

Incivility begets incivility: Understanding the relationship between experienced and enacted
incivility with customers over time

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Workplace incivility, characterized by low-intensity, ambiguous, and rude interpersonal interactions, is typically conceptualized with an events-based perspective (Andersson & Pearson, 1999). Research suggests, however, that both experienced and enacted incivility may be more pervasive and occur consistently or repeatedly, and this cumulative strain experience may impact future enacted incivility. Here, we examine negative emotions and compassion fatigue as mechanisms that explain experienced and enacted incivility between nurses in a high-stakes hospital setting and their patients. Data were collected once per week for four weeks, enabling us to examine how these relationships unfold over time. Results from the four-wave survey indicate that experienced patient incivility is positively related to negative emotions and to compassion fatigue, and that perceived patient acuity can exacerbate these detrimental relationships. Lastly, experienced patient incivility is related to increased future enacted incivility towards patients indirectly through increased negative emotions and compassion fatigue. These findings suggest that repeated exposure to incivility leads to both poor wellbeing outcomes for the target of incivility and to future enacted incivility. Implications for theory and practice are discussed.

Keywords: Incivility; customer incivility; enacted incivility; experienced incivility; compassion fatigue

Incivility begets incivility: Understanding the relationship between experienced and enacted incivility with customers over time

For employees working in service industries, experiencing incivility from customers is a consistent and pervasive problem (e.g., Grandey et al., 2007; LeBlanc & Kelloway, 2002; Sliter et al., 2010; Wilson & Holmvall, 2013). The research on workplace incivility overwhelmingly documents the high prevalence of and negative consequences from experiencing incivility at work (e.g., Cortina et al., 2001; Cortina et al., 2017). For example, Porath and Pearson (2013) reported that an estimated 98 percent of workers in the United States experience incivility at work, with 50 percent experiencing such conduct at least weekly. Although there are clear links between experiencing incivility and decreased employee wellbeing (e.g., Lim et al., 2008), how, why, and under what conditions experiencing incivility from customers impacts employee behavior towards customers remains less clear. Because incivility is likely a common experience for most service-oriented employees (e.g., Grandey et al., 2007; Porath & Pearson, 2013; Sliter et al., 2010), building successful organizational supports and interventions depends on our understanding of the downstream impacts of customer incivility over time, the mechanisms through which these outcomes are occurring, and conditional factors that may be worsening the outcomes of experienced incivility.

Like early conceptualizations of incivility (e.g., Andersson and Pearson's 1999 incivility spiral), much of the research on customer incivility takes an events-based perspective, looking at how instances of incivility are processed and reacted to (e.g., Meier & Gross, 2015; Walker et al., 2014, 2017). However, for employees within service industries, incivility from customers is likely a frequent occurrence that represents a chronic hassle in their job duties. Therefore, we propose that it is not only important to examine events-based reactions to incivility from a single

person, as much of the previous reciprocation research has done, but also how cumulative weekly exposure to incivility across customers and workdays can influence employee wellbeing and behaviors.

Furthermore, previous cross-sectional research (e.g., Torres et al., 2017) has shown that incivility towards customers and negative emotions can be outcomes of experiencing incivility from customers; however, these relationships and the emotional process of experiencing incivility have not been examined over time. To fill this gap in the literature, we primarily draw from the stressor-emotion model of counterproductive work behavior (Spector & Fox, 2005), to support our investigation concerning the effect over time of experiencing incivility on nurses. Several tenets of this model (e.g., negative emotions as process mechanisms for the relationship between environmental stressors and enacted incivility) provided groundwork for the processes within our hypothesized relationships. Within this paper, we (a) examine how experiencing incivility from customers is related to future enacted incivility towards customers, (b) identify affective and exhaustion-related mechanisms that drive these experienced-enacted relationships over time, and (c) examine the exacerbating role of a customer-based contextual factor, patient acuity, on these relationships.

Background on incivility & theoretical foundations

Workplace incivility is defined as “low-intensity deviant behavior with ambiguous intent to harm a target, in violation of norms for mutual respect” (p. 457) and can be viewed as a mild counterproductive workplace behavior (Andersson & Pearson, 1999). Within the current study, we look at two perspectives of workplace incivility: experiencing incivility from others and engaging in uncivil behaviors towards others. To help distinguish these experiences, we use the terms “experienced” and “enacted” – however the definition of both terms is the same, aligned

with Andersson and Pearson's seminal definition (1999), with changes only to who the instigator and who the target is. In our study, experienced *incivility* refers to when the employee is the target of incivility; *enacted incivility* refers to when the employee is the instigator of incivility. This terminology (i.e., enacted incivility) for instigator uncivil behavior is commonly used within the incivility literature (e.g., Hershcovis et al., 2017; Hülshager et al., 2020). Due to the complex nature of human social interactions, a single individual can both experience incivility (i.e., other people are rude to them) and enact incivility (i.e., they are rude to other people). Although original conceptualizations of incivility focused on incivility occurring within existing workplace interpersonal relationships, there is ample evidence that incivility between employees and customers (both enacted and experienced) is common within organizations with frequent customer interactions and is associated with similarly negative outcomes as incivility from other workplace sources (e.g., Grandey et al., 2007).

To understand how incivility experiences from customers may be impacting employee affect and behavior over time, we utilize the stressor-emotion model of counterproductive work behavior (Spector & Fox, 2005). This model considers how environmental stressors and an individual's perception of them are related to negative emotions and, ultimately, counterproductive work behaviors (CWB), such as enacted incivility. Applied to enacted incivility, the general premise of the model suggests that enacted incivility occurs due to a sequence of events where environmental stressors at work lead to enacted incivility through appraisal, perceptions of the stressor, and negative emotions (Spector & Fox, 2005). Within this framework, enacted incivility can be viewed as a type of relational, interpersonal CWB that likely has important environmental and affective antecedents. Furthermore, we look specifically

at experienced incivility as the environmental stressor that can trigger the emotional process leading to enacted incivility.

We address current gaps in the literature by extending our investigation of incivility beyond the context of single incivility interactions or interactions with other employees to look at the impact of customer-based incivility experiences over time on enacted incivility towards customers and examine the emotion-based process through which this is occurring using the stressor-emotion model of CWB. Although pieces of this process and relationships have received empirical support in previous research (e.g., experienced incivility is positively related to enacted incivility, Gallus et al., 2014; experienced incivility is related to burnout symptoms, Schilplzand et al., 2016; negative emotions can serve as a mediator between experienced incivility and organizational outcomes, Kabat-Farr et al., 2018), the full process has not been examined, particularly as it unfolds over time, within the context of customer incivility, or looking at the interaction between multiple stressors (i.e., experienced incivility and patient acuity). To do this, we focus on nurses within healthcare settings, who are embedded within high-stakes patient care. This study brings novel insight to incivility research by taking a longitudinal perspective to examine how uncivil behaviors from customers impacts employee experiences and behaviors over time and assessing theoretically grounded process mechanisms for these relationships.

Emerging research on customer incivility experiences shows that experiencing incivility from customers is associated with negative employee outcomes (e.g., Arnold & Walsh, 2005; Grandey et al., 2007; LeBlanc & Kelloway, 2002; Kern & Grandey, 2009; Rupp & Spencer, 2006; Sliter et al., 2010), although it is less clear what chronic exposure to incivility from customers means for how employees treat their future customers, particularly when they are embedded in work contexts where they have high patient demands. The often fleeting or temporary interactions with

customers means that retaliatory mechanisms are likely not as informative for understanding exposure to customer rudeness as they may be with exposure to incivility from supervisors or coworkers. Alternative to retaliation and individual-directed anger/rumination, which are likely more important for incivility from work sources where interpersonal relationships are established and maintained over time, incivility from customers likely serves less as an interpersonal cue and more as a workplace stressor. Past research has shown that workplace incivility is comparable with fixed and continuous low-level stressors, such as recurring hassles, which are seemingly harmless but tend to have ongoing negative effects (Cortina et al., 2001; Lim et al., 2008). These chronic stressors may impair mental and physical health due to their ongoing occurrence in everyday life (e.g., Baker, 2006; Jacobs et al., 2006; Lim & Lee, 2011). Therefore, in line with recurring hassle research, we examine the affective- and energy-based mechanisms that influence employee incivility behaviors towards others. We build on the existing customer incivility research to examine how customer incivility experiences are influencing incivility enactment over time, and how interpersonal-based affective (negative emotions towards customers) and exhaustion (compassion fatigue) mechanisms are driving the experienced-enacted relationship. Furthermore, we examine the ways in which additional interpersonal job demands (i.e., patient acuity) may be interacting with incivility experiences to strengthen the relationships of incivility with negative affective and CWB outcomes.

Impacting the individual: Mechanisms and conditional factor

Negative emotions as a mechanism

Prior empirical and theoretical work has identified negative affective responses as central components to understanding how workplace stressors impact employee wellbeing and behavior. For example, within the lens of the stressor-emotion model of CWB, job-related negative affect

has been shown to be an outcome of interpersonal stressors, which helps explain why such demands are associated with increased engagement in CWBs (Spector & Fox, 2005). Therefore, when trying to understand how incivility from customers (an interpersonal, environmental stressor) influences employee experiences, it is important to examine employees' affective responses to incivility. Although negative emotions may occur in response to general workplace stressors, we examine the role of negative affect specifically experienced towards the perpetrators of the incivility (i.e., experiencing negative emotions towards customers).

Affective responses to work events can build over time to influence overall affective states at work (e.g., Carlson et al., 2011). Based on this, individuals who experience consistent incivility from their customers likely develop increased negative emotions towards their customers, even if some of the individuals they are interacting with are not the specific sources of the incivility. Research supports that experiencing incivility, from any source, is associated with affective outcomes such as increased negative emotions (e.g., Giumetti et al., 2013; Kabat-Farr et al., 2018; Kim & Shapiro, 2008; Porath & Pearson, 2012; Sakurai & Jex, 2012; Torres et al., 2017) and decreased positive emotions (e.g., Bunk & Magley, 2013; Guimetti et al., 2013; Reich & Hershcovis, 2015). In line with theory and research that argues for the finite nature of resources and cost of dealing with affective demands (Job Demands Resources Model, Bakker & Demerouti, 2017; Conservation of Resources Theory, Hobfoll, 1989, 2011), we contend that experiences of incivility siphon resources otherwise allocated for general demands or future investments. As these resources become strained due to chronic (i.e., multiple occurrences) or prolonged (i.e., sustained incivility) experiences of incivility, employees likely become more susceptible to deleterious emotional effects of uncivil behaviors. This relationship between experiencing incivility and experiencing affective responses is robust, and these results are

consistent across methodologies, samples, and sources. Like incivility from other workplace sources (e.g., coworkers), incivility from customers is associated with increased negative affective responses (Torres et al., 2017). As we are assessing this within a healthcare setting, the customers that the nurses interact with are the patients and their family members. In this context, we propose the following replication hypothesis:

Hypothesis 1: Experienced patient incivility is positively related to negative emotions towards patients.

Compassion fatigue as a mechanism

Exhaustion and burnout have long been understood to be outcomes of chronic workplace stressors, particularly from emotional and interpersonal demands (e.g., Maslach et al., 2001). In line with this, experienced incivility is related to increased emotional exhaustion and decreased energy (Schilplzand et al., 2016). Although workers can adapt to infrequent experiences of incivility, repeated exposure to incivility is associated with decreased employee wellbeing and increased burnout over time (Matthews & Ritter, 2019). Likewise, research suggests that experienced incivility from customers is positively related to employee burnout symptoms (Campana & Hammoud, 2015). Within the current study, we look specifically at the relationship between experiencing coworker incivility and experiencing a caregiving specific form of job burnout, compassion fatigue.

