THE RELATIONSHIP BETWEEN EMOTIONAL INTELLIGENCE, BURNOUT, AND COMPASSION SATISFACTION OF MENTAL HEALTH CASE MANAGERS WORKING IN AN OUTPATIENT MENTAL HEALTH FACILITY

A Dissertation

by

BENJAMIN REECE ROBERTSON

B.A., The University of Texas at Brownsville, 2013
M.Ed., University of Texas Rio Grande Valley, 2016

Submitted in Partial Fulfillment of the Requirements for the Degree of

DOCTOR OF PHILOSOPHY

in

COUNSELOR EDUCATION

Texas A&M University-Corpus Christi
Corpus Christi, Texas

May 2022

May 2022

THE RELATIONSHIP BETWEEN EMOTIONAL INTELLIGENCE, BURNOUT, AND COMPASSION SATISFACTION OF MENTAL HEALTH CASE MANAGERS WORKING IN AN OUTPATIENT MENTAL HEALTH FACILITY

A Dissertation

by

BENJAMIN REECE ROBERTSON

This dissertation meets the standards for scope and quality of
Texas A&M University-Corpus Christi and is hereby approved.

K. Michelle Hunnicutt Hollenbaugh, Ph.D.
Chair

Joshua C. Watson, Ph.D.
Committee Member

Richard Ricard, Ph.D.
Committee Member

Abu N. M. Waheeduzzaman, Ph.D.
Graduate Faculty Representative

May 2022

ABSTRACT

Mental health issues can have colossal and dismal consequences for not only those directly afflicted by them but also their circles of contacts. Mental health case managers (MHCMs) are often involved in the peoples' lives who are affected by these mental health concerns. As a result, relevant constructs associated with the work of MHCMs are of interest. The prime purpose of this quantitative investigation is to identify if and to what degree emotional intelligence (EI) moderates the relationship between compassion satisfaction (CS) and burnout (BO). The purpose of additional inquiries is to determine if there are statistically significant relationships between the main variables themselves as well as between the main variables and selected demographics. The sample in this study involved 73 MHCMs working in eight distinct outpatient mental health facilities throughout the state of Texas. All the participants were provided an information sheet (see Appendix A), a demographic questionnaire (see Appendix B), a ProQOL questionnaire (Stamm, 2010; see Appendix C), and an SSEIT questionnaire (Schutte et al., 2009; see Appendix D). The findings of a three-step hierarchical regression analysis indicated that EI did not moderate the relationship between CS and BO. However, statistically significant findings were discovered between the main variables themselves and between the main variables and selected demographics. The conclusions from this study may be useful for MHCMs and administrators. Implications and recommendations for various stakeholders are offered.

Keywords: emotional intelligence, compassion satisfaction, burnout, mental health case manager

DEDICATION

To my beautiful and loving wife, Flor Robertson, I am immeasurably blessed and honored to have you in my life. To my wonderful and kindhearted parents, Hilda and Reece Robertson, I am humbled by the sacrifices and compassion you have demonstrated during my lifetime. I dedicate this accomplishment to all three of you for your indelible impression on me. I do not deserve your benevolence and devotion. Nonetheless, I am thankful every day I breathe for your everlasting contributions.

ACKNOWLEDGEMENTS

I would like to make several noteworthy acknowledgements. Without their influences, I would not have had the vision, conviction, and perseverance that have enhanced my personal and professional experiences. I will forever be indebted to the following mentioned.

I want to thank the counselor education faculty at TAMU-CC for sharing their expertise and knowledge with me. Specifically, I want to thank Dr. Hollenbaugh for chairing my dissertation and offering me the patience and guidance that has helped me before and throughout my doctoral candidacy. To Dr. Watson, I thank you for your significant insights and consideration as I have been able to learn much from your teachings. To Dr. Ricard, I truly appreciate and thank you for your kind and genuine disposition that made it easy to go to you for assistance. To Dr. Waheeduzzaman, I thank you for your honest feedback and your desire to help me improve my work.

