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# The Relationships Between Individual Characteristics, Work Factors, and Emotional Labor Strategies in the Prediction of Burnout among Mental Health Service Providers

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The Relationships Between Individual Characteristics, Work Factors, and Emotional  
Labor Strategies in the Prediction of Burnout among Mental Health Service Providers

by

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A dissertation submitted in partial fulfillment  
of the requirements for the degree of  
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## Abstract

Relatively few empirical studies in the professional burnout literature have examined mental health providers (MHPs). Research on other professional groups has demonstrated that certain emotion regulation strategies, known as emotional labor (i.e., deep acting and surface acting), are common responses to perceived display rules (i.e., professional guidelines for emotional expression), and are differentially associated with burnout. The present study aimed to fill a gap in the literature by evaluating the empirical links between work stressors (i.e., role conflict, role ambiguity, and lack of autonomy), personality (i.e., extraversion), emotional labor (i.e., surface acting and deep acting), and burnout in a sample of MHPs. Additional variables (i.e., perceived emotional display rules, client characteristics, etc.) were also explored. Data from an online survey of 188 MHPs working in Florida was analyzed using multivariate and univariate regressions. The results of this study supported several of the hypothesized relationships between predictor variables and burnout. Most notably, extraversion, role conflict, role ambiguity, autonomy, and surface acting were significantly associated with one or more dimensions of burnout. Support was not found for extraversion as a moderator of the relationships between work stressors and burnout or between work stressors and emotional labor strategies. The effects of emotional labor strategies as mediators of the relationships between work stressors and burnout were not statistically

significant. Implications and limitations of the findings, as well as suggestions for future research, are discussed.

## Introduction

Professional burnout – “a unique response syndrome” (Zohar, 1997, p.101) arising out of chronically elevated occupational stress (Maslach, Schaufeli, & Leiter, 2001) – has gained international attention and been the focus of thousands of publications since it first appeared in the social sciences literature (Freudenberger, 1974) over thirty years ago. The most prominent and influential model of burnout, developed by Maslach and her colleagues, conceptualizes professional burnout on a tri-dimensional continuum (Maslach and Jackson 1986). The first dimension, Emotional Exhaustion (EE), refers to a depletion of emotional and psychological resources available to perform in one’s professional role, resulting in fatigue and/or distress (Maslach & Jackson, 1986; Schaufeli & Enzmann, 1998). The second dimension, Depersonalization (DP), refers to a cognitive bias towards making negative, impersonal, and dehumanizing attributions about the recipients of one’s services (Maslach & Jackson, 1986; Schaufeli & Enzman, 1998). The third dimension, diminished Personal Accomplishment (PA), refers to reduced feelings of fulfillment and satisfaction regarding one’s work or impact on clients, as well as the development of more negative self-evaluations regarding one’s ability to perform his/her professional roles competently and with ease (Maslach & Jackson, 1986; Schaufeli & Enzman, 1998).

Although research indicates that burnout occurs across a variety of occupations, mental health service providers (MHPs) are thought to be at increased risk for burnout given the demanding and “intensely personal nature” of their work (Rupert & Morgan,

2005, p.544; see also Cherniss, 1993; Freudenberger, 1975; Jackson, Schwab, & Schuler, 1986; Leiter & Maslach, 1988; Lim, Kim, Kim, Yang, & Lee, 2010; Maslach & Jackson, 1981). Working in the mental health field can be both personally rewarding and demanding of one's emotional, cognitive, and physical resources. Within the context of providing direct clinical services (e.g., assessment, treatment, case management), MHPs' personal resources are directed toward not only identifying and accommodating their clients' individual needs, but also self-monitoring their own thoughts, feelings, and behaviors in clinical situations, particularly those that elicit cognitive dissonance, emotional dissonance, or other "countertransference" reactions. In providing services to certain populations (e.g., youth, elderly, incarcerated, court-mandated, developmentally disabled, etc.), MHPs' personal resources also are devoted to developing positive working relationships with their clients' primary caregivers, teachers, and other individuals, who may be relied upon for the purposes of supplying information, scheduling sessions, transporting clients to and from sessions, facilitating clinical interventions during and between sessions, and monitoring clients' safety and compliance with treatment recommendations (e.g., Fields, Handelsman, Karver, and Bickman, 2004; Handelsman, 2006). However, the professional demands on MHPs extend beyond their therapeutic roles.

Over the last half-century, the field of psychology has undergone dramatic changes related, in part, to socio-cultural and economic shifts. Today, MHPs in the United States are struggling to reconcile the conflicting interests of individual clients, referral sources, program administrators, insurance companies, and other vested parties (Rupert & Morgan, 2005; An Action Plan for Behavioral Health Workforce

Development, SAMHSA, 2007). The rise of managed healthcare has put greater financial pressure on MHPs to increase their caseloads and shorten the length of treatment, while generating rapid and long-lasting clinical results (Rupert & Baird, 2004; Rupert & Morgan, 2005). In addition, changes in professional and legal guidelines regarding assessment, documentation, and reporting, coupled with downsizing within organizations due to financial constrictions, have increased the demands placed on MHPs (Rupert & Baird, 2004; Rupert & Morgan, 2005; An Action Plan for Behavioral Health Workforce Development, SAMHSA, 2007).

Given the types of demands and pressures they face, it reasons that MHPs would be at high risk for developing burnout. While contemporary prevalence rates have not been published, burnout was estimated to affect as many as one-third of practicing psychologists in the 1980s (Ackerley, Burnell, Holder, & Kurdek, 1988), and a number of recent studies indicate that it continues to be a significant concern for psychologists and other service providers within mental health settings (e.g., Bakker et al., 2006; Rosenberg & Pace, 2006; Rupert & Baird, 2004; Rupert & Kent, 2007; Rupert & Morgan, 2005).

The importance of research in this area is underscored by evidence linking burnout to a variety of negative outcomes for individual workers, organizations, and consumers. Specifically, empirical studies of MHPs and/or other types of human service workers have shown burnout to be positively related to mental health problems (e.g., stress, anxiety, depression, decreased self-esteem), physical health problems (e.g., headaches, insomnia, gastrointestinal disturbance, prolonged illnesses), and cognitive impairments (e.g., deficits related to nonverbal memory and both auditory and visual attention), as well as job dissatisfaction, poor work performance, absenteeism, and

turnover (e.g., Burke & Deszca, 1986; Burke & Greenglass, 1996; Cherniss, 1992; Elman & Dowd, 1997; Kahill, 1988; Lee & Ashforth, 1993; Maslach & Leiter, 1997; Raquepaw & Miller, 1989; Rupert & Morgan, 2005; Sandstrom, Rhodin Lunberg, Olsson, & Nyberg, 2005; Zhang, Xu, & Jiang, 2006). As such, it is not surprising that research has shown burnout to be a significant predictor of MHPs' reported intentions to leave the mental health field altogether (e.g., Raquepaw & Miller, 1989; Rupert & Morgan, 2005).

The potential impact of burnout extends beyond the individual level. Burnout also has implications at the organizational level, as agencies confront problems associated with diminished productivity, creativity, and innovation; lower organizational commitment and job satisfaction; and higher healthcare costs, absenteeism, and turnover, among burned-out employees (Evans et al., 2006; Halbesleben & Buckley, 2004; Shirom, 2003). Furthermore, reduced productivity, increased absenteeism, and higher turnover may result in staff shortages and excessive workloads for remaining staff (Evans et al., 2006; Halbesleben & Buckley, 2004; Shirom, 2003), which may place remaining staff at greater risk for burnout (Evans et al., 2006). Related, a number of researchers have indicated that the behavioral manifestations of burnout may be transmitted to coworkers through a social contagion effect. That is, symptoms of burnout (e.g., cynical attitudes, emotional distress, diminished performance, etc.) may be perceptible to others and, thus, negatively influence their coworkers' attitudes, feelings, and behavior patterns (e.g., Bakker, Demerouti, & Schaufeli, 2003; Bakker, Le Blanc, & Schaufeli, 2005; Bakker & Schaufeli, 2000; Bakker, Schaufeli, Sixma, & Bosveld, 2001; Buunk & Schaufeli, 1993; Cherniss 1980, Edelwich & Brodsky 1980; Schaufeli, & Enzmann, 1998). Studies have provided preliminary evidence to support this theory. For instance, Bakker and Schaufeli

(2000) found that teachers who frequently talked with their burned out colleagues were more likely to demonstrate negative changes in their own work-related attitudes. Bakker, Demerouti, and Schaufeli (2003a) found evidence for burnout contagion within work teams, as burnout at the team level was shown to be related to individual team members' burnout scores, both directly and indirectly through its relationship with individual members' job demands, job control, and perceived social support. Though more research is needed in order to determine whether burnout contagion occurs among MHPs, it reasons that exposure to coworkers with high levels of burnout may put individual MHPs' at greater risk for developing symptoms of burnout.

It has been suggested that allowing MHPs with significant symptoms of burnout to continue practicing presents ethical concerns, as the quality of services provided to their clients may decline (e.g., Enochs & Etzbach, 2004; McCarthy & Frieze, 1999; Rupert & Morgan, 2005). In one study of practicing psychologists (Pope, Tabachnick, & Keith-Spiegel, 1987), an alarming 60% of the sample indicated that they had practiced therapy when they were "too distressed to be effective". Another study (Guy, Poelstra, & Stark, 1989) found that 37% of distressed MHPs in their sample indicated that their distress had decreased the quality of care they had provided to their clients. Although the definitions of "distress" used in these studies encompass more than symptoms of burnout, these findings point to the importance of considering MHPs' personal well-being in relation to their professional functioning.

It reasons that therapists who become emotionally, cognitively, and/or physically over-extended in trying to meet the many demands associated with their professional roles may have inadequate resources available for fostering therapeutic relationships and

facilitating treatment with clients. More specifically, affective symptoms of burnout may undermine MHPs' abilities to convey warmth, trustworthiness, concern, engagement, and other interpersonal characteristics shown to promote collaboration, consensus, and a therapeutic bond with clients (Ackerman & Hilsenroth, 2003), which in turn have been shown to predict better treatment outcomes (Norcross, 2002). Emotional distress also may interfere with MHPs' abilities to self-monitor and attend to clients' behavior during sessions. Cognitive manifestations of burnout – such as the development of negative, callous, cynical, or ambivalent attitudes towards clients – could lead MHPs to demonstrate poor motivation, inattention, decreased investment and authenticity, and/or negative emotionality with respect to clients. In addition, burned-out MHPs who lack positive professional attitudes may adopt less prosocial approaches to treatment and may be less able to elicit engagement and participation from clients. Burned-out MHPs' negative self-perceptions and attitudes regarding their clinical competence, therapeutic abilities, and actual performance may lead to increased anxiety, frustration, pessimism, or hopelessness that is apparent to clients. The fact that client perception of the therapeutic alliance is among the most robust predictors of both proximal treatment outcomes (i.e., attendance, compliance with recommendations, etc.) and distal treatment outcomes (i.e., reduction of symptoms, improved functioning, etc.), for both youth clients (Karver, Handelsman, Fields, & Bickman, 2005, 2006; Shirk & Karver, 2003) and adult clients (Lambert & Barley, 2002; Martin, Grasko, & Davis, 2000, Safran & Muran, 2000) underscores the importance of considering how burned-out MHPs' behaviors during sessions may influence clients' willingness to engage in the therapeutic process and follow through with treatment recommendations.

Although the detrimental impact of burnout on the quality of mental health services has been a longstanding, fundamental assumption (Cherniss, 1980; Garner, Knight, & Simpson, 2007; Maslach, 1993; Maslach, Jackson, & Leiter, 1996), few studies have empirically examined the relationship between burnout and treatment process or outcome variables. This gap in the empirical literature has been attributed to “the difficulty of gaining access to the necessary information (which typically requires collection of sensitive information from multiple sources, as well as having an excellent working relationship with the participating organization, staff, and clients)” (Garner, 2006, p. 5; Maslach, Jackson, & Leiter, 1996). Nonetheless, preliminary evidence suggests that MHP burnout and treatment process and outcome variables are probably linked.

Barnes (1999) found burnout to be positively correlated with negative perceptions of clients and Homqvist and Jeanneau (2006) found burnout to be positively correlated with unhelpful and rejecting feelings towards clients. Similarly, Todd and Watts (2005) found burnout among nurses and psychologists in the United Kingdom to be positively associated with self-reported negative emotional responses to clients’ behavior and negatively associated with self-reported willingness to help clients. It reasons that having negative perceptions of and feelings toward clients may influence MHPs’ behaviors during sessions and interfere with development of positive therapeutic relationships with clients. Consistent with this, Garner (2006) found a negative relationship between MHP-rated burnout and client-rated rapport with MHPs. Handelsman (2006) found small-to-medium effects between MHP-rated burnout and perceptions of their therapeutic alliances with youth clients, and McCarthy and Frieze (1999) found that adult clients’

ratings of therapist burnout were positively related to therapists' use of ineffective interpersonal approaches (i.e., social influence strategies) and negatively related to clients' perceptions of the successfulness of therapy. As such, it is not surprising that college students (who were blind to condition) rated burned-out therapists more negatively than non-burned-out control therapists, in an analog study (Renjilian, Baum, & Landry, 1998). Students indicated that they liked the burned-out therapists less, that the burned-out therapists were less attentive to the clients, and that they would be less likely to refer a friend or family member to the burned-out therapists. Interestingly, Dennis and Leach (2007) found that the burnout dimension of depersonalization (i.e., a cognitive bias towards making negative, impersonal, and dehumanizing attributions about the recipients of one's services; Maslach & Jackson, 1986; Schaufeli & Enzman, 1998) was positively related to independent observer ratings of MHPs' negative expressed emotion towards clients. This finding is concerning, as greater tendencies to express negative attitudes and feelings to clients may jeopardize the therapeutic alliance. Although more research is needed before firm conclusions can be made about the impact of MHP burnout on treatment processes and client outcomes, the potential implications are enough to warrant concern in the mental health field.

Given the prevalence and possible consequences of burnout, particularly among MHPs, research examining who develops symptoms, and under which conditions, is critical. Identifying factors that explain variance in levels of burnout among MHPs represents an important step in understanding how this condition develops.

Researchers have in fact identified a number of environmental/work-related and individual variables that reliably predict levels of burnout in various occupational

samples. A small proportion of the literature, however, focuses on MHPs and only two meta-analytic studies of antecedent and consequences of burnout among MHPs have been published (Lee et al., 2011; Lim et al., 2010). Furthermore, those two studies focused on a relatively narrow selection of antecedents (i.e., gender, age, educational level, work experience, work hours, work setting, job stress, over-involvement, control, support, professional identity) and consequences (i.e., job satisfaction and turnover intentions) of burnout. The literature on MHPs also has yet to clarify the underlying processes that account for the relationships between predictor variables and burnout. Greater understanding of these processes may inform efforts to develop prevention and intervention strategies.

Research on other types of human service professionals (e.g., store clerks, customer service representatives, law enforcement, flight attendants, teachers, medical personnel, etc.) has demonstrated that certain types of emotion regulation, known as emotional labor strategies (i.e., deep acting and surface acting), are differentially associated with burnout. The primary objectives of the present study are to (a) determine whether these relationships generalize to a sample of MHPs, and (b) evaluate the empirical links between work factors and individual factors in predicting MHPs' emotional labor and levels of burnout. Before discussing emotional labor, it is important to review what is known about the development and expression of burnout, particularly among MHPs.

## *Professional Burnout*

The concept of professional burnout was first introduced by Freudenberger (1974), who described it as a state of exhaustion, being worn out, and otherwise failing to manage an overload of work demands. An examination of the subsequent literature reveals that multiple conceptualizations of burnout have been proposed, each emphasizing different aspects of the condition. For instance, while Freudenberger focused on failure to receive rewards, Edelwich and Brodsky (1980) focused on loss of idealism, and many others have focused on motivational changes (e.g., Pines and Maslach, 1978; Perlman & Hartman, 1982). Pines, Aronson, and Kafry (1981) equated burnout with the concept of tedium and created a self-report instrument they named The Burnout Measure (i.e., the BM). Subsequent research has challenged the accuracy of this framework and found limited support for the psychometric properties of the BM (e.g., Shirom & Ezrachi, 2003).

As aforementioned, however, the most prominent and influential model of burnout was introduced by Maslach and her colleagues. Maslach and Jackson (1986) conceptualized professional burnout on a tri-dimensional continuum comprised of Emotional Exhaustion (EE), Depersonalization (DP), and diminished Personal Accomplishment (PA). According to this model, burnout is viewed not as a collection of individual symptoms, but as a transactional process that involves the interplay between internal and external factors (Bakker, Van Der Zee, Lewig, & Dollard, 2006; Corey & Corey, 1998; Evans et al., 2006; Kestnbaum, 1984; Maslach, Schaufeli, & Leiter, 2001; Rosenberg & Pace, 2006). Extensive research – much of which has utilized the Maslach Burnout Inventory (MBI; Maslach & Jackson, 1981, 1996), a measure comprised of three

subscales that correspond with the three dimensions of burnout – has demonstrated support for this model (Maslach, Jackson, & Leiter, 1996).

Although the MBI is unequivocally the most utilized and cited measure of burnout (Halbesleben & Buckley, 2004), some researchers have questioned its three-factor structure (see Schaufeli & Enzmann, 1998). For instance, several studies have shown that emotional exhaustion and depersonalization loaded on a single factor (e.g., Brookings, Bolton, Brown, & McEvoy, 1985; Dignam, Barrera, & West, 1986). Many other studies have demonstrated support for the three-factor structure of the MBI (e.g., Belcastro, Gold, & Hays, 1983; Fimian & Blanton, 1987; Golembiewski, Munzenrider, & Stuvenson, 1986; Green & Walkey, 1988; Iwanicki & Schwab, 1981; Lee & Ashforth, 1990; Maslach & Jackson, 1981; Pierce & Molloy, 1989; Schaufeli & Enzmann, 1998; Vanheule, Rosseel, & Vlerick, 2007). Lee and Ashforth (1990) demonstrated support for the MBI's three-factor structure, although they noted that the high association between emotional exhaustion and depersonalization made it difficult to determine the unique contributions of these dimensions.

Related, some researchers have suggested that the dimensions of burnout may not develop simultaneously (e.g., Lee & Ashforth, 1993; Leiter, 1989; Leiter & Maslach, 1988). Rather, it is suggested that “workers respond to exhaustion by depersonalizing clients, and as commitment to clients diminishes, and exhaustion continues, they lose their sense of personal accomplishment and develop a full burnout syndrome” (Rupert & Morgan, 2005, p. 549). Accordingly, emotional exhaustion has a central role in the development of burnout. Although this theory has earned some research support (Lee & Ashforth, 1993; Leiter, 1989; Leiter & Maslach, 1988), it is not universally accepted and

lack of longitudinal studies has not allowed for firm conclusions to be made about the progression of burnout symptoms. Thus, most researchers evaluate the three dimensions of burnout simultaneously, but separately. While not all researchers have adopted Maslach et al.'s model, most agree that a combination of external (work-related) factors and individual differences accounts for the development of professional burnout.

### *Predictors of Burnout*

*Environmental/Work-related Factors.* Much of the burnout literature has focused on how specific environmental conditions and other work-related variables may be implicated in the development of burnout. Studies of burnout in MHPs have examined a variety of such factors, including: work setting; income; position in the organizational hierarchy; total hours worked per week; caseload; time spent with clients, doing administrative tasks (e.g., paperwork), and performing other professional activities (e.g., teaching, supervision, research); percentage of managed care versus self-pay clients served; type and severity of clients' presenting problems; and aspects of the organizational climate (e.g., Ackerley et al., 1988; Allen, 1983; Boice & Myers, 1987; Dupree & Day, 1995; Farber, 1983; Finnoy, 2000; Fortener, 1999; Hellman & Morrison, 1987; Lee & Ashforth, 1996; Onyett, Pillinger, & Muijen, 1997; Radeke & Mahoney, 2000; Raquepaw & Miller, 1989; Rupert & Baird, 2004; Rupert & Kent, 2007; Rupert & Morgan, 2005; Vredenburgh, Carlozzi, & Stein, 1999). Evidence on antecedents of burnout and the magnitudes of such relationships have been somewhat equivocal (Lee, Lim, Yang, & Lee, 2011).

One relatively consistent finding across studies has been the relationship between burnout and work setting, with MHPs in the private sector reporting significantly less burnout than those who are agency-employed (Ackerley et al., 1988; Farber, 1983; Fortener, 1999; Hellman & Morrison, 1987; Raquepaw & Miller, 1989; Rupert & Kent, 2007; Rupert & Morgan, 2005; Vredenburgh, Carlozzi, & Stein, 1999). Although it has been suggested that the solitary nature of individual private practice can result in feelings of isolation and loneliness (Freudenberger, 1990a; Guy, 1987; Sherman, 1996), existing evidence suggests that working in an agency setting puts MHPs at greater risk for burnout. Explanations for this finding include that MHPs in agency settings tend to be less experienced, work more hours per week, carry higher caseloads, work with more severe clinical populations and a higher percentage of managed healthcare clients, report more over-involvement with their clients, experience less autonomy and control in their professional roles, and spend more time doing administrative tasks/paperwork and providing supervision (Ackerley, 1988; Rupert & Baird, 2004; Rupert & Morgan, 2005). Accordingly, relative to MHPs in private practice, agency-employed MHPs may face a higher number and wider range of demands, thereby making them more vulnerable to burnout.

It is not surprising, therefore, that numerous studies have examined levels of burnout in relation to MHPs' workload and involvement in specific occupational activities (e.g., Boice & Myers, 1987; Dupree & Day, 1995; Farber, 1990; Finnoy, 2000; Onyett, Pillinger, & Muijen, 1997; Radeke & Mahoney, 2000; Raquepaw & Miller, 1989; Vredenburgh, Carlozzi, & Stein, 1999). For instance, research has investigated whether caseload or amount of direct client contact is associated with burnout. Surprisingly,

studies have shown that time spent with clients is not related to emotional exhaustion or depersonalization, but is positively associated with personal accomplishment (e.g., Rupert & Kent, 2007; Rupert & Morgan, 2005). Similarly, Raquepaw and Miller (1989) found that, caseload was not associated with the first two dimensions of burnout, but was positively related to personal accomplishment, in their sample of MHPs. It is noteworthy however that MHPs' satisfaction with their caseloads did demonstrate significant negative relationships with MHPs' levels of emotional exhaustion and depersonalization. That is, therapists who indicated that their caseloads were higher than their ideal caseloads reported more emotional exhaustion and depersonalization than did therapists who indicated being satisfied with their caseloads. Related, Rupert and colleagues (2005, 2007) found that perceived over-involvement with clients was positively related to emotional exhaustion and depersonalization. Interestingly, perceived over-involvement also was positively related to personal accomplishment. One possibility is that MHPs tend to perceive over-involvement with clients to be a necessary aspect of performing well in their clinical roles and, thus, a measure of personal accomplishment. Nonetheless, over-involvement with clients may over-tax MHPs' personal resources, thereby increasing their susceptibility to symptoms of emotional exhaustion and depersonalization. It further is possible that individuals with higher levels of emotional exhaustion and depersonalization may experience diminished personal accomplishment over-time, in accordance with the aforementioned progressive theory of burnout development (Rupert & Morgan, 2005). Taken together, it seems that environmental variables such as time spent with clients and caseload size may be less important for emotional exhaustion and depersonalization than how these factors interact with

individual factors (i.e. perceptions of and feelings about environmental factors may matter more than objective measures of such factors).

In addition to direct client contact, research has examined the relationships between MHP burnout and involvement in other professional activities. Most notably, several large-scale studies (Rupert & Baird, 2004; Rupert & Kent, 2007; Rupert & Morgan, 2005) found time spent doing administrative tasks and paperwork to be positively related to levels of emotional exhaustion and depersonalization, and negatively related to levels of personal accomplishment, in practicing psychologists. Rupert and Kent (2007) also found personal accomplishment to be negatively related to time spent supervising, consulting, teaching, and doing research. Taken together with the literature on direct client contact, the existing research on workload and work activities suggests that MHPs who spend more time doing tasks other than therapy/assessment tend to be at greater risk for burnout compared to MHPs who spend less time engaged in such tasks. It reasons that MHPs may find direct clinical work more rewarding and/or less draining than other professional activities. Despite evidence that greater time spent providing direct care to clients, relative to doing other tasks, is associated with more favorable outcomes for MHPs in terms of burnout (e.g., Ackerley, 1988; Rupert & Kent, 2007; Rupert & Morgan, 2005), research suggests that working with certain types of clients may put MHPs at greater risk of burnout. Numerous studies have shown that exposure to challenging client behavior is associated with stress (e.g., Chung & Harding, 2009; Freeman, 1994; Jenkins, Rose, & Lovell, 1997; etc.). In addition, studies have shown working with clients who have severe mental illnesses and/or exhibit particularly challenging behavior to be positively associated with emotional exhaustion and

depersonalization in MHPs (Acker, 1999; Linehan Cochran, Mar, Levensky, & Comtois, 2000; Rupert & Baird, 2004; Rupert & Kent, 2007; Rupert & Morgan, 2005). Based on Farber and Heifetz's (1982) assumption that MHPs expect their work to be challenging but their clinical efforts to be rewarding, Lee et al. (2011) suggest that "providing constant caring without the compensation of success (e.g., positive changes in their clients) apparently produces burnout in psychotherapists" (1). It reasons that working with individuals who demonstrate more significant and/or complicated presenting problems may require MHPs to utilize more emotional, cognitive, and physical resources, both during and between (e.g., more critical incident reports, more need for consultation and collaboration with other service providers, etc.) sessions, thereby overwhelming those resources and putting them at greater risk for burnout. If those efforts do not yield positive therapeutic outcomes with such challenging clinical populations, MHPs may be at even greater risk.

Related, research has demonstrated a positive association between burnout and MHPs' levels of involvement with clients covered by managed healthcare insurance. As aforementioned, the rise of managed healthcare has led to greater pressure on MHPs (particularly those in the public sector) to increase their caseloads, shorten the length of treatment, and provide more extensive documentation for the purposes of financial reimbursement (Rupert & Baird, 2004; Rupert & Morgan, 2005). It reasons that MHPs may find it difficult to reconcile these external demands with their perceptions of what is in their clients' best interests clinically. This may evoke stress, which in turn may contribute to burnout. Research has shown that greater involvement with managed care clients is associated with a variety of factors that are linked to burnout, including: more

frequent exposure to negative/challenging client behaviors, doing more administrative tasks/paperwork, receiving less supervision, working longer hours, experiencing more stress, and being less satisfied with one's income (Rupert & Baird, 2004; Rupert & Kent, 2007; Rupert & Morgan, 2005). It is not surprising, therefore, that Rupert and colleagues (2004, 2005, 2007) consistently found percentage of managed care clients comprising MHPs' caseloads to be positively related to levels of emotional exhaustion and depersonalization, and negatively related to levels of personal accomplishment. Accordingly, the unique characteristics and demands associated with providing services to managed care clients may put MHPs at greater risk for burnout.

The literature suggests that MHPs today, especially those who work in agency-settings and/or are more involved with managed care, have fewer opportunities to practice decision-making, have less control over resources, and are more likely to "view their professional activities as inappropriate and incongruent with their training, professional expertise, and desires (Acker, 2003, p.65; see also Acker, 1999; Drolen & Harrison, 1990; Sederer & Mirin, 1994; Minikoff, 1994; Wells, Astrachan, Tichler & Unutzer, 1995). As such, it is not surprising that studies have shown specific work stressors to be associated with symptoms of burnout. Among the variables that have been studied are role stressors. Chen, Chen, Tsai, and Lo (2007) state: "Role stress can arise from different patterns of mismatch in expectations, resources, capability and values about the role....In contrast to role strain, which is a state of emotional arousal when an individual experiences role-related stress events, role stress is external to role takers and results from social demands" (498). Accordingly, role stress plays a part in shaping professionals' thoughts, feelings, and behavior. Role conflict is a type of role stress

conceptualized as the result of “incompatible demands or expectations placed upon workers”, while role ambiguity is another type of role stress conceptualized as the result of “uncertainty as to what to do and/or from questioning the impact of practice interventions in the lives of clients with mental illness” (Acker, 2003, p.66). Acker (2003) found that role conflict and role ambiguity were positively correlated with both emotional exhaustion and depersonalization in a sample of MHPs. Furthermore, when controlling for demographic variables, a set of organizational climate variables that included role conflict and role ambiguity (as well as social support at work) added significantly to the total variance accounted for in all three dimensions of burnout.

Another type of work stressor that has been examined in relation to burnout is lack of autonomy, which is conceptualized as the amount of control employees have over their decisions and work activities, given the limits of organizational rules. It reasons that MHPs who feel less able to exert control and independence within their work environments (that is, lower autonomy) may experience more strain in trying to perform their professional roles, and thus may be more vulnerable to symptoms of burnout. While multiple studies have found a significant negative association between autonomy and burnout (e.g., Allen, 1983; Cherniss, 1992; Demerouti, Mostert, & Bakker, 2010; Garner, Knight, and Simpson, 2007; Oktay, 1992; Pines & Kafry, 1981; ; Schaufeli, Bakker, & Van Rhenen, 2009), studies of MHPs have provided mixed evidence. For instance, Kim and Stone (2008) did not find a direct relationship between autonomy and burnout in their sample of social workers, while Garner et al. (2007) did find a significant relationship in their sample of drug abuse counselors. More research is needed to clarify the relationship between these variables.

