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Counselors' Experiences of Workplace Aggression and Organizational Values: A Descriptive Analysis

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Limited research exists on workplace aggression within the counseling profession despite its negative ramifications for clinical practice. The authors conducted a descriptive study to explore the prevalence and common forms of workplace aggression experienced by a sample of practicing counselors ($N = 117$). More than 50% of counselors reported the experience of at least 1 aggressive act, and nearly 25% met the threshold for workplace aggression. The authors discuss the implications of these results and consider workplace aggression's incongruity with professional counseling values.

Keywords: workplace aggression, counseling, professional values, bullying, Negative Acts Questionnaire–Revised

The Occupational Safety and Health Administration (OSHA; n.d.) reported that nearly 2 million Americans experience episodes of workplace aggression on an annual basis. Reported incidents stretch across a spectrum and include threats, verbal hostility, physical assault, and homicide (OSHA, n.d.). Researchers and scholars have examined distinct facets of adversarial work conditions (e.g., harassment, discrimination) and linked these facets to the overarching phenomenon of workplace aggression (Schat, Frone, & Kelloway, 2006; Schat & Kelloway, 2005). Workplace aggression encompasses multiple variables that may negatively affect an employee physically or psychologically (Schat et al., 2006). Schat et al. (2006) examined workplace aggression within a blended sample of social workers, counselors, doctors, and nurses and discovered that employees in these occupations reported high prevalence rates of physical abuse and psychological aggression. Although commonalities exist between the helping professions (e.g., helping clients in times of need), the counseling profession is distinct in its operational values, professional philosophy, training procedures, and clinical applications (Kaplan & Gladding, 2011). Schat et al.'s findings are alarming to all helping professions;

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however, specific factors (e.g., professional values) raise particular concern about workplace aggression in the counseling profession.

Generations of leaders labored to stake the field of counseling in distinctive philosophical and ethical ground. Ponton and Duba (2009) illuminated the genesis of counseling values by exploring the vision of Frank Parsons, whose dream of a nation steered by vocational harmony and social justice runs perpendicular to the concept of workplace aggression. Almost half a century after Parsons's death, Carl Rogers proposed core conditions for personal growth that depend on relationships constructed through unconditional positive regard (Kirschenbaum, 2004). Decades after Rogers crystallized the humanistic vision for a generation of counselors, Van Hesteren and Ivey (1990) called for a paradigmatic focus on the importance of healthy, functional systems to individual wellness. Shortly thereafter, Guterman and Rudes (2008) forwarded a social constructionist foundation for counseling that embraced a collaborative and respectful working alliance grounded in an ethic of intentionality that minimizes harm. Finally, the *ACA Code of Ethics* (American Counseling Association [ACA], 2014) states that counselors "advocate to promote changes at the individual, group, institutional, and societal levels that improve the quality of life for individuals," and "engage in self-care activities to maintain and promote their own emotional, physical, mental, and spiritual well-being" (Standard C, Introduction, p. 8). The values and philosophical foundation of counseling promote individual and systemic wellness ideals that are incompatible with the notion of workplace aggression.

Numerous counseling organizations have also promoted professional and ethical mandates that are discordant with the idea of workplace aggression. The 20/20: A Vision for the Future of Counseling (2010) defined counseling as "a professional relationship that empowers diverse individuals, families, and groups to accomplish mental health, wellness, education, and career goals" (Kaplan, Tarvydas, & Gladding, 2014, p. 366). The 29 professional organizations that endorsed this definition of counseling include ACA; the National Board for Certified Counselors; the Council for Accreditation of Counseling and Related Educational Programs (CACREP); the Association for Spiritual, Ethical, and Religious Values in Counseling; the Association for Lesbian, Gay, Bisexual, and Transgender Issues in Counseling; and the Association for Counselor Education and Supervision (ACES; 20/20: A Vision for the Future of Counseling, 2010). The values amplified in the definition encompass social justice advocacy, holistic wellness, and an empowering relationship—all of which distinguish counseling from other helping relationships and are inharmonious with the presence of workplace aggression.

Although Schat et al. (2006) included counselors among other mental health professionals in their investigation of workplace aggression, examinations of workplace aggression solely among professional counselors are nearly negligible. Workplace aggression is associated with negative affective or physical employee experiences (Demir & Rodwell, 2012; Einarsen & Mikkelsen, 2003; Lewis & Orford, 2005; Rospenda, Richman, & Shannon, 2009),

adverse client outcomes, and increased frequency of unethical behavior in practitioners within a variety of fields (Randle, 2003; Roche, Diers, Duffield, & Catling-Paull, 2009). Therefore, an examination of workplace aggression in the counseling profession may determine the risk of both counselors and clients experiencing harmful consequences.

The purpose of this study was to initiate an investigation into the nature of workplace aggression in the counseling profession and to clarify the unique experience of this problem among a sample of professional counselors. Our study focused on both the scope and intensity of perceived workplace aggression that a sample of counselors have experienced and the identification of avenues for further research. Researchers must substantiate the existence and prevalence of workplace aggression in counseling before determining the nature of unhealthy work environments or implementing advocacy efforts that align organizational conduct with professional values. Therefore, this study examined self-reported prevalence rates and common forms of workplace aggression in a sample of practicing counselors.

Workplace Aggression

Researchers have studied the prevalence and implications of adversarial work conditions through different constructs that have encompassed discrimination (e.g., ageism, sexism, racism), harassment (e.g., sexual, generalized; Rospenda et al., 2009), victimization, abusive supervision, and workplace bullying (Tepper, 2007). Rospenda et al. (2009) found significant correlations between these various forms of harassment and discrimination in the workplace. Additionally, overlapping operational definitions for harassment exist, such as being ridiculed, sworn at, negatively spoken about to others, ignored, intimidated by unreasonable work demands, secluded from others, and reminded of past mistakes while not receiving credits for successes (Tepper, 2007). Schat et al. (2006) accounted for this overlap and used the phrase *workplace aggression* to describe the cumulative components of adversarial working conditions. This shift in language allowed for a holistic interpretation of aggression in the workplace regardless of motive or perpetrator through the use of a constant construct.