Service employees with caregiving responsibilities (e.g., healthcare or education) can experience a specific type of burnout called compassion fatigue. Caregiving employees have a duty to routinely care for others, in turn exposing them to others' suffering, high stress, and trauma, in addition to the typical emotional stressors associated with service jobs (Coetzee & Klopper, 2010). Compassion fatigue was originally developed by Joinson (1992) as a term for

caregivers who have “lost the ability to nurture” (p. 119). Compassion fatigue consists of burnout and secondary trauma components, with employees experiencing compassion fatigue if they are experiencing either caregiving-related burnout or secondary trauma (or both of these simultaneously). The burnout component of compassion fatigue relates to feelings of hopelessness, anxiety, irritability, aggression, cynicism, and difficulty in performing one’s job effectively or dealing with stressors from work (Figley, 2002; Finzi-Dottan & Kormosh, 2018) that are related to caregiving responsibilities. Secondary trauma can be thought of as the vicarious experience of another person’s trauma (Figley, 2002). For example, witnessing a negative work event (e.g., adverse surgery outcome) or hearing about traumatic experiences (e.g., rape) can cause feelings of trauma in the caregiver even though they are not the one experiencing the negative event. It is a state of exhaustion and biological, psychological, and social dysfunction (Coetzee & Klopper, 2010). Combined, both components of compassion fatigue are progressive and cumulative and can lead to severe work and health-related outcomes – such as effects that are physical (e.g., lack of energy or accident proneness), emotional (e.g., apathy), social (e.g., unresponsiveness or indifference towards customers), spiritual (e.g., disinterest in introspection), and cognitive (e.g., disorderliness) – if not relieved (Coetzee & Klopper, 2010). This process is driven by prolonged, continuous, and intense contact with customers and exposure to caregiving stressors.

Existing research supports a relationship between experiencing incivility from customers and employee burnout symptoms (e.g., Campana & Hammoud, 2015; Grandey et al., 2007). Due to the persistent relationships between job demands, such as incivility, fatigue, and strain experiences (e.g., Bakker et al., 2014; Crawford et al., 2010), and the conceptual overlap between burnout and compassion fatigue, we believe this relationship will replicate with a

caregiving-specific form of burnout (i.e., compassion fatigue). We propose that negative emotions generated due to incivility experiences may be an important reason for why repeated exposure to customer incivility may place employees at increased risk of experiencing compassion fatigue.

Like the stressor-emotion model of CWB, affective responses to workplace stressors have been suggested as important mechanisms for how stressors influence employee wellbeing (e.g., Folkman et al., 1986; Taylor et al., 2017; Weiss & Cropanzano, 1996). Stress appraisals lead to various negative emotions, as well as emotional and physical arousal (e.g., Folkman et al., 1986; Spector & Fox, 2005). Over time, this eventually leads to self-depletion or exhaustion from emotional and physical fatigue. Regarding incivility, while one single event may not be perceived as stressful, frequently experiencing incivility likely influences the extent to which these events are appraised as stressful and are associated with increased fatigue. In line with this, negative emotions from incivility experiences have been found to mediate the relationships between experiencing incivility and work outcomes, such as work withdrawal or job satisfaction (Bunk & Magley, 2013; Kabat-Farr et al., 2018; Sakurai & Jex, 2012). Applying this to the current study, we expect that incivility experiences will be related to compassion fatigue experiences due to increased negative emotions towards patients over time:

Hypothesis 2: Experienced patient incivility is positively and indirectly related to compassion fatigue through negative emotions towards patients: higher levels of experienced patient incivility is associated with increased compassion fatigue due to increased negative emotions towards patients.

The conditional role of perceived patient acuity

Given the nature of caregiving roles, it is likely these employees experience multiple job stressors occurring simultaneously. The impact of stressors on employee health and well-being outcomes is frequently researched across multiple occupations (e.g., Bowling et al., 2015; Crawford et al., 2010). However, most studies examine the collective or independent effects of multiple stressors on an outcome. The way in which multiple work demands interact to either heighten or reduce stress reactions has been less frequently studied (Jimmieson et al., 2017). Part of the stressor-emotion model of CWB relies on the stressor being appraised and perceived as stressful. Work factors have been shown to influence employees' perceptions of stressors as being a threat and, within nursing, interpersonal interactions and high patient acuity are consistently rated as threatening to wellbeing (Qureshi, 1996). In line with the stressor-emotion model of CWB, it is likely that recurring incivility experiences combined with workplace stressors, such as increased patient-based workload, can lead to a higher likelihood that the incivility will be appraised as stressful and, therefore, associated with heightened negative emotions.

A common way in which workers within the healthcare industry quantify workload is by patient acuity. Patient acuity is defined as “a measure of the severity of illness of the patient and the intensity of nursing care that patient requires” (Brennan & Daly, 2009, p. 1119). In other words, it is a system of measurement to gauge how much time, care, and/or effort a single patient will require of the caregiver. High levels of patient acuity, which often translates to high workload or work overload, is a frequent cause of stress in caregivers (e.g., Gilin Oore et al., 2010), and relates to mental health symptoms (Brotheridge, 2001), including depression and anxiety (Peterson et al., 2008), as well as fatigue (Mollica, 2020), frustration (Spector et al.,

2000), job dissatisfaction (Newton & Keenan, 1990), and physical health symptoms (Lambert et al., 2004). Within this study, we look at perceptions of patient acuity across all patients seen within a given work week as a potential stressor that may be exacerbating the negative effects of experienced incivility.

The complex and unpredictable nature of patient acuity requires heightened attention and intervention from caregiving employees (MacPhee et al., 2017). For example, a study examining multiple indicators of workload found that patient acuity was related to higher levels of emotional exhaustion in nurses, as this type of work demand requires abundant time and resources and is often outside the control of the caregivers (MacPhee et al., 2017). When considering patient acuity as an additional workload demand beyond experienced incivility, it is likely these cumulative stressors may diminish psychological resources needed to recover. In a study examining the impact of multiple stressors and incivility experiences on burnout, the authors found that increased patient acuity levels, escalated caregiver shortages, and minimal programs that reduce or buffer incidents of workplace violence can combine to create an environment where acts of incivility flourish (Clark & Springer, 2010; Babenko-Mould, & Laschinger, 2014). Therefore, we expect the interaction effects of experienced customer incivility and perceptions of patient acuity will lead to increased negative emotions towards patients and ultimately, higher levels of compassion fatigue:

Hypothesis 3: The relationship between experienced patient incivility and negative emotions towards patients is moderated by perceived patient acuity: Increased perceived patient acuity strengthens the relationship between experienced patient incivility and negative emotions towards patients.

Impacting others: incivility enacted towards customers

Early conceptualizations of workplace incivility proposed an incivility spiral occurring, where experienced incivility leads to reciprocation and increasingly severe outcomes within the interpersonal relationship (Andersson & Pearson, 1999). Although conceptually appealing, this spiral is not well-supported within the research and may be an outdated way of thinking about how incivility experiences are impacting the workplace (Cortina et al., 2017). However, moving beyond focusing on the target-perpetrator dyad, there is consistent evidence that experiencing incivility is related to a general spread of negative experiences and behaviors within the workplace (e.g., Lim & Teo, 2009; Penney & Spector, 2005; Schilpzand et al., 2016). Experiencing incivility, for example, is related to decreased performance, increased deviant behaviors, and increased negative social interactions with others at work (Chen et al., 2013; Giumetti et al., 2013; Lim & Teo, 2009; Penny & Spector, 2005; Porath & Erez, 2007; Schilpzand et al., 2016).

Outside of dyadic, events-based incivility occurrences, there is evidence that incivility experiences are related to general incivility perpetration (e.g., Gallus et al., 2014; Rosen et al., 2016; Trudel & Reio, 2011; Vahle-Hinz et al., 2019; Van Jaarsveld et al., 2010). Furthermore, these effects of experienced incivility are not constrained to immediately following the incivility incident: Vahle-Hinz and colleagues (2019) found, for example, that negative emotional and incivility enactment outcomes of an incivility experience occur after work and in following workdays. Looking specifically at customer incivility, customer-to-employee incivility is positively related to employee-to-customer incivility (Torres et al., 2017), and service events containing targeted verbal aggression from customer to employee are associated with employee incivility enactment (Walker et al., 2017). From this, it is clear that incivility experiences can

lead to increased incivility enactment. However, how these relationships play out over time, and the mechanisms through which experienced incivility can lead to future enactment, has not yet been examined, particularly through longitudinal designs. To help identify evidence-based interventions and help stop the spread of incivility within an organization, it is important that these gaps be addressed and mechanisms for why these relationships are occurring be well understood.

Affective and exhaustion reactions to incivility have been identified as mechanisms for the experienced-perpetration incivility relationships (Schilpzand et al., 2016). Unlike early proposals of the incivility spiral, revenge intentions and rumination-based negative coping behaviors following a workplace incivility experience, although occurring, are not helpful explanatory mechanisms for why experienced incivility is associated with future enacted incivility (Vahle-Hinz et al., 2019). From the stressor-emotion model of CWB, negative affective responses serve as mediating mechanisms for why interpersonal stressors, such as experienced incivility, are related to increased CWB perpetration (Spector & Fox, 2005). Supporting this, Roberts (2012) applied the stressor-emotion model of CWB to incivility and found that negative emotions were one mechanism through which organizational stressors were associated with incivility behaviors. In addition, burnout and decreased energy have been identified as mediators in the relationships between experienced incivility and job outcomes (Giumetti et al., 2013; Rahim & Cosby, 2016). Similarly, using the emotion-stressor model of CWB, Margulescu (2020) found that compassion fatigue was a predictor of CWB enactment. Brought together, research on the antecedents of incivility perpetration indicate that negative affective experiences and energy depletion are associated with increased incivility enactment (e.g., Blau & Andersson, 2005; Rosen et al., 2016). This research suggests that exposure to incivility likely drains the affective and energetic

resources of employees – making them less likely to engage in emotion regulation and more likely to have negative interpersonal interactions with others at work; however, these relationships have not been tested over time.

Like other incivility sources, experienced incivility from customers has been shown to be related to increased incivility enactment to customers (Torres et al., 2017). Negative emotions and emotional exhaustion have been suggested as mechanisms through which experienced customer incivility is related to enacted incivility towards customers (e.g., van Jaarsveld et al., 2010). Within the framework of the stressor-emotion model of CWB, Hunter and Penney (2014) found, at least cross-sectionally, that customer stressors are related to customer-directed CWB indirectly through emotion-regulation strain (which includes emotional exhaustion). However, this has not been examined longitudinally nor in conjunction to more proximal affective responses. To better understand the full process through which customer incivility is related to future incivility behaviors, we examine both emotional response and exhaustion mechanisms and examine the sequential mediation pathway from stressor to emotion to compassion fatigue to CWB over time. Based on the stressor-emotion model of CWB (Spector & Fox, 2005), experiencing incivility likely creates a buildup of negative emotions that can deplete the energetic resources of the employees, leading them to engage in more frequent negative interpersonal interactions with others at work. We therefore propose a two-step process through which experiencing incivility from customers relates to future incivility perpetration towards customers at work (see Figure 1 for the conceptual model):

Hypothesis 4: The positive relationship between experienced patient incivility and enacted incivility towards patients is indirect through negative emotions towards patients and compassion fatigue.