The empirical literature clearly indicates that multiple, inter-related environmental variables contribute to the prediction of burnout in MHPs. However, the fact that not all people facing the same working conditions experience equivalent levels of burnout suggests that individual differences also are important (Buhler & Land, 2003; Jacobs & Dodd, 2003).

*Individual Factors.* Although researchers have tended to emphasize environmental and work-related factors that predict burnout (Halbesleben & Buckley, 2004), numerous studies have examined individual factors to determine which variables may help to explain variance in burnout across employees. Some of the factors studied in samples of MHPs include: demographic variables, professional background variables (e.g., years experience, education, theoretical treatment orientation, etc.), and personality traits. Despite the large quantity of research, the roles of certain variables remain unclear. In particular, mixed findings have been reported in regards to the relationships between demographic variables and burnout.

The relationship between burnout and gender, for example, has differed across studies (Rupert & Jamie, 2007). While it was initially suggested that women may be at greater risk for burnout compared to men (Freudenberger, 1986; Maslach, 1982a), many studies have found no differences in levels of burnout by gender (e.g., Ackerley et al., 1988; Farber, 1985; Mills & Huebner, 1998; Raquepaw & Miller, 1989; Thornton, 1992). Other studies have found significant differences by gender (e.g., Acker, 2003; Dupree & Day, 1995; Krogh, 1996; Maslach & Jackson, 1985; Rosenberg & Pace, 2006; Vredenburg et al., 1999) and, in some cases, female MHPs have had lower levels of burnout than men, particularly in regards to depersonalization (e.g., Acker, 2003;

Maslach & Jackson, 1985; Rosenberg & Pace, 2006; Vredenburg et al., 1999). It has been suggested that these findings may be the result of traditional gender-role socialization, as females are traditionally taught to be emotionally invested (Rosenberg & Pace, 2006). Interestingly, Rupert and Morgan (2005) and then Rupert and Kent (2007) found that women in agency settings reported higher levels of emotional exhaustion than women in independent practice settings reported, while emotional exhaustion among men did not vary across work settings. These authors suggest that gender differences may in fact exist within work settings, but average out when men and women are compared across settings. It is not clear why this interaction effect occurs, but one possible explanation is that the greater flexibility in work hours associated with independent practice may be more important for women than men, as women tend to assume more childcare and other household duties than men (Rupert & Kent, 2007). Additional studies need to be conducted by other researchers before conclusions can be made about the nature of the relationship between gender and burnout; however, at this point, there is not sufficient evidence to suggest that gender is a reliable and meaningful predictor of burnout.

The relationship between race/ethnicity and burnout also remains unclear. Studies that include race/ethnicity as a variable have typically reported no significant differences in levels of burnout. This may be related to the fact that most studies have used samples in which Caucasian MHPs comprised the vast majority. Given the relatively modest size of the samples used in most studies, it is possible that lack of statistical power may have prevented detection of small or medium effects. Two studies, however, have found significant differences by race/ethnicity. Both Maslach and Jackson

(1986) and Salyers and Bond (2001) found Caucasian MHPs reported higher levels of Emotional Exhaustion and Depersonalization than their African Americans counterparts reported. In the latter study, these differences remained after controlling for geographic location and work environment. Salyers and Bond suggest that “psychological thresholds for defining levels of stress or type of interactions that are considered stressful may differ as a function of cultural or ethnic background” (402). Accordingly, the Caucasian MHPs may have had higher levels of burnout due to lower levels of stress-tolerance. This finding is consistent with evidence from other studies. For instance, Haley, et al. (1996) found that African American caregivers of family members with Alzheimer’s disease appraised patient problems as less stressful than Caucasian caregivers did. Similarly, in a sample of parental caregivers of individuals with severe mental illness, Pickett, Vraniak, Cook, and Cohler (1993) found that racial groups did not significantly differ on perceived burden, but African Americans had significantly higher levels of coping mastery and self-esteem, and lower levels of depression. Additional studies have shown that, compared to Caucasians, African Americans tend to report less burden and strain as caregivers for people with a variety of illnesses, including: dementia (Connell & Gibson, 1997; Haley et al., 1996), mental retardation (Valentine, McDermott, & Anderson, 1998), and HIV/AIDS (Turner & Catania, 1997). Further research is needed in order to determine whether these patterns generalize to burnout among MHPs. Salyers and Bond (2001) also found racial congruence to be important for burnout, as clinicians who were racially incongruent with the majority of their clients reported higher levels of emotional exhaustion and depersonalization than did those who were racially congruent. It reasons that understanding and responding to the needs of clients from different ethnic/cultural

backgrounds may require greater cognitive and emotional resources, which, in turn, may contribute to MHPs' occupational stress and, thus, their risk of developing burnout. Once again, given the overall scarcity and mixed nature of findings from existing studies, more research in this area is needed before sound conclusions can be made. Presently, there is not sufficient evidence to suggest that race/ethnicity is a reliable and meaningful predictor of burnout across samples of MHPs.

Findings on the relationship between age and burnout have been somewhat mixed, as well. While most studies have found burnout to be negatively correlated with age (e.g., Garland, 2004; Garner, Knight, & Simpson, 2007; Rupert & Morgan, 2005; Rupert & Kent, 2007; Vredenburg, Carlozzi, & Stein, 1999), other studies have reported no relationship (e.g., Mills & Huebner, 1998; Raquepaw & Miller, 1989). It is noteworthy however that many of the findings reported in Raquepaw and Miller's (1989) study are inconsistent with preceding and subsequent research, suggesting that their sample may have been distinct in some way and, thus, the results may not generalize to other MHPs. It has been proposed that the negative relationship typically found between age and levels of burnout may reflect that older MHPs have learned how to cope with work pressures over time or, alternatively, that more burned out MHPs tend to find positions in less demanding work-settings (private-practice) or to leave the field altogether (e.g., Rupert & Morgan, 2005; Rupert & Kent, 2007). Accordingly, only the most resilient and adaptive MHPs remain in strenuous positions for many years.

Related to age is the amount of experience MHPs have had providing mental health services. Despite initial theories that burnout develops over time as one is worn down by professional strain, recent research shows a negative relationship between

burnout and years experience, as novice MHPs tend to report greater difficulties in their roles than more seasoned MHPs do (e.g., Ackerley et al., 1988; Rupert & Kent, 2007; Rupert & Morgan, 2005). Explanations for this include that less experienced MHPs are less confident in their professional abilities and less practiced in managing work related demands (e.g., Ackerley et al., 1988; Rupert & Kent, 2007; Rupert & Morgan, 2005). More seasoned MHPs have had more opportunities to build a repertoire of techniques for managing clinical and administrative demands. In addition, greater exposure to various clinical situations may enhance MHPs' abilities to anticipate and prepare for potential obstacles to treatment. In turn, more experienced MHPs may be better able to prevent or at least mitigate the effects of these potential stressors. As aforementioned, it also is possible that MHPs who are less able to cope effectively with occupational stress may discontinue working in the field, and therefore only the more adaptive individuals continue to be MHPs. Based on this reasoning, it follows that individuals with certain personality traits (as discussed in more detail below) may be inherently more able to manage work-related stress effectively, and to improve on or develop new stress management strategies over time, thereby allowing them to avert burnout and remain in the field longer than individuals without these characteristics. Given that age and years of professional experience are likely to be significantly intercorrelated, it is surprising that studies have neglected to examine the unique versus shared variance accounted for by these variables. As such, it has not been possible to tease apart the respective contributions of age and years of experience in predicting burnout.

Many other professional training/background variables also have been examined in relation to burnout, including: education level (e.g., Bachelors, Masters, Doctorate),

graduate program type (e.g., psychology, psychiatry or other medical, social work, counseling, education, etc.), and treatment orientation (e.g., cognitive-behavioral, psychodynamic, pharmacological, etc.). Although not well explained in the research literature, it reasons that researchers may have suspected that certain types of training could help to protect against the stressors and cognitions that lead to professional burnout. Regardless, these variables typically have shown no relationship with burnout (e.g., Ackerley et al., 1988; Raquepaw & Miller, 1989; Rupert & Morgan, 2005), suggesting that MHPs' levels and types of education may not matter as much as more ingrained individual characteristics in the context of burnout development.

Borrowing from the stress and coping literature (e.g., Hurrell, 2005; Lazarus, 1993), researchers posit that differences in stable individual characteristics, such as personality traits, may directly contribute to burnout and also moderate the relationships between stressors and experienced stress, as well as between experienced stress and stress responses (Brief & Weiss, 2002; George & Brief, 2004; Lazarus & Cohen-Charash, 2001), both of which may contribute to burnout. Thus, it is not surprising that a large number of studies have empirically examined the relationships between personality traits, other predictor variables, and burnout. In fact, Schaufeli and Enzmann (1998) counted over 100 studies that included measures of burnout and at least one personality variable. Based on a search of the PsycInfo database (using the keywords "burnout" and "personality" and the following limits: published 1998-2008, peer-reviewed journal, empirical study), it appears that over 100 additional studies examining the relationship between burnout and personality have been published in peer-reviewed journals since Schaufeli and Enzmann's count. Some of the personality variables studied include: locus

of control (e.g., Browning, Ryan, Greenberg, & Rolniak, 2006; Buhler & Land, 2003), cognitive adaptation disposition (Browning et al., 2006), existential frustration (Buhler & Land, 2003), self-aggression (Buhler & Land, 2003), ability to love (Buhler & Land, 2003), self-esteem (e.g., Browning et al., 2006; Buhler & Land, 2003), personal satisfaction (Buhler & Land, 2003), reactive aggression (Buhler & Land, 2003), exactness (Buhler & Land, 2003), appreciation need (Buhler & Land, 2003), temperament/trait affect (e.g., Freudenberger, 1974; Houkes, Janssen, & de Jonge, 2001a, 2001b, 2003a, 2003b; Kahn, Schneider, & Jenkins-Henkelman, 2006; Langelaan, Bakker, van Doornen, & Schaufeli, 2006; Thoresen, Kaplan, Barsky, Warren, & de Chermont, 2003; Zellars, Perrewé, & Hochwarter, 1999), and the so-called Big Five traits (i.e., Neuroticism, Extraversion, Openness, Agreeableness, and Conscientiousness; e.g., Bakker, van der Zee, Lewig, & Dollard, 2006; Bahner & Berkel, 2007; Buhler & Land, 2003; Eastburg, Williamson, Gorsuch, & Ridley, 1994; Francis, Loudon, & Rutledge, 2004; Ghorpade, Lackritz, & Singh, 2007; Kim, Shin, & Umbreit, 2007; Kokkinos, 2007; Lundström, Graneheim, Eisemann, Richter, & Åström 2007; Michielsen, Willemsen, Croon, De Vries, & Van Heck, 2004; Piedmont, 1993; Zellars, Perrewé, & Hochwarter, 2000).

Despite the large quantity of studies, several issues make the findings on personality and burnout difficult to interpret. One problem with the literature is that conceptualizations and measurement of personality, and to a lesser extent burnout, have varied across studies. Langelaan, Bakker, van Doornen, and Schaufeli (2006) argue that “the inclusion of certain personality variables in a research design seems to have been dependent more often on the arbitrary choice of the researcher than on a theory of

personality” (34). That is, studies examining the relationships between personality variables and the dimensions of burnout have not been sufficiently grounded in theory. Another challenge in interpreting the literature relates to the occupational diversity of samples used in studies of personality and burnout. It reasons that people with certain traits may be more or less likely to pursue (and obtain employment within) particular occupational fields. Furthermore, it reasons that the demands associated with specific occupational roles and environmental conditions may be more or less difficult for individuals with certain personality traits to manage in a positive (i.e., adaptive) manner. Accordingly, it is important for the relationships between burnout and personality traits to be assessed within the context of a given occupation (i.e., mental health services) and setting (i.e., agency, school, private-practice, etc.), and to take specific environmental conditions (e.g., workload, coworker/supervisor support, etc.) into consideration. Unfortunately, studies on MHPs comprise a relatively small proportion of the literature in this area. Nonetheless, evidence from the existing research suggests that personality traits are related to levels of burnout in MHPs.

In a study of school psychologists, for instance, Mills and Huebner (1998) found that four of the Big Five personality traits – Extraversion, Openness to experience, Agreeableness, and Conscientiousness – explained 10% of the variance in emotional exhaustion, above and beyond that accounted for by demographic and work variables (i.e., total environmental stressors). Together, the set of predictors accounted for 41% of the variance in EE scores on the MBI. Regarding depersonalization, the complete set of predictors accounted for 22% of the variance in DP scores, with the four personality traits contributing 12% above and beyond that accounted for by demographic and work

variables. Neither the set of demographic factors nor the set of work factors accounted for significant variance in personal accomplishment. However, with the additional variance explained by personality factors (24%), the complete set of predictor variables accounted for 30% of the total variance in PA scores.

One Big Five personality trait that has earned attention in the general burnout literature and demonstrated a relatively consistent relationship with burnout in MHPs and other human service professionals is Extraversion (the polar opposite of introversion). This trait is characterized by tendencies to engage in a higher frequency and intensity of personal interactions, to experience and exhibit more positive emotions, and to be more optimistic, self-confident, dominant, active, and excitement seeking (e.g., Bakker et al, 2006; Costa & McCrae, 1992). In addition, extraversion is associated with the use of effective coping strategies, such as rational problem-solving, social support seeking, and positive cognitive reappraisal of problems (e.g., Dorn & Matthews, 1992; Watson & Hubbard, 1996). It has been suggested that extraverts' sanguine temperament lends itself to adaptive functioning (e.g., Watson & Clark, 1992). Thus, it is not surprising that most research has shown extraversion to be negatively related to emotional exhaustion (Eastburg, Williamson, Gorsuch, & Ridley, 1994; Francis, Loudon, & Rutledge, 2004; Ghorpade, Lackritz, & Singh, 2007; Kim, Shin, & Umbreit, 2007; Michielsen, Willemsen, Croon, De Vries, & Van Heck, 2004; Piedmont, 1993) and depersonalization (Bakker et al., 2006; Francis et al., 2004; Ghorpade, Lackritz, & Singh, 2007; Kim, Shin, & Umbreit, 2007; Zellars et al., 2000), and positively related to personal accomplishment (Bakker et al., 2006; Eastburg et al., 1994; Francis et al., 2004; Ghorpade, Lackritz, & Singh, 2007; Kim, Shin, & Umbreit, 2007; Zellars et al., 2000).

Interestingly, in Bakker et al.'s study of volunteer counselors, extraversion was unrelated to emotional exhaustion, but a negative predictor of depersonalization and a positive predictor of personal accomplishment. Extraversion was particularly related to personal accomplishment for volunteer counselors who reported many negative experiences with clients. The authors suggest that the tendency of extraverts to engage in intense personal interactions may counteract depersonalization, while their tendencies to be optimistic and self-confident may foster feelings of personal accomplishment. Though the finding of a non-significant association between emotional exhaustion and extraversion is inconsistent with most research, Bakker et al.'s study is not the first that failed to find a negative relationship. Specifically, Zellars et al. (2000) found extraversion to be unrelated to emotional exhaustion in a sample of American nurses and Buhler and Land (2003) found that extraversion was positively related to emotional exhaustion in German nurses who reported low social support from coworkers (Buhler & Land, 2003). One explanation for this latter finding is that individuals with high extraversion may rely on interpersonal relationships to help mitigate or buffer against the impact of work stress. Studies have found mixed evidence regarding the association between social support and burnout (Lee et al., 2011), as some studies have found strong relationships (e.g., Delia & Patrick, 1996; Ross, Altmaier, & Russell, 1989), while others have found very modest relationships (e.g., Elman & Dowd, 1997; Kruger, Botman, & Goodenow, 1991). Lack of social support may be particularly detrimental for extraverts, given their tendencies to seek social affiliation. Related, Piedmont (1993) found the excitement-seeking component of the extraversion scale of the Eysenck Personality Inventory to be positively correlated with emotional exhaustion. Extraverts' tendencies

to be sensation seeking and to engage in risky behaviors may be taxing of their internal resources and thus, without adequate external resources (such as social support at work) to facilitate coping, they become more susceptible to emotional exhaustion. More research is needed in order to identify moderating and mediating factors that may help to clarify the relationships between extraversion and the dimensions of burnout in MHPs.

Research indicates that environments characterized by high demands and low resources tend to be more taxing of individuals' abilities to manage stress and, thus, often elicit negative emotions (i.e., anger, anxiety, or depression) (Folkman & Moskowitz, 2004). Such emotions can be stressful in and of themselves, and often require down-regulation before a stressful situation can be addressed (Folkman & Moskowitz, 2004). It follows that employees with low extraversion (i.e., less sanguine temperaments), who work in environments characterized by high demands and low resources, may be particularly likely to experience negative emotions, to have difficulty regulating their experiences of and responses to these emotions and the situational stressors associated with them, and, thus, to demonstrate higher levels of burnout, compared to employees with higher extraversion.

In addition to studying Big Five personality traits, many researchers (particularly in the industrial/organizational psychology literature) have examined trait affect in relation to the dimensions of burnout and occupational stress. Positive and negative affectivities are viewed as two distinct, but partially correlated, unipolar dimensions of personality (Thoresen et al., 2003; see also, Watson et al., 1988; Watson, Wiese, Vaidya, & Tellegen, 1999). Positive trait affect (PTA) is characterized by tendencies to be optimistic and experience feelings of enthusiasm, alertness, activeness, and energy, while

negative trait affect (NTA) is characterized by tendencies to be pessimistic and experience feelings of anger, guilt, fear, nervousness, and perceived stress (Grandey, 2000; Watson, 2000; Watson & Clark, 1984; Watson & Tellegen, 1985; Watson et al., 1988, 1999).

Given their conceptual overlap, it is not surprising that PTA has most often been empirically associated with extraversion (Thoresen et al., 2003; Watson & Clark; 1992, 1997, Watson et al., 1988). A review of the literature reveals that many authors have used the term extraversion interchangeably with PTA, implying that they are synonymous (e.g., Thoresen et al., 2003). In fact, some researchers have proposed that findings on extraversion are applicable to PTA, and vice versa (e.g., Conard & Matthews, 2008; Watson & Clark, 1992, 1997). Support for this argument is provided by evidence of similar patterns of association with other factors. For instance, both extraversion and PTA are associated with cognitive tendencies to focus more on positive information, to retrieve more positive memories, and to make more positive attributions about hypothetical events (e.g., Byrne, & Eysenck, 1993; Hemenover; 2001; Noguchi, Gohm, & Dalsky, 2006; Rusting, 1999). Although PTA was not measured in the present study, because it overlaps significantly with extraversion, relevant research will be reviewed.

Evidence of the relationships between PTA and perceptions of work factors has been provided by a variety of research. For instance, numerous studies have empirically demonstrated the importance of PTA in the prediction of burnout (and occupational stress) across a variety of work samples (e.g., Barsky, Thoresen, & Warren, 2004; Brief, Burke, & George, 1988; Elliott, Chartrand, & Harkins, 1994; Fogarty, Machin, & Albion, 1999; Hoge, & Bussing, 2004; Houkes, Janssen, & de Jonge, 2001a, 2001b, 2003a,

2003b; Jacobs & Dodd, 2003; Kahn, Schneider, & Jenkins-Henkelman, 2006; Schaubroeck, Ganster, & Fox, 1992; Thompson, Page, & Cooper, 1993; Thoresen et al., 2003; Zellars, & Perrewé, 2001; Zellars, Perrewé, & Hochwarter, 1999; Zellars, Perrewé, & Hochwarter, 2006). Most notably, in their meta-analysis of over 200 published and unpublished studies, Thoresen et al. (2003) found that PTA (as well as NTA) contributed unique variance to the prediction of burnout, job satisfaction, organizational commitment, and turnover intentions. Interestingly, although PTA was at least moderately correlated with all of these dependent variables at the bivariate level, the associations generally were stronger when affect and outcome were matched in terms of hedonic tone (i.e., PTA's relationship with personal accomplishment is stronger than its relationships with emotional exhaustion and depersonalization), suggesting that PTA is more related to positive than negative outcomes.

In addition to demonstrating the direct relationships between PTA and burnout (e.g., Jacobs & Dodd, 2003; Thoresen et al., 2003), studies also have shown that PTA may moderate the relationships between other predictor variables and burnout (and other measures of occupational stress). For instance, Smith and Tziner (1998) found that PTA moderated the relationship between work satisfaction and burnout. As with other personality characteristics, the literature indicates that the associations between PTA and the dimensions of burnout are complex and warrant further investigation.

This review of the literature on environmental (work-related) and individual predictors of burnout reveals that theories tend to emphasize how cognitive and affective tendencies associated with particular traits are likely to influence individuals' perceptions of and responses to working conditions (demands and resources) and, thus, individuals'

levels of occupational stress and burnout. This is consistent with the notion that burnout arises in individuals who are more inclined to experience work-related situations as stressful and/or less inclined to respond to work-related demands in an adaptive manner (i.e., in ways that facilitate their positive functioning in the short-term and, perhaps more importantly, in the long-term). One factor that has earned increasing attention in the human services literature over the past few decades, and has been empirically linked to work demands, personality, and burnout, is emotional dissonance (e.g., Arvey, Renz, & Watson, 1998; Brotheridge & Grandey, 2002; Diefendorff, & Richard, 2003; Fisher & Ashkanasy, 2000; Hochschild, 1983; Morris & Feldman, 1996; Rafaeli & Sutton, 1987; Rubin, Tardino, Daus, & Munz, 2005).

### *Emotional Dissonance*

First introduced by Hochschild (1983), emotional dissonance is defined as the state of strain that results when individuals' true or felt emotions are inconsistent with their perceptions of what emotional expressions are appropriate or required in a given situation (Rubin et al., 2005). Evidence suggests that a combination of environmental and individual characteristics – such as personality traits and affective tendencies – make it more or less likely for emotional dissonance to occur (e.g., Diefendorff, & Richard, 2003; Rubin et al., 2005). More specifically, research indicates that experiences of and responses to emotional dissonance are conceptually and empirically associated with employees' perceptions of and attitudes about emotional display rules (e.g., Abraham, 1998; Cheung, Tang, & So-Kum, 2007).

Emotional display rules represent formal and informal guidelines or standards for behavioral expression of emotions within a given context. In other words, they “spell out which emotions are appropriate in particular situations, as well as how those emotions should be expressed to others” (Diefendorff, & Richard, 2003, p. 284; also see Ashforth & Humphrey, 1993; Grandey, 2000; Hochschild, 1983; Morris & Feldman, 1996; Rubin et al., 2005). These standards emphasize the publicly observable side of emotional expressions rather than the genuine feelings employees experience at work (Ashforth & Humphrey, 1993; Rubin et al., 2005). Research in this area has tended to focus on organizational (or site-specific) standards for employees’ emotional expressions during interactions with customers/clients and, in some cases, with coworkers. These display rules can be formally transmitted through training manuals (Rafaeli & Sutton, 1987) or informally transmitted through organizational culture (Van Maanen & Kunda, 1989). The potential importance of occupation-specific standards/norms for emotional expressions has been largely ignored in the empirical literature, but it reasons that they may operate in the same manner as organizational display rules. For instance, individuals (such as MHPs) may learn and internalize display rules during their professional education and training, and may perceive these guidelines as relevant in their current professional roles, even in the absence of explicit organizational standards (Rubin et al., 2005).

Wharton and Erickson (1993) describe three main types of emotional display rules - integrative, differentiating, and masking. Integrative display rules encourage expression of emotions that are hedonically positive and tend to “create good feelings in others and encourage harmony among people (e.g., love, happiness, compassion)”

(Johnson, 2007, p. 3). Conversely, differentiating display rules encourage expression of emotions that are hedonically negative and “tend to drive people apart (e.g., fear, hate, anger)” (Johnson, 2007, p. 3). The third type of display rule, masking, involves suppression of felt emotions in order to express a different emotion or neutrality (Cropanzano, Weiss & Elias, 2004). Research indicates that the most prevalent display rules in organizations promote expression of integrative emotions and masking of differentiating emotions (Diefendorff & Richard, 2003). However, the particular emotional expressions considered to be appropriate and/or required in a given job vary by occupation and work setting (Rubin et al., 2005).

Using Hochschild’s (1983) dichotomous grouping approach, which classifies occupations into high and low interpersonal requirements (see Wharton, 1993), Schaubroeck and Jones (2000) found that this occupational classification was positively related to perceived demands to express positive (integrative) emotions but was unrelated to perceived demands to suppress negative (differentiating) emotions. Additionally, Brotheridge and Grandey (2002) compared display rule perceptions for five occupations (service/sales, managerial/professional, clerical, labor, human service) and found no between-group differences for perceived demands to suppress negative emotions, but significant between-group differences for perceived demands to express positive emotions, with laborers being the lowest and human service workers being the highest. The results of these two studies provide support for a relationship between occupational differences and perceived demands to express positive emotions but not for perceived demands to suppress negative emotions. It may be that individuals perceive similar demands to suppress negative emotions, regardless of their particular occupations.

However, it also is possible that previous operationalizations of occupational differences have not been sensitive enough to reveal important differences in interpersonal demands between jobs.

The literature is silent on the matter of MHPs' perceptions of and attitudes about display rules for emotional expressions with/toward clients. It reasons that, in the context of providing mental health services, display rules may be more variable, less clearly defined, and less explicit than in many other types of human service contexts, as the goals of social exchanges between MHPs and clients are not clear-cut. For example, in many circumstances, MHPs' expressions of integrative emotions during sessions are likely to foster client engagement; however, if a MHP exhibits positive affect while a client is crying, the MHP's emotional displays may be perceived by the client as highly invalidating and lead to a rupture of the therapeutic relationship. Likewise, MHPs' expressions of differentiating emotions during sessions are likely to deter client engagement in most cases; however, certain clinical situations may prompt a MHP to exhibit negative affect (e.g., disappointment, frustration, etc.) toward a client in order to facilitate the therapeutic process. Fostering engagement is a short-term objective of most types of service interactions, but social exchanges between MHPs and clients are unique in that their ultimate purpose is to facilitate clinical improvement and reduced need for services in the long-term. While a full discussion of the important distinctions between theoretical orientations/treatment approaches is beyond the scope of the current paper, it is noteworthy that interactions between MHPs and clients do not always follow a traditional or normative social script and are likely to dramatically differ across MHP-client pairs based on the MHP's professional background, the client's clinical

presentation and reason for referral, and setting characteristics. Given the complexity of these issues, it is not surprising that the literature has yet to identify what emotional display rules MHPs perceive to apply in their interactions with clients. Even if the content of professional or setting-specific display rules for MHPs were known, it would be difficult to assess the extent to which MHPs in real-world settings demonstrate behavior consistent with these requirements, as the confidential nature of therapy and other mental health services typically requires that they be conducted “behind closed doors” (i.e., without being directly observed by coworkers or supervisors). Nonetheless, an important step toward understanding the importance of display rules within the context of mental health service delivery is to determine the range of emotional expressions that MHPs perceive to be acceptable or inappropriate. Because no measure of MHP display rules was found in the literature, an exploratory measure was developed and piloted as part of the present study.

The general purpose of display rules is to promote positive and successful working environments and service experiences for customers/clients (Rubin et al., 2005). Yet, display rules also may act as a job stressor for employees. Emotional displays usually are met with a prescribed range of responses. However, when an interaction partner’s reaction significantly deviates from that range, the exchange may become socially awkward and stressful (Johnson, 2007; Keltner & Kring, 1998). For instance, if a MHP is attempting to express empathy and acceptance to a distressed therapy client and the client becomes angry, the MHP may experience emotions (e.g., surprise, disdain, frustration) that conflict with his/her perception that conveying understanding and unconditional positive regard to clients is appropriate. As Cheung, Tang, and So-Kum

(2007) suggest, while explicit display rules may reduce ambiguity at work by providing standards for appropriate emotional expression, they also may undermine employees' autonomy in expressing their genuine emotions, create emotional dissonance, and therefore become a source of job stress.

Although display rules play a central role in emotion management at work, few empirical studies have systematically investigated predictors of employees' perceptions of and responses to display rules. Morris and Feldman (1996) contend that trait affect influences how frequently individuals experience emotional dissonance within a given environment. Accordingly, when employees' levels of NTA and/or PTA are incompatible with work demands (such as showing or not showing a particular emotion), emotional dissonance is likely to occur more often. This theory suggests that individuals with high PTA are more likely to experience emotional dissonance when display rules call for limited expression of positive emotions, individuals with low PTA are more likely to experience emotional dissonance when display rules call for frequent expression of positive emotions, individuals with high NTA are more likely to experience emotional dissonance when display rules call for limited expression of negative emotions, and individuals with low NTA are more likely to experience emotional dissonance when display rules call for frequent expression of negative emotions. Although not specifically mentioned by Morris and Feldman (1996), it reasons that similar patterns of association with emotional dissonance may be demonstrated with high and low levels of neuroticism and extraversion, each respectively. Researchers have proposed that, regardless of its origin, when emotional dissonance does occur, employees with high levels of positive and/or negative affectivity are likely to have more difficulty regulating their emotional

expressions (e.g., Brotheridge & Lee, 2003). Again, the same may be true of employees with high levels of neuroticism and/or low levels of extraversion.