Research into workplace aggression in counseling is sparse; however, several studies have been conducted on the prevalence of workplace aggression in the field of mental health. Rudberg (2017) surveyed a sample of certified rehabilitation counselors and discovered that 29% of respondents reported experiences with workplace aggression; additionally, 26% of survey respondents reported the presence of clinical or severe depression (Rudberg, 2017). Firm implications for counseling cannot be ascertained from these results because Rudberg tracked workplace aggression as a single construct and did not process correlations between the two outcomes. Schat et al. (2006) investigated the prevalence of workplace aggression in a sample of 2,058 workers in the United States. Social workers, counselors/therapists, and psychiatrists reported the second highest rate of physical abuse in the nation at 9.1%, and 36.9% of this subsample reported psychological aggression.

Schat et al.'s definition of workplace aggression included acts of physical or psychological harm directed toward employees by either fellow employees or clients. Schat et al. used a five-item instrument for psychological aggression that limited the identification of workplace aggression to (a) being shouted at, (b) being insulted, (c) being explicitly threatened, (d) being physically threatened, and (e) being attacked with a weapon. An instrument with more items might capture a broader spectrum of aggressive behaviors; furthermore, the implications of the Schat et al. and Rudberg studies warrant further investigation on the impact of workplace aggression within the field of counseling.

Despite the concerns raised by the aforementioned studies, not all examinations of harmful workplace culture in the mental health disciplines have yielded results indicating substantial experiences with workplace aggression. Kurjenluoma et al. (2017) surveyed a sample of psychiatric nurses and found that most participants experienced workplace stress only occasionally and reported that they were mostly satisfied with their workplace culture. These findings are consistent with research conducted by Sørgaard, Ryan, Hill, and Dawson (2007), who surveyed a group of acute-care psychiatric nurses and found that participants were largely content with the social support and organizational culture in the workplace. Sørgaard et al. also examined a sample of community mental health workers in the same study; participants reported minimal accounts of workplace cliques, conflicts, negative relations with colleagues, and quarreling. The equivocal findings of workplace aggression in the field of mental health necessitate further clarifying research. In addition, the scant research on counselors and workplace aggression highlights the need for further inquiry into the prevalence and intensity of workplace aggression as they affect counselors' experience.

Employee Mental Health and Client Outcomes

A review of existing and related literature identified systemic links between workplace aggression and consequences that could affect client outcomes. Several researchers linked workplace aggression with adverse affective–physical employee experiences (Einarsen & Mikkelsen, 2003; Lewis & Orford, 2005; Rospenda et al., 2009). Einarsen and Mikkelsen (2003) noted that aggression in the workplace "may not only ruin employees' mental health but also their career, social status and thus their way of life" (p. 127). Researchers and scholars specified that victims of workplace aggression experienced decreased job satisfaction (Rowe & Sherlock, 2005), increased mental health consequences (Einarsen & Mikkelsen, 2003; Rospenda et al., 2009), increased interpersonal conflicts outside of work (Lewis & Orford, 2005), increased drinking outcomes (Rospenda et al., 2009), and decreased work performance (Rowe & Sherlock, 2005). Arnetz and Arnetz (2001) found an association between the presence of workplace aggression in hospitals and lowered employee mental energy and work efficiency. Additionally, researchers have found that workplace aggression may decrease employee performance by triggering withdrawal behaviors such as avoiding essential job tasks, absenteeism, and terminating employment

(e.g., Arnetz & Arnetz, 2001; Bowling & Beehr, 2006; Deery, Iverson, & Walsh, 2002; Hogh, Hoel, & Carneiro, 2011; Jackson, Clare, & Mannix, 2002; Rowe & Sherlock, 2005; Sliter, Sliter, & Jex, 2012).

Researchers have also identified a relationship between workplace aggression and diminished ethical capacity and competence in employees (e.g., Randle, 2003; Roche et al., 2009). Randle (2003) and Roche et al. (2009) linked workplace aggression with both poor mental health outcomes in employees and harmful client outcomes. Prilleltensky, Walsh-Bowers, and Rossiter (1999) examined the values and challenges of 17 clinicians related to ethical decision-making and found that desultory work environments (e.g., insufficient resources, heavy caseloads) had an impact on the participants' perception of acceptable ethical behavior. Clients who received services in organizations with high turnover rates had pronounced difficulty in connecting with their counselor on an emotional level (Hiatt, Sampson, & Baird, 1997). Similar results are found in other helping professions; for example, nurses working in aggressive environments reported more medication errors (Roche et al., 2009), decreased compassion toward patients, and more frustration toward their patients (Randle, 2003). Roche et al. (2009) also found an increased association between workplace aggression and patient falls, possibly as a result of employee negligence.

Additionally, Magnuson and Norem (2009) determined that workplace aggression might lead to physical and psychological harm in victims, damage to organizational well-being, absenteeism, and both victims and witnesses alike prematurely leaving the organization. These consequences could have particularly destructive effects on the counseling profession, because emotional exhaustion and a high turnover rate among counselors may be damaging to client outcomes (Knudsen, Ducharme, & Roman, 2006).