Methods

Participants & Procedure

The target population of this research included nurses within healthcare industries, particularly those working in high-stakes or critical care settings. Although incivility occurs across multiple service contexts, high-stakes nursing settings (e.g., emergency departments, intensive care units, operating rooms) are especially prone to workplace mistreatment due to the high-stress environment (Nikstaitis & Simko, 2014). A healthcare sample was specifically selected due to several contextual job factors that we believe are well suited to the research questions: healthcare workers are customer facing, interact in one-on-one and group settings, interact with multiple customers per shift (and with some over extended periods), and work in settings that are emotionally demanding for both employees and customers. Although the full population size that was sampled from is unknown, nursing represents a significant employment category: as of 2020, there were 2,986,500 registered nurses currently employed within the U.S., with approximately 30.9% of these employees working in hospital settings (U.S. Bureau of Labor of Statistics, 2021).

Within this context, the customers are the patients and their families. The incivility examined is therefore incivility from patients and their families (experienced incivility) and incivility towards patients and their families (enacted incivility). We view the patient-nurse relationship as a specialized form of customer-employee relationship. However, it is important to understand that this relationship includes care provision and care coordination, which is more complex and dynamic than some other employee-customer relationships. In addition, our sample includes nurses within high-stakes patient care settings. This means that this relationship (i.e., employee-customer or nurse-patient) is likely embedded within a larger social context beyond the nurse and

patient as care is commonly provided by a team of care providers (e.g., physicians, specialists, nurses, technicians...), with nurses working with multiple patients simultaneously and transferring care to other nurses at the end of their shifts. Therefore, depending on the nature of the shift and patient care needs, the length of any one patient-nurse relationship is likely brief. Finally, unlike other customer interactions, patient interactions within healthcare settings often include interactions with additional stakeholders (e.g., family members) beyond the person receiving care.

Participants were recruited from various hospitals across the U.S. using three recruitment strategies. First, we dropped off recruitment flyers with the study information at three hospitals local to the research team. At each location, we asked the manager/head of the department to post the fliers in employee common areas, such as the break room. Second, we sent emails to nurses and other healthcare professionals in our personal networks that would be willing to facilitate recruitment at their workplace and in their professional networks (approximately 20-30 healthcare professionals emailed for help recruiting). The emails contained the study flier and study information. Our goal was to have these healthcare professionals pass along our study information to colleagues or friends in order to request that those who may be interested in our study contact us or access the study via the link/QR code on the flier. Finally, we posted study information and recruitment materials online via personal social network accounts (e.g., Twitter and LinkedIn), nurse/healthcare specific forums or groups within social media networks (e.g., support group for midwest ICU nurses on Facebook), and the research team's university's hospital news forum. For all recruitment strategies, participants initiated the contact and study procedures by clicking on the study link or QR code that was listed in recruitment materials (no participant emails were obtained or used during the recruitment process). The study information

included in the recruitment fliers stated: “The purpose of the study is to investigate the influence of work experiences on employee wellbeing and success. The goal is to identify ways to optimally help support nurses. This study is a four-wave panel longitudinal design that will include administration of self-report online questionnaires (20 minutes long each) to nurses weekly for four consecutive weeks.” Information about inclusion criteria (working full time in a high-stakes/critical care setting as a nurse) and compensation were also provided along with the link to participate.

Data were collected at four time points across four consecutive weeks, with each survey administered one week apart (i.e., interval contingent sampling). Participants received a \$5 gift card for each survey they completed (with a possible \$20 total earned). The sample size and retention rates between each measurement time point were as follows: $n = 468$ nurses responded at time 1; $n = 458$ responded at time 2 (98% retention rate between T1 and T2); $n = 454$ responded at time 3 (98% retention rate between T2 and T3); and $n = 450$ responded at time 4 (98% retention rate between T3 and T4). Due to budgetary constraints, participants who did not respond to a measurement period were not invited for subsequent surveys (i.e., a participant who did not complete T2 survey was not sent the link for the T3 or T4 surveys). Participants who responded only to the T1 survey reported similar demographic information compared to those who completed all four time periods and had scale values on the key study constructs within one standard deviation of the means for the final sample of respondents who completed all four time periods – this suggests that the participants who did not complete all time periods were likely not substantially different from those included in the final sample.

Only participants who completed all four surveys ($n = 16$ people excluded due to missing time points) and whose responses passed a priori determined data quality checks ($n = 78$ people

excluded for poor data quality) were included in the final sample. Responses were considered failed data quality checks if they had any of the following characteristics: (a) demographic information was not consistent across measurement periods ($n = 56$ people failed to provide reasonably consistent responses to tenure, gender, and/or age); (b) missing values exceeded 50% of the questions ($n = 1$); or (c) duplicate responses (identical content, syntax, and formatting) to open ended attention check questions as other participants (suggesting repeat survey participation and/or collusion) ($n = 21$). This resulted in a final sample size of $N = 372$.

To help ensure that the participants were from high stakes and/or critical care contexts, we engaged in the following strategies: highlighted the high stakes/critical care focus in the recruitment and consent information; directly asked participants if they met the inclusion criteria; and included a survey item at the end of T1 survey asking about their work context, with “high stakes and/or critical care” as an option; reviewed job titles and tasks. In addition, we reviewed the O*Net job descriptions for a randomly selected group of $n = 20$ participants. Within this subsample, all 20 participants’ job titles aligned with descriptions and tasks reported by O*Net that included one of the following indicators that the care was being provided in critical care settings: “critical care,” “acute care,” “emergency,” “critically ill,” “acute conditions,” “basic life support,” or “life-threatening.”

The majority of respondents were female (96.64%), with a mean age of 34.44 ($SD = 5.49$) years. This gender distribution, although overwhelmingly female, is not atypical of the healthcare profession: around 76% of healthcare workers are women and, as of 2019, around 88% of registered nurses are women (Connor et al., 2020; U.S. Census Bureau, 2019). 74.55% of the respondents self-identified as White, 15.45% self-identified as Hispanic or Latino, 5.76% self-identified as Black, and 4.85% self-identified as Asian. The average organizational tenure

was 6.70 years ($SD = 3.08$). All participants were currently employed as a nurse (part- or full-time), worked more than one shift a week, on average, and routinely worked with high severity/high-risk patients.

Measures

Identical surveys were administered at each time point across four consecutive weeks. As an exception, demographic questions were asked solely during the first wave (T1). For each scale, the highest loading items were chosen from reported factor analytic data to maintain a reasonable survey length and achieve internal consistency reliability (Maloney et al., 2011). Because of the healthcare sample, the word “customer” was replaced with “patient” or “patient or patient family members/friends” for any scales that asked about customer interactions. For all scales, participants were prompted to respond about their experiences over the past week. We conducted two, independent exploratory pilot studies before beginning our study: (1) qualitative interviews and focus groups ($n = 6$) to develop the survey and ensure relevance/understandability of content for the target population and (2) quantitative online survey testing ($n = 50$) to ensure the material was understandable and easy to use and to provide validity evidence for the shortened scales. The qualitative pilot consisted of $n = 6$ nurses who worked in critical-care units at local hospitals and were recruited from the research team’s personal networks. The qualitative pilot questions and discussion were aimed at understanding the working experiences for these nurses, the degree to which incivility was occurring at their workplace, and perceived patient acuity measurement. The quantitative pilot consisted of $n = 50$ nurses who worked in high-stakes settings and were recruited from MTurk. The quantitative pilot

survey included all final survey items, the full scales for any shortened scales, and additional questions asking about relevance and clarity of items.

Patient Incivility. Patient incivility was assessed using four items from the Workplace Incivility Scale (WIS) developed by Cortina et al. (2001). This scale measures the extent to which employees experience discourteous, rude, or condescending behaviors in the workplace. Lim and Cortina (2005) used these four items (of the original seven) as a shortened scale to assess incivility at work and found support for the reliability and validity of this shortened version. In addition, in alignment with Gabriel et al.'s (2019) and Heggstad et al.'s (2019) recommendations for using shortened scales, we (a) reviewed the included items to ensure that the full content domain of incivility was captured, (b) solicited feedback from healthcare professionals to ensure that the behaviors in the short scale occurred frequently enough to be captured within the one week timeline, (c) assessed part-whole correlations between the full scales and shortened versions during pilot testing ($r(48) = .91, p < .001$ for experienced patient incivility and $r(48) = .93, p < .001$ for enacted patient incivility), and (d) examined the eigenvalues reported in the original scale development paper (Cortina et al., 2001) to ensure that the selected items are highly loaded onto the incivility factor. Participants were asked, "Thinking about your experiences at work during the *past week*, how often have you been in a situation where any of your *patients or patient family members/friends...*" The following items were used: "Put down or was condescending to you," "Doubted your judgment on a matter over which you had responsibility," "Paid little attention to your statements or showed little interest in your opinions," and "Made demeaning or derogatory remarks about you." Items were rated on a 5-point Likert scale ranging from 1 (Never) to 5 (Always).

Negative Emotions Towards Patients. The Negative Emotions Scale (Hornung et al., 2018) measures the frequency with which respondents feel negative emotions towards their patients. Participants were asked to rate “How often do you feel the following emotions towards patients” on a 5-point Likert-type scale ranging from 1 (Never) to 5 (Always). The scale items consisted of four negative emotions: (a) aversion, (b) disgust, (c) anger, (d) fear.

Patient Acuity. Patient acuity is a commonly used term within the healthcare sciences literature (Brennan & Daly, 2009). However, the way in which it is operationalized varies by specialty or department within a healthcare organization. Based on Brennan and Daly’s (2009) findings that the judgement of severity is a key component of patient acuity, we measure the respondents’ perceptions of patient acuity across all patients they attended to within the last work week by asking them to estimate a percentage of their patients that were “severe.” To help standardize judgements of severity, we built our question around existing workplace patient acuity indicators (i.e., “based on your department’s patient acuity scale...”). Because participants were all required to work within some level of critical care or high-stakes setting, they were asked to rate, “Based on your department's patient acuity scale (i.e., the measure you use to determine the severity of your patient's condition), what percentage of patients under your care in the past week would be considered "severe"? Some example scales include: the Emergency Severity Index (ESI), the Clinical Risk Index for Babies (CRIB), the Severity of Illness Scale (SOIS), or other patient-reported outcome (PRO) assessment tools”.

To develop our perceived patient acuity measure, we first discussed patient acuity measurement strategies with our qualitative pilot participants via small focus groups and individual interviews. We explained that we were interested in assessing the severity of health issues their patients generally face. We initially suggested asking about the ESI (Emergency

Severity Index, typically used within Emergency Room (ER) settings). However, only around 50% of respondents were familiar with it or thought that all critical-care nurses would be familiar with it. So, based on suggestions that arose in the focus groups, the type of patient acuity scale was expanded to include all common critical care severity indexes (e.g., ESI, CRIB, SOIS, or other PRO tools). Following the survey development, we tested this new item within the quantitative pilot study. In this, the item was followed by two questions asking (1) if they understood and felt capable of accurately responding to the perceived patient acuity item and (2) if the item was applicable/relevant based on their own patient interactions. For the quantitative pilot, all participants provided an answer to the perceived patient acuity question, responded that they felt capable of accurately responding to the item, and that it was applicable to their patients.

Compassion Fatigue. The Compassion Fatigue-Short Scale (Adams et al., 2006) asked participants, “Please indicate how often you experience the following at your job.” The scale consisted of 13 items, rated on a 5-point Likert-type scale ranging from 1 (Never) to 5 (Always). Example items include “I have felt a sense of hopelessness associated with working with patients” and “I am losing sleep over a patient’s traumatic experiences.”

