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**No Accident:  
Health, Wellbeing, Performance...and Danger**

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## Abstract

- 1. Purpose** Our purpose was to develop a theory of preventive health management for high-risk employees, who are the 1 – 3 percent with a propensity to become dangerous.
- 2. Design/methodology/approach** We review the literature and design a prevention model for high-risk employees that relies on primary, secondary, and tertiary surveillance indicators as well as prevention methods. The behaviors of these employees are often not accidental, even if not always intentional.
- 3. Findings** Primary prevention through organizational socialization and supervision can reduce emergence of high-risk employees. Early identification through secondary surveillance then prevention of incivility and deviance can deter escalation to violent behaviour. When high-risk employees become dangerous and violent, tertiary prevention calls for containment, caregiving, forgiveness, and resilience.
- 4. Research implications** Refinement of the tipping points and triggering mechanisms that escalate high-risk employee behaviours from initial vulnerability to negative deviance, dysfunctional behaviour, and then finally danger and violence is necessary.
- 5. Practical implications** We suggest that HR professionals can advance health, wellbeing, and performance while averting danger and violence by identifying and managing high-risk employees, anticipating their needs, and providing supportive resources and advising.
- 6. Social implications** The same principles of surveillance and prevention are amenable to communities and neighbourhoods that are used here within an organization.
- 7. Originality** The conceptual model we offer is original but draws on secondary sources.

We illustrate the problem of high-risk employees with one wrongful death case, one sexual assault case, and one management harassment case where harm, and death were intentionally or foreseeably done to an employee or supervisor. These are worst case examples in what we argue is stage 3 of the life history of a high-risk employee. Further, we present one positive organizational case where harm and death were averted.

- Wrongful death

Steve Barger as a supervisor failed to terminate an employee after 2 safety violations. The employee's third safety violation in a dangerous work environment resulted in the death of Mr. Barger when half a rail car was dropped on him due to the absence of a safety-chain connecting the two halves of the rail car during overhaul. (Civil Action Case No. 342-153039-95, 342<sup>nd</sup> Judicial District Court, Tarrant County, Texas).

- Sexual assault

A male medical technician had 7 documented incidences of negative deviant or dysfunctional behavior over a 7+ year period in 2 hospitals. He was warned by management about his behavior but apparently not subject to close supervision. He committed sexual assault of a female hospital patient. This event was foreseeable and preventable. (Cause No. 342-23724 09, District Court of Tarrant County).

- Management Threat and Harassment

The management of an insurance company harassed, intimidated, and threatened a group of employees by intentionally creating "high-strain jobs" in at least one district office, which drove many agents from the office while leaving one agent in a debilitating depression. Management actions were malicious and inhumane. (Civil Action Case Number 88-2099, U.S. District Court, Western District of Louisiana).

These three cases of harm and death are not unforeseeable accidents. These are cases where intentional or foreseeably unintentional damage was done by one or more persons. The health, wellbeing, and performance of each organization and its personnel were adversely impacted by these events. Further, problems and failures such as these can become infectious

and contagious problems that foster additional harm and suffering in the workplace. Things do not need to be that way!

There is an alternative to such management actions and human behavior in organizations. By identifying and managing high-risk employees, much damage and harm can be averted, lightening the burden of suffering in the organization (Macik-Frey, Quick, & Nelson, 2007). We illustrate this with one positive case example where death and workplace violence were averted and over \$33 million in HR costs avoided by comprehensive preventive stress management in the organization. Just as harm and suffering can be contagious, so too can positive actions resulting in good outcomes be contagious.

- San Antonio Air Logistics Center, Air Force Materiel Command (USAF), 1995-2001. The realignment and closure of this 13,000 person industrial organization placed everyone's health and wellbeing at risk, along with the logistics support for 40% of the U.S. Air Force. By identifying approximately 300 at-risk employees very early in the process and triaging them to help and support as required, there were no major adverse events over the six year period. (Klunder, 2008; Quick, Wright, Adkins, Nelson, & Quick, 2013: 117-119)

### **What's the Problem?**

We explore the problem of the high-risk employee. Very few employees become high-risk, and in the worst case, dangerous. High-risk employees are a very small pool of individuals who may become negatively deviant, dysfunctional or dangerous. We distinguish these employees from those who display positive deviant behavior because while they depart from established norms of behavior, they add value in the workplace. Hence, two types of deviant behavior exist, positive and negative. Negative deviant and dysfunctional behavior signals the

need for closer examination and corrective action, either self-correction or management intervention.

Griffin, O'leary-Kelly, & Collins (1998) subsume under their rubric of dysfunctional behavior both nonviolent employees who sabotage the organization, engage in criminal acts, or otherwise do nonviolent harm and damage, and violent employees who display acts of aggression, commit homicide, commit suicide, or violently destroy property. We take a different approach, distinguishing nonviolent dysfunctional behavior, which we find more equivalent to negative deviant behavior, from violent dysfunctional behavior, to which we give the label "dangerous behavior." Exhibit 1 illustrates distinctions for five key concepts central to our development of the problem.

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#### Exhibit 1: Key Term Definitions

Deviant behavior:	Behavior that deviates from an established norm or standard within to organization.
Positive deviance:	Behavior with honorable intentions which is substantially against established norms.
Negative deviance:	Behavior that is often intentional, departs from established norms, and does harm to persons or property within the organization.

**Dysfunctional behavior:** Behavior that is nonviolent, sabotages the organization, may be passive-aggressive and/or criminal, but is harmful and destructive.

**Dangerous behavior:** Behavior that is violent in nature, such as acts of homicide, suicide, or physical destruction of property within the organization.