Furthermore, workplace aggression also correlates with decreased wellness and low morale in affected employees; these outcomes have an impact on employee performance and put clients at risk of receiving inadequate services. Wood, Braeken, and Niven (2013) investigated workplace aggression (e.g., discrimination) among mental health workers in the United Kingdom and found significant relationships between discrimination and poor well-being, especially when management was the perpetrator. Happell (2008) identified the reflexive relationship between organizational culture, employee morale, and workplace aggression in the field of mental health nursing and called for the development of a more proactive and sustainable organizational model. Establishing the existence of workplace aggression in the field of counseling may lead to further inquiry into how the construct affects wellness and morale for counselors and potentially inform organizational policy and counselor education and preparation.

Finally, workplace aggression is of particular interest to counseling professionals because of its potential effects on the therapeutic relationship. Negative and aggressive working environments have been linked to counselor burnout; distraught and emotionally distressed counselors are at risk of experiencing decreased empathy, developing negative opinions about clients,

and engaging in unprofessional conduct (e.g., chronic tardiness; Maslach, 2003). Strong therapeutic alliances are even more predictive of positive treatment outcomes than are therapist competency level (Owen, Miller, Seidel, & Chow, 2016), and counselor burnout has been linked to multiple behaviors that damage therapeutic relationships (Maslach, 2003). Therefore, counselors affected by workplace aggression may deliver uncaring and ineffective treatment.

Excessive Workplace Criticism and the Counseling Profession

Because many counselors begin their careers in community settings that use both clinical and administrative oversight, the possibility of excessive or destructive criticism contributing to workplace aggression is of particular interest to counseling. A study by Marras, Davis, Heaney, Maronitis, and Allread (2000) demonstrated that delivering excessive negative feedback to a group of introverts during a strenuous task led to elevated blood pressure and increased musculoskeletal strain in comparison with a control group. Although little is known about workplace aggression in the field of counseling, there is evidence that excessive negative feedback from supervisors may have similarly negative outcomes for counselors. For example, ineffective and detrimental supervision predicted counselor career change (Cherniss, 1989), burnout (Bush, Powell, & Herzberg, 1993; Cherniss, 1989), and low self-efficacy.

Furthermore, Staninger (2016) identified humiliating or excessive workplace criticism as integral to workplace aggression in the library profession and stated that such behaviors lead to systemic failures that prevent libraries from providing clients with quality service. Fleming (2016) reviewed the literature on workplace aggression in the field of occupational health in the United Kingdom, identifying disrespectful and excessive criticism as components of workplace aggression and citing research (Bloom & Farragher, 2010) that demonstrated how these behaviors contribute to employees experiencing demoralization and decreased critical thinking skills (Fleming, 2016). Although the phenomenon of workplace aggression may manifest itself differently in the field of counseling with different outcomes, these findings suggest detrimental results for employees experiencing workplace aggression. Quality client service and critical thinking skills are necessary for effective counseling. Further research is needed to first clarify the prevalence of workplace aggression experienced by counselors and to identify what aggressive acts counselors experience most frequently. This is a necessary first step before exploring the implications of workplace aggression in the counseling profession.

Researchers have examined the prevalence of workplace aggression in the context of multiple helping occupations (Schat et al., 2006); however, the incidence of workplace aggression in counseling is currently unknown. The purpose of the current study was to initiate an investigation into the

prevalence and nature of counselors' experiences with workplace aggression. This exploratory study used descriptive research questions that included the following: (a) What is the self-reported prevalence of workplace aggression experienced among a sample of professional counselors as measured by the Negative Acts Questionnaire–Revised (NAQ-R; Einarsen, Raknes, Matthiesen, & Hellesøy, 1994; Hoel, 1999)? and (b) What are the most commonly reported acts of workplace aggression experienced among a sample of professional counselors as measured by the NAQ-R?

Method

We used a descriptive research design and implemented online survey methodology to answer our research questions. Our decision was partly grounded in our preference for a large sample size, because we hoped to gain access to a wide and diverse sample (e.g., with respect to specialty area and place of employment). Furthermore, as workplace aggression stretches over a wide spectrum of behaviors and intensity (OSHA, n.d.; Schat et al., 2006), we chose survey research over qualitative designs because surveys are better suited to both describing sample norms and capturing extreme outcomes (Gable, 1994). Online survey methodology potentially benefited this exploratory study (Creswell, 2013) because participation was not limited to one type of agency.

Participants and Procedure

The present study aimed to examine the prevalence and nature of workplace aggression as experienced by counselors. Thus, we identified counselors in a variety of different settings as our target sample. Inclusion criteria comprised identifying as a professional counselor working in clinical practice as defined by (a) enrollment or graduation from a graduate-level counseling program and (b) current engagement in professional clinical practice (e.g., field experience, agency setting). We used a sample-size calculator provided by the National Statistical Service set at a 95% confidence level with a standard error of 0.05; results indicated a minimum sample size of 100 participants. We obtained approval from an institutional review board and permission to use the NAQ-R (S. Einarsen, personal communication, September 29, 2013) for the study. The NAQ-R was converted into Qualtrics, and the demographic questions were added to the end of the survey. We placed three calls for participation on the Counselor Education and Supervision Network Listserv (CESNET-L), which targets counselor educators, and posted an additional participation request on counseling-related social media sites (e.g., LinkedIn). We used these specific recruitment forums because of their cost-effectiveness; other avenues required monetary fees for membership access (e.g., ACA, Qualtrics). Those who viewed the call for participation were also encouraged to disseminate the survey to interested parties. We used the Qualtrics database to house the informed consent and measures. We also included a debriefing form that provided information

for participants who self-identified as victims of workplace aggression (i.e., the role of a human resources office and contact information for the U.S. Department of Labor Occupational Safety and Health Information Services).