Enacted Incivility. Four items from the Enacted Incivility Scale (Cortina et al., 2001) were used to measure the frequency participants instigated incivility towards their patients. The item content for these four items was similar to the four items used in the customer incivility scale, with changes to the instructions that prompted participants to respond about how they behaved towards their patients (instead of how their patients behaved towards them). Our quantitative pilot testing results indicated that these behaviors are applicable to the patient context: 100% of respondents indicated that these behaviors could occur in nurse-patient interactions and 90% of respondents indicated that they personally had engaged in these

behaviors towards patients or their families. This subset of four items have been previously used to assess enacted incivility (Rosen et al., 2016). Participants were asked, “Thinking about your interactions with *patients* during the *past week*, how often have you...?” The following items were used: “Put down one or more patients/patient family members or acted condescendingly towards them,” “Doubted one or more patient’s/patient family members’ judgment on a matter over which they had responsibility,” “Paid little attention to one or more patient’s/patient family members’ statements or showed little interest in their opinions,” and “Made demeaning or derogatory remarks about one or more patients/patient family members.” Responses were rated on a 5-point Likert-type scale ranging from 1 (Never) to 5 (Always).

Analytic Strategy

We tested our hypotheses using data collected across four waves separated by one-week lags. Previous studies have shown that lags spanning this length of time are sufficient for observing emergence of such counterproductive behaviors as incivility and that the observed effects will not meaningfully differ from studies featuring longer periods of time between waves (Meier & Spector, 2013; Shoss et al., 2018). To better understand the effect of the predictor variables on the criterion variable at the subsequent time point, we assessed each variable during each wave. This allowed us to assess stability over time by modeling the autocorrelations (AR1) between each variable and its prior occasions and the covariances between all variables (including controls) within each wave (Liu et al., 2016). Because it was impossible to account for same or other variable effects prior to the first time point in our study, the first wave was reserved for controlling for autoregressive effects, and the subsequent waves were included for hypothesis testing (see Figure 1 for information what measurement period each variable in the model was taken from). As such, the first time point is modeled to control for baseline effects in the

regression model in the second through fourth waves. This autoregressive mediation approach (Cole & Maxwell, 2003) has been adopted in other studies (e.g., Baillien et al., 2019) and features an added benefit of minimizing over- or underestimation (Selig & Preacher, 2009). This method also supports a lower likelihood of third variable effects (Bliese et al., 2020; Cole & Maxwell, 2003; Duncan et al., 2004) and allows for stronger causal inferences by modeling the longitudinal effects of predictors across multiple points in time. Finally, our multiwave approach allows for temporal separation of each measure in our hypothesized model, thus reducing the likelihood of bias commonly ascribed to survey data (Podsakoff et al., 2003, 2012; Spector et al., 2019).

Next, we followed procedures described by Edwards and Lambert (2007), Hayes (2015, 2017), Preacher et al. (2007), and Selig and Preacher (2009) to estimate direct and indirect effects at each stage of the simple and moderated mediation models. Predictors in the moderated mediation model were centered at their respective grand means. We then used a Monte Carlo simulation with 20,000 replications (Zyphur et al., 2016) to construct confidence intervals around the parameter estimates of all indirect effects and the Index of Moderated Mediation (IMM). The Monte Carlo simulation addresses potential imbalances in confidence limits by simulating a population distribution using the sample parameter estimates (Mackinnon et al., 2004). This approach is increasingly featured in recently published work (da Motta Veiga & Gabriel, 2015; Koopman et al., 2016; Lanaj et al., 2014).

Before evaluating our hypotheses, we investigated the discriminant validity of our measures by employing a series of confirmatory factor analyses. First, we assessed our hypothesized four-factor model absent of the temporal control measures. We applied procedures recommended by Nye and Drasgow (2011) to model the data at the item-level using WLSMV in MPlus 8.0. The

fit of the four-factor model was acceptable ($\chi^2(269) = 862.05$, RMSEA = .08, CFI = .99, TLI = .99) and fit the data better than a three-factor model wherein both incivility measures were set to load onto the same factor ($\Delta\chi^2(3) = 82.52$, RMSEA = .09, CFI = .98, TLI = .98), a two-factor model wherein both incivility measures were loaded onto one factor and negative emotions towards patients and compassion fatigue were loaded onto the second factor ($\Delta\chi^2(2) = 82.65$, RMSEA = .10, CFI = .98, TLI = .98), and a one-factor model ($\Delta\chi^2(1) = 8.02$, RMSEA = .10, CFI = .98, TLI = .98).

Finally, our perceived patient acuity measure had missing data. For missing cases, responses were either left blank (55% of missing values were due to no-response) or the value provided was outside of the expected numerical range (45% of missing values were due to an incorrect response). However, a comparison of personal demographics and workplace characteristics did not find any significant differences between participants with and without missing values for perceived patient acuity.

Results

Table 1 presents intercorrelations among study variables and descriptive information. An overview of the results, as they relate to our hypothesized model, can be viewed in Figure 2. Hypothesis 1 predicted a positive relationship between experienced patient incivility and negative emotions towards patients. We tested this hypothesis by regressing negative emotions toward patients (T3) onto experienced patient incivility (T2). As predicted and in support of Hypothesis 1, experienced patient incivility was positively related to negative emotions toward patients ($B = .26$, $SE = .06$, $p < .001$).

Hypothesis 2 predicted that the positive relationship between experienced patient incivility and compassion fatigue was indirect through negative emotions towards patients. Hypothesis 1

established support for the first step (path a) in this relationship. In the second step (path d), Time 3 negative emotions toward patients were positively related to Time 4 compassion fatigue ($B = .37, SE = .04, p < .001$). We then used MPlus' model constraint feature to estimate the indirect path $a \times d$. In support of Hypothesis 2, the positive indirect relationship between experienced patient incivility and compassion fatigue through negative emotions was significant ($B = .07, SE = .03, p < .05, 95\% CI [0.02, 0.14]$). Of note, the direct relationship between experienced patient incivility and compassion fatigue was also significant ($B = .13, SE = .03, p < .001$).

Hypothesis 3 predicted that the first stage of the relationship (experienced incivility related to negative emotions towards patients) between experienced incivility and compassion fatigue would be moderated by perceived patient acuity. Results revealed that the *Time 2 experienced incivility* \times *Time 2 perceived patient acuity* interaction term was significant ($B = .34, SE = .12, p < .01$). Hypothesis 3 also predicted that the conditional relationship would be such that employees reporting higher perceived patient acuity would also report higher negative emotions. Simple slope analysis estimates at low ($B = .13, SE = .12, p = .26, 95\% CI [-0.10, 0.35]$), medium ($B = .22, SE = .09, p < .05, 95\% CI [0.04, 0.40]$), and high ($B = .32, SE = .08, p < .001, 95\% CI [0.17, 0.46]$) levels of the moderator revealed support for Hypothesis 3. Figure 3 provides visual confirmation of these results.

Finally, Hypothesis 4 predicted that experienced patient incivility would be positively indirectly related to enacted incivility toward patients through negative emotions toward patients and compassion fatigue. Here, the indirect effect was estimated by multiplying each stage in the serial mediation process ($a \times b \times d$). As expected, Time 2 experienced patient incivility was

indirectly related to Time 4 enacted incivility toward patients ($B = .06$, $SE = .04$, $p < .01$, 95% CI [0.02, 0.10]).

Supplemental analyses. We conducted a series of supplemental analyses to 1) address unhypothesized moderation effects and 2) investigate the relationship between compassion fatigue and enacted incivility.

Support for Hypothesis 3 provided preliminary support for a conditional indirect effect. Combining Hypothesis 3 and Hypothesis 4, we would expect the positive indirect relationship between experienced incivility and enacted incivility to be strengthened by higher levels of perceived patient acuity. We evaluated this expectation by estimating the conditional indirect effect at low, medium, and high levels of the moderator. Interestingly, our expectations were not supported as the slopes at low ($B = .02$, $SE = .02$, $p = .35$, 95% CI [-0.01, 0.06]), medium ($B = .03$, $SE = .02$, $p = .16$, 95% CI [-0.03, 0.08]), and high levels ($B = .04$, $SE = .03$, $p = .12$, 95% CI [-0.01, 0.10]) of perceived patient acuity were all non-significant. Hayes (2015) recommends estimation of the index of moderated mediation to verify the indirect effect is conditional upon the proposed moderator. Further confirming the above results, the IMM was non-significant ($B = .04$, $SE = .03$, $p = .15$, 95% CI [-0.01, 0.11]). Taken together, these results reveal the indirect effect is not conditional upon perceived patient acuity.

Next, we turn to our investigation of the relationship between compassion fatigue and enacted incivility. As seen in Table 2, the last step of the simple mediation reflects a parameter estimate for compassion fatigue that is nearly six times that of negative emotions. Because regression only provides information on how much scores a given outcome change following a single unit change in a given predictor, we conducted a relative importance analysis to understand the proportion of variance each predictor accounts for in enacted incivility

(Tonidandel & LeBreton, 2011). First, using the native *lm()* function in R (R Core Team, 2021), we regressed enacted incivility on predictors from this stage--experienced incivility ($B = -.03$, $SE = .04$, $p = .40$), negative emotions ($B = .23$, $SE = .04$, $p < .001$), and compassion fatigue ($B = .23$, $SE = .04$, $p < .001$). Next, we used the *relaimpo* package in R (Grömping, 2006) to estimate the relative importance metrics based on the regression model parameter estimates. The results revealed compassion fatigue, negative emotion, and experienced incivility accounted for 45.1%, 30.8%, and 24.1% of the variance in enacted incivility, respectively.

Discussion

Using a four-wave data collection of service employees within the healthcare industry, we examined how and why experiencing incivility from patients is related to future enactment of incivility towards patients. Our results support a partial mediation process: in support of our hypotheses, experiencing incivility from patients was related to increased future incivility enactment towards patients indirectly through increased negative emotions towards patients and compassion fatigue. Further, the presence of an additional job stressor (i.e., perceived patient acuity) exacerbates the negative relationship between experienced incivility and negative affective responses (the first step in the tested mediation pathway). These findings align with the stressor-emotion model of CWB and provide evidence for a serial mediation mechanism whereby patient incivility experiences are related to future employee customer service behavior through a sequence of service-oriented affective and energetic responses.

Implications for Theory

Our study shows that people experiencing high levels of incivility from patients are more likely to be suffering negative affective and energetic outcomes and, ultimately, more likely to be perpetrators of incivility. These findings are consistent with the stressor-emotion model of CWB:

job stressors (experienced incivility from patients) are related to emotion-based responses (negative emotions towards patients) and energetic depletions (compassion fatigue) which are then related to CWB performance (enacted incivility towards patients). Moreover, our results suggest that multiple environmental, interpersonal stressors (experienced incivility from patients and perceived patient acuity) interact to influence the way incivility stressors and strain relate to each other. Although supported by the stressor-emotion model and prior research, the full process model, including both proximal and distal mechanisms had not been previously examined. Using a longitudinal design, our study provides evidence for how the stressor-emotion model of CWB plays out over time and the way in which the experienced-enacted incivility relationship with patients is occurring across work weeks. Furthermore, consistent with hassle perspectives of incivility (e.g., Sliter et al., 2010), our results suggest that continued exposure to incivility from patients is a serious job demand and stressor. Over time, experiencing incivility from patients is related to disruptions in mood, energy, and behavior. This is consistent with the stressor-emotion model of CWB and research on chronic stressors that suggests that these types of stressors are best at predicting which employees are likely to engage in negative workplace behaviors. Our results suggest that employees experiencing high levels of incivility from patients are more likely to engage in future incivility behaviors, and that this process unfolds over time through affective and energetic processes.