The relationships between display rules, emotional dissonance, and individual outcomes remain somewhat unclear (e.g., Diefendorff, & Richard, 2003; Rubin et al., 2005). For instance, although Best, Downey, and Jones (1997) found the perceived requirement to avoid differentiating emotional expressions was positively associated with burnout, Brotheridge and Grandey (2002) found that the relationship between perceptions of this display rule and emotional exhaustion became nonsignificant when the effect of NTA was partialled out. Another study found that the importance supervisors place on interpersonal job demands of their workers (i.e., how explicit display rules were) was positively related to worker emotional exhaustion (Wilks & Moynihan, 2005). Further complicating this picture, evidence from research outside the United States (i.e., studies of Chinese, German, Dutch, and other employee samples) has shown that the mismatch between felt and expressed emotions (i.e., emotional dissonance), rather than the perceived requirement to express sanctioned emotions or suppress unsanctioned emotions (i.e., display rules), is a stronger predictor of negative outcomes such as burnout (Abraham, 1998; Cheung, Tang, & So-Kum, 2007; Lewig & Dollard, 2003; Rubin et al., 2005; Zapf et al., 1999, 2001). It is noteworthy, however, that emotional dissonance is challenging, if not impossible, to measure accurately, as it is a complex and dynamic process, much of which occurs without conscious awareness. How individuals typically respond to emotional dissonance in their professional roles is more feasible to measure than levels of emotional dissonance and is a more proximal predictor of stress that may

have greater implications than display rules for more distal outcomes, such as burnout (e.g., Brotheridge & Grandey, 2002; Grandey, 2000).

When individuals' genuine emotions conflict with their perceptions of display rules for a given situation, the resulting emotional dissonance they experience is aversive and individuals are inherently motivated to reduce it (e.g., Grandey, 2000). Efforts to resolve emotional dissonance represent a subset of emotion regulation strategies known as emotional labor (e.g., Brotheridge & Lee, 1998; Grandey, 2000; Gross, 1998a, 1998b; Rubin et al., 2005). Types of emotional labor have been differentially associated with burnout in a variety of occupational groups (e.g. Brotheridge & Grandey, 2002; Brotheridge & Lee, 1998; Cheung, Tang, & So-Kum, 2007; Morris & Feldman, 1997; Rubin et al., 2005). To better understand emotional labor it is important to first provide further context by briefly reviewing the broader literature on emotions and emotion regulation.

### *Emotions and Emotion Regulation.*

Emotions play critical roles in many aspects of human functioning, such as by facilitating decision-making, providing information about the organism-environment match, and preparing the individual for rapid motor responses (Frijda, 1986; Gross, 1998b; Oatley & Johnson-Laird, 1987; Schwarz & Clore, 1983). Emotions also aid in social functioning, as they “inform us about others’ behavioral intentions, give us clues as to whether something is good or bad, and script our social behavior” (Gross, 1998b, p. 273; also see Fridlund, 1994; Keltner, & Buswell, 1997; Walden, 1991). In turn, our own

emotional expressions convey important information to others about our own feelings and intentions, and help to script others' social behavior.

Early researchers viewed emotions as adaptive behavioral and physiological response tendencies that are directly activated by evolutionarily significant situations and can be modulated (James, 1884, 1894). Contemporary researchers typically view emotions as flexible response sequences that are activated whenever an individual assesses a situation (which may be real or imagined) as “offering important challenges or opportunities” (Gross, 1998b, p.272; also see Buck, 1994; Scherer, 1984; Tooby & Cosmides, 1990). The complex processes underlying the management of emotions are known collectively as emotion regulation.

Emotion regulation frameworks have been used to conceptualize the interactive processes underlying burnout development (e.g., Brotheridge, 2001; Brotheridge & Grandey, 2002; Goldberg & Grandey, 2007; Grandey, 2003; Hochschild, 1979, 1983; Zammunier & Galli, 2005; Zapf, 2002; Zapf & Holtz, 2006). Unfortunately, there are several limitations to the cumulative literature on this topic. First, although many studies have examined aspects of emotion regulation in human service professionals with and without burnout, very few have focused explicitly on MHPs. This is problematic given that human service roles (e.g., sales representative, bill collector, mental health counselor) may significantly vary in terms of work demands, including: the average frequency and duration of interactions with clients, display rule requirements (i.e., expression, suppression, or masking of positive and negative emotions), and enforcement of display rule compliance. Furthermore, MHPs' training in helping clients deal with their emotions may influence how MHPs experience and respond to their own emotions.

Another significant weakness of research in this area is that the term “emotion regulation” has not been defined in a consistent manner and has sometimes been used interchangeably with the term “coping”. Despite the fact that these constructs seem to overlap significantly (depending on the researcher’s framework of choice), the literatures on emotion regulation and coping have developed somewhat independently. Before proceeding, it is therefore important to clarify the definition of emotion regulation that guided the present study.

Following the work of Gross and colleagues as well as many other researchers who have published on burnout, the term emotion regulation will be defined as “the processes by which individuals influence which emotions they have, when they have them, and how they experience and express these emotions” (Gross, 1998b, p. 275, see also Folkman & Moskowitz, 2004; Gross, 1998a; Gross & John, 2003; Gross & Levenson, 1997; Rottenberg, & Gross, 2007). Although emotion regulation researchers have borrowed from the coping literature, they have distinguished emotion regulation in multiple ways. The most critical and commonly cited difference is that coping includes “nonemotional actions taken to achieve nonemotional goals as well as actions taken to regulate emotions,” while emotion regulation pertains exclusively to the processes associated with modulating emotions (Gross, 1998b, p. 275; see also Scheier, Weintraub, & Carver, 1986).

Extensive research has demonstrated the complex dependencies between affective, cognitive, and behavioral processes (e.g., Gross, 1998b; Richards & Gross, 1999; Rusting, 1999; Sandström et al., 2005; Scherer, 1984; Zajonc, 1985). Gross’ framework therefore stresses that emotion regulation should be viewed as a

multicomponential and dynamic process that serves to increase or decrease the experience and expression of both negative and positive emotions. Accordingly, when an individual consciously or unconsciously evaluates internal or external stimuli (i.e., emotional cues) to be important, emotional response tendencies (ERTs) are activated. These are “relatively short lived” changes in behavioral, cognitive, experiential, autonomic, and neuroendocrine systems (p. 272). ERTs develop out of the ongoing interaction between nature and nurture (i.e., genetic predispositions and experiences accumulated over one’s lifetime); however, they do not always correspond with the most appropriate or adaptive responses in all situations, and may call for modification. Emotion regulation processes that modulate ERTs determine the “final shape of the emotional response” (273). These processes involve changes in what have been termed emotion dynamics, or “the latency, rise time, magnitude, duration, and offset of responses in behavioral, experiential, or physiological domains” (Gross, 1998b, p. 275). This conceptualization of emotion regulation views the nervous system as “multiple, partially independent information processing subsystems... [that] monitor one another to varying degrees and are in continuous bidirectional excitatory or inhibitory interaction” (Gross, 1998b, p. 275). An important underlying assumption in this model is that there are bidirectional links between limbic centers that generate emotions and cortical centers that regulate emotions. Accordingly, the physiological, cognitive, and behavioral manifestations of emotion regulation may be automatic or controlled, conscious or unconscious, and active at one or more points in the emotion generative process.

Gross’ view of emotion regulation – unlike many models of coping – makes no a priori assumptions about whether particular emotion regulation strategies are inherently

“good” or “bad”. Rather, his model focuses on distinguishing between two types of strategies that differentially target components of the emotion regulation process “along the timeline of the unfolding emotional response” (Johnson, 2007, p. 5). The first type, antecedent-focused emotion regulation, refers to individuals’ preemptive efforts to manage emotions before ERTs are fully activated. These include situation selection (i.e., approach or avoidance), situation modification (i.e., altering a situation to mitigate its emotional impact), attentional deployment (i.e., selective attending and shifting focus), and cognitive change (i.e., reappraisal of situational meaning) (e.g., Gross, 1998b). Research suggests that problem-solving coping strategies (i.e., efforts to reduce or prevent stress by altering circumstances that contribute to stress), which conceptually overlap with the antecedent-focused emotion regulation strategies of situation selection and modification, tend to be more adaptive in situations that are controllable. For instance, in order to prevent additional stress, a MHP may avoid discussing topics that s/he believes are likely to elicit negative client reactions (e.g., anger, noncompliance). In situations that are not controllable, other antecedent-focused emotion regulation strategies (i.e., attentional deployment and cognitive change) may be more helpful (Christensen, Benotsch, Wiebe, & Lawton, 1995; Folkman & Moskowitz, 2004; Terry & Hynes, 1998). For instance, MHPs do not have control over whether their clients will present to treatment in a state of crisis; and, thus, anticipatory situation selection or modification are not always possible. However, MHPs may be able to regulate their emotional experiences and expressions using attentional deployment and cognitive reappraisal strategies while interacting with clients in crisis. Even if the use of situation selection or

modification is possible, it may be counter-productive for the client and use of other antecedent-focused strategies may be more appropriate.

The second type of emotion regulation strategies, response-focused, is conceptualized as attempts to curb emotional responses that already are fully activated – that is, to modify ERTs (Gross, 1998b). These strategies include suppression of emotions (i.e., masking) and simulation of emotions (i.e., faking; Gross, 1998b; Rubin et al., 2005). For instance, when confronted by a hostile customer, a sales clerk may feel anxious, sad, or angry, but, rather than expressing these negative emotions, s/he might regulate his/her behavior in order to maintain a smile and courteous tone. In the context of mental health services, when a therapy client expresses dissatisfaction with the treatment process, makes excuses for not following through with recommendations, or is hostile in response to clinical feedback, a MHP might experience frustration, disappointment, or resentment, but suppress these negative emotions and either remain silent or feign empathy for the client. According to emotion regulation theory, because response-focused emotion regulation occurs after ERTs have been fully activated, these strategies require continuous monitoring and modification of physiological, experiential, and behavioral systems (Gross, 1998b).

### *Emotional Labor*

As aforementioned, emotional labor refers to the subset of antecedent- and response-focused emotion regulation strategies used to regulate emotional experiences and expressions in order to abide by organizational (or professional) display rules and goals (e.g., Grandey, 2000; Hochschild, 1983). This construct has gained a great deal of

scholarly interest in the organizational literature over the last two decades (e.g., Ashforth & Humphrey, 1993; Ashforth, Kulik, & Tomiuk, 2008; Brotheridge & Grandey, 2002; Brotheridge & Lee, 1998, 2002; Fisher & Ashkanasy, 2000; Grandey, 2000, 2003; Kruml & Geddes, 2000; Pugliesi, 1999; Rubin et al., 2005; Schaubroeck & Jones, 2000; Wharton & Erickson, 1993). In one of the most comprehensive reviews to date, Rubin, et al. (2005) discuss how conceptual and semantic inconsistencies within this literature have contributed to “a current state of theoretical disorientation” regarding the nature of emotional labor (189). For instance, because some researchers (e.g., Abraham, 1998) have defined emotional dissonance as a component of rather than the catalyst for emotional labor, it has been difficult to interpret and consolidate findings across studies. Rubin et al. (2005) therefore present an integrated and empirically driven model of emotional labor that helps to clarify the definition of this construct and its relationships with other variables, such as emotional dissonance. According to their framework, emotional labor strategies are employed in order to reduce perceived emotional dissonance. Thus, when employees’ felt emotions are consistent with their perceptions of emotional display rules, they will not experience emotional dissonance or be motivated to engage in strategies that might be described as emotional labor; rather, their expressions will be genuine.

Rubin and colleagues (2005) also note that emotional labor is not the only response to emotional dissonance, as individuals may engage in other emotion regulation strategies. For instance, if an individual is not sufficiently motivated to comply with perceived organizational/professional display rules, s/he might respond to emotional dissonance by engaging in task withdrawal (e.g., ask a coworker to step in and finish with

a customer), task avoidance (e.g., choose to work in the stock-room rather than behind the cash register, in order to limit interaction requirements), passive-aggressiveness (e.g., not returning with the item a rude customer requested), or genuine emotional expression (i.e., unsanctioned behavior; Rubin et al., 2005). However, emotional labor is viewed as the more likely regulatory response to emotional dissonance in most cases, as deviance from emotional display rules introduces the potential for negative consequences (e.g., Rubin et al., 2005), such as unpleasant client reactions, therapeutic alliance “ruptures”, reprimands from supervisors, termination of employment, being passed over for promotions or raises, and so forth. Alternatives to emotional labor, which are sometimes referred to as acts of emotional deviance (Rubin et al., 2005), have received little attention in the empirical literature. As such, it is not clear how common they are or what impact they may have on individual and organizational outcomes. In contrast, there has been increasing interest in emotional labor responses to dissonance (Rubin et al., 2005).

Two types of emotional labor strategies have been identified. The first, deep acting, involves modifying felt emotions before ERTs are fully activated, using the antecedent-focused emotion regulation strategies of attentional deployment (i.e., selective attending and shifting focus) and cognitive change (i.e., reappraisal of situational meaning). These strategies allow employees to bring their felt emotions into alignment with perceived display rules and thus to exhibit sanctioned behavioral responses in an authentic manner (Gross, 1998b; Gross & John, 2003; Rubin et al., 2005). For instance, the aforementioned sales clerk might reduce emotional dissonance by selectively focusing on the customer’s needs, rather than the customer’s hostile tone of voice (attentional deployment), and/or by evaluating the situation from the customer’s point of

view (cognitive reappraisal). In turn, the sales clerk would be able to engage in courteous behavior without continued emotional dissonance. Similarly, in the second example, rather than simply keeping silent or feigning empathy, the MHP might engage in deep acting by selectively focusing on the client's strengths (attentional deployment) and considering how aspects of the client's personal situation represent real obstacles to treatment (cognitive reappraisal). By genuinely empathizing with the client, the MHP would avert full activation of negative ERTs and be more able to express authentic patience, understanding, and acceptance. Thus, deep acting strategies serve to decrease unsanctioned expressive behavior as well as subjective emotional experience (Gross, 1998a).

The second type of emotional labor, surface acting, is synonymous with response-focused emotion regulation (i.e., masking and faking), as it involves suppressing genuine emotions and regulating observable expressions of emotions, after ERTs have been activated, in order to comply with perceived display rules (Gross, 1998b; Gross & John, 2003; Rubin et al., 2005). For instance, the aforementioned sales clerk may respond to emotional dissonance by suppressing his/her negative emotions (masking) and maintaining a smile and courteous tone (faking) because s/he believes this is how the store manager expects him/her to respond in such situations. Similarly, the aforementioned MHP may mask his/her true feelings and fake empathy because s/he believes professional norms dictate that therapists avoid negative reactions towards clients. Although surface acting allows individuals to approximate expressions that are consistent with perceived display rules, it may not have a substantial or enduring impact

on emotional dissonance, as masking and faking primarily serve to regulate expressive behavior rather than experienced emotions (Rubin et al., 2005).

When evaluating the relative benefits of emotional labor strategies, it is important to consider how effective they are in reducing unsanctioned behavior and discordant emotions. Gross (1998a) conducted a study in which participants were assigned to one of three conditions: a suppression (i.e., surface acting) condition in which they were told to hide emotional reactions to a negative emotion-eliciting film so that an observer could not see what they were feeling, a reappraisal (i.e., deep acting) condition in which they were told to think about the film so that they would not respond emotionally, or a control condition in which they were not instructed to do anything while watching the film (Gross, 1998a). Although participants in the masking group exhibited significantly less expressive behavior, they reported experiencing as much negative emotion as participants in the control condition did. In contrast, participants in the reappraisal condition not only exhibited significantly less expressive behavior but also reported experiencing less negative emotion. Interestingly, other studies have shown that suppressing positive emotions is associated with both expressing and experiencing less positive emotions (Gross & Levenson, 1997; Stepper & Strack, 1993; Strack, Martin, & Stepper, 1988). The reasons for this finding remain unclear, and have received little attention, most likely because suppression of positive emotions is a less common requirement than suppression of negative emotions in the occupational context (Diefendorff & Richard, 2003). Regardless, it seems that suppressing either negative or positive emotions is associated with undesirable individual outcomes (i.e., experiencing continued negative emotions or reduced positive emotions).

Another important consideration is that those emotional labor strategies that are helpful in the short-term may have drawbacks and/or not be as effective in the long-term (Preece & DeLongis, 2005; Stone, Kennedy-Moore, & Neale, 1995). Beal, Trougakos, and Weiss (2006) found that camp counselors who engaged in surface acting reported being able to regulate emotional expressions effectively on an episode-to-episode (i.e., case by case) basis, but perceiving each episode to be more difficult to manage than individuals who engaged in deep acting reported. It has been argued that surface acting strategies involve greater resource expenditure than deep acting strategies, as the former require continuous monitoring and modification of ERTs, which have already been fully activated, in order to match behavior with perceived display rules (e.g., Grandey, 2003; Gross, 1998b; Gross & John, 2003; Totterdell & Holman, 2003). Another possibility is that the resources required for surface acting may be more limited and/or less easily replenished than the resources tapped during deep acting. Regardless, resource expenditure may only be detrimental if it is more costly than it is beneficial.

Studies outside the emotional labor literature have shown that the expression of positive emotions can trigger physiological changes that result in increased well-being for employees (Zajonc, 1985); yet surface acting has been associated with negative individual outcomes. For instance, research has shown that attempts to suppress emotional thoughts are associated with increased accessibility and intrusive recurrences of these thoughts, which in turn are associated with heightened emotionality (Wegner, 1994; Wegner, Shortt, Blake, & Page, 1990; Wegner & Zanakos, 1994). Wegner (1994) demonstrated that attempts to regulate negative emotions via thought suppression often yield paradoxical increases in negative mood, particularly if cognitive load is high. Gross

(1998b) suggests, “the conscious operating system that seeks out desired mental contents is out-performed by a less cognitively costly monitoring system that flags undesirable mental contents,” when cognitive resources are limited (277-278). In other words, efforts to suppress the feelings and thoughts associated with undesirable ERTs may have the opposite effect (i.e., increase these feelings and thoughts) when an individual’s cognitive resources already are allocated to other mental tasks. Furthermore, increased sensitivity (i.e., psychophysiological responding) to previously suppressed emotional thoughts has been shown to persist after suppression is discontinued (Wegner & Gold, 1995). Wegner and Zanakos (1994) suggest, “suppression of emotional thoughts prevents the person from habituating to the thoughts and thus lessening their emotional impact. It may even be that suppression promotes a dishabituation or relative elevation of emotional response to that thought” (617). Related, Richards and Gross (1999) found that suppression of emotions impaired female participants’ incidental memory for information presented during suppression. It follows that the emotion regulation processes underlying masking may interfere with human service providers’ abilities to receive and store critical information during interactions with clients (Johnson, 2007). Furthermore, Gross (1998a) found that masking and faking were associated with impaired performance on subsequent cognitive tasks, suggesting psychological resources had been depleted.

With depleted resources, it is not surprising that numerous studies have linked masking and/or faking with perceived stress (e.g., Abraham, 1998; Brotheridge, 1999; Erickson & Wharton, 1997; Pugliesi, 1999). Research also has linked suppression of negative emotions to sympathetic activation of the cardiovascular system and impaired immune functioning (Gross & Levenson, 1997), which are indicators of increased stress

and are associated with a variety of stress-related health problems, including: asthma (Florin, Freudenberg, & Hollander, 1985), cardiovascular disease (Guyton & Hall, 1997), and cancer (Gross, 1989; Greer & Watson, 1985). This is noteworthy given that burnout is similarly associated with ineffective coping and health problems (e.g., Burke & Greenglass, 1996; Zhang, Xu, & Jiang, 2006).

The associations between surface acting and stress-related outcomes often are attributed to “internal tension and the physiological effort” associated with both masking genuine emotions and faking alternative emotions (Brotheridge & Grandey, 2002, p. 22; see also Gross & Levenson, 1997; Morris & Feldman, 1998; Pugliesi, 1999). It reasons that surface acting may allow individuals to comply with perceived display rules and reduce emotional dissonance (if only slightly) in the moment, but may not help reduce overall stress or deter emotional dissonance from occurring in the future. It is also possible that the positive relationship between surface acting and stress is reciprocal, with elevated stress representing both an antecedent and consequence of surface acting. More research is needed in order to clarify the association between stress indicators and surface acting.

Aside from the personal costs associated with surface acting, research has shown that the cognitive costs associated with this type of emotional labor, such as distraction and reduced responsiveness, elicit increased physiological responding (i.e., stress) in surface actors’ interaction partners (Butler, Egloff, Wilhelm, Smith, Erickson & Gross, 2003). It reasons that if MHPs’ surface acting causes their clients to experience increased stress, therapeutic relationships may be jeopardized. Furthermore, if clients react

negatively (e.g., become disengaged, skeptical, or hostile), their MHPs may be more likely to experience further emotional dissonance and higher overall stress.

In contrast, research has associated the deep acting strategies of attentional deployment and cognitive reappraisal with positive outcomes. For instance, evidence has shown that deep acting is not associated with increased physiological responding (a stress indicator) in employees or their interaction partners, and is positively associated with service quality (i.e., affective delivery and task performance) and job satisfaction (e.g., Butler et al., 2003; Grandey, 2003; Johnson, 2007; Totterdell & Holman, 2003). It reasons that if deep acting is less taxing (relative to surface acting) of one's internal resources, or is at least as beneficial as it is costly, overall, it may allow employees to devote more attention and energy to their occupational tasks, to experience lower stress in managing work demands, and ultimately to exhibit lower levels of burnout. Deep acting may not only reduce emotional dissonance but also lead to internalization of new cognitions and, ultimately, more adaptive ERTs, such that emotional dissonance is less likely to reoccur. It is possible that individuals who are more likely to engage in deep acting are also more likely to have the characteristics that promote successful stress management and positive performance.

Research on the relationship between emotional labor and burnout is relatively limited compared to the literature on other predictors of burnout, and no published studies have empirically examined this relationship in a sample of MHPs. Nonetheless, existing research has yielded some interesting findings. Hochschild (1983) initially hypothesized that, relative to surface acting, deep acting would be more associated with burnout, as he presumed that aligning one's felt emotions with display rules requires an individual to

become emotionally involved with coworkers or customers/clients, and thus is more taxing than simply faking. Yet, most evidence suggests that surface acting is a better predictor of burnout than is deep acting (e.g., Brotheridge & Grandey, 2002; Brotheridge & Lee, 1998; Cheung, Tang, & So-Kum, 2007; Goldberg & Grandey, 2007; Martínez-Iñigo, Totterdell, Alcover, & Holman, 2007; Morris & Feldman, 1997; Rubin et al., 2005). For instance, Goldberg and Grandey (2007) conducted an analog study (using a call center simulation) to examine whether efforts to comply with display rules lead to depletion of energy and attentional resources during service encounters. The authors found that participants who had been given positive display rules (e.g., be enthusiastic and hide frustration) reported more post-simulation emotional exhaustion (EE) and made more errors on the order form, compared to participants who had not been given display rules to follow during the simulated interaction. However, surface acting rather than deep acting accounted for the energy depletion effect of display rules. In another study, Martínez-Iñigo, Totterdell, Alcover, & Holman (2007) found that surface acting had a positive association with EE, while deep acting was unrelated to EE. Brotheridge and Grandey (2002) found that surface acting was positively related to EE and depersonalization (DP) and negatively related to personal accomplishment (PA), while deep acting was unrelated to EE and DP and positively related to PA. The authors suggest that the greater stress associated with surface acting may help to explain its association with EE. They also argue that, over time, the lack of authenticity associated with surface acting may lead employees to experience feelings of detachment from one's true feelings and those of others, thereby leading to higher DP. Furthermore, if surface

actors view their own emotional displays as disingenuous or unsuccessful, they may experience diminished PA.

Few studies have examined specific work factors (other than emotional display requirements) as predictors of employees' emotional labor strategies. Evidence suggests that occupational demands and role stressors are positively associated with emotional dissonance (see review by Bono & Vey, 2005). In turn, it follows that higher levels of work-related stress also may contribute to higher rates of emotional labor, overall. Despite research indicating that surface acting may be more costly than deep acting is of employees' internal resources, individuals experiencing high levels of work-related strain may be more inclined to engage in surface acting, as they may "presume" (not necessarily on a fully-conscious level) that it is less taxing. Related, MHPs who experience more role conflict (i.e., incompatible demands/expectations), role ambiguity (i.e., uncertainty about expectations, goals, or impact of role), and/or lack of autonomy (i.e., control over decisions and activities) may feel unable or unmotivated to engage in deep acting strategies. Regardless of whether MHPs engage in surface or deep acting, it is possible that greater work stressors (e.g., role conflict, role ambiguity, and lack of autonomy) increases the likelihood that MHPs will engage in emotional labor, which in turn may increase their risk for burnout. Accordingly, work stressors may have a direct and indirect effect through emotional labor on burnout. While some studies have found evidence that such work stressors may moderate the relationship between emotional labor and burnout (e.g., Johnson & Spector, 2007), no studies were found that examine emotional labor as a mediating variable between work stressors and burnout.

In addition to studies examining the relationships between work characteristics and emotional labor strategies, research has examined individual characteristics. It is possible that whether employees tend to engage in surface or deep acting may largely depend on individual characteristics such as personality. Although relatively few studies have evaluated the relationship between surface acting and extraversion, most have found a negative relationship (e.g., Austin, Dore, & O'Donovan, 2008; Diefendorff, Croyle, & Gosserand, 2005; Gross & John, 2003; Judge, Woolf, & Hurst, 2009). Similarly, Beal, Trougakos, and Weiss (2006) found that experiencing positive emotions was negatively related to surface acting. It is possible that these results reflect the influence of trait affect; however, it has also been suggested that surface actors experience a diminished sense of well-being due to the inauthenticity of their interactions (Brotheridge & Lee, 2002; Gross & John, 2003; Rubin et al., 2005; Sheldon, Ryan, Rawsthorne, & Ilardi, 1997). It reasons that the strain associated with use of surface acting strategies may be greater in individuals with lower extraversion, as “emotional labor should be more effortful and provide fewer payoffs” (Judge, Woolf, & Hurst, 2009, p. 58). That is, individuals with lower extraversion should experience greater strain because they have to work harder to engage in surface acting and experience less fulfillment from such exchanges, assuming that the emotions they fake are positive and the emotions they mask are negative.

Findings on the relationship between personality and deep acting have not been as clear. Austin, Dore, and O'Donovan (2008), Johnson (2004), and Gosserand and Diefendorff (2005) all found positive relationships between extraversion and deep acting. Johnson (2007) found that individuals with high PTA were more likely to engage in deep

acting than surface acting. In addition, if one considers evidence that associations tend to be stronger when variables are matched in terms of hedonic tone (Thoresen et al., 2003), it reasons that deep acting, which typically involves refocusing and/or reframing information in ways that foster positive emotions, cognitions, and behaviors, would be more strongly related to PTA than NTA.

In summary, research has demonstrated that a variety of situational factors and individual characteristics are implicated in human service employees' use of particular emotional labor strategies and experiences of burnout. The theoretical and empirical evidence reviewed in this paper was used to develop a model illustrating the hypothetical relationships between these variables among MHPs (Figure 1). The present study aimed to evaluate some of the associations depicted in this model by testing the following primary hypotheses.

- 1) Extraversion will be negatively related to EE and DP, and positively related to PA.
- 2) (a) Role conflict and role ambiguity will be positively related to EE and DP, and negatively related to PA, while autonomy will be negatively related to EE and DP, and positively related to PA, but (b) these relationships will be moderated by extraversion, such that the associations between the three work demand/stressor variables and the three burnout dimensions will be stronger for individuals with lower extraversion.
- 3) Emotional labor strategies will account for significant variance in the three dimensions of burnout, with (a) surface acting (faking and masking) being positively related to EE and DP, but negatively related to PA, and (b) deep acting strategies (attentional deployment and reappraisal) being negatively related to EE and DP, but positively related to PA..

- 4) Extraversion will be (a) negatively related to surface acting, and (b) positively related to deep acting.
- 5) Extraversion will moderate the relationships between work demands/stressors and emotional labor, such that:
  - (a) Role conflict and role ambiguity will be more strongly positively associated with surface acting in individuals with lower extraversion, and autonomy will be more strongly negatively associated with surface acting in individuals with lower extraversion.
  - (b) Role conflict and role ambiguity will be more strongly negatively related to deep acting in individuals with lower extraversion, and autonomy will be more strongly positively related to deep acting in individuals with lower extraversion.
- 6) (a) Surface acting and (b) deep acting will partially mediate the relationships role conflict, role ambiguity, and autonomy have with levels of burnout.

