propensity for workplace aggression and job satisfaction? I conducted Pearson correlation and one-way ANOVA statistical tests to answer this research question. The independent variable for the Pearson correlation was the aggression score, and the dependent variable was the job satisfaction score. Based on the statistical analysis of the data, there was no significant relationship between the propensity for aggression and job satisfaction as measured by a p value of 0.589. Therefore, the null hypothesis was not rejected. I conducted one-way ANOVA

tests to determine whether there was a difference in job satisfaction by job titles or length of employment. Similar ANOVA tests were conducted to investigate aggression propensity by job title. Statistical tests revealed that there was a significant difference for job satisfaction when categorized by job titles as indicated by a p value of 0.053. Based on the mean job satisfaction scores, MHTs had the highest job satisfaction with a score of 5.580. Clinicians' job satisfaction was 4.797, and nurses' job satisfaction was 4.664. Subsequent statistical tests revealed that job satisfaction score decreased as length of employment at the organization increased.

The statistical tests did not reveal a significant difference between the aggression scores when categorized by job titles. The p value for aggression based on job title was 0.837. The clinicians had the highest aggression score of 4.676. Nurses had the second highest aggression score of 4.545, and the MHTs had the lowest aggression score of 4.367. Although there was not a significant difference between the scores, it should be noted that MHTs had the highest job satisfaction score and the lowest aggression score.

Research Question 2

Do Frontline workers (i.e., mental health technicians and nurses) have a higher propensity for workplace aggression than workers in other mental health disciplines? To determine whether frontline workers had a higher propensity for workplace aggression, I conducted several two-sample t tests. For this analysis, the clinicians' aggression scores were compared to the combined aggression scores of the frontline workers (MHTs and nurses). No physicians participated in the research study; the clinicians were the only other mental health staff included in this study apart from the nurses and MHTs. Based on the statistical analysis of all respondents, there was no significant difference between the

propensity for aggression for frontline workers and other mental health staff as measured

by a p value of 0.610. Therefore, the null hypothesis was not rejected. Similar to the

methodology used to answer the first research question, I conducted statistical tests based

on length of employment to determine whether there was a difference in aggression scores

between the disciplines. Based on the findings, length of employment correlated with

workplace aggression when categorized by disciplines. Statistical results revealed

significant differences between clinician and frontline workers for those employed

between 2 and 5 years and those employed more than 5 years. Clinicians employed

between 2 and 5 years had a mean aggression score of 5.5; MHTs and nurses had a mean

score of 3.62. This indicated a significant difference with a p value of 0.012. Results for

respondents employed more than 5 years also revealed a significant difference related to

aggression scores with a p value of 0.001. MHTs and nurses had a mean aggression score

of 5.25, and clinicians had a mean aggression score of 3.4. There was no significant

difference in the aggression score for clinicians and frontline workers for respondents

employed less than 2 years. Surprisingly, frontline workers employed between 0 and 2

years had the highest aggression score of 5.33. Frontline workers' aggression score

decreased to 3.62 for individuals employed between 2 and 5 years and increased to 5.25

for individuals employed more than 5 years. Conversely, clinicians' aggression scores

declined as length of employment increased. Clinicians employed between 0 and 2 years

had an aggression score of 5.75. For those employed 2 to 5 years, the aggression score was

5.5, and this decreased significantly to 3.4 for clinicians employed more than 5 years.

Based on my involvement with mental health employees, a higher level of aggression for

frontline staff with 0-2 years of employment was not surprising, considering that most

frontline staff have very little or no exposure to working in close proximity with mental

health patients. As implied by the COR theory, individuals tend to protect what they

consider are valuable, therefore, it is my assumption that the 0-2 years employees utilize

specific justification mechanisms to cope with the perception of possible threats related to

their safety. However, I was surprised to note that the aggression level for frontline

workers increased with employment greater than 5 years. I speculate that this increase in

aggression scores arise from several factors: complacency with the job, job burnout,

and/or compassion fatigue. Secondary to many possible reasons for the significant

difference in aggression scores based on length of employment the findings warrant closer

examination to assist in closing the literature gap related to workplace aggression and job

satisfaction for mental health workers.