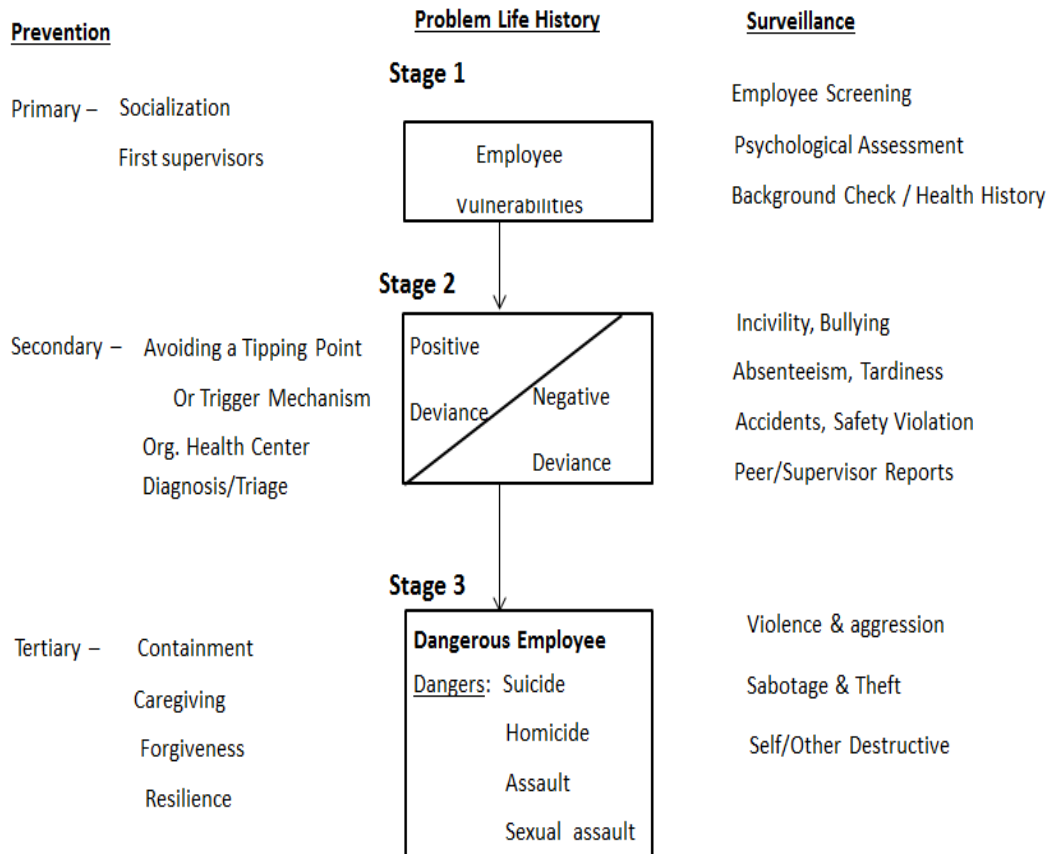
NOTE: For our purposes, negative deviance is roughly equivalent to dysfunctional behavior as the terms are used throughout the article.

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We turn to population-based public health to understand the process whereby an employee may progress from vulnerable to deviant or dysfunctional and, without intervention, even dangerous. Dangerous employees do not suddenly appear, there is a life history leading to the evolution of a problem employee. Tetric & Quick (2011) offer a three-stage model that classifies people as not-now-at-risk (stage 1), at-risk (stage 2), or with-health-problems (stage 3) (cf. Wallace & Doebbeling, 1998). We adapt this model as shown in Figure 1 with the life history of the high-risk employee, or causal chain, under the problem stem shown in three stages. Stage 1 considers employee vulnerabilities, which all employees possess. Vulnerabilities stand in contrast to strengths and abilities, which again all employees possess. Stage 2 considers employee deviance, both positive and negative deviance. Negative deviant and dysfunctional behavior are problems for the organization. Positive deviance is not. Good leader assessments and clinical judgments are needed to distinguish whether the deviance is negative or positive. Stage 3 is the full blown dangerous employee who is verbally or physically

aggressive, suicidal, homicidal, or otherwise violent. Employees displaying negative deviance, dysfunction, and dangerous behavior are a problem.

Figure 1: Preventive Health Management Model for High-Risk Employees



Stage 1: Employee Vulnerabilities

Everyone has some vulnerability even though they are not currently subject to health risks. Vulnerability is an individual’s susceptibility and predisposition to become unhealthy.

Significant at this stage is acknowledging both known and unknown vulnerabilities that an employee possesses. Potentially most dangerous from the organization's standpoint is that which is unknown, or unknowable. While employee screening, psychological assessments, background checks, and health histories provide a lot of information to include flagging vulnerabilities, some vulnerability can go undetected, such as early life traumas. The problem with the unknown is that the vulnerability may still become manifest and cause problems in the workplace, leading to Stage 2 deviance and/or dysfunctional behavior, or in the worst case a dangerous employee because they have been triggered by another person or event and crossed a "tipping point." According to Merriam Webster, a "tipping point" is "the critical point in a situation, process, or system beyond which a significant and often unstoppable effect or change takes place." Recognizing an employee's positive and negative potential becomes critical to surveillance and prevention.

#### Stage 2: Employee Deviance and Dysfunction

Kaplan (1975), Griffin et al. (1998), and Robinson & Bennett (1995) address dysfunctional behavior in organizations by using a three part classification scheme which includes workplace violent behavior, aggression, and terrorism; deviant behavior, which stands in contrast to normative behavior; and non-violent behavior, that includes criminality, substance abuse, absences, and theft.

Figure 1 distinguishes between employee positive and negative deviance. Positive deviance could add value as energized and vibrant employees who are thriving in a dynamic, exciting, and excited organization may display positive deviance from standards of acceptable



behavior, thus adding value to the workplace (Spreitzer & Sutcliffe, 2007 & Sutcliffe, 2007). However, negative deviance may be disruptive and, by our definition a nonviolent problem.

Spreitzer and Sonenshein (2004) explore the construct of positive deviance beginning with the early negative associations connected to the word “deviance.” They include consideration of statistical deviance, reactive deviance, and supraconformity (i.e., excessive conformity to norms). They bring positive deviance to life through a normative approach to the construct and the definition: intentional behaviors that depart from the norms of a referent group in honorable ways. Departure from the norm is what makes a behavior deviant while “honorable” is what makes the deviance explicitly positive. We embrace this definition and accept their distinguishing positive deviance from related prosocial behaviors such as organizational citizenship and corporate social responsibility. Within our framework, positive deviance adds value to the organization, enriching relationships and performance. (See also Cameron, Mora, Leutscher, & Calarco (2011 for an exploration of the effects of positive practices within the realm of organizational effectiveness.)