One hundred forty-six potential participants accessed the survey. We did not gather information about those who viewed participation requests, but more than 3,400 CESNET-L members had access to the survey. This recruitment method resulted in a potentially low participation response rate of 4.3%; however, Erford (2015) indicated that response rates below 20% are typical with electronic surveys. Seven of the 146 participants did not identify as professional counselors working in clinical practice and were not included in the study. We removed an additional 22 participants using listwise deletion because of the impact of missing data on NAQ-R scores. After deleting these 29 participants, 117 participants (80.1%) remained.

Of the total sample (N = 117), 77.8% (n = 91) of participants identified as female, 19.7% (n = 23) as male, and 0.9% (n = 1) as transgender; the remaining 1.7% (n = 2) of participants did not respond to the question. (Percentages may not total 100 because of rounding.) Participants' ages ranged from 22 to 73 years (M = 37.72, SD = 12.97). The majority of participants identified as Caucasian (80.3%, n = 94), 7.7% identified as African American (n = 9), 4.3% identified as Asian (n = 5), 3.4% identified as Latina/o (n = 4), 3.4% identified as biracial (n = 4), and 0.9% identified as Indian (n = 1). Some participants listed multiple specialization areas, including community mental health (n = 76), marriage and family counseling (n = 40), addictions counseling (n = 29), counselor education and supervision (n = 22), school counseling (n = 21), inpatient mental health (n = 17), rehabilitation counseling (n = 10), career counseling (n = 9), crisis/trauma counseling (n = 6), child/adolescent counseling (n = 4), play therapy (n = 4), college counseling (n = 2), religious-based counseling (n = 1), domestic violence counseling (n = 1), and veteran counseling (n = 1). Length of experience in the counseling profession ranged from 0 to 44 years and was reported in 2-year increments. Twenty-one (17.9%) participants reported 2 or fewer years of counseling-related field experience.

Measures

We used the NAQ-R (Einarsen et al., 1994; Hoel, 1999) to assess the prevalence, frequency, and intensity of perceived workplace aggression in the sample (Einarsen, Hoel, & Notelaers, 2009). The NAQ-R consists of 22 items that examine different components of workplace aggression (e.g., being ridiculed, undermined, verbally harassed, physically abused). According to Einarsen et al. (2009), the NAQ-R assesses "interpersonal aggression and mistreatment from colleagues, superiors, or subordinates" (p. 24). Therefore, aggression originating from clients is not assessed. Table 1 includes a full list of the 22 items reprinted with permission (S. Einarsen, personal communication, September 29, 2013). Sample NAQ-R items include "Someone withholding information which affects your performance" (Item 1), "Being humiliated or ridiculed in connection with your work" (Item 2), and "Being ordered to

TABLE 1

Descriptive Item Analysis of the Negative Acts Questionnaire–Revised (NAQ-R)

NAQ-R Item	Range	*M*	*SD*
1. Someone withholding information which affects your performance	1–5	1.58	0.90
2. Being humiliated or ridiculed in connection with your work	1–3	1.26	0.50
3. Being ordered to do work below your level of competence	1–5	1.79	1.09
4. Having key areas of responsibility removed or replaced with more trivial or unpleasant tasks	1–5	1.44	0.85
5. Spreading of gossip and rumors about you	1–4	1.38	0.64
6. Being ignored, excluded or being 'sent to Coventry'	1–4	1.29	0.62
7. Having insulting or offensive remarks made about your person (i.e., habits and background), your attitudes or your private life	1–5	1.32	0.68
8. Being shouted at or being the target of spontaneous anger (or rage)	1–5	1.27	0.65
9. Intimidating behavior such as finger-pointing, invasion of personal space, shoving, blocking/barring the way	1–4	1.13	0.45
10. Hints or signals from others that you should quit your job	1–4	1.19	0.52
11. Repeated reminders of your errors or mistakes	1–4	1.26	0.62
12. Being ignored or facing a hostile reaction when you approach	1–4	1.31	0.64
13. Persistent criticism of your work and effort	1–3	1.26	0.55
14. Having your opinions and views ignored	1–5	1.62	0.86
15. Practical jokes carried out by people you don't get on with	1–4	1.09	0.37
16. Being given tasks with unreasonable or impossible targets or deadlines	1–4	1.34	0.75
17. Having allegations made against you	1–4	1.14	0.47
18. Excessive monitoring of your work	1–5	1.39	0.83
19. Pressure not to claim something which by right you are entitled to (e.g., sick leave, holiday entitlement, travel expenses)	1–4	1.26	0.61
20. Being the subject of excessive teasing and sarcasm	1–4	1.15	0.50
21. Being exposed to an unmanageable workload	1–5	1.50	0.99
22. Threats of violence or physical abuse or actual abuse	1–4	1.06	0.36

Note. From *The Negative Acts Questionnaire–Revised*, by S. Einarsen, B. I. Raknes, S. B. Matthiesen, & O. H. Hellesøy, 1994, Bergen, Norway: Bergen Bullying Research Group. Reprinted with permission. NAQ-R items are on a Likert-type scale (1 = *never*, 2 = *now and then*, 3 = *monthly*, 4 = *weekly*, and 5 = *daily*).

do work below your level of competence" (Item 3). For each item, participants self-reported their own perceived work experience within the past 6 months and rated item occurrence on a 5-point Likert-type scale ranging from 1 (*never*) to 5 (*daily*).

