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Empowering public service workers to face bystander conflict: Enhancing resources through a training intervention

Kim J. P. M. van Erp^{1*} , Josette M. P. Gevers², Sonja Rispens² and Evangelia Demerouti²

¹Organization Sciences, VU University Amsterdam, The Netherlands

²Human Performance Management Group, Eindhoven University of Technology, The Netherlands

Public service employees work in occupations that are accompanied with high psychosocial risks. Police, firefighters, and paramedics are increasingly being confronted with argumentative, conflicting bystanders that frustrate them in executing their task. We developed a resource-enhancement intervention and tested its usefulness for securing employees' effective functioning and well-being in bystander conflict. In a simulation-based pre-test post-test control group design, paramedics in the intervention condition received training about how to increase their resources in terms of conflict management efficacy, perspective taking, task support, and emotional support. For those in the control condition, no such training was provided. Comparing pre- and post-test measures ($n = 81$) of the participants in the intervention and control groups, we found evidence that the intervention successfully increased employees' resources over time. Moreover, we found considerable support for a positive link between these resources and employees' affective well-being and job dedication. Thus, our study suggests that a resource-enhancing intervention can serve as an important means to protect public service employees against the deleterious effects of bystander conflict.

Practitioner points

- A resource-enhancing intervention can protect public service employees against the deleterious effects of bystander conflict.
- Resources related to dealing with a hindering bystander, as well as resources facilitating the continuation of the primary task, are positively associated with employees' affective well-being, job dedication, and job performance.

Healthy and motivated employees are a prerequisite for organizations to create a versatile and efficient workforce (e.g., Bakker & Demerouti, 2007; Wright & Cropanzano, 2000, 2004). This becomes increasingly challenging in work environments characterized by high levels of psychosocial risk factors. Psychosocial risk factors are aspects of work and

*Correspondence should be addressed to Kim J. P. M. van Erp, VU University Amsterdam, Department of Organization Sciences, Boelelaan 1105, 1081 HV Amsterdam, The Netherlands (email: kjpgmvanerp@gmail.com).

The first three authors equally contributed to this work. During the time of research Kim van Erp was affiliated to the Human Performance Management Group of Eindhoven University of Technology.

its social and environmental context, 'which have the potential for causing psychological, social or physical harm' (Dollard, Skinner, Tuckey, & Bailey, 2007, p. 2). Public service employees (e.g., paramedics, police officers, firefighters, social workers) are particularly susceptible to psychosocial risks as their jobs require continuous interaction with clients, patients, and other members of the public, sometimes under stressful or tense circumstances (Barling, Dupré, & Kelloway, 2009; Hogh, Sharipova, & Borg, 2008; Hogh & Viitasara, 2005). Indeed, studies from several countries have indicated that public service employees experience high levels of third-party aggression, with figures ranging from one-third to an astonishing 87.5% of employees reporting having been subjected to intimidation and harassment (Boyle, Koritsas, Coles, & Stanley, 2007; Suserund, Blomquist, & Johansson, 2002; Van Zwieten, De Vroome, & Van den Bossche, 2015). Here, we propose and test an intervention to help employees handle this psychosocial risk factor.

Our focus is specifically on bystander conflict. Bystander conflict refers to the phenomenon where public service employees are being confronted with intervening, argumentative, sometimes even aggressive bystanders that frustrate them in executing their task (Van Erp, Gevers, Rispen, & Demerouti, 2013). For example, firefighters are sometimes confronted with passers-by who try to verbally or physically intimidate them; paramedics may find their work being obstructed by a very upset family member refusing to let go of the patient. As such, bystander conflict may involve aggression – which is characterized by high intensity and a clear intention of the bystander (Barling *et al.*, 2009) – but also includes situations in which a bystander is frustrating task execution unknowingly or unintentionally (Raver & Barling, 2008).

Bystander conflict poses a threat to patient or public safety as well as employee health and well-being (e.g., Arnetz & Arnetz, 2001; Hershcovis & Barling, 2010; Hogh *et al.*, 2008; Van Zwieten *et al.*, 2015). In a recent study among firefighters, bystander conflict was associated with burnout symptoms and turnover intention (Sliter, 2015). The literature on workplace aggression, too, has documented the devastating consequences for victims of aggression or violence (e.g., Aubé & Rousseau, 2011; Rafaeli *et al.*, 2012). More specifically, bystander conflict may diminish employees' (1) affective, (2) motivational, and (3) behavioural work outcomes. First, the threatening character of bystander conflict may induce fear or anxiety (e.g., Dijkstra, Van Dierendonck, & Evers, 2005; Spector, Chen, & O'Connell, 2000), while reducing job-induced positive emotions such as enthusiasm. Second, being hindered in the execution of one's job may suggest that one's actions are not being appreciated, thereby decreasing one's dedication to the job (Cho, Laschinger, & Wong, 2006; Creed, French, & Hood, 2015). Furthermore, experiencing conflict impedes information processing and distracts focus (De Wit, Greer, & Jehn, 2012; Hershcovis & Barling, 2010; Rafaeli *et al.*, 2012). Overall, conflict is detrimental to employees' motivational and affective responses and, in turn, to their performance (e.g., Bakker, Demerouti, & Verbeke, 2004; Van De Voorde, Paauwe, & Van Veldhoven, 2012).

The fact that bystander conflict typically takes place outside organization walls renders it virtually impossible for organizations to secure their members against it (Barling, Rogers, & Kelloway, 2001). The key to minimizing deleterious effects to affective and motivational outcomes as well as to performance, therefore, lies in ensuring employees' ability to effectively deal with these conflict situations when they occur. Conflict resolution studies have shown the benefits of mediation and negotiation in solving conflict (Karambayya, Brett, & Lytle, 1992; Movius, 2008), but such interventions will fail to provide the prompt solutions that are needed given the high-stakes and urgent characteristics of many

bystander-conflict situations. Abandoning the (emergency) situation is not always an option, nor can employees spend much time and energy resolving bystander conflicts; they need to focus on their patients/clients in the primary process. In fact, the primary goal in bystander-conflict situations is not to reach a satisfying conflict solution for both conflict parties, but to resolve the conflict situations with minimal harm to (the execution of) the primary process. Fighting its deleterious effects thus requires an approach that addresses these specific dynamics of bystander conflict.

The central aim of this study was to examine the effectiveness of a bystander-conflict training intervention to enhance paramedics' resources necessary for dealing with bystander conflict. Previous research has shown the empowering effects of resource-enhancing interventions in stressful situations in general (e.g., McGonagle, Beatty, & Joffe, 2014), and for dealing with incivilities at work in particular (e.g., Laschinger, Leiter, Day, Gilin-Oore, & Mackinnon, 2012; Leiter, Laschinger, Day, & Oore, 2011). Up till now, though, such research predominantly focused on intra-organizational processes. Arguably, occurring outside organization walls, bystander-conflict situations require a different focus. An important contribution of the current intervention is that it aims to enhance employees' resources related to dealing with the bystander (i.e., conflict management, perspective taking) and the continuation of the primary task (i.e., task support and emotional support). We will use a quasi-experimental design, consisting of a pre-test and a post-test measurement, to determine changes in these resources over time of participants in the intervention condition vis-à-vis those of participants in the control condition. In addition, we will assess the relationship of these resources with paramedics' work-related outcomes (i.e., affective well-being, job dedication, and performance) 2 months after the training.