<div align="center">**Theoretical Framework and Research Results**</div>

According to the conservation of resources theory used for this study, individuals

accrue resources (e.g., money, self-esteem, social status) that they believe will assist them

in tolerating or overcoming real or perceived threats (Hobfoll, 2012). Mental health

workers' job satisfaction and work performance are influenced by their exposure to

difficult working conditions that include large caseloads, insufficient training, and lack of

supervision and peer support (Lee & Del, 2011). Additional stressors for mental health

workers include the personal threat of violence from patients (Rossler, 2012). According

to Hickey (2012), the COR theory suggests that stress arises from the inability to achieve

goals or expectations. Aggressive individuals typically perceive themselves as victims

and therefore see their aggressive acts as justifiable (James & McIntyre, 2000).

My participants' responses to the CRTA aligned with the COR theory, particularly the responses associated with victimization, social discounting, and hostile attribution biases. Participants who selected the aggressive choice on the CRTA applied justification mechanisms to rationalize their aggressive choice. Victimization and social discounting were the primary justifications used with 41.01% and 33.33% respectively. According to Hochwarter et al. (2007), an individual may use his or her reputation to secure other resources. For example, an individual's reputation may assist him or her in gaining more autonomy, which may subsequently lead to improved job performance and promotions (Hochwarter et al., 2007).

Limitations

This research study had several limitations including the potential of social desirability bias associated with the self-reported measures assessing sensitive topics (e.g., workplace aggression). According to Krumpal (2013), respondents may not answer truthfully due to concerns for potential negative consequences related to their responses (e.g., job loss). The premise of social desirability bias is that individuals tend to select the socially acceptable responses (Krumpal, 2013). Regardless of the survey being conducted online and the responses being anonymous, it was possible that respondents' selections were not truthful due to not wanting to be perceived as having undesirable traits and/or behaviors (Dalton & Ortegren , 2011). The type of respondents was another limitation. Eligible respondents included nurses, mental health technicians, clinicians, and physicians; however, no physicians participated in this study. Although the lack of physician participation was a limitation, it did not adversely impact the research study. Physicians' exposure and experiences with the clients are markedly different from direct

care staff (nurses, mhts, and clinicians). Therefore, it is my belief that obtaining the perceptions of the direct care staff as it relates to their job satisfaction and workplace aggression propensities were substantially more revealing.

Recommendation for Future Research

Further research is needed to investigate the reasons for the significance differences in aggression score when categorized by length of employment. Future studies could address, not only the length of employment at the current organization, but also the total time working in mental health services. It would also be worth investigating work shifts.

Briggs, Brough, and Barbour (2014) stated that employees' level of work engagement is influenced by their perception of support from their supervisor and organizational leaders. Typically, employees experiencing high levels of stress are less engaged at work (Briggs et al., 2014). As stated in Chapter 4, clarity and coworker cohesion were among the lowest ranking WES subscales with a score of 4. Therefore, I recommend a qualitative study to investigate the reasons why staff perceived lack of support from coworkers and peers.

Social Implications

Approximately 20% of the working population has mental health disorders (Organisation for Economic Co-operation and Development [OECD], 2012). Therefore, qualified mental health workers are essential for providing services and treatment to individuals seeking assistance in local communities. The social implications related to the study findings include assisting organizations in developing policies and trainings to

detect aggressive behaviors in staff and in creating strategies to retain qualified and committed employees by sustaining job satisfaction and engagement.