Our research answers the call of Meier and Spector (2013) and Hunter and Penney (2014) to better examine the underlying mechanisms that link job stressors and CWB. By looking at these relationships over time, we find that the effect of incivility experiences from patients exists across work weeks and impacts future behaviors through emotion and fatigue processes. Further, our results suggest that while the emotion response is an important proximal response to

incivility experiences, the subsequent compassion fatigue response is a stronger driver of enacted incivility. This builds on the stressor-emotion model of CWB by adding additional clarity on the ways in which emotion responses are translating into workplace behaviors. Our results suggest that the resulting fatigue and burnout symptoms that can occur due to prolonged exposure to job stressors and negative emotions is an important component of why emotions are related to CWB behaviors. In addition, these processes can be exacerbated when nurses are also perceiving high patient care-related demands, suggesting that nurses are at increased risk of the negative emotional processes and behaviors when they are simultaneously experiencing interpersonal (i.e., experienced customer incivility) and task-related (i.e., perceived patient acuity) stressors.

Furthermore, although we use a healthcare specific population, our findings that incivility experiences from customers are negatively related to employee wellbeing (i.e., increased negative emotions and fatigue) are consistent with research using samples in other service sectors (e.g., Arnold & Walsh, 2015). Examining perceived patient acuity as an additional workplace demand, the findings add to the literature that multiple demands examined simultaneously lead to harmful employee outcomes through the role of stress appraisals (Jimmieson et al., 2017). This adds to the generalizability of prior customer incivility research to further support that experiencing incivility from customers – even when the customers are patients, a population of people you have dedicated your career to care for – is associated with detrimental employee and customer outcomes over time.

Our study suggests that the experienced-enacted incivility relationship unfolds over time and that experienced incivility can have lasting effects beyond the work week they are experienced in. Although the stressor-emotion model of CWB and most incivility research assumes longitudinal relationships, assessment of the relationship and processes for experienced-enacted

incivility are not often tested that way. Supplementing cross-sectional and experience sampling methodologies, we find support for a longer-term impact of incivility that needs to be better addressed in theory and future research. Our findings of the over time experience of incivility outcomes suggests that we need to expand our view on incivility to more closely examine how these experiences build, accumulate, and are recovered from.

Implications for Practice

Incivility perpetrated by employees is not supportive of successful organizational functioning, with high costs to both the targets and witnesses of the incivility (Cortina et al., 2017; Schilpzand et al., 2016). Because of this, understanding which employees may be at higher risk for perpetrating incivility and the mechanisms for why this may be occurring is necessary to help provide important resources to stop the process from occurring, even if we cannot stop the incivility from the customers. Our results directly support this. Our findings suggest that nurses experiencing incivility from their patients are at higher risk of experiencing negative affective and energetic outcomes and that they may be more likely to engage in future incivility enactment. Thus, when building targeted interventions for wellness, incivility, or customer service, employees facing high levels of incivility from customers are likely an important target population. Organizations should identify who is experiencing high levels of incivility and develop support systems and interventions for these employees to stop the negative affective and energetic process our results suggest are occurring.

Our results also support that incivility experiences from customers (something that is largely out of the organization's control) are related to future mistreatment of customers. Within healthcare, this (combined with high workloads and increased feelings of compassion fatigue) could mean decreased quality care provision. Moreover, some job demands, such as patient

acuity, are also out of the organization's control and not immediately changeable by the employee. Together, our results suggest that employees experiencing incivility from patients and who have a high perceived patient acuity load are at the highest risk of experiencing increased negative affect and fatigue and, ultimately, engaging in incivility. Because customer incivility and patient acuity are not easily changed, employees experiencing high levels of these job stressors likely need additional support to prevent the cascade of negative affective, energetic, and behavioral outcomes that our results suggest occurs. For example, prior research has found that establishing a work unit that encourages civility and respect can provide a supportive environment for employees to function optimally despite multiple stressors (Gilin Oore et al., 2010). Because incivility from customers is likely a common experience for employees in the service industries, providing resources that can help buffer the negative effects of experienced incivility is likely vital to support employees and stop this negative downstream impact on customer service/care that our study found.

Limitations and Future Directions

This study has several limitations that should be discussed. First, our data were collected using self-report questionnaires. Self-report was specifically utilized to allow us to capture the experiences of incivility, which are often subtle and harder to accurately observe, affective experiences, and compassion fatigue experiences – all of which the individual is likely the best source of information. Whereas prominent stress models (i.e., Hobfoll, 2011; Lazarus & Folkman, 1984; Spector & Fox, 2005) contend that outcomes of environmental stressors are primarily determined by the subjective experience (perception), using a single source can raise concerns associated with common method variance (Podsakoff et al., 2003). To help minimize the impact of common method variance, we adopted a measure- and design-centric approach to

minimize potential common method issues (Spector et al., 2019). Specifically, we temporally separated the measurement of variables across four measurement periods, used validated scales, and ensured respondents of the confidentiality of their results (Conway & Lance, 2010; Podsakoff et al., 2003; Podsakoff et al., 2012; Spector et al., 2019).

Incorporating multi-source information in future research would not only help address the role of common method variance within the current model but also allow for additional, follow up questions to be answered about the nature and frequency of the experienced-enacted incivility relationships. For example, building off our findings, it would be interesting to see how customers are perceiving and reacting to the negative emotions and incivility enactment towards them that our respondents indicated were occurring. Alternatively, comparisons of affective responses between incivility targets and that of bystanders in a deontic justice (Folger, 2001) framework would help build a more holistic perspective of how incivility is occurring at work. Recent research reveals that observers experience similar negative emotions as targets, can become aggressive toward instigators, and generally favorably evaluate and engage targets of observed incivility behavior (Reich & Herschovis, 2015). Future investigations should investigate the parallel (or intersecting) experiences of targets and observers to further unpack the environmental experience of incivility.

Second, although a notable strength of our design is the longitudinal framework, we did not assess negative emotions or compassion fatigue immediately following an experienced incivility event. We purposefully chose this measurement strategy to align with the persistent hassle view of incivility (where it isn't any particular instance of incivility but rather a consistent exposure that drives outcomes) and to better capture how being embedded in uncivil environments impacts employee experiences over time instead of focusing on specific incivility occurrences. Because

individual perceptions and subsequent processing of events can vary from moment to moment (Beal, 2011; Fisher & To, 2012), future studies can build off of our findings by utilizing an experience sampling approach to capture variability in the emotional experience and how these micro-experiences add up over time. However, experience sampling methodology requires multiple daily measurements (i.e., survey or diary) over a predetermined window of time. Because this type of design is highly dependent on the temporal order of measures—meaning measurement should occur following the affective event—this approach may be less practical for some job types (i.e., nurses). Additionally, diary studies of this nature may produce inflated correlations between variables within and across points in time due to the within-focused nature of the design (Beal, 2015). We acknowledge this particular issue in this study as some of the bivariate relationships are higher than convention. Future researchers may address this particular issue by integrating a latent multilevel framework that reduces potential serial and inflation effects by employing a within design that centers variables on the individual mean (Beal, 2015; Gabriel et al., 2019).

Third, another limitation to the longitudinal design of this study is the chance that an employee may continue an uncivil relationship with certain patients across various time points (i.e., via retribution pathways). Our theoretical framework and hypotheses did not incorporate interpersonal relationships and may not be reflective of direct experienced-enacted relationships if they existed. However, although we are not able to directly assess this for the current sample, we do not believe this is very likely due to the nature of the profession. Nurses frequently engage with patient handoffs (i.e., "transfer of essential information and the responsibility for care of the patient from one health care provider to another", Friesen et al., 2008, p. 285) either to the next nurse on shift, other nursing units, or other facilities. To illustrate the frequency of handoffs,

some nursing units may hand off approximately 40-70% of their patients every day (Hendrich et al., 2004). Continuity of care for patients is not very common in healthcare, in fact, there is substantial literature investigating solutions to increasing this practice (e.g., Raddish et al., 1999; Van Servellen et al., 2006). In combination with condensed 3-day work weeks (Merrifield, 2017) and an average length of stay for all hospitals at 6.1 days (CDC, 2016), the likelihood that participants would be treating the same patients at multiple time points is very unlikely. However, it is important to note this could be a circumstance to evaluate, and it would be interesting to see if the same emotion-based process we found is at play when specifically dealing with the same patients over time.

Fourth, we focus our study on a healthcare sample, which may not generalize fully to other service-oriented jobs. The healthcare sample was specifically selected due to the frequency of customer (i.e., patient) interactions. However, the focus on healthcare workers, and specifically on nurses, could limit generalizability of the findings to employees outside of this field or role. Nurses, for example, are often women (U.S. Census Bureau, 2019) and often have limited authority within the healthcare structure. It is possible that the effects found are exacerbated or influenced by power dynamics specific to nurses that are beyond the employee-customer relationship. Moving forward, it will be helpful to replicate and extend this work by looking at these relationships beyond healthcare and nursing samples.

Finally, our results suggest that high perceived patient acuity over a work week may be an exacerbating condition that can worsen the impact of experiencing incivility on employee well being and behavior. These findings provide preliminary support for the idea that feeling like you are working with a high proportion of severe patients can be an additional job demand that can interact with other social stressors. However, our measure of patient acuity was a self-report

perception-based item where we asked people to report a judgement on the proportion of patients they saw that they considered severe. Although we prompted the respondent to think about their workplace's patient acuity assessments, we did not ask them to report on the specific assessment used, number of patients seen in that week, or the number of patients that were actually classified as severe within their assessment tool. Therefore, their responses represent a perceived acuity load and may not necessarily reflect actual acuity numbers. To build off of our findings, future research should dive deeper into patient-based job demands through the use of objective data and more detailed reporting from respondents.

Conclusion

The purpose of this four-wave study was to examine the trickle-down effects of experiencing customer incivility (a common occurrence within the service industries) to understand how incivility experiences are related to future emotions, resource depletions, and behaviors. Our results suggest that experiencing incivility from customers can have negative downstream costs for how future customers are treated. Understanding the necessary supports to minimize the occurrence of customer incivility and employee resources associated with increased resilience is an important next step in advancing reciprocal incivility research and informing practice.

References

- Adams, R. E., Boscarino, J. A., & Figley, C. R. (2006). Compassion fatigue and psychological distress among social workers: A validation study. *American Journal of Orthopsychiatry*, 76(1), 103-108.
- Andersson, L. M., & Pearson, C. M. (1999). Tit for tat? The spiraling effect of incivility in the workplace. *Academy of Management Review*, 24, 452–471.
- Arnold, K. A., & Walsh, M. M. (2015). Customer incivility and employee well-being: Testing the moderating effects of meaning, perspective taking and transformational leadership. *Work and Stress*, 29, 362–378.
- Babenko-Mould, Y., & Laschinger, H. K. S. (2014). Effects of incivility in clinical practice settings on nursing student burnout. *International Journal of Nursing Education Scholarship*, 11(1), 145-154.
- Baillien, E., Griep, Y., Vander Elst, T., & De Witte, H. (2019). The relationship between organisational change and being a perpetrator of workplace bullying: A three-wave longitudinal study. *Work & Stress*, 33(3), 211-230.
- Bakker, A. B., & Demerouti, E. (2017). Job demands–resources theory: Taking stock and looking forward. *Journal of Occupational Health Psychology*, 22(3), 273.
- Bakker, A. B., Demerouti, E., & Sanz-Vergel, A. I. (2014). Burnout and work engagement: The JD–R approach. *Annual Review of Organizational Psychology and Organizational Behavior*, 1. 389-411.
- Beal, D. J. (2011). Industrial/organizational psychology. In M. R. Mehl, & T. A. Conner (Eds.), *Handbook of research methods for studying daily life* (pp. 601–619). New York, NY: Guilford Press.