Certainly, variability in human behavior is potentially very desirable. Weick & Sutcliffe, (2007) point out that high degrees of reliability does not mean lack of variation, noting that when high reliability organizations falter, the potential for error and disaster is overwhelming and severe harm results. Given the significant variability in human behavior in organizations, how can leaders preventively manage to capitalize on human deviations yet anticipate and avert disaster and trauma caused by the 1–3%? Weick and Sutcliff (2007) offer some insights. The high reliability organizations (HRO) they studied anticipate, avoid, and recovery from

disasters well because of their preoccupation with failure, reluctance to simplify, sensitivity to operations, commitment or resilience, and deference to expertise. By tracking the development of unexpected events, by mindfully attending to discriminatory details, and by seeing in the blind spots, these HROs are able to cope with inevitable uncertainty while managing the limitless sources of harm. For high-risk employees, this translates to mindfully attending of all employees on a continuous ongoing basis, their highs and lows, ups and downs, and variations in their habits and routines. Many leaders know when someone is off even if they cannot tell you exactly why. The well trained behavioral scientist may be able to provide detailed explanations that underpin the executive's gut-hunch. The executive-clinician partnership can be value-added for the organization.

We are advancing the case for mindfully observing, not for the excessive control of employees. Levinson (2002) implies that over-control of employees is counterproductive and that the highest levels of employee motivation occur where employee needs and organizational requirements converge. His approach hinges on the belief that much of human behavior is self-regulated; organizations should expect people to behave in accordance with norms and standards that allow them to meet work expectations. Only excessive, negative deviations from workplace norms call for corrective action by management. Excessive positive deviations which honor the workgroup and workplace only require attention to the extent to which they elicit anxiety or are disruptive to the work environment. In addition, management is responsible for insuring ethical and appropriate norms. Dysfunctional behavior, however, and dangerous behavior explicitly call for management intervention (see Griffin et al., 1998 for the full spectrum of dysfunctional and dangerous workplace behaviors). Our preventive

management framework offers primary, secondary, and tertiary prevention actions for consideration, most of which are not designed as quick-fix solutions to immediate problems or crises though we do consider these conditions.

Stage 3: Dangerous Employees

High-risk employees who are dysfunctional may be triggered or pass a tipping point, thus becoming actively dangerous employees; that is, violent. Dangerous employees pose an immediate threat to the health, wellbeing, and performance of the entire organization. The dangers they pose include suicide, homicide, assault, sexual assault, and wrongful death. They are a danger to others and potentially to themselves. We propose that through the preventive management of health, wellbeing, and performance in the workplace, incident rates of dangerous employees emerging in a workplace can be significantly reduced or eliminated. Preventive management rests on the public health notions of surveillance and preventive intervention.

The concept of tipping point can be positive or negative. Individuals who have positive experiences in the workplace may be inspired to increase their level of helping others, organizational citizenship, corporate responsibility, innovation and creative and simply going beyond their job descriptions (Staw, Sutton, & Pelled, 1994). Yet others, who may perceive that they have been treated unfairly, may act out against the organization's norms of established behavior. Positivity plays an important role in human flourishing but more is not always better and excessive positivity might be harmful (Fredrickson 2013). There is value in the concept of positivity ratios and tipping points, although the exact ratios of positive-to-negative emotions

(for examples, 3:1, 5:1, or 3.4:1) are debated. Interpersonal relationships with 1:1 ratios are likely to struggle if not dissolve because of the comparative high proportion of negativity. While the exact “tipping point” for individuals to develop the skills to flourish, thrive, and grow may not be precisely known, an excess of positive-to-negative emotions does have real value within range (see Fredrickson, 2013). Hence, the notion of tipping point becomes instrumental in the management of employee deviance and dysfunction so as to preclude their progression into dangerous employees.

A second concept central to managing employees to prevent progression into the danger stage is the trigger event. We discuss later and offer specific examples from the FBI of triggering conditions and behaviors that can give rise to aggressive and even violent behavior in the workplace. A dangerous employee is the worst case but not inevitable. One FBI estimate is that 85–90% of workplace violence is preventable (Mack, Shannon, Quick, & Quick, 1998) and preventive management offers positive alternatives and staged interventions solutions.

### **Preventive Management of Health, Wellbeing, and Performance**

Preventive management is a broader, more encompassing concept for a wide range of chronic organizational problems such as stress, sexual harassment, and workplace violence (Quick, Quick, & Nelson, 1998; Bell, Quick, & Cocyota, 2002; Mack, Shannon, Quick, & Quick, 1998). The fundamental thesis is that chronic workplace problems can be managed, if not eliminated, thus mitigating their negative impact and damage. Dangerous employees are not inevitable but even when a dangerous employee strikes, preventive management can respond.

The first two guiding principles of preventive stress management have applicability in addressing high-risk employees (see Quick et al., 1998: 247).

1. Individual and organizational health are interdependent.
2. Leaders have a responsibility for individual and organizational health.

Figure 1 illustrates the preventive management model for high-risk employees. In the first section we discuss the causal chain of events that can lead from employee vulnerability through employee deviance and dysfunction to a dangerous employee. Understanding this epidemiology becomes the basis for bringing the public health notions of prevention to bear. We do this in the next sections by addressing each of the three stages in the model, starting with Stage 1 – employee vulnerabilities.

#### **Stage 1: Employee Vulnerabilities**

Primary prevention is always the preferred point of intervention from a public health perspective in dealing with chronic problems. With employees, the two key primary prevention interventions in Figure 1 are socialization and first supervisor behaviors. These should be based on good surveillance information. Employee screening, psychological assessments, background checks, and health histories are among the battery of information that supervisors need to systematically collect and evaluate. While selection may be seen as a primary prevention intervention, strong evidence exists that high-risk employees cannot be reliably identified during the selection process. We address research on selection in our discussion even though it does not appear in Figure 1, because selection is instrumental to the identification and attraction of knowledgeable, skilled, and able employees who strengthen the organization,

making it healthier and more productive. For that reason, selection is essential for the broader discussion of health, well-being, and performance in the workplace.

### Selection

Selection is critical to healthy, high performance organizations. Screening procedures such as background checks may potentially exclude some dangerous employees, thus essential to the selection process. Serious red flags may appear during background checks, but the question is whether any practical utility exists in attempting to “profile” a candidate who may be aggressive or violent. The evidence is unconvincing. In addition to the practical limitation of selection as a prevention screening approach, there are doubtless ethical and legal issues that arise on screening out potential offenders without highly reliable evidence. What we have found follows.

Some discuss the relationship between individual differences and demographic characteristics and workplace aggression. Douglas & Martinko (2001), for example, found that individual differences explain up to 62% of the variance in aggressive behavior at work. In an extensive review of workplace aggression studies, Barling, Dupre, & Kelloway (2009) examined the evidence for demographic factors on workplace aggression, including gender, age, socioeconomic status, colocation (time spent together by the perpetrator and the target of aggression). Further, they reviewed the evidence for links between workplace aggression and individual differences such as negative affect, self-esteem, trait anger, aggressive personality, and personal history of aggression. Their conclusion was that many of the studies involved

zero-order correlations and thus might perpetuate commonly held stereotypes, and they urged caution in basing selection on demographics.