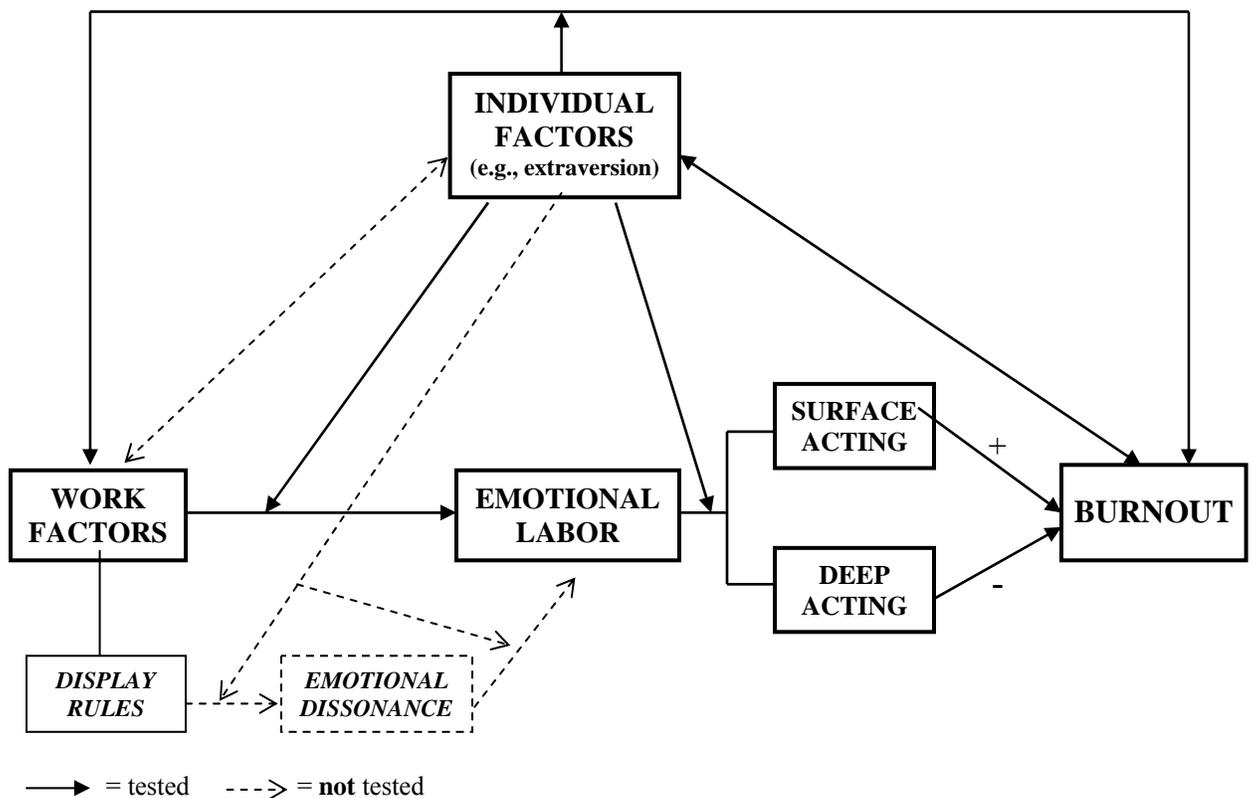
Several exploratory hypotheses were tested as well in an effort to provide preliminary evidence regarding variables that have yet to be addressed in the literature.

- 7) Caseload characteristics (i.e., client severity and proportion of caseload with medical assistance insurance) will be positively associated with surface acting and burnout.
- 8) MHPs will perceive display rules to dictate that integrative and neutral emotional expressions are acceptable, while differentiating emotional expressions are not acceptable, within the therapeutic context.
- 9) The stringency of perceived display rules will be (a) positively associated with EE and DP, and negatively associated with PA; and (b) positively associated with both types of emotional labor, but more strongly associated with surface acting strategies than deep acting strategies.

10) Perceived importance of controlling emotional displays at work will be (a) positively associated with surface acting and deep acting; and (b) positively associated with EE and DP, and negatively associated with PA.

11) MHPs' job-related affective well-being will be (a) negatively associated with EE and DP, and positively associated with PA and (b) negatively associated with role conflict and role ambiguity, and positively associated with autonomy.

Figure 1



Conceptual Model

## Methods

### *Participants*

The final sample consisted of 188 MHPs working in Florida. This number exceeds the estimated minimum  $N$  needed to provide adequate power ( $1-\beta \geq 0.80$ ) for detecting medium effects at an alpha level of 0.05. Demographic and professional characteristics of the final sample are shown in Table 1. Participants ranged in age from 24 to 74 ( $X=45$ ,  $SD=13$ ) and were predominately female (72%), White/Caucasian American (94%), non-Hispanic/non-Latino (85%), currently married (69%), and parents (63%). These demographic characteristics are relatively consistent with reported norms for the mental health workforce, (Duffy et al., 2004; Manderscheid & Henderson, 2004; SAMHSA, 2002; An Action Plan for Behavioral Health Workforce Development, SAMHSA, 2007). MHPs' highest education levels included high school/general education diploma, specialty certifications, Master's degrees, and Doctorates, though most participants' (91%) had one or more advanced degrees. While not all participants provided further information about their disciplines, the vast majority of those who did reported degrees in psychology, counseling, social work, or marriage/family therapy. Participants' amounts of professional experience ranged from under one year to 41-50 years. About 18% had five or fewer years, while over 40% had more than 15 years of experience. Accordingly, this sample represents MHPs with disproportionately high levels of education and experience relative to the national workforce, which consists increasingly of individuals without graduate level training and less time working in the

field (Duffy et al., 2004; Manderscheid & Henderson, 2004; SAMHSA, 2002 An Action Plan for Behavioral Health Workforce Development, SAMHSA, 2007). It is not clear whether the demographic and professional characteristics of this sample are consistent with state norms, as estimates for the mental health workforce in Florida at the time of this study were not found.

Participants were asked to identify their theoretical orientations by selecting one or more categories. As shown in Table 1, the vast majority of participants endorsed having a cognitive theoretical orientation, while a striking minority endorsed having a psychoanalytic theoretical orientation. Most participants (72%) indicated having more than one theoretical orientation and some indicated having as many as six theoretical orientations,

Active caseloads ranged from one to “hundreds” of clients/patients. Because an open-ended response format was used to collect this information, responses widely varied and it was not possible to consolidate the data in a valid and reliable way. For instance, some participants indicated the number of groups they run per week, while other participants reported the average number of evaluations they conduct per day. Perhaps more importantly, only 52% of MHPs reported being satisfied with the size of their current caseloads, while 25% and 21% reported that their ideal caseload would be larger and smaller, respectively, than their current caseloads.

A wide variety of work settings in Florida is represented by this sample (Table 1). Participants worked in as many as four types of settings, though most (79%) reported providing services in one type of setting. Over half of the sample reported working in private practice and 25% of those MHPs worked in at least one additional setting.

Participants were asked to indicate the percentage of clients they serve who are covered by different types of insurance or are private pay. Over two-thirds of participants had at least some private pay clients, though these clients comprised a small proportion of total cases for most MHPs. About 45% of the sample reported having no clients with private managed care insurance and over half the sample reported seeing no clients with Medicaid or Medicare insurance. Most MHPs in this study had clients with various types of coverage, as less than one third of the sample reported working exclusively with clients having a particular type of coverage (e.g., only private pay or only medical assistance).

Participants were asked to indicate the percentage of their clients in different age groups (see Table 2). Only 13.2% of MHPs in this sample reported working exclusively with child/adolescent clients (0-17 years old) and only 34% reported working exclusively with adult clients (at least 18 years old). MHPs also were asked to indicate whether they would prefer to provide services to a different age group than they currently serve. A small minority (8.5%) reported that they would prefer to work with clients who were younger or older, suggesting that over 90% were satisfied with the age groups comprising their current caseloads.

Participants' involvement in various professional activities also is summarized in Table 2. At least 50% of MHPs in this sample reported spending at least  $\geq 18$  hours per week providing direct care (treatment plus assessment), five hours per week doing clinical support tasks, five hours per week on administrative tasks, and one hour per week on consultation. The majority of the sample spent one or less hours per week providing and receiving supervision, respectively.

## *Procedures*

MHPs were recruited from the public and private sectors within the state of Florida. Participation in this study was solicited via emails, professional listservs, word-of-mouth, and telephone. Public listings of MHPs in Florida were used to contact potential participants by email and phone. Individuals contacted by phone who agreed to provide valid email addresses were sent a follow-up recruitment email with information about participating in the study. In addition to contacting potential participants directly, administrators at numerous mental health care facilities and professional organizations were contacted and asked to disseminate recruitment information to potential participants by forwarding it in an email, including it in newsletters, posting it on electronic listservs, mentioning it during staff meetings, and/or posting flyers (provided by the researcher).

Potential participants were asked to visit a secure website to take a completely voluntary and anonymous online survey about their professional activities, attitudes, and experiences. They were informed that no personally identifying information (i.e., names, contact information, IP addresses, etc.) would be collected and no identifying information would be collected about individual clients/patients, coworkers, or employers. Upon accessing the website, individuals were required to provide informed consent to participate in the study prior to beginning the survey (Appendix A). Data collection occurred between April 2009 and March 2010.

Individuals were eligible to participate in this study if they were at least 18 years old, fluent in the English language, and providing direct mental health care within the state of Florida. Participants could be working in any setting and with clients/patients of

any age. No specific level of education, amount of experience, or professional title was required to be eligible for this study. Participation was completely anonymous, voluntary, and uncompensated. Participants who did not meet all inclusion criteria (e.g., were not currently providing direct care to clients/patients) or did not respond to more than one measure were excluded from the sample and their data were not used in any analyses.

### *Measures*

*Background Information.* MHPs' demographic and professional characteristics were assessed using a questionnaire created for the present study (Appendix B). Participants were asked to indicate their sex, race/ethnicity, age, marital status, parent status, and education (see Table 1). In addition, this measure included items that assess MHPs' years of mental health service experience, work setting, involvement in different professional tasks (i.e., time spent providing treatment/assessment, doing paperwork, etc.), and caseload characteristics (i.e., average number of concurrent clients, involvement with managed care cases, client age range, etc.).

Information about MHPs' exposure to various challenging client behaviors and circumstances was evaluated using the *Challenging Client Behaviors and Circumstances Questionnaire* (CCBCQ), a 16-item questionnaire created for this study (see Appendix C). It was developed based on two of the six items from Ackerley et al.'s (1988) *Psychologist's Burnout Inventory*, as well as anecdotal and empirical research on clinical characteristics that contribute to client severity and difficulties providing effective mental health services. Respondents are asked to estimate the percentage (0-100%) of their

clients/patients within the past 30 days who demonstrated the behaviors or characteristics described. Examples of items include “Within the last 30 days, what percent of your clients made suicidal statements or gestures, or engaged in self-harm behaviors (e.g., skin cutting or burning)?” and “Within the last 30 days, what percent of your clients refused to participate in session/were noncompliant with treatment recommendations?” Total scores were computed by summing the percentages across items, such that a total percentage of 202% across items, for instance, was considered a score of 202. High scores on this measure represent greater exposure to challenging client behaviors and circumstances. A Cronbach’s alpha of 0.79 was found in the present study, suggesting the measure had acceptable internal consistency.

*Personality.* MHPs’ levels of extraversion were evaluated using the extraversion items of *The Eysenck Personality Questionnaire- Brief Version* (EPQ-BV; Sato, 2005; Appendix D), adapted from the *Eysenck Personality Questionnaire Revised-Short* (EPQR-S; Eysenck & Eysenck, 1992). This measure is comprised of twelve extraversion items (e.g., “Do you like plenty of action and excitement around you?”), which are rated on a Likert-type scale ranging from 0 (“not at all”) to 4 (“extremely”). The EPQ-BV also includes twelve neuroticism items (e.g., “Are you an irritable person?”) that were not included in the present study. This measure has demonstrated superior psychometric properties to the EPQR-S and another abbreviated version of the EPQR-S (EPQR-A; Francis et al., 1992), both of which have been criticized for having poor reliability. More specifically, in Sato’s (2005) study, the coefficient alpha for the Extraversion scale of the EPQ-BV ( $\alpha = 0.9$ ) was higher than that of the original EPQR-S. This value also was higher than the values reported for the EPQR-S and the EPQR-A in the past (Eysenck &

Eysenck, 1992; Francis et al., 1992). The test–retest reliability values of the EPQ–BV subscale are  $r = 0.92$ , which is comparable to those reported for other measures of extraversion (Sato, 2005). The construct validity of the EPQ–BV was demonstrated as the extraversion subscale was highly correlated ( $r = 0.88$ ) with the corresponding measures in the original EPQR–S. In sum, the EPQ–BV seems to have acceptable construct validity, internal consistency, test–retest reliability, and a relatively robust factor structure (Sato, 2005). In the present study, internal consistency was evaluated to be  $\alpha = 0.904$ .

*Work-related Stressors.* MHPs’ perceived role conflict and role ambiguity were assessed with Rizzo, House, and Lirtzman’s (1970) widely used questionnaire (Appendix E). This measure asks respondents to indicate how accurately each statement reflects their experiences at work, using a Likert-type scale ranging from 1 (“very false”) to 7 (“very true”). The eight-item role conflict subscale taps into perceptions of incompatible or incongruous performance or role requirements (e.g., “I receive an assignment without adequate resources and materials to execute it.”). Acceptable internal consistency has been reported for this scale [ $\alpha = 0.86$  (Jawahar, Stone, & Kisamore, 2007);  $\alpha = 0.82$  (Kelloway & Barling, 1990)]. In the present study, a lower alpha of 0.68 was found (which will be addressed in the *Discussion* section). The six-item role ambiguity subscale taps into perceived lack of role predictability and clarity of behavioral requirements (e.g., “I feel certain about how much authority I have.”). Numerous studies have examined the validity of Rizzo et al.’s measure. For instance, Kelloway and Barling (1990) and Gonzalez-Roma and Lloret (1998) used various factor analytic techniques to demonstrate the construct validity of the role conflict and ambiguity scales. Acceptable

internal consistency has been reported in prior studies (e.g.,  $\alpha = 0.80$ ; Kelloway & Barling, 1990). The present study also found this subscale to have acceptable internal consistency ( $\alpha = 0.83$ ).

MHPs' perceived autonomy was assessed using Idaszak and Drasgow's (1987) modified version of the Autonomy subscale from the *Job Diagnostic Survey* (JDS; Hackman & Oldham, 1975; Appendix E). This measure is comprised of three items (e.g., "I decide on my own how to go about doing the work"), which are rated on a Likert-type scale ranging from 1 ("very inaccurate") to 7 ("very accurate"). Total scores were computed such that higher scores represent higher levels of perceived autonomy at work. Extensive support for the external criterion validity of the JDS has been reported (see Hackman & Oldham, 1974, 1975) Idaszak and Drasgow's (1987) version were used because the minor changes made to the wording of the original JDS items resulted in stronger internal validity. The present study found the autonomy scale to have an alpha of 0.927, which is comparable to the high internal consistency reliability previously reported (e.g.,  $\alpha = 0.91$ ; Johnson & Spector, 2007).

MHPs' emotional reactions to their work were measured with the *Job-related Affective Well-being Scale* (JAWS; Van Katwyk, Fox, Spector, & Kelloway, 1999; Appendix F). This questionnaire asks respondents to indicate how often their jobs made them feel 20 emotions in the prior 30 days, using a five-point Likert response format ranging from *never* to *always*. The negative affect items were reverse scored to allow a total score to be calculated by summing the positive and negative emotion scores. Accordingly, high scores on this measure indicate high levels of affective well-being (i.e., experiencing positive emotions frequently and negative emotions infrequently). The 20-

item version of the JAWS used in the present study was adapted from the original 30-item version by Fox, Spector, Goh, and Bruursema (2003), reported to have an acceptable alpha of 0.93. In the present study, an alpha of 0.81 was found for the JAWS.

*Display Rules.* Perceived display rules were evaluated using the Perceived Display Rules Survey (PDRS; Appendix G), a questionnaire created for this study. Items were generated by the author and pilot tested using a sample of clinical psychology graduate students. Respondents are asked to rate how often (never, sometimes, always) it is acceptable, according to formal or informal professional standards, for mental health service providers to display (outwardly express) 18 emotions during interactions with clients/patients. Respondents are given the option of selecting *Not Applicable* if they do not believe that a professional standard exists for displays of a given emotion. Items were developed in order to tap into perceived display rules regarding expressions of integrative, differentiating, and neutral emotions. Responses of *Never*, *Sometimes*, and *Always* were recoded as 0, 1, and 2, respectively. The internal consistency reliability for this measure was found to be 0.729 (when excluding responses of *Not Applicable*). Total subscale scores were calculated for integrative, differentiating, and neutral emotional displays by summing across items of similar hedonic tone. Responses of *Not Applicable* were excluded from these calculations. Items included in the Integrative Emotional Displays score included Enthusiasm, Happiness/Joy, Admiration, Empathy, Sympathy, Patience, Calmness, and Excitement. Items included in the Differentiating Emotional Displays score included Boredom, Dislike/Contempt, Anger, Disgust, Frustration, Fear/Anxiety, and Disappointment. Sadness was not included in these calculations because, although it is a negative emotion, it is not necessarily differentiating. Ratings on

the No Emotions and Neutral Emotions items were included in the Neutral Emotional Displays score. Cronbach's alphas for the Integrative and Differentiating Emotional Displays total scores were 0.815 and 0.706, respectively, suggesting that both had acceptable internal consistency. On the other hand, the alpha for Neutral Emotional Displays was 0.156, indicating that these two items may be addressing different types of display rules and should not be analyzed together. The Pearson correlation for the Integrative and Differentiating scores was 0.094, suggesting that the association between these subscales is minimal.

The perceived importance of controlling one's emotional displays at work was evaluated using eight items (Appendix H) adapted from the Emotional Abilities Scale developed by Miller (2004). Respondents are asked to rate items on a four-point scale ranging from 1 (Not Important) to 4 ("Very Important"). Items tap into respondents' perceptions of how important it is to regulate their emotional expressions in general and using specific regulation strategies (i.e., emotional labor). Items do not make distinctions between the importance of regulating specific types of emotions (i.e., integrative and differentiating). While items do not refer explicitly to surface and deep acting, the perceived importance of using emotional labor strategies to regulate emotional displays is reflected in many of the items. An example of an item from this scale is "Based on professional standards for working with clients/patients, how important is it for mental health service providers to not show their true feelings in emotional situations?". Possible total scores range from eight to 32, with higher scores indicating that the respondent perceives controlling emotional displays at work to be of high importance.

The internal consistency of the adapted Emotional Abilities Scale (AEAS) used in this study was 0.774, suggesting it has acceptable reliability.

*Emotional Labor.* Modified versions of three established scales were used in order to evaluate MHP's emotional labor strategies (Appendix I). These measures were used to broadly cover the emotional labor strategies of deep acting and surface acting. The only modifications to items were to change the word "customers" to "clients". Deep acting was measured using three items from Brotheridge and Lee's (2003) *Emotional Labour Scale* (ELS), which tap into the attentional deployment component, and six items from Gross and John's (2003) *Emotion Regulation Questionnaire* (ERQ), which tap into the cognitive reappraisal component. MHP's surface acting was assessed using four items from the ERQ and two items from the ELS, which tap into the masking component, as well as five items from Grandey's (2003) antecedent- and response-focused emotion regulation measure, which tap into the faking component.

The revised ELS items ask respondents "On an average day at work, how often do you do each of the following when interacting with clients?" Statements are rated on a Likert-type scale ranging from 0 ("never") to 4 ("always"). Higher average scores on each of the subscales represent higher levels of the dimension being assessed. A sample item from the deep acting subscale (which taps into the attentional deployment dimension) is "Make an effort to actually feel the emotions that I need to display to others." A sample item from the surface acting subscale (which taps into the masking dimension) is "Hide my true feelings about a situation." Brotheridge and Lee (2003) reported acceptable coefficient alphas for the deep acting and surface acting subscales ( $\alpha = 0.89$ ,  $\alpha = 0.86$ ). In the present study, internal consistency alphas were 0.94 and 0.80 for

the deep acting (i.e., attentional deployment) and surface acting (i.e., masking) subscales, respectively. The convergent validity of the ELS has been demonstrated, as the surface acting and deep acting subscales are correlated with another commonly used measure, Best et al.'s (1997) *Emotional Work Requirements Scale* (Brotheridge & Lee, 2003).

Gross and John's (2003) *Emotion Regulation Questionnaire* (ERQ) assesses individual differences in expressive suppression and cognitive reappraisal with a Likert-type scale, ranging from 1 ("strongly disagree") to 7 ("strongly agree"). Items measure emotional experience, or feelings, and emotional expressions, in the form of speech, gestures, and behaviors. The suppression (i.e., masking) subscale consists of four items (e.g., "I control my emotions by not expressing them."). The reappraisal subscale is comprised of six items (e.g., "When I want to feel more positive emotion (such as joy/amusement), I change what I'm thinking about."). Gross and John (2003) reported acceptable alphas for the reappraisal and suppression subscales ( $\alpha = 0.79$ ,  $\alpha = 0.73$ ). The present study found acceptable internal consistency alphas of 0.84 and 0.81 for the reappraisal and suppression subscales, respectively. The convergent validity of the ERQ has been demonstrated in multiple ways. For instance, Gross and John (2003) showed that Suppression was significantly related to Inauthenticity, while Reappraisal was not. In addition, Reappraisal was shown to have a positive association with coping through reinterpretation, while Suppression was shown to have a negative association with coping through venting.

Response-focused emotion regulation items from Grandey's (2003) measure ask respondents to indicate how often they engage in faking behaviors in their jobs (e.g., "I put on an act in order to deal with customers."). A Likert-type scale ranging from 0

(“never”) to 4 (“always”) is used to rate items. Grandey (2003) reported an acceptable coefficient alpha for this subscale ( $\alpha = 0.88$ ). The present study found an alpha of 0.86. Although the measure also includes three antecedent-focused emotion regulation items, they were not included in this study, as they are redundant with the items from Brotheridge and Lee’s (2003) deep acting subscale that was used in this study. The validity of Grandey’s measure was demonstrated by correlating the subscales with observer rating of affective delivery and self-reported stress (Grandey, 2003).

Johnson (2007) found that the composite score for the masking dimension (which includes items from both the ELQ and ERQ) demonstrated acceptable internal consistency reliability (masking,  $\alpha = 0.69$ ). The present study found a higher Cronbach’s alpha for the composite masking score ( $\alpha = 0.80$ ).

*Burnout.* Levels of professional burnout were measured with the *Maslach Burnout Inventory – Human Services Survey* (MBI; Maslach & Jackson, 1981; see Appendix J). This 22-item, paper-and-pencil questionnaire asks respondents to indicate how frequently they experience specific job-related feelings, using a 7-point Likert-type scale (0 = never; 6 = everyday). Ratings are used to calculate subscale scores representing the three dimensions of burnout: Emotional Exhaustion (EE), Depersonalization (DP), and Personal Accomplishment (PA). While some items are associated with more than one dimension, scores for each subscale are considered to be independent. The most recent MBI manual (Maslach, Jackson, & Leiter, 1996) discourages researchers from computing a composite burnout score based on all 22 items, given research suggesting that EE, DP, and PA have differential patterns of association with predictor and outcome variables. As such, multivariate analyses with the three

subscales examined as a criterion set and separate univariate analyses were run for each of the MBI subscales in the present study.

The EE subscale is comprised of 9 items and yields a potential score range of 0 to 54. A sample item is “I feel emotionally drained from my work.” The DP subscale is comprised of 5 items and yields a potential score range of 0 to 30. A sample item is “I feel I treat some recipients as if they were impersonal objects.” The PA subscale is comprised of 14 items and yields a potential score range of 0 to 48. A sample item is “I feel I’m positively influencing other people’s lives through my work.” A higher degree of burnout is represented by higher scores on the EE and DP subscales, but lower scores on the PA subscale. Qualitative score classification guidelines are presented in Table 3 and the percentages of sampled MHPs with low, moderate, and high burnout based on these guidelines are presented in Table 4.

The MBI has been widely used and has earned extensive empirical support. Evidence of the convergent validity of the MBI has been demonstrated in several ways, including through correlations with behavioral ratings of burnout made by coworkers and spouses (Maslach, Jackson & Leiter, 1996). The MBI manual (3<sup>rd</sup> edition) reports Cronbach’s alphas of 0.90 for EE, 0.79 for DP, and 0.71 for PA (Maslach, Jackson & Leiter, 1996). In the present study, reliability coefficients were 0.92 for EE, 0.74 for DP, and 0.71 for PA. The correlations between the three MBI subscales for the present sample and the normative sample are relatively consistent (see Table 5).

Table 1. MHP Demographic and Professional Characteristics (N=188)

Variable	N	%
<b>Age (In Years)</b>		
<i>Missing</i>	8	<5 %
<30	30	16 %
30-39	40	21 %
40-49	43	23 %
50-59	37	20 %
60+	30	16 %
<b>Sex</b>		
Male	53	28 %
Female	135	72 %
<b>Ethnicity</b>		
Latino/Hispanic	26	14 %
<b>Race (Multiple Responses Possible)</b>		
<i>Missing</i>	1	<1 %
White/Caucasian	175	93 %
Black/African American	12	6 %
Asian	2	1 %
Native American/Alaskan Native	5	3 %
Native Hawaiian/Pacific Islander	0	0 %
Other	6	3 %
Multiracial	6	7.7%
<b>Marital Status</b>		
<i>Missing</i>	1	<1 %
Currently Married	129	69 %
Divorced/Separated/Widowed	28	15 %
Never Married	30	16 %
<b>Parent?</b>		
<i>Missing</i>	1	<1 %
Yes	118	63 %
No	69	37 %

Table 1. (*continued*) MHP Demographic and Professional Characteristics (N=188)

Variable	N	%
<b>Highest Education</b>		
<i>Missing</i>	5	<3%
High School Diploma/G.E.D.	1	<1 %
Associate's	1	<1 %
Bachelor's	11	6 %
Master's	101	54 %
Doctorate's	69	37 %
<b>Years Experience</b>		
Less Than 1	1	<1 %
1-5	32	17 %
6-10	36	19 %
11-15	30	16 %
16-20	25	13.3 %
21-30	37	19.7 %
31-40	14	7.4 %
41-50	1	<1 %
Over 50	0	0
<b>Theoretical Orientations (<i>Multiple Responses Permitted</i>)</b>		
<i>Missing</i>	1	<1%
Don't Know	2	1.1 %
Biological/Pharmacological	28	15 %
Cognitive	132	70.2 %
Behavioral	107	57 %
Psychodynamic	47	25 %
Humanistic	38	20.2 %
Family Systems	74	39.4 %
Psychoanalytic	9	4.8 %
Other	43	23 %
>2 Theoretical Orientations	136	72%

Table 1. (continued) MHP Demographic and Professional Characteristics (N=188)

Variable	N	%
<b>Ideal Caseload Size</b>		
<i>Missing</i>	4	2 %
Same	98	52 %
Larger	47	25 %
Smaller	39	21 %
<b>Services Settings</b>		
<i>Missing</i>	1	<1 %
Private Practice	97	51.3 %
Primary School	18	9.6 %
College/Univ. Counseling Center	11	5.9 %
University-Based Outpatient Clinic	21	11.2%
Other Outpatient Clinic	38	20.2 %
Emergency Room	4	2.1 %
Inpatient Facility	23	12.2 %
Residential Treatment Facility	8	4.3 %
VA Inpatient/Outpatient	6	3.2 %
Jail/Detention Center	2	1.1 %
Other <sup>1</sup>	33	17.6 %
Private Practice Only	73	38.8%
<b># Treatment Settings</b>		
<i>Missing</i>	1	.5%
1	149	79.3%
2	28	14.9%
3	9	4.8%
4	1	.5%

<sup>1</sup> Examples of responses coded as “Other” include (but are not limited to) home-based services, domestic violence/homeless shelters, Department of Children and Families, and child care facilities.