- Beal, D. J. (2015). ESM 2.0: State of the art and future potential of experience sampling methods in organizational research. *Annual Review of Organizational Psychology and Organizational Behavior*, 2(1), 383–407.
- Blau, G., & Andersson, L. (2005). Testing a measure of instigated workplace incivility. *Journal of Occupational and Organizational Psychology*, 78(4), 595-614.
- Bliese, P. D., Schepker, D. J., Essman, S. M., & Ployhart, R. E. (2020). Bridging methodological divides between macro- and microresearch: Endogeneity and methods for panel data. *Journal of Management*, 46(1), 70–99.
- Bowling, N. A., Alarcon, G. M., Bragg, C. B., & Hartman, M. J. (2015). A meta-analytic examination of the potential correlates and consequences of workload. *Work & Stress*, 29(2), 95-113.
- Brennan, C. W., & Daly, B. J. (2009). Patient acuity: A concept analysis. *Journal of Advanced Nursing*, 65(5), 1114-1126.
- Brotheridge, C. M. (2001). A comparison of alternative models of coping: Identifying relationships among coworker support, workload, and emotional exhaustion in the workplace. *International Journal of Stress Management*, 8(1), 1-14.
- Bunk, J. A., & Magley, V. J. (2013). The role of appraisals and emotions in understanding experiences of workplace incivility. *Journal of Occupational Health Psychology*, 18(1), 87-105.
- Campana, K. L., & Hammoud, S. (2015). Incivility from patients and their families: Can organisational justice protect nurses from burnout? *Journal of Nursing Management*, 23(6), 716-725.

- Carlson, D., Kacmar, K. M., Zivnuska, S., Ferguson, M., & Whitten, D. (2011). Work-family enrichment and job performance: A constructive replication of affective events theory. *Journal of Occupational Health Psychology, 16*(3), 297.
- Chen, Y., Ferris, D. L., Kwan, H. K., Yan, M., Zhou, M., & Hong, Y. (2013). Self-love's lost labor: A self-enhancement model of workplace incivility. *Academy of Management Journal, 56*(4), 1199-1219.
- Clark, C. M., & Springer, P. J. (2010). Academic nurse leaders' role in fostering a culture of civility in nursing education. *Journal of Nursing Education, 49*(6), 319-325.
- Coetsee, S. K., & Klopper, H. C. (2010). Compassion fatigue within nursing practice: A concept analysis. *Nursing & Health Sciences, 12*(2), 235-243.
- Cole, D. A., & Maxwell, S. E. (2003). Testing mediational models with longitudinal data: Questions and tips in the use of structural equation modeling. *Journal of Abnormal Psychology, 112*(4), 558-577.
- Connor, J., Madhavan, S., Mokashi, M., Amanuel, H., Johnson, N. R., Pace, L. E., & Bartz, D. (2020). Health risks and outcomes that disproportionately affect women during the Covid-19 pandemic: A review. *Social Science & Medicine, 113364*.
- Conway, J. M., & Lance, C. E. (2010). What reviewers should expect from authors regarding common method bias in organizational research. *Journal of Business and Psychology, 25*(3), 325-334.
- Cortina, L. M., Kabat-Farr, D., Magley, V. J., & Nelson, K. (2017). Researching rudeness: The past, present, and future of the science of incivility. *Journal of Occupational Health Psychology, 22*(3), 299.

- Crawford, E. R., Lepine, J. A., & Rich, B. L. (2010). Linking job demands and resources to employee engagement and burnout: A theoretical extension and meta-analytic test. *Journal of Applied Psychology, 95*, 834 – 848.
- Cortina, L. M., Magley, V. J., Williams, J. H., & Langhout, R. D. (2001). Incivility in the workplace: Incidence and impact. *Journal of Occupational Health Psychology, 6*(1), 64.
- Duncan, G. J., Magnuson, K. A., & Ludwig, J. (2004). The endogeneity problem in developmental studies. *Research in Human Development, 1*(1–2), 59–80.
- Edwards, J. R., & Lambert, L. S. (2007). Methods for integrating moderation and mediation: A general analytical framework using moderated path analysis. *Psychological Methods, 12*(1), 1–22.
- Figley C. R. (2002). Compassion fatigue: Psychotherapists' chronic lack of self-care. *The Journal of Psychotherapy Practice and Research, 58*, 1433–1441.
- Finzi-Dottan, R., & Kormosh, M. B. (2018). The spillover of compassion fatigue into marital quality: A mediation model. *Traumatology, 24*(2), 113-122.
- Fisher, C. D., & To, M. L. (2012). Using experience sampling methodology in organizational behavior. *Journal of Organizational Behavior, 33*(7), 865-877.
- Folger, R. (2001). Fairness as deonance. In S. W. Gilliland, D. D. Steiner, & D. P. Skarlicki (Eds.), *Research in social issues in management: vol. 1*, pp. 3-33. New York: Information Age Publishers
- Folkman, S., Lazarus, R. S., Dunkel-Schetter, C., DeLongis, A., & Gruen, R. J. (1986). Dynamics of a stressful encounter: Cognitive appraisal, coping, and encounter outcomes. *Journal of Personality and Social Psychology, 50*(5), 992.

- Friesen M. A., White S. V., Byers J. F. (2008). Handoffs: Implications for nurses. In: Hughes R. G. (Ed.), *Patient safety and quality: An evidence-based handbook for nurses*. Rockville (MD): Agency for Healthcare Research and Quality (US).
<https://www.ncbi.nlm.nih.gov/books/NBK2649/>
- Gabriel, A. S., Podsakoff, N. P., Beal, D. J., Scott, B. A., Sonnentag, S., Trougakos, J. P., & Butts, M. M. (2019). Experience sampling methods: A discussion of critical trends and considerations for scholarly advancement. *Organizational Research Methods*, 22(4), 969-1006.
- Gallus, J. A., Bunk, J. A., Matthews, R. A., Barnes-Farrell, J. L., & Magley, V. J. (2014). An eye for an eye? Exploring the relationship between workplace incivility experiences and perpetration. *Journal of Occupational Health Psychology*, 19(2), 143.
- Gilin Oore, D. E. B. R. A., Leblanc, D., Day, A., Leiter, M. P., Laschinger, H. K. S., Price, S. L., & Latimer, M. (2010). When respect deteriorates: incivility as a moderator of the stressor–strain relationship among hospital workers. *Journal of Nursing Management*, 18(8), 878-888.
- Giumetti, G. W., Hatfield, A. L., Scisco, J. L., Schroeder, A. N., Muth, E. R., & Kowalski, R. M. (2013). What a rude e-mail! Examining the differential effects of incivility versus support on mood, energy, engagement, and performance in an online context. *Journal of Occupational Health Psychology*, 18(3), 297.
- Grandey, A. A., Kern, J. H., & Frone, M. R. (2007). Verbal abuse from outsiders versus insiders: Comparing frequency, impact on emotional exhaustion, and the role of emotional labor. *Journal of Occupational Health Psychology*, 12(1), 63.

- Hayes, A. F. (2015). An index and test of linear moderated mediation. *Multivariate Behavioral Research*, 50(1), 1–22.
- Hayes, A. F. (2017). Introduction to mediation, moderation, and conditional process analysis, second edition: A regression-based approach (Second). Guilford Publications.
- Heggestad, E. D., Scheaf, D. J., Banks, G. C., Monroe Hausfeld, M., Tonidandel, S., & Williams, E. B. (2019). Scale adaptation in organizational science research: A review and best-practice recommendations. *Journal of Management*, 45(6), 2596-2627.
- Hendrich, A. L., Fay, J., Sorrells, A. K. (2004). Effects of acuity-adaptable rooms on flow of patients and delivery of care. *American Journal of Critical Care*, 13, 35–45.
- Hershcovis, M. S., Ogunfowora, B., Reich, T. C., & Christie, A. M. (2017). Targeted workplace incivility: The roles of belongingness, embarrassment, and power. *Journal of Organizational Behavior*, 38(7), 1057-1075.
- Hobfoll, S. E. (1989). Conservation of resources: A new attempt at conceptualizing stress. *American Psychologist*, 44(3), 513–524.
- Hobfoll, S. E. (2011). Conservation of resource caravans and engaged settings. *Journal of Occupational and Organizational Psychology*, 84(1), 116–122.
- Hornung S., Lampert B., Weigl M., Glaser J. (2018) Modeling self-determination in emotional labor: Stressful patient interactions, emotion regulation, and burnout in geriatric nursing. In V. Duffy & N. Lightner (eds.) *Advances in Human Factors and Ergonomics in Healthcare and Medical Devices*, Vol. 590 (pp. 180-192). Springer.
- Hunter, E. M., & Penney, L. M. (2014). The waiter spit in my soup! Antecedents of customer-directed counterproductive work behavior. *Human Performance*, 27(3), 262-281.

- Hülshager, U. R., van Gils, S., & Walkowiak, A. (2021). The Regulating Role of Mindfulness in Enacted Workplace Incivility: An Experience Sampling Study. *Journal of Applied Psychology, 106*(8), 1250-1265
- Jimmieson, N. L., Tucker, M. K., & Walsh, A. J. (2017). Interaction effects among multiple job demands: an examination of healthcare workers across different contexts. *Anxiety, Stress, & Coping, 30*(3), 317-332.
- Joinson, C. (1992). Coping with compassion fatigue. *Nursing, 22*(4), 116-118.
- Kabat-Farr, D., Cortina, L. M., & Marchiondo, L. A. (2018). The emotional aftermath of incivility: Anger, guilt, and the role of organizational commitment. *International Journal of Stress Management, 25*(2), 109-128.
- Kern, J. H., & Grandey, A. A. (2009). Customer incivility as a social stressor: The role of race and racial identity for service employees. *Journal of Occupational Health Psychology, 14*, 46–57.
- Kim, T.-Y., & Shapiro, D. (2008). Revenge against supervisor mistreatment: Negative emotion, group membership, and crosscultural difference. *International Journal of Conflict Management, 19*, 339–358.
- Lambert, V. A., Lambert, C. E., Itano, J., Inouye, J., Kim, S., Kuniviktikul, W., ... & Ito, M. (2004). Cross-cultural comparison of workplace stressors, ways of coping and demographic characteristics as predictors of physical and mental health among hospital nurses in Japan, Thailand, South Korea and the USA (Hawaii). *International Journal of Nursing Studies, 41*(6), 671-684.

- Lanaj, K., Johnson, R. E., & Barnes, C. M. (2014). Beginning the workday yet already depleted? Consequences of late-night smartphone use and sleep. *Organizational Behavior and Human Decision Processes*, *124*(1), 11-23.
- Lazarus, R.S. & Folkman. (1984). Stress, appraisal, and coping. Michigan. Springer Press
- LeBlanc, M. M., & Kelloway, E. K. (2002). Predictors and outcomes of workplace violence and aggression. *Journal of Applied Psychology*, *87*(3), 444.
- Lim, S., & Cortina, L. M. (2005). Interpersonal mistreatment in the workplace: the interface and impact of general incivility and sexual harassment. *Journal of Applied Psychology*, *90*(3), 483-496.
- Lim, S., Cortina, L. M., & Magley, V. J. (2008). Personal and workgroup incivility: Impact on work and health outcomes. *Journal of Applied Psychology*, *93*(1), 95.
- Lim, S., & Lee, A. (2011). Work and nonwork outcomes of workplace incivility: Does family support help?. *Journal of Occupational Health Psychology*, *16*(1), 95.
- Lim, V. K., & Teo, T. S. (2009). Mind your E-manners: Impact of cyber incivility on employees' work attitude and behavior. *Information & Management*, *46*(8), 419-425.
- Liu, Y., Mo, S., Song, Y., & Wang, M. (2016). Longitudinal analysis in occupational health psychology: A review and tutorial of three longitudinal modeling techniques. *Applied Psychology*, *65*(2), 379-411.
- MacKinnon, D. P., Lockwood, C. M., & Williams, J. (2004). Confidence limits for the indirect effect: Distribution of the product and resampling methods. *Multivariate Behavioral Research*, *39*(1), 99-128.
- MacPhee, M., Dahinten, V. S., & Havaei, F. (2017). The impact of heavy perceived nurse workloads on patient and nurse outcomes. *Administrative Sciences*, *7*(1), 7.