Cumulative NAQ-R scores can range from 22 to 110. A score of 22 signifies no presence of workplace aggression, and scores above 22 indicate the presence of criticism that might represent workplace aggression; higher scores represent increased intensity/frequency of aggressive acts in the workplace (Nielsen, Notelaers, & Einarsen, 2011). Notelaers and Einarsen (2013) used a receiver-operating characteristic curve to determine cutoff scores that distinguish some work criticism (i.e., NAQ-R scores of 23 to

32) from environments that produce occasional workplace aggression (i.e., NAQ-R scores of 33 to 45) and/or continuous workplace aggression (i.e., NAQ-R scores above 45). Einarsen et al. (2009) performed a factor analysis and identified three subscales that differentiated work, person, and physical forms of aggression. However, Nielsen et al. (2011) highlighted that the NAQ-R total score captures a gamut of aggressive acts. We chose to use the NAQ-R total score and calculated a Cronbach's alpha of .90 for our sample, which indicates a good reliability score (Creswell, 2013). In addition, we included demographic questions to gather data on participants' age, years of counseling experience, gender, ethnicity, and counseling specialty areas.

Data Analysis

We used SPSS Version 24 to conduct univariate analysis and examined the self-reported prevalence of workplace aggression and the most commonly reported acts of workplace aggression experienced among our participants as measured by the NAQ-R. We first applied the NAQ-R cutoff scores defined by Notelaers and Einarsen (2013) and assessed the following workplace aggression levels: 1 = *no presence*, 2 = *some work criticism*, 3 = *occasional workplace aggression*, and 4 = *continuous workplace aggression*. We then examined frequency statistics of the NAQ-R total scores, NAQ-R cutoff scores, and NAQ-R single items (e.g., means and standard deviations). We considered the exploratory nature of this study while identifying the most commonly reported acts and rank ordered NAQ-R items by their means. Finally, we isolated the upper quartile of individual items ranked by mean scores (i.e., five items).

Results

Research Question 1: Prevalence of Workplace Aggression

We first examined the range, mean, standard deviation, standard error, skewness, and kurtosis of the NAQ-R total scores. NAQ-R total scores ranged from 22 to 65 (M = 29.03, SD = 9.30, SE = 0.86). The data were nonnormally distributed, with a significant skewness of 2.08 (SE = 0.22) and a significant kurtosis of 4.51 (SE = 0.44). A histogram of the score distribution indicated that more participants had lower scores on the NAQ-R with few outliers (i.e., skewness) and flatness of data as evidenced by more values located in the tails of the distribution (i.e., kurtosis; see Figure 1).

We then examined the mode, mean, standard deviation, standard error, and frequencies of the cumulative NAQ-R cutoff score levels. The most frequently represented cutoff category (e.g., mode) of aggregate scores was some work criticism (M = 2.05, SD = 0.82, SE = 0.08). We examined the frequency of NAQ-R levels and found that 28 participants scored a 22 on the NAQ-R (23.9%) and indicated no presence of workplace aggression within the past 6 months. The remaining 89 participants (76.1%) reported the presence of at least one aggressive incident. Sixty-three participants (53.8%)

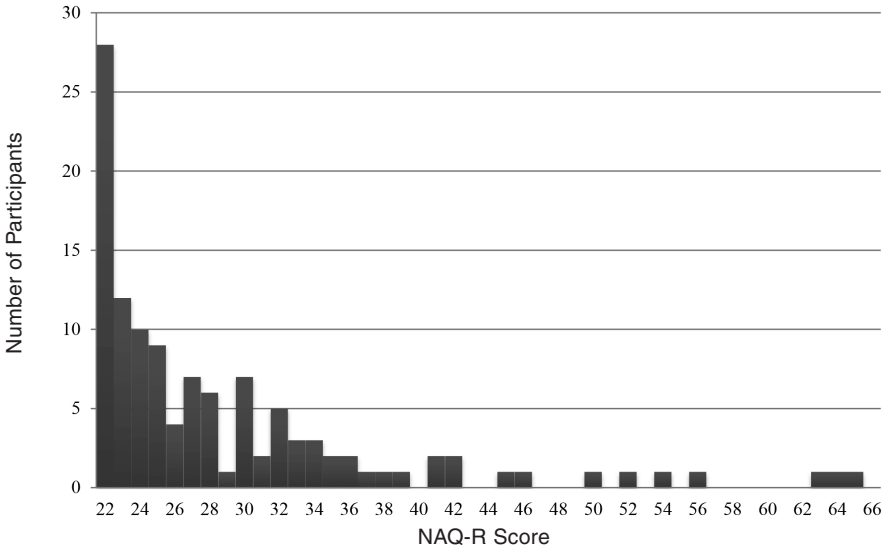

FIGURE 1

Participants' Negative Acts Questionnaire–Revised (NAQ-R) Total Score Distribution

had NAQ-R scores ranging from a 23 to 32 and represented the presence of some work criticism. Twenty-six participants (22.2%) scored above a 32 on the NAQ-R and met the threshold for workplace aggression with either an occasional or a continuous frequency. Of these 26 participants, 18 (15.4% of the total sample) met the criteria for occasional workplace aggression and eight participants (6.8% of the total sample) met the criteria for continuous workplace aggression. Table 2 delineates the frequencies and percentages of the NAQ-R cutoff score levels.

Research Question 2: NAQ-R Item Analyses

To determine the most common self-reported acts of workplace aggression, we first examined the ranges, means, and standard deviations for the 22 items

TABLE 2

Descriptive Analysis of the Negative Acts Questionnaire–Revised (NAQ-R) Levels

NAQ-R Level	*n*	%
No presence	28	23.9
Some work criticism	63	53.8
Occasional workplace aggression	18	15.4
Continuous workplace aggression	8	6.8

Note. $N = 117$. NAQ-R levels represent Notelaers and Einarsen's (2013) cutoff scores.

on the NAQ-R (see Table 1). We then rank ordered the NAQ-R items. The five items with the highest mean, in numerical order from highest to lowest, included Item 3, "Being ordered to do work below your level of competence" (M = 1.79, SD = 1.09); Item 14, "Having your opinions and views ignored" (M = 1.62, SD = 0.86); Item 1, "Someone withholding information which affects your performance" (M = 1.58, SD = 0.90); Item 21, "Being exposed to an unmanageable workload" (M = 1.50, SD = 0.99); and Item 4, "Having key areas of responsibility removed or replaced with more trivial or unpleasant tasks" (M = 1.44, SD = 0.85).