Table 2 MHP Client and Work Characteristics

	N	Mean	SD	Min	Max
<b>Percent of Clients by Pay Categories</b>					
<i>Missing</i>	2				
% Private pay	186	29.1	37.3	0	100
% Private managed care	186	27.3	33.7	0	100
% Medicare/Medicaid	186	18.0	29.2	0	100
% Other	186	24.1	38.0	0	100
<b>Percent of Clients of Different Ages</b>					
<i>Missing</i>	1				
% 0-3 years	188	3.9	15.6	0	100
% 4-10 years	188	11.8	21.2	0	90
% 11-17 years	188	16.4	23.4	0	100
% 18-24 years	188	15.9	19.0	0	95
% 25-64 years	188	45.6	33.0	0	100
% 65+ years	188	5.8	13.8	0	100
% Adult	188	67.3	37.9	0	100
<b>Hours/Week on Professional Activities/Tasks</b>					
Treatment	186	15.4	10.1	1	40
Assessment/Testing	184	3.1	4.5	0	22
Direct Care (Treatment + Assessment)	183	18.4	10.4	1	45
Clinical Support/Administrative Tasks	177	13.5	9.1	1	60
Providing Supervision	163	6.4	5.4	0	40
Receiving Supervision	158	.82	1.3	0	8
Providing Consultation	168	1.89	2.9	0	20
Total Hours	187	36.0	13.8	4	100
# Treatment Settings	187	1.26	.57	1	4

Table 3 MBI Subscale Score Classifications\*

	EE	DP	PA
Low	0-16	0-6	39-84
Moderate	17-26	7-12	32-38
High	27-78	13-102	0-31

\*Maslach, Jackson, & Leiter, 1996

Table 4 Percentage of Sampled MHPs with Low, Moderate, and High Burnout

	EE	DP	PA
Low	59%	83%	77.1%
Moderate	32.4%	11.7%	14.4%
High	8.5%	5.3%	8.5%

Table 5 MBI Subscale Correlation Matrix

	DP	PA
<u>EE</u>		
Study sample	0.377**	-0.286**
Normative sample <sup>1</sup>	0.520**	-0.220*
<u>DP</u>		
Study sample		-0.267**
Normative sample <sup>1</sup>		-0.260*

Note: \* $p \leq .05$ , one-tailed; \*\*  $p \leq .01$ , one-tailed

<sup>1</sup> Reported in the most recent MBI manual (Maslach, Jackson & Leiter, 1996)

## Results

### *Descriptive Statistics*

Table 6 presents descriptive statistics for each of the independent and dependent variables measured. An examination of the data revealed that scores on all measures were normally distributed (neither skewed nor kurtotic). It is noteworthy, however, that there was restriction of range on the three MBI subscales. Most of the EE and DP scores fell at the low end of the scale, while most of the PA scores fell at the high end of the scale, suggesting floor and ceiling effects, respectively. Range restriction was most severe on the DP subscale. Floor and ceiling effects were also found for the role ambiguity and autonomy scales, respectively. None of the measures were significantly skewed or kurtotic.

### *Correlational Analyses*

Pearson product-moment correlation coefficients were calculated to evaluate the strength of the linear relationships among the independent and dependent variables. Relationships between primary and secondary measures are displayed in Table 7.

The intercorrelations among the three dimensions of burnout range from moderate to strong and are all statistically significant. Relationships between each of the MBI subscales and the other variables measured range from negligible to large in size. The work demand/stressor variables – role conflict (RC), role ambiguity (RA), and autonomy

(AU) were strongly intercorrelated with one another, but the associations were not so large as to suggest redundancy. The correlation between the surface acting variables of masking and faking was significant ( $r=.434$ ,  $p=.00$ ), while the deep acting variables of attentional deployment and reappraisal were not significantly related ( $r=.123$ ,  $p=.10$ ). Associations among each of the variables measured will be discussed further within the context of each hypothesis.

### *Hypothesis Testing*

Multivariate multiple regression analyses were conducted using SAS 9.2 software in order to test the relationships between predictor and criterion variables simultaneously, and thus control for possible intercorrelations between these variables and avoid the risk of inflated Type I error associated with performing numerous tests on the same variables. This approach allows for predictors to be tested across equation models and is appropriate when: “(a) one set of variables is a priori designated as the predictor set and the other as the criterion set, (b) the underlying conceptual framework treats the criterion variables separately, and hence independent regression equations are appropriate for each criterion variable, and (c) no reasons exist for estimating mutually uncorrelated dimensions or structure among observed predictor variables” (Lambert, Wildt, & Durand, 1988, p. 282). In regards to the first of these guidelines, although the present study was cross-sectional and non-experimental in design, an a priori theoretically-based distinction was made between predictor and criterion variables included in this study. The second criterion also is met, given that researchers are discouraged from creating a composite burnout score from the three MBI subscales (Maslach, Jackson & Leiter, 1996). With

respect to the third specification, the predictor variables were hypothesized to be intercorrelated. Assumptions of multivariate regression are 1) multivariate normality of the residuals, 2) homogenous variances of residuals conditional on predictors, 3) common covariance structure across observations, and 4) independent observations (UCLA Academic Technology Services, 2011). Because there is no a standard way to evaluate these assumptions and neither SAS nor other common statistical packages include tests of multivariate normality, alternative methods were used to evaluate these assumptions. White's test of homoscedasticity was run for each of the dependent variables and univariate normality of residuals was evaluated using the Shapiro-Wilk test. No violations were detected based on these indicators of normality. Follow-up univariate regression analyses were then performed to examine the relative contributions of particular predictor variables to particular criterion variables (e.g., MBI subscales).

Hypothesis 1 stated that extraversion would be negatively related to EE and DP, and positively related to PA. Extraversion demonstrated significant but small correlations in the expected directions with EE and PA, but was not significantly correlated with DP. The coefficient for extraversion and PA (which are matched in terms of hedonic tone) was strongest, but still modest. To examine these relationships further, a multivariate regression was conducted with extraversion predicting the three burnout scales. The overall regression equation was significant [Wilks  $\lambda=.935$ ,  $F(3, 184)=4.23$ ,  $p\leq.01$ ]. Follow-up univariate regressions (Table 8) indicated that extraversion was a significant predictor of EE [adjusted  $R^2=.016$ ,  $F(1, 186)=4.03$ ,  $p\leq.05$ ,  $\beta=-0.15$ ] and PA [adjusted  $R^2=.038$ ,  $F(1, 186)=8.45$ ,  $p\leq.01$ ;  $\beta=0.21$ ], but not DP [adjusted  $R^2=-.005$ ,  $F(1, 186)=.09$ ,  $ns$ ;  $\beta=0.02$ ]. Accordingly, Hypothesis 1 was partially supported.

Hypothesis 2a stated that role conflict and role ambiguity would be positively related to EE and DP, and negatively related to PA, while autonomy would be negatively related to EE and DP, and positively related to PA. Role conflict (RC) demonstrated significant correlations in the expected directions with the three MBI subscales. Medium positive associations were found with EE and DP, and a small negative association was found with PA. Role ambiguity demonstrated similar relationships with the three dimensions of burnout, although the positive association with DP was smaller and the negative association with PA was larger. A moderate negative correlation was found between autonomy and EE, but autonomy's association with DP and PA were modest and failed to reach statistical significance. The overall multivariate regression equation with role conflict (RC) predicting the three burnout dimensions simultaneously was significant [Wilks  $\lambda$ =.871,  $F(3, 173)$ =8.5,  $p \leq .01$ ]. Follow-up univariate regressions (Table 9) indicated that RC was a significant predictor of EE [adjusted  $R^2$ =.085,  $F(1, 175)$ =17.38,  $p \leq .01$ ;  $\beta$ =.30], DP [adjusted  $R^2$ =.063,  $F(1, 175)$ =12.82,  $p \leq .01$ ;  $\beta$ =.26], and PA [adjusted  $R^2$ =.04,  $F(1, 175)$ =8.35,  $p \leq .01$ ;  $\beta$ =-.21]. The overall multivariate regression equation with role ambiguity (RA) predicting the three burnout dimensions simultaneously was significant [Wilks  $\lambda$ =.826,  $F(3, 174)$ =12.24,  $p \leq .01$ ]. Follow-up univariate regressions (Table 10) indicated that RA was a significant predictor of EE [adjusted  $R^2$ =.107,  $F(1, 176)$ =22.24,  $p \leq .01$ ;  $\beta$ =.33], DP [adjusted  $R^2$ =.043,  $F(1, 176)$ =8.92,  $p \leq .01$ ;  $\beta$ =.22], and PA [adjusted  $R^2$ =.101,  $F(1, 176)$ =20.83,  $p \leq .01$ ;  $\beta$ =-.33]. The overall multivariate regression equation with autonomy (AU) simultaneously predicting the three burnout dimensions was significant [Wilks  $\lambda$ =.889,  $F(3, 173)$ =7.19,  $p \leq .01$ ]. Follow-up univariate regressions (Table 11) indicated that AU was a significant predictor of EE [adjusted  $R^2$ =.102,  $F(1,$

175)=21.03,  $p \leq .01$ ;  $\beta = -.33$ ], but not DP [adjusted  $R^2 = .004$ ,  $F(1, 175) = 1.79$ ,  $ns$ ;  $\beta = -.10$ ] or PA [adjusted  $R^2 = .015$ ,  $F(1, 175) = 3.63$ ,  $ns$ ;  $\beta = .14$ ]. Accordingly, Hypothesis 2a was partially supported.

Hypothesis 2b stated that extraversion would moderate the associations between the three work demand/stressor variables and the three burnout dimensions. To test this hypothesis, centered variables were created from each of the independent variables (extraversion, role conflict, role ambiguity, and autonomy) by subtracting the group mean of each variable from the individual scores within those variables. Interaction terms were then created based on these centered variables. Multiple regressions were conducted for the dimensions of burnout, using the centered variables and the interaction terms predicting the three dimensions of burnout (EE, DP, PA). The overall regression equation [Wilks  $\lambda = .677$ ,  $F(21, 471.47) = 3.27$ ,  $p \leq .01$ ] was significant, however follow-up univariate regressions demonstrated that none of the interaction terms were significant in the prediction of EE [adjusted  $R^2 = .16$ ;  $F(7, 166) = 5.76$ ,  $p \leq .01$ ], DP [adjusted  $R^2 = .07$ ;  $F(7, 166) = 2.96$ ,  $p \leq .01$ ], or PA [adjusted  $R^2 = .10$ ;  $F(7, 166) = 3.81$ ,  $p \leq .01$ ] (Table 12). This indicates that extraversion did not significantly moderate the relationships between the work demand/stressor variables (RC, RA, and AU) and EE, DP, or PA and thus Hypothesis 2b was not supported.

Hypothesis 3a stated that surface acting would be positively related to EE and DP, but negatively related to PA. As expected, both types of surface acting were significantly positively correlated with EE and DP. While faking was significantly negatively correlated with PA, masking was not significantly correlated with PA. A multivariate multiple regression was conducted with the surface acting variables (masking and faking)

predicting the three burnout subscales. The overall multivariate regression equation was significant [Wilks  $\lambda=.80$ ,  $F(6, 352)=7.01$ ,  $p\leq.0001$ ]. Follow-up univariate regressions (Table 13) indicated that both faking ( $\beta=.16$ ) and masking ( $\beta=.21$ ) were significant predictors of EE [adjusted  $R^2=.094$ ,  $F(2, 178)=10.33$ ,  $p\leq.0001$ ], while faking ( $\beta=.29$ ) but not masking ( $\beta=.14$ ) was a significant predictor of DP [adjusted  $R^2=.13$ ;  $F(2, 178)=14.56$ ,  $p\leq.0001$ ]. Similarly, faking ( $\beta=-.25$ ) but not masking ( $\beta=-.04$ ) was a significant predictor of PA [adjusted  $R^2=.061$ ;  $F(2, 178)=6.82$ ,  $p\leq.01$ ]. Accordingly, Hypothesis 3a was partially supported.

Hypothesis 3b stated that deep acting would be negatively related to EE and DP, but positively related to PA. Deep acting strategies were not significantly correlated with any of the MBI subscales and were not significant predictors in the regression equations. Hypothesis 3b was not supported, therefore.

Hypotheses 4a and 4b stated that extraversion would be negatively associated with surface acting and positively associated with deep acting, respectively. These hypotheses were not supported, as extraversion was not significantly correlated with any of the emotional labor strategies (faking:  $r=-.04$ ,  $p=.57$ ; masking:  $r=-.05$ ,  $p=.45$ ; attentional deployment:  $r=0$ ,  $p=.99$ ; reappraisal:  $r=.035$ ,  $p=.63$ ).

Small to moderate correlations were found between role conflict and the surface acting subscales (faking:  $r=.18$ ,  $p\leq.05$ ) masking:  $r=.25$ ,  $p\leq.01$ ), and between role ambiguity and the surface acting subscales (faking:  $r=.21$ ,  $p\leq.01$ ; masking:  $r=.17$ ,  $p\leq.05$ ). In contrast, autonomy was not significantly related to faking or masking. To test whether extraversion moderated the relationships between work demands/stressors and surface acting (Hypothesis 5a), a multivariate multiple regression with moderation was

performed with the centered variables and their interaction terms (Table 14) predicting the two surface acting strategies [Wilks  $\lambda=.884$ ,  $F(14, 318)=1.45$ ,  $p=.13$ ]. Follow-up univariate regressions demonstrated that none of the interaction terms were significant in the prediction of faking [adjusted  $R^2=.027$ ;  $F(7,160)=1.67$ ,  $p=.12$ ] or masking [adjusted  $R^2=.038$ ;  $F(7,160)=1.93$ ,  $p=.07$ ], indicating that extraversion did not significantly moderate the relationships between the work stressor variables (RC, RA, and AU) and surface acting. Thus, Hypothesis 5a was not supported.

Hypothesis 5b stated that extraversion would moderate the relationships between work demands/stressors and deep acting. The work stressor variables and deep acting strategies were not significantly associated and, as aforementioned, extraversion was not significantly related to any of the work stressor or emotional labor variables.

Nonetheless, given that moderation effects can occur in the absence of significant bivariate relationships, a multivariate multiple regression with moderation was performed with the centered variables and their interaction terms (Table 15) predicting the two deep acting strategies [Wilks  $\lambda=.945$ ,  $F(14, 316)=.64$ ,  $p=.82$ ]. Neither the overall multivariate model [Wilks  $\lambda=.945$ ,  $F(14, 316)=.64$ ,  $p=.82$ ], nor follow-up univariate regressions, were significant [Refocus: adjusted  $R^2=-.02$ ;  $F(7,159)=0.53$ ,  $p=.81$ ; Reappraisal: adjusted  $R^2=-0.02$ ;  $F(7,159)=0.62$ ,  $p=.74$ ]. Accordingly, extraversion did not significantly moderate the relationships between the work stressor variables (RC, RA, and AU) and deep acting strategies. Hypothesis 5b was not supported.

Hypothesis 6a stated that surface acting would partially mediate the relationships between the work demand/stressor variables (RC, RA, and AU) and the dimensions of burnout. Baron and Kenny's (1986) statistical approach with Sobel's method (1982) was

used to evaluate surface acting scores as partial mediators of the relationships role conflict, role ambiguity, and autonomy had with the dimensions of burnout. According to Baron and Kenny (1986), a variable may be considered a partial mediator if four conditions are met: 1) the independent predictor variable is significantly associated with the proposed mediator variable, 2) the independent predictor variable is significantly associated with the dependent variable, 3) the proposed mediator is significantly associated with the dependent variable, and 4) the association between the independent predictor and the dependent variable significantly decreases, but remains significant, after accounting for the proposed mediator. Sobel's test is then used to determine the significance of the indirect effect of the mediator.

To evaluate the first condition, the correlations between the predictor variables (RC, RA, AU) and the proposed mediators (faking, masking) were examined. While small to moderate positive correlations were found between both RC and RA and both types of surface acting, autonomy was not significantly correlated with faking or masking scores. Therefore, mediation of autonomy's relationship with the burnout subscales was not tested. To determine whether Baron and Kenny's second condition was met, the associations between the remaining predictor variables (RC and RA) and the dependent variables (EE, DP, and PA) were examined. As aforementioned, significant relationships between the three dimensions of burnout and both RC and RA were found. Associations between the two types of surface acting (faking and masking) and the dimensions of burnout were examined to determine if condition three was met. As determined in testing Hypothesis 3a, both types of surface acting were significantly positively correlated with EE and DP, but only faking (not masking) was significantly correlated with PA scores.

Accordingly, masking does not mediate the relationships between work demands/stressors (RC and RA) and PA. To determine whether Baron and Kenny's fourth condition was met, a series of multivariate multiple regressions predicting each burnout dimension and follow-up univariate analyses were conducted. Due to the large number of tests being conducted, a Bonferroni adjustment was used to correct for family-wise Type I error and the critical value of  $p$  was adjusted to .005 for the follow-up univariate analyses.

The multivariate regression equation was significant for RC and the surface acting strategies predicting the three burnout subscales [Wilks  $\lambda=.733$ ,  $F(9, 399.28)=6.04$ ,  $p\leq.01$ ]. Follow-up univariate analyses for EE [ $F(3, 166)=10.62$ ,  $p\leq.0001$ ], DP [ $F(3, 166)=11.20$ ,  $p\leq.0001$ ], and PA [ $F(3, 166)=5.91$ ,  $p\leq.0007$ ], showed significant effects of RC and faking, but not masking (Table 16). Separate univariate regressions with faking and role conflict predicting each of the three burnout dimensions were then performed and the slopes and standard errors generated were used to perform subsequent Sobel tests (Table 17). For EE [ $_{adjusted}R^2=.132$ ;  $F(2, 171)=14.18$ ,  $p\leq.0001$ ], DP [ $_{adjusted}R^2=.157$ ;  $F(2, 171)=17.16$ ,  $p\leq.0001$ ], and PA [ $_{adjusted}R^2=.091$ ;  $F(2, 171)=9.62$ ,  $p\leq.0001$ ] the indirect effect of RC through faking were not statistically significant (using the adjusted  $p$ -value).

Similar, results were found for RA. The multivariate regression equation was significant for RA [Wilks  $\lambda=.693$ ,  $F(9, 401.72)=7.26$ ,  $p\leq.01$ ] predicting the three burnout subscales]. Follow-up univariate analyses for EE [ $F(3, 167)=13.84$ ,  $p\leq.0001$ ], DP [ $F(3, 167)=10.04$ ,  $p\leq.0001$ ], and PA [ $F(3, 167)=8.32$ ,  $p\leq.0001$ ], showed significant effects of RA and faking, but not masking (Table 18). Separate univariate regressions with faking and role ambiguity predicting each of the three burnout dimensions were then performed

and the slopes and standard errors generated were used to perform subsequent Sobel tests (Table 19). For EE [ $adjustedR^2=.154$ ;  $F(2, 172)=16.88$ ,  $p\leq.0001$ ], DP [ $adjustedR^2=.144$ ;  $F(2, 172)=15.65$ ,  $p\leq.0001$ ], and PA [ $adjustedR^2=.128$ ;  $F(2, 172)=13.76$ ,  $p\leq.0001$ ] the indirect effect of RA through faking were not statistically significant (using the adjusted p-value). Accordingly, Hypothesis 6a was not supported.

Hypothesis 6b stated that deep acting would partially mediate the relationships role conflict, role ambiguity, and autonomy had with levels of burnout. Because deep acting was not significantly correlated with any of the other variables, this hypothesis was not supported.

### *Supplemental Analyses*

Relationships between burnout and several secondary variables (i.e., demographic and professional characteristics of MHPs, client characteristics, and exploratory measures) were also examined.

*Demographic Variables.* No significant differences by sex were found for EE or PA. Compared to male MHPs, female MHPs had significantly lower DP scores [ $F(1,186)= 5.837$ ,  $p=.017$ ]. No significant differences in burnout were found when Caucasian and non-Caucasian MHPs were compared. MHP age demonstrated a small negative correlation with EE but was not significantly correlated with DP or PA. No meaningful differences between MHPs with and without children were found with respect to burnout [EE:  $F(1, 185)=5.654$ ,  $p=.018$ ; DP:  $F(1, 185)=.255$ ,  $p=.61$ ; PA:  $F(1, 185)=2.426$ ,  $p=.121$ ] although parents reported significantly lower EE.

*Professional Variables.* MHPs' years of experience was examined in several ways. First responses were group into the following categories: 10 or less years, 11-20 years, 21-30 years, 31-40 years, and 41-50 years. No significant differences were found for EE [F(4, 182)=1.448, p=.22], DP [F(4, 182)=.234, p=.92], or PA [F(4, 182)=1.084, p=.37]. Given that prior research has shown MHPs with less experience to report higher levels of burnout, scores on the MBI were compared across MHPs with less than one year, one year, two years, three years, four years, and five years of experience. Again, no significant differences across groups were found for EE [F(4, 39)=.88, p=.49], DP [F(4, 39)=1.175, p=.37], or PA [F(4, 39)=.223, p=.92]. Emotional exhaustion ( $r=.214$ ,  $p=.003$ ), but not DP ( $r=.116$ ,  $p=.11$ ) or PA ( $r=.013$ ,  $p=.86$ ), was found to be correlated with the number of treatment settings in which MHPs were currently providing services, with those working in more settings reporting more emotional exhaustion. MHPs working in at least part time in private practice had significantly lower EE [F(1, 185)=21.61, p=.00] and DP [F(1,185)=5.33, p=.022], and significantly higher PA [F(1, 185)=380.34, p=.00] compared to those who were not working in private practice. Individuals working exclusively in private practice had lower levels of burnout compared to those working at least part-time in other settings [EE: F(1, 185)=24.216, p=.00; DP: F(1,185)=7.176, p=.008; PA: F(1, 185)=9.767, p=.002]. MHPs working exclusively in private practice reported significantly more hours spent providing direct care [F(1, 180)=5.99, p=.015], less hours spent on administrative and clinical support tasks [F(1, 180)=5.99, p=.015], lower role ambiguity [F(1, 175)=13.733, p=.000], and higher autonomy [F(1, 174)=24.825, p=.000], compared to MHPs working at least part time in other settings. No difference between these groups were found for exposure to

challenging client behavior and circumstances [ $F(1, 178)=2.047, p=.154$ ] or role conflict [ $F(1, 174)=3.472, p=.064$ ].

When examining the total sample of MHPs, average hours per week spent on administrative and clinical support tasks was significantly positively associated with EE ( $r=.20, p=.007$ ) and DP ( $r=.25, p=.001$ ), and significantly negatively associated with PA ( $r=-.20, p=.007$ ). Average hours per week spent providing direct care services (i.e., assessment plus treatment hours) was moderately positively correlated with PA ( $r=.30, p<.001$ ), but unrelated to EE and DP.

*Caseload/Client Characteristics.* The proportion of MHPs' caseloads that were children versus adults was examined in relation to burnout. Percent adult clients was moderately positively correlated with EE ( $r=.256, p\leq.001$ ), while percent child clients was negatively correlated ( $r=-.259, p\leq.001$ ). These variables were unrelated to DP and PA. MHPs who reported a preference for working with a different age group than that with which they were currently working had significantly higher EE than MHPs who reported being satisfied with the age group with which they were working ( $F(1, 185)=9.109, p=.003$ ). No significant differences were found for DP or PA on this variable.

Client insurance type was also examined in relation to burnout. Percent of clients with medical assistance demonstrated a small negative association with PA ( $r=-.19, p=.009$ ), but no relationship with EE or DP. In contrast, percent of private pay clients in MHPs' caseloads demonstrated small negative associations with EE ( $r=-.20, p=.006$ ) and DP ( $r=.21, p=.005$ ), but was unrelated to PA. No significant associations were found between proportions of other insurance types (e.g., private managed care) and burnout.

Client severity (i.e., cumulative proportion of caseload with particularly challenging pathology and circumstances) demonstrated small positive and negative correlations with EE and PA, respectively, but a large positive correlation with DP. Client severity also demonstrated small but significant positive correlations with role conflict ( $r=.16, p\leq.03$ ), faking ( $r=.18, p\leq.05$ ), masking ( $r=.11, p\leq.05$ ), average hours per week spent on administrative and support tasks ( $r=.24, p=.002$ ), and proportion of clients with medical assistance ( $r=.16, p=.003$ ), and a moderate negative correlation with JAWS scores ( $r=-.24, p\leq.01$ ).

*Perceived Emotional Display Rules.* Responses on the display rules measure created for this study revealed that MHPs' perceptions of the acceptability of displaying different emotions while interacting with clients are variable. Frequency data for this measure are shown in Table 20. For each of the 18 items, at least some MHPs indicated that no display rules exist, although ratings of *Not Applicable* were rare. For all but four items, responses ranged from *Never* to *Always*. No MHPs rated Enthusiasm, Neutral Emotions, Empathy, and Patience as never being acceptable. A small minority of MHPs rated negative emotional displays as being always acceptable and a large majority of MHPs rated neutral and positive emotional displays as being sometimes or always acceptable. The only items that over 50% of MHPs rated as being *always* acceptable were Empathy, Patience, and Calmness. The only items that over 50% of MHPs rated as *never* being acceptable were Boredom, Dislike/Contempt, and Disgust, although the response of *Never* for Fear/Anxiety had the largest relative percentage. The majority of MHPs rated displays of the remaining 11 emotions (Enthusiasm, Admiration, Sadness, Happiness/Joy, Neutral Emotions, Anger, Sympathy, Frustration, No Emotions,

Disappointment, and Excitement) as being sometimes acceptable. Average ratings for integrative emotional displays (Enthusiasm, Happiness/Joy, Admiration, Empathy, Sympathy, Patience, Calmness, and Excitement) were 1.49, with a standard deviation of 0.32. Average ratings for differentiating emotional displays (Boredom, Dislike/Contempt, Anger, Disgust, Frustration, Fear/Anxiety, and Disappointment) were 0.53, with a standard deviation of 0.29. Average ratings for neutral emotional displays (No Emotions, Neutral Emotions) were 1.04, with a standard deviation of 0.38.

Associations with MHPs' perceptions of professional display rules were examined using a composite score ( $X=20.05$ ,  $SD=3.06$ ) representing display rules that promote integrative and censure differentiating emotional expressions in the context of treatment (i.e., the sum of integrative emotion items and reverse coded differentiating emotion items). For the sake of brevity, this combination of display rules will be referred to here as simply "positive display rules". Significant correlations were found with EE ( $r=.151$ ,  $p=.04$ ), attentional deployment ( $r=.214$ ,  $p=.004$ ), perceived importance of emotional abilities (AEAS total scores), and MHP age ( $r=-.179$ ,  $p=.018$ ). No associations with other primary or secondary variables reached statistical significance. Display rules for integrative and differentiating emotions also were examined separately in relation to the other variables. A significant positive association was found between integrative display rules and attentional deployment ( $r=.189$ ,  $p=.011$ ), while differentiating display rules demonstrated a significant positive association with masking ( $r=.259$ ,  $p=.000$ ), percent of caseload with medical assistance insurance ( $r=.171$ ,  $p=.02$ ), and AEAS total scores ( $r=.256$ ,  $p=.001$ ).

*Job-related Affective Well-being.* Scores on the JAWS were significantly correlated with the three MBI subscales in the expected directions. JAWS scores demonstrated a strong negative relationship with EE ( $r=-.48, p=.00$ ), a moderate negative relationship with DP ( $r=-.27, p=.00$ ), and a strong positive relationship with PA ( $r=.365, p=.00$ ). Thus, as expected, individuals who reported lower job-related affective well-being tended to report higher burnout. JAWS scores were significantly positively correlated with extraversion ( $r=.191, p=.009$ ), though this effect was small. JAWS scores demonstrated a moderate negative association with role conflict ( $r=-.281, p=.00$ ), a large negative association with role ambiguity ( $r=-.445, p=.00$ ), and a large positive correlation with autonomy ( $r=.415, p=.00$ ). Accordingly, MHPs who reported higher role conflict, higher role ambiguity, and/or lower autonomy tended to report lower job-related affective well-being. A small but significant negative correlation was found between JAWS scores and Client Severity scores ( $r=-.225, p=.002$ ).

*Adapted Emotional Abilities Scale.* Scores on the AEAS, which measured individuals' perceptions of how important it is for MHPs to control their emotions at work, was examined in relation to MBI subscale scores. The AEAS demonstrated a small positive correlation with DP ( $r=.210, p=.005$ ), but no relationship with EE or PA. The AEAS was moderately positively correlated with faking ( $r=.36, p=.00$ ) and masking ( $r=.318, p=.00$ ), but was unrelated to the deep acting scales.

