STRESS, COPING, OCCUPATIONAL ATTITUDES, AND

BURNOUT AMONG MENTAL HEALTH PRACTITIONERS

BY

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ABSTRACT

While the concept of stress has intrigued researchers for centuries, occupational stress is a

relatively new area and found to be critical in the understanding of physical and psychological

health as well as occupational attitudes and performance (Abbott, 1990; Cox, 1993; Lambert &

Hogan, 2009; Lazarus & Folkman, 1984; Lloyd, King, & Chenoweth, 2002; Snow, Swan,

Raghavan, Connell, & Klein, 2003; Väänänena, Anttilab, Turtiainena, & Varje, 2012). Due to

the nature of their work, mental health practitioners are particularly susceptible to work stress

and ensuing burnout and turnover. Previous research, guided by the transactional theory of stress

and coping (Lazarus & Folkman, 1984), suggests that coping style mediates the impact of stress

on the individual. As such, the paper starts with a review of stress and coping via the

transactional theory, and then explores the impact on employee functioning. Subsequently, 150

mental health practitioners were sampled to examine stress, coping, and occupational attitudes.

Results suggest that stress, coping, burnout, job satisfaction, and organizational commitment are

significantly related, and that levels of stress, burnout, job satisfaction, and organizational

commitment vary based on coping style, years of practice, work setting, and presenting client

concerns. Furthermore, stress has direct effects on coping style, emotional exhaustion, and job

satisfaction, while job satisfaction directly affects emotional exhaustion, depersonalization, and

affective commitment.

Keywords: transactional theory of stress, coping, burnout, job satisfaction, organizational
commitment, mental health practitioners

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CHAPTER 1

Abstract

Research on occupational stress is a relatively new field but has implications for employees' physical health, mental health, organizational commitment, job satisfaction, and overall life satisfaction (Backé, Seidler, Latza, Rossnagel, & Schumann, 2012; Brunner, Chandola, & Marmot, 2007; Cox, 1993; Melchior et al., 2007; Steptoe & Kivimaki, 2012; van Praag, 2005). As helping professionals, mental health practitioners are particularly vulnerable to the adverse effects of chronic work stress due to the job tasks and emotional investment required. As a result, mental health practitioners report high levels of distress, emotional exhaustion, and burnout, which can impact performance (Ackerley, Burnell, Holder, & Kurdek, 1988; Farber, 1985). This paper reviews the concepts of stress and coping through the lens of Lazarus and Folkman's (1984) transactional theory and discusses the impact of stress on work via job satisfaction and organizational commitment. Lastly, organizational interventions and future directions are considered.

Keywords: transactional theory of stress, coping, burnout, job satisfaction, organizational commitment

CHAPTER 1

Stress, Coping, Occupational Attitudes, and Burnout among

Mental Health Practitioners: A Literature Review

Most individuals devote more than one third of their lives engaging in work

(Wrzesniewski, McCauley, Rozin, & Schwartz, 1997), which could lead to beneficial outcomes,

such as income, a sense of meaning, increased self-esteem, a sense of identity, and work

satisfaction (Henry, 2004; Snyder & Lopez, 2007; Wrzesniewski, 2003), thus improving general

well-being. However, depending on the job tasks, work climate, and access to supports, work can

also lead to stress. Stress at work can have repercussions for both the organization and the

individual: decline in performance, absenteeism, injury, turnover, increase in organizational

costs, burnout, impaired relationships with colleagues and clients, physical illness, mental

distress, and decreased satisfaction (Cox, 1993; WHO, 2000; WHO, 2005). Indeed, extensive

research to date has focused on the negative ramifications of stress on employee and

organizational health.

Stress among helping professionals (e.g., social workers, psychologists, teachers) is well-

documented (e.g., Clay Siebert & Siebert, 2007; Huebner, 1993; Killian, 2008; Lazarus &

Folkman, 1984; Maslach & Jackson, 1981; Wisniewski & Gargiulo, 1997), and practicing

psychologists report a significant amount of stress (Ackerley, Burnell, Holder, & Kurdek, 1988;

Farber, 1985). This is particularly important because elevated stress, inadequate resources, and

demanding interpersonal work can result in burnout, impaired performance, potential ethical

violations, and withdrawal from the organization or field (Cherniss, 1980; Lloyd, King, &

Chenoweth, 2002). In fact, work-related stressors and stress tend to be greater predictors of

turnover intent and burnout than individual characteristics (Griffin, Hogan, Lambert, Tucker, &

Baker, 2010). Thus, it is important to understand the relationship between occupational distress (stress, burnout), coping styles, and occupational attitudes (job satisfaction, organizational commitment) among mental health practitioners in order to assist individuals in adjusting to their work as well as assist organizations in providing mental health interventions.

Work Stress and Burnout

Stress is a universal experience and known to be beneficial in acute form (Lambert & Kinsley, 2011). For example, acute stressors (i.e., short-lived) aid in survival instincts, whether physically (e.g., slamming on the brakes when the vehicle ahead suddenly stops) or socially (e.g., public speaking). Chronic stress, on the other hand, is the accumulation of daily struggles and stressors that frequently trigger the stress response (Lambert & Kinsley, 2011). In general, chronic stress can interfere with the execution of healthy behaviors (e.g., adequate sleep, balanced diet, physical activity), leading to poor health, obesity, and coping via substance use [Brunner, Chandola, & Marmot, 2007; Cox, 1993; National Institute for Occupational Safety and Health (NIOSH), 2013]. Stress is also linked to cardiovascular illness (Backé, Seidler, Latza, Rossnagel, & Schumann, 2012; Steptoe & Kivimaki, 2012), suppressed immune functioning (Segerstrom & Miller, 2004), and depression and anxiety (Melchior et al., 2007; van Praag, 2005).

The concept of stress can be traced back to the 14th century, but research studies and application to health did not originate until the 19th century (Abbott, 1990; Lazarus & Folkman, 1984). The focus on stress and its consequences grew exponentially during and after the World Wars, starting with an emphasis on combat stress and expanding to include stressors inherent in civilian life (e.g., marriage, school, loss; Lazarus, 1993). Over time, the sources, components, impact, and neurophysiology of stress have been considered extensively, suggesting a strong

interest in the experience of stress. In the United States, researchers began attending to work stress and stressors in the early 1960s (Väänänena, Anttilab, Turtiainena, & Varje, 2012). Väänänena and colleagues (2012) argue that both societal developments, such as the human rights movement and feminism efforts, and psychological concepts, such as humanist theory, provided a historical context for the concern of workers' health. As interest unfolded, research on work stress focused on role characteristics (e.g., role overload, role conflict), person-environment fit, self-efficacy, coping, and cardiovascular health, among other topics (Väänänena et al., 2012).

Many examples of work-related stressors have been cited in literature: role conflict, role ambiguity, role overload, low level of control, limited input in decision-making, poor communication, work overload, time pressure, dangerousness, work-life conflict, inflexible schedule, long hours, poor pay, lack of meaning, lack of support or resources, unfair treatment, clients, and management/bureaucracy, among others (Cox, 1993; Day & Livingstone, 2001; Griffin et al., 2010; Prosser et al., 1997). The majority of work-related stressors presented in this review are inherent to the work climate (e.g., limited input, bureaucracy) or the job (e.g., long hours, dangerous); thus, they are likely to be consistently experienced and can be identified as chronic stressors. Acute work stressors might include giving a presentation or working towards a deadline.

Transactional Theory of Stress

A frequently cited theory of stress and coping is that presented by Lazarus and Folkman (1984). In this transactional theory, stress is defined as "a particular relationship between the person and the environment that is appraised by the person as taxing or exceeding his or her resources and endangering his or her well-being" (p. 19). To reiterate, stress only occurs when individuals believe their well-being will be threatened or damaged as a result of interacting with

their environment (which can include stressors and other individuals). Thus, stress is transactional in that the person and environment interact, and an imbalance (i.e., stress) can occur if the demands of the environment outweigh the resources available to the person. Two processes are involved in the stress transaction: cognitive appraisal and coping (Colquitt, Lepine, & Wesson, 2011; Lazarus & Folkman, 1984). In any event, an individual assesses the stressor and its potential impact, which is known as primary appraisal. During this phase, it is important to ask *"Is this event potentially harmful/stressful, helpful, or irrelevant?"* An event may be considered harmful to well-being if it may cause physical or psychological harm (e.g., injury, low self-esteem, death) to oneself or other people and helpful to well-being if positive outcomes are expected (e.g., love, fun; Lazarus & Folkman, 1984). Secondary appraisal occurs when individuals consider whether action is warranted, is feasible considering resources available, and is likely to reduce stress. Next, individuals may employ various coping strategies (described below). Due to the cognitive appraisal component, the perception of events and subsequent actions differ across individuals (Lazarus & Folkman, 1984). Thus, employees are likely to evaluate work stressors in multiple ways, leading to differences in stress levels, coping behaviors, and adjustment.

As presented, coping has both a cognitive (evaluating the situation, potential consequences, and likely actions) and a behavioral component (acting in response to the stressor). As such, it requires significant attention and energy from the individual. Frequent exposure to various stressors or presence of chronic stress is likely to result in fatigue and withdrawal, and in the workplace setting, work stressors can lead to professional distress and burnout (Griffin et al., 2010; Lloyd et al., 2002). Maslach and Jackson (1981) define burnout as "emotional exhaustion and cynicism that occurs frequently among individuals who do 'people-

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work' of some kind" (p. 99). Burnout is characterized by three components: emotional exhaustion (EE), depersonalization (DP), and personal accomplishment (PA). EE, the main component of burnout, refers to feeling emotionally drained due to one's work and relates to the stress factor of burnout (Maslach & Jackson, 1981; Wheeler, Vassar, Worley, & Barnes, 2011). DP refers to distancing or disengaging oneself from clients or job tasks, which is a result of altered thoughts and burned out individuals viewing clients in a negative way; this shift in perspective is likely to have an (negative) impact on how affected professionals treat clients. Lastly, PA is feeling competent or productive in one's job (Maslach & Jackson, 1981; Wheeler et al., 2011). High levels of EE and DP, in combination with low levels of PA, are indicative of an individual experiencing burnout.

Transactional Theory of Stress in Work Settings

The transactional theory of stress by Lazarus and Folkman (1984) has since been applied to work settings and work-related stressors. In a review of occupational stress theories, which includes the transactional theory, Babatunde (2013) highlights the employee-work interaction in that the employees must evaluate the work environment, stressors, and conditions to determine potential harm or threats. This view encapsulates both the transactional and appraisal components of the theory. Lazarus (1995) posits that stress is based upon the outcome of an ongoing interaction between an environment and a person in that environment. Thus, in the context of work, work stress results from the interaction between a particular employee and the work environment, demands, and colleagues. Since the interaction is ongoing (assuming the employee stays in the job), the level of stress and coping change over time as demands from the external environment and internal resources/reactions of the employee change.

Several research studies have focused on the role of stressor appraisal in occupational settings. Workplace stressors are commonly presented as either hindrances or challenges. Hindrances are evaluated as job aspects with negative outcomes that might negatively impact well-being and interfere with goal attainment or success, and challenges are job aspects associated with more positive outcomes such as new learning opportunities or aiding in future success (Crawford, Lepine, & Rich, 2010). Whether the stressor is perceived as a hindrance or challenge depends on individuals' evaluation of their abilities and available resources to address the task at hand. Support for the challenge-hindrance occupational model has been found. Among a sample of employees, the impact of a stressor was mediated by its appraisal (Webster, Beehr, & Love, 2011). Additional research has found that workplace hindrance stressors relate to negative emotions and job turnover while challenge stressors relate to positive emotions and job satisfaction (Cavanaugh, Boswell, Roehling, & Boudreau, 2000; Mawritz, Folger, & Latham, 2014).

Furthermore, stressor appraisal among police offers has been examined (Lucas, Weidner, & Janisse, 2012). In a sample of 115 police officers, an occupation known to produce high stress, support was found for both individual and work effects. However, an interaction effect was present as well, suggesting that police officers with certain individual traits were more likely to report certain work stressors. While previous research had focused on *either* the role of individual characteristics (e.g., neuroticism) *or* work characteristics (e.g., control) in workplace stress, Lucas et al. (2012) focused on the interaction between the two variables. That is, certain aspects of a job may be stress-inducing for certain employees, but not affect all employees similarly. Consistent with the transactional theory of stress, employees appraise workplace

variables differently; therefore, while one worker may find a particular work aspect stressful, another worker may not.

A commonly cited occupational stress theory that is related to the transactional theory is the Job Demands-Resources (JD-R) model (Demerouti, Bakker, Nachreiner, & Schaufeli, 2001). The JD-R model includes four separate variables: job demands, job resources, disengagement, and exhaustion. Researchers propose that high job demands can result in employee exhaustion, and when coupled with low job resources, can result in disengagement from work and eventually, burnout. In essence, the impact of job demands on burnout level is moderated by resources. What is conceptualized as a demanding aspect of a job is likely to differ across employees, as will the tolerance of job demands in relation to resources. This is where the transactional effect comes into play. Employees may evaluate job demands as either hindrances (e.g., bureaucratic demands) or challenges (e.g., time pressure; Crawford et al., 2010). As a result of these appraisals, individuals may be more likely to approach challenges with active coping strategies, which results in increased engagement, while hindrances are met with passive strategies, such as avoidance or withdrawal, which leads to disengagement from the job tasks (Crawford et al., 2010).

Additional research provides support for the transactional theory of stress in the workplace. Mark and Smith (2012) took an inclusive approach to examining the impact of job stressors and coping on mental health outcomes. Specifically, the researchers addressed both environmental and personal characteristics factors by considering demands-control-support model, effort-reward model, and transactional theory in the study. In a sample of nurses, the researchers found strong links between the included variables of job demands, supports, extrinsic effort, job rewards, anxiety, and depression. While the demands-control-support factors (job

demands, social support) and effort-reward factors (extrinsic effort, job rewards) fit for the analyzed model, the transactional factor (coping) accounted for variance in anxiety and depression beyond those factors. In a separate study conducted with university employees, Mark and Smith (2012) also found strong associations between the factors of job demands, supports, extrinsic effort, job rewards, anxiety, and depression, along with job satisfaction. Among their findings, problem-focused coping (active coping) was negatively associated with anxiety and depression, while wishful thinking and avoidance (avoidant coping) were positively associated with anxiety and depression. Following the findings from both studies, the researchers call for the inclusion of transactional theory and coping in workplace stress research.

Job Satisfaction and Organizational Commitment

When considering individuals' relationships with work, it is important to address their occupational attitudes, namely job satisfaction and organizational commitment. Job satisfaction and organizational commitment have been studied extensively in relation to industrial-organizational psychology and occupational health, as both variables have been repeatedly linked to job performance, turnover intent, and burnout (Colquitt et al., 2011; Griffin et al., 2010; Imran, Arif, Cheema, & Azeem, 2014; Lambert & Hogan, 2009; Nagar, 2012; Ogresta, Rusac, & Zorec, 2008; Shore & Martin, 1989; Tett & Meyer, 1993). Job satisfaction is also positively linked with life satisfaction and happiness (Bowling, Eschleman, & Wang, 2010; Judge & Watanabe, 1993), while organizational commitment may reduce the impact of job strain (Schmidt, 2007).

Job satisfaction is essentially the degree to which people are satisfied with, or like, their current job (Colquitt et al., 2011). Job satisfaction has even been defined as an emotional attachment with one's job (Griffin et al., 2010; Tett & Meyer, 1993), but also has a cognitive

component in that people are assumed to evaluate their current position against expected outcomes and determine whether the outcomes are pleasing (Griffin et al., 2010; Judge & Klinger, 2008).

The concept of organizational commitment has been largely advanced by the work of Allen and Meyer (1990) and their development of the Organizational Commitment Questionnaire (OCQ). Describing the three components of organizational commitment—affective, continuance, and normative—is useful in understanding organizational commitment. Affective commitment consists of emotional ties to the organization, while continuance refers to the consideration of the costs associated with leaving the organization. Normative is the responsibility one feels to stay with the organization. Simply stated, Allen and Meyer (1990) describe the three components as the want (affective), need (continuance), or ought (normative) to stay with the organization.

Impact of Work Stress on Occupational Outcomes

Individual and Organizational Impact

In a recent report released by the American Psychological Association (APA; 2015), 60% of Americans reported work as a significant source of stress, second only to finances. As previously implicated, work stress influences burnout; furthermore, work stress and burnout impact the daily functioning and well-being of individuals. Of organizational concern, poor individual performance, reduced organizational performance, and greater organizational costs could follow from stressed and burned out employees. More specifically, cross-sectional research suggests relationships between work-related stressors and low job satisfaction, low confidence and self-esteem, increased stress, psychological symptoms, physical complaints, increase in error rates, absenteeism, and greater turnover intent (see Cox, 1993 for a review; Day

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& Livingstone, 2001; Snow, Swan, Raghavan, Connell, & Klein, 2003). Several longitudinal studies have been conducted to explore the effects of work stress on employee health and occupational engagement. Snow et al. (2003) suggested that employees reporting a greater degree of work-related stressors also reported more symptoms of depression and anxiety in addition to bodily complaints.

Recent research on work stress exposes a moderately complex relationship between stress, burnout, and occupational attitudes. Work-related stressors, such as role ambiguity, work overload, and role conflict, have negative effects on job satisfaction and organizational commitment (Lambert & Hogan, 2009). Moreover, individuals who experience high levels of work-related stress may be more likely to experience burnout, while job satisfaction may serve as a buffer to burnout (Griffin et al., 2010). Furthermore, job satisfaction and job stress are identified as stronger predictors of burnout than organizational commitment (Griffin et al., 2010). It is important to attend to occupational attitudes, especially job satisfaction and organizational commitment, due to their influence on other work variables. For example, job satisfaction has been identified as a predictor of organizational commitment, and both job satisfaction and organizational commitment predict employee job performance and intent to stay at the organization (Colquitt et al., 2011; Imran et al., 2014; Lambert & Hogan, 2009; Tett & Meyer, 1993). The findings are plausible, in that the more satisfied employees are with their job and the more committed they are to their organization, the less likely they are to leave their position and the organization (in essence, the lower the turnover intent).