- Maloney, P., Grawitch, M. J., & Barber, L. K. (2011). Strategic item selection to reduce survey length: Reduction in validity? *Consulting Psychology Journal: Practice and Research*, 63(3), 162-175.
- Margulescu, A. M. (2020). The Relationship between Burnout and Counterproductive Work Behavior. The Role of Compassion Fatigue and Organizational Justice. *Studia Doctoralia, Psychology and Educational Science*, 11(2), 72-80.
- Maslach, C., Schaufeli, W. B., & Leiter, M. P. (2001). Job burnout. *Annual Review of Psychology*, 52, 397– 422.
- Matthews, R. A., & Ritter, K. J. (2019). Applying adaptation theory to understand experienced incivility processes: Testing the repeated exposure hypothesis. *Journal of Occupational Health Psychology*, 24(2), 270.
- Meier, L. L., & Gross, S. (2015). Episodes of incivility between subordinates and supervisors: Examining the role of self-control and time with an interaction-record diary study. *Journal of Organizational Behavior*, 36(8), 1096-1113.
- Meier, L. L., & Spector, P. E. (2013). Reciprocal effects of work stressors and counterproductive work behavior: A five-wave longitudinal study. *Journal of Applied Psychology*, 98(3), 529–539.
- Merrifield, N. (2017). Trust makes 12-hour shifts standard for most nursing staff. *Nursing Times*. Retrieved at: <https://www.nursingtimes.net/news/hospital/trust-makes-12-hour-shifts-standard-for-most-nursing-staff-12-05-2017/>
- Mollica, J. A. (2020). Exploring the Relationship between Patient Acuity and Fatigue among Nurses (Doctoral dissertation, Ohio University).

- da Motta Veiga, S. P., & Gabriel, A. S. (2016). The role of self-determined motivation in job search: A dynamic approach. *Journal of Applied Psychology, 101*(3), 350.
- Newton, T. J., & Keenan, A. (1990). The moderating effect of the Type A behavior pattern and locus of control upon the relationship between change in job demands and change in psychological strain. *Human Relations, 43*(12), 1229-1255.
- Nikstaitis, T., & Simko, L. C. (2014). Incivility among intensive care nurses: The effects of an educational intervention. *Dimensions of Critical Care Nursing, 33*(5), 293-301.
- Nye, C. D., & Drasgow, F. (2011). Assessing goodness of fit: Simple rules of thumb simply do not work. *Organizational Research Methods, 14*(3), 548–570.
- Penney, L. M., & Spector, P. E. (2005). Job stress, incivility, and counterproductive work behavior (CWB): The moderating role of negative affectivity. *Journal of Organizational Behavior, 26*(7), 777-796.
- Peterson, U., Demerouti, E., Bergström, G., Samuelsson, M., Åsberg, M., & Nygren, Å. (2008). Burnout and physical and mental health among Swedish healthcare workers. *Journal of Advanced Nursing, 62*(1), 84-95.
- Podsakoff, P. M., MacKenzie, S. B., Lee, J.-Y., & Podsakoff, N. P. (2003). Common method biases in behavioral research: A critical review of the literature and recommended remedies. *Journal of Applied Psychology, 88*(5), 879–903.
- Podsakoff, P. M., MacKenzie, S. B., & Podsakoff, N. P. (2012). Sources of method bias in social science research and recommendations on how to control it. *Annual Review of Psychology, 63*(1), 539–569.
- Porath, C. L., & Erez, A. (2007). Does rudeness really matter? The effects of rudeness on task performance and helpfulness. *Academy of Management Journal, 50*(5), 1181-1197.

- Porath, C. L., & Pearson, C. M. (2012). Emotional and behavioral responses to workplace incivility and the impact of hierarchical status. *Journal of Applied Social Psychology, 42*(S1), E326–E357.
- Porath, C. L., & Pearson C. (2013). The price of incivility. *Harvard Business Review, 91*(1–2), 115–121.
- Preacher, K. J., Rucker, D. D., & Hayes, A. F. (2007). Addressing moderated mediation hypotheses: Theory, methods, and prescriptions. *Multivariate Behavioral Research, 42*(1), 185–227.
- Qureshi, P. (1996). The effects of threat appraisal. *Nursing Management, 27*(3), 31-32 .
- R Core Team (2020). R: A language and environment for statistical computing. Vienna, Austria. Retrieved from <https://www.R-project.org/>.
- Raddish, M., Horn, S. D., & Sharkey, P. D. (1999). Continuity of care: is it cost effective. *American Journal of Managed Care, 5*(6), 727-734
- Rahim, A., & Cosby, D. M. (2016). A model of workplace incivility, job burnout, turnover intentions, and job performance. *Journal of Management Development, 35*(10), 1255-1265.
- Reich, T. C., & Herscovis, M. S. (2015). Observing workplace incivility. *Journal of Applied Psychology, 100*(1), 203–215.
- Roberts, S. J. (2012). *Application of the stressor-emotion model of counterproductive work behavior to incivility* (Publication Order No. 3503620) [Doctoral dissertation, University of Nebraska at Omaha]. Available from ProQuest Dissertations & Theses Global. (1010273071).

- Rosen, C. C., Koopman, J., Gabriel, A. S., & Johnson, R. E. (2016). Who strikes back? A daily investigation of when and why incivility begets incivility. *Journal of Applied Psychology, 101*(11), 1620.
- Rupp, D. E., & Spencer, S. (2006). When customers lash out: The effects of customer interactional justice on emotional labor and the mediating role of discrete emotions. *Journal of Applied Psychology, 91*, 971–978.
- Sakurai, K., & Jex, S. M. (2012). Coworker incivility and incivility targets' work effort and counterproductive work behaviors: The moderating role of supervisor social support. *Journal of Occupational Health Psychology, 17*(2), 150.
- Schilpzand, P., De Pater, I. E., & Erez, A. (2016). Workplace incivility: A review of the literature and agenda for future research. *Journal of Organizational Behavior, 37*, S57-S88.
- Selig, J. P., & Preacher, K. J. (2009). Mediation models for longitudinal data in developmental research. *Research in Human Development, 6*(2–3), 144–164.
- Shoss, M. K., Lixin Jiang, & Probst, T. M. (2018). Bending without breaking: A two-study examination of employee resilience in the face of job insecurity. *Journal of Occupational Health Psychology, 23*(1), 112–126.
- Shoss, M. K., Reynolds, C., Maurer, A., & Jundt, D. K. (2014). Deterring CWB: A qualitative investigation based on the theory of planned behavior. Paper presented at the annual conference of the Academy of Management. Philadelphia, PA.
- Sliter, M., Jex, S., Wolford, K., & McInnerney, J. (2010). How rude! Emotional labor as a mediator between customer incivility and employee outcomes. *Journal of Occupational Health Psychology, 15*, 468 – 481.

- Spector, P. E., Chen, P. Y., & O'Connell, B. J. (2000). A longitudinal study of relations between job stressors and job strains while controlling for prior negative affectivity and strains. *Journal of Applied Psychology, 85*(2), 211-218.
- Spector, P. E., & Fox, S. (2005). The Stressor-Emotion Model of Counterproductive Work Behavior. In S. Fox & P. E. Spector (Eds.), *Counterproductive work behavior: Investigations of actors and targets* (p. 151–174). American Psychological Association.
- Spector, P. E., Rosen, C. C., Richardson, H. A., Williams, L. J., & Johnson, R. E. (2019). A new perspective on method variance: A measure-centric approach. *Journal of Management, 45*(3), 855–880.
- Taylor, S. G., Bedeian, A. G., Cole, M. S., & Zhang, Z. (2017). Developing and testing a dynamic model of workplace incivility change. *Journal of Management, 43*(3), 645-670.
- Tonidandel, S., & LeBreton, J. M. (2011). Relative importance analysis: A useful supplement to regression analysis. *Journal of Business and Psychology, 26*(1), 1-9.
- Torres, E. N., van Niekerk, M., & Orłowski, M. (2017). Customer and employee incivility and its causal effects in the hospitality industry. *Journal of Hospitality Marketing & Management, 26*(1), 48-66.
- Trudel, J., & Reio Jr, T. G. (2011). Managing workplace incivility: The role of conflict management styles—antecedent or antidote?. *Human Resource Development Quarterly, 22*(4), 395-423.
- U.S. Bureau of Labor Statistics. (2021, March 31). Occupational Employment and Wages, May 2020: 29-1141 Registered Nurses. Division of Occupational Employment and Wage Statistics. Retrieved from <https://www.bls.gov/oes/current/oes291141.htm>

- U.S. Census Bureau. (2019). Table 1. STEM and STEM-Related Occupations by Sex and Median Earnings: ACS 2019. [Data file]. Retrieved from <https://www.census.gov/data/tables/time-series/demo/income-poverty/stem-occ-sex-med-earnings.html>.
- Vahle-Hinz, T., Baethge, A., & Van Dick, R. (2019). Beyond one work day? A daily diary study on causal and reverse effects between experienced workplace incivility and behaving rude towards others. *European Journal of Work and Organizational Psychology, 28*(2), 272-285.
- Van Jaarsveld, D. D., Walker, D. D., & Skarlicki, D. P. (2010). The role of job demands and emotional exhaustion in the relationship between customer and employee incivility. *Journal of Management, 36*(6), 1486-1504.
- Van Servellen, G., Fongwa, M., & Mockus D'Errico, E. (2006). Continuity of care and quality care outcomes for people experiencing chronic conditions: A literature review. *Nursing & Health Sciences, 8*(3), 185-195.
- Walker, D. D., van Jaarsveld, D. D., & Skarlicki, D. P. (2014). Exploring the effects of individual customer incivility encounters on employee incivility: The moderating roles of entity (in) civility and negative affectivity. *Journal of Applied Psychology, 99*(1), 151.
- Walker, D. D., van Jaarsveld, D. D., & Skarlicki, D. P. (2017). Sticks and stones can break my bones but words can also hurt me: The relationship between customer verbal aggression and employee incivility. *Journal of Applied Psychology, 102*(2), 163.
- Weiss, H. M., & Cropanzano, R. (1996). Affective events theory: A theoretical discussion of the structure, causes and consequences of affective experiences at work. In B. M. Staw & L. L. Cummings (Eds.), *Research in organizational behavior: An annual series of analytical essays and critical reviews, Vol. 18* (p. 1–74). Elsevier Science/JAI Press.

Wilson, N. L., & Holmvall, C. M. (2013). The development and validation of the Incivility From Customers Scale. *Journal of Occupational Health Psychology, 18*, 310–326.

Zyphur, M. J., Zammuto, R. F., & Zhang, Z. (2016). Multilevel latent polynomial regression for modeling (in)congruence across organizational groups: The case of organizational culture research. *Organizational Research Methods, 19*(1), 53–79.