Another important social implication of this study is the potential impact on the community as it relates to understanding the mechanism staff used to cope with situations and factors that influence mental health workers' job satisfaction and engagement. Unfortunately, it is not uncommon for mental health workers to overlook signs of their stressors despite regularly counseling others on how to manage stress and traumatic events (Ting, Jacobson, & Sanders, 2011). Furthermore, mental health workers typically do not seek support from others in their social network when they experience stress (Ting et al., 2011). Mental health workers who are physically and mentally able to handle the increasing demands for mental health services are needed to support the growing number of individuals seeking services for mental health issues.

Conclusion

Workplace aggression can contribute to staff burnout, low staff retention rates, and decreased productivity (Rossler, 2012). According to Fujishiro, Gee, and de Castro (2011), organizations that allow employees to engage in aggressive acts are unlikely to provide a supportive work environment. By reviewing my findings and conducting subsequent research to explore the correlation between years of employment as a mental health worker and the factors associated with job satisfaction, organizations may develop methods to provide more support and effective training to staff to maintain work engagement and job satisfaction. The purpose of this quantitative study was to determine whether a correlation existed between the propensity for workplace aggression and job satisfaction for mental health workers. Additionally, I sought to determine whether

frontline workers had a higher propensity for aggression than other mental health workers. I conducted several statistical tests to answer the two research study questions. Findings did not reveal a direct correlation between aggression and job satisfaction nor did they support frontline workers having a higher propensity for aggression. However, they did reveal a potential phenomenon of staff aggression based on years of service, which should be explored further. This study also revealed key mechanisms used to justify aggressive acts and key areas related to staff job satisfaction. Despite the study's limitations, results may be used to further investigate ways to address mental health workers' aggressive behaviors and job satisfaction.

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Appendix A: WES Permission

m nd garden

www.mindgarden.com

To whom it may concern,

This letter is to grant permission for the above named person to use the following copyright material solely for his/her thesis research.

Instrument: **Work Environment Scale**

Author: **Rudolf H. Moos and Paul N. Insel**

Copyright: **Copyright © 1974, 2008 by Rudolf H. Moos**

Five sample items from this instrument may be reproduced for inclusion in a proposal, thesis, or dissertation.

The entire instrument may not be included or reproduced at any time in any other published material.

Sincerely,

Robert Most
Mind Garden, Inc.
www.mindgarden.com

Appendix B: CRTA Permission

Fwd: CRTA permission

Tashua Grizzle <tashua.grizzle@waldenu.edu>

Thu 2/12/2015 8:43 PM

Inbox

To:

📎 3 attachments

Test Manual 1c.doc; IAT Form R Scoring Key; IAT Reasoning Test Form R-1.doc c;

---------- Forwarded message ----------
From: **James, Lawrence R** <lawrence.james@psych.gatech.edu>
Date: Mon, Mar 31, 2014 at 2:50 PM
Subject: Re: CRTA permission
To: Tashua Grizzle <tashua.grizzle@waldenu.edu>

No problem. You have permission to make 110 copies of the CRTA. The test, scoring key, and a test manual are attached. Good luck in your research.

Larry James

----- Original Message -----
From: "Tashua Grizzle" <tashua.grizzle@waldenu.edu>
To: "Lawrence R James" <lawrence.james@psych.gatech.edu>
Sent: Sunday, March 30, 2014 8:12:38 PM
Subject: Re: CRTA permission

Good Evening Dr. James. After conferring with my chair and narrowing down my targeted audience, the number of participants to take the test will be approximately 90 individuals. If it is more convenient, I will be more than happy to come to your office at Georgia Tech and pick up the test, scoring key and permission to copy the test.

My mailing address is:

1473 Cherry Hill Rd
Conyers, Ga 30094

Again, thank you so much

On Thu, Feb 13, 2014 at 4:33 PM, James, Lawrence R <
lawrence.james@psych.gatech.edu> wrote:

> You are welcome to use the CRT-A for research purposes. Please send me an
> email requesting the number of tests you estimate you would like to copy
> (estimate on the high side). I will send you a copy of the test, a scoring

Appendix C: NIH Certificate

Certificate of Completion

The National Institutes of Health (NIH) Office of Extramural Research certifies that **Tashua Grizzle** successfully completed the NIH Web-based training course "Protecting Human Research Participants".