Work Stress across Occupations

The general effects of stress on physical, psychological, and occupational functioning are well-documented. In addition, numerous studies have been conducted on job stress, coping, and occupational functioning for various human service professionals: correctional officers, teachers, social workers, and psychologists/therapists. Among correction officers, stress has been linked with turnover and absenteeism, cardiovascular-related concerns (e.g., high blood pressure, hypertension), lower job satisfaction, and risk of burnout (Griffin et al., 2010; Schaufeli & Peeters, 2000). While job satisfaction was negatively related to burnout, job stress correlated positively with the experience of emotional exhaustion and depersonalization, two dimensions of burnout. Both general and special education teachers are at risk of leaving their teaching positions, and even the field, due to stress stemming from various factors (e.g., low control, diminished resources, high demands; Wisniewski & Gargiulo, 1997). The field of social work, with high levels of engagement with clients, conflicting roles, and time pressures, is characterized by work stress and anxiety, as well. Across studies, anywhere from a third to three-quarters of social worker samples were characterized by work stress or emotional distress, and commonly cited outcomes included lower job satisfaction, higher turnover rates, psychological symptoms of depression and anxiety, and burnout (Lloyd et al., 2002).

Several studies have been conducted on levels of stress and burnout among mental health practitioners (licensed therapists and psychologists) and are important to consider due to prevalence and impact. Professionals working with people in an emotional capacity may be more likely to experience work distress and burnout (Maslach & Jackson, 1981; Zapf, Seifert, Schmutte, Mertini, & Holz, 2001). In a sample of clinical psychologists, more than a third of respondents felt moderately affected (in an adverse or draining way) by their work (Farber,

1985). In a later survey, about 30% of licensed psychologists indicated high burnout, with about 40% reporting emotional exhaustion and 34% experiencing depersonalization (Ackerley et al., 1988). This experience may be even higher among certain groups of practitioners; in a sample of Veteran's Health Affairs (VHA) practitioners who were treating veterans with posttraumatic stress disorder (PTSD), about 50% reported emotional exhaustion and cynicism (Garcia, McGeary, McGeary, Finley, & Peterson, 2014). Factors like work load and organizational politics were cited as sources of exhaustion and cynicism, and also related to absence from work and turnover intent.

Mental health professionals are affected by stress and work-related stressors in various ways. Professional distress has been associated with poor mental health, substance use, mistreatment of clients, and turnover (Ackerley et al., 1988; Lloyd et al., 2002). For mental health professionals, commonly identified stressors include demanding client problems, secondary trauma, emotional engagement/involvement, time pressures, and bureaucratic policies, making for stressful employment if support is low and/or coping is maladaptive. Prosser and colleagues (1997) examined sources of stress and level of satisfaction among mental health professionals, and found that the stressors of work overload, low levels of support, challenging clients, thinking about the future, and their role in and of itself accounted for 70% of the total variance in stress reported by participants. Certain aspects of mental health work, like paperwork, negative client behaviors, and over-involvement with clients were positively correlated with dimensions of burnout (emotional exhaustion and depersonalization; Rupert & Morgan, 2005). As a result, the researchers suggest that "psychologists who feel less control over their work activities, work longer hours, spend more time in administrative/ paperwork activities,

see fewer direct pay clients, and deal with more negative client behaviors may be a higher risk of developing burnout" (p. 550).

Employee stress and satisfaction differ by several factors: work setting, job/position, gender, and/or age (Halbesleben & Buckley, 2004; Prosser et al., 1997). In relation to work setting, research suggests that practitioners in private practice may experience greater job satisfaction and less burnout than practitioners in public or agency settings (Ackerley et al., 1988; Halbesleben & Buckley, 2004). Female practitioners have reported greater frequency and intensity of emotional exhaustion, while male practitioners reported greater frequency and intensity of depersonalization and reduced personal accomplishment (Maslach & Jackson, 1981). However, more recent findings suggest that men and women report different levels of emotional exhaustion in different settings: women report greater levels of exhaustion in agency settings while men report greater levels in private practice settings (Halbesleben & Buckley, 2004). Older practitioners (who also tend to be more experienced) report lower levels of burnout than younger participants (Ackerley et al., 1988; Griffin et al., 2010; Halbesleben & Buckley, 2004; Maslach, Schaufeli, & Leiter, 2001).

Coping

As highlighted, work-related stressors, work stress, and burnout have a negative impact on individual health and performance, as well as turnover and organizational performance (both of which lead to financial demands on the organization). Due to the deleterious effects of stress, interventions are necessary for positive adjustment (e.g., restoring physical and psychological health and improving job performance and satisfaction).

Coping Strategies

A common view of coping is "changing cognitive and behavioral efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person" (Lazarus & Folkman, 1984, p. 141). Coping has been described in opposing ways—as situation-specific, in which an individual uses different coping strategies depending on the situation, and as disposition-based, which suggests an individual uses the same fixed coping strategy across situations (Carver, Scheier, & Weintraub, 1989; Lazarus, 1993; Lazarus & Folkman, 1984). The first account suggests that people adapt to stressors by reflecting upon previous stressful encounters, while the second account suggests that personality strongly influences and/or guides coping.

Coping is further dichotomized in relation to *how* an individual copes with stress. Some researchers cite problem-focused vs. emotion-focused coping, while others highlight active vs. avoidance coping (Latack & Havlovic 1992; Lazarus & Folkman, 1984; Snow et al., 2003). Problem-focused coping suggests that an individual attempts to solve the problem or change the situation directly, while emotion-focused coping includes attempts to manage or minimize emotional reactions to the stressor (Lazarus & Folkman, 1984). Problem-focused and emotion-focused coping can be further categorized by behavioral coping methods (e.g., obtaining social support, drinking) or cognitive coping methods (e.g., prioritizing activities, reappraising the stressor; Colquitt et al., 2011; Lazarus & Folkman, 1984).

Active coping strategies involve directly changing the stressful situation by solving the problem or seeking additional support, while avoidant strategies include trying to avoid the event, stimuli associated with the event, and/or thoughts associated with the event (Lazarus & Folkman, 1984). Emotional coping strategies include suppressing emotions and avoiding the

stressors, and so aligns with avoidance (avoiding the problem or associated thoughts) while problem-focused aligns more with active approaches (directly changing the situation). In a more inclusive proposal, Carver et al. (1989) developed the COPE Inventory, which is informed by Lazarus and Folkman's theory. Based on their work, avoidance is delineated from emotion-focused coping, resulting in three coping approaches: problem-focused, emotion-focused, and behavioral/mental disengagement (i.e., avoidance).

Effectiveness of Coping

Previous research on coping suggests that active strategies have a positive effect, as they are associated with less burnout, fewer psychological symptoms, and better adjustment (Maslach et al., 2001; Snow et al., 2003). Alternatively, individuals relying solely (or mostly) on passive or avoidant strategies tend to report more symptoms, higher levels of stress, decreased well-being, difficulty adjusting, and burnout (Begley, 1998; Day & Livingstone, 2001; Maslach et al., 2001; Snow et al., 2003). Snow and colleagues (2003) conducted one of the first longitudinal studies in this area of research. Based on their findings, both avoidance strategies and psychological symptoms were positively correlated with work-related stressors over time, and form a cycle: as amount of stressors increase, avoidance strategies increase, which relate to more symptoms. However, individuals who responded to stressors by coping actively reported fewer symptoms.

Active strategies are deemed more beneficial, but discretion may be helpful to evaluate strategies for different situations. For example, approach strategies may be less helpful if the individual has little to no control over changing the situation. On the other hand, avoidance may be further damaging if it leads to restricting activities, use of drugs/alcohol, or increased distress (Roth & Cohen, 1986). As such, a situation-specific response may be a more adaptive and effective approach than strictly adhering to just approach or avoidance strategies. This idea

relates to the transactional component of Lazarus and Folkman's theory, as individuals tend to evaluate the stressor and associated demands, as well as their cognitive abilities and support in order to determine a course of action.

Differences in Coping Preferences

Researchers have suggested that coping styles may differ based on one's age, sex, and position. For example, older individuals, males, and individuals in higher-ranking positions and with greater income are more likely to engage in problem-focused and active approaches, while younger individuals, women, and individuals from lower social classes are more likely to engage in avoidance and emotion-focused coping (Kim & Agrusa, 2010).

There are also inconsistencies related to work stressors (Snow et al., 2003). Some studies suggest that active coping *mediates* the effect of work-related stressors on psychological symptoms, while other studies suggest that active coping serves as a *moderator* (Snow et al., 2003). In situations resulting in higher stress reactions, active coping methods are thought to be more effective; this relationship seems to dissipate in lower stress situations (Felsten, 1998; Koeske, Kirk, & Koeske, 1993; Snow et al., 2003). In other research (Day & Livingstone, 2001; Ingledew, Hardy, & Cooper, 1997; Koeske et al., 1993), avoidance coping impacts the stress-symptom relationship, with reliance on avoidance coping methods associated with higher stress and more symptoms. Snow et al. (2003) provides additional support for these ideas, reporting a positive relationship among avoidance, stress, and psychological symptoms and a negative relationship between active (cognitive) coping and psychological symptoms.

Organizational Interventions

The World Health Organization (WHO; 2005) has identified depression, substance use, work stress, and anxiety as major mental health concerns for employees. Due to the prevalence of mental health problems and associated costs, this area cannot be ignored, and organizational leaders are becoming more cognizant of this. In a national study, about 1% and 6% of employees met diagnostic criteria for bipolar disorder and major depressive disorder, respectively (Kessler et al., 2006). In a sample collected by Substance Abuse and Mental Health Services Administration (SAMHSA; 2007), about 7% of adults working full-time and 9% of those working part-time reported a major depressive episode in the previous year.

Concerns related to mental wellness and coping can impact employee productivity as well as organizational costs. Employees with mood disorders missed an average of 27 days a year related to major depression and 65 days a year related to bipolar disorder (Kessler et al., 2006). In Europe, mental health-related costs are estimated at about 240 billion Euros (or about 260 billion US dollars; ENWHP, 2011), while in the United States, the cost rises to about 300 billion for stress-related concerns (American Institute of Stress, 2011). Considering the impact of stress and psychological distress on organizational and employee functioning, organizations have addressed and implemented stress-reducing interventions. Failure to address stress in the workplace may result in companies paying more in healthcare, experiencing a higher number of workers' compensation claims, losing worker productivity, and suffering greater employee turnover (O'Keefe, Brown, & Christian, 2014).

Mental Health Policies in the Workplace

WHO (2000) posits that organizations have an obligation to address job stress and mental health concerns of employees, as well as assist them in improving their well-being and work

situation. Typically, organizational involvement includes evaluating the mental health concerns of the workplace and developing a policy based on those concerns (WHO, 2005). According to O'Keefe and colleagues (2014), companies should address the area of stress in their organizational policies, revise the policies annually, assess for stress in the workplace, and provide counseling services to employees.

To date, organizations across several countries have developed mental health policies in an effort to reduce suicide rates, decrease mental illness, and improve general functioning of employees (WHO, 2000). In the European Union (EU), 38 of the 42 countries have developed mental health policies consistent with World Health Organization guidelines (WHO, 2008). Some of these policies are stand-alone while other policies are integrated into the general health policies (WHO, 2008). The Department of Health (2014) of the United Kingdom recently released a document incasing change in mental health care by supporting employees who are coping with mental health problems in addition to assisting individuals with mental health problems in finding work. In the United States, the National Institute for Occupational Safety and Health (NIOSH) presented a new program, called Total Worker Health (TWH), in 2011 (NIOSH, 2015). TWH is committed to improving employees' overall well-being via organizational policies and practices, and stress and fatigue issues among employees is included within the TWH approach.

Program Development

In addition to policy formation and revision, organizational leaders need to develop programs and initiate organizational changes to aid in the positive adjustment and functioning of employees. To date, most interventions have focused on changing the individual, but research suggests that burnout is more likely due to situational (e.g., organizational) factors than

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individual factors (Halbesleben & Buckley, 2004; Maslach et al., 2001). For example, conventional interventions focus on changing employee behaviors or job tasks, increasing coping abilities, and/or modifying expectations. In the United States, stress management training and employee-assisted programs are commonly employed to initiate individual change, but preventative interventions, such as stressor reduction, may be more promising (Cox, 1993).

In recent years, researchers have called for inclusion of primary and preventative interventions. Babatunde (2013) suggests that greater focus on primary interventions is needed in order to best protect the employee and organization from ensuing harm. Primary interventions are preventative in nature and include reducing known stressors. Secondary interventions, which are the most widely employed, include stress management and coping training. Tertiary interventions are those implemented once a problem is identified and likely already causing problems for the individual and/or organization.

Similar to Babatunde's (2013) suggestions, LaMontagne et al. (2014) introduce an integrative approach to mental health as a means to address, and even prevent, related issues in the workplace. Within this approach, they call attention to *prevention* of psychological concerns through modifying working conditions and improving coping skills, *promotion* of mental health by expanding upon positive working conditions (e.g., individual strengths, positive leadership), and *management* of mental disorders/concerns that arise via psychological and psychiatric services. The authors are hopeful that including primary, secondary, and tertiary interventions, in addition to the prevention, promotion, and management, will have beneficial outcomes for the employees and organizations by addressing mental health problems and improving working conditions (LaMontagne et al., 2014).

According to WHO (2005), viable interventions for organizational consideration include providing education on, support for, and interventions related to mental health issues. Primary interventions include increased autonomy, flextime, part-time options, and employee engagement (Babatunde, 2013), while organizational changes, such as changes to one's role or responsibilities, the work environment, or interpersonal practices, can help as well (WHO, 2005). Other suggestions include revising workloads, allowing flexibility in schedules, ensuring variety in job tasks, increasing employee input and involvement in decisions, attending to violence/bullying, training supervisors on stress, and explicitly outlining job tasks and responsibilities (NIOSH, 2015; O'Keefe et al., 2014). The European Network for Workplace Health Promotion (ENWHP; 2011) released a document in which mental health concerns are addressed and the authors suggest using cognitive-behavioral strategies, exercise, and relaxation as appropriate interventions for stress management/reduction.

As national, multinational, and international organizations increase emphasis on mental wellness in the workplace, organizational policies and interventions should continue to evolve to include preventative measures and additional employee support. In doing so, there is the potential to restore physical and psychological health and improve work performance and job satisfaction.

Conclusion

While the concept of stress has been explored for many centuries, the investigation of stress in the workplace is a new field, relatively speaking. Research conducted thus far suggests that work stress, work-related stressors, and burnout have adverse effects on individual health, well-being, and performance, and may lead to organizational concerns of reduced performance, high turnover, and associated costs. Due to the deleterious effects of stress, interventions are

necessary for positive adjustment (e.g., restoring physical and psychological health and improving work performance and job satisfaction) and have been implemented to a greater extent in recent decades. However, additional information is needed regarding the relationship between stress, coping, and organizational attitudes among mental health practitioners, with an interest in improving organizational involvement in employee mental health and well-being. Transactional theory of stress, particularly the emphasis on coping, provides a promising avenue from which to explore this notable topic.

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CHAPTER 2

Abstract

Due to centrality of work, job tasks and the workplace setting have a strong influence on individual experiences, resulting in either meaning and satisfaction or stress and impaired functioning. Mental health practitioners are especially susceptible to stress and burnout due to the nature of their work. Research has been conducted on the impact of stress on occupational variables, the effectiveness of coping styles, and the prevalence of stress and burnout among human service professionals, and this study builds upon previous research to examine a model of stress, coping, burnout, and occupational attitudes among 150 mental health practitioners. Results suggest the following: 1) stress is significantly associated with coping style, burnout, job satisfaction, and organizational commitment, 2) job satisfaction is significantly correlated with both burnout and organizational commitment, and 3) levels of stress, burnout, job satisfaction, and organizational commitment vary based on coping style, years of practice, work setting, and presenting client concerns. Examination of a presented model indicates that stress has a direct effect on coping style, emotional exhaustion, and job satisfaction, while job satisfaction directly affects emotional exhaustion, depersonalization, and affective commitment.

Keywords: transactional theory of stress, coping, burnout, job satisfaction, organizational commitment, mental health practitioners

CHAPTER 2

Stress, Coping, Occupational Attitudes, and Burnout among

Mental Health Practitioners

Mental health practitioners experience a considerable amount of work stress (Ackerley, Burnell, Holder, & Kurdek, 1988; Clay Siebert & Siebert, 2007; Farber, 1985; Huebner, 1993; Killian, 2008; Lazarus & Folkman, 1984; Maslach & Jackson, 1981; Wisniewski & Gargiulo, 1997). Stress is inherent in the duties performed by mental health practitioners due to the complex interpersonal work, compassion fatigue, challenging client concerns, secondary trauma, time pressures, and emotional exhaustion, which can be accompanied by poor organizational resources, limited staff members, and bureaucratic concerns (DeAngelis, 2002; Garcia, McGeary, McGeary, Finley, & Peterson, 2014; Lloyd, King, & Chenoweth, 2002). When the demands of job tasks outweigh coping abilities, work stress and strain can ensue. And when work stress is ongoing, an employee may experience negative personal and professional ramifications. For example, research to date has found that stress can result in physical symptoms (e.g., headaches, insomnia), social withdrawal or disengagement, cognitive impediments (e.g., ruminations regarding clients), impaired performance, increased absence, decreased job satisfaction, propensity for burnout, withdrawal from the field, and potentially unethical judgments or actions (Cherniss, 1980; Cox, 1993; DeAngelis, 2002; Lloyd et al., 2002; WHO, 2000; WHO, 2005). This impact is particularly significant for practitioners working with trauma-related client concerns of combat veterans or sexual assault survivors.