Barling et al. (2009) noted that demographic and individual differences could moderate the effects of perceived provocation at work. Concurring with other researchers (e.g. Day & Catano, 2006), they concluded that profiling based on demographics is not supported by empirical research. And, although individual difference variables such as negative affect and trait anger may be promising from an empirical standpoint, they noted that workplace experiences explained far more variance in workplace aggressive behaviors than personality variables.

Research summarized by the U.S. Federal Bureau of Investigation (Ruekert & Walker, 1987) presents a similar picture. In attempting to identify risk factors of employees, no litmus test exists to predict whether an employee may become aggressive. Alternatively, the FBI suggested that both employees and employers should be vigilant for problematic behaviors that may be precursors to violent behavior at work. Drug or alcohol abuse at work, bringing a weapon into the workplace, a mismanaged disciplinary action or severe personality conflicts are behaviors that may suggest a greater potential for workplace aggression.

In summary, relying on the selection process to screen out dangerous employees may not be a failsafe approach. Indeed, workplace aggression is better predicted by behaviors and situational factors, which may be more effective targets for primary interventions. While we exclude selection as a prevention intervention for high-risk employees, we also restate the value of selection for the development of health, well-being, and performance in organizations.

Chaparral Steel Company provides a very positive example of carefully screening, selecting, and then attracting the best employees (cf. Forward, Beach, Gray, & Quick, 1991). While selection may not be valuable as a prevention approach, one process through which behavioral and situational factors may be managed is through new employee socialization.

### Organizational Socialization

We consider organizational socialization as the first stage of prevention in identifying and managing the potentially dangerous employee. Organizational socialization is the process whereby new hires as outsiders are transformed into productive and committed organizational insiders. In the absence of formal socialization processes, new employees are socialized through their encounters and experiences on the job, and learn the culture of the organization. In the case of preventing workplace aggression and violence, an intentional, mindful socialization program is a key ingredient in reinforcing a zero-tolerance culture.

Socialization generally occurs in three phases: anticipatory socialization, which encompasses all the learning that takes prior to the first day on the job; encounter, in which the newcomer's expectations meet the reality of the job's demands, and mastery, in which the newcomer begins to have a sense of efficacy and commitment to the organization. The socialization process can be stressful, but organizations can support the newcomer by providing information, training, and role modeling (Nelson & Quick, 1991). These support processes communicate organizational culture. A healthy organizational culture is characterized by values and norms centering on competence, trust, integrity, psychological safety, organizational fairness, and civility. Communicating and enacting these norms and values sends a message to newcomers about "the way we do things here."



Preventing workplace aggression requires healthy cultures, where people treat each other with respect and fairness. Sustaining such cultures involves policies and procedures, effective communication, training, and enforcement (Dillon, 2012). Policies that emphasize zero-tolerance for aggression, create effective mechanisms for reporting aggressive acts, and encourage the use of employee assistance programs should be thoroughly explained to newcomers early in the socialization process. Indeed, the perception that the organization is serious about zero-tolerance, and that actions will be taken against workplace aggression can significantly reduce acts of aggression (Barling et al., 2009).

Mandatory training during the socialization process should emphasize stress management and productive, healthy ways of dealing with frustration at work. Assessments and training in emotional intelligence competencies can provide newcomers with skills like self-awareness, empathy, and conflict management to help prevent aggressive behaviors (Olson, Nelson, & Parayitam, 2006). Training in crucial conversations and negotiations may also be valuable in providing skills needed to resolve conflicts effectively.

Organizational socialization can be a primary avenue for preventing workplace aggression if designed as a vehicle for communicating a healthy culture of trust and mutual respect. Given that the majority of influences on aggressive acts are situational, socialization educates employees and reduces the risk of situations that may provoke aggressive or violent behaviors. Especially powerful during the socialization process is the transmission of behavioral norms and standards around key positive constructs such as fairness, transparency, and integrity, aimed to build up an honorable, inclusive, and positive culture. As we see in the

discussion of first supervisor, norms of fairness and justice are central to a healthy and productive work environment while their absence can trigger dysfunctional and disruptive behaviors.

### First Supervisor

The first supervisor is the central figure in the socialization process, the focal role model of the organization's culture. Newcomers watch their supervisors' modeled behavior to ascertain whether the values communicated match the values enacted in the organization. Supervisors should model norms of fairness and civility, and reinforce appropriate behavior among newcomers. Whether or not newcomers believes in the zero-tolerance for aggression policy will depend upon what they see rewarded and punished by the first supervisor. Things that supervisors pay attention to, measure, and control will be deemed important by newcomers. How the supervisor reacts in an emotionally charged situation will be observed and potentially adopted by newcomers. Organizations should provide training to supervisors so that they can serve as appropriate cultural role models. Supervisors should pay particular attention to issues of fairness. Perceptions of interactional injustice and abusive supervision are strongly related to workplace aggression (Hershcovis et al., 2007; Inness, Barling, & Turner, 2005).

In addition to modeling and reinforcing appropriate behavior, first supervisors play important roles in surveillance for problem behaviors and risk factors. Importantly, no single behavior predicts the potential for aggression, but patterns are important to discern. The FBI (Rugula & Isaacs, 2003) outline problematic behaviors for surveillance at work (see Exhibit 2).

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Exhibit 2: FBI Proposed Problematic Behaviors for Surveillance at Work

- Increasing belligerence
- Ominous threats
- Hypersensitivity to criticism
- Recent acquisition or fascination with weapons
- Obsession with a supervisor, coworker, or grievance
- Preoccupation with violent themes or publicized violent events
- Angry outbursts

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The literature on workplace aggression and violence clearly indicates that most aggressive acts are a function of the individual and the situation. In addition to perceptions of unfair treatment and abusive supervision, workplace situational factors identified by the FBI (see Exhibit 3) can contribute to a negative, stressful work environment and play a role in aggressive behavior.

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Exhibit 3: Negative, Stressful Work Conditions Identified by FBI in Aggressive Behavior

- Understaffing, especially resulting in work overload or compulsory overtime
  - Frustration from poorly defined jobs and role ambiguity
  - Downsizing and reorganizations
  - Poor management styles
  - Inadequate workplace security or poorly trained security staff
  - Lack of employee counseling
  - High rates of injury or grievances (as symptoms of problem environments)
- 

First supervisors trained to recognize individual behaviors that are precursors to aggression can take early actions to triage individuals appropriately. Because of the importance of organizational influences on aggressive behavior, supervisors should also take actions to prevent work conditions that create an environment that encourages (or fails to discourage) aggressive behavior.