Date of completion: 02/11/2016.

Certification Number: 2000222.

Curriculum Vitae

Tashua L. Grizzle
Tashua***@att.net
(678) 772-**** (mobile)

Education:
Walden University
   PhD Healthcare Leadership, Expected Degree Conferment- November 2016

Clayton State University, Morrow, GA
   Master of Healthcare Administration, December 2009

Clayton State University, Morrow, GA
    Bachelor of Science in Healthcare Management May 2004

Pierce College, Puyallup, WA
         Associate of Applied Science, January 1996

Academy of Health Sciences
         Practical Nurse Diploma, July 1995

Academy of Health Sciences, Washington, DC
          Ear, Nose and Throat Specialist Diploma, July 1991

Accreditations and Certifications:
         Licensed Nursing Home Administrator
         Licensed Practical Nurse
         Basic Life Support (CPR) Instructor
         Six Sigma Green Belt Certification

Professional Experience:

Jan 2013-Present   *Behavioral Health Quality and Compliance Manager,*

                         Grady Health System, Atlanta, GA

- ➤ Plans, coordinates, and directs Quality and Compliance programs to ensure compliance with all federal, state and Joint Commission regulatory and accreditation standards;
- ➤ Provides leadership related to performance improvement initiatives through collaborative efforts with Unit Directors, Managers, and other Administrators to develop policies and performance indicators;
- ➤ Directs Compliance Staff in assessing and monitoring departmental processes to ensure compliance with all relevant laws and regulations through formal compliance audits;
- ➤ Monitors key performance indicators, initiates process improvements, develops training session, and assist with maintaining an overall Joint Commission readiness for the Department of Behavioral Health;
- ➤ Provide oversight for data collection and data analysis to ensure compliance with state, local, federal and Joint Commission standards.

➢ Develop training curriculum and provide education to direct care related to various healthcare modalities to ensure compliance with all federal, state and Joint Commission regulatory and accreditation standards.

Jan 2013-Present   *Professional Care Worker, LNHA Consultant*

Georgia Regional Hospital at Atlanta, Decatur, GA

➢ Provides consultation and assistance with the planning and implementation of quality improvement and health care delivery initiative to ensure compliance with all federal, state and Joint Commission regulatory and accreditation standards;
➢ Monitors key performance indicators, initiates process improvements, develops training session, and assist with maintaining an overall Joint Commission readiness for the Department of Behavioral Health;
➢ Develop training curriculums and provide education to direct care related to various healthcare modalities to ensure compliance with all federal, state and Joint Commission regulatory and accreditation standards.

Dec 2007-Jan 2013   *Consumer Services Administrator,*

Georgia Regional Hospital at Atlanta, Decatur, GA

➢ Provided planning, organization and administration of the adult mental health, Skilled Nursing facility, developmental disability, addictive diseases service programs within the 306 bed state-operated psychiatric hospital, ensuring continuity and consistency in delivery and quality of services;
➢ Responsible for the oversight of Risk Management, Utilization Review, Patients Advocacy, Medical Records, Rehabilitation Services, and Education Departments;
➢ Provided additional supervisory oversight of the Unit Directors for the three Adult Mental Health units, the Skilled Nursing Facility, and six Community Homes, which includes three Forensics Integrated Community Homes, two Adolescent Addictive Disease Homes and one Developmental Disability home;
➢ Served as the Licensed Nursing Home Administrator for the Skilled Nursing Facility to include the following:
    o Supervise, plan, develop, monitor and maintain appropriate standards of care.
    o Work with the department heads in the hiring of personnel and assure adequate numbers of staff to meet the needs of the residents on a twenty-four hour basis.
    o Liaison among the governing authority, the medical staff and the departments within the Skilled Nursing Facility.
    o Ensure quality control reviews are conducted, to assure adherence to regulating and accrediting standards.
    o Review and revise facility policies and procedures to minimize liability exposures, and maintain adherence to current guidelines and requirements.
➢ Coordinate procedures for release of medical information and correspondence requests according to local policies, state and federal statutes and laws;
➢ Develop policies and procedures to ensure facility is in compliance with all state, federal and Joint Commission regulations and applicable laws governing Adult Mental Health, Skilled Nursing Facility and ICF/MR;
➢ Serve as a liaison with the Healthcare Facility Regulation, Centers of Medicare & Medicaid Services, Georgia Advocacy Office, Joint Commission and other external agencies; provide