In two separately conducted studies, about a third of psychologists reported feeling negatively affected by their work (Farber, 1985), which included lowered well-being, coping via substance use, and withdrawal from the position (Ackerley et al., 1988; Lloyd et al., 2002). The

researchers reported that about a third of practitioners reported high levels of burnout, while almost 40% of practitioners experienced emotional exhaustion (Ackerley et al., 1988). Subsequent research findings indicate that emotional exhaustion occurs at an even higher rate (50%) among those working with trauma (Garcia et al., 2014).

Work stress among mental health practitioners can vary by organizational and individual factors, such as setting, gender, and age (Halbesleben & Buckley, 2004; Prosser et al., 1997). For example, burnout seems to be higher for mental health professionals in public rather than private settings, as well as for younger, less experienced practitioners (Ackerley et al., 1988; Griffin, Hogan, Lambert, Tucker, & Baker, 2010; Halbesleben & Buckley, 2004; Maslach, Schaufeli, & Leiter, 2001; Vredenburgh, Carlozzi, & Stein, 1999). Lastly, male practitioners have reported greater depersonalization in their work, while female practitioners have indicated greater emotional exhaustion (Maslach & Jackson, 1981; Vredenburgh et al., 1999).

In work stress research, a theory that has been gaining attention for its theoretical and empirical implications is the transactional theory of stress and coping presented by Lazarus and Folkman (1984). Lazarus and Folkman (1984) define stress as "a particular relationship between the person and the environment that is appraised by the person as taxing or exceeding his or her resources and endangering his or her well-being" (p. 19), which suggests that stress occurs as a result of the interaction (or transaction) between the person and environment. Inherent in this interaction, however, are two processes: cognitive appraisal and coping, in which the individual must assess the situation and related stressors, predict impact on physical or emotional well-being, and determine if and which interventions are necessary (Colquitt, Lepine, & Wesson, 2011; Lazarus & Folkman, 1984). Since appraisal differs across individuals due to personality, ability, and previous experiences, stressors are likely to be evaluated in various ways and coping

strategies may be applied differently. In work settings, employees are likely to evaluate work aspects differently as well, either as helpful or harmful, and act accordingly. Furthermore, even if two employees find the same work aspect to be harmful or stressful, they may respond in different ways: seeking social support, avoiding the stressor, or addressing the situation directly. In the present study, actively addressing the stressor/situation via approach or planning methods is referred to as "active coping" while distancing oneself from the stressor/situation through behavioral (e.g., "quit trying," "reduce effort") or mental activities (e.g., "daydream about other things," "sleep more") is referred to as "disengagement coping" (similar to active and avoidance coping, respectively).

Thus far, research supports the application of the transactional theory in the workplace; it has been demonstrated that employees appraise stressors as either hindrances (negatively associated) or challenges (positively associated), which can then impact emotional reactions and job satisfaction (Cavanaugh, Boswell, Roehling, & Boudreau, 2000; Lucas, Weidner, & Janisse, 2012; Mawritz, Folger, & Latham, 2014; Webster, Beehr, & Love, 2011). Furthermore, if an employee is met with demanding stressors but has inadequate resources, they may experience emotional exhaustion, anxiety, depression, disengagement, and work burnout (Demerouti, Bakker, Nachreiner, & Schaufeli, 2001; Mark & Smith, 2012a; 2012b). These supporting studies, while promising, have been conducted with samples of police officers, nurses, and university staff. Mental health, an equally stressful field, should be included in this body of research to better understand practitioners' reactions and coping efforts.

It is important to understand the relationship between occupational distress (stress, burnout), coping styles, and occupational attitudes (job satisfaction, organizational commitment) among practicing psychologists in order to assist individuals in adjusting to their work and guide

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organizations in providing mental health interventions. Extensive research studies have been

employed to investigate the impact of stress on employee health and performance as well as the

impact of coping on levels of stress; however, additional research is needed to better understand

the relationships among stress, coping, burnout, job satisfaction, and organizational commitment

among mental health practitioners due to the prevalence of stress and burnout in this field. While

mental wellness has become a focus in organizational policy and intervention in recent decades,

organizational involvement should be expanded upon to include preventative measures and

additional employee support in an effort to improve overall health, work-life balance, and

organizational performance.

Purpose and Hypotheses

The effects of coping on psychological symptoms and adjustment have been explored,

but research is scant regarding the impact of coping on job satisfaction and organizational

commitment among mental health practitioners. Since practitioners are at risk of work stress and

burnout, and stress and burnout can negatively impact their psychological and physical health,

work with clients, and relationship to their job, a better understanding of the relationship between

work stress, individual coping, and occupational attitudes is needed. These findings may also

inform current attempts at addressing and ameliorating work stress among employees in mental

health fields. Thus, the purpose of the study is twofold: 1) to assess the stress, burnout, and

coping styles among mental health practitioners, and 2) to examine a model of stress, coping

styles, burnout, and occupational attitudes (e.g., job satisfaction, organizational commitment)

among mental health practitioners.

Based on existing literature and research (Ackerley et al., 1998; Day & Livingstone, 2001; Griffin et al., 2010; Halbesleben & Buckley, 2004; Kim & Agrusa, 2010; Lambert & Hogan, 2009; Maslach et al., 2001), the following hypotheses are presented:

H1: Perceived stress level will have significant positive bivariate correlations with burnout and disengagement coping, and significant negative bivariate correlations with active coping, job satisfaction, and organizational commitment.

H2: Mental health practitioners with more professional practice experience (measured by years) will be significantly more likely to engage in active coping approaches and experience lower levels of stress.

H3: Levels of stress and burnout will be significantly different depending upon setting and clientele. Previous research (Ackerley et al., 1988; Rupert & Morgan, 2005) has found that psychologists in private settings report lower levels of stressors and burnout than psychologists in public settings. As such, reported stress and burnout will be significantly higher for practitioners working in public settings, such as hospital, community mental health, or correctional settings, when compared to private settings. Results from a recent study provide support for the relationship between psychologists' burnout and clients presenting with personality disorders (Garcia et al., 2016). However, the results were reported based on a sample of psychologists working at Veteran Administration Medical Centers (VAMC), and the impact of client characteristics on stress and burnout should be replicated across settings.

H4: Reported job satisfaction and burnout will vary depending on coping style. More specifically, practitioners engaging in disengaging coping styles will report significantly

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lower levels of job satisfaction and greater burnout. The inverse is expected for

practitioners engaging in active coping styles.

Proposed Model

Lastly, informed by existing literature and research, a model on stress, coping, burnout,

and occupational attitudes is presented (see Appendix A) and examined. According to Lazarus

and Folkman (1984), individuals perceive and respond to events differently due to cognitive

appraisal. As such, individuals perceiving an event or stressor to be harmful (which, in the world

of work, could be a threat to self-esteem or job/income security), may respond to the stressor in

either an active or avoidant way in an attempt to cope. Different outcomes may be associated

with each coping style, though. In a sample of case managers, Koeske, Kirk, and Koeske (1993)

reported that control-oriented coping (similar to active coping) may mediate the impact of stress

on burnout and lower job satisfaction. In the proposed model, then, active coping is assumed to

relate to greater job satisfaction and lower burnout, while disengagement coping may relate to

higher levels of burnout and lower job satisfaction.

Stress not only influences coping, but job satisfaction and burnout as well (Day &

Livingstone, 2001; Griffin et al., 2010; Lambert & Hogan, 2009; Lloyd et al., 2002); as such, its

direct influence on job satisfaction and burnout (represented by depersonalization and emotional

exhaustion) is included in the proposed model. Stress is assumed to correlate negatively with job

satisfaction and positively with burnout. The impact of stress on burnout is supported by the

multidimensional model presented by Maslach and colleagues (Maslach & Jackson, 1984;

Maslach & Goldberg, 1998), which contends that chronic exposure to stress results in burnout.

More so, job satisfaction has been cited as a predictor of burnout (Griffin et al., 2010; Ogresta,

Rusac, & Zorec, 2008; Salehi & Gholtash, 2011), and even as a stronger predictor than

organizational commitment (Griffin et al., 2010); thus, job satisfaction is hypothesized to have a negative relationship with burnout, but no such hypothesis is presented for organizational commitment. Instead, organizational commitment is assumed to be influenced *by* both job satisfaction and burnout in the presented model. Job satisfaction has been cited as a predictor of organizational commitment in samples from several countries (Colquitt et al., 2011; Dirani & Kuchinke, 2012; Nagar, 2012; Suma & Lesha, 2013). On the other hand, existing research on the relationship between burnout and organizational commitment is less clear: studies have either cited burnout as a predictor of organizational commitment (Gemlik, Sisman, & Sigri, 2010; Leiter & Maslach, 1988; Maslach et al., 2001), organizational commitment as a predictor of burnout (Kalliath, O'driscoll, & Gillespie, 1998), or no relationship between the two (Griffin et al., 2010). In the proposed study, burnout is assumed to predict organizational commitment based on two of the three components of burnout: emotional exhaustion and personal accomplishment. Emotional exhaustion, for example, can lead to lack of energy and decreased motivation to continue with work, which could impact one's commitment to their current job and organization. Also, if personal accomplishment is low, practitioners may start to doubt their abilities and believe they are incapable of helping clients. As a result, they may consider jobs in different settings or fields. A summary of the model is included in the final hypothesis:

> H5: A model of stress, coping styles, burnout, job satisfaction, and organizational
> commitment will reveal direct and indirect effects between the variables. Specifically,
> stress reported by practitioners will have a direct effect on coping style (active or
> disengagement), job satisfaction, and burnout. (Burnout is represented by two factors in
> the model: emotional exhaustion and depersonalization.) Stress level will also indirectly
> affect job satisfaction and burnout variables via active or disengagement coping styles.

Job satisfaction will have both direct and indirect effects on organizational commitment, represented by affective, continuance, and normative commitment; the indirect effect will be mediated by level of burnout. Lastly, burnout will have a direct effect on the organizational commitment variables.

Methods

Participants

The participants in this study include 150 currently licensed and practicing professionals in the field of mental health. One hundred and seventy surveys were started and one hundred and sixty were completed. Nine respondents were deleted from the sample because they indicated "No" to "Are you currently a licensed and practicing clinician?" Another respondent was deleted from the sample due to incorrect responses to both validity items (e.g., "Please select option 3" and "Select the word 'Blue'"). As a result, the sample size consists of 150 participants.

The demographic composition of the sample was largely homogenous in gender, ethnicity, sexual orientation, and marital status, as can be seen in Table 1. Participants ranged in age from 24 to 74, with a mean age of 43 (SD = 12.71) and adequate representation of age. Most participants held either a Master's or Ph.D. degree, while some participants indicated having a Psy.D. or "Other" degree (Ed.S. n = 2 and Bachelor's n = 1; see Table 2). Degrees were most often obtained in Counseling Psychology, Social Work, or Clinical Psychology, but also in Marriage/Family Therapy and "Other" (e.g., Art Therapy, Community Counseling, Behavioral Sciences), and participants indicated working in their particular field from 6 months to 45 years, providing a range of tenure. Most (n = 100) indicated being in the field 10 years or less. Participants were commonly employed in private (solo or group) practice (n = 39), community mental health (n = 38), or hospital/medical centers (n = 42), but employment also included

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university counseling centers/college faculty/school settings (n = 14), correctional settings (n = 3), and "Other" settings (n = 14; nursing homes, non-profit organizations, etc.). Participants' tenure in their current position ranged from 1 week to 38 years, with most holding their position for 5 years or less (n = 106). Most participants indicated full-time work (40-45 hours) and reported salaries from $9,000 to $200,000 (M = $68, 235, SD = $32, 241). See Table 2 for additional information on composition of this sample.

Participants were asked to estimate the percentage of work time spent on various work tasks. Job tasks related to administration and therapy consumed most of the participants' work hours (see Table 3). Participants also estimated the percentage of their clients who presented with concerns/diagnoses related to PTSD/Trauma or personality disorders (see Table 3), as well as the level of pathology with which they usually worked. The majority of participants (n=82, 55%) reported working with "moderate" pathology, while 42 (18%) reported working with "severe" pathology and the remaining 26 (17%) worked with "mild" pathology.

Measures

Demographic Measure. Participants responded to various demographic questions (e.g. age, years of practice, current setting), in addition to briefly identifying with which client concerns they typically receive for therapy (e.g., trauma/PTSD) and percentage of work hours devoted to various work tasks (e.g., therapy, paperwork, assessment). Participants also ranked their top three work stressors; examples include role ambiguity, time pressure, and bureaucracy. See Appendix B for the demographic measure.

Perceived Stress. The 10-item Perceived Stress Scale (PSS10) was used to assess how participants view the extent of stress from current life situations (Cohen, Kamarck, & Mermelstein, 1983). The PSS10 is slightly/moderately correlated with the life events scales, but

asks participants to consider stressful situations from the past month instead of the past year (Cohen et al., 1983). The original PSS includes 14 items, to which participants respond based on a 5-point Likert scale (*0=Never, 4=Very Often*). Cohen et al. (1983) reported alpha coefficients of .84-.86 across their first three samples, suggesting sufficient internal consistency. In a more recent analysis, the internal reliability of the PSS14 was slightly lower (α=.75); as such, four items with the lowest factor loadings were dropped, which resulted in the PSS10 with an alpha coefficient of .78 (see Appendix C for PSS10 items; Cohen & Williamson, 1988). Cronbach's alpha for the PSS10 based on the current study is .86, demonstrating good reliability (George & Mallery, 2003); alpha would not increase by deleting any items (see Table 4).

Burnout. Burnout experienced by participants was measured by the Maslach Burnout Inventory-Human Services Survey (MBI-HSS; Maslach & Jackson, 1981). Twenty-two items are used to assess burnout in relation to three dimensions: emotional exhaustion (EE; 9 items), depersonalization (DP; 5 items), and reduced personal accomplishment (PR; 8 items). Emotional exhaustion, the main component of burnout, refers to the emotional draining of one's work and relates to the stress factor of burnout (Maslach & Jackson, 1981; Wheeler, Vassar, Worley, & Barnes, 2011). Depersonalization refers to distancing or disengaging oneself from the clients or job tasks, and Personal Accomplishment is feeling competent or productive in one's job. See Appendix D for the MBI-HSS.

The original burnout inventory, MBI, assessed both frequency and intensity of burnout among respondents; more recently, however, researchers tend to assess frequency of burnout in studies. Thus, participants respond to items on a 7=point Likert scale, with *0=Never* and *6=Every Day*. The original MBI had respectable internal consistency (α=.89, .77, and .74 for EE, DP, and PA, respectively; Maslach & Jackson, 1981). A recent meta-analysis of MBI revealed

respectable internal consistency coefficients as well (Wheeler et al., 2011). The average

coefficient alphas reported for EE, DP, and PA were .87, .71, and .76, respectively. Wheeler and

colleagues (2011) found support for the three-factor model (EE, DP, and PR) originally reported

by Maslach and Jackson (1981). Cronbach's alpha levels for the MBI-HSS in the current sample

are higher than previous findings: EE (α = .92), DP (α = .82), and PA (α = .77; see Table 4). It

should be noted that for the 4-item DP scale, Cronbach's alpha would increase to .84 if the fourth

item were deleted; however, researchers refrained from deleting additional items from the scale,

especially for a small increase in alpha.

Coping Strategies. In order to assess the coping styles of participants, the COPE

Inventory was used (Carver, Scheier, &Weintraub, 1989). Specifically, the COPE Inventory

includes items relating to problem-focusing coping, emotion-focused coping, and avoidance. The

COPE Inventory was chosen for the study because it is informed by Lazarus and Folkman's

(1984) theory of stress and coping. The inventory includes five scales of problem-focused coping

(active coping, planning, suppression, restraint, seeking instrumental social support), five scales

of emotion-focused coping (seeking emotional social support, positive reinterpretation,

acceptance, denial, turning to religion), and four scales of avoidance/less useful coping (denial,

venting emotions, behavioral disengagement, mental disengagement, alcohol/drug use). Each

scale has 4 items for a total of 60 items (see Appendix E). The Cronbach's alphas for internal

consistency and 8-week test-rest range from .45-.92 and .46-.86, respectively (Carver et al.,

1989). Aside from mental disengagement (α=.45), each scale demonstrated adequate reliability

(>.62). For the current sample, two newly-created constructs of active and disengagement coping

achieved Cronbach's alpha levels of .86 and .71, respectively (see Table 4).

Job Satisfaction. Job satisfaction was used to assess an individual's view of their job as either positive or negative. In order to measure job satisfaction, participants completed a shortened version of Brayfield and Rothe's (1951) Job Satisfaction Index (JSI; see Appendix F). The original job satisfaction measure has been commonly used in job outcome research, and consists of 18 items to which participants respond using a 5-point Likert scale (*Strongly Agree to Strongly Disagree*). Reliability coefficients of .87 and .92 have been reported for the original JSI (Agho, Price, & Mueller, 1992; Brayfield & Rothe, 1951). Judge and Klinger (2008) have shortened the 18-item JSI to 5 items, while maintaining the 5-point Likert structure (Judge & Klinger, 2008; Judge, Heller, & Mount, 2002). Based on their research, the 5-item JSI maintains internal consistency alpha of .80 or greater. For the current sample, the JSI achieved Cronbach's alpha of .89, demonstrating good reliability (see Table 4).

Organizational Commitment. The Organizational Commitment Questionnaire (OCQ; Allen & Meyer, 1990) was used to assess engagement in and commitment to one's current organization. The OCQ measures three components of commitment: affective, which consists of emotional ties to the organization; continuance, in which one considers the costs associated with leaving the organization; and normative, which is the responsibility one feels to stay with the organization. The OCQ consists of 8 items for each of the three commitment components, for a total of 24 items (see Appendix G for samples of items). Participants are asked to respond to items on the OCQ with the use of a 5-point Likert scale, which range from "strongly disagree" to "strongly agree." Higher scores represent a stronger willingness to stay with the organization. Support has been provided for the reliability of the OCQ, with alpha levels ranging from .74 to .87 for affective commitment, .73 to .81 for continuance, and .65 to .79 for normative (Allen & Meyer, 1990; Cohen, 1996; Dunham, Grube, & Castañeda, 1994). Cronbach's alphas of the

OCQ subscales for the current sample were similar to previous findings: .86 for Affective Commitment, .80 for Continuance Commitment, and .71 for Normative Commitment, indicating adequate to good internal consistency (see Table 4). Cronbach's alphas would not be higher if any items were deleted.