### **Stage 2: Employee Deviance and Employee Dysfunctions**

Primary prevention must be supplemented with secondary and tertiary prevention, as Figure 1 suggests. Regardless of how well an organization selects, socializes, and supervises employees, employee deviance, which is not necessarily bad, and employee dysfunctions, which is negative and problematic, may occur. A key question arises: What is the tipping point that moves an employee into exhibiting negative deviance and dysfunctional behavior, even dangerous and violent behavior? Surveillance indicators for this second stage in the life history

of a dangerous employee are incivility and bullying, absenteeism, tardiness, and accidents and safety violations.

### Employee Deviance and Dysfunction

Deviant behavior may be positive or negative, constructive or destructive (Warren, 2003). One individual's deviance may devastate or destroy a company, yet another's may save it. A recent example occurred at JP Morgan Chase, where an employee took unauthorized risks costing the company billions of dollars in fines, legal fees and losses (Fitzpatrick, 2013). Another example concerned a Navy whistle-blower who revealed welding problems on an aircraft carrier, problems potentially causing the aircraft to stall and crash, injuring or potentially killing pilots and other armed forces (Lee, 2005). In both examples, employees acted outside the norms of established behaviors. The question becomes when does deviant behavior put the organization and its employees at risk, not simply economic risk but at times risk of employees lives.

Deviant behavior is intentional voluntary acts by an individual which go against the established norms and standards of behavior (Bettenhausen & Murnighan, 1985; Warren, 2003). Some organizations may have established norms of bullying and harassment, whereas others have a zero tolerance for such behaviors. We define established norms and standards as all individuals at all times should be treated fairly and with respect in accordance with the broad global societal values (Vardi & Wiener, 1996). We note deviance has both immediate and long term impacts. An employee's deviant behavior today, may not be discovered until many years later, alternatively, the impact may be immediate.

Deviance behavior departs from what is expected (Merton, 1968; Goode, 1991), it “catches peoples’ attention” (Spreitzer & Sonenshein, 2003: 209). A positive departure may benefit the organization, while negative departures may result in individual or organizational harm. Positive and negative deviance are substantial and intentional departures from expected norms (Robinson & Bennett, 1995). Notably deviant behavior is rarely an accident.

Positive deviance is behavior with honorable intentions which goes substantially against established norms (Spreitzer & Sonenshein, 2004) and a departure from the expected (Goode, 1991). It is a subset of yet distinct from pro-social behaviors (Spreitzer & Sonenshein, 2004). While both involve behavior which depart from norms, the magnitude of the departure from norms with positive deviance is much larger. Further, pro social behavior improves organizational functions, at no cost to the organization. Positive deviance may or may not improve organizational function, and may prove costly to the organization (Spreitzer & Sonenshein, 2004).

Positive deviant behavior goes beyond the ordinary to the extraordinary (Cameron, 2012). Employees deviate positively from the norm when they care deeply about matters (Spreitzer, 1995) and when they desire to serve others (Quinn, 2000). Employees who are focused on others are “life giving rather than life depleting” (Spreitzer & Sonenshein, 2004:213). Further, individuals will positively deviate from expected norms of behavior when they have autonomy, and the courage and belief that they are capable of making a difference (Quinn, Spreitzer, & Brown, 2000). Positive deviance benefits the organization as it often results in long term stronger relationships, and higher individual performance and

organizational effectiveness (Spreitzer & Sonenshein, 2004). Notably, not all positive deviance results in positive outcomes and not all honorable intended deviations are observable. What is important is that the behavioral intentions were good.

Conversely, negative deviance is often costly and disruptive to the organization (Porath & Pearson, 2010; Leblanc & Kelloway, 2002; Neuman & Baron, 1998; Penney & Spector, 2005; Peterson, 2002). Negative deviance goes against established organizational norms and does harm (Lawrence & Robinson, 2007; Warren, 2003). Negative deviance ranges from low intense activity such as incivility towards other employees to more intense negative deviance as sabotage, theft, or to more destructive, dangerous behavior such as physical and even deadly violence. Notably, compelling evidence exists that violent behavior simply does not happen in isolation. Put differently, violent behavior in the work place does not appear without provocation, and generally does not occur spontaneously as a one-time event. Violent behavior is often precipitated by previous cumulative stressors. It is often a result of a series of escalating stressors over time (Pearson & Porath, 2005; Andersson & Pearson, 1999; Leblanc & Kelloway, 2002); with the final stressor resulting in the “straw that breaks the camel’s back” (Andersson & Pearson, 1999:482). Understanding, identifying and preventing negative deviance is important to workplace health.

In general, negative deviant behavior may be directed toward the organization (i.e. wasting resources), or toward a specific individual or group of individuals (incivility, rudeness) (Neuman & Baron, 1998). Negative deviance occurs when employees are either not motivated to conform to, or actively seek to violate expected norms (Robinson & Bennett, 1995; Kaplan,

1975). Even innocuous feelings of boredom may lead to deviant workplace behavior (Bruursema, Kessler, & Spector, 2011). Robinson & Bennett, 1995) provide a typology of deviant behavior from minor infractions to serious incidences. Acts such as leaving early, taking excessive breaks, intentionally working slow, wasting resources, showing favoritism, gossiping, and blaming others are considered minor breaches of good productive organizational citizenship (Robinson & Bennett, 1995). While these acts appear quite diverse, all violate the standard norms of behavior and may lead to harm to an individual or the organization (Marcus & Schuler, 2004).

One of the most prevalent provocations or stressors of negative deviance is workplace incivility. Incivility is considered a “low intensity deviant behavior, with ambiguous intent to harm the target, in violation of workplace norms for mutual respect” (Andersson & Pearson, 1999: 457). Incivility is often verbal, passive and indirect (Pearson & Porath, 2005). Notably, acts of incivility may or may not be conducted with intent to harm another or maliciousness. Unique to uncivil behavior is that the person to whom the behavior was directed (perceived or real) is also likely to retaliate with additional negative deviant behavior. Indeed, incivility of one person may actually instigate others to act deviantly in retaliation.