Resources for dealing with bystander conflict

The guiding theoretical frameworks for this intervention study are Hobfoll's (1989) Conservation of Resources theory (COR) and the Job Demands-Resources model (JD-R; Bakker & Demerouti, 2007). The central premise of the COR theory is that all activity requires energy and that coping with unexpected, adverse, and/or stressful events in particular requires that people have sufficient resources at their disposal. Resources are 'those entities that either are centrally valued in their own right (e.g., self-esteem, close attachment, health, and inner peace) or act as a means to obtain such centrally valued ends (e.g., money, social support, credit)' (Hobfoll, 2002, p. 307). The more demanding or stressful the circumstances, the more important resources become in order to protect employees from the negative consequences (Bakker, Hakanen, Demerouti, & Xanthopoulou, 2007).

For paramedics, policemen, and firefighters, bystander conflict places an extra demand, as it requires them to maintain work activities and simultaneously respond to the conflict situation. This may result in demand overload, thereby causing distress and depletion of employees' energy and mental resources, which ultimately eliminates their ability to respond effectively to the situation (Fredrickson, 2001). In line with the JD-R model, we suggest that to protect against these potential losses, employees need to have resources at their disposal that can help them cope with the situation and safeguard the efficient continuation of their primary task in terms of affective, motivational, and behavioural work outcomes. Indeed, studies have indicated that personal and job resources positively influence employee (affective) well-being, motivation, and

performance through a motivational process (Bakker & Demerouti, 2007; Bakker *et al.*, 2004; Balducci, Schaufeli, & Fraccaroli, 2011; Schaufeli & Bakker, 2004).

The bystander-conflict training intervention

We designed a bystander-conflict training intervention for paramedics to enhance these personal and job resources following the principles of the Experiential Learning Theory (ELT; Kolb, 1984). ELT emphasizes the central role that experience plays in learning, and portrays learning as an active process – consisting of experiencing, reflecting, thinking, and acting – whereby knowledge is created through the transformation of experience. In an idealized learning cycle, the learner “touches all bases” – experiencing, reflecting, thinking, and acting – in a recursive process that is responsive to the learning situation and what is being learned (Kolb, Boyatzis, & Mainemelis, 2001; Kolb & Kolb, 2005). ‘Immediate or *concrete experiences* are the basis for observations and *reflections*. These reflections are assimilated and distilled into *abstract concepts* from which new implications for action can be drawn. These implications can be *actively tested* and serve as guides in creating new experiences’ (Kolb & Kolb, 2005, p. 194).

The intervention consists of half-day training in which participants are taught strategies for how to handle bystander conflict in high-demanding, urgent situations. Following ELT, we offer participants the opportunity to experience bystander conflict (experiencing), observe others in dealing with bystander conflict (reflecting), analyse and conceptualize about bystander conflict in more abstract terms to draw implications for future strategies (thinking), and practise these strategies in a realistic, simulated setting (acting). Towards this end, the intervention consisted of two simulation exercises involving bystander conflict, interspersed with a 1.5-hr classroom-based educational session. Figure 1 shows how the intervention incorporates the ELT principles.

In the simulation exercises, the paramedic teams have to provide medical emergency assistance to a patient (simulator) with serious life-threatening symptoms (unconsciousness, not breathing). Simultaneously, participants are being confronted with a hindering bystander, played by an actor, who hinders the paramedics by demanding attention, acting frantically, being very emotional, or swearing at and threatening the paramedics, and by trying to prevent them from doing their jobs. Participants engage in the simulation exercises and also observe how colleagues handle the same exercises. After the first simulation exercise, the participants take part in an educational session in which relevant theories on conflict handling, perspective taking, and providing task and emotional support are being discussed to tie bystander-conflict experiences to more abstract conceptualizations of what is to be learned. Participants then enter a second simulation

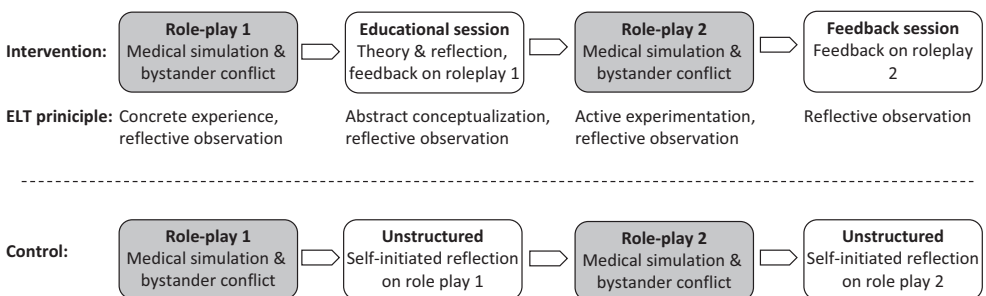


Figure 1. Design and procedure.

exercise, comparable to the first one, to practise with the newly obtained insights. The intervention ends with feedback on how the content of the training could have been implemented in the exercise and in future bystander-conflict situations. Participants in the control condition also take part in the simulation exercises, but they do not receive the educational and feedback sessions (see Figure 1).

Enhancing personal and job resources for dealing with bystander conflict

We expect two types of resources to be particularly important to maintain high levels of motivation and performance. First, the personal resources *conflict management efficacy* and *perspective taking* are considered important, for they will increase paramedics' ability to defuse an emotionally charged bystander. Second, *task support* and *emotional support* are considered important job resources that are instrumental for an effective continuation of the primary work process during bystander conflict (Bakker *et al.*, 2004; Gevers, Van Erven, de Jonge, Maas, & de Jong, 2010; Miner, Settles, Pratt-Hyatt, & Brady, 2012; Salas, Nichols, & Driskell, 2008). We will now discuss these constructs in more detail, and describe how they were addressed in the bystander-conflict training intervention.

Conflict management efficacy and perspective taking

Conflict management efficacy refers to an individual's belief that he or she is able to handle conflict situations effectively and to resolve conflicts smoothly (see Bandura, 1989, 1994). Research has consistently shown that efficacy beliefs are important predictors of individuals' attitudes and their effective and adaptive (i.e., preventive or defensive) behaviour in the face of a threat (e.g., Floyd, Prentice-Dunn, & Rogers, 2000; Stajkovic & Luthans, 1998; Witte & Allen, 2000). Individuals high in self-efficacy are more motivated and persistent in overcoming obstacles to reach their goals (e.g., Bandura, 1977; see also Jex, Bliese, Buzzell, & Primeau, 2001). Consistently, employees high in conflict management efficacy may be better equipped to overcome the obstacles of bystander conflict, and to maintain positive work outcomes in the face of this threat.

Second, *perspective taking*, the cognitive capacity to take another person's point of view and to assess his/her thoughts and motives accurately (Gilin, Maddux, Carpenter, & Galinsky, 2013; Shamay-Tsoory, 2011), is a resource that will strengthen employees experiencing bystander conflict because it offers them insight into the broad range of possible behavioural strategies of others. Psychological perspective taking, first, increases one's understanding of the other party and his/her strategic intentions (e.g., Gilin *et al.*, 2013) and reduces parties' divergent perspectives. Second, perspective taking is associated with a more constructive manner of conflict handling (Rizkalla, Wertheim, & Hodgson, 2008), thereby decreasing the chances of escalation. It decreases the likelihood that employees will act on their negative emotions (anger, frustration), and encourages them to consider more constructive strategies for conflict resolution. Therefore, higher levels of psychological perspective taking should enable public service employees to assess a bystander's motives, intentions, and behavioural strategies more accurately, and help them to de-escalate and constructively resolve bystander-conflict situations.