Procedures

In order to estimate sample size, two a priori power analyses were performed using G*Power 3.1, a software used for power analysis (Faul, Erdfelder, Buchner, & Lang, 2009). Effect size was estimated based on a review of literature in which research studies reported the correlation coefficients between variables used in the current study. Then, the correlation coefficients were squared to achieve effect sizes, which were considered in determining effect size for computation (see Table 5). Most variables reached effect sizes of .10 or greater, with many reaching .20 and beyond. In consideration of findings from the literature review, an effect size of .15 was determined for the sample size computation. Several of the goals of this study include comparing group means; therefore, the first computation was completed based on a MANOVA test estimated with 3 groups and 4 response variables (aligned with hypotheses). Results from this computation suggested that 81 participants would be needed in order to detect effects at power level .95 ($\alpha = .05$). A second goal of the study is to examine a proposed model in which 6 variables were hypothesized; as such, the second computation was completed based on a Linear Multiple Regression (R^2 increase) with 6 variables (aligned with SEM diagram). Results revealed that 146 participants were needed for detecting effects at power level .95 ($\alpha = .05$). As such, a sample size of 150 participants was identified.

Participants were recruited for the study three ways: by listserve, by licensure list, and by snowball sampling. First, participants were recruited via Divisions 17 (Counseling Psychology)

and 29 (Advancement of Psychotherapy) of the American Psychological Association. An e-mail was distributed to the divisions' listserves and included a description of the study and the survey link (see Appendix H for e-mail). After the listserve method failed to attract an adequate sample size of 150 participants, the Behavioral Sciences Regulatory Board (BSRB) was contacted for a list of licensed mental health workers in the state. The list contained 12,687 licensed practitioners, which was categorized by 6 license types: Psychologists, Social Workers, Professional Counselors, Master Level Psychologists, Marriage & Family Therapists, and Addiction Counselors. Three rounds of e-mails were distributed for participation solicitation with the BSRB list. First, 202 recipients were randomly selected by identifying every 63rd individual on the list. Five e-mails were returned as undeliverable, due to recipients' full mailbox, an incorrect address, or rejection by the recipient's system. To prevent resubmitting to a previous e-mail address, practitioners from round 1 were deleted from the list. About a week later, a second round was sent to 595 recipients who were randomly selected by identifying every 21st individual on the list. Twenty-one e-mails were returned as undeliverable. Recipients from round 2 were deleted from the list to prevent receipt of the survey again. For round 3, 610 recipients were identified by selecting every 18th individual on the list. Twenty-five e-mails were returned as undeliverable. Lastly, snowball sampling was used in an effort to increase sample size. For example, participants were encouraged to disseminate the survey to other known licensed practitioners in the mental health field.

Upon accessing the link and starting the survey, participants were asked if they were currently licensed and practicing in the field of mental health. If they answered "no" to this question, they were directed to the exit with a message stating "Thank you for your interest in this study. Unfortunately, only licensed and practicing clinicians qualify for participation." If

they answered "yes" to the question, they were welcome to complete the survey and could withdraw at any time.

Plan of Analyses

Sample size did not allow evaluation of hypotheses using latent constructs given the ratio of sample size (n=150) to variables (n=121); thus, manifest variables were used to address the study's hypotheses. Prior to conducting analyses of the hypotheses with manifest variables, however, confirmatory factor analyses (CFA) were performed separately for each scale in order to increase confidence that the manifest variables represented their intended latent construct (see Table 6). CFA was selected over exploratory factor analysis (EFA) since previous published research indicates a structural model for each of the measures. The CFA was conducted using Mplus, Version 6 (Muthen & Muthen, 2010) with the maximum likelihood robust (MLR) estimator. A scale was "identified" using the fixed-factor method: setting the scale variance to '1' and freely estimating the loadings.

Fit of the data to a given model was determined via the comparative fit index (CFI) and the root-mean-square error of approximation (RMSEA). The criteria for acceptable model fit were a CFI > .90 and RMSEA < .08. In cases of model misspecifications (e.g., CFI < .90), factor loadings were first examined to identify sources of misfit: a loading of R^2 < .25 was interpreted at a poor item loading and was dropped in subsequent models. In addition, modification indices (MI) were also examined to identify potential correlated residuals among items and when there were multiple latent factors. When MI indicated a significant improvement in model fit by allowing correlated residuals, items pairs were examined to determine if correlating the residuals was conceptually justified (e.g., similar wording). In such cases, the correlated residual was added to the subsequent models. Modifications were made when necessary until the model

achieved adequate fit. The results of the CFA determined which items would be used to compute manifest scale scores (i.e., means) in all subsequent analyses.

Descriptives. Following CFA, reliability analyses were conducted to determine internal consistency of the measures. Cronbach's reliability $\alpha > .7$ is considered acceptable fit (George & Mallery, 2003), with a higher α indicating greater internal reliability. All scales demonstrated adequate reliability based on Cronbach's alpha (Table 4). Correlations between the manifest variables were weak to strong and represented in Table 8.

Group Comparisons. In order to address the first three hypotheses of the study, analyses were performed in SPSS Version 22.0. First, bivariate intercorrelations among hypothesized demographic characteristics and manifest variables were examined (Table 7). In order to examine the relationship between perceived stress, coping, burnout, job satisfaction, and organizational commitment (*Hypothesis 1*), bivariate intercorrelations were considered. To address whether experience in the field affected active coping and stress (*Hypothesis* 2), a MANOVA was conducted. Years of experience in the field was first recoded into a categorical variable from a continuous variable. Three groups were created for years of experience: 1) practitioners in their field for up to 5 years (low experience), 2) those in their field for 6-14 years (moderate experience), and 3) those in their field for 15 or more years (high experience). Tukey's post hoc analysis was selected to determine between-group differences.

In order to examine differences in stress and burnout by work setting and client concerns (*Hypothesis 3*), MANOVA analyses were performed. Work setting was already coded as a categorical variable, but client concerns of PTSD/trauma and personality disorders were continuous variables. In order to analyze via MANOVA, the continuous variables were recoded into categorical variables. As such, practitioners who indicated that less than 25% of their clients

presented with PTSD/trauma were recoded as "low" (n=54), 25-49% of clients presenting with

PTSD/trauma were recoded as "low/moderate" (n=35), 50-74% recoded as "moderate/high"

(n=30), and above 74% recoded as "high" (n=31). For those working with personality disorders,

if fewer than 20% of their clients presented with personality disorders, the variable was coded as

"low" (n=82), 20-49% as "moderate" (n=55), and above 60% as "high" (n=13). Categories were

selected in an attempt to create balanced groups while maintaining practical groupings based on

percentages; while this attempt produced balanced groups for PTSD/trauma grouping, the

personality disorder groupings vary from 82 responses in the low category to 13 responses in the

high category. Tukey's post hoc analysis was selected to determine between-group differences.

Path Analyses. In order to address the fourth (*effect of coping on job satisfaction and*

burnout) and fifth (*direct and indirect effects among manifest* variables) hypotheses, regressed

paths within an SEM framework were conducted using Mplus, Version 6 (Muthen & Muthen,

2010). Analyses of the hypothesized regression paths among scales were conducted within an

SEM framework because it provided greater control over different sources of error that can

undermine the trustworthiness of results when non-SEM methods are used. The analyses

proceeded as follows. First, a model was estimated that included all of the specified regressive

pathways. This model's fits statistics served as a base model from which fit statistics from

subsequent models could be statistically evaluated. Second, each regressive path was evaluated

separately in subsequent models by setting the path to zero and comparing the change in chi-

square between models. A chi-square change per degree of freedom of $p < .01$ indicated that the

model with the path set to zero fit as well as the previous model, and thus was considered not

statistically significant (Cheung & Rensvold, 2002; Kline, 2011; Little, Card, Slegers, &

Ledford, 2007). When a model indicated a non-significant path, that path was set to zero in subsequent models.

<div align="center">**Results**</div>

Confirmatory Factor Analysis

     Perceived Stress Scale (PSS). The PSS contains 10 items loading on a single latent factor. The data did not adequately fit the original 10-item model ($\chi^2(35) = 103.915$, $p < .05$, CFI $= .866$, RMSEA $= .115$, CI $= .083$-$.134$; see Table 6, Row 1).

     Modification indices (MI) identified correlated residuals of items 1 and 9 as a source of misfit and examination of the items suggested the correlation was due to similarity of item wording ("...upset because of something that happened unexpectedly" and "...angered because of things that were outside of your control"). A new model was estimated in which the residuals were allowed to correlate, and although there was substantial improvement in fit, the model did not achieve adequate fit (Table 6, Row 2). MI indicated that the residuals for items 7 and 10 were correlated, and inspection of the items suggested the correlation was due to both items being wording in the opposite direction of other items. (All items worded in an opposite direction were recoded prior to analyses to match the directionality of the other items). With items 7 and 10 allowed to correlate, the model achieved an adequate fit ($\chi^2(33) = 62.218$, $p < .05$, CFI $= .935$, RMSEA $= .077$, CI $= .047$-$.106$; Table 6, Row 3). Although the confidence interval for RMSEA included values beyond .08, no further modifications were made in order to preserve the integrity of the original 10-item scale.

     Maslach Burnout Inventory-Human Services Survey (MBI-HSS). The MBI-HSS contains 22 items loading onto three latent factors: Emotional Exhaustion (9 items), Depersonalization (5 items), and Personal Accomplishment (8 items). The data did not

adequately fit the original 3-factor model ($\chi^2(206) = 459.107$, $p < .05$, CFI = .828, RMSEA = .091, CI = .079-.102, Table 6, Row 1). Results of a follow-up analysis indicated that PA was a source of misfit, as the factor correlated negatively with EE and DP (-.437 and -.458, respectively). As such, PA items were dropped from the model, which resulted in an improvement in fit for this model (see Table 6, Row 2); however, fit did not reach an acceptable level. MI identified correlated residuals of items 1 and 2 as a source of misfit and so the residuals were allowed to correlate, but the model did not achieve adequate fit (Table 6, Row 2). Next, item 22 (from the DP scale) was deleted due to a low loading with the factor ($R^2=.151$), but model still did not achieve an adequate fit (Table 6, Row 3). Review of the MI indicated correlated residuals of items 6 and 16 as a source of misfit, and with these items correlated, the model resulted in an adequate fit (Table 6, Row 4). To ensure best fit to the model, an additional model was assessed in which DP and EE were combined into a single factor. This modification did not result in a significant change in fit and was rejected (Table 6, Row 5). As such, the final burnout factors were the 8-item EE scale and 4-item DP scale.

COPE Inventory. The COPE Inventory includes 60 items loading onto 15 latent factors of 4 items each: Positive Reinterpretation/Growth, Active Coping, Restraint, Acceptance, Suppression of Competing Activities, Planning, Focus on/Venting of Emotions, Use of Instrumental Social Support, Use of Emotional Social Support, Humor, Religion, Mental Disengagement, Behavioral Disengagement, Denial, and Substance Use. In an effort to improve reliability of the COPE Inventory for this sample, as well as predict a new set of factors that align with active and avoidant coping styles, a factor analysis was conducted using the original subscales as predictors.

Existing literature was consulted to develop a priori hypotheses for factor loadings. Many studies have cited the COPE Inventory as assessing three coping styles: problem-focused, emotion-focused, and avoidant (e.g., Iglesias-Rey et al., 2013; Litman, 2006; Schnider, Elhai, & Gray, 2007). Similarly, Litman (2006) derived four factors from the 15 subscales: 1) Problem-Focused, comprising of the Active, Planning, and Suppression scales, 2) Emotion-Focused, comprising of the Restraint, Positive Reinterpretation, Acceptance, and Humor scales, 3) Social Support, comprising of the Emotional Support, Instrumental Support, and Venting of Emotions scales, and 4) Avoidant, comprising of the Behavioral Disengagement, Mental Disengagement, Denial, and Substance Use scales. For subsequent analyses, the Problem-Focused and Emotion-Focused were combined into a single factor, which overlapped with approach/active motives; conversely, the Avoidant scale overlapped with avoidance motives. This provides initial support for combining Active, Planning, Suppression, Restraint, Positive Reinterpretation, Acceptance and Humor scales into a factor representing Active coping styles, while Behavioral Disengagement, Mental Disengagement, Denial, and Substance Use scales may be combined to represent Avoidant coping. However, previous research, as presented by Litman (2006), demonstrates mixed findings regarding Humor and Substance Use subscale loadings; as such, the two subscales were not considered for active and avoidant factor loadings in the current study.

In order to determine latent variables for active and avoidant coping styles, the subscales of Active, Planning, Suppression, Restraint, Positive Reinterpretation (PR), and Acceptance were loaded onto "Active," while Behavioral Disengagement (BD), Mental Disengagement (MD), and Denial were loaded onto "Avoidant." The data did not adequately fit the initial model (χ^2(593) = 1097.198, p < .05, CFI = .657, RMSEA = .075, add CI = .068-.082, Table 6, Row 1). As such, alternative models were considered to identify sources of misfit. Based on the findings presented

by Litman (2006), Active, Planning, and Suppression scales were loaded onto "Problem-Focused" while Positive Reinterpretation, Restraint, and Acceptance scales were loaded onto "Emotion-Focused." Avoidance loadings remained the same; however, this model did not achieve an adequate fit (Table 6, Row 2).

Review of standardized estimates indicated that the Emotion-Focused items loaded poorly onto the factor; as such, Emotion-Focused was dropped as a factor and only Problem-Focused and Avoidance factors were considered in the model. Even after dropping Emotion-Focused, the model did not achieve adequate fit (Table 6, Row 3), as the Suppression subscale loaded poorly onto the Active coping factor, with loadings ranging from .206 to .487 for the 4 items. Furthermore, Acceptance and Restraint loaded poorly onto Emotion-Focused factor, with standardized estimates ranging from .185 to .432 for 7 of the 8 items. As such, an alternative model was considered in which Suppression, Acceptance, and Restraint subscales were dropped and Active, Planning, and PR subscales loaded onto a single 12-item "Active" factor. BD, MD, and Denial items, on the other hand, loaded onto a 12-item "Avoidant" factor. This model indicated an improvement in fit, but still not acceptable (Table 6, Row 4); furthermore, review of standardized estimates indicated that the BD, MD, and Denial items loaded poorly onto the Avoidant coping factor (loadings ranged from .104 to .444 for the 12 items). However, the BD and MD scales were strongly associated (.815) with each other and less so with Denial (.472 and .438, respectively). As a result, a new model was estimated in which the Avoidant coping factor was separated into two factors: Disengagement coping factor consisting of the BD and MD items and Denial coping factor consisting of the 4 Denial items. This model, consisting of "Active," "Disengagement," and "Denial" factors did not result in improvement of fit (Table 6, Row 5).

In sequential follow-up analyses, and in alignment with identified sources of misfit, the first MD item was deleted due to low loading with the factor (R^2=.012); however, this model did not result in improvement of fit (Table 6, Row 6) and the first MD item was re-included. Instead, standardized estimates identified poor loading of the fourth MD item (R^2=.122) and was deleted, resulting in improvement of fit (Table 6, Row 7).

In an additional estimation of the model, the 8-item Active coping factor was assessed for fit and demonstrated adequate fit (see Table 6, Row 8). However, for purposes of the study and proposed model, an Avoidant coping factor needed to be included in the model as well. As such, in sequential steps, additional models were estimated and failed to demonstrate improved fit until a model consisting of the 8-item Active, 7-item Disengagement (the first MD item was removed), and 4-item Denial scales were represented (Table 6, Rows 9-11). Since only one factor was needed to represent avoidant coping and Disengagement factor had stronger loadings, the Denial factor was dropped. As a result, the data adequately fit the model consisting of the 8-item Active scale and 7-item Disengagement scale ($\chi^2(89) = 116.168$, $p < .05$, CFI = .953, RMSEA = .045, CI = .016-.067, Table 6, Row 12).

Job Satisfaction Index (JSI). The JSI contains 5 items loading onto a single factor of job satisfaction. The data from the sample was an excellent fit of the original 5-item model ($\chi^2(5) = 8.345$, $p < .05$, CFI = .985, RMSEA = .067). As such, the original 5 JSI items adequately represent the variable of job satisfaction (see Table 6, Row 1).

Organizational Commitment Questionnaire (OCQ). The OCQ includes 24 items loading onto 3 factors of 8 items each: Affective Commitment (AC), Continuance Commitment (CC), and Normative Commitment (NC). The data did not adequately fit the original 24-item model ($\chi^2(252) = 737.720$, $p < .05$, CFI = .509, RMSEA = .113, CI = .104-.123, Table 6, Row 1),

and in a follow-up estimation, data did not fit for the original 3-factor model either ($\chi^2(248) =$ 419.129, $p < .05$, CFI = .827, RMSEA = .068, CI = .056-.079, Table 6, Row 2). MI identified correlated residuals between the 5th and 8th AC items as a potential source of misfit, and examination of the items suggested the correlation was due to similarity of item wording ("I do not feel like 'part of the family' at my organization" and "I do not feel a strong sense of belonging to my organization"). Therefore, their residuals were allowed to correlate, but failed to produce adequate fit (Table 6, Row 3). Similar results were found for the 1st and 7th NC items, in which these items shared similar item wording. As a result, their residuals were allowed to correlate (see Table 6, Row 4). Subsequent review of standardizes estimates indicated poor loadings of several items, resulting in the following items being deleted: the 3rd AC item was deleted due to poor loading ($R^2 = .056$) and identified conceptual difference (e.g., this item focused on adopt the organization's problems, while the other items focused on attachment or belonging to the organization), as was the 3rd NC item (negatively scored; $R^2 = .157$), the 1st NC item ($R^2 = .069$), the 4th CC item (negatively scored; $R^2 = .091$), 1st CC item (negatively scored; $R^2 = .135$), and the 7th NC item ($R^2 = .152$). See Table 6, Rows 5-9 for model results. As a result of these modifications, the model indicated an improved and adequate fit ($\chi^2(130) = 230.842$, $p < .05$, CFI = .911, RMSEA = .062, Table 6, Row 9), resulting in a 7-item AC scale, 6-item CC scale, and 5-item NC scale.