Uncivil behavior includes acting rudely or discourteously, without regard for others. Incivility results in others feeling ignored or excluded (i.e. given the silent treatment), as if one could not voice one’s opinion, ideas, and or concerns, that assigned tasks were below one’s job level (Penney & Spector, 2005), being the recipient of derogatory comments, feeling as if the aggressor was rude (Bunk, Karabin, & Lear, 2011), or a general lack of respect or regard from



the aggressor (Pearson & Porath, 2005). Incivility may take the form of falsely taking credit for another employee's work, or passing the blame for mistakes to someone else, texting, checking email in meetings, and withholding information (Porath & Pearson, 2010).

Importantly, incivility is often the starting point of negative deviant behavior and unchecked may lead to more dangerous deviance. While not all acts of incivility lead to violent behaviors; the vast majority of negative deviant and violent behaviors are preceded by interactions involving incivility. Individuals, when repeatedly insulted will reach a "tipping point" (Andersson & Pearson, 1999) and may respond with anger and aggressive behavior (Felson, 1982; Felson & Tedeschi, 1993). An incivility spiral may ensue (Andersson and Pearson, 1999). As the spiral escalates, the intensity and level of negative deviance increases and may eventually result in an attempt to seek revenge through aggressive and or violent behavior with clear intent to harm (Leblanc & Kelloway, 2002). Individuals who have been targeted with incivility may retaliate to restore fairness (Donnerstein & Hatfield, 1982) and to demand deserved respect (Lawrence & Robinson, 2007). The retaliation may result in often escalated aggression by the initial aggressor. The target retaliates often to avoid future attacks or to exert his or her ability to face down the aggressor (Felson & Tedeschi, 1993).

While minor acts of deviance, such as incivility, seem somewhat harmless, more serious acts may follow as individuals at risk will have the tendency to increase the level of deviant behavior to more serious and more harmful acts. It is important to recognize that low levels of deviant behavior escalate to higher levels of deviance and even dysfunctional behavior (Penney & Spector, 2005). More serious levels of deviant behavior include sabotaging equipment,

accepting kickbacks, lying, stealing, sexual harassment, verbal abuse, and violent physical attacks, putting both employees and the organizational at risk (Robinson & Bennett, 1995; Neuman & Baron, 1998).

Negative deviance, similar to positive deviance, is a voluntary act which significantly goes against established workplace norms (Warren, 2003). Negative deviance however, brings harm to the organization and may threaten the well-being of the employees. Individuals will display negative deviance when feeling treated unjustly or dissatisfied, or even when simply wanting to seek thrills (Bennett & Robinson, 2000). Negative workplace deviance may be directed at the organization (i.e. theft) or an individual (i.e. sexual harassment) (Robinson & Bennett, 1995; Warren, 2003). Employees of organizations who feel the need to “look out” for themselves, which feel little perceived empathy by the organization, and which are not held to a strong code of ethics are more likely to display negative deviant behavior (Peterson, 2002; Trevino, Butterfield, & McCabe, 1998).

#### *Secondary Surveillance*

Secondary surveillance begins by examining organizational stressors, those that are likely to provoke negative deviant and dysfunctional behavior, such as incivility (Spector, 1998). Disturbingly, incivility is on the rise due to increased work complexity and overload, time pressures at home and work, difference in cultural norms among employees, lack of interpersonal interaction among employees due to technology ( i.e. voice mail, email, text), ambiguity of acceptable norms of behavior due to less formal workplaces, “me-first” attitude of employees (Pearson & Porath, 2005; Pearson, Andersson, & Porath, 2000) and use of

temporary, contract and part time workers (Pearson, Andersson, and Porath, 2000). While most individuals acknowledge having behaved rudely at one time, habitual uncivil behavior puts the organization and its employees at risk.

Unfortunately, organizations may ignore and sometimes even reward uncivil behavior (Pearson & Porath, 2005; Litzky, Eddleston, & Kidder, 2006). **Secondary surveillance** thus begins with monitoring the organization for incivility. No matter how trivial the incivility might appear, supervisors and peers should be encouraged to monitor and report any suspected repeated acts. While not advocating for all acts of incivility to be reported simply because most incivility, although inappropriate, is not likely to lead to higher acts of deviance, repeated acts of incivility are highly likely to lead to more severe behavior. Not only should the organization set up a monitoring system, imperatively, the monitoring system must be perceived as “safe” to use (Robinson & Bennett, 1995).

Monitoring and eliminating stressors plays a critical role in preventing the escalation of negative deviance (Robinson, 2008; Robinson & Bennett, 1995). Stressors such as role ambiguity and conflict and work load itself have been linked to counterproductive work behavior (Penney & Spector, 2005). Other known factors that lead to increased stress are uncertainties associated with changes in the organization. Secondary prevention activity would monitor stress inducing events which have taken place within the organization is critical (i.e. mergers, layoffs, management changes, negative performance appraisals, salary changes, etc.) as often these events involve perceived injustice and increased uncertainty, leading to an increased likelihood of negative deviance (Marcus & Schuler, 2004).

Monitoring absenteeism and tardiness, known predictors of deviant behavior, are also needed as early warning signs of potential higher levels of negative behaviors (Bolin & Heatherly, 2001). Monitoring accidents and safety violations will also aid in averting more serious problems. Accidents are generally thought of as low occurring events and not necessarily intentional. However, much evidence suggests that accidents and safety violations increase when employees perceive increase in job stress (Quick, Horn, & Quick, 1986; Danna & Griffin, 1999; Neal & Griffin, 2006). Importantly, deviant behavior of one individual who fails to comply with safety rules may not be subject to an accident, but his or her actions or lack of actions may result in an accident for someone else (Neal & Griffin, 2006). Further, intent to quit and job dissatisfaction are known predictors of negative deviance (Bolin & Heatherly, 2001). Proper supervisor monitoring and understanding employees' attitudes may avert negative deviance. Peers also play a role in reporting others taking unnecessary breaks, leaving early, and intentionally working slow work. Finally, alcohol and substance abuse are to be monitored and reported (Bolin & Heatherly, 2001) before deviant behavior is escalated.

#### *Secondary Prevention*

Employees engage in negative deviant behavior for a wide variety of reasons. From stealing from the organization due to financial problems at home, to physically harming others at work due to mental illness. Obviously, the organization cannot monitor nor be accountable for all of the employees' activities or needs. Yet, while individual personality types and personal situations play a part in the individuals' behaviors, extant research has not been able to establish a strong positive association between individual factors and workplace deviance

(Arbuthnot, Gordon, & Jurkovic, 1987; Robinson & Greenberg, 1998; Peterson, 2002).