In order to evaluate whether the supplemental variables explained additional variance in burnout, above and beyond that accounted for by the primary predictor variables a multivariate hierarchical regression was performed. Role conflict, role ambiguity, autonomy, extraversion, faking, masking, direct care hours per week, clinical

support/administrative hours per week, MHP age, percent private pay clients, percent medical assistance clients, and client severity were examined as predictors of the three burnout dimensions. The overall multivariate regression equation was significant [Wilks  $\lambda=.38$ ,  $F(39, 391.63)=3.89$ ,  $p\leq.001$ ]. The follow-up univariate multiple regression for EE [adjusted  $R^2=.31$ ,  $F(13, 134)=6.09$ ,  $p\leq.001$ ] revealed that autonomy ( $\beta=-.21$ ), extraversion ( $\beta=-.16$ ), direct care hours ( $\beta=.21$ ), clinical support/administrative hours ( $\beta=.15$ ), MHP age ( $\beta=.17$ ), and the percent of MHPs' caseloads comprised of adult clients ( $\beta=-.16$ ) accounted for significant variance. The increase in variance accounted for by adding the six supplemental variables to the primary predictor variables was statistically significant [ $F_{\text{change}}=(7, 134)=3.892$ ,  $p<.05$ ]. The follow-up univariate multiple regression for DP [adjusted  $R^2=.25$ ,  $F(13, 134)=4.68$ ,  $p\leq.001$ ] revealed that role conflict ( $\beta=.20$ ), faking ( $\beta=.23$ ), and client severity ( $\beta=.30$ ), accounted for significant variance. Again, adding the six supplemental variables to the six primary predictors resulted in significant increases in variance accounted for in DP [ $F_{\text{change}}=(7, 134)= 3.86$ ,  $p<.05$ ]. The univariate regression for PA revealed that extraversion ( $\beta=.19$ ) and direct care hours ( $\beta=.24$ ) accounted for significant variance [adjusted  $R^2=.16$ ,  $F(13, 134)=3.19$ ,  $p\leq.001$ ]. However, the increase in variance accounted for in PA by adding the supplemental variables to the original set of predictors was not statistically significant [ $F_{\text{change}}=(7, 134)=1.75$ , *ns*]

Table 6. Descriptives for Measures of Independent and Dependent Variables

	N	Missing	Possible Score Range	Observed Score Range	Mean	SD
MBI-Emotional Exhaustion (EE)	188	0	0-54	0-44	15.28	8.04
MBI-Depersonalization (DP)	188	0	0-30	0-20	3.42	4.26
MBI-Personal Accomplishment (PA)	188	0	0-48	22-48	41.23	5.50
Extraversion (EXT)	187	1	0-48	5-43	25.34	7.19
Role Conflict (RC)	177	11	8-56	8-46	25.23	7.45
Role Ambiguity (RA)	178	10	6-42	6-40	14.12	6.37
Autonomy (AU)	177	11	3-21	3-21	18.41	2.95
Deep Acting-Reappraisal	185	3	6-42	6-42	30.17	6.91
Deep Acting-Attentional Deployment	184	4	0-12	0-12	6.16	3.51
Surface Acting-Faking	185	3	0-20	0-15	5.05	3.30
Surface Acting-Masking	184	4	4-36	4-32	14.58	5.32
Total Client Severity	181	7	0-1600	0-743	134.11	124.17
Job-related Affective Wellbeing (JAWS)	188	0	0-80	26-68	48.88	7.82
Perceived Positive Display Rules	179	9	0-30	17-33		
AEAS	177	11	8-32	9-32	20.38	3.97

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Table 7. Pearson Correlation Coefficients among Primary and Secondary Variables

	1	2	3	4	5	6	7	8	9	10	11
1 MBI-Emotional Exhaustion	1	.366**	-.286**	-.146*	.301**	.335**	-.328**	.124	-.004	.255**	.285**
2 MBI-Depersonalization	.366**	1	-.267**	.022	.261**	.220**	-.101	.107	.048	.363**	.275**
3 MBI-Personal Accomplishment	-.286**	-.267**	1	.208**	-.213**	-.325**	.143	.037	.021	-.273**	-.137
4 Extraversion	-.146*	.022	.208**	1	-.034	-.063	-.055	.000	.035	-.042	-.052
5 Role Conflict	.301**	.261**	-.213**	-.034	1	.564**	-.435**	-.062	.009	.181*	.251**
6 Role Ambiguity	.335**	.220**	-.325**	-.063	.564**	1	-.666**	-.003	-.024	.213**	.166*
7 Autonomy	-.328**	-.101	.143	-.055	-.435**	-.666**	1	-.055	.088	-.103	-.143
8 Deep Acting Attentional Deployment	.124	.107	.037	.000	-.062	-.003	-.055	1	.123	.176*	.014
9 Deep Acting – Reappraisal	-.004	.048	.021	.035	.009	-.024	.088	.123	1	.104	.018
10 Surface Acting – Faking	.255**	.363**	-.273**	-.042	.181*	.213**	-.103	.176*	.104	1	.434**
11 Surface Acting – Masking	.285**	.275**	-.137	-.052	.251**	.166*	-.143	.014	.018	.434**	1

\*  $p \leq .05$ ; \*\*  $p \leq .01$

Table 7 (continued). Pearson Correlation Coefficients among Primary and Secondary Variables

	1	2	3	4	5	6	7	8	9	10	11
12 Client Severity Total	.160*	.344**	-.207**	.034	.162*	.133	-.131	.137	.001	.184*	.107
13 Hrs/Wk Direct Care Activities	.143	-.012	.301**	.066	-.029	-.038	.037	.018	.042	-.056	.018
14 Hrs/Wk Admin. & Support Activities	.201**	.247**	-.204**	-.067	.097	.028	-.091	.028	-.012	.166*	.149
15 AEAS Total	.073	.210**	.107	.028	.079	.012	.049	.119	.111	.360**	.318**
16 Positive Display Rules	.151*	.080	-.005	-.012	.027	.036	.032	.224**	.146	.087	.144
17 JAWS	-.481**	-.266**	.365**	.191**	-.281**	-.445**	.415**	.018	.072	-.150*	-.099
18 MHP Age	-.259**	-.078	.096	-.131	-.106	-.141	.180*	-.166*	-.002	-.187*	-.125
19 % Adult Clients	-.259**	-.087	.075	.065	-.078	.023	-.033	-.025	.148*	-.030	-.119
20 % Child Clients	.256**	.095	-.070	-.063	.077	-.006	.020	.018	-.161*	.009	.080
21 % Private Pay	-.200**	-.206**	.102	.070	-.133	-.174*	.110	-.110	-.175*	-.105	-.123
22 % Medical Assistance Insurance	.141	.131	-.191**	-.093	.164*	.074	-.101	.065	.158*	.063	.108

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Table 7 (continued). Pearson Correlation Coefficients among Primary and Secondary Variables

	12	13	14	15	16	17	18	19	20	21	22
12 Client Severity Total	1	-.073	.237**	.144	-.005	-.225**	-.095	.050	-.050	-.079	.160*
13 Hrs/Wk Direct Care Activities	-.073	1	-.217**	.018	-.014	-.014	.110	.037	-.014	-.059	-.158*
14 Hrs/Wk Admin. & Support Activities	.237**	-.217**	1	.155*	.115	-.207**	.006	-.017	-.035	-.187*	.139
15 AEAS Total	.144	.018	.155*	1	.249**	.055	-.080	.016	-.016	-.140	.185*
16 Positive Display Rules	-.005	-.014	.115	.249**	1	.093	-.200**	-.112	.121	-.040	.060
17 JAWS	-.225**	-.014	-.207**	.055	.093	1	.065	.040	-.041	.191**	-.139
18 MHP Age	-.095	.110	.006	-.080	-.200**	.065	1	.321**	-.304**	.048	-.121
19 % Adult Clients	.050	.037	-.017	.016	-.112	.040	.321**	1	-.981**	.192**	-.210**
20 % Child Clients	-.050	-.014	-.035	-.016	.121	-.041	-.304**	-.981**	1	-.192**	.195**
21 % Private Pay	-.079	-.059	-.187*	-.140	-.040	.191**	.048	.192**	-.192**	1	-.354**
22 % Medical Assistance Insurance	.160*	-.158*	.139	.185*	.060	-.139	-.121	-.210**	.195**	-.354**	1

Table 8. Extraversion Predicting Burnout

	B	Standard Error	t	p	$\beta$
Extraversion					
EE	-0.16	0.08	-2.01	0.05	-0.15
DP	0.01	0.04	0.30	0.76	0.02
PA	0.15	0.05	2.91	0.004	0.21
Role Conflict					
EE	0.32	0.08	4.17	<.0001	0.30
DP	0.15	0.04	3.58	0.0004	0.26
PA	-0.16	0.06	-2.89	0.004	-0.21
Role Ambiguity					
EE	0.42	0.09	4.72	<.0001	0.33
DP	0.15	0.05	2.99	0.003	0.22
PA	-0.28	0,06	-4,56	<.0001	-0.33
Autonomy					
EE	-0.89	0.19	-4.59	<.0001	-0.33
DP	-0.15	0.11	-1.34	0.19	-0.10
PA	0.26	0.14	1.91	0.06	0.14

Table 9. Role Conflict Predicting Burnout

	B	Standard Error	t	p	$\beta$
Role Conflict					
EE	0.32	0.08	4.17	<.0001	0.30
DP	0.15	0.04	3.58	0.0004	0.26
PA	-0.16	0.06	-2.89	0.004	-0.21

Table 10. Role Ambiguity Predicting Burnout

	B	Standard Error	t	p	$\beta$
Role Ambiguity					
EE	0.42	0.09	4.72	<.0001	0.33
DP	0.15	0.05	2.99	0.003	0.22
PA	-0.28	0,06	-4,56	<.0001	-0.33

Table 11. Autonomy Predicting Burnout

	B	Standard Error	t	p	$\beta$
Autonomy					
EE	-0.89	0.19	-4.59	<.0001	-0.33
DP	-0.15	0.11	-1.34	0.19	-0.10
PA	0.26	0.14	1.91	0.06	0.14

Table 12. Burnout Predicted From Work Stressors and Extraversion: Moderation Model

	B	Standard Error	t	p	$\beta$
EE					
Intercept	25.17	6.91	3.65	.00	0
Role Ambiguity (RA)	.065	.134	.49	.62	.05
Role Conflict (RC)	.169	.09	1.84	.07	.157
Autonomy (AU)	-.617	.260	-2.37	.02	-.226
Extraversion (EXT)	-.152	.077	-1.98	.05	-.142
EXTxRA	-.016	.016	-.98	.33	-.101
EXTxRC	.022	.012	1.88	.06	.152
EXTxAU	.037	.031	1.2	.23	.114
DP					
Intercept	-4.69	3.92	-1.2	.23	0
Role Ambiguity (RA)	.109	.076	1.43	.16	.16
Role Conflict (RC)	.123	.052	2.36	.02	.21
Autonomy (AU)	.161	.148	1.09	.28	.11
Extraversion (EXT)	.027	.043	.61	.54	.05
EXTxRA	-.005	.009	-.50	.62	-.05
EXTxRC	.011	.007	1.74	.08	.15
EXTxAU	.021	.018	1.22	.22	.12

Table 12 (*continued*). Burnout Predicted From Work Stressors and Extraversion:  
Moderation Model

	B	Standard Error	t	p	B
PA					
Intercept	45.1	4.84	9.31	.00	0
Role Ambiguity (RA)	-2.4	.09	-2.55	.012	-.276
Role Conflict (RC)	-.06	.064	-.92	.36	-.081
Autonomy (AU)	-.155	.18	-.85	.40	-.084
Extraversion (EXT)	.152	.054	2.93	.005	.21
EXTxRA	.011	.011	.97	.33	.104
EXTxRC	-.005	.008	-.57	.566	-.048
EXTxAU	.01	.022	.49	.626	.048

Table 13. Surface Acting Predicting Burnout

	B	Standard Error	t	p	$\beta$
EE					
Faking	0.41	0.19	2.13	0.034	0.17
Masking	0.32	0.12	2.69	0.008	0.21
DP					
Faking	0.36	0.10	3.74	0.0002	0.29
Masking	0.11	0.06	1.88	0.06	0.15
PA					
Faking	-0.40	0.13	-3.06	0.003	-0.25
Masking	-0.04	0.08	-0.53	0.59	-0.04

Table 14. Surface Acting Predicted From Work Stressors and Extraversion: Moderation Model

	B	Standard Error	t	P	$\beta$
<b>Faking</b>					
Role Ambiguity (RA)	.10	.06	1.63	.10	.19
Role Conflict (RC)	.04	.04	.89	.38	.08
Autonomy (AU)	.09	.11	.81	.42	.08
Extraversion (EXT)	-.01	.03	-.27	.79	-.02
EXTxRA	-.01	.01	-.78	.43	-.09
EXTxRC	.00	.01	.08	.93	.01
EXTxAU	.01	.01	.06	.53	.06
<b>Masking</b>					
Role Ambiguity (RA)	.07	.10	.68	.50	.08
Role Conflict (RC)	.16	.07	2.3	.02	.22
Autonomy (AU)	.03	.18	.15	.88	.02
Extraversion (EXT)	-.02	.05	-.31	.75	-.02
EXTxRA	.005	.01	.40	.69	.0
EXTxRC	-.01	.01	.74	.46	.06
EXTxAU	.014	.022	.62	.54	.06

Table 15. Deep Acting Predicted From Work Stressors and Extraversion: Moderation

Model

	B	Standard Error	t	P	$\beta$
Attentional Deployment (i.e., Refocus)					
Role Ambiguity (RA)	-.00	.06	-.08	.94	-.01
Role Conflict (RC)	-.04	.04	-.88	.38	-.08
Autonomy (AU)	-.10	.13	-.79	.43	-.09
Extraversion (EXT)	.02	.04	.42	.67	.03
EXTxRA	.01	.01	.74	.46	.09
EXTxRC	-.01	.01	-1.37	.17	-.12
EXTxAU	.01	.01	.63	.53	.07
Reappraisal					
Role Ambiguity (RA)	.08	.12	.60	.55	.07
Role Conflict (RC)	.06	.09	.66	.51	.06
Autonomy (AU)	.42	.24	1.72	.09	.19
Extraversion (EXT)	.02	.07	.34	.73	.03
EXTxRA	.00	.02	.15	.88	.02
EXTxRC	.01	.01	.70	.49	.06
EXTxAU	.01	.03	.36	.72	.04

Table 16. Burnout Predicted from Role Conflict and Surface Acting

	B	Standard Error	t	P	$\beta$
EE					
Role Conflict (RC)	.27	.08	3.33	.001	.25
Surface Acting -Faking	.45	.19	2.37	.02	.19
Surface Acting- Masking	.19	.12	1.56	.12	.12
DP					
Role Conflict (RC)	.11	.04	2.75	.01	.20
Surface Acting -Faking	.34	.10	3.44	.00	.27
Surface Acting- Masking	.07	.06	1.12	.26	.09
PA					
Role Conflict (RC)	-.13	.06	-2.25	.03	-.17
Surface Acting -Faking	-.40	.14	-2.93	.00	-.24
Surface Acting -Masking	.01	.08	.17	.87	.01

Table 17. Burnout Predicted from Role Conflict and Faking : Mediation Test

	B	Standard Error	t	P	$\beta$	Sobel Test	P
EE							
Role Conflict (RC)	.28	.08	3.65	.000	.263		
Surface Acting -Faking	.554	.175	3.16	.002	.227		
						2.39	.008
DP							
Role Conflict (RC)	.12	.04	2.95	.004			
Surface Acting -Faking	.416	.09	4.45	.000			
						2.46	.007
PA							
Role Conflict (RC)	-.12	.05	-2.29	.023	-.169		
Surface Acting -Faking	-.402	.123	-3.265	.001	-.241		
						1.88	.03

Table 18. Burnout Predicted from Role Ambiguity and Surface Acting

	B	Standard Error	t	P	$\beta$
<b>EE</b>					
Role Ambiguity (RA)	.40	.09	4.45	.00	.32
Surface Acting -Faking	.37	.19	1.98	.05	.15
Surface Acting- Masking	.22	.12	1.9	.06	.14
<b>DP</b>					
Role Ambiguity (RA)	.10	.05	2.04	.04	.15
Surface Acting -Faking	.33	.10	3.32	.00	.26
Surface Acting- Masking	.09	.06	1.48	.14	.12
<b>PA</b>					
Role Ambiguity (RA)	-.22	.06	-3.44	.00	-.25
Surface Acting -Faking	-.35	.13	-2.61	.01	-.21
Surface Acting-Masking	.003	.08	.04	.97	.00

Table 19. Burnout Predicted from Role Ambiguity and Faking

	B	Standard Error	t	P	$\beta$	Sobel Test	P
EE							
Role Ambiguity (RA)	.39	.09	4.29	.000	.395		
Surface Acting -Faking	.51	.17	2.9	.004	.208		
						2.40	.008
DP							
Role Ambiguity (RA)	.12	.05	2.38	.019	.171		
Surface Acting -Faking	.42	.10	4.44	.000	.319		
						2.09	.02
PA							
Role Ambiguity (RA)	-.23	.06	-3.60	.000	-.261		
Surface Acting -Faking	-.36	.12	-2.96	.004	-.214		
						2.29	.01

Table 20. Response Frequencies for Perceived Emotional Display Rules Survey

	Missing		Never		Sometimes		Always		N/A	
	N	%	N	%	N	%	N	%	N	%
No Emotions	2	1.1	56	29.8	101	53.7	8	4.3	21	11.2
Neutral Emotions	1	.5	0	0	111	59	66	35.1	10	5.3
Calmness	3	1.6	2	1.1	38	20.2	135	71.8	10	5.3
Patience	2	1.1	0	0	31	16.5	148	78.7	7	3.7
Happiness/Joy	3	1.6	1	.5	122	65.9	56	29.8	6	3.2
Admiration	1	.5	9	4.8	114	60.6	55	29.3	9	4.8
Enthusiasm	2	1.1	0	0	103	54.8	77	41	6	3.2
Excitement	1	.5	2	1.1	125	66.5	53	28.2	7	3.7
Sympathy	1	.5	12	6.4	111	59	57	30.3	7	3.7
Empathy	1	.5	0	0	39	20.7	142	75.5	6	3.2
Boredom	2	1.1	124	66	46	24.5	1	.5	15	8
Sadness	1	.5	11	5.9	152	80.9	17	9	7	3.7
Dislike/Contempt	1	.5	12	6.6	4	28.2	53	.5	1	4.8
Anger	1	.5	73	38.8	102	54.3	4	2.1	8	4.3
Disgust	1	.5	118	62.8	57	30.3	2	1.1	10	5.3
Fear/Anxiety	1	.5	92	48.9	83	44.1	1	.5	11	5.9
Frustration	1	.5	32	17	143	76.1	5	2.7	7	3.7
Disappointment	1	.5	32	17	14	75.5	2	2.7	58	4.3

## Discussion

The present study aimed to fill a gap in the literature by evaluating the empirical links between work stressors (i.e., role conflict, role ambiguity, and lack of autonomy), extraversion, emotional labor strategies, and burnout in a sample of MHPs. Prior studies have demonstrated relationships between combinations of these variables in other professional samples. The primary objectives of the present study were to (a) determine whether these relationships would generalize to a sample of MHPs, and (b) evaluate the empirical links between work factors and individual factors in predicting MHPs' emotional labor and levels of burnout. No prior studies were found that examined these variables in this professional group. The current study also aimed to provide preliminary information about MHPs' perceptions of professional display rules and the importance of controlling emotional displays at work. The relationships between these variables and emotional labor and burnout among MHPs were also of interest. The following sections provide a summary of the current study's findings, a discussion of their implications and limitations, and ideas for future research in this area.

### *Extraversion and Burnout*

Extraversion is one personality trait that has been negatively associated with burnout in prior empirical studies (e.g., Bakker et al., 2006; Chung & Harding, 2009; Eastburg et al., 1994; Francis et al., 2004; Ghorpade et al., 2007; Kim et al., 2007;

Michielsen et al., 2004; Piedmont, 1993; Zellars et al., 2000), most of which used professional groups other than MHPs. Consistent with previous research and Hypothesis 1, the present study found that extraversion was a significant negative and positive predictor of emotional exhaustion and personal accomplishment, respectively, in the MHPs sampled. These effects were relatively small, however, as extraversion accounted for 1.6% and 3.8% of the variance in EE and PA, respectively. The strength of these relationships is somewhat smaller than that reported in prior studies. It is possible that the present findings are underestimates due to lack of variability on the MBI subscales. It reasons that the qualities that characterize extraversion – such as tendencies to experience and express more positive emotions (e.g., Bakker et al, 2006; Costa & McCrae, 1992) and to use more effective coping strategies (e.g., Dorn & Matthews, 1992; Watson & Hubbard, 1996) – may act as protective factors that mitigate the emotional strain of working in the mental health field. Tendencies to be more optimistic and self-confident (e.g., Bakker et al, 2006; Costa & McCrae, 1992) may lead extraverted MHPs to make more positive self-evaluations regarding their abilities to perform their professional roles competently and to experience more feelings of fulfillment and satisfaction regarding work and their impact on clients. In turn, such MHPs may report higher personal accomplishment. Although the present findings are correlational and causality therefore cannot be assumed, the relationships between extraversion and burnout highlight the potential importance of intrinsic personality characteristics for MHPs' interpretations of and reactions to professional experiences. If MHPs with lower levels of extraversion could be provided with additional supports or resources and taught strategies for

improving their adaptive functioning and increasing their use of effective coping strategies, it may be possible to mitigate the impact of stressors that can lead to burnout.

In contrast to its significant relationships with emotional exhaustion and personal accomplishment, extraversion's correlation with depersonalization was close to zero in the present sample, indicating that these variables were not significantly associated. This finding is inconsistent with previous evidence of a negative association between extraversion and DP (Bakker et al., 2006; Francis et al., 2004; Ghorpade, Lackritz, & Singh, 2007; Kim, Shin, & Umbreit, 2007; Zellars et al., 2000). It is important to note that range restriction on the MBI was most severe on the DP subscale, with the highest score being 20 out of a possible 30. One possible explanation for this range restriction is that clinical training might decrease MHPs' risk of developing negative and dehumanizing attributions about their clients, or at least decrease the likelihood that MHPs will report depersonalizing their clients. Beneficence and non-maleficence are two central ethical standards in the mental health field (Koocher & Keith-Spiegel, 1998). Therapists are often trained directly, and indirectly through exposure to professional mores, not to allow their personal attitudes and values to color their views and treatment of clients. MHPs are encouraged to be wary of so-called "countertransference" reactions toward clients, which might diminish the effectiveness of treatment (Hayes, Gelso, & Hummel, 2011). Related, emphasis on the importance of tailoring therapeutic approaches to accommodate individual differences among clients has increased over the last several decades (see Norcross, 2002). Accreditation institutions, such as the American Psychological Association, now require training programs to incorporate cultural diversity training into curricula and the literature emphasizes the importance of

integrating culture into evidence-based practice (Alegria, Atkins, Farmer, Slaton, & Stelk, 2010; Yamada & Brekke, 2008). As such, practitioners may be trained to view respect, empathy, acceptance, and/or unconditional positive regard for clients as critical and abide by these standards or feel reluctant to admit otherwise. This does not explain, however, why higher rates of depersonalization have been found in other samples. It is possible that a self-selection bias occurred, such that MHPs with higher levels of burnout were less likely to participate in this study, particularly if they viewed the task of completing the online survey as an additional stressor. Regardless, lack of variability in DP scores may have precluded detection of an association with extraversion, particularly given that these variables are not matched in terms of hedonic tone and are therefore likely to demonstrate lower correlations (Thoresen et al., 2003). It is also possible, however, that these results are an accurate representation of the relationship between extraversion and depersonalization. MHPs' tendencies to de-individualize clients and view them in a negative manner may occur regardless of MHPs' levels of extraversion. Perhaps some extraverts respond to work-related strain by making negative external attributions about their clients (e.g., my client is not trying hard to get better in treatment), while other extraverts respond by making other types of attributions (e.g., I am not the best match for this client, but I am successful with other clients and this client might be successful under other circumstances). Accordingly, extraversion may be less implicated in the development of depersonalization than the other dimensions of burnout.

### *Work Stressors and Burnout*

This study examined the associations between several work stressors (i.e., role conflict, role ambiguity, and lack of autonomy) and the dimensions of burnout (Note: secondary work stressor variables, such as exposure to challenging client pathology and circumstances, will be discussed later in the *Supplemental Findings* section). As hypothesized (2a), role conflict and role ambiguity were positively related to EE and DP, and negatively related to PA. It is important to note that these results should be interpreted with caution, as the role conflict measure had lower reliability than has been previously reported and is typically considered acceptable. While it is unclear why a lower alpha was found in the present study, it is possible that role conflict items were interpreted differently by the MHPs in this sample than they have been by previously studied occupational groups. In addition, the relationships between role ambiguity and the burnout dimensions may be underestimated due to range restriction on these measures. Nonetheless, the finding of significant relationships between the two role stressors and burnout is consistent with Acker's (2003) study of MHPs.

It reasons that those individuals who experience more incompatible work demands and expectations (i.e., role conflict), and/or who perceive their roles to be more poorly delineated (i.e., role ambiguity), are at greater risk for experiencing strain in their roles and thus at greater risk for burnout. Lack of clarity with respect to one's role and the impact of one's role in the lives of clients may create a sense of professional disorientation that is distressing in itself. This role stress may also predispose MHPs to role strain, which is the emotional response to specific stressful events (Chen et al.,

2007). Repeated experiences of role strain, in addition to role stress, may contribute to burnout. However, causality cannot be inferred from this study's findings and alternative explanations must be considered.

The literature on depression has provided evidence for the development and exacerbation of negativistic thinking among individuals with depressive disorders (e.g., Beck, 1976, Coyne & Gotlib, 1983). Accordingly, individuals with depression tend to focus on aspects of their environments that are consistent with their negative feelings and thoughts, and to filter out information that is incompatible with their internal experiences (e.g., Beck, 1976, Coyne & Gotlib, 1983). Individuals' depressive symptoms (e.g., irritability, harsh judgments of others, social withdrawal, etc.) also can lead to strained relationships and thus negative feedback from people around them (e.g., Beck, 1976, Coyne, 1983, Coyne, 1976). Symptoms of depression are then reinforced by individuals' negatively biased and sometimes accurate interpretations of their environments (e.g., Beck, 1976, Coyne, 1983). A similar process may occur among individuals with burnout. By definition, burnout involves the experience of negative emotions and thinking. Therefore, individuals with higher burnout may be more likely to perceive aspects of their work environments in a negative manner, which in turn may reinforce their symptoms of burnout. For instance, MHPs with high levels of emotional exhaustion may be more easily distressed when they receive inconsistent feedback from two different supervisors about how to manage particular clinical situations, and thus begin to perceive themselves as facing more role conflict. Similarly, MHPs with higher depersonalization or lower personal accomplishment may report higher role ambiguity due to the development of cynical attitudes about their clients and their own abilities to have a

meaningful impact on them. That is, the ambiguity MHPs perceive about their roles may in fact be an extension of their disconnectedness with clients and skepticism about their own abilities to help clients. In sum, the relationships observed between these role stressors and the dimensions of burnout may be reciprocal.

It is also possible that one or more other variables accounts for the association between the two role stressors and burnout. That is, mental health settings in which MHPs experience high role conflict and ambiguity may have other characteristics (e.g., less social support, more administrative demands) that contribute to burnout. Future studies with a longitudinal design are needed to help determine the progression of burnout. It would be interesting, for instance, to examine whether ratings of work stressors such as role conflict and role autonomy are mediated or moderated by other setting characteristics and change over time in conjunction with levels of burnout. If such work stressors precede burnout, prevention and intervention efforts can be directed toward identifying ways to decrease MHPs' exposure to these stressors.

The present study found autonomy to be a significant negative predictor of EE as hypothesized, but not associated with DP or PA (Hypothesis 2a). It reasons that MHPs with less control and independence in their work environments are at greater risk for the emotional symptoms of burnout, as the limitations and restrictions they experience in working with clients are likely to elicit feeling of frustration and despair. It is also possible, however, that MHPs are given less autonomy when they evidence emotional exhaustion at work. Supervisors who view MHPs to be experiencing distress in their professional roles may respond by providing increased structure and oversight. Another possibility is that the relationship between EE and autonomy is spurious. Environments

that allow for limited autonomy may have other characteristics, or employ more MHPs with particular characteristics, that increase risk for emotional exhaustion. This is an empirical question that should be examined in future studies. As with the aforementioned work stressors, longitudinal research on autonomy and burnout is needed. If inadequate autonomy is found to precede the development of burnout symptoms, it may be beneficial for administrators and supervisors to increase MHPs' independence and control in ways that mitigate stress that contributes to the development and maintenance of emotional exhaustion. Independent practitioners also may be able to make changes in their professional lives to afford themselves greater autonomy (e.g., by seeing fewer clients with insurance and more who self-pay).

As aforementioned, the present study failed to support the hypotheses that autonomy would be a negative predictor of depersonalization and a positive predictor of personal accomplishment. These findings are consistent with some prior studies (e.g., Kim & Stone, 2008) and suggest that the amount of control MHPs perceive themselves to have in their professional roles is unrelated to their attitudes about clients and their own abilities to have a positive impact on their clients. MHPs may be able to separate their perceptions of their clients and their own work from their perceptions of autonomy, or autonomy may not be experienced as a stressor in all cases. It is possible that increased external controls are helpful to some MHPs who face difficult clinical situations and therefore mitigate stress that leads to depersonalization of clients. In addition, some MHPs who view their supervisors as dictating how treatment must be conducted (i.e., who perceive lower levels of autonomy) may still take ownership of the positive impact they have on clients (PA). Furthermore, some MHPs who feel that they have substantial

autonomy at work may nonetheless view their own abilities to conduct therapy as inadequate. It is also important to consider that the present findings may be underestimates due to significant range restriction on the burnout and autonomy measures.

#### *Extraversion as a Moderator of the Relationships between Work Stressors and Burnout*

The findings of this study did not support the hypothesis that extraversion would moderate the relationships between the three primary work stressor variables (role conflict, role ambiguity, and autonomy) and the three burnout dimensions (Hypothesis 2b). Accordingly, levels of extraversion do not explain the extent to which these work stressors are associated with burnout. Personality factors are thought to influence the extent to which individuals are affected by potential stressors as they are implicated in the processes of appraisal and coping (Brief & Weiss, 2002; Chen et al., 2007; George & Brief, 2004; Lazarus & Cohen-Charash, 2001). While substantial research has examined the moderating role of neuroticism in stressor-burnout relationships, few studies have looked at the moderating role of extraversion, and no studies were found that examined whether extraversion moderated burnout's relationships with the three work stressors examined here. It had been hypothesized that the relationships between these stressors and burnout would be stronger in individuals with lower extraversion because extraversion is associated with use of effective coping strategies. That is, extraversion was theorized to act as a buffer against the strain resulting from stressors such as role conflict, role ambiguity, and lack of autonomy. The results of this study indicate that extraversion did not have this mitigating role among the MHPs sampled. The strength of

the relationships role conflict, role ambiguity, and autonomy had with the dimensions of burnout did not vary significantly based on MHPs' levels of extraversion. It is possible that range restriction on each of the measures precluded detection of a moderation effect. However, it is also possible that these results are an accurate depiction of the relationships. Further research should attempt to use a sample of MHPs that represents a wider distribution of experiences with respect to these work stressors. It would also be interesting if future studies examined other personality traits (e.g., neuroticism and agreeableness), and combinations of personality traits (e.g., low extraversion and high neuroticism), as moderators of burnout.