In an effort to obtain an overall commitment score, the three subscales were then entered together as a single factor. This model did not demonstrate an improvement in fit (see Table 6, Row 11), and after a review of the standardized estimates, the poor fit was likely due to the low loadings of the 6 CC items; however, entering the AC and NC items as a single factor and the CC items as a second factor did not improve fit either (Table 6, Row 10). As such, both of the

single-factor and two-factor models were rejected in lieu of the better fit of the three-factor model in which organizational commitment is identified by three factors: 7-item AC scale, 6-item CC scale, and 5-item NC scale.

Descriptive Analyses

Descriptive analyses identified the reported levels of stress, burnout, and occupational attitudes among licensed practitioners. Scores on the 10-item PSS ranged from 0-40, and the average for this sample fell on the lower end of the range (M=14.29, SD=5.88, Mo=16.00). Furthermore, practitioners reported, on average, a high level of personal accomplishment (M=40.23, SD=5.43, Mo=41.00) and low level of depersonalization (M=4.28, SD=4.57, Mo=4.28), but a moderate level of emotional exhaustion (M =20.93, SD=11.14, Mo=15.00). Overall, about 29% (n=44) of participants indicated high levels of emotional exhaustion, 29% (n=43) indicated moderate levels, and 42% (n=63) indicated low levels. Only 8% (n=12) indicated high levels of depersonalization, while 15% (n=23) indicated moderate levels and 77% (n=115) indicated low levels. For personal accomplishment, 70% (n=105) indicated high levels, 22% (n=33) indicated moderate levels, and 8% (n=12) indicated low levels. Job satisfaction was high in this sample (M=20.38, SD=3.74, Mo=20.00) while organizational commitment was moderate (AC M=33.76, SD=9.05, Mo=34.00; CC M=26.21, SD=8.29, Mo=34.00; NC M =18.87, SD=5.89, Mo=22.00).

Participants were asked to rank job characteristics that they found to be the most stressful. The stressors that were most often ranked #1 included "bureaucratic concerns" (n = 20), time pressure (n = 14), and pay (n = 9), stressors most commonly ranked as #2 were time pressure (n = 22), pay (n = 14), and work-life conflict (n = 10), and stressors most often ranked as #3 were work-life conflict (n = 16), pay (n = 16), and bureaucratic concerns (n = 15). When

applying weighted scores to the ranked stressors, time pressure was most often ranked as a top three stressor ($\sum$= 96), followed by bureaucratic concerns ($\sum$= 92), pay ($\sum$= 61), work-life conflict ($\sum$= 60), hours ($\sum$= 43), and management ($\sum$= 42). Other identified concerns related to insurance, new program implementation, documentation, colleague/employee cohesion and relationships, and technology.

Based on initial analyses, the licensed practitioners in this sample appear to be experiencing emotionally exhaustion but have low levels of stress, feel personally accomplished, and are generally satisfied with their jobs.

Correlations among Variables

Bivariate intercorrelations were examined for all dependent variables and demographic factors of age, gender, years in practice, hours worked per week, annual income, working with PTSD/Trauma, working with Personality Disorders, and estimated level of client pathology (Table 7).

Hypothesis 1. In order to address Hypothesis 1 (*Perceived stress level will have significant positive bivariate correlations with burnout and avoidance coping, and significant negative bivariate correlations with active coping, job satisfaction, and organizational commitment*), bivariate intercorrelations among the variables of stress, burnout, coping style, job satisfaction, and organizational were examined. Correlations were in the hypothesized direction (see Table 7). Perceived stress (PS) was strongly and positively correlated with emotional exhaustion (EE), moderately and positively correlated with depersonalization (DP), and moderately and negatively associated with personal accomplishment (PA); it seems sensible that if perceived stress is elevated among professionals, then EE and DP are likely to be elevated as

well while PA is likely to be lower. Furthermore, PS and disengagement coping were moderately and positively associated. These relationships provide preliminary support for Hypothesis 1.

Bivariate intercorrelations provided partial support for the second part of the hypothesis. Perceived stress had a small, negative relationship with AC, which lends support for Hypothesis 1. However, perceived stress also had a small, positive relationship with CC, which was unexpected. These findings suggest that high levels of stress are associated with lower affective commitment, which relates to happiness in one's job, and higher continuance commitment, which involves limited alternatives available. The large and positive relationship between PS and job satisfaction (JS) aligns with Hypothesis 1 as well, in that those reporting higher levels of stress are also reporting lower levels of job satisfaction. Or, the inverse, those reporting lower levels of stress are reporting high levels of job satisfaction. Also in support of Hypothesis 1, active coping had a small, negative relationship with PS.

Correlations among Latent Variables. The remaining bivariate intercorrelations revealed interesting associations as well. Correlations among the three subscales of the MBI-HSS (EE, DP, and PA) were moderate to strong. EE was strongly and positively correlated with DP, while PA was negatively and moderately correlated with EE and DP. The correlations among the burnout subscales are to be expected since high emotional exhaustion and depersonalization in combination with low personal accomplishment indicate burnout (Maslach & Jackson, 1984). Bivariate intercorrelations were also considered for the three subscales of the OCQ (Affective, Continuance, and Normative Commitment). Continuance Commitment (CC) failed to reach significance with Affective (AC) or Normative (NC), but AC and NC were strongly and positively related. There were also several significant correlations between the burnout and commitment subscales. AC was moderately and negatively correlated with EE,

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minimally and negatively correlated with DP, and minimally and positively correlated with PA. CC held a small and positive correlation DP and a small and negative correlation with PA. NC failed to reach significant associations with the variables.

AC demonstrated a minimally, negative correlation with disengagement coping, while CC demonstrated minimal, positive correlations with the less favorable outcomes of DP and PS. CC was also minimally and negatively associated with JS. Disengagement coping was moderately and negatively related to active coping, JS, and PA, while positively correlated with EE and DP, as generally expected. Active coping, on the other hand, was moderately and positively correlated with PA, while minimally and negatively associated with PS.

It is conceivable that job satisfaction is strongly and positively correlated with AC, and moderately and positively associated with PA, as each variable suggests a positive association with one's work. In essence, high satisfaction is associated with higher commitment to the organization and greater levels of perceived accomplishment (or vice versa). JS also achieved large, negative correlation with EE and moderate, negative correlation with DP. As such, high levels of EE and DP in one's work is associated with low levels of job satisfaction.

Correlations among Demographic and Professional Characteristics. Tenure, measured by years of practice in the field, was associated with greater AC, JS, active coping, and PA, and lower EE. Years of practice also negatively correlated with CC; the longer one has been practicing in the field, the less likely they are to "need" to stay with the current organization or position. Age, unsurprisingly, was strongly and positively related to years of practice in the field. Furthermore, it was positively correlated with income, PA, active coping, job satisfaction, and AC, while negatively correlated with working with PTSD/trauma or personality disorders, EE, DP, disengagement coping, and PS. Annual income obtain minimal-moderate positive

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correlations with years of practice in the field and hours worked per week, as would be expected, and minimally and negatively correlated with gender. Greater income was also associated with greater AC and JS.

Working with client concerns of PTSD/trauma and personality disorders was often associated with less favorable occupational outcomes. For example, working with PTSD/trauma and personality disorders was positively associated with EE, estimated level of client pathology, and PS, and negatively associated with AC. Working with personality disorders was negatively associated with JS and PA and positively associated with disengagement coping. Furthermore, those working with PTSD/trauma were also more likely to work with personality disorders.

In summary, the more experienced and older practitioners may engage in active coping more often, experience greater JS, PA, and AC, and experience less EE. A greater annual income seems to be associated with AC and JS for practitioners in this sample as well. Lastly, those working with demanding client concerns, such as PTSD/trauma or personality disorders, may notice greater EE and PS with lower JS and PA.

Group Differences

In order to analyze stress, burnout, job satisfaction, and organizational commitment based on gender, race/ethnicity, sexual orientation, and marital status, MANOVA analyses were conducted. No significant differences were found based on gender, race/ethnicity, sexual orientation, or marital status.

Hypothesis 2. Results of a MANOVA provided support for the second hypothesis (*Mental health practitioners with more professional practice experience will be more likely to engage in active coping and experience lower levels of stress*). For the three groups (low, moderate, and high experience), there was a significant effect of years of experience on active

coping and stress at the $p < .05$ level (F(4,292) = 3.77, $p < .05$, Wilk's $\lambda = .904$, partial $\eta^2 =$ .049). Univariate tests indicated statistically significant differences for active coping (F(2,147) = 4.761, $p < .05$, partial $\eta^2 = .061$) and stress (F(2,147) = 4.300, $p < .05$, partial $\eta^2 = .055$) based on years of experience. Following Tukey's post hoc comparisons, active coping was significantly higher for practitioners with more than 15 years of experience ($\textsc{m} = 27.558$, SD = 4.129) when compared with practitioners with moderate experience ($\textsc{m} = 24.884$, SD = 3.917; $p < .05$) but not when compared with practitioners with low experience ($\textsc{m} = 26.078$, SD = 4.266, $p = .153$). No statistically significant differences were found between the moderate experience condition and the low experience condition on active coping ($p = .292$). Perceived stress was significantly lower among practitioners with more than 15 years of experience ($\textsc{m} = 12.12$, SD = 5.58) compared to those with moderate ($\textsc{m} = 15.23$, SD = 6.72; $p < .05$) and low experience ($\textsc{m} = 15.11$, SD = 5.13; $p < .05$). However, the moderate experience condition did not significantly differ from the low experience condition in levels of perceived stress ($p = .994$). The results suggest, then, that the practitioners with greater tenure, or more years of experience in the field, reported more active coping and lower levels of stress than practitioners with less experience in the field.

Hypothesis 3. To test the third hypothesis (*Perceived stress and reported burnout will be higher for practitioners working in inpatient or hospital settings compared to private settings*), a MANOVA was conducted. The results support hypothesis 3, suggesting a statistically significant difference in perceived stress and burnout based on practitioners' work setting (F(5,144) = 2.135, $p < .05$; Wilk's $\lambda = .749$, partial $\eta^2 = .070$). Univariate tests indicated that work setting had a significant effect on perceived stress (F(5,144) = 2.920, $p < .05$; partial $\eta^2 = .092$), emotional exhaustion (F(5,144) = 3.401, $p < .05$; partial $\eta^2 = .106$), depersonalization (F(5,144) = 4.655, $p < .05$; partial $\eta^2 = .139$), and personal accomplishment (F(5,144) = 4.044, $p < .05$; partial $\eta^2 =$

.123). There were statistically significant differences in PS, EE, DP, and PA for practitioners in private practice (solo or group) settings compared to those in public (hospital, community mental health) settings. Tukey's post hoc analysis was conducted to determine which groups were significantly different. Practitioners in community mental health settings reported greater stress (Μ = 16.45, SD = 5.99; p = .021), emotional exhaustion (Μ = 25.53, SD = 11.71; $p < .05$), and depersonalization (Μ = 6.34, SD = 5.25; $p < .05$), as well as lower personal accomplishment (Μ = 38.45, SD = 6.18; $p < .05$) compared to practitioners in private practice settings (Μ = 12.31, SD = 4.82; Μ = 15.64, SD = 8.09; Μ = 1.72, SD = 2.49; Μ = 43.31, SD = 4.50, respectively).

Furthermore, practitioners working in the hospital (inpatient, residential, or outpatient) or medical center settings reported greater depersonalization (Μ = 4.71, SD = 4.47, $p < .026$) and lower personal accomplishment (Μ = 39.55, SD = 5.23, $p < .017$) than those working in private practice (Μ = 1.72, SD = 2.49; Μ = 43.31, SD = 4.50, respectively). Thus, practitioners working in certain public settings seem to experience higher levels of burnout, via greater emotional exhaustion and depersonalization and lower personal accomplishment, compared with those working in private practice.

As a follow-up, organizational commitment was considered based on working setting via MANOVA analysis and reached statistical significance (F(5,144) = 3.789, $p < .05$; Wilk's λ = .688, partial η^2 = .117). Work setting demonstrated a significant effect on affective commitment (F(5,144) = 6.858, $p < .05$; partial η^2 = .192) and continuance commitment (F(5,144) = 2.593, p = .05; partial η^2 = .083), but not normative commitment (F(5,144) = 1.365, p = .241; partial η^2 = .045). Practitioners in private practice reported significantly greater affective commitment (Μ = 35.67, SD = 4.70) to their positions/company than practitioners in hospital settings (Μ = 30.38, SD = 6.88; $p < .05$), academic settings (Μ = 28.21, SD = 4.66; $p < .05$), and community mental

health settings ($M = 29.39$, SD = 5.96; $p < .05$). Furthermore, they reported significantly lower

continuance commitment ($M = 22.33$, SD = 8.16) than practitioners in community mental health

($M = 28.05$, SD = 7.59, $p < .05$).

The second part of Hypothesis 3 involved differences in stress and burnout depending

upon client concerns; specifically, it is hypothesized that practitioners more likely to work with

PTSD/trauma or personality disorders will experience greater levels of stress and burnout. The

MANOVA results suggested a statistically significant difference in perceived stress and burnout

based on presenting client concerns of PTSD/trauma ($F(12,346.531) = 1.884$, $p < .05$; Wilk's λ =

.847, partial $\eta^2 = .054$) but not personality disorders ($F(8,264) = 1.237$, $p = .278$; Wilk's λ = .929,

partial $\eta^2 = .036$). Working with PTSD/trauma had a significant effect on emotional exhaustion

($F(3,135) = 4.883$, $p < .05$; partial $\eta^2 = .098$) and perceived stress ($F(3,135) = 3.032$, $p < .05$;

partial $\eta^2 = .063$). Tukey's post hoc comparison was considered for PTSD/trauma; results

suggest that practitioners in the "high" category (e.g., practitioners whose client load includes at

least 75% PTSD/trauma concerns) reported higher emotional exhaustion ($M = 27.00$, SD = 13.00,

$p < .05$) and stress ($M = 17.23$, SD = ,7.23, $p < .05$) than those in the "low" category (e.g.,

working with client load of less than 25% PTSD/trauma concerns; $M = 17.98$, SD = 8.82 and M =

13.23, SD = 4.94, respectively). No such differences were found for the "low/moderate" or

"moderate/high" categories.

Hypothesis 4. For hypothesis 4, it was hypothesized that job satisfaction and burnout

would vary depending on coping style; specifically, practitioners engaging in avoidance coping

styles, measured by mental and behavioral disengagement, would report lower levels of job

satisfaction and greater burnout. The inverse was expected for practitioners engaging in active

coping styles. Upon examining the hypothesized regressed paths (Table 9), Hypothesis 4 was

poorly supported. Disengagement coping significantly predicted greater depersonalization, but failed to predict emotional exhaustion or job satisfaction. Furthermore, active coping failed to predict job satisfaction or burnout. For the most part, then, coping style did not predict organizational outcomes of job satisfaction and burnout. However, in an exploratory analysis conducted as a follow-up in SPSS, coping style significantly predicted stress ($F(2,147=19.364$, $p < .05$, $R^2 = .209$). Taken together, active and disengagement coping accounted for about 21% of the variance in stress, but only disengagement reached statistical significance as a predictor ($t = 5.244$, $p < .05$, $\beta = -.404$, $b = -.762$). Based on the standardized coefficient (β), a point increase on the disengagement subscale would result in a .4-point increase on the perceived stress scale.

Hypothesis 5: Model Fit. Structural equation modeling (SEM) was employed to determine the direct and indirect effects of stress on coping style, burnout, and occupational attitudes of job satisfaction and organizational commitment. Results of the analyses appear in Table 9, and a model of significant paths is depicted in Figure 2. Before examining the hypothesized model paths, non-hypothesized paths were examined in order to determine covariance between variables, as well as determine if covariance was a source of misspecification in the model. Since some variables in the hypothesized model originated from the same measure, it was assumed the manifest variables might be correlated. For example, paths between the three Organizational Commitment Questionnaire (OCQ) variables—affective, commitment, and normative—were examined. Similarly, emotional exhaustion and depersonalization were examined, as was active and disengagement coping. Three of the five non-hypothesized paths were significant and untenable to zero; see Table 9.

After covariance between variables was accounted for in the model, twenty-two hypothesized paths were assessed. Nine of the twenty-two paths were untenable to be zero

(Table 9), which suggests the nine paths were statistically significant and allowed to estimate in the model. Significant findings suggest that perceived stress significantly predicted emotional exhaustion, low job satisfaction, disengagement coping, and active coping, while low job satisfaction significantly predicted affective commitment, emotional exhaustion, and depersonalization. Furthermore, disengagement significantly predicted depersonalization, while depersonalization significantly predicted continuance commitment.

Indirect effects between variables were hypothesized but not conducted due to insignificant direct paths between variables included in the indirect paths (Table 9). Since there were not significant direct paths between active and job satisfaction or active and burnout variables, the indirect path of stress on job satisfaction and burnout via active coping style was void. Similarly, the indirect effect of job satisfaction on commitment variables via burnout levels was not examined either due to insignificant direct paths between some of the variables.

Discussion

The aim of this study was to further explore the impact of stress on mental health practitioners. Specifically, this study examined the relationship between stress, burnout, coping style, job satisfaction, and organizational commitment (*Hypothesis 1*), as well as stress level and coping style by years of professional practice (*Hypothesis 2)*, stress and burnout level by job setting and client concerns (*Hypothesis 3*), and impact of coping style on job satisfaction and burnout (*Hypothesis 4*). Lastly, a model of stress, burnout, coping style, job satisfaction, and organizational commitment was presented and examined (*Hypothesis 5*).

Before addressing the hypotheses, confirmatory factor analyses were completed to ensure that the measures used in the study assessed their intended constructs; subsequent reliability analyses suggested that the measures have acceptable to strong internal consistency.