In the training intervention, we used the Table of Ten Framework, developed by Giebels (2002; see also Beune, Giebels, & Taylor, 2010), to explain the role of conflict management and perspective taking in bystander conflicts. This framework distinguishes several types of *influencing tactics* – deliberate actions and communication towards

another party aimed at changing that party's attitudes, beliefs, or behaviours in the desired direction (Perloff, 1993) – that are particularly applicable in real-life, high-stakes situations (Giebels & Noelanders, 2004). These strategies were mapped onto a set of different types of bystander (e.g., anti-social, emotional; Van Erp *et al.*, 2013; see also Giebels & Noelanders, 2004). Whereas the anti-social bystander intentionally obstructs others by swearing or threatening, by using physical violence (beating, spitting), or by destroying paramedics' properties, the emotional bystander's motives are primarily to vent all sorts of felt emotions, unintentionally resulting in bystander conflict. For instance, emotional bystanders may refuse to let go of the patient or cling onto a public service employee.

Research shows that the effectiveness of influencing tactics depends on the type of conflict party one has to deal with (for a more extensive overview, see Giebels & Noelanders, 2004). Therefore, the different types of bystander were introduced to the participants, and it was explained that making an effort to understand the viewpoints and motives of a bothersome bystander would be important to address the conflict. It was furthermore explained how certain actions feed certain reactions and how participants can circumvent or steer away from a negative, escalating interaction with a bystander using these insights (on the basis of Giebels, 2002; Giebels & Noelanders, 2004; Kloosterboer & Van de Vliert, 1987). For example, it was explained that anti-social bystanders are most constructively answered with consistent, neutral, and directive strategies (e.g., using direct pressure, being credible), whereas emotional bystanders are better answered with empathic and guidance strategies (e.g., being kind, making emotional appeals; Giebels & Noelanders, 2004; see also Kloosterboer & Van de Vliert, 1987). We expect that these insights will increase participants' ability to put themselves in the bystander's position and create higher confidence regarding their ability to deal with bystander conflict effectively. Therefore, we formulate the following hypothesis.

Hypothesis 1: Compared to a control group, paramedics who participated in the bystander-conflict training intervention will experience significantly higher levels of personal resources (a) perspective taking and (b) conflict management efficacy after the training intervention (T2) compared to their levels prior to the intervention (T1).

Task support and emotional support

Facing bystander conflict, employees may be better able to continue their primary task efficiently when they support one another (Gevers *et al.*, 2010; Salas *et al.*, 2008). Support can be either task-oriented (i.e., *task support*) or relationship-oriented (i.e., *emotional support*). First, with regard to task support, employees may require the help of a colleague to execute tasks effectively. However, as offering help is cognitively demanding in itself, effective task support may deteriorate when situations become more demanding (e.g., when facing bystander conflict) and employees' attentional focus becomes constrained (Driskell, Salas, & Johnston, 1999). When task support is well established (i.e., automated) and thoroughly embedded in the employees' functioning, valuable cognitive capacity is preserved, so employees will have more energy and cognitive means available to cope with the extra demands of bystander conflict.

Based on the work of Salas and colleagues (e.g., Driskell *et al.*, 1999; Salas, Rosen, Held, & Weissmuller, 2009; Salas, Sims, & Burke, 2005), it was explained and demonstrated to participants that task support is essential for effective collaboration, especially when situations are becoming increasingly stressful (e.g., Salas *et al.*, 2005, 2009). Participants received detailed information on how to enhance task support through closed-loop

communication (i.e., reassuring a correct interpretation of communication), mutual performance monitoring (i.e., monitoring each other's performance deficiencies and need for support), backup behaviour (i.e., asking for or providing physical or cognitive support), and adaptability (i.e., adapting to changing circumstances).

Second, the importance of providing emotional support to colleagues, especially after impactful incidents like bystander conflicts, was also discussed. Emotional support involves perceptions that one has access to helping relationships, which provide resources such as emotional empathy, or tangible assistance (Skilbeck & Payne, 2003; Viswesvaran, Sanchez, & Fisher, 1999). First, receiving emotional support implies one is a respected and worthy colleague. Second, individuals who receive emotional support feel less helpless and alone in difficult situations (Miner *et al.*, 2012). Third, when bystander conflict evokes feelings of anger, disgust, or disbelief, receiving emotional support acknowledges and affirms these reactions. This enables employees to place incidents in a realistic perspective, to protect their self-identity, and to restore feelings of trust and safety while at work (Miner *et al.*, 2012; Ng & Sorensen, 2008). As a result, emotional support is associated with reduced stress levels (Bakker *et al.*, 2004) and helps to maintain positive attitudes towards the job (Ng & Sorensen, 2008). It alleviates the negative effects of stressful situations on physical and mental well-being (Miner *et al.*, 2012).

We expect that the attention devoted to these topics will result in higher levels of experienced task support and emotional support for participants in the intervention. Therefore, we posit:

Hypothesis 2: Compared to a control group, paramedics who participated in the bystander-conflict training intervention will experience significantly higher levels of job resources (a) task support and (b) emotional support after the training intervention (T2) compared to their levels prior to the intervention (T1).

The positive relationship between resources and work outcomes

We expect that the intervention is, indirectly, beneficial for employees' work outcomes through the enhanced personal and job resources. That is, according to the JD-R model, resources may contribute positively to employees' affective well-being, dedication, and finally, performance (Bakker & Demerouti, 2007; Bakker *et al.*, 2004; Salanova, Schaufeli, Xanthopoulou, & Bakker, 2010; Schaufeli & Bakker, 2004). Indeed, extant research has provided strong evidence that resources have a motivational nature and are beneficial for work outcomes such as (affective) well-being, job dedication, and job performance (e.g., Balducci *et al.*, 2011; Bolier *et al.*, 2013; Sin & Lyubomirsky, 2009; Xanthopoulou, Bakker, Demerouti, & Schaufeli, 2007).

We expect that employees with high personal resources (conflict management efficacy, perspective taking) will feel better equipped to handle any interpersonal interaction during job execution. This enhances performance and enables paramedics to be more dedicated to and have a more positive attitude towards their jobs compared to those paramedics who lack these resources. Additionally, task and emotional support are valuable job resources for paramedics to conserve a positive outlook on their jobs and maintain high levels of job performance. Whereas well-established task support preserves cognitive capacity that enables employees to cope with the extra demands of bystander conflict, emotional support is important to satisfy one's need to belong and helps to

protect from pathological consequences of stressful events such as bystander conflict (Bakker & Demerouti, 2007; Ng & Sorensen, 2008).

Overall, we hypothesize that higher levels of resources after the intervention will be beneficial for work-related outcomes:

- Hypothesis 3:* The intervention will affect work outcomes through personal resources such that higher levels of (a) conflict management efficacy and (b) perspective taking will be associated with lower levels of negative affective well-being and higher levels of positive affective well-being, dedication, and job performance.
- Hypothesis 4:* The intervention will affect work outcomes through the job resources such that higher levels of (a) task support and (b) emotional support will be associated with lower levels of negative affective well-being and higher levels of positive affective well-being, dedication, and job performance.