#### *Emotional Labor and Burnout*

It was hypothesized that the surface acting strategies of faking and masking would be positively associated with burnout (Hypothesis 3a), due to prior research indicating that this type of emotional labor is associated with negative outcomes in other occupational groups. While faking was a significant positive predictor of EE and DP and negative predictor of PA, as expected, masking was only a significant predictor of EE, indicating that the two forms of surface acting may have different implications for burnout.

The positive relationship between both surface acting strategies and emotional exhaustion is consistent with prior studies of other types of professionals (e.g., Brotheridge & Grandey, 2002; Goldberg & Grandey, 2007; Martinez-Inigo et al., 2007; etc.). Given that faking and masking are thought to involve continuous monitoring and modification of emotional response tendencies (ERTs) after they have been fully

activated (e.g., Grandey, 2003; Gross, 1998b; Gross & John, 2003; Totterdell & Holman, 2003), it reasons that using these strategies may be more costly than beneficial for MHPs. Studies have shown that although surface acting allows individuals to regulate their observable emotions, it does not alter their felt emotions (e.g., Beal et al., 2006; Grandey, 2003; Gross, 1998b; Gross & John, 2003; Totterdell & Holman, 2003). Furthermore, research has shown that suppression of emotional thoughts is associated with greater accessibility and intrusive recurrences of these thoughts, which is associated with increased emotionality (Wegner, 1994; Wegner, Shortt, Blake, & Page, 1990; Wegner & Zanakos, 1994). Accordingly, masking may in fact lead to paradoxical increases in negative mood (e.g., Wegner, 1994), which in turn is associated with indicators of increased stress such as sympathetic activation of the cardiovascular system and impaired immune functioning (e.g., Gross & Levenson, 1997). Surface acting may allow MHPs to comply with perceived display rules and to some extent reduce emotional dissonance when it occurs, but may not help MHPs to reduce their overall stress or prevent emotional dissonance from occurring in the future. Surface acting also may require resources that are limited and/or difficult to replenish. Over time, the use of surface acting strategies may result in emotional exhaustion, which in turn may lead to greater susceptibility to daily stress and thus increased use of surface acting in the future, if MHPs are not practiced in other emotional labor strategies or “believe” (perhaps not on a fully conscious level) that surface acting is an appropriate response to emotional dissonance.

It is also possible that Butler et al.’s (2003) findings of increased physiological responding in surface actors’ interaction partners generalize to MHPs, such that faking and masking among MHPs leads to increased stress in clients, thereby interfering with

the therapeutic alliance, and ultimately creating more strain and susceptibility to emotional exhaustion for MHPs. Related, research on employee-customer interactions has found surface acting to elicit more negative reactions from customers. Cote (2005) suggests that this leads to more strain for employees. When customers perceive employees' positive emotional displays to be more authentic, they tend to have more positive perceptions of such employees and to report greater satisfaction with their encounters with those employees (Grandey, Fisk, Mattila, Jansen, & Sideman, 2005). In turn, this may result in less stressful exchanges between customers and employees. By extension, if clients perceive MHPs' emotional displays to be inauthentic, they may have more negative perceptions of the MHPs, experience less satisfaction in their interactions with MHPs, and ultimately have more negative exchanges that result in greater strain for both clients and MHPs.

Another possibility is that the relationships between surface acting strategies and emotional exhaustion are explained by other unknown factors. Further research is needed to determine whether it is possible to train MHPs to use alternatives to surface acting.

The finding that faking was positively associated with depersonalization is also consistent with prior studies of other professionals (e.g., Brotheridge & Grandey, 2002). It reasons that the inauthenticity of faking may lead MHPs to experience feelings of detachment from their clients and thus higher DP. Again, if clients are able to sense that MHPs are faking and/or depersonalizing them, the therapeutic alliance is likely to be negatively affected, which may then increase MHPs' rate of emotional dissonance, use of faking, and burnout symptoms. MHPs with higher levels of DP also may be less motivated to engage in other emotion regulation strategies and instead resort to faking in

order to adhere to perceived display rules. It is also possible that depersonalization and faking may be associated due to other unidentified variables.

Although masking demonstrated a significant positive correlation with depersonalization ( $r=.28$ ,  $p\leq.01$ ), the predictive relationship fell just below levels of statistical significance ( $p=.0518$ ) when entered into the multivariate multiple regression with faking. It is possible that rates of masking are variable among individuals with higher DP, as some MHPs may be less inclined to suppress feelings that are inconsistent with display rules if they perceive clients in a more negative manner. That is, some MHPs with elevated levels of DP may justify the unorthodox expression of particular emotions (presumably negative emotions) by reasoning that clients' behavior warrants such displays. It is also possible that range restriction on the DP scale prevented a stronger link with masking from being detected.

Mixed support was found for the hypothesized relationship between surface acting and personal accomplishment. As expected, faking emerged as a significant negative predictor of PA. This is consistent with prior studies with other professional groups (e.g., Brotheridge & Grandey). It reasons that individuals who express emotions that are inauthentic may experience less fulfillment and confidence in regards to their work. In addition, the higher levels of EE and DP associated with faking may result in diminished PA. It is also possible that the relationship between faking and PA is reciprocal, as low levels of perceived personal accomplishment may foster an attitude of disillusionment that leads MHPs to participate in clinical interactions without committing to the therapeutic process with any real interest or authenticity. As aforementioned, research has associated surface acting with increased physiological responding (i.e., stress) in

surface actors' interaction partners (Butler et al, 2003). If surface acting causes MHPs' clients to experience increased stress, it may have a negative impact on therapeutic relationships; and, if clients' reactions are negative, MHPs may experience further emotional dissonance and higher overall stress. This in turn may lead to further diminishment of perceived personal accomplishment.

Personal accomplishment and masking were not significantly related on the univariate or multivariate levels. It is possible that some MHPs view masking as appropriate and therefore do not experience diminished PA, while other MHPs view masking as a reflection of their own professional inadequacy. That is, some MHPs may consider it the proper response to hide emotions that are inconsistent with professionally sanctioned emotional expressions (i.e., display rules) and thus a personal accomplishment to mask such emotions, while other MHPs may view their experience of unsanctioned emotions (and thus their masking of such emotions) to be an indication that they failed to maintain objectivity and personal boundaries with respect to their clients. Similarly, diminished personal accomplishment may lead some but not all MHPs to experience strain that results in the use of masking. Accordingly, the effects of masking on PA, or vice versa, may cancel out.

It was anticipated that burnout would be lower among individuals who reported higher rates of deep acting (Hypothesis 3b), as attentional deployment and reappraisal are thought to allow individuals to decrease subjective emotional experiences in addition to unsanctioned expressive behavior (Gross, 1998a) and to involve less resource expenditure (e.g., Grandey, 2003; Gross, 1998b; Gross & John, 2003; Totterdell & Holman, 2003). Support was not found for this hypothesis. These results are consistent

with some studies of other types of professionals that found surface acting to be a better predictor than deep acting of burnout (e.g., Brotheridge & Grandey, 2002; Brotheridge & Lee, 1998; Cheung, Tang, & So-Kum, 2007; Goldberg & Grandey, 2007; Martínez-Iñigo, Totterdell, Alcover, & Holman, 2007; Morris & Feldman, 1997; Rubin et al., 2005). The present findings must be interpreted with caution, however, given that the deep acting subscales were not significantly correlated with one another, suggesting that they may not tap into the same construct. This finding is not consistent with that reported by Johnson (2007;  $r=.30$   $p\leq.01$ ), suggesting that the measure performed differently in the present sample. It is also possible, however, that self-reports are not a valid or reliable method of measuring individuals' use of deep acting strategies. By definition, deep acting involves modifying felt emotions before ERTs are fully activated and thus is unlikely to occur on an entirely conscious level. MHPs therefore may not be aware of the extent to which they employ deep acting strategies. This is in contrast to surface acting, which is characterized by emotion regulation efforts that occur after emotional response tendencies have been fully activated and thus are likely to occur on a more conscious level. MHPs may be more able to recognize when they are faking and masking, even if there are instances in which they use these strategies automatically. In sum, the relationships found between deep acting strategies and burnout (as well as the other variables) in this study may not be an accurate depiction of the true associations between these variables.

It is also possible, however, that deep acting strategies simply are not reliably associated with burnout in MHPs. Deep acting may require more resources and create more strain for some MHPs than others. In addition, deep acting may not mitigate the

impact of overall stress. Strategies such as attentional deployment and reappraisal may change individuals' perceptions of felt emotions but not their levels of physiological arousal (Grandey, 2000). Another theory is that "the draining influence of deep acting might be counteracted by the uplift from changing underlying feelings to be consistent with expected displays of positive emotion" (Judge, Woolf, & Hurst, 2009, p. 59-60; also see Goldberg & Grandey, 2007). That is, the benefits and costs of deep acting may equal out. Further work developing valid and reliable measures of emotional labor, and particularly deep acting, is needed. Perhaps neurological or physiological measures could be used in analogue studies to determine whether individuals' perceptions of emotional labor are consistent with their internal responses to emotional stimuli. Based on the evidence from such studies, researchers may be able to refine the emotional labor construct and determine whether it is possible to measure specific strategies adequately using a self-report questionnaire method. It would also be interesting to compare neurological and physiological indicators of emotion regulation in MHPs with and without burnout who use different EL strategies.

#### *Extraversion and Emotional Labor*

Support was not found for the hypotheses (4a and 4b) that extraversion would be significantly associated with both types of emotional labor. In fact, extraversion's relationships with surface acting and deep acting strategies were close to zero. It had been theorized that extraversion would be negatively associated with surface acting and positively associated with deep acting as this personality trait has been empirically linked to the use of effective coping strategies, and deep acting strategies were conceptualized as

a more adaptive forms of emotion regulation than surface acting strategies. In addition, several studies of other professional groups have found a negative relationship between extraversion and surface acting (e.g., Austin, Dore, & O'Donovan, 2008; Diefendorff, Croyle, & Gosserand, 2005; Gross & John, 2003; Judge, Woolf, & Hurst, 2009) and a positive relationship between extraversion and deep acting (e.g., Austin, Dore, & O'Donovan, 2008; Johnson, 2004; Gosserand & Diefendorff, 2005). It is possible that these relationships do not generalize to MHPs because such individuals are different from other professionals or emotional labor is different in the context of mental health work. The vast majority of research examining emotional labor focuses on occupations that promote expressions of positive emotion and discourage expressions of negative emotion. Extraversion is presumed to be beneficial in such jobs given that the emotions employees are expected to display are congruent with their tendencies to experience more positive emotions. It remains unknown whether the same display rules apply in the mental health field. While the present study piloted a measure of MHPs' perceived display rules (which is further discussed below), more work in this area is needed before conclusions can be made.

#### *Extraversion as a Moderator of the Relationships Between Work Stressors and Emotional Labor*

This study did not find support for extraversion as a moderator of the relationships between work stressors and emotional labor (Hypothesis 5b). It was theorized that MHPs with lower levels of extraversion would be more inclined to engage in surface acting and less inclined to engage in deep acting when they experienced greater

work stressors, because introverts tend to engage in less effective coping strategies. The results of this study, however, suggest that extraversion is not implicated in the strength of the relationships between work stressors and emotional labor strategies. Accordingly, when faced with work stressors, MHPs with low levels of extraversion are no more or less likely to engage in surface acting or deep acting. Extraversion was not significantly correlated with any of the work stressor or emotional labor variables. While lack of power may have played a role, it is possible that extraversion simply is not reliably associated with MHPs' perceptions of work stressors or their use of particular emotional labor strategies. While role conflict and role ambiguity demonstrated small to moderate positive associations with both faking and masking, autonomy was not significantly associated with either surface acting strategy, and none of the work stressors were significantly associated with the deep acting strategies of attentional deployment and cognitive reappraisal. Given the above described limitations of the deep acting scales and lack of variability on the work stressor measures, these results should be considered with caution. If this study's findings are accurate, MHPs with low levels of extraversion report comparable levels of autonomy and rates of emotional labor .

#### *Emotional Labor Strategies as Mediators between Work Stressors and Burnout*

This study did not support the hypotheses that emotional labor strategies would partially mediate the relationships between the primary work stressor variables (role conflict, role ambiguity, lack of autonomy) and burnout (Hypothesis 6a and 6b). In regards to surface acting, role conflict and role ambiguity (but not autonomy) were directly related to burnout, but their indirect relationships through the surface acting

strategies failed to reach statistical significance. It had been hypothesized that MHPs experiencing higher levels of those work stressors may experience greater emotional dissonance (Bono & Vey, 2005) and thus be more likely to engage in surface acting to reduce that strain, which in turn was hypothesized to contribute to burnout. The present results, however, showed that the indirect effects of role conflict and role ambiguity through surface acting were not significant. While it is likely that inadequate power prevented mediation from being detected, the present findings may be accurate in reflecting that the indirect effects of work stressors through surface acting are minimal. Additional research is needed to determine if this finding is replicated.

Neither faking nor masking was significantly related to autonomy. Autonomy also was not related to DP or PA. Therefore, surface acting strategies were not examined as mediators between autonomy and burnout. It is possible that range restriction on the autonomy scale and burnout subscales did not allow for the complex relationships between these variables to be realized. Another possibility, however, is that autonomy simply does not play a reliable role in the use of particular emotional labor strategies and development of burnout. Again, further research is needed to see if these findings are replicated

Support was not found for the hypothesis that deep acting strategies would partially mediate the relationships between work variables and burnout (Hypothesis 6b), as neither attentional deployment nor cognitive reappraisal were associated with any of the other variables. The previously mentioned psychometric issues with the deep acting measure, in combination with range restriction on the other measures, may have prevented relationships between these variables from being detected. Nonetheless, it is

also possible that work stressors are not reliable predictors of deep acting. MHPs may engage in cognitive reappraisal and attentional deployment to regulate their emotions regardless of the role conflict, role ambiguity, and autonomy they experience at work.

### *Supplemental Findings*

A variety of secondary variables were included in this study to provide further information about the sample (and thus assist with interpretation of findings), and to begin evaluating relationships that are not addressed in the empirical literature on MHPs. While some of the variables have been previously studied (e.g., MHP demographic characteristics), other variables have received minimal or no attention (e.g., display rules). The following section summarizes these findings and presents ideas for future research.

*Demographic Variables and Burnout.* Demographic characteristics were examined in relation to the other variables in order to ascertain whether prior findings would be upheld with this MHP sample. No significant differences by sex were found for EE or PA. This is consistent with some prior studies (e.g., Ackerley et al., 1988; Farber, 1985; Mills & Huebner, 1998; Raquepaw & Miller, 1989; Thornton, 1992). Compared to male MHPs, female MHPs in this study reported significantly lower DP scores. Gender differences in depersonalization have been reported in a number of other studies (e.g., Acker, 2003; Maslach & Jackson, 1985; Rosenberg & Pace, 2006; Vredenburg et al., 1999). It is possible that sex differences in depersonalization are associated with differences in gender socialization. Traditional gender-norms dictate that males value and strive for personal achievement, power, status, goal-attainment, self-

reliance, competition, and restriction of emotionality (Freudenberger, 1990b; Heppner & Gonzales, 1987; Wester & Vogel, 2002), while females value and strive for closeness, supportiveness, caring, interpersonal warmth, and understanding (Romans, 1996).

Accordingly, female MHPs' gender socialization may, to some extent, protect them from developing depersonalization because the ideals of empathy and intimacy have been more reinforced and internalized over time.

No significant differences in burnout were found when Caucasian and non-Caucasian MHPs were compared. This was expected given that most previous research has found burnout levels to be similar across racial/ethnic groups.

MHP age demonstrated a moderate negative correlation with EE but was not significantly correlated with DP or PA. An inverse relationship between age and burnout, particularly EE, has been reported in numerous studies of MHPs (e.g., Garland, 2004; Garner, Knight, & Simpson, 2007; Rupert & Morgan, 2005; Rupert & Kent, 2007; Vredenburgh, Carlozzi, & Stein, 1999). It is possible that emotional exhaustion is lower among older MHPs because they have learned how to cope with work stressors over time and/or that MHPs with higher emotional exhaustion have left the field, leaving only the most resilient and adaptive older MHPs (e.g., Rupert & Morgan, 2005; Rupert & Kent, 2007).

Although MHPs who were parents reported slightly lower EE, no meaningful differences between MHPs with and without children were found with respect to burnout. No studies examining differences in burnout between MHPs who are parents and non-parents were found in the literature.

*Professional Background Variables and Burnout.* A variety of professional background variables was examined in relation to burnout. As with MHP age, years of experience providing mental health services was negatively associated with EE, but was unrelated to the other burnout dimensions. Some prior studies have found less experienced MHPs to report higher burnout, relative to more seasoned MHPs (e.g., Ackerley et al., 1988; Rupert & Kent, 2007; Rupert & Morgan, 2005). As aforementioned in regards to MHP age, it is possible that time in the field has provided more experienced MHPs with greater confidence and more opportunities to refine their coping skills for better managing work related demands. It is also possible that burned-out MHPs tend to change careers, leaving only the most resilient MHPs to continue working in the field.

In the present study, average hours per week spent on administrative and clinical support tasks was significantly positively associated with EE and DP, and significantly negatively associated with PA; while average hours per week spent providing direct care services (i.e., assessment plus treatment hours) was moderately positively correlated with PA, but unrelated to EE and DP. These findings are consistent with prior research (Rupert & Baird, 2004; Rupert & Kent, 2007; Rupert & Morgan, 2005). It reasons that time spent providing direct care to clients may be more rewarding than time spent on other tasks. Administrative and clinical support tasks may not only yield fewer rewards, but also elicit more feelings of frustration regarding bureaucratic requirements and drain MHPs internal resources.

MHPs who were working in a greater number of treatment settings tended to report significantly higher emotional exhaustion. No other studies were found that

examined number of treatment settings in relation to burnout. It reasons that splitting time across multiple sites may add extra strain and/or drain more personal resources, leaving MHPs at greater risk for emotional exhaustion. Further research is needed to determine whether working in more settings in fact puts MHPs at greater risk for emotional exhaustion and, if so, what it is about working in more settings that explains this effect.

Compared to MHPs working exclusively in the public sector, MHPs who were working at least part-time in private practice reported significantly lower burnout scores on all three MBI subscales. Lower levels of burnout among MHPs in the private sector have been reported in numerous studies (e.g., Ackerley et al., 1988; Farber, 1983; Fortener, 1999; Hellman & Morrison, 1987; Raquepaw & Miller, 1989; Rupert & Kent, 2007; Rupert & Morgan, 2005; Vredenburgh, Carlozzi, & Stein, 1999). One possible explanation for these findings is that MHPs in private practice have less exposure to colleagues' burnout symptoms and, therefore, are less susceptible to a social contagion effect. Prior research has provided some evidence that symptoms of burnout may be transmitted to coworkers (e.g., Bakker & Schaufeli, 2000; Bakker, Demerouti, & Schaufeli, 2003a). Further research in this area is needed to determine the prevalence and relative importance of a contagion effect in the development of burnout among MHPs. Another possible explanation for lower levels of burnout among MHPs in private practice is that they tend to face fewer demands compared to those in other settings (Ackerley, 1988; Rupert & Baird, 2004; Rupert & Morgan, 2005). To test this theory, MHPs working exclusively in the private sector and those working at least part-time in the public sector were compared on several variables. The former group reported

significantly more time spent providing direct care, less time spent on administrative and clinical support tasks, lower role ambiguity, and higher autonomy, but this group also reported levels of role conflict and exposure to challenging client behavior and circumstances that were comparable to those reported by MHPs working at least part-time in the public sector. Although these are only correlational data, one explanation for lower levels of burnout occurring among MHPs working exclusively in private practice is that they may experience relatively less strain secondary to having relatively fewer administrative and clinical support demands and relatively less role ambiguity. Furthermore, they may experience relatively more fulfillment as a result of doing relatively more direct care and having relatively more autonomy. Given the current financial and political climate, perhaps it is not surprising that MHPs in private practice and other settings experience comparable levels of role conflict. As aforementioned, MHPs must try to reconcile the interests of individual clients, referral sources, insurance companies, and other vested parties (Rupert & Morgan, 2005; An Action Plan for Behavioral Health Workforce Development, SAMHSA, 2007). This may lead to clinical situations in which MHPs experience conflict in their professional roles. While outside the scope of the present study, it would be interesting for more research to examine interactions between predictors of burnout among MHPs working in different settings. For instance, it reasons that the association between burnout and predictor variables such as direct care hours and autonomy among MHPs in private practice may be more variable when client characteristics, caseload size, and clinical experience (to name only a few) are considered. The present study found that MHPs across settings reported equivalent levels of challenging client behavior and circumstances, but the analyses did not control

for caseload size, direct care hours, or any other factors that may or may not differ across settings. In addition, those working exclusively in private practice were compared to a combined group of MHPs who were working either exclusively in public practice or in both the public and private sectors. It is possible that a different pattern of associations with burnout would emerge if MHPs working exclusively in private practice were compared to those working exclusively in the public sector or in particular treatment settings (e.g., V.A. hospital, university-based medical setting, community mental health clinic, etc.), as client and MHP characteristics, as well as environmental conditions, are likely to vary across sites.

The present study's finding that MHPs with relatively more exposure to challenging client pathology and circumstances tended to have higher levels of burnout is consistent with prior research (Acker, 1999; Linehan, Cochran, Mar, Levensky, & Comtois, 2000; Rupert & Baird, 2004; Rupert & Kent, 2007; Rupert & Morgan, 2005). Preliminary evidence suggests that prior experiences with clients do play a role in the development of burnout. For instance, Truchot, Keirsebilck, and Meyer (2000) found that therapists who sense inequity or a lack of reciprocity with their clients experienced a decrease in perceived levels of personal accomplishment. Related, Bakker et al. (2006) found that high neuroticism and low extraversion predicted higher levels of depersonalization for volunteer counselors who reported many negative experiences with clients, but not for those who reported few negative experiences with clients. Similarly, high neuroticism and low extraversion, respectively, predicted lower levels of personal accomplishment for volunteer counselors who reported many negative experiences with clients, but not for those who reported few negative experiences with clients. A

limitation of that study, however, was the use of retrospective self-reports to measure therapists' prior experiences with clients, rather than prospective methods and multiple informant ratings. Increased understanding about how internal variables and external variables, such as exposure to more severe clinical populations or negative client experiences, interact over time to produce symptoms of burnout may allow researchers to identify risk and protective factors that could be targeted in prevention or intervention efforts.

The age composition of MHPs' caseloads was examined in relation to burnout. Percent adult clients was moderately positively correlated with EE, while age composition was unrelated to DP and PA. No prior studies were found that reported on the relationship between client age and MHP burnout. It is possible that MHPs who work with relatively more adults may face more stressors due to challenges of working with older clients or to environmental characteristics specific to settings in which adults are served. For instance, older clients are more likely to present with long-standing mental illness, personality disorders, and high-risk behaviors that may result in more strain for MHPs. In addition, the atmosphere within treatment settings for children may be more warm and nurturing in an effort to cater to the younger population. Future research is needed to test this and other differences between settings that serve clients of different age groups. It is also possible that MHPs who work with relatively more adults tend to have characteristics that put them at greater risk for emotional exhaustion. For instance, perhaps MHPs who provide treatment to adults tend to be more formal and focused on impression management with their clients, which may then result in greater strain.

MHPs who reported a preference for working with a different age group than that with which they were currently working had significantly higher EE than MHPs who reported being satisfied with the age group with which they were working, but similar levels of DP and PA. Again, no prior studies were found that examined the relationship between MHP satisfaction with the age group with which they work and MHP burnout. It reasons that MHPs' dissatisfaction with the age composition of their caseloads may create strain that contributes to the development of emotional exhaustion. However, it is also possible that emotional exhaustion leads MHPs to experience less satisfaction with their work in general, and more specifically their caseload composition. These variables could also be associated through one or more other variables (e.g., MHP experience, caseload size, treatment type, etc.).

*Perceived Display Rules.* The exploratory measure of perceived display rules that was created for and piloted in this study revealed some interesting associations. Integrative emotional displays were considered more acceptable than neutral emotional displays, and both integrative and neutral emotional displays were considered more acceptable than differentiating emotional displays, overall. The distribution of composite positive display rules scores suggests that the vast majority of MHPs viewed the expressions of integrative emotions to be acceptable and differentiating emotions to be unacceptable.

While neither integrative nor differentiating display rules were significantly related to any burnout dimension, composite positive display rules scores were positively correlated with EE. This suggests that MHPs with stronger views about integrative emotional displays being acceptable and differentiating emotional displays being

unacceptable tended to experience higher rates of emotional exhaustion. It is possible that MHPs who perceive more stringent positive display rules may become drained in trying to abide by these standards and therefore experience more emotional symptoms of burnout. Alternatively, MHPs who face these rules in their work environments may be more likely to experience other stressors (e.g., more administrative demands or paperwork requirements) that put them at risk for emotional exhaustion. Future studies should examine whether the relationship between perceived display rules and emotional exhaustion is mediated or moderated by the use of particular emotional labor strategies.

Another interesting finding is that MHP age was negatively correlated with perceptions of positive display rules. Given that age is highly correlated with experience, it is possible that MHPs who are older have been in the field longer and therefore had different and/or more training than younger, less experienced MHPs. If older MHPs have had more time in the field, they also may have had more opportunities to be exposed to supervisors and coworkers who model or otherwise promote adherence to varying display rules. It is also possible that older MHPs have less stringent perceptions of display rules because, over time, they have developed more independent attitudes about, and personalized approaches to, working with clients. If such a trend occurs, it may be due not only to having more professional experience but also to tendencies to become more self-directed with age. It is also possible that age influenced how MHPs made their ratings, with older MHPs tending towards less extreme responding (i.e., more ratings of “sometimes”). Further research is needed to identify individual and setting characteristics that contribute to MHP’s display rule perceptions.

Given that the PDRS was created for the present study to provide preliminary information about MHPs' perceptions of display rules, its psychometric properties (particularly its content validity and external reliability, but also its factor structure) have yet to be examined. Furthermore, there was inadequate power to run comprehensive analyses of the measure itself or further analyses of its relationships with the other variables. Future research should attempt to explore the quality and utility of this measure further.

The questions that remain unasked and unanswered about the consistency and importance of display rules in the context of providing mental health services are too numerous to delineate in this paper. However, the preliminary evidence provided by this study of an association between perceived display rules and burnout suggests that further work in this area is warranted. Next steps in this area may include investigating the consistency of perceived display rules within and across settings, as well as variations in perceived display rules across clinical contexts. Rules may be different depending on clients' ages/developmental levels, socio-cultural backgrounds, genders, and presenting problems. For instance, in dialectical behavior therapy (DBT) for clients with borderline personality disorder, MHPs are encouraged to share feelings of frustration with clients in certain situations (Linehan, 1993), which is directly in contrast with the notion that MHPs' negative emotions should not be expressed toward clients. It also will be important to examine the relationships between perceived display rules and MHPs' actual behavior. Aside from the impact perceived display rules may have on individual MHPs (i.e., burnout), they may also influence clients' experiences in treatment. For instance, some clients may view MHPs as more genuine and relatable if they show some negative

emotions and/or less positive emotions. The empirical research in this area is limited, but some empirical support has been found for therapist self-disclosure in general. Hill and colleagues (1988) found therapist self-disclosure was associated with clients' positive evaluations of therapist helpfulness. Knox and colleagues (1997) found therapist self-disclosure to be associated with clients' insight and perceptions of the therapist as more real and human, which in turn were associated with the therapeutic relationship. Barrett and Berman (2001) found that clients liked their therapists more and had less distress associated with symptoms following treatment, when their therapists engaged in self-disclosure in response to similar client self-disclosure. Despite the positive findings reported in some studies, other studies have reported negative or neutral relationships between therapist self-disclosure and therapeutic outcomes (Hill & Knox, 2002). Further research on perceived display rules is needed to determine their implications for both MHPs and clients.