Table 1
Correlation and Descriptive Information for Hypothesized Model with Time 1 Controls

Variable	<i>M</i>	<i>SD</i>	1	2	3	4	5	6	7	8	9	10	11	12
1. T1 Customer Incivility	2.68	1.20	.91											
2. T1 Negative Emotions	2.39	1.22	.72	.94										
3. T1 Compassion Fatigue	2.59	1.05	.80	.83	.96									
4. T1 Enacted Incivility	2.58	1.19	.78	.81	.85	.92								
5. T1 Patient Acuity	.54	.25	.28	.13*	.30	.21	-							
6. T1 Work Hours	36.29	9.83	-.39	-.38	-.38	-.38	-.22	-						
7. T2 Customer Incivility	2.56	1.09	.75	.83	.86	.78	.26	-.42	.83					
8. T3 Negative Emotions	2.66	1.20	.74	.71	.82	.73	.37	-.44	.83	.91				
9. T4 Compassion Fatigue	2.73	1.22	.71	.70	.85	.72	.36	-.39	.85	.86	.96			
10. T4 Enacted Incivility	2.77	1.21	.67	.69	.82	.72	.36	-.40	.82	.87	.94	.91		
11. T2 Patient Acuity	.52	.28	.26	.05	.22	.13*	.66	-.25	.13*	.34	.32	.33	-	
12. T2 Work Hours	37.54	8.26	-.38	-.35	-.38	-.35	.24	.47	-.37	-.40	-.38	-.42	-.30	
13. T3 Work Hours	37.13	7.93	-.37	-.36	-.40	-.39	.23	.59	-.39	-.38	-.43	-.43	-.30	.56

Note. $N = 321$. Cronbach's α presented on the diagonal. Coefficients above $|.20|$ significant at $p < .001$.

* $p < .05$

Table 2
Simultaneous mediation regression results

Variables	Customer Incivility (T2)			Negative Emotions (T3)			Compassion Fatigue (T4)			Enacted Incivility (T4)		
	<i>B</i>	<i>SE</i>	<i>t</i>	<i>B</i>	<i>SE</i>	<i>t</i>	<i>B</i>	<i>SE</i>	<i>t</i>	<i>B</i>	<i>SE</i>	<i>t</i>
T2 Customer Incivility				.26***	.06	4.50	.13***	.03	4.05	-.07	.05	-1.14
T3 Negative Emotions							.37***	.04	8.56	.28**	.10	2.89
T4 Compassion Fatigue										.57***	.17	3.35
T2 Work Hours				-.01***	.01	-3.61						
T3 Work Hours							.01	.01	.44	-.01	.01	-.38
<i>Indirect Effects</i>												
Incivility → Negative Emotions → Compassion Fatigue	.07*	.03	2.43									
Customer Incivility → Negative Emotions → Compassion Fatigue → Enacted Incivility	.06**	.02	2.58									
<i>R</i> ²				.14			.62			.81		

Note. *N* = 321.

* *p* < .05

** *p* < .01

*** *p* < .001

Table 3
Moderated regression results

Variables	Customer Incivility (T2)			Negative Emotions (T3)			Compassion Fatigue (T4)			Enacted Incivility (T4)		
	<i>B</i>	<i>SE</i>	<i>t</i>	<i>B</i>	<i>SE</i>	<i>t</i>	<i>B</i>	<i>SE</i>	<i>t</i>	<i>B</i>	<i>SE</i>	<i>t</i>
	T2 Customer Incivility (A)				.22*	.09	2.44	.16**	.05	3.13	.17**	.07
T3 Negative Emotions							.30***	.05	5.67	.35	.11	3.14
T4 Compassion Fatigue										.40	.23	1.74
T2 Patient Acuity (B)				-.09	.27	-.35						
<i>A</i> × <i>B</i>				.34**	.12	2.75						
T2 Work Hours							.00	.00	.25			
T3 Work Hours										.01	.01	.32
<i>Simple Slopes</i>												
Low Patient Acuity	.13	.12	1.13									
Medium Patient Acuity	.22*	.09	2.44									
High Patient Acuity	.32***	.08	4.15									
<i>R</i> ²	.			.24			.45			.71		

Note. *N* = 244. The sample size was reduced due to missingness on the moderator variable.

* *p* < .05

** *p* < .01

*** *p* < .001

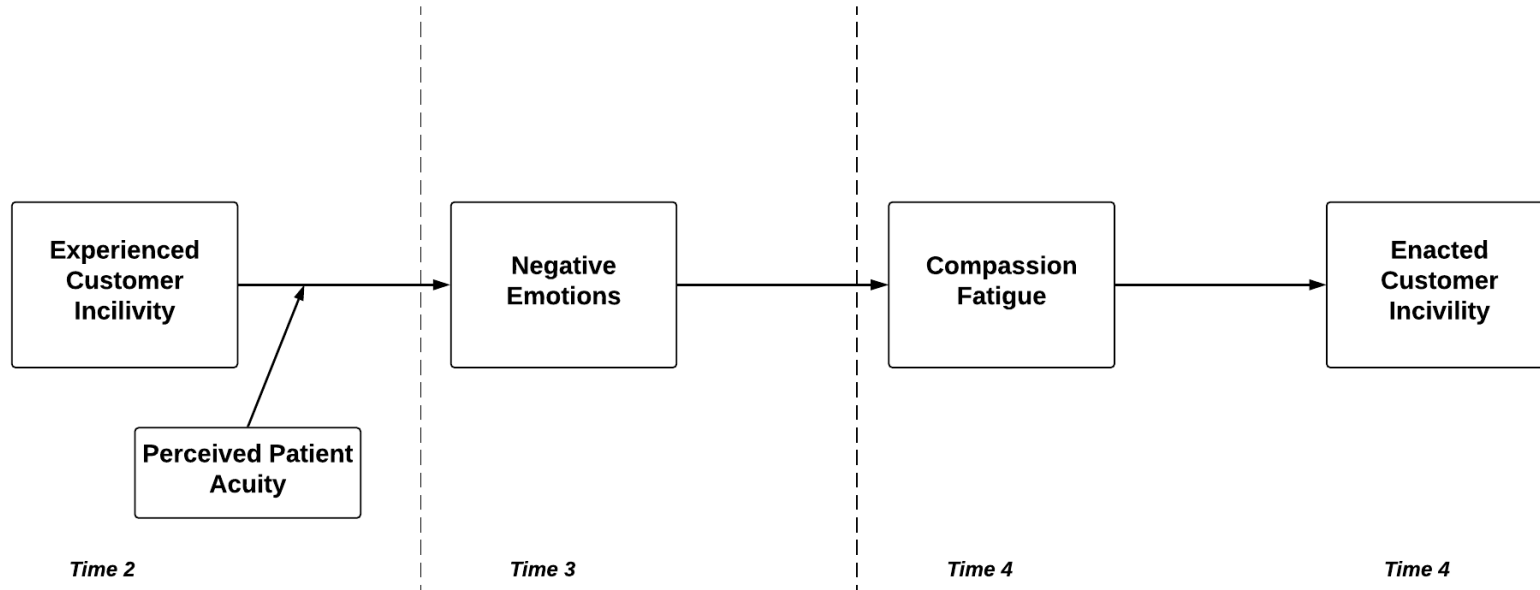
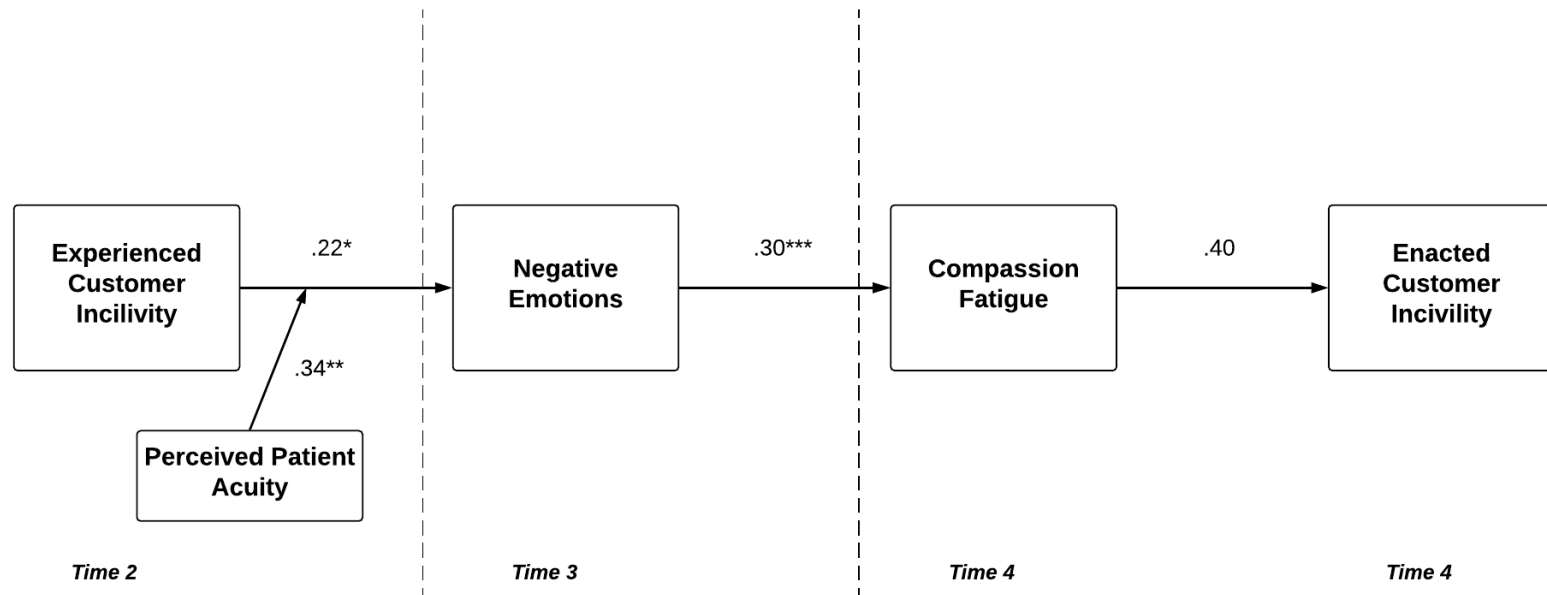
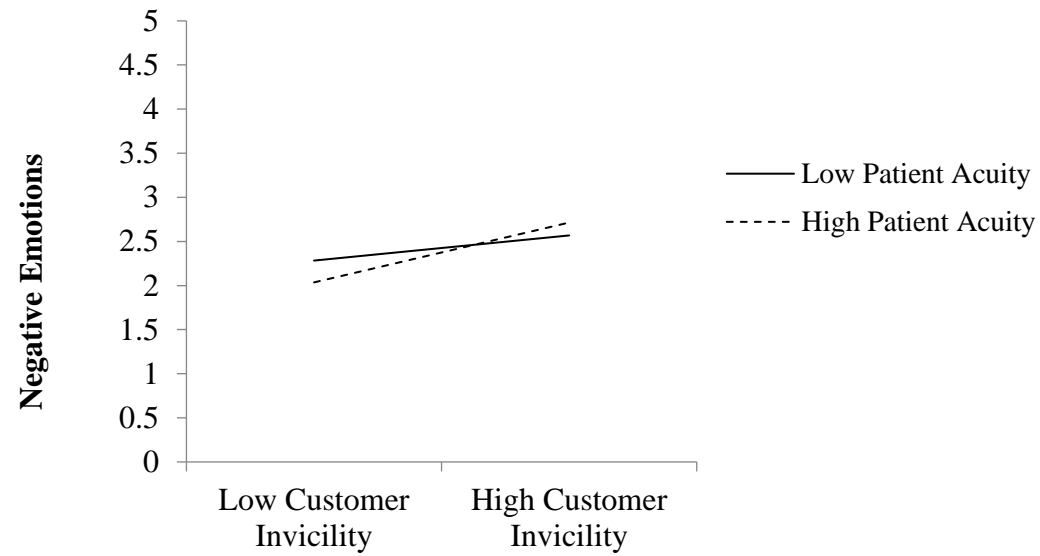
Figure 1*Hypothesized Model*

Figure 2*Moderated Mediation Results*

Note. * $p < .05$, ** $p < .01$, *** $p < .001$

Figure 3

The interactive effect of customer incivility and perceived patient acuity on negative emotions



Note. Higher = 1 SD above the mean. Lower = 1 SD below the mean.