Discussion

The primary purpose of this study was to investigate the prevalence of workplace aggression and to examine common aggressive acts that a sample of counselors have experienced. Approximately one fourth of our sample reported no work aggression, and over half of participants reported the occurrence of aggressive acts in the work environment that constituted some work criticism. Even though their response of some work criticism does not constitute workplace aggression, it may speak toward nonideal work environments that are incongruent with the values of the counseling profession. For example, a supervisor who perpetuates work criticism may neglect the fostering of "meaningful and respectful professional relationships" (*ACA Code of Ethics*, Standard F, Introduction, p. 12; ACA, 2014). Also, Nielsen et al. (2011) reported that just one aggressive act within the workplace could generate unhealthy and adversarial work conditions for the employee. A lower presence of aggression in the workplace does not discount the experience of the employee; he or she might still experience conditions that may be unpleasant.

According to the results of this study, 22.2% of survey respondents reported the perceived presence of occasional/continuous workplace aggression in the counseling field within the past 6 months. Occasional/continuous workplace aggression indicates a realm of aggressive acts no longer justifiable as potential commonplace behaviors (e.g., monitoring of work) within the counseling profession. Similarly, some participants also endorsed the presence of physical abuse, with responses that ranged from never to weekly occurrences (M = 1.06, SD = 0.36; see Table 1). The presence of physical aggression in the workplace is an alarming result that has implications for counselor well-being and the counseling profession as a whole. A workplace culture that tolerates physical aggression toward employees can be addressed through legal channels (e.g., OSHA) and through the advocacy of counselors for a safe and ethical organizational culture.

Most Prevalent Reported Aggressive Acts

Participants described an array of unpleasant work experiences that warrant consideration (see Table 1). We further examined the five most common reported acts of workplace aggression to understand their contextual nature

better; as noted earlier, these items, from highest to lowest rating score, were "Being ordered to do work below your level of competence" (Item 3), "Having your opinions and views ignored" (Item 14), "Someone withholding information which affects your performance" (Item 1), "Being exposed to an unmanageable workload" (Item 21), and "Having key areas of responsibility removed or replaced with more trivial or unpleasant tasks" (Item 4).

The aforementioned aggressive behaviors captured a range of unpleasant work-related experiences and may illuminate potential ethical problems within some counseling agency environments regarding administrator–employee relationships. Sound ethical practice is paramount to counselors' professional and ethical identity and includes the concepts of autonomy, nonmaleficence, beneficence, justice, fidelity, and veracity toward clients (ACA, 2014; Kitchener, 1984). The most commonly reported aggressive acts in this study describe experiences that may restrict counselor autonomy, a finding similar to that of other research related to workplace aggression (Einarsen et al., 2009). Knudsen et al. (2006) found when counselors perceive diminished job autonomy, they are more likely to experience emotional exhaustion and turnover intention. Deficient autonomy support for counselors has a negative impact on counselor well-being and retention in the field of counseling. If counselors honor the autonomy of clients as a foundational value in helping relationships (ACA, 2014; Ponton & Duba, 2009), a disregard for the autonomy of coworkers may reveal discrepancies in organizational commitments to the principle.

The five most frequently endorsed items may also describe supervisor–supervisee interactions. Because participants responded to questions regarding their perceived victimization with respect to workplace aggression, the alleged perpetrator's intention and perspective are unknown. A supervisee may regard aggressive acts that a supervisor warrants as standard practice and as necessary for supervision or remediation purposes. For example, new professionals may feel their supervisor is exposing them to an unmanageable workload, but their supervisor may intend the assigned workload as an appropriate challenge to cultivate growth (Bernard & Goodyear, 2009). Similarly, counselors may feel their supervisor ignores their opinions, whereas their supervisor may be unable to actualize their ideas within the constraints of the contemporary workplace. Supervisors may be able to avert these misunderstandings by eliciting "candid and ongoing feedback from the supervisee" (ACES, 2011, Standard 5.b.ix.) and providing a safe and supportive supervisory relationship (ACES, 2011, Standard 4.b.).

Implications for Counselors

The modest level of workplace aggression (endorsed by nearly 25% of participants) calls for further investigation to assess the potential consequences of adversarial environments for the counseling profession. Researchers and scholars have indicated that workplace aggression is associated with

detrimental effects on employees' mental status and the organizational system (e.g., Einarsen & Mikkelsen, 2003; Lewis & Orford, 2005; Rospenda et al., 2009). Employee consequences of workplace aggression are concerning and include, but are not limited to, decreased job satisfaction (Rowe & Sherlock, 2005), increased mental health consequences (Bowling & Beehr, 2006; Einarsen & Mikkelsen, 2003; Rospenda et al., 2009), more interpersonal conflicts outside of work (Lewis & Orford, 2005), reduced performance at work (Rowe & Sherlock, 2005), employee turnover (Hogh et al., 2011; Jackson et al., 2002), and lack of commitment toward work obligations (Demir & Rodwell, 2012). Perhaps more troubling, however, is the potential for widespread workplace aggression to cause systemic and cultural damage to the counseling profession, which strives to embody humanistic organizational values. Ponton and Duba (2009) noted that counselors "address those societal needs in professional relationships with clients that foster client growth and recognize contextualistic variables that affect the client" (p. 119). Counselors have a responsibility to protect client welfare (*ACA Code of Ethics*, Standard A.4.a.; ACA, 2014) and also to challenge organizational variables that may have a negative impact on ethical care and due diligence (*ACA Code of Ethics*, Standard D.1.h.; ACA, 2014).