*Perceived Importance of Emotion Management.* When MHPs' attitudes regarding the importance of emotion management at work (as measured by the AEAS) were evaluated in relation to the other variables, several significant associations emerged. Depersonalization demonstrated a small positive relationship with AEAS scores. One explanation for this finding is that MHPs who perceive emotion management at work to be of greater importance are more likely to experience strain that contributes to burnout. Depersonalizing clients may be a way for MHPs to cope with the (perceived) demand to control their emotions, as it may allow MHPs to maintain emotional distance. It is noteworthy, however, that the relationship between these variables was modest. The perceived stringency of display rules was significantly positively correlated with MHPs

perceptions about the importance of emotion management in their work. It reasons that MHPs who view display rules to be stricter would also view emotional management skills to be more essential. AEAS scores demonstrated moderate and large correlations with masking and faking, respectively. It is possible that MHPs who perceive emotion management at work to be more important engage in more surface acting as a means of adhering to these demands. It is important to note, however, that there are several limitations of this measure. The AEAS includes items that tap into both the perceived importance of regulating one's emotional displays (irrespective of type of emotion) and the perceived importance of using emotional labor strategies, making the total score difficult to interpret. In addition, this measure uses terminology (i.e., "masking") that may result in misleading findings. For instance, MHPs may have endorsed items about the importance of masking negative emotions when they actually meant that it is important not to show those emotions. Such responses are different in that masking refers to suppression while other strategies (deep acting) could be used to avoid showing negative emotions. Given that most people are not familiar with emotional labor terminology, it may appear that MHPs were endorsing surface acting, when in fact their ratings reflect their perceptions of display rules that sanction expressions of negative emotions, or vice versa. Future research in this area is needed to develop a measure or measures that discriminate between the perceived importance of controlling one's emotions and of using specific strategies to do so. No published studies were found that examined MHPs' perceptions about the importance of emotion management in the context of providing direct care. Further empirical research is needed to determine whether MHPs who perceive emotion management to be more important are actually

more likely to monitor and modify their own emotional displays. Related, it would be interesting if a measure was created to examine rates of emotional dissonance, which theoretically follows experiences of emotions that are inconsistent with perceived display rules and precedes the use of emotional labor strategies (Rubin et al. 2005). Although emotional dissonance may not occur on a fully conscious level, MHPs self-reports may yield interesting associations with burnout and related variables.

*Job-related Affective Well-being.* The JAWS demonstrated moderate to large associations with the three burnout dimensions, as well as role conflict, role ambiguity, and autonomy, as expected. While causality cannot be inferred from these results, it reasons that the stress associated with experiencing more work stressors leads to a diminished sense of well-being, and that that in turn puts MHPs at greater risk for burnout. Future studies with large samples and, ideally, longitudinal designs, should examine whether job-related affective well-being mediates or moderates the relationships between work stressors and burnout in MHPs.

### *Limitations*

Besides its correlational design and the other limitations of this study that were discussed earlier, several additional limitations should be noted. The present sample was relatively small given the number of analyses conducted. This effected power levels and precluded the use of more sophisticated statistical methods (e.g., factor analysis, modeling techniques) for evaluating the data. In addition, the sample was geographically limited to MHPs providing direct care services in Florida and so these results may not generalize to MHPs in other regions. Moreover, it is not clear whether the demographic

and professional characteristics of this sample are consistent with state norms, as estimates for the mental health workforce in Florida around the time of this study were not found. It is therefore difficult to assess whether the sample is representative of MHPs in Florida.

Another potential limitation to the generalizability of this study's findings is that the MHPs' sampled had disproportionately high levels of education and experience. In contrast to the national workforce, which consists increasingly of individuals without graduate level training and with less time working in the field (Duffy et al., 2004; Manderscheid & Henderson, 2004; SAMHSA, 2002 An Action Plan for Behavioral Health Workforce Development, SAMHSA, 2007), over 90% of the present sample had one or more advanced degrees and over 40% had greater than 15 years of clinical experience. It is possible that the relationships examined in this study would differ in a sample of MHPs with less training and time in the field. Lack of power prevented further analysis of differences across MHPs with different degrees and amounts of experience. It would be interesting for future research to examine whether experience has a non-linear relationship with burnout. It is possible that there is a point after which the benefits of having more experience level off. A larger and more diverse sample of MHPs is needed to investigate the relative importance of education and experience. MHPs from a wide variety of work settings in Florida are represented in this sample. Although the vast majority of MHPs (70%) reported working in one type of setting, others worked in as many as four types of settings. Again, lack of power prevented the author from performing comparisons of MHPs working in different settings. Data from the combined

sample were used to evaluate the hypotheses and therefore it is unclear whether the associations of interest vary across settings.

Another limitation of this study is that the sample is comprised of MHPs who volunteered to participate after learning about the project via email, phone, flyer, or word-of-mouth. Those who chose to participate may represent a select group of MHPs that differ in important but unknown ways from those who declined to participate. It is also possible that efforts to solicit participation from a diverse and representative sample of MHPs were not successful. In either case, results from the current sample may not generalize to other MHPs.

The use of self-report measures to evaluate the variables of interest represents another limitation of this study. While it is often the only feasible method of data collection, there are important disadvantages to using self-report questionnaires. Response bias is the most notable difficulty associated with such measures (Kazdin, 1998). Although participation in this study was completely anonymous, MHPs may have been unconsciously influenced to respond in particular ways in order to appear more favorably or to be consistent with their core beliefs about how they ought to think, feel, and act given their perceptions of what is prototypical of professionals in the mental health field. Another limitation of self-report measures is that respondents do not always consider important information when deciding how to answer questions and are likely to be influenced by whatever is most salient to them (often information obtained from their most recent or impactful experiences) and their moods (i.e., state affect) at the time they are making ratings (Kazdin, 1998). In addition, people often have varying interpretations of items and, given that the present survey was administered electronically, MHPs were

unable to ask for clarification. While biased responding should be evenly distributed across a sample, it is possible that MHPs with particular characteristics are more likely to respond to questionnaires in important ways.

Another limitation of this study is the single informant design. Having only one informant can inflate relationships between variables due to lack of method variance (Kazdin, 1998). Future research should obtain ratings from multiple informants, such as supervisors, coworkers, and clients. This would allow for comparison across informants to assess whether there are differences between MHPs' self-perceptions and others' perceptions of them. Multiple informant studies are nearly absent in the burnout literature at this time.

Related, it is possible that exposure to questions early in a survey can influence respondents ratings on later questions (Kazdin, 1998). The present study used a single version of the survey instead of randomizing the order of measures for each participant. It is therefore possible that the relationships between variables are influenced by the order in which MHPs completed the individual questionnaires comprising the survey.

Another limitation of this study is that an open-ended response format was used to collect information about MHPs' caseload size. As such, responses widely varied and it was not possible to consolidate the data in a valid and reliable way. It reasons that MHPs with larger caseloads are greater risk for burnout due to increased demands and exposure to potential stressors. Future studies should use a forced choice format to obtain information about caseload size.

For the 30% of MHPs in the present sample who reported working in multiple settings, it is unclear whether their ratings of work stressors and other variables (e.g.,

involvement in particular professional activities, caseload characteristics, etc.) reflect their experiences in one, several, or all of the settings in which they were employed. Similarly, it is impossible to determine whether symptoms of burnout among these MHPs occurred secondary to their experiences in one or several settings. Future studies can try to counteract these limitations by asking MHPs to provide separate ratings for each of the settings in which they work, although the effects of working in one setting may influence ratings about other settings.

Another limitation of this study is that percentage of Medicaid and Medicare patients comprising MHPs' caseloads was inadvertently combined into a single response option, rather than allowing respondents to provide separate estimates of each. Those varieties of medical assistance insurance do not necessarily represent the same client demographic group.

As aforementioned, the internal reliability of the role conflict scale was lower in this study than in prior research, suggesting it may not be an appropriate measure of this construct for MHPs. It may be helpful to consider revising the role conflict scale, as well as the role ambiguity scale, to include items that tap into specific professional contexts in which MHPs may experience these stressors (e.g., in providing treatment, in completing administrative requirements, in receiving or providing supervision). MHPs in the present study were provided with very general directions on the work stressor scales to rate how accurately each statement reflected their "experiences working as a mental health service provider". These instructions, and the phrasing of individual items, did not provide respondents with a means to distinguish between professional contexts when providing ratings of the stressors. It is not known whether the items comprising the role conflict

and role ambiguity scales used in the present study adequately capture the experiences of MHPs.

Related, the autonomy measure used in the present study is very brief (three items) and was not designed specifically for use with MHPs. It is possible that Idaszak and Drasgow's (1987) modified version of the *Job Diagnostic Survey's* autonomy subscale (Hackman & Oldham, 1975) does not adequately or accurately capture MHPs' perceptions of this variable. It may be beneficial to collect qualitative data through interviews and focus groups with MHPs in order to develop new items and/or revise the original items. It is possible that the implications of autonomy for providing direct care services to clients versus doing less clinically-oriented tasks (e.g., administrative tasks, making decisions about one's own work schedule) are different.

### *Future Directions*

In addition to the future research directions already noted, a number of other areas warrant mention. This section will discuss remaining questions and areas for further study.

An important next step for researcher is to examine the relationships between the dimensions of burnout and MHPs' in-session and between-session behavior. It reasons that there are some observable differences between MHPs with different levels of burnout. Knowing more about how MHPs with moderate to high levels of burnout actually behave in relation to clients will help promote better understanding of how burnout impacts the therapeutic process. For instance, it is possible that burnout leads MHPs to spend less time preparing for sessions; to be less compliant with perceived

display rules; to be less patient with client resistance, ambivalence, noncompliance, or lack of insight; to be less compliant with paperwork/administrative duties; to be less invested in client outcomes; and to be more pessimistic about client prognosis, treatment efficacy, and the mental health system in general. By comparing the behavior of MHPs with various levels of burnout, it may be possible to identify reliable indicators that this condition is developing or worsening. Such knowledge could then be used to inform burnout prevention and intervention efforts.

Related, another area that warrants further exploration is the effectiveness of burnout prevention and intervention strategies. The literature includes suggestions for ways that individual therapists can reduce their symptoms of burnout or their risks of developing burnout in the future (Norcross, 2000). For example, some authors encourage MHPs to set boundaries on their therapeutic responsibility and resist tendencies to take ownership of their clients' problems (Friedman, 1985; Kaslow & Shulman, 1987). Other authors have suggested that MHPs work to establish balance between their professional involvement and their personal lives. For instance, developing strong networks of social support (Maslach, 1978; Patterson, Williams, Grauf-Grounds, & Chamow, 1998), maintaining healthy eating habits (Raquepaw & Miller, 1989), engaging in exercise (Freudenberger, 1974), taking regular vacations (Maslach, 1976), and participating in personal psychotherapy (Fleischer & Wissler, 1985; Kaslow & Shulman, 1987; Piercy & Wetchler, 1987) have all been recommended as potential ways to manage work-related stress that can lead to burnout. For MHPs working in the private sector who may not have peer or supervisor supports readily available, Lee et al (2011) argue that "the responsibility fundamentally rests with the psychotherapist himself or herself to devise

and implement self-care strategies that accommodate the specific demands and challenges of the private practice... It is imperative for independent practitioners working without regular supervision or guidance to make self-monitoring a top priority”

(6). Finding support through consulting with peers or joining supervision groups are suggested as an alternative to support from colleagues or supervisors within an organization or institution. Future studies are needed to examine the relative efficacy of individual prevention and intervention strategies. Research to determine which strategies are most successful among MHPs with particular characteristics, such as low extraversion, is also needed. It reasons that MHPs with low extraversion, for instance, may be less likely to rely on social support and may benefit from learning more internally focused strategies.

Suggestions for prevention and intervention strategies at the organizational level have also been presented in the burnout literature. For instance, Martin and Schinke (1998) recommend that orientation programs and in-service training workshops be used to address issues of professional burnout. The authors also suggest that supervisors and administrators promote an atmosphere of open communication and exchange of constructive feedback. Other suggestions for organizational prevention and intervention include limiting the time therapists are required to spend on administrative tasks (Raquepaw & Miller, 1989), and otherwise decreasing workload (Pines & Maslach, 1978). These recommendations, however, may be unrealistic given the current financial and political pressures organizations face. Perhaps more practical are Selvini and Selvini-Palazzoli's (1991) suggestions that employers encourage collaboration, team consultation, and emotional connection within the workplace, or Lee et al.'s (2011)

suggestions that training directors and supervisors simplify case management processes, help therapists to maintain appropriate boundaries with clients, and increase resources and supports for therapists. Lee et al. (2011) suggest “inviting psychotherapists into decision-making processes, providing formal and informal peer consultation, and offering opportunities for professional development” as examples of resources that may decrease MHPs’ burnout risk (6). Despite the large number of suggestions for preventing and ameliorating burnout at the organizational level, no studies have been published about the relative efficacy of these strategies. Future studies are needed to examine which strategies are more effective and in which settings.

In conclusion, the present study attempted to fill a gap in the empirical literature by examining the relationships between extraversion, work stressors, emotional labor, and burnout, as well as perceived display rules and several other exploratory variables, in a sample of MHPs. Despite the aforementioned limitations of this study, several interesting associations were found. Most notably, extraversion, role conflict, role ambiguity, autonomy, surface acting, and perceived display rules were significantly associated with one or more dimension of burnout. The findings of this study underscore the importance of continued work examining the complex relationships between internal and external factors in the development and maintenance of burnout among MHPs. What is learned from such research may then be used to inform efforts to develop and disseminate effective prevention and intervention strategies.

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**The following information is provided to help you decide whether you are willing to take part in this VOLUNTARY, ANONYMOUS study about mental health service providers' experiences. Please read this section carefully and then select the box if you are willing to participate in this study.**

PRIMARY INVESTIGATOR: Jessica Handelsman, M.A., Clinical Psychology Doctoral Candidate, University of South Florida

FACULTY ADVISOR: Marc Karver, Ph.D., Dept. of Psychology, University of South Florida

STUDY DESCRIPTION: If you choose to participate in this study, you will be asked to complete an online survey. The primary objective of this study is to examine various factors that may be associated with the professional experiences of mental health service providers.

ELIGIBILITY: Individuals are eligible to participate in this study if they are: (a) at least 18 years old, (b) fluent in English, and (c) currently provide direct mental health services (in a professional context) to clients/patients of any age, within Florida. Eligible participants may be working in private practice or the public sector, and may be psychologists, psychiatrists, nurses, social workers, counselors, mental health technicians, case-managers, or other mental health service providers, as long as the above criteria are met.

CONFIDENTIALITY: You will not be asked to provide any personally identifying information about yourself, such as your name, phone number, social security number, IP address, etc. A unique identification number will be used to keep track of your survey responses. Because participation in this study is completely anonymous, there will be no way to trace any responses back to you. Nonetheless, all anonymous data will be stored in secure electronic files and/or locked file cabinets at the University of South Florida (USF). The results of this evaluation may be published. However, the data obtained from you will be combined with data from others and published results will not include information that would personally identify you in any way.

POTENTIAL RISKS & BENEFITS: No known risks are associated with participation in this study. Your involvement would be completely anonymous and voluntary. If you choose to participate and then change your mind while completing the survey, you are free to discontinue at any time without penalty of any kind. You will not be paid for your participation; however, you may find answering the survey questions interesting and enjoyable. Furthermore, the information gained by this evaluation may contribute to quality improvement efforts within the mental health field.

QUESTIONS??? If you have questions about this study, please contact the primary investigator, Jessica Handelsman, MA, at 813-974-6595 or the faculty supervisor, Marc Karver, Ph.D. at 813-974-7443. If you have questions about your rights as a person taking part in a research study, you may contact the Division of Research Integrity and Compliance of the University of South Florida at (813) 974-9343.

I understand the above information and volunteer to participate in this anonymous study. \_\_\_  
Dissertation

**In which of the following treatment settings do you currently provide mental health services? (Select all that apply)**

- Private practice (independent or group)
- Primary school (elementary, middle, or high school)
- College/university-based counseling center (open to students and/or employees)
- University-based outpatient clinic (open to public)
- Other outpatient facility (e.g., community clinic)
- Hospital emergency room
- Inpatient facility (e.g., hospital, crisis stabilization unit)
- Partial inpatient facility
- Residential treatment facility
- Other (please specify)

**Approximately how many years of experience do you have providing mental health related services (e.g., treatment, assessment, case management, etc.)?**

- Under one year
- 1 year
- 2 years
- 3 years
- 4 years
- 5 years
- 6-10 years
- 11-15 years
- 16-20 years
- 21-30 years
- 31-40 years
- 41-50 years
- Over 50 years (please specify)

**What is the highest educational degree you have earned to date?**

- High School Diploma/G.E.D.
- Associate's Degree
- Bachelor's Degree
- Master's Degree
- Doctorate's Degree
- Other (please specify)

**Please further describe your highest degree(s) and the discipline(s) in which you earned it/them.**

- Master of Sciences
- Master of Arts
- Other (please specify)

**Please further describe your doctorate degree(s) and the discipline(s) in which you earned it/them.**

- PhD
- PsyD
- MD
- Other (please specify)

**What is/are your current job titles/professional roles (e.g., therapist/counselor, evaluator, consulting psychiatrist, social worker, mental health technician, case manager, nurse, etc.)?**

**Approximately how many HOURS PER WEEK do you typically spend on the following tasks:**

- Providing treatment (e.g., psychotherapy, counseling, skills training, medication administration, behavior management/monitoring, etc.)
- Doing assessment/testing
- Doing clinical support activities (e.g., writing clinical reports and client contact/progress notes, scoring and interpreting assessment measures, case conceptualization, etc.)
- Doing administrative tasks (e.g., doing financial paperwork, attending staff meetings, etc.)
- Providing supervision
- Receiving supervision
- Providing consultation

**Which of the following describe(s) your theoretical orientation? (select all that apply)**

- Don't Know
- Biological/Pharmacological
- Cognitive
- Behavioral
- Psychodynamic
- Humanistic
- Family Systems
- Psychoanalytic
- Other (please specify)

**On average, how many active cases (i.e., current clients/patients) do you have on your caseload at a given time?**

**What is your ideal caseload size?**

- Smaller than it is now (I would prefer to work with fewer clients/patients)
- The same size it is now (I would not change the number of clients/patients on my caseload)
- Larger than it is now (I would prefer to work with more clients/patients)

**On average, approximately what percentage of your clients/patients fit into the following age categories (total must equal 100%):**

- 0-3 years old
- 4-10 years old
- 11-17 years old
- 18-24 years old
- 25-64 years old
- 65+ years old

**Would you prefer to work with a different age group of clients/patients than you currently work with?**

- No
- Yes

**Approximately what percentages of your clients/patients are covered by:**

- Private pay
- Private managed-care insurance (e.g., HMO, PPO, POS)
- Medicaid or Medicare
- Other

**What is your age (in years)?**

**What is your sex?**

- Male
- Female

**Are you Latino or Hispanic (A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race)?**

- No
- Yes
- Don't know

**Which of the following racial categories most accurately describe you (please select all that apply)?**

- Don't know
- Black or African American (origins in any of the black racial groups of Africa)
- Asian (origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam)
- Native American or Alaska Native (origins in any of the original peoples of North and South America, including Central America, and who maintains tribal affiliation or community attachment)
- Native Hawaiian or other Pacific Islander (origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands)
- White or Caucasian (origins in any of the original peoples of Europe, the Middle East, or North Africa)
- Other (please specify)

**What is your current relationship status? (Note that the term “married” is used here to describe civil unions and domestic partnerships, in addition to legal marriages)**

- Never married
- Separated/divorced/widowed
- Currently married

**Are you a parent?**

- No
- Yes

## Appendix C

### Challenging Client Behavior And Circumstances Questionnaire

*Please estimate the percentage (0-100%) of your clients/patients within the past 30 days who demonstrated the behaviors or characteristics described.*

#### **Within the last 30 days, what percent of your clients...**

- 1) made suicidal statements or gestures, or engaged in self-harm behaviors (e.g., skin cutting or burning)?
- 2) had been court-ordered to treatment?
- 3) were sexual offenders?
- 4) had engaged in neglect or abuse of their children?
- 5) made psychopathic (i.e., antisocial, sociopathic) statements?
- 6) lacked remorse when their actions were harmful to others?
- 7) were highly oppositional or defiant toward you or others?
- 8) were verbally aggressive toward you or others?
- 9) were physically aggressive toward you or others?
- 10) had delusions, hallucinations, or other psychotic symptoms?
- 11) had substance use disorders?
- 12) had eating disorders (e.g., anorexia, bulimia, etc.)?
- 13) had borderline personality disorder?
- 14) canceled or did not show up for scheduled sessions?
- 15) refused to participate in session/were noncompliant with treatment recommendations?
- 16) expressed negative attitudes about mental health treatment?

## Appendix D

### Eysenck Personality Questionnaire-Brief Version : Extraversion Subscale (Sato, 2005;)

*Please select one response for each question about your characteristics.*

(Not at All, Slightly, Moderately, Very Much, Extremely)

- 1) Are you a talkative person?
- 2) Are you rather lively?
- 3) Do you enjoy meeting new people?
- 4) Can you usually let yourself go and enjoy yourself at a lively party?
- 5) Do you usually take the initiative in making new friends?
- 6) Can you easily get some life into a rather dull party?
- 7) Do you tend to keep in the background on social occasions?
- 8) Do you like mixing with people?
- 9) Do you like plenty of action and excitement around you?
- 10) Are you mostly quiet when you are with other people?
- 11) Do other people think of you as being very lively?
- 12) Can you get a party going?

## Appendix E

### Role Conflict, Role Ambiguity, Job Autonomy Scales (Rizzo, House, & Lirtzman's, 1970; Idaszak & Drasgow, 1987)

*Please indicate how accurately each statement reflects your experiences working as a mental health service provider. If you provide mental health services in multiple settings, please rate the statements based on your experiences overall.*

(Very False, Mostly False, Slightly False, Uncertain, Slightly True, Mostly True, Very True)

- 1) I have to work on things that should be done differently. (ROLE CONFLICT)
- 2) I work on unnecessary things. (ROLE CONFLICT)
- 3) I rarely receive an assignment without the resources to complete it. (ROLE CONFLICT)
- 4) I work with several groups of professionals that operate quite similarly. (ROLE CONFLICT)
- 5) I receive assignments without adequate resources and materials to complete them. (ROLE CONFLICT)
- 6) I usually do NOT have to break a rule or policy in order to carry out my work. (ROLE CONFLICT)
- 7) I rarely receive incompatible requests from two or more people. (ROLE CONFLICT)
- 8) I do things that are likely to be accepted by one person but not accepted by others. (ROLE CONFLICT)
- 9) I feel uncertain about how much authority I have. (ROLE AMBIGUITY)
- 10) Clear, planned goals and objectives do not exist for my job. (ROLE AMBIGUITY)
- 11) I know that I have divided my time properly. (ROLE AMBIGUITY)
- 12) I'm not sure what my responsibilities are. (ROLE AMBIGUITY)
- 13) I know exactly what is expected of me. (ROLE AMBIGUITY)
- 14) Explanations of what has to be done (on the job) are clear. (ROLE AMBIGUITY)
- 15) I decide on my own how to go about doing the work. (AUTONOMY)
- 16) The job gives me a chance to use my personal initiative or judgment in carrying out the work. (AUTONOMY)
- 17) The job gives me considerable opportunity for independence and freedom in how I do the work. (AUTONOMY)

## Appendix F

### Job-Related Affective Well-Being Scale

*Below are a number of statements that describe different emotions that a job can make a person feel. Please select ONE response to indicate the extent to which any part of your job as a mental health service provider (e.g., the work, coworkers, supervisors, clients/patients, pay, etc.) has made you feel each emotion in the past 30 days.*

Never, Rarely, Sometimes, Quite Often, Extremely Often

- 1) My job made me feel angry.
- 2) My job made me feel anxious.
- 3) My job made me feel at ease.
- 4) My job made me feel bored.
- 5) My job made me feel calm.
- 6) My job made me feel content.
- 7) My job made me feel depressed.
- 8) My job made me feel discouraged.
- 9) My job made me feel disgusted.
- 10) My job made me feel ecstatic.
- 11) My job made me feel energetic.
- 12) My job made me feel enthusiastic.
- 13) My job made me feel excited.
- 14) My job made me feel fatigued.
- 15) My job made me feel frightened.
- 16) My job made me feel furious.
- 17) My job made me feel gloomy.
- 18) My job made me feel inspired.
- 19) My job made me feel relaxed.
- 20) My job made me feel satisfied.

## Appendix G

### Perceived Display Rules Questionnaire

*Please indicate how often it is acceptable, ACCORDING TO FORMAL OR INFORMAL PROFESSIONAL STANDARDS, for mental health service providers to DISPLAY (outwardly express) the following emotions during interactions with clients/patients. If you do not believe that a professional standard exists for displays of a given emotion, please select "Not Applicable". (Note: Do NOT rate the items based on how often you or others genuinely feel or outwardly express the specified emotions during client/patient interactions).*

Never, Sometimes, Always, Not Applicable

- 1) Boredom
- 2) Enthusiasm
- 3) Sadness
- 4) Happiness/Joy
- 5) Dislike/Contempt
- 6) Neutral Emotions
- 7) Admiration
- 8) Anger
- 9) Empathy
- 10) Disgust
- 11) Sympathy
- 12) Frustration
- 13) No Emotions
- 14) Patience
- 15) Fear/Anxiety
- 16) Calmness
- 17) Disappointment
- 18) Excitement

## Appendix H

### Adapted Emotional Abilities Scale

*The following items assess your perceptions of professional standards regarding mental health service providers' management of their own emotions during client/patient interactions. Please indicate how important it is, according to professional standards, for mental health service providers to engage in the specified behavior or internal process. Based on professional standards for working with clients/patients, how important is it for mental health service providers to...*

Not Important, Slightly Important, Moderately Important, Very Important

- 1) ...control how they express their emotions to clients.
- 2) ...express emotions that are different from those they are actually feeling.
- 3) ...try to make themselves feel a certain emotion so their emotional expressions are sincere and not faked.
- 4) ...hide their emotions from clients.
- 5) ...know when and how to express an appropriate emotion
- 6) ...not show their true feelings in emotional situations.
- 7) ...work to try to make themselves feel the emotion that they want to show.
- 8) ...suppress their feelings.

## Appendix I

### Emotional Labor Items (Brotheridge & Lee, 2003; Gross & John, 2003; Grandey 2003)

*On the average day at work, how frequently do you do each of the following when interacting with clients/patients?*

Never, Rarely, Sometimes, Often, Always

- 1) Make an effort to actually feel the emotions that I need to display to others. (ATTENTIONAL DEPLOYMENT)
- 2) Try to actually experience the emotions that I must show. (ATTENTIONAL DEPLOYMENT)
- 3) Really try to feel the emotions I have to show as part of my job. (ATTENTIONAL DEPLOYMENT)
- 4) Resist expressing my true feelings. (MASKING)
- 5) Hide my true feelings about a situation. (MASKING)
- 6) Put on an act in order to deal with clients in an appropriate way. (FAKING)
- 7) Fake a good mood when interacting with clients. (FAKING)
- 8) Put on a “show” or “performance” when interacting with clients. (FAKING)
- 9) Just pretend to have the emotions I need to display for my job. (FAKING)
- 10) Put on a “mask” in order to display the emotions I need for the job. (FAKING)

*The following questions ask about how you control (that is, regulate or manage) your emotions while interacting with clients/patients. Please indicate the extent to which you agree with each statement by selecting one of the following responses.*

Strongly Disagree, Disagree, Slightly Disagree, Neutral, Slightly Agree, Agree, Strongly Agree

- 1) When I want to feel more positive emotion (such as joy/amusement), I change what I’m thinking about. (REAPPRAISAL)
- 2) When I want to feel more negative emotion (such as sadness/anger), I change what I’m thinking about. (REAPPRAISAL)
- 3) When I’m faced with a stressful situation, I make myself think about it in a way that helps me stay calm. (REAPPRAISAL)
- 4) When I want to feel more positive emotion, I change the way I’m thinking about the situation. (REAPPRAISAL)
- 5) I control my emotions by changing the way I think about the situation I’m in. (REAPPRAISAL)
- 6) When I want to feel more negative emotion, I change the way I’m thinking about the situation. (REAPPRAISAL)
- 7) When I am feeling positive emotions, I am careful not to express them. (MASKING)
- 8) I control my emotions by not expressing them. (MASKING)
- 9) When I am feeling negative emotions, I make sure not to express them. (MASKING)
- 10) I keep my emotions to myself. (MASKING)

## Appendix J

### Maslach Burnout Inventory– Human Services Survey (Maslach & Jackson, 1981)

*Please read each statement carefully and indicate how often you feel this way about your job by selecting one of the following responses.*

Never, A few times a year or less, Once a month or less, A few times a month,  
Once a week, A few times a week, Every Day

- 1) I feel emotionally drained from my work.
- 2) I feel used up at the end of the workday.
- 3) I feel fatigued when I get up in the morning and have to face another day on the job.
- 4) I can easily understand how my recipients feel about things.
- 5) I feel I treat some recipients as if they were impersonal objects.
- 6) Working with people all day is really a strain for me.
- 7) I deal very effectively with the problems of my recipients.
- 8) I feel burned out from my work.
- 9) I feel I'm positively influencing other people's lives through my work.
- 10) I've become more callous toward people since I took this job.
- 11) I worry that this job is hardening me emotionally.
- 12) I feel very energetic.
- 13) I feel frustrated by my job.
- 14) I feel I'm working too hard on my job.
- 15) I don't really care what happens to some recipients.
- 16) Working with people directly puts too much stress on me.
- 17) I can easily create a relaxed atmosphere with my recipients.
- 18) I feel exhilarated after working closely with my recipients.
- 19) I have accomplished many worthwhile things in this job.
- 20) I feel like I'm at the end of my rope.
- 21) In my work, I deal with emotional problems very calmly.
- 22) I feel recipients blame me for some of their problems.