Secondary prevention tactics may avert escalation to the “tipping point” or “triggering mechanism” by instituting proper monitoring and procedures.

#### *Avoiding the Tipping Point or Trigger Mechanism*

Organizations can institute secondary practices to prevent negative deviant, dysfunctional behavior from escalating to dangerous behavior. Important is establishing a strong organizational climate of zero tolerance for negative deviance (Vardi, 2001; Trevino, 1986) as individuals are more likely to adhere to the established norms of behavior (Vardi, 2001). Negative deviances is more likely to occur if employees perceive that the organization tolerates deviant dysfunctional behavior (Whyte, 1993). The stronger the organizational climate to no tolerance for deviance, the less likely deviant behavior will occur (Vardi, 2001).

A strong organizational climate begins with a strong code of ethics and a cooperative work climate, known reducers of ambiguity and workplace stressors (Trevino et al., 1998; Peterson, 2002). Establishing a strong positive climate and enforcing a clear code of conduct stating expected norms of behavior, ambiguity in terms of expected norms of behavior is eliminated. At minimal, the code establishes that employee conduct should at all times be civil, respectful and treat others with dignity. Further, the code of conduct should state norms of behavior of mutual respect and dignity for all stakeholders (customers, employees, supplier, etc.). Further, the code of conduct should include expected norms of responsibility, fairness, caring and citizenship (Schwartz, 2005). A zero tolerance for violence and verbal aggression is likely to eliminate deviant behavior. Further, an organization which focuses and rewards safety

prevention activity increases motivation to act safely (Neal & Griffin, 2006). Organizations whose norms include civil behavior within their core values and business strategies, explicitly state a “zero tolerance” for incivility, regardless of the power or prestige of the employee.

Organizations offering training on expected behavior will also decrease ambiguity of acceptable norms. While most organizations train on diversity, sexual harassment, etc. few train on expected norms and even fewer on incivility, which may lead to more disruptive behaviors. Complaints from peers and supervisors of reported violations need to be taken seriously and appropriate follow up action should take place (Pearson, Andersson, and Porath, 2000).

#### Organizational Health Centers

The concept of an Organizational Health Center (OHC) is a structural prevention mechanism conceived within the United States Air Force (Adkins, 1999; Adkins, Quick, & Moe, 2000; Quick, Tetrick, Adkins, & Klunder, 2003). The OHC represents a comprehensive, integrated, cross-functional organizational health approach which engages in the diagnosis, triage, and counseling with employees who display negative deviance or dysfunctional behavior. An OHC can enhance the health, wellbeing, and performance of individuals and the organization. These goals are achieved by focusing on employee vulnerabilities, employees at-risk, and employees in distress. As such, the OHC seeks to bring together concepts of organizational protection along with individual-level prevention in a single organizational function reporting to the chief executive of the organization. This reporting chain provides the executive team with a single point of entry into the health of the organization and its employees.

An OHC in an organization is best led by a chief clinical officer who embodies both organizational and clinical expertise, be the latter psychology, social work, or allied clinical discipline. Dealing with the small percent of employees who display negative deviance and dysfunctional behavior requires clinical knowledge and skills in partnership with operational line management. The OHC rests on active early warning or surveillance systems that seek equally to identify organizational risk factors as well as to identify employees at risk for physical, psychological, emotional, or behavioral distress. Because of the scope and complexity of the operations, implementation of an OHC necessarily requires collaboration among a range of organizational functions concerned with human resources and relies on public health notions of surveillance that offer earning warnings before disasters strike, and a full range of preventive interventions to strengthen individuals and the organization.

While a chief clinical officer in an organization is ideal to lead an OHC, a fully functioning OHC requires a team of professional expertise from human resource professional, workers compensation and healthcare staff, occupational safety personnel, security, legal advisors, payroll and financial services, health and fitness staff, and chaplains in partnership with representatives from labor and management. The team approach brings a synergy to the work, reduces conflict among the various subgroups in the organization, and can provide a ready source of social support to fellow team members, reducing the stress often associated with the emotional work of service provision. This full range of experts is also critical to establishing a monitoring system within the organization. A cross-functional team approach reduces gaps and redundancies in services, enables better targeting of risk factors, and leverages resources to address those risk factors. A clear composite picture of who's healthy, who's not, and who's at

risk only emerges when the entire spectrum of experts who have specific responsibility for people and their well-being pool information. The collaboration is central to the protection of people in an organization and the prevention of dangerous employees emerging.

### **Stage 3: Dangerous Employees**

“People should learn to see and so avoid all danger.

Just as a wise man keeps away from mad dogs,

so one should not make friends with evil men.”

Buddha

While there is wisdom in Buddha’s saying, it would be wrong to say that all dangerous employees are evil. However, their actions can become evil and for that reason management should be especially concerned for the health and well-being of all concerned. Once an employee becomes dangerous and damage is done in the organization and/or to employees, tertiary prevention becomes an essential requirement. Leaders and senior management play a crucial, often direct caregiving, role in tertiary prevention. Key is first acknowledging the trauma, harm, injustice, and damage that were caused by the dangerous employee (Cameron, 2007). The first requirement is to contain the damage and preclude the occurrence of secondary or tertiary victims in some kind of negative spiral, followed by caregiving, forgiveness, and resilience.

*Containment*



All harm and damage in work organizations cannot be prevented, although, through primary and secondary prevention, can be minimized, even anticipated. While Weick & Sutcliffe, (2007) note that HROs expend a good deal of resource on the process of anticipating and preventing errors, disasters, and severe harm, these organizations are realistic in recognizing that disasters do occur. Therefore, they have excellent resources for containment of the disaster as well, limiting the ripple effects of the problem. Further, HROs are relentless in learning from catastrophe. The healthy process of acknowledging the disaster, actively engaging in the response and containment, and then moving on to recovering and repairing damage and harm where possible is the hallmark of a healthy, well, and high performance organization.

Violence, aggression, sabotage, self-harm and harm to others are manifestations of a dangerous employee. Procedures and mechanisms for containing a violent or aggressive act and experts trained as first responders within the organization are essential to tertiary prevention. While organizations can display zero tolerance for dangerous employees, it is impossible to eliminate all risk that an employee may slip through the screens. The deployment of security forces, employee assistance, and caregiving by first responders are keys to containing, even ending the negative event. Essential to acknowledge, it is not over when it is over. Trauma, harm, and injustice do not just end with life going on at work as though nothing had happened.