In addition to underscoring the importance of advocating for clients who may be vulnerable to the by-products of workplace aggression, this study also has implications for counselor wellness. The occurrence of aggressive acts may be subtle and easy to overlook or discount. Identifying potentially harmful behavior and acknowledging the possible presence of workplace aggression constitute a practical first step. Counselors can cope with workplace challenges by seeking out and providing coworker and supervisory support. Counselors-in-training have an added layer of vulnerability when experiencing workplace aggression or some work criticism; these trainees are dependent on faculty supervisors for their grades and on more seasoned professionals for mentorship and positive role modeling. Providing a supportive supervisory relationship while addressing workplace aggression and its incongruence with the values of counselor education could foster students' ethical and professional development. Most important, supervisors and counselor educators can inform counselors that some aspects of workplace aggression are illegal because employers must provide safe working conditions for employees. Counselors who are victims of workplace aggression can seek consultation (e.g., through supervision and with human resources), find support (e.g., through employee assistance programs), or contact the associated reporting agency (e.g., OSHA).

Counselor educators also have an obligation to prepare students for the work environment they may face postgraduation. Our study indicated that nearly 25% of participants experienced occasional or continuous workplace aggression in their role as counselors. Counselor educators can acknowledge that the counseling profession is not immune to this destructive phenomenon and can initiate a classroom discussion around

the incongruence of workplace aggression and counseling values. A discussion of the implications of workplace aggression is pertinent in a counselor education curriculum because workplace aggression may result in counselor burnout (Maslach, 2003). CACREP-accredited programs address self-care strategies for counselors to implement to maintain their wellness and effectiveness (CACREP, 2015, Standard 2.F.1.l.). Self-reflection is also necessary for identifying aggressive behavior in oneself and personal reactions to the aggressive behavior of others. Counselor educators may address workplace aggression as a self-reflective exercise in the context of a practicum or internship class and generate strategies for addressing the issue personally through self-care, interpersonally through conflict resolution, or systemically through addressing policies or procedures that may maintain the existence of workplace aggression.

Implications for Ethical Practice

The results of this study indicate a substantial prevalence of perceived self-reported aggressive acts in this sample (i.e., over 50% experiencing some work criticism, nearly 25% reporting occasional/continuous workplace aggression) and warrant ethical consideration. First, it is essential to distinguish potential legal consequences from ethical implications. Some forms of workplace aggression may represent probable cause for legal action (e.g., sexual harassment, racial discrimination). When workplace aggression affects clients either directly or indirectly, counselors may be in violation of ethical practice. Furthermore, a counselor who is sexually harassing a peer may be in violation of Standard C.6.a. of the *ACA Code of Ethics* (ACA, 2014). Additionally, a supervisor who subjects a supervisee to racial discrimination and microaggressions is demonstrating culturally insensitive behavior and violating Standard F.2.b. of the *ACA Code of Ethics* (ACA, 2014).

Counselors working in aggressive environments can thoroughly review the *ACA Code of Ethics* (ACA, 2014) and pay specific attention to the following topics: (a) avoiding harm (Standard A.4.a.), (b) monitoring for impairment (Standard C.2.g.), (c) navigating negative agency conditions (Standard D.1.h.), (d) conducting informal resolutions (Standard I.2.a.), and (e) reporting ethical violations (Standard I.2.b.). Researchers in related fields have found correlations between workplace aggression and adverse client outcomes (Arnetz & Arnetz, 2001; Randle, 2003; Roche et al., 2009). To avoid client harm (Standard A.4.a.; ACA, 2014), counselors can take measures to ensure that adverse work conditions do not have an impact on clients. One of these steps might include monitoring self and others for signs of impairment, because employees working in adverse conditions report poor mental health outcomes (Bowling & Beehr, 2006; Einarsen & Mikkelsen, 2003; Rospenda et al., 2009; Rowe & Sherlock, 2005). Next, counselors can advocate for the enforcement of ethical standards and enact changes to adverse agency conditions; such actions might include consultation with a supervisor and/or employer, making a formal ethical report, or terminating one's employment (Standard

D.1.h.; ACA, 2014). Also, if the alleged perpetrator of the aggression is another counselor, a fellow counselor may address the issue through an informal resolution (Standard I.2.a.; ACA, 2014). However, if the workplace aggression has not been resolved after the informal resolution, or if an informal process is unsuitable and if the workplace aggression has the potential to result in harm or has already resulted in harm to a person or organization, counselors can follow the recommendations in Standard I.2.b. of the *ACA Code of Ethics* (ACA, 2014) for formally reporting ethical violations.

Limitations of the Study

A limitation of this study included the use of online survey methodology. First, individuals experiencing workplace aggression may have been more likely to respond to the online call for participation and thus may have skewed the data in favor of higher prevalence rates (Creswell, 2013; Erford, 2015). Next, participants' self-reported data may have over- or underestimated prevalence rates because of social desirability (e.g., protection of self and/or agency, desire to fulfill the researchers' topic of interest; Van de Mortel, 2008). Also, we used an online call for participation that made it difficult to calculate the actual response rate (e.g., how many individuals viewed the call). We estimated a conservative response rate of 4.3% (e.g., if all CESNET-L members viewed the survey request). As mentioned earlier, Erford (2015) indicated that response rates below 20% are common with electronic surveys; however, other recruiting methods could be used to address low response rates. Also, CESNET-L is primarily used by current or potential counselor educators and underrepresents master's-level counselors. We encouraged CESNET-L members to disseminate the survey to current and former students and supervisees; however, we did not collect data on how participants gained access to the study (e.g., CESNET-L, supervisor referral).