Method

Participants

The quasi-experimental design of this study consisted of pre-test and post-test measurements (i.e., a pre-test post-test control group design) among 117 ambulance drivers and nurses of a Dutch, regional, ambulance care organization. This organization was very suitable to test our hypotheses regarding empowering public service employees facing bystander conflict, because paramedics (like firemen and police officers) frequently encounter psychosocial risks in general and bystander conflict in particular (e.g., Van Zwieten *et al.*, 2015) while working in high-stakes situations (see Giebels, Ufkes, & van Erp, 2014). Participants filled in two surveys, one prior to the intervention (T1) and one 2 months after the intervention (T2). Of the 117 people who participated at T1, 82 participated at T2. We excluded one participant who was an outlier on several measures.¹ As a result, the total sample ($n = 81$) for this study consisted of 44 ambulance nurses and 37 ambulance drivers. The experimental and control conditions comprised 45 participants (24 nurses and 21 drivers) and 36 participants (20 nurses and 16 drivers), respectively. Participants were predominantly male ($n = 61$). On average, participants were 42.22 years old ($SD = 7.35$) and had been working for the organization for 9.59 years ($SD = 7.54$). A MANOVA revealed that those participants who returned the follow-up questionnaires did not differ from participants who did not respond to the follow-up questionnaires on all (T1) measures included in the current study.

Design and procedure

All participants were invited to a training day. The employees of this organization receive mandatory training sessions on a regular basis in which responses to medical emergencies are practised. We used this established set-up, and incorporated our research design, meaning that all employees were enrolled in a mandatory medical emergency training. Prior to the training days, participants could self-assign to a morning or afternoon session of the training. A total of 17 half-day sessions were held over 9 days. The first 4 days (seven

¹ This respondent had values of more than 1.5 times the variables interquartile range on six, and values of more than three times the interquartile range on three of the 16 included variables. Inclusion of the outlier did not change the overall pattern of the results.

half-day sessions) were control condition sessions only. The next 5 days (10 half-day sessions) were intervention condition sessions. Employees were unaware of the existence of two conditions. A few weeks prior to the start of the sessions, participants needed to sign in for a specific date and time (depending on their work schedule). There was a maximum of eight participants per half-day training session.

Training days started with an introduction for all participants. We explained that the bystander-conflict session also comprised filling in questionnaires for research purposes and that participation in the research was voluntary. All participants agreed to participate and signed informed consents.

Before the start of their session, participants in both conditions filled in questionnaire T1. In both conditions, the session started with a 5-min role-play/simulation exercise. The exercise involved a medical simulation in which the paramedics had to provide medical emergency assistance to a patient (simulator) who showed severe life-threatening symptoms. While treating the patient, participants were confronted with a hindering bystander (played by an actor) who tried to prevent them from doing their jobs. The bystander scenario was based on prior interviews with ambulance employees. Similar to their actual work situation, the exercise was carried out by a driver and a nurse, wearing their uniforms. We matched participants such that every pair consisted of a driver and nurse who normally did not work together. Pairs carried out their simulation exercise sequentially, so participants also observed their colleagues performing the simulation exercise subsequently. Every pair started their simulation without seeing their predecessors, so they would not know what to expect.

After the initial exercise, participants in the intervention groups received a 1.5-hr educational session aimed at enhancing their resources perspective taking, conflict management efficacy, task support, and emotional support. A trainer provided participants with information on how to use constructive, de-escalating influencing tactics and steer away from destructive and escalating influencing tactics in bystander-conflict situations (based on the work of Giebels, 2002; Giebels & Noelanders, 2004; Kloosterboer & Van de Vliert, 1987; see the Introduction section for further details about the content). Participants reflected on the simulation exercise and discussed how the interaction with the bystander had unfolded, and why the conflict had evolved as it did, according to those principles. Participants were actively encouraged by the trainer to bring their work experiences into the discussion. Additionally, participants received information on how teams could enhance task support by means of effective communication, backup behaviour, performance monitoring, and adaptability, based on Salas *et al.* (2005). The trainer discussed the importance of providing emotional support to colleagues, especially after impactful incidents like bystander conflicts.

The participants in the control condition did not receive such an educational session. In this group, the experimenter asked participants how they had experienced the simulation exercise. Participants discussed their experiences among themselves. They did not receive any information concepts or possible strategies from the experimenter or trainer, nor were they encouraged to reflect on their personal work experiences. In other words, whereas the content of the intervention condition was directed towards reflecting the use of the specific techniques based on theory, in the control condition the content was left up to the participants themselves. The unstructured discussion session had about the same length as the educational session.

After the respective educational/unstructured discussion sessions, participants in both conditions entered a second simulation exercise, comparable to the first one: Again, the paramedics had to provide medical emergency assistance to a patient (simulator) who

showed severe life-threatening symptoms, while being hindered by a bystander. This time, however, participants in the intervention condition had been encouraged to experiment actively with the concepts from the educational session.

During the training session, all participants were exposed to two types of bystander, with an anti-social bystander in one, and an emotional bystander in the other simulation exercise. The order of the bystander types altered among the half-day training sessions.

The intervention was concluded with a final session in which was reflected on how the content of the training could have been implemented in the simulation exercise even better, and key concepts were summarized. Participants of the control group simply discussed their experiences, again, in an unstructured discussion session without input from the experimenter or trainer.

Participants from both conditions received a follow-up questionnaire 2 months after the training day. Filled-in questionnaires could be returned with a stamped envelope, and a 50-euro voucher was raffled. To further encourage participation, a reminder was sent a few weeks later, including a spare questionnaire and return envelope. The time lag of 2 months was chosen for methodological and organizational reasons: This time lag was sufficiently large for the principles of the intervention to be internalized by the participants, and to measure sustainable rather than volatile effects (Knight, Patterson, & Dawson, 2016). Furthermore, for practical reasons, the time lag was sufficiently restricted to provide the cooperating organization within an acceptable term with results and to minimize attrition.

Measures

Conflict management efficacy

Adapting the wording of the Dutch scale for general self-efficacy (Teeuw, Schwarzer, & Jerusalem, 1994), we constructed a 7-item domain-specific efficacy scale regarding conflict management (available upon request) measured on a 6-point scale (1 = *strongly disagree*, 6 = *strongly agree*; T1, $\alpha = .85$; T2, $\alpha = .88$). A sample item is 'In conflict situations, I am able to respond in a variety of ways'.

Perspective taking

We used the three items with the highest factor loadings of the perspective-taking scale of the Dutch version of the Interpersonal Reactivity Index (Davis, 1983; De Corte *et al.*, 2007). Participants answered the questions 'I try to look at everybody's side of a disagreement before I make a decision', 'I believe that there are two sides to every question and try to look at them both', and 'Before criticizing somebody, I try to imagine how I would feel if I were in their place' on a 5-point scale (1 = *does not describe me well*, 5 = *describes me very well*; T1, $\alpha = .65$; T2, $\alpha = .79$).

Task support

We asked participants to reflect on their perceptions of the level of task support between them and their colleagues in the past 2 months, in terms of closed-loop communication (three items), backup behaviour (three items), performance monitoring (three items), and adaptation (three items) on a 5-point scale (1 = *(almost) never* to 5 = *(almost) always*). Items were used in a similar context by Gevers *et al.* (2010). Sample items were 'we verify communicated information' (closed-loop communication), 'we anticipate on what the other person(s) need(s)' (backup behaviour), 'we point out impending mistakes and

complications to each other' (performance monitoring), and 'we adapt to the circumstances, whenever that is required' (adaptation). Reliability of the overall scale was good (T1, $\alpha = .90$; T2, $\alpha = .94$).