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On average, the mental health practitioners in this study perceived lower levels of stress and depersonalization (characterized by negative attitude towards clients and low empathy), felt accomplished with high job satisfaction, and seemed moderately committed to their current position or organization. However, they reported a moderate amount of emotional exhaustion (i.e., emotionally drained from work) based on their work with clients, and the most commonly reported stressors included time pressure, bureaucratic concerns, pay, work-life conflict, hours, and management.

For the most part, the presented hypotheses were supported. Several factors related to practitioners' stress, burnout, coping style, job satisfaction, and organizational commitment for this sample. Burnout, specifically higher levels of emotional exhaustion and depersonalization and lower levels of personal accomplishment, and disengagement coping were associated with greater levels of stress (*Hypothesis 1*). Lower levels of stress were associated with active coping and higher levels of job satisfaction and affective commitment (*Hypotheses 1*). An unexpected finding, however, was that continuance commitment was positively correlated with stress, suggesting that practitioners experiencing greater levels of stress also experience greater continuance commitment or possibly that greater continuance commitment might contribute to stress. In reviewing the continuance commitment subscale, many of the items assess whether or not there are other "options" or "alternatives" available for employees (e.g., *I am not afraid of what might happen if I quit my job without having another one lined up.*). As such, practitioners reporting a high level of continuance commitment may also experience higher levels of stress because they feel "stuck" in their current job. This may be particularly impacting if the position is already being perceived as particularly stressful or exhausting. Furthermore, those who are experiencing higher levels of stress may feel less affectively committed to their

position/company, as many of the items address being happy or attached to one's company. Overall, practitioners experiencing a higher level of stress may also be experiencing emotional exhaustion and depersonalization, less accomplishment and satisfaction with their jobs, and weaker emotional attachment to their current position.

Furthermore, coping style was significantly related to practitioners' perception of stress and organizational attitudes. Disengagement coping was associated with less favorable outcomes, such as lower job satisfaction, reduced personal accomplishment, and lower affective commitment, in addition to higher levels of stress, emotional exhaustion, and depersonalization. That is, practitioners implementing disengagement coping strategies, such as reducing their efforts to address the problem or suppressing thoughts related to the stressor, may also experience more stress, feel less satisfied with their jobs, experience burnout, and have less desire to stay at their current position. The relationship between active coping and organizational outcomes were fewer, but suggested that active coping is associated with more favorable outcomes, such as lower stress and greater personal accomplishment. These findings align with previous research in which avoidant coping is associated with negative outcomes (e.g., anxiety, burnout) while active coping was associated with more positive outcomes (e.g., adjustment, fewer psychological symptoms; Maslach et al., 2001; Snow, Swan, Raghavan, Connell, & Klein, 2003).

Results also revealed a positive relationship between years of professional experience and active coping, in addition to negative relationship between experience and stress. As such, as experience in the field increases, active coping increases and stress decreases (*Hypothesis 2*). More specifically, practitioners with over 15 years of experience reported more active coping strategies than practitioners with a more moderate level of experience, as well as lower levels of

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stress than those who entered the field in the last 5 years or who had been practicing in the field for 5-15 years. The difference in active coping between high tenure and moderate tenure is an interesting finding, and may be related to the experience of burnout. Some practitioners new to the field (e.g., less than 5 years) are viewed as highly engaged and enthusiastic in their work, which could lead to over-involvement and high emotional investment in work with clients (Maslach et al., 2001). These practitioners may be at higher risk for burnout than those with more realistic levels of engagement and expectations, and as they practice longer in the field, may perceive higher levels of stress (as was supported by the present study). While some burned-out practitioners may withdraw from the field in a few years, others may stay but distance themselves from their work and their clients, which might explain why practitioners with moderate experience (5-15 years), but not low experience (less than 5 years), reported less active coping than practitioners with high experience (over 15 years) in the field. While this analysis employed categorical variables, by grouping years of experience, analyzing stress and coping by tenure as a continuous variable might reveal a linear relationship between the variables.

Tenure in the field was also strongly correlated with age ($r = .791$), as would be expected, and both variables were associated with greater active coping strategies, job satisfaction, affective commitment, and personal accomplishment, alongside less stress and emotional exhaustion. It may be the case that, over time and with more experience, professionals learn how to more effectively approach work stressors, which could result in less stress, greater job satisfaction, and ongoing commitment to their job. This aligns with a developmental coping theory presented by Folkman, Lazarus, Pimley, and Novacek (1987), in which coping is believed to change as people age.

Based on organizational outcomes, work setting and client concerns have a significant impact on mental health practitioners. In support of the hypothesis, practitioners in private settings seem to fare better than their public setting counterparts (*Hypothesis 3*). For example, practitioners in private practice reported lower levels of stress, emotional exhaustion, and depersonalization and greater personal accomplishment when compared to those in community mental health. They also felt more accomplished and less depersonalized than practitioners in hospital/medical center settings. It is also important to note that private practitioners felt more emotionally attached to and less trapped in their positions/company when compared to those in the hospital/medical center, academic, and community mental health settings. By nature, private practice may allow for more control or autonomy (actual or perceived) in job tasks, which has consistently been associated with greater job satisfaction, greater organizational commitment, lower stress, and fewer turnover intentions (Kim & Stoner, 2008; Spector, 1986; Thompson & Prottas, 2006).

Working with PTSD/trauma was also associated with greater stress and emotional exhaustion and lower affective organizational commitment, while working with clients with personality disorders was associated with greater emotional exhaustion, higher stress, lower job satisfaction, and reduced personal accomplishment (*Hypothesis 3*). This lends support for the impact of client concerns on practitioner functioning and suggests that as working with PTSD/trauma or personality disorders increases, burnout increases and job satisfaction and commitment decrease. However, this may only be true for practitioners who work with these populations predominantly. Results indicate that practitioners whose caseloads were over 75% comprised of working with PTSD/trauma had significantly greater emotional exhaustion and stress levels compared with practitioners who were less involved with these presenting concerns.

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There were no statistically significant differences in burnout or stress depending on prevalence of personality disorder cases. These findings provide a contrast to findings reported by Garcia and colleagues (2016) in which working with personality disorders predicted burnout in a sample of Veteran's Health Administration (VHA) practitioners while trauma content did not.

Coping via active strategies was associated with lower levels of stress and greater personal accomplishment, while disengagement strategies were positively associated with stress, emotional exhaustion, and depersonalization. While associations between coping styles and outcomes were in the expected direction, coping style rarely *predicted* these organizational outcomes. For example, active coping failed to predict job satisfaction or burnout for practitioners in this study, and disengagement coping failed to predict job satisfaction. However, disengagement coping predicted depersonalization among the mental health practitioners in this study (*Hypothesis 4*). This finding suggests that if practitioners respond to work stressors by distancing themselves from the stressor or their work, they may inevitably be distancing themselves from their clients as well, which could result in loss of empathy and a cynical outlook.

Overall, hypothesis 4 was not supported, which was not only unexpected but undermines previous research findings indicating that active coping predicts better adjustment and lower burnout while avoidant strategies predict poor adjustment, higher stress, and greater burnout (Maslach et al., 2001; Snow et al., 2003). However, a post hoc analysis tested the assumption that coping style might predict stress instead of occupational outcomes, and in fact, results suggested that disengagement coping predicted stress level while active coping strategies did not. These findings align with previous research, which implicated negative ramifications of avoidance coping but non-significant effects of active coping (Day & Livingstone, 2001).

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Several areas could be explored in an effort to understand the failure of coping styles as predictors in the current study. First, generally speaking, practitioners in this study perceived low levels of stress and burnout and high levels of job satisfaction. As such, active and disengagement coping may be poor predictors of organizational outcomes for better-adjusted populations, whereas coping styles may be stronger mediators as stress and burnout increase. Second, the effect of coping style on outcomes may differ in situations where levels of control and autonomy wane, such as in workplace settings. For employees with limited control or autonomy in addressing stressors, responding in an active manner may inadvertently exacerbate distress (since no change occurs) while disengagement strategies may seem like a less-distressing approach, at least as a short-term response. In an approach-avoidance theory presented by Roth and Cohen (1986), for example, approach motives may actually produce greater stress if little can be done to change the situation, suggesting that avoidance may be a more appropriate action. Avoidance over time, however, can also relate to disruptions and greater distress. Lastly, the associations between active coping and more positive outcomes, combined with correlations between disengagement and less positive outcomes, suggest that other variables may account for the impact of stress and coping on organizational outcomes. Perhaps level of control/autonomy mediates the impact of active coping on burnout and job satisfaction; however, this variable was not assessed among practitioners.

As expected, perceived stress was negatively related to active coping and positively related to disengagement coping. Furthermore, perceived stress predicted both active and disengagement coping styles; specifically, lower stress levels were associated with greater active coping and higher stress was associated with greater disengagement coping (*Hypothesis 5*). Perceived stress also predicted lower levels of job satisfaction and higher levels of emotional

exhaustion. While active coping did not predict job satisfaction or burnout, as hypothesized, disengagement coping predicted greater depersonalization and depersonalization predicted higher levels of continuance commitment. This finding suggests that practitioners coping via disengagement strategies experience greater depersonalization; moreover, greater depersonalization relates to higher levels of continuance commitment. Put another way, as practitioners distance themselves from stressors, they may experience a negative outlook towards their clients. Furthermore, they may feel as though they are trapped in their position, either due to inability to effect change in their current position or limited alternative employment opportunities. Lastly, job satisfaction had a direct effect on emotional exhaustion, depersonalization, and active commitment. Specifically, practitioners in this sample who were less satisfied with their jobs experienced greater emotional exhaustion and depersonalization, and furthermore, less emotional attachment to their company or position. Job satisfaction is strongly associated with affective commitment and moderately associated with personal accomplishment, suggesting that those who are happier with their jobs may be more invested in the company and feel more accomplished in their work. These findings provide additional support for the already vast literature on the importance of job satisfaction in organizational outcomes (Colquitt et al., 2011; Imran, Arif, Cheema, & Azeem, 2014; Tett & Meyer, 1993). Overall, perceived stress, disengagement coping, and job dissatisfaction were associated with more negative occupational outcomes, such as feeling emotionally drained, having negative or cynical feelings towards clients, and being less attached to one's job or company. While coping style failed to adequately predict occupational outcomes in the model, disengagement coping predicted stress, which is a predictor of job satisfaction and burnout, in addition to predicted depersonalization.

An interesting finding to note is that continuance commitment consistently associated with the less favorable occupational outcomes. All three types of organizational commitment—affective, continuance, normative—were expected to correlate positively with favorable outcomes, such as job satisfaction, but negatively with variables of stress and burnout. Affective commitment was the only commitment variable that aligned with these expectations, demonstrating positive correlations with job satisfaction and personal accomplishment and negative correlations with stress, emotional exhaustion, and burnout. Normative commitment did not share significant correlations with any occupational variable, and higher levels of continuance commitment were associated with greater stress and depersonalization and lower job satisfaction. Furthermore, continuance commitment failed to correlate with affective or normative commitment, even though affective and normative were strongly and positively associated; similar results have been reported (Meyer et al., 2002; Somers, 2009). Additionally, Meyer and colleagues (2002) found that only affective and normative commitment correlated positively with (the more favorable) work-related variables of job attendance, job performance, and organizational citizenship behavior while continuance commitment correlated negatively with these variables, and Garland and colleagues (2014) reported that continuance commitment correlated positively with burnout variables. In reviewing the subscales, the affective commitment scale seems to represent a more positive relationship with one's job or company, as the items address positive emotions towards the company and desire to stay with the company (Allen & Meyer, 1990). Normative commitment addresses the importance of staying with, or a moral obligation to, an organization. Continuance commitment, on the other hand, seems to represent a feeling of being stuck or trapped with the current company or position, as many of the items assess the cost of leaving or whether or not alternative opportunities are available.

Those who plan to stay with their company may *want* to stay (affective) partly because they are satisfied with their job and are experiencing less stress and exhaustion, whereas those who feel as though they *need* to stay (continuance) may be less satisfied with their jobs but stay out of financial or other obligations, which could undoubtedly add to their stress level. Therefore, those experiencing higher levels of stress may feel less affective commitment to their position or company but higher levels of continuance commitment if they feel "stuck" in their current job.

Limitations

A notable limitation of this study is the homogeneity of the sample. Most respondents identified as white, heterosexual females, which hinders generalizability to demographic groups that were less represented in the study. Furthermore, a third of the sample indicated no involvement with therapy tasks, which limits representation of practitioners engaging in therapeutic work with clients. Sample size hindered evaluation of paths between latent constructs and may have limited statistical analyses as well. While an a priori power analysis provided support for a sample size of 150 participants to detect effects for the SEM model, the power analysis was based on the assessment of 6 SEM variables. In actuality, following the confirmatory factor analyses, 9 variables were identified as best representing the constructs in this study. A post hoc power analysis at the .95 power level ($\alpha = .05$) revealed that 166 participants would be needed to detect a moderate effect size ($d = .15$) for a linear Multiple Regression (R^2 increase) of 9 predicting variables.

An additional limitation of the study may be the lower levels of stress and burnout reported by practitioners on average. This might be explained, in part, by the voluntary nature of participation, in that practitioners perceiving a positive relationship with their work may have viewed the participation invitation as less threatening than practitioners struggling with their

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work in some way. Lower levels of stress may also be explained by the nature of work tasks, as almost a third of participants indicated completing administrative tasks for the majority of their work hours while lower levels of therapeutic tasks were implicated. A better representation of varying levels of stress and burnout (e.g., "low," "moderate," and "high") would provide an opportunity to detect the impact of coping style by level of stress and burnout. As such, findings may more accurately portray how highly stressed and burned out practitioners respond to stress via coping and the impact of coping style on organizational outcomes.

Lastly, the instruments used to assess the study variables may have posed concerns and interfered with expected findings. Except for the Perceived Stress Scale (PSS10) and Job Satisfaction Index, the data did not fit the instruments well and required modifications, some of which involved dropping items from the scales. As such, caution may be warranted when selecting instruments for future research with similar variables. Similarly, additional measures of job-specific coping styles may need to be considered when assessing stress and occupational outcomes. The coping measure used in this study assessed general coping strategies, which is to say, how individuals typically respond to stressors. As such, individuals may have responded in relation to arenas beyond job settings, such as marital concerns, financial pressures, or health concerns. While one may assume that coping strategies transcend settings, not all situations offer opportunities to directly change one's environment or problem. Assessing for and including control in the current study may have provided consequential information on stress and occupational outcomes.

Future Research

Additional research is necessary to further explore the relationship between stress, burnout, coping style, job satisfaction, and organizational commitment for less-represented

practitioners in the current study (e.g., those identifying as non-white and/or non-heterosexual). This is particularly important given that LGBT and ethnic minority populations are marginalized groups and experience stressors related to discrimination and harassment in the workplace (Deitch et al., 2003; Ozturk, 2011). Their experience of work stressors tends to differ, and research suggests that the experience of subtle discrimination relates to increased stress and disengagement (e.g., withdrawal) from the source of the stressor, which in this case would be the work setting and/or colleagues. As the sources of their work stressors differ, coping strategies may differ as well, and could be further explored.

Furthermore, practitioners working in correctional and academic (college faculty, college counseling centers, high schools) settings were less represented in the sample compared to practitioners working in community mental health, private practice (group or solo), and hospital/medical center settings. Even though the sample size for practitioners working in correctional settings was low (n=3), the three participants reported a high level of emotional exhaustion (M = 23.00). Furthermore, practitioners in community mental health settings reported the highest levels of stress (M = 16.45), exhaustion (M = 25.52), and depersonalization (M = 8.08), in conjunction with the lowest levels of accomplishment (M = 38.45) and second-to-lowest affective commitment (M = 33.39) and normative commitment (M = 30.21) when compared to the settings of academic, private practice, and hospital/medical centers. Due to the potential for stress and burnout for practitioners in correctional and community mental health settings, this study could be replicated to better fit the unique work stressors, job demands, and clientele of these settings.

Similarly, therapy-related work tasks were less frequently reported than what was expected, while administrative tasks were more frequently reported. While administrative tasks

have been shown to related to stress in previous studies (Rupert & Morgan, 2005), future research on the impact of stress and coping on occupational attitudes may want to highlight these concerns with a sample of practitioners highly engaged in therapeutic work.

As a result of the impact of control and autonomy on individual occupational outcomes (Kim & Stoner, 2008; Spector, 1986; Thompson & Prottas, 2006), coping measures encompassing work-specific stressors and perceived control in effecting change should be considered. This might provide a more accurate depiction of how employees, especially lower-tiered workers, perceive and address stressors in the workplace.

Recommendations

As the significance of work stress and job satisfaction has gained attention in recent decades and demonstrated value in productivity and health, organizations have turned to policy and interventions to address mental health- and stress-related concerns among employees. Addressing these concerns may be as passive as developing and revising a mental health policy, as active as evaluating stress-related concerns in the workplace and providing counseling, or as proactive as modifying the work stressors themselves (O'Keefe et al., 2014; WHO, 2005). Regardless of the approach style, most interventions focus on implementing change at the individual employee level, whereas research suggests that interventions should occur at the organizational level (Cox, 1993; Halbesleben & Buckley, 2004; Maslach et al., 2001; Morse, Salyers, Rollins, Monroe-DeVita, & Pfahler, 2012). Organizational-level changes could include identifying and reducing the stressors known to be causing harm (i.e., stress) to employees or modifying working conditions in order to benefit employees collectively (Babatunde, 2013; Cox, 1993; LaMontagne et al., 2014).