#### *Caregiving*

While containment focus on the perpetrator of violence and aggression, caregiving must focus on the victims of dangerous employees. Caregiving should include physical and medical

attention as well as psychological and emotional attention. Organizational resources for caregiving are important for more than victims because there are powerful messages sent to all employees about the value management places on the health and well-being of each employee. The failure to render aid in time of disaster compounds the problem and sends a message of indifference and inhumanity.

These two essential first elements of tertiary prevention address the source of the danger and the target of the danger, along with collateral damage in the form of secondary, tertiary, or even quaternary victims. Insuring that the needs of all affected are addressed is essential to the overall health, well-being, and performance of the organization. The emerging science of post-traumatic growth is instrumental in caregiving as well as recovery. Post-traumatic growth is a protective factor against post-traumatic stress disorder when action-based growth is present (Stasko & Ickovics, 2007). Good caregiving and treatment intervention may be protective factors against time-lagged symptomatic problems such as PTSD.

#### *Forgiveness*

The process of forgiving dangerous employees for what s/he did and leaders for not preventing a disaster is a central pathway to reconciliation and recovery that leads to renewed health, wellbeing, and performance (Cameron, 2007). This does not relieve the perpetrator or the aggressor of the responsibility for the harm that has been done or the suffering that has occurred. Forgiveness is not condoning, excusing, denying, minimizing, or forgetting a wrong. Forgiveness *is* a freely made choice to give up revenge, resentment, or harsh judgments toward

the one who caused hurt while striving to respond with generosity, compassion, and kindness (Enright, Freedman, & Rique, 1998).

Failure to forgive does more harm to the unforgiving person than to a perpetrator. Indeed, conditional forgiveness of others (i.e., only forgiving a perpetrator after s/he meets certain conditions) is to increased mortality risk (Toussaint, Owen, & Cheadle, 2012). Further, forgiveness (i.e., unconditional forgiveness) may help ameliorate suffering through reducing depression, hopelessness, and stress while also building resistance and modulating psychophysiological homeostasis that offer protection against mortality.

### *Resilience*

Tertiary prevention is concerned with more than containment, caregiving, and forgiveness related to the immediate disaster. The individual and organizational bounce from harm, hurt, and suffering is essential and the mark of a healthy, productive organization. High reliability organizations are committed to resilience and recovery (Weick & Sutcliffe, 2007). Disaster or tragedy becomes a learning event through which the individual and the organization renew themselves, never leaving the negative events behind but rather extracting lessons from the events, taking responsibility for what transpired, and revitalizing their energies. Rather than being gripped by fear or anxiety over what has happened, healthy people and organizations bounce back from these events with renewed vitality and vigor. Disasters and tragedies are never over when they are over, the key to recovery is resilience and renewal.

### **Conclusion and Look Back**

The purpose of our paper was to develop a theory of preventive health management for high-risk employees, the 1 – 3 percent of employees who may have a propensity to become dangerous. We propose that workplace violence is no accident and with proper surveillance and prevention mechanisms workplace violence may be prevented, minimized, and/or managed. We developed a three stage life history causal chain model of the problem stem, highlighting the progression of vulnerable employees to violent employees. We first addressed important characteristics of employee vulnerabilities. By adopting prevention and surveillance procedures, the organization socializes and supervises employees so as to minimize the risk of negative deviant, dysfunctional, and dangerous behavior. While working conditions and coworkers may unintentionally trigger negative employee responses, preventive management can use early warning signs as opportunities to intervene before disaster strikes.

Vulnerable employees may progress to deviant or dysfunctional behavior regardless of the organization's efforts. We proposed that secondary prevention and surveillance methods aid the organization to identify and address these issues before they advance to a dangerous level. Employees' attendance and tardiness records, proclivity for accidents and safety violations as well as supervisor and peer reports provide important insights into potential future problems. Further, by establishing Organization Health Centers, counseling options and diagnosis and triage capabilities, potentially dangerous employees may be identified and offered resources with healthy alternatives before becoming a threat to the organization or to themselves.

We focused on both positive and negative aspects of deviant behavior. Positive deviance may result in innovative decisions and creations, and may play an important role in avoiding and halting violent behavior. By deepening our understanding of positive behavior we may develop a better understanding of negative behavior.

Finally we focused on ways to identify and prevent employees progression to a dangerous level. Workplace violence does not occur in isolation, rather is often a result of cumulative events. Incivility is a behavior which may escalate, and while not all incivility leads to violent behavior, violent behavior is almost always preceded by acts or perceived acts of incivility. We explained how preventive measures such as EAP, PTG, forgiveness and caregiving may avert a dangerous employee from carrying out violence to him or herself, other employees and or the organization.

We highlighted a positive application of preventive stress management at the San Antonio Air Logistics Center where many of the core concepts we include were applied to prevent fatalities and workplace violence. We featured three negative cases of wrongful death, sexual assault, and management threat and harassment. How could those cases have turned out different in light of our prevention concepts, or Weick and Sutcliffe's (2007) anticipation and containment concepts, or Cameron's (2007) notion of forgiveness?

- Wrongful death  
If Steve Barger as a supervisor had been more mindful in tracking the small failures (safety violations) of his employee and resisted oversimplifying the problem by discounting their significance, he might have recognized more clearly their potential for future errors, severe harm, and disaster. If Steve had not been blinded by the humanitarian appeal of an employee needing a job, he might have foreseen the disaster

that ultimately befell him. If he had done these things, then events would have unfolded differently and his own death been averted.

- Sexual assault  
If the hospital had been more diligent in examining the whole employment history of the male medical technician and been more mindful of attending to small failures in his record, they may actually have questioned whether to have hired him. Given the hiring and subsequent warning signs, if the hospital had been more preoccupied with failures and sensitive to its human operations, the med-tech would have been much more closely observed by supervision. If either of these courses had been pursued, then the med-tech would not have had the opportunity open in which to act.
- Management Threat and Harassment  
If management had established clear realistic work expectations and not over-controlled the work environment, the employee(s) might have crafted strategies for fulfilling work expectations. If management had not coupled over-control with very high work demands, then the probability of the agent breaking would have been very low.

Our high-risk employee prevention model provides fertile ground for future research.

While we provided anecdotal evidence and built our model on established theory and case study practice, systematic empirical evidence can strengthen our arguments. Workplace violence appears to be increasing, an rising concern for management. We offer insights into how, with proper surveillance and prevention mechanisms, work place violence may be averted.

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