Emotional support

We adapted three items of the Dutch Demand-Induced Strain Compensation (DISC 3.0) scale (De Jonge, Willemse, & Spoor, 2011) to the specific situation of the paramedics (T1, $\alpha = .83$; T2, $\alpha = .86$): 'When a distressing situation occurs ... I get emotional support from my direct colleagues', '... I have the opportunity to express my emotions without experiencing negative reactions from direct colleagues', and '... my direct colleagues are willing to listen to me'. Answers were given on a 5-point scale (1 = [almost] never to 5 = [almost] always).

Job-related affective well-being

We used six items of the short version of the Job Affective Well-being Scale (JAWS; Schaufeli & Van Rhenen, 2006) to measure positive affect. Participants indicated how they had felt in their jobs in the past 2 months. Sample items are 'enthusiastic' and 'at ease'. We used six items of the shortened JAWS (Schaufeli & Van Rhenen, 2006) to measure negative affect (e.g., 'sombre' and 'discouraged'). Furthermore, in preliminary interviews, paramedics had elaborated on their affective reaction of fear, frustration, and threat during bystander conflict. To sufficiently capture this, we added four items of the original JAWS (Schaufeli & Van Rhenen, 2006), namely feeling 'irritated', 'frustrated', 'afraid', and 'threatened'. Both measures were reliable (positive affect: T1, $\alpha = .77$; T2, $\alpha = .88$; negative affect; T1, $\alpha = .83$; T2, $\alpha = .87$).

Dedication to the job

We used the dedication subscale (three items) of the short version of the Utrecht Work Engagement Scale (UWES-9, Schaufeli & Bakker, 2004) to measure participants' dedication to the job. Participants answered items such as 'I am enthusiastic about my job' on a 7-point scale (1 = never, 7 = always/every day). Cronbach's alpha showed high consistency reliability (T1, $\alpha = .87$; T2, $\alpha = .89$).

Job performance

Job performance was measured with the 5-item scale from Denison, Hooijberg, and Quinn (1995). This 7-point scale includes items as 'my overall effectiveness was very ineffective (1) to very effective (7)'. Consistency reliability was high (T1, $\alpha = .84$; T2, $\alpha = .85$).

Control variables

We controlled for participants' function (0 = ambulance nurse, 1 = ambulance driver).² The job of an ambulance nurse, who is primarily in charge of the patient, differs from the

² We re-analysed the data using additional control variables gender, age, tenure, and working hours. The inclusion of the additional control variables did not have any implications for the findings, nor were there any significant direct effect of the additional control variables (see Appendix S1). For reasons of power, we decided not to include these additional control variables in the final analyses. Results are available upon request.

job of an ambulance driver, who has a more supportive role and is responsible for the logistic choices. This may result in a higher susceptibility of nurses to experiencing conflict and, hence, in differential effects of the intervention.

Statistical analysis

The data have a nested structure with participants reporting at T1 (before the intervention) and T2 (2 months after the intervention). Therefore, we evaluated the effectiveness of the intervention with multilevel analyses using MLwiN 2.25 (Rasbash, Browne, Healy, Cameron, & Charlton, 2012), comparing the changes in resources from the baseline measurement T1 to the follow-up measurement T2 for the intervention and the control groups. To this end, we created the dummy-coded variables *time* (0 = T1, 1 = T2) and *intervention* (1 if the participant was assigned to the intervention condition, and 0 otherwise). All independent variables were grand-mean-centred (Aiken & West, 1991; Snijders & Bosker, 2004). After including the main effects of time and intervention, we included the interaction of time by intervention. To control for a possible differential effect of the intervention on drivers and nurses, we also included a three-way interaction of function by intervention by time (i.e., function \times time \times intervention) as well as its associated first-order and second-order terms in the equation (Aiken & West, 1991). Note, however, that the interaction term of time by intervention (i.e., time \times intervention) indicates the effect of the intervention as compared to the control condition over time. Finally, to demonstrate an indirect effect of the intervention on work outcomes, through resources (Hypotheses 3 and 4), three conditions should be met. First, the interaction of time \times intervention on the work outcome (e.g., dedication) has to be significant. Second, one or both of the following patterns should hold: (1) The interaction effect of time \times intervention on resources is significant, and there is a significant main effect of resources on work outcomes. (2) The main effect of time on resources is significant and the interaction of resource \times intervention on work outcome is significant. Finally, the interaction effect of time \times intervention on work outcome should be reduced in strength when the effects of resources are added to the equation (Muller, Judd, & Yzerbyt, 2005).

Results

Table 1 depicts the means, standard deviations, and minimum and maximum scores of the study variables. The zero-order correlations between these measures are depicted in

Table 1. Descriptive statistics of study variables at time 1 and time 2 ($N = 81$)

	Time 1				Time 2			
	<i>M</i>	<i>SD</i>	Min	Max	<i>M</i>	<i>SD</i>	Min	Max
Conflict management efficacy	4.43	0.52	3.29	5.86	4.72	0.52	2.86	5.86
Perspective taking	3.90	0.55	2.33	5.00	3.97	0.62	2.33	5.00
Task support	3.98	0.45	3.00	5.00	4.10	0.54	2.67	5.00
Emotional support	4.47	0.50	3.33	5.00	4.41	0.59	1.67	5.00
Positive affect	4.25	0.39	3.33	4.83	4.16	0.54	2.33	5.00
Negative affect	1.91	0.47	1.00	3.00	1.81	0.56	1.00	3.40
Dedication	6.22	0.76	4.00	7.00	6.08	0.96	3.33	7.00
Job performance	5.51	0.55	3.80	6.80	5.62	0.59	3.80	7.00

Table 2. Correlations between study variables at time 1 and time 2

	1	2	3	4	5	6	7	8	9	10	11
1. Condition	–	.05	.02	.00	–.06	–.33**	–.27*	.01	.13	–.08	.01
2. Gender	.05	–	–.07	–.06	.03	.10	.05	.00	.02	–.04	–.16
3. Function	.02	–.07	–	.01	.01	.40**	.21	.24*	–.13	.29*	.12
4. Conflict management efficacy	.01	–.34**	–.05	.61**	.50**	.27*	.25*	.28*	–.19	.24*	.28*
5. Perspective taking	–.14	–.05	–.05	.38**	.53**	.19	.16	.25*	–.16	.16	.21
6. Task support	–.08	.00	.39**	.20	.15	.60**	.52**	.41**	–.44**	.34**	.12
7. Emotional support	–.02	.13	.20	.12	.12	.61**	.64**	.41**	–.33**	.40**	.08
8. Positive affect	.17	–.05	–.02	.24*	.21	.47**	.65**	.58**	–.54**	.59**	.10
9. Negative affect	.02	–.05	–.06	–.08	–.07	–.34**	–.37**	–.48**	.70**	–.36**	–.01
10. Dedication	.21	–.04	.02	.12	.07	.42**	.56**	.69**	–.35**	.57**	.24*
11. Job performance	.09	–.23*	–.09	.29**	.14	.24*	.43**	.31**	–.23*	.27*	.67**

Notes. Condition is coded 0 = control condition, 1 = intervention condition; gender is coded 0 = male, 1 = female; function is coded 0 = ambulance nurse, 1 = ambulance driver; Correlations at T1 above the diagonal, T2 below the diagonal. Values in bold refer to test-retest correlation (T1, T2)

** $p < .01$; * $p < .05$ (2-tailed); $N = 81$.

Table 2 (T1 above the diagonal; T2 below the diagonal). In the following, we systematically go through the results of the analyses testing our hypotheses.