In relation to the current study, practitioners commonly identified work stressors of time pressure, bureaucratic concerns, work-life conflict, pay, work hours, and management. In alignment with a more traditional, individual-level approach, organizations may respond to these concerns by providing education on stress and its impact on health, demonstrating effective coping strategies, and modifying expectations about the company or job characteristics. However, findings from the current study suggest that changing coping style may not be enough to change the impact of stress on occupational outcomes, and previous research suggests the effects of individually-based burnout interventions dissipate within a year (Awa, Plaumann, & Walter, 2010). Instead, organizational-level changes should be considered and might include actively assessing for common work stressors via surveys or focus groups, which requires an organizational culture perceived as accepting and supportive. After stressors have been identified, organizational leaders could implement changes at a larger level: offering flextime or part-time options in an attempt to address concerns regarding work-life conflict or hours; providing employees with opportunities to be involved in rule- or procedure-setting tasks to address management or bureaucratic concerns; training supervisors to provide support and effective communication; and establishing an accommodating work environment in which employees are invited to discuss and collaborate on client-related or task-related concerns in order to better manage time pressures and work-life conflicts (Halbesleben & Buckley, 2004; O'Keefe et al., 2014; WHO, 2005). While pay is difficult to address directly, the remaining work stressors could be addressed via individual *and* organizational practices in order to better support employee functioning. By doing so, employees may perceive greater autonomy in their schedule and work tasks as well as sense organizational and collegial support, which could result in reduced stress, greater job satisfaction, and desire to stay with the organization.

Findings from the current study may also have implications for graduate training programs as novice practitioners may experience higher levels of stress and stress may predict emotional exhaustion and lower job satisfaction. As such, graduate training programs and faculty may address the balancing of professional and personal roles and management of stress while also encouraging self-care strategies and social support networks. Graduate training provides a unique opportunity to offer guidance and feedback on coping due to interactions with trainees in classes, research, and supervision, as well as the stress that trainees are already experiencing in relation to academic-family balance and role strain (Mallinckrodt & Leong, 1992; Myers et al., 2012). Furthermore, trainees may benefit from conversations surrounding job demands and tasks (both therapy-related and non-therapy-related, such as administrative and research work) that are unique to certain settings, especially for work settings associated with greater stress and burnout, such as community mental health settings. Candid conversations about demands of the field and the importance of stress management may better prepare trainees to enter their professional roles with realistic expectations and effective coping strategies.

While stress itself may be difficult to diminish in entirety, due to job tasks, client demands, and organizational structure, *coping* with stress could be addressed in various ways. Practitioners interested in making changes individually should consider the impact coping strategies have on work-related outcomes. While active coping was not a significant predictor of outcomes in this study, it was found to be associated with less stress and greater personal accomplishment in this study. Furthermore, disengagement coping was associated with higher stress, emotional exhaustion, and depersonalization and lower personal accomplishment and job satisfaction, and also significantly predicted higher levels of stress (which is a predictor of job satisfaction) and depersonalization. So while active coping may not necessarily predict positive

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outcomes, it may serve as a preferable approach to the negative outcomes associated with disengagement coping strategies.

Active coping strategies in the study included brainstorming strategies/making plans to address the problem and/or taking action to address or remove the stressor in some way. Disengagement coping strategies, on the other hand, included withdrawing by suppressing thoughts about the problem, sleeping more than usual, and/or abandoning attempts to deal with/solve the problem. In relation to work, then, practitioners should consider addressing work stressors, such as work-life conflict or bureaucratic concerns, rather than ignoring them. Active approaches may involve changing one's work schedule or caseload or communicating with supervisors about concerns. Consulting with colleagues about demanding client cases, especially for practitioners frequently working with PTSD/trauma, could result in improved problem-solving, consideration of alternative approaches in session, and emotional support. Consultation may also aid in reduction of stress and modification of cynical attitudes towards clients, which have implications in unethical actions (Cherniss, 1980). Furthermore, practitioners should strive to monitor their experiences, including their attitudes towards work and clients, their level of energy and stress, and their work-life struggles. If attitude, energy, stress, and/or personal concerns are interfering with one's work with clients, therapy could be considered in order to address these areas and make changes to one's work and personal life.

Conclusion

Overall, practitioners in the sample seemed well-adjusted, as they reported low levels of stress and depersonalization and high levels of job satisfaction and personal accomplishment. However, they reported a moderate amount of emotional exhaustion, and practitioners new to the field, working in community mental health, or with a heavy caseload of PTSD/trauma indicated

greater levels of exhaustion and stress. Stress was associated with burnout, coping style, and job satisfaction, while coping style was associated with stress and burnout. SEM results indicated that stress has a direct effect on job satisfaction, coping style, and emotional exhaustion, while disengagement coping affects depersonalization, low job satisfaction affects emotional exhaustion, depersonalization, and affective commitment, and depersonalization affects continuance commitment. While coping style did not predict occupational outcomes, disengagement coping predicted stress and depersonalization among practitioners.

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Appendices and Tables

Appendix A

Proposed Input Diagram for Stress-Coping-Occupational Attitudes
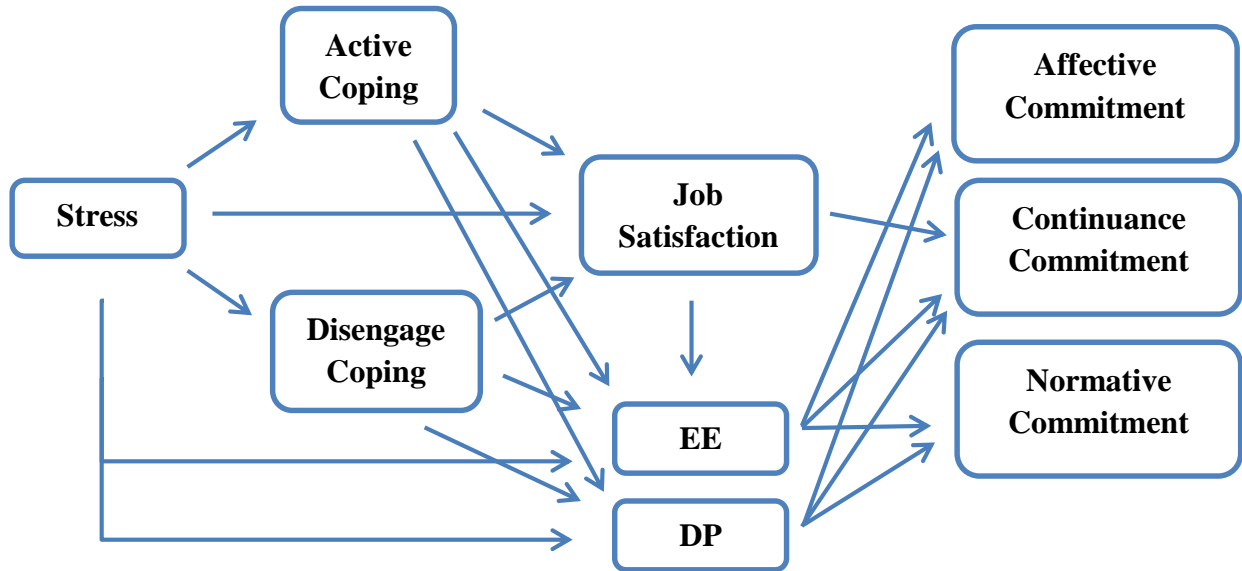
Appendix B

Demographic Measure

1. Are you currently a licensed and practicing clinician?

    a. Yes

    b. No

2. Please indicate your age: _____ (open-ended)

3. Please indicate your sex: _____ (open-ended)

4. Marital status:

    a. Single

    b. Married

    c. Unmarried, living with partner

    d. Separated

    e. Divorced

    f. Widowed

5. Sexual orientation:

    a. Heterosexual

    b. Gay/Lesbian

    c. Bisexual

    d. Other: _____

6. Race/ethnicity: (Choose all that apply)

    a. Asian American/Pacific Islander

    b. Black/African American

    c. Caucasian/White American

d. Hispanic/Latino American

e. Native American

f. Other _____

7. Please choose the highest level of education you have obtained:

a. Master's degree

b. Doctoral degree (Psy.D.)

c. Doctoral degree (Ph.D.)

d. Other: _____

8. Please choose the area in which you have obtained the graduate degree:

a. Counseling Psychology

b. Clinical Psychology

c. Other: _____

9. Are you currently a Fellow of Division 17?

a. Yes

b. No

10. Please indicate how long you have been practicing. Round to the nearest year _____

11. Please indicate how long you have held your current position. Round to the nearest year ____

12. In which setting do you currently work? (Choose all that apply)

a. Hospital, inpatient

b. Hospital, residential

c. Hospital, outpatient

d. Solo private practice

e. Group private practice

f. University/college counseling center

g. University/college faculty

h. Community mental health

i. Correctional Facility

j. Other: _____

13. How many hours do you work each week? _____

14. Estimate your current yearly income from practice (e.g., salary, consulting, etc.).

	0	20	40	60	80	100	120	140	160	180	200
Salary	←										→

15. Please estimate what percentage (%) of your time at work is dedicated to each task

(Percentages must equal 100%).

	0	10	20	30	40	50	60	70	80	90	100
Administration	←										→
Assessment	←										→
Consultation	←										→
Research	←										→
Supervision	←										→
Therapy	←										→
Other	←										→

16. Approximately what percentage of your clients present with PTSD/trauma or personality

disorders?

	0	10	20	30	40	50	60	70	80	90	100
PTSD/trauma	←										→
Personality	←										→

17. What would you describe as the level of pathology you typically work with?

    a. Mild

    b. Moderate

    c. Severe

18. Please type the numbers 1, 2, and 3 next to the **three** work stressors that you perceive to be the most stressful.

    a. Role ambiguity or uncertainty

    b. Heavy workload

    c. Limited control or autonomy in tasks

    d. Time pressure

    e. Dangerousness

    f. Work-life conflict

    g. Inflexible schedule

    h. Too many work hours

    i. Limited involvement in important decision

    j. Inadequate pay

    k. Insufficient support or resources

    l. Poor management

    m. Bullying, Harassment, or Discrimination

    n. Demanding client problems

    o. Bureaucratic concerns

    p. Lack of job security

    q. Other: _____

Appendix C

Perceived Stress Scale

The questions in this scale ask you about your feelings and thoughts **during the last month**. In each case, you will be asked to indicate *how often* you felt or thought a certain way.

Never	Almost Never	Sometimes	Fairly Often	Very Often

1. In the last month, how often have you been upset because of something that happened unexpectedly?

2. In the last month, how often have you felt that you were unable to control the important things in your life?

3. In the last month, how often have you felt nervous and "stressed"?

4. In the last month, how often have you felt confident about your ability to handle your personal problems?

5. In the last month, how often have you felt that things were going your way?

6. In the last month, how often have you found that you could not cope with all the things that you had to do?

7. In the last month, how often have you been able to control irritations in your life?

8. In the last month, how often have you felt that you were on top of things?

9. In the last month, how often have you been angered because of things that were outside of your control?

10. In the last month, how often have you felt difficulties were piling up so high that you could not overcome them?

Appendix D

Maslach Burnout Inventory-Human Services Scale

Below is 22 statements of job-related feelings. Please read each statement carefully and decide if

you ever feel this way about your job. If you have *never* had this feeling, select Never for the

statement. If you have had this feeling, indicate *how often* you feel it by selecting the option that

best describes how frequently you feel that way.

Note: Recipients refers to clients/patients.

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

Sample Items (due to copyright, not all items can be shared):

1. I feel emotionally drained from my work.

2. I have accomplished many worthwhile things in this job.

3. I don't really care what happens to some recipients.

Appendix E

COPE Inventory

The following questions ask you to indicate what you generally do and feel, when you experience stressful events. Please try to respond to each item separately in your mind from each other item. Choose your answers thoughtfully, and make your answers as true FOR YOU as you can. There are no "right" or "wrong" answers, so choose the most accurate answer for YOU.

1 = I usually don't do this at all; 2 = I usually do this a little bit; 3 = I usually do this a medium amount; 4 = I usually do this a lot

1. I try to grow as a person as a result of the experience.

2. I turn to work or other substitute activities to take my mind off things.

3. I get upset and let my emotions out.

4. I try to get advice from someone about what to do.

5. I concentrate my efforts on doing something about it.

6. I say to myself "this isn't real."

7. I put my trust in God.

8. I laugh about the situation.

9. I admit to myself that I can't deal with it, and quit trying.

10. I restrain myself from doing anything too quickly.

11. I discuss my feelings with someone.

12. I use alcohol or drugs to make myself feel better.

13. I get used to the idea that it happened.

14. I talk to someone to find out more about the situation.

15. I keep myself from getting distracted by other thoughts or activities.

16. I daydream about things other than this.

17. I get upset, and am really aware of it.

18. I seek God's help.

19. I make a plan of action.

20. I make jokes about it.

21. I accept that this has happened and that it can't be changed.

22. I hold off doing anything about it until the situation permits.

23. I try to get emotional support from friends or relatives.

24. I just give up trying to reach my goal.

25. I take additional action to try to get rid of the problem.

26. I try to lose myself for a while by drinking alcohol or taking drugs.

27. I refuse to believe that it has happened.

28. I let my feelings out.

29. I try to see it in a different light, to make it seem more positive.

30. I talk to someone who could do something concrete about the problem.

31. I sleep more than usual.

32. I try to come up with a strategy about what to do.

33. I focus on dealing with this problem, and if necessary let other things slide a little.

34. I get sympathy and understanding from someone.

35. I drink alcohol or take drugs, in order to think about it less.

36. I kid around about it.

37. I give up the attempt to get what I want.

38. I look for something good in what is happening.

39. I think about how I might best handle the problem.

40. I pretend that it hasn't really happened.

41. I make sure not to make matters worse by acting too soon.

42. I try hard to prevent other things from interfering with my efforts at dealing with this.

43. I go to movies or watch TV, to think about it less.

44. I accept the reality of the fact that it happened.

45. I ask people who have had similar experiences what they did.

46. I feel a lot of emotional distress and I find myself expressing those feelings a lot.

47. I take direct action to get around the problem.

48. I try to find comfort in my religion.

49. I force myself to wait for the right time to do something.

50. I make fun of the situation.

51. I reduce the amount of effort I'm putting into solving the problem.

52. I talk to someone about how I feel.

53. I use alcohol or drugs to help me get through it.

54. I learn to live with it.

55. I put aside other activities in order to concentrate on this.

56. I think hard about what steps to take.

57. I act as though it hasn't even happened.

58. I do what has to be done, one step at a time.

59. I learn something from the experience.

60. I pray more than usual.

Appendix F

Job Satisfaction Index

Below are five statements about jobs. Please indicate how you feel about your present job, by deciding whether you Strongly Agree, Agree, are Undecided, Disagree, or Strongly Disagree with each statement.

Strongly Agree   Agree   Undecided   Disagree   Strongly Disagree

1. I feel fairly satisfied with my present job.

2. Most days I am enthusiastic about my work.

3. Each day at work seems like it will never end

4. I find real enjoyment in my work.

5. I consider my job to be rather unpleasant.

Appendix G

Organizational Commitment Questionnaire

Listed below is a series of statements that represent feelings that individuals might have about

the company or organization for which they work. With respect to your own feelings about the

particular organization for which you are now working, please indicate the degree of your

agreement or disagreement with each statement.

Strongly Disagree

Disagree

Slightly Disagree

Undecided

Slightly Agree

Agree

Strongly Disagree

<u>Sample Items:</u>

1. I would be very happy to spend the rest of my career with this organization. (Affective)

2. I am not afraid of what might happen if I quit my job without having another one lined

    up. (Continuance)

3. I think that people these days move from company to company too often. (Normative)

Appendix H

Recruitment Letter

Dear Division 17 Members:

My name is Danna Letsch and I am a doctoral student at the University of Kansas. As part of my

dissertation project, I am conducting a study examining stress, coping, job satisfaction, and

organizational commitment of practicing psychologists. I am seeking currently practicing

psychologists.

Your participation in the study is voluntary and you may withdraw your participation at any time

by exiting the survey. No identifying information will be collected, and all responses will be kept

confidential. Potential risks associated with participation are minimal.

If you are willing to participate, please click on the link below. The survey should take about 20-

30 minutes to complete.

<Qualtrics link pasted here>

If you have any questions or concerns, feel free to contact me at dannaharvey@ku.edu, or my

doctoral advisor, Karen D. Multon, at kmulton@ku.edu. This research has been approved by the

University of Kansas Institutional Review Board (will include number upon approval).

Thank you for your time and consideration.

Best,

Danna Letsch, M.S.

Doctoral Candidate, Counseling Psychology

University of Kansas

Table 1

Demographic Characteristics of Participants

Characteristic	*N*	*%*
Gender		
Male	34	23
Female	116	77
Ethnicity		
Asian American /Pacific Islander	3	2
African American/Black	2	1
Caucasian	139	93
Hispanic/Latin American	1	<1
Native American	1	<1
Biracial/Multiracial	4	3
Sexual Orientation		
Heterosexual	137	91
Gay/Lesbian	4	3
Bisexual	8	5
Unanswered	1	<1
Marital Status		
Single	20	13
Married	103	69
Unmarried, living with partner	15	10
Separated	3	2
Divorced	9	6
Age		
20s	18	12
30s	56	37
40s	27	18
50s	25	17
60s	22	15
70s	2	1

Note. N=150

Table 2

Professional Characteristics of Participants

Characteristic	*N*	*%*
Highest Degree Obtained		
Master's	91	61
Psy.D.	10	7
Ph.D.	46	31
Other (e.g., B.S., Ed.S.)	3	2
Specialty Area		
Counseling	54	36
Clinical	28	19
Marriage/Family Therapy	16	11
Social Work	43	29
Other	9	6
Years in Specialty Area/Field		
<3	30	20
3-5	34	23
6-10	36	24
11-20	23	15
21-30	17	11
31-40	9	6
>40	1	<1
Work Setting		
Inpatient Hospital	11	7
Residential Hospital	7	5
Outpatient Hospital	29	19
Solo Private Practice	19	13
Group Private Practice	25	17
Community Mental Health	40	27
University Counseling Center	6	4
College Faculty	8	5
Correctional Setting	3	2
Other	33	22
Years in Current Position		
<3	64	43
3-5	42	28
6-10	23	15
11-20	13	9
21-30	6	4
>30	2	1
Work Hours/Week		
<20	3	2
20-39	17	11
40-45	55	37
46-60	24	16
>60	2	1
0/No response	22	15
Salary		
<40,000	18	12

40-65,000	70	47
66-89,000	23	15
90-120,000	27	18
>121,000	11	7
No response	1	<1

Note. *N*=150.