Also, our target population definition (i.e., professional counselors working in clinical practice) may have limited the representativeness and generalizability of the results. Our sample had an unequal distribution among counseling specialty areas and years of professional experience. Greater representativeness and/or generalizability could be achieved by using a larger heterogeneous sample or a homogeneous target population across the variables of interest. In addition, a change in our demographic questions could facilitate bivariate or multivariate analyses—for example, by assessing the actual rather than the range of years of experience and by assessing the current work setting in addition to specialty areas. Finally, some of the aggressive behaviors that the NAQ-R measured (Einarsen et al., 1994; Hoel, 1999) might not possess compatible analogues in the counseling profession (e.g., excessive monitoring of work might be misapplied to appropriate supervisory oversight). Despite the aforementioned limitations, the results of this study ground warranted discourse around the topic of workplace aggression in counseling. This dialogue

can be furthered by research that implements methodological design and participant recruitment measures that will assist in generalizability and prospective bivariate/multivariate analysis.

Future Research

The existence of workplace aggression among the participants warrants continued research, including (a) multivariate/bivariate analysis to better understand variable relationships, (b) qualitative inquiry to identify discrepancies between intent to harm and perceived workplace aggression, and (c) action research to assist in reducing potential harm to counselors and clients. We investigated the prevalence of perceived workplace aggression in practicing counselors to ground continued and more in-depth, focused research on the matter. As such, we chose a liberal definition of counselors in clinical practice and did not place restrictions on clinical work setting, experience, and other demographic criteria. The participants were overwhelmingly female and Caucasian, and the data were not suited to between-groups/within-group analyses. Future researchers may consider recruiting a more substantial heterogeneous sample to enhance group representation for bivariate or multivariate analyses. This more extensive sample would allow researchers to identify how workplace aggression varies according to ethnicity, gender, or clinical specialty. In addition, because we did not ask participants how they were recruited for the survey (e.g., CESNET-L, LinkedIn), we were unable to determine how the experience of workplace aggression differed by recruitment method. It would be beneficial to explore this variable in future studies.

The impact of workplace setting is another area for future inquiry. Rosenberg and Pace (2006) explored the impact of work setting on the counselor burnout of 116 marriage and family therapists. The results indicated that individuals in private practice experienced significantly less burnout than those in medical settings, community mental health settings, and academia (Rosenberg & Pace, 2006). Individuals working in community mental health reported greater emotional exhaustion than those in medical settings and academia (Rosenberg & Pace, 2006). These results indicate that agency setting may play a key role in counselor welfare. Because counselors in our study were given the freedom to choose multiple work settings, we were unable to identify the individual impact of workplace environment on the experience of workplace aggression. Workplace aggression may vary depending on counselors' specialization and workplace setting; therefore, the results of this study must be interpreted with caution. Future research should investigate how agency setting affects counselors' experience with work aggression. In addition, the definition of workplace aggression used in this study denoted the presence of behaviors "intended to physically or psychologically harm a worker" (Schat & Kelloway, 2005, p. 191). However, because the NAQ-R measured only the recipient's perspective on behaviors occurring in the workplace, the intent or motive of the perceived aggressor

remained unknown. Although this study is an essential first step in the exploration of workplace aggression in the counseling field, further research is needed to differentiate intention and perception in workplace interactions. Future researchers could elicit supervisory and administrative perspectives to provide a more comprehensive account of workplace aggression in counseling. Also, researchers could use data triangulation to investigate the intention of alleged perpetrators, the perceived aggressive acts, and other themes from interviews. Such qualitative inquiry may prove useful in distinguishing aggressive behaviors from acceptable practices (e.g., supervision).

Furthermore, client care represents a core facet of the counseling profession (ACA, 2014; Kaplan et al., 2014), and future research should investigate the effects of workplace aggression on clients. Within other helping professions, adversarial work conditions have negatively affected the ethical culture of the working environment and have led to negative consequences for client care (Arnetz & Arnetz, 2001; Randle 2003; Roche et al., 2009). Future researchers should also investigate the consequences of workplace aggression on counselor well-being as counselor wellness can have an impact on the clinical progress of clients (Landrum, Knight, & Flynn, 2011) because workplace aggression can "ruin employees' mental health . . . and thus their way of life" (Einarsen & Mikkelsen, 2003, p. 127).

Finally, because our study indicated that nearly 25% of participants met the threshold for workplace aggression, we recommend further investigation into the potential causes and detriments of these adversarial work environments, followed by action research. Advocates and agencies can use this knowledge to reduce potential harm to counselors and clients by (a) identifying variables that may perpetuate aggressive environments, (b) addressing the detrimental variables through interventions, and (c) locating and connecting counselors and clients with mediating resources. Organizations can use this knowledge to restructure their practices at a systemic level to uphold the values of the profession and foster wellness for counselors and their clients.

Summary

This descriptive study explored the prevalence rates and forms of workplace aggression in a sample of professional counselors working in clinical practice. In our sample (N = 117), over 50% of participants reported the presence of at least one aggressive act and nearly 25% met the threshold for workplace aggression. Because employee impairment and negative client outcomes can be effects of workplace aggression (e.g., Arnetz & Arnetz, 2001; Randle, 2003; Roche et al., 2009), the results of this study indicate that some counselors might work in environments incongruent with the ethos and aim of the counseling profession. Similarly, we found incongruence with professional counseling values (e.g., respect for autonomy) in the five most reported aggressive acts. This study's results underscore the importance of continued research to achieve a better understanding of workplace aggression in counseling settings.

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