Intervention effects on resources

The hypothesized increase of resources (Hypotheses 1a,b; 2a,b) was tested for each resource separately. Table 3 depicts the results of the models. With respect to perspective taking, the interaction of intervention and time is significant. As expected, the change in perspective taking over time differed for the control group and intervention group ($B = 0.44$, $SE = .17$, $t = 2.64$, $p = .01$, see Figure 2). Simple slope analyses revealed that the intervention group reported significantly higher levels of perspective taking at T2 as compared to T1 (simple slope = 0.24 , $SE = .11$, $z = 2.15$, $p = .032$), whereas the control group reported no significant change over time in perspective taking (simple slope = -0.20 ; $SE = .12$, $t = -1.64$, $p = .10$). Hypothesis 1a was supported.

Regarding conflict management efficacy, the results indicated that both the control group and the intervention group had improved at the follow-up and that conflict management efficacy had increased irrespective of the condition. Hypothesis 1b was therefore not supported.

There was a statistically significant difference in the change in task support between the intervention group and the control group ($B = 0.35$, $SE = .13$, $t = 2.69$, $p < .01$; see Figure 3a). As expected, whereas the participants in the intervention group reported a significant increase in task support (simple slope = 0.25 , $SE = .09$, $z = 2.80$, $p = .005$), the control group did not report significant changes in task support over time (simple

Table 3. Results of multilevel analyses testing intervention effects on resources

	Perspective taking		Conflict management		Task support		Emotional support	
	B	SE	B	SE	B	SE	B	SE
Fixed effects								
Controls								
Function	-0.18	.19	0.11	.17	0.54***	.14	0.27	.17
Function × time	0.30	.18	-0.06	.15	0.24	.14	0.35*	.15
Function × intervention	0.23	.26	-0.29	.23	-0.32	.19	-0.12	.23
Function × intervention × time	-0.42	.25	0.21	.20	-0.31	.19	-0.54**	.20
Predictors								
Intercept	4.02	.13	4.38	.12	3.90	.09	4.50	.12
Time	-0.20	.12	0.31***	.10	-0.10	.10	-0.35***	.10
Intervention	-0.17	.17	0.13	.16	-0.16	.13	-0.22	.16
Time × intervention	0.44*	.17	-0.08	.14	0.35**	.13	0.49***	.13
Random parameters								
Level 2 – individuals level	0.18	.04	0.16	.04	0.09	.02	0.17	.04
Level 1 – occasion level	0.15	.02	0.10	.02	0.09	.01	0.09	.02
-2*log-likelihood	250.205		206.643		157.942		200.385	

Notes. Intervention is a dummy-coded variable with 0 = control condition, 1 = intervention condition; function is coded 0 = ambulance driver, 1 = ambulance nurse.

*** $p < .001$, ** $p < .01$, * $p < .05$; $N = 161$ (81 participants × 2 measurement points) minus missing values.

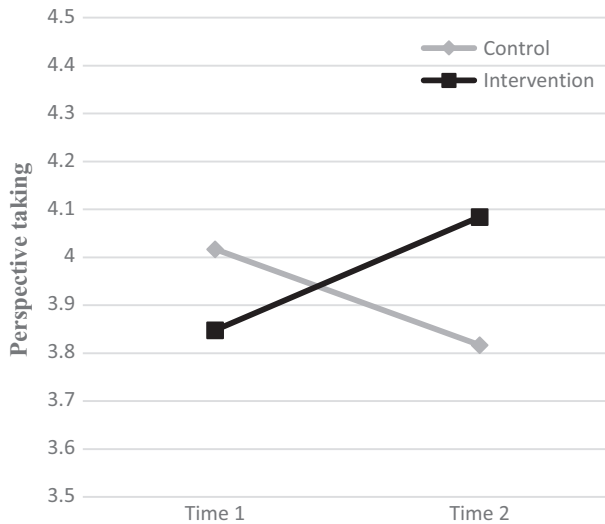


Figure 2. Perspective taking at time 1 and time 2 for control and intervention groups.

slope = -0.10 , $SE = .10$, $z = 1.05$, $p = .29$; see Figure 3a). These findings lend support to Hypothesis 2a.

Furthermore, the results show a statistically significant difference in the change in perceived emotional support between the intervention group and the control group ($B = 0.49$, $SE = .13$, $t = 3.73$, $p < .001$; see Figure 3b). Participants in the intervention group reported stable levels of experienced emotional support over time (simple slope = 0.14 , $SE = .09$, $z = 1.55$, $p = .12$), whereas the participants in the control group experienced a decrease in emotional support (simple slope = -0.35 , $SE = .10$, $z = -3.69$, $p < .001$). Hypothesis 2b was therefore not supported.

Resources' relationship with work-related outcomes

We expected the intervention to affect work outcomes through resources (Hypotheses 3 and 4). Following the three-step procedure outlined by Muller *et al.* (2005), we tested these indirect effects. First, we tested whether the interaction of time \times intervention on the work outcomes was significant, which was true for positive affect ($B = .32$, $SE = .12$, $t = 2.66$, $p = .009$) and dedication ($B = 0.70$, $SE = .22$, $t = 3.15$, $p = .002$), but not for negative affect and performance. Further mediation analyses were therefore restricted to positive affect and dedication.

Positive affect

In line with the procedure outlined by Muller *et al.* (2005), we tested whether the main effect of resources (perspective taking, conflict management efficacy, task support, or emotional support)³ or the interaction term resource \times intervention on positive affect was significant. There were no significant results for perspective taking ($B = -.01$,

³In order to be considered a potential mediating resource, a significant effect of time or of time \times intervention should exist (Muller *et al.*, 2005; see Statistical analysis section). We already showed that this was the case for all resources (see Table 3).

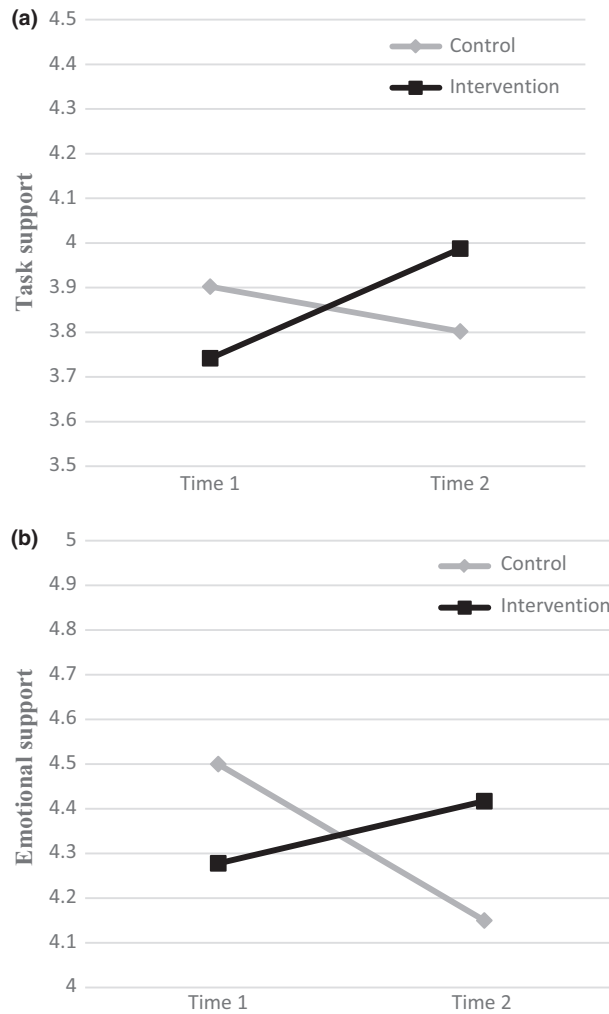


Figure 3. (a) Task support at time 1 and time 2 for control and intervention groups. (b) Emotional support at time 1 and time 2 for control and intervention groups.