feedback and consultation to appropriate staff on corrective action plans related to areas of responsibility;

➢ Chair of the Falls Prevention and SNF Quality Assurance Committees Member of several other committees, including the Executive Team, Clinical Leadership, Patient Rights, Utilization Review, Clinical Leadership and Performance Improvement committees

Dec 2004-Dec 2007   *Licensed Nursing Home Administrator/ Service Director,*

Georgia Regional Hospital at Atlanta, Decatur, GA

➢ Administered, directed and coordinated all activities for the daily operation of a licensed 66 bed Skilled Nursing Facility and a licensed 65 bed ICF/MR Unit developmental disability facilities for the State of Georgia;

➢ Reviewed all reported events and took steps necessary to assure appropriate investigations and follow-up reviews were conducted;

➢ Reduced staff turnover while improving organization's delivering of care;

➢ Developed several new programs and initiatives, which enhanced the quality of resident life;

➢ Decreased facility's cited deficiencies by developing and implementing policies in procedures to ensure that potential risks are minimized;

➢ Collaborate with the Safety Officer in the development of environmental and safety guidelines, as well as routine inspections of the facility to ensure that procedures and regulations are strictly followed;

➢ Ensured compliance with all state, federal and Joint Commission regulations governing Long-Term Care and ICF/MR.

Aug 2001-Dec 2005   *Licensed Practical Nurse/Unit Manager,*

Riverside Health Care Center, Covington, GA

➢   Provided direct patient care and delivery of quality nursing care in a 159-bed long-term care facility;

➢   Provided timely input into planning, implementing, and evaluating the plan of care; modifies the patient's plan of care, as indicated, in collaboration with the RN;

➢   Collected and reported pertinent clinical information to the appropriate RN or provider and conveyed essential patient information to members of the health care team;

➢   Participated in developing, implementing, and documenting the client/family/caregiver educational plan;

➢   Conducted unit-based and organizational in-services for newly assigned nursing assistants and licensed practical nurses, along with continuing education activities and committee/teamwork opportunities.

Apr 2000-Jul 2001   *Licensed Practical Nurse, Starcrest of Conyers, Conyers, GA*

➢   Provided care for assigned residents and oversight of subordinate direct care staff in a long-term care facility;

➢ Delegated and supervised the care provided by nursing assistants and the certified medicine aide;

➢ Ensured smooth operation of the unit for a designated shift;

➢ Provided patient/family education;

➢ Orientated newly assigned nursing assistants and licensed practical nurses.

Feb 1991-Jan 2000　　　*Licensed Practical Nurse/ENT Specialist, United States Army*

➢ Supervised and provided oversight for an Audiology, Plastic Surgery, ENT, General Surgery and Urology Clinic;

➢ Served as the Assistant Non-Commissioned Officer in Charge of the Medical and Coronary Care Intensive Care Units;

➢ Directly supervised enlisted and civilian personnel;

➢ Administered performance evaluations, counseling, training, and provided technical guidance and advice;

➢ Provided direct nursing services from admission to discharge, to include patient and family education;

➢ Administered acute and routine outpatient ear, nose and throat medical treatments

➢ Provided specialized care for critically ill patients and patients requiring close observation in the Medical and Coronary Intensive Care Units;

➢ Assisted physicians with clinical and operating room surgical procedures.