Table 3

Percentage of Work Tasks and Client Concerns

% of Work Tasks	*0*	*<10*	*10-25*	*26-50*	*51-75*	*>75*
Work Tasks						
Administration	6	23	39	37	43	2
Assessment	20	27	53	45	4	1
Consultation	50	53	42	5	0	0
Therapy	53	7	18	34	31	7
Research	117	18	8	7	0	0
Supervision	80	37	30	3	0	0
Other	104	26	17	2	1	0
Client Concerns						
PTSD/Trauma	4	8	45	42	25	26
Personality Disorders	10	34	64	33	6	3

Note. N=150.

Table 4

Reliability of Scales following CFA Analyses

Scale	# of Items	Cronbach α
PSS	10	.862
MBI-HSS		
EE	9	.922
DP	4	.821
PA	8	.767
COPE		
Active	8	.860
Disengage	7	.713
JSI	5	.886
OCQ		
AC	7	.856
CC	6	.802
NC	5	.708

Note. PSS=Perceived Stress Scale, MBI-HSS=Maslach Burnout Inventory-Human Services Survey, EE=Emotional Exhaustion, DP=Depersonalization, PA=Personal Accomplishment, COPE=COPE Inventory, Active=Active coping style, Disengage=Disengagement coping style, OCQ=Organizational Commitment Questionnaire, AC=Affective Commitment, CC=Continuance Commitment, NC=Normative Commitment.

Table 5

Correlation Coefficients for Power Analysis

Variables Observed	Researchers	Correlation Coefficient	Computed ES
Job Satisfaction & Organizational Commitment	Lumley, Coetzee, Tladinyane, & Ferreria, 2011	r = .28-.62	.08-.38
		ρ = .65, .31, -.07	.42, .10, .00
	Meyer, Stanley, Herscovitch, & Topolnytsky, 2002	r = .53	.28
	Blegen, 1993		
Job Satisfaction & Burnout	Faragher, Cass, & Cooper, 2003	r = .48	.23
		r = -.26, -.33, .22	.07, .11, .05
	Lee & Ashforth, 1996		
Burnout & Organizational Commitment	Garland, Lambert, Hogan, Kim, & Kelley, 2014	r = .43, .40, .37, .49	.18, .16, .14, .24
		r = -.38, -.33, -.02	.14, .11, .00
	Lee & Ashforth, 1996		
Coping Style & Job Satisfaction	Kang & Kim, 2014	r = .43	.18
Coping Style & Perceived Stress	Chang & Taylor, 2013	r = .11, -.28	.01, .08
Perceived Stress & Job Satisfaction	Blegen, 1993	r = -.61	.37
	Zangaro & Soeken, 2007	r = .66	.44
Perceived Stress & Burnout	Cieslak, Shoji, Douglas, Melville, Luszczynska, & Benight, 2014	r = .69	.48
		r = .09 (avg)	.01
	Lee & Ashforth, 1996		

Table 6

Assessment of Model Fit Using MLR

Model	χ^2	χ^2 df	χ^2 df$_{diff}$	CFI	ΔCFI	RMSEA	RMSEA CI	Tenable?
PSS10								
1. Original Model (single factor)	96.663	35	-	0.862	-	.108	0.08- 0.134	no
2: Correlated residuals 1 and 9	73.762	34	1	0.911	.049	.088	0.06- 0.116	yes
3: Added correlated residuals 10 and 7R	62.218	33	1	0.935	.024	.077	0.04- 0.106	yes
MBI-HSS								
1. Original Model (3 factors)	459.107	206	206	0.828	-	.091	0.07- 0.102	no
2: EE and DP as factors	199.885	76	130	0.879	.051	.104	0.08- 0.122	yes
3: Added correlated residuals EE1 and EE2	159.281	75	1	0.918	.039	.087	0.068-0.105	yes
4: Deleted DP5 due to low loading	126.432	63	12	0.934	.016	.082	0.061-0.103	yes
5: Added correlated residuals EE4 and EE8	102.385	62	1	0.958	.024	.066	0.042-0.088	yes
6: EE and DP as one factor	86.933	51	11	0.962	.004	.069	0.043-0.093	no
JSI								
1. Original Model (single factor)	8.345	5	5	0.985	-	.067	0.000-0.144	yes
OCQ								
1. Original Model (single factor)	737.720	252	252	0.509	-	.113	0.104-0.123	no
2: 3 factors; correlated residuals CC6 and CC7	419.129	248	4	0.827	.318	.068	0.056-0.079	yes
3: 3 factors; added correlated residuals AC8 and AC5	391.358	247	1	0.854	.027	.062	0.050-0.074	yes
4: 3 factor; added correlated residuals NC7 and NC1	361.388	246	1	0.883	.029	.056	0.043-0.068	yes
5: 3 factor; dropped AC3 due to low loading	337.604	224	22	0.884	.001	.058	0.045-0.071	no
6: 3 factor; dropped NC1 due to low loading	313.723	204	42	0.882	-.001	.060	0.046-0.073	no

Model	χ²	df						
7: 3 factor; dropped CC4 due to low loading	286.917	184	62	0.887	.004	.061	0.047-0.074	no
8: 3 factor; dropped CC1 due to low loading	256.321	165	81	0.897	.014	.061	0.046-0.075	yes
9: 3 factor; dropped NC 7 and NC3 due to low loadings	203.842	130	35	0.911	.014	.062	0.045-0.077	yes
10: Single factor	368.497	133	3	0.717	-.194	.109	0.096-0.122	no
11: 2 factors	237.273	132	2	0.874	-.037	.073	0.058-0.088	no
COPE Inventory								
1. Original Model (Active and Avoidant factors)	1097.178	593	593	0.657	-	.075	0.068-0.082	no
2: Problem, Emotion, Avoidant as 3 factors	1050.682	591	2	0.687	.030	.072	0.065-0.079	yes
3: Dropped Emotion; 2 factors	445.193	251	340	0.793	.106	.072	0.061-0.083	yes
4: Active and 3 Avoidant factors (BD, MD, Denial)	384.866	246	5	0.852	.059	.061	0.049-0.073	yes
5: Active and 2 Avoidant factors (Diseng from BD and MD, and Denial)	389.339	249	3	0.85	-.002	.061	0.049-0.073	no
6: Active and 2 Avoidant factors; dropped MD1due to low loading	371.009	227	19	0.847	-.005	.065	0.053-0.077	no
7: Active and 2 Avoidant factors; dropped MD4 due to low loading	321.090	205	41	0.875	.023	.061	0.048-0.074	yes
8: Active ONLY	29.258	20	185	0.975	.100	.056	0.000-0.096	yes
9: Active with 3 Avoidant factors (BD, MD, Denial)	184.477	164	144	0.97	-.005	.029	0.000-0.049	no
10: Active with Diseng (BD and MD)	190.289	167	147	0.966	-.009	.030	0.000-0.050	no
11: Active with Diseng (BD and MD) and Denial; remove MD1 due to low loading	174.402	149	129	0.963	-.012	.034	0.000-0.053	yes
12: Active and Diseng (BD and MD)	116.168	89	60	0.953	-.010	.045	0.016-0.067	yes

Note. EE=Emotional Exhaustion, DP=Depersonalization, CC=Continuance Commitment, AC=Affective Commitment, NC=Normative Commitment, BD= Behavioral Disengagement, MD=Mental Disengagement, Diseng=Disengagement coping

Table 7

Correlation Coefficients

		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
1.	Age	1																	
2.	Gender	-.095	1																
3.	Years in Field	.791**	-.101	1															
4.	Hours/ Week	-.071	.107	.006	1														
5.	Income	.288**	-.187*	.358**	.166*	1													
6.	PTSD/ Trauma	-.227**	.079	-.194*	-.005	-.079	1												
7.	Pers Dis.	-.278**	.138	-.180*	-.016	-.144	.377**	1											
8.	Pathology	-.083	-.009	-.014	.034	-.020	.471**	.442**	1										
9.	PS	-.287**	.181*	-.216**	-.017	-.144	.200*	.311**	.162*	1									
10.	EE	-.304**	.144	-.238**	-.068	-.148	.258**	.298**	.146	.641**	1								
11.	DP	-.288**	-.030	-.132	-.040	.013	.091	.105	.149	.372**	.600**	1							
12.	PA	.285**	.162*	.177*	-.024	.152	-.051	-.172*	-.024	-.465**	-.361**	-.423**	1						
13.	Active	.230**	.095	.187*	-.055	.095	.010	-.144	.001	-.246**	-.082	-.124	.441**	1					
14.	Disengage	-.221**	.120	-.153	.076	-.119	.082	.202*	.118	.442**	.379**	.370**	-.346**	-.307**	1				
15.	JS	.345**	-.103	.294**	-.003	.245**	-.156	-.267**	-.140	-.596**	-.724**	-.495**	.474**	.138	-.346**	1			
16.	AC	.263**	-.007	.262**	.059	.254**	-.167*	-.114	-.119	-.279**	-.428**	-.240**	.251**	.080	-.277**	.604**	1		
17.	CC	-.181*	.052	-.182*	.124	.073	.032	.061	-.026	.185*	.152	.281**	-.219**	-.091	.131	-.184*	-.059	1	
18.	NC	.026	.065	-.019	.064	-.038	-.074	.012	-.079	-.041	-.113	-.016	-.059	-.022	-.172*	.147	.545*	.057	1

Note. *p <. 05, **p <. 01*;* Age (in years), Gender (Male/Female), Years in Field=Number of years practicing in mental health field, Hours/Week=Average number of hours spent at work each week, Income=Estimated annual income, PTSD/Trauma=Percentage of clients presenting with PTSD/Trauma, Pers Dis=Percentage of clients presenting with personality disorders, Pathology=overall estimate of level of pathology based on client concerns, PS=Perceived Stress, EE=Emotional Exhaustion, DP=Depersonalization, PA=Personal Accomplishment, Active=Active coping Style, Disengage=Disengagement coping style, JS=Job Satisfaction, AC=Affective Commitment, CC=Continuance Commitment, NC=Normative Commitment.

Table 8

Correlation between Manifest Variables

Variable	1	2	3	4	5	6	7	8	9
1. AC	1.000								
2. CC	-.059	1.000							
3. NC	.545**	.057	1.000						
4. JS	-.604**	.184*	-.147	1.000					
5. Active	.080	-.091	-.022	-.138	1.000				
6. Diseng	-.277**	.131	-.172*	.346**	-.307**	1.000			
7. EE	-.0428**	.152*	-.113	.724**	-.082	.379**	1.000		
8. DP	-.240**	.281**	-.016	.495**	-.124	.370**	.600**	1.000	
9. PS	-.268**	.171*	-.037	.572**	-.252**	.439**	.617**	.347**	1.000

*Note.* *p<*.05, **p<.01; AC=Affective Commitment, CC=Continuance Commitment, NC=Normative Commitment, JS=Job Satisfaction, Active=Active coping style, Diseng=Disengagement coping style, EE=Emotional Exhaustion, DP=Depersonalization, PS=Perceived Stress

Table 9

Assessment of Model Fit Using MLR

Model	χ^2	df	χ^2 p-value	CFI	ΔCFI	RMSEA	RMSEA CI	Tenable?
Baseline Model	10.622	9		0.996		.035	0.000-0.102	
Non-hypothesized paths								
ac with cc@0	10.864	10	0.565634531	0.998	-.002	.024	0.000-0.094	yes
ac with nc@0	73.055	11	5.73865E-14	0.852	.146	.194	0.153-0.237	no
cc with nc@0	11.257	11	0.516570023	0.999	.001	.012	0.000-0.087	yes
depers with exhaust@0	36.475	12	6.17099E-06	0.942	.057	.117	0.074-0.161	no
act with diseng@0	19.217	12	0.007577854	0.983	.016	.063	0.000-0.114	no
Hypothesized paths								
ac on jobsat@0	50.154	12	6.52414E-08	0.909	.057	.146	0.105-0.188	no
ac on exhaust@0	11.275	12	0.820798841	1.000	.001	.000	0.000-0.079	yes
ac on depers@0	12.291	13	0.315476031	1.000	.000	.000	0.000-0.077	yes
nc on jobsat@0	14.055	14	0.160109248	1.000	.000	.005	0.000-0.079	yes
nc on exhaust@0	16.071	15	0.134956347	0.997	.145	.022	0.000-0.082	yes
nc on depers@0	16.145	16	0.614956226	1.000	.003	.008	0.000-0.076	yes
cc on jobsat@0	17.267	17	0.289488209	0.999	.147	.010	0.000-0.075	yes
cc on exhaust@0	17.345	18	0.78002627	1.000	.001	.000	0.000-0.070	yes
cc on depers@0	30.367	19	0.000157812	0.973	.027	.063	0.007-0.103	no
act on ps@0	27.529	19	0.001848282	0.980	.016	.055	0.000-0.097	no
dis on ps@0	50.204	19	1.29969E-07	0.926	.074	.105	0.070-0.140	no
jobsat on act@0	17.341	19	0.668306124	1.000	.000	.000	0.000-0.065	yes
jobsat on dis@0	19.749	20	0.139249639	1.000	.000	.000	0.000-0.069	yes
jobsat on pstress@0	78.739	21	7.28288E-11	0.863	.137	.135	0.104-0.168	no
dp on jobsat@0	40.164	21	0.0005317	0.954	.046	.078	0.040-0.114	no
dp on dis@0	27.763	21	0.00298731	0.984	.016	.046	0.000-0.088	no
dp on act@0	20.080	21	0.939170837	1.000	.000	.000	0.000-0.066	yes
dp on ps@0	19.739	22	0.890328604	1.000	.000	.000	0.000-0.060	yes
ee on js@0	82.824	23	5.83927E-20	0.858	.142	.132	0.102-0.163	no
ee on dis@0	22.307	23	0.116535266	1.000	.000	.000	0.000-0.065	yes
ee on act@0	24.339	24	0.177647331	0.999	.001	.010	0.000-0.067	yes
ee on ps@0	47.085	25	7.66116E-07	0.947	.052	.077	0.042-0.110	no

Figure 2. Initial Structural Equation Model.
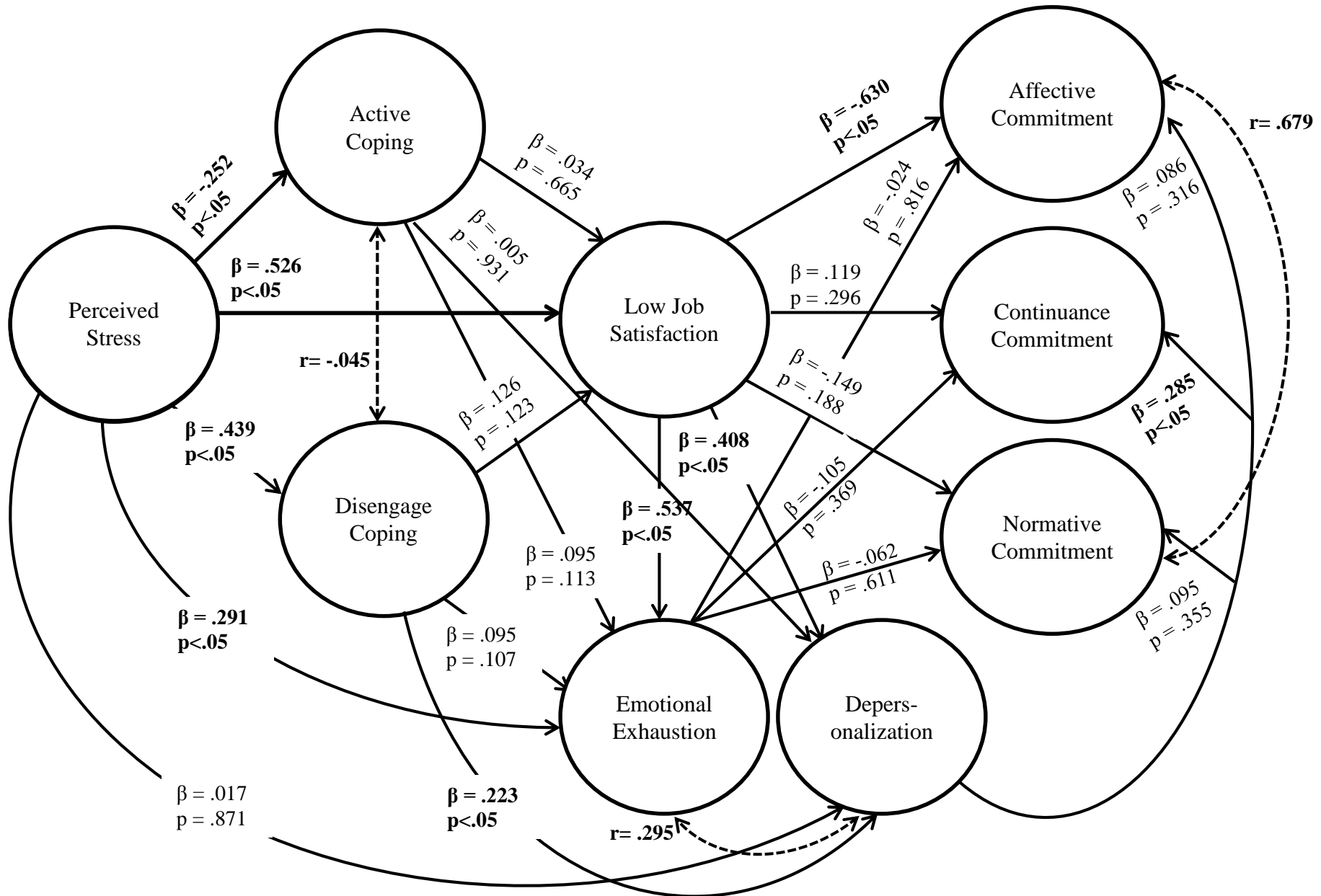
Note. Statistically significant paths (*p* < .05) are indicated in bold font. Dotted lines indicate non-hypothesized (covariance) paths.