$SE = .08, t = 0.06, p = .95$) or conflict management efficacy ($B = .16, SE = .11, t = 1.50, p = .14$).

Task support had a significant main effect on positive affect (Model 1, Table 4: $B = 0.55, SE = .11, t = 4.98, p < .001$). Additionally, the effect of time \times intervention on positive affect ($B = 0.33, SE = .13, t = 2.51, p = .01$) decreased considerably compared to the null model. Thus, task support partially mediated the effect of the intervention on positive affect over time.

The main effect of emotional support on positive affect was also significant (Model 2, Table 4: $B = 0.53, SE = .09, t = 6.26, p < .001$). Furthermore, the time \times intervention coefficient ($B = 0.09, SE = .11, t = 0.76, p = .45$) decreased significantly (to a non-significant level, see Table 4). Thus, emotional support mediated the effect of the intervention on positive affect over time.

Table 4. Results of multilevel analyses testing effect of resources on positive affect

Fixed effects	Model 1 Positive affect		Model 2 Positive affect	
	B	SE	B	SE
Controls				
Function	-0.14	.14	0.01	.12
Function × time	0.33*	.13	0.28*	.12
Function × intervention	-0.06	.19	-0.22	.17
Function × intervention × time	-0.21	.18	-0.10	.16
Predictors				
Intercept	4.25	.09	4.14	.08
Time	-0.34***	.08	-0.21	.09
Intervention	-0.14	.12	0.25	.11
Time × intervention	0.21	.12	0.09	.11
Task support	0.55*	.11		
Task support × intervention	-0.32*	.15		
Emotional support			0.53***	.09
Emotional support × intervention			-0.15	.12
Random parameters				
Level 2 – individuals level	0.08	.02	0.07	.02
Level 1 – occasion level	0.08	.01	0.06	.01
-2*log-likelihood	131.028		106.186	

Notes. Intervention is a dummy-coded variable with 0 = control condition, 1 = intervention condition; function is coded 0 = ambulance driver, 1 = ambulance nurse.

*** $p < .001$, ** $p < .01$, * $p < .05$; $N = 161$ (81 participants × 2 measurement points) minus missing values.

Job dedication

Next, we analysed whether the intervention affected job dedication through the various resources (Hypotheses 3 and 4). There was no significant effect of perspective taking on dedication ($B = -.15$, $SE = .15$, $t = 0.94$, $p = .35$). However, we did find significant results for conflict management efficacy, task support, and emotional support (see Table 5). The interaction of conflict management efficacy × intervention was significant ($B = 0.67$, $SE = .25$, $t = 2.73$, $p = .007$, see Model 1, Table 5). Following Muller *et al.* (2005; see also our Statistical analysis section), we can conclude that there is a significant mediated moderation effect indicating that, over time, conflict management efficacy increases in both conditions, whereas only for participants in the intervention condition conflict management efficacy related positively to job dedication.

The main effect of task support on job dedication was significant (Model 2, Table 5: $B = 0.58$, $SE = .21$, $t = 2.71$, $p = .008$), and the time × intervention coefficient decreased significantly (Table 5: $B = 0.56$, $SE = .23$, $t = 2.41$, $p = .017$). Task support thus partially mediated the effect of the intervention on job dedication over time. The main effect of emotional support on job dedication was also significant (Model 3, Table 5: $B = 0.75$, $SE = .17$, $t = 4.57$, $p < .001$). Furthermore, the effect of the time × intervention ($B = 0.36$, $SE = .22$, $t = 1.65$, $p = .101$) decreased to a non-significant level. Emotional support thus partially mediated the effect of the intervention on job dedication over time.

Table 5. Results of multilevel analyses testing effect of resources on job dedication

Fixed effects	Model 1		Model 2		Model 3	
	Job dedication		Job dedication		Job dedication	
	B	SE	B	SE	B	SE
Controls						
Function	.36	.26	.05	.28	.14	.24
Function × time	.72**	.24	.59*	.26	.47*	.24
Function × intervention	-.49	.35	-.33	.36	.45	.32
Function × intervention × time	-.44	.32	-.21	.34	.00	.31
Predictors						
Intercept	6.00	.18	6.21	.17	6.01	.16
Time	-.72***	.17	-.71***	.17	-.51**	.16
Intervention	.19	.24	.15	.24	.28	.22
Time × intervention	.54*	.22	.56*	.23	.36	.22
Conflict management efficacy	-.15	.19				
CME × intervention	.67**	.25				
Task support			.58**	.21		
Task support × intervention			-.25	.28		
Emotional support					.75***	.17
Emotional support × intervention					-.12	.28
Random parameters						
Level 2 – individuals level	.36	.08	.30	.07	.28	.06
Level 1 – occasion level	.24	.04	.28	.04	.23	.04
-2*log-likelihood	339.896		343.139		318.179	

Notes. Intervention is a dummy-coded variable with 0 = control condition, 1 = intervention condition; function is coded 0 = ambulance driver, 1 = ambulance nurse. CME = conflict management efficacy. *** $p < .001$, ** $p < .01$, * $p < .05$; $N = 161$ (81 participants × 2 measurement points) minus missing values.

In sum, the intervention affected positive affect and job dedication through resources of conflict management efficacy, task support, and emotional support. Hypotheses 3 and 4 are therefore partially supported.

Discussion

Public service employees work under high pressure and face great (societal) responsibilities. Working under these conditions, conflicting bystanders embody an unpleasant and unwelcome distraction, especially when every second counts. Bystander conflict interferes with employees' (physical and mental) well-being, motivation, and performance (e.g., Bakker *et al.*, 2004; Dollard *et al.*, 2007) and, consequently, constitutes a danger to public and patient safety (e.g., Van Zwieten *et al.*, 2015). Organizations therefore need to protect their employees from the negative impact of bystander conflict to ensure a sustainable workforce. We developed an intervention to empower paramedics in bystander conflict. The training aimed at enhancing paramedics' resources and consequently preserving important work-related outcomes.

Following the ELT (Kolb, 1984), our bystander-conflict training intervention combined simulation-based role-play exercises in a medical simulation with theory-driven instructions. Using a pre-test post-test control group design, we examined the effectiveness of this intervention on the enhancement of participants' resources 2 months later. In line with our expectations, the results revealed the constructive contribution of the intervention to both personal and job resources. More specifically, unlike participants in the control condition, participants in the resource-enhancement condition showed increases in perspective taking and task support over time. Moreover, whereas participants in the intervention condition reported stable levels of emotional support over time, the levels decreased for participants in the control condition. Somewhat surprisingly, both conditions reported an increase in conflict management efficacy. Apparently, the mere participation in the simulation exercises, without further theoretical elaboration, already sufficed to increase conflict management efficacy. Besides these positive contributions of the bystander-conflict intervention to employees' personal and job resources, we found considerable support for the positive link between these resources and employees' affective well-being, and job dedication, in line with our expectations based on the Job Demands-Resources model (Bakker & Demerouti, 2007).

Theoretical and practical implications

Our findings have some important implications for theory. First, the results corroborate the claims that resources are important for dealing with high-demanding situations (Bakker *et al.*, 2007). Every resource included in this research, in some way or another, contributes to sustaining an enthused, engaged, and effective workforce. The intervention indirectly affected work outcomes through conflict management efficacy, task support, and emotional support, which each contributed in their own way to high levels of affective and motivational well-being. Surely, many studies have demonstrated the effects of resources on work-related outcomes and well-being (e.g., Le Blanc, Hox, Schaufeli, Taris, & Peeters, 2007; Knight *et al.*, 2016). However, previous studies mainly focused on intra-organizational settings, such as insider mistreatment (Laschinger *et al.*, 2012; Leiter *et al.*, 2011). The current study specifically focused on outsider mistreatment, thereby contributing insight into how resources facilitate interactions with outsiders, which is particularly important for public service employees.

Moreover, a particularly important contribution of this study is that we demonstrate that these resources can be enhanced through a training intervention. The resource-enhancing intervention thereby offers a promising means of protecting employees against psychosocial risk factors, such as bystander-conflict situations, even when they reach beyond organizational walls. Conflict literature has shown the importance of interpersonal conflict management or negotiation strategies to deal with conflict parties in past research. However, such research generally does not focus on public work environments with accumulative psychosocial risk factors (like time pressure and emotional load), which strongly influence employees' possibilities to deal with bystander conflict. This study demonstrates training interventions for public services benefit from a focus on diminishing negative effects of conflict, preventing conflict escalation, and sustaining work outcomes, rather than conflict resolution. Our findings also show that task support and emotional support from colleagues are both powerful means for maintaining employee effectiveness and well-being in high-demand situations. This suggests that although their value may easily be overlooked or underestimated, enhancing a supporting co-worker climate should be top priority for organizations, especially when their

employees face psychosocial risks. A resource-enhancing intervention would be one way of stimulating this supporting work environment. As such, our intervention broadens the available arsenal of resource-enhancement interventions (e.g., Le Blanc *et al.*, 2007; Leiter *et al.*, 2011; Luthans, Avey, & Patera, 2008). It should be mentioned, for example, that the literature on coaching also provides evidence that coaching enables building of personal resources to improve work-related well-being (e.g., McGonagle *et al.*, 2014). However, whereas such coaching activities are usually aimed at building more generic resources for intra-organizational settings, the current intervention is aimed specifically at embedding resources for dealing with bystander conflict in public service employees' primary tasks, for an efficient work continuation.

More generally, our findings suggest that a resource-enhancing intervention approach could facilitate employees in a wide variety of jobs. Many employees, especially those in public services (nurses, doctors, firefighters, policemen, social workers), are faced, on a daily basis, with the psychosocial risk factors inherent to their jobs: emotional demands, time pressure, lack of control in work planning (e.g., Le Blanc *et al.*, 2007). To create and maintain a sustainable workforce, organizations should protect their employees from the negative impact these risk factors can have on their well-being and attitudes towards the job (see Bakker & Demerouti, 2007). The current study suggests that enhancing resources related to dealing with a risk factor (i.e., conflicting bystander) and the continuation of the primary task enables employees to stay motivated, enthusiastic, and effective in their daily jobs.

Strengths, limitations, and future research needs

Naturally, our study has some limitations. First, the duration of the intervention, a half-day programme, is arguably short for the relatively large number of topics discussed and practised. Nonetheless, despite the limited length of the intervention, its intensity is apparently sufficiently high to have a sustainable impact over a 2-month period in terms of perspective taking, task support, and emotional support, as our results showed improvement for these resources over time in the intervention condition. We believe the results of our study to be encouraging, and future research is needed to see whether more lengthy or recurring interventions may lead to even better results.

Another concern is that the study was based on self-reported data. The study design could certainly be strengthened by the use of more objective measures in future research, but one should keep in mind that some of the central constructs (e.g., conflict management efficacy, affect, dedication, perceived support) may only validly be assessed by participants themselves. Additionally, the data were collected within a 2-month time interval, which reduces the likelihood of consistency biases. Still, future research may use insights from studies of Schoorman and Mayer (2008) indicating that self-reports on performance are more accurate when participants are asked to indicate how their supervisors would rate their performance.

Moreover, in the present study, we assessed work outcomes at a general level rather than during or after specific incidents of bystander conflict, which hinders strong conclusions regarding the value of the resources when paramedics are really confronted with a hindering bystander. Relatedly, although our research shows how resources are enhanced and how they associate to work-related outcomes, we did not measure participants' actual behaviour. As such, we cannot draw strong conclusions whether building resources is associated with increased display of skills or constructive and effective behaviours. Future research should try to include behavioural measures as well.

This would provide further evidence for the presumed resources work–behaviour link. Using innovative ways for data collection, such as wearable sensory badges, one could accurately measure a range of behaviours including speech patterns and body movements (see, e.g., Olguín *et al.*, 2009). Although now predominantly used in intra-organizational settings (e.g., Kim, McFee, Olguín, Waber, & Pentland, 2012), exploring the possibilities in settings outside the organizational walls may be fruitful.

A major strength of our study is the inclusion of a control condition. In field research, creating a control group is often problematic because it is not feasible or desirable for participating organizations. Its application strengthens the conclusion that the found effects can be attributed to the intervention rather than general learning experience unrelated to the intervention. The use of the control group additionally rules out the possibility that the results are due to a biased sample rather than the effectiveness of intervention.

A second methodological strength of this study is the fact that the control group participated in an activity (simulation exercise and discussions) that explicitly involved the topic of bystander conflict. As a result, we can rule out the options that the results are due to a mere increased awareness of or preoccupation with the bystander-conflict dilemma. Future research could gain further insight into the contribution of the simulation exercise and discussion activities for the control group. For instance, research could use an experimental set-up that allows for a distinction between a control condition without any activity regarding bystander conflict and a control condition including simulation exercises. As such, effects of merely participating in simulation exercises could be isolated. As the rather small sample size is another limitation of the present research, creating more than two conditions was not feasible.

Furthermore, future research may want to explore the effectiveness of the intervention in other occupations that face bystander conflict, to test the generalizability of our findings across occupations. Many occupations, especially those in social services, are subject to this specific psychosocial risk factor. When prevention or reduction of risks like bystander conflict is not optimally feasible, a resource-enhancement intervention is an interesting alternative. Enhancing resources, particularly those provided by working with colleagues, not only helps employees to maintain an appropriate level of job performance, but also contributes to the preservation of employees' well-being and motivation for the job, which is of pivotal importance for retaining a healthy public service workforce.

Conclusion

In all, we believe that the enhancement of resources through training is a promising route towards empowering employees in public service jobs against the deleterious effects of bystander conflict. Even though these incivilities occur outside organization walls (cf. Laschinger *et al.*, 2012; Leiter *et al.*, 2011), it is in the interest of the organization to make sure that their employees feel supported in facing these challenges. By offering an intervention to enhance resources that help employees deal with bystander conflict, organizations show their commitment towards their employees, and actively provide them with tools to deal with the deleterious situation. It is our conviction that many more public service workers could benefit from a dedicated training intervention to help them deal with bothersome bystanders.

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Supporting Information

The following supporting information may be found in the online edition of the article:

Appendix S1. Additional tables.