To my pre-k and kindergarten teacher, Ms. Aguilar, you had more of an influence on me than you know. I thank you for your belief in me at such a young age. It was a tremendous encouragement to me. To my longtime mentor, Dr. Ikonomopoulos, I have learned so much from you and I thank you for the positive impact you have had on my life. Your humility and capability are astounding. I continually strive to emulate you in my work.

I have friends and colleagues that I am grateful for having in my life. I thank my friends Basilio Rodriguez, Wendy Rivera, and Kristyn Heins for being there for me during the highs and lows of the doctoral program. I look up to each of you and am so appreciative of your friendship and support throughout the last several years.

To my family, you are the inspiration that propels me. I love you dearly. To my dad, your gentle and generous soul gives me wholesome perspective. I wish to be at least half the man you

have been. To my mom, your selflessness and thoughtfulness show me what unfettered goodness looks like. I aspire for my interactions with others to contain the same purity. The values that you both have imbued me with are those that I hope to carry on for the rest of my existence. To my wife, your love sustains me. It is a beacon, a haven, and my home. Your smile and laughter warm my heart. The memories you have given me are cherished in my mind and I excitedly look forward to waking up next to you for all my days.

Lastly and most profoundly, I would like to thank God for the time and grace that I have been given on this earth. As is, I have purpose, meaning, opportunities, and blessings. Without God in my life, I would be wayward and lost. I am eternally satiated by God's love and forgiveness.

TABLE OF CONTENTS

Page

LIST OF TABLES

Page

CHAPTER I: INTRODUCTION

Mental health case managers (MHCMs) perform several functions, such as assessment, planning, linkage to resources/services, monitoring, and advocacy (Joint Commission on Accreditation of Healthcare Organizations, 1979). Generally, these professionals are frequently tasked with meeting the demands of consumers and other stakeholders they serve. This can, over time, leave them feeling depleted of their psychological, emotional, and physiological resources (Lent & Schwartz, 2012). A lack of resources, coupled with the emotional exposure from occupational demands, can negatively affect their personal and professional lives can be negatively affected, and it may lead to what is known as burnout (BO) (Hatton et al., 1999). Maslach and Jackson (1986) documented three main components of BO: depersonalization, emotional exhaustion, and reduced personal accomplishment. According to Gutierrez and Mullen (2016) mental health workers affected by BO can have lessened energy, both mentally and physically, and may lead to them diminishing consumers' value and experiences. That is to say these workers may devalue/dehumanize consumers as a result of BO. An example of this might be a MHCM making snide remarks regarding a consumer's care or mental health state. Comments such as these can sometimes be the initial repercussions from BO and lead to more deleterious problems. For instance, MHCMs who are experiencing more severe BO may exhibit a lack of professional engagement and/or attendance in their jobs. As a result, consumers receiving services might not get adequate care (Morse et al., 2011). Sullivan et al. (2015) discussed several variables that contribute to case manager BO, including low salaries, high workloads, and struggles working with challenging consumers.

Conversely, MHCMs can experience happiness and contentment with their roles, duties, and interactions with those to whom they provide assistance. This phenomenon is defined as

compassion satisfaction (CS) (Kraus, 2005). According to Collins and Long (2003), there is an inverse relationship between CS and compassion fatigue (CF) and BO. There are several factors that contribute to CS for MHCMs. These factors include being involved with a group of other workers that are supportive and contribute to a healthy working environment, witnessing clients achieving goals and making progress with their treatment, and having a sense of 'community' (Kraus, 2005). In some instances, perceived need of training, quality of meetings, and risks for the future have been found to be potential workplace-related aspects that influence CS (Cetrano et al., 2017). The experience of CS can not only be a positive phenomenon for MHCMs, but it may lengthen MHCMs' tenure, thus allowing for a stronger continuity of services provided to consumers.

One component that may have an impact on MHCMs and their experiences of BO and/or CS is emotional intelligence (EI). Shkoler and Tziner (2017) reported that workers with high levels of EI have a lower proclivity to engage in unethical behavior when threatened by unfairness or BO. Other studies have found a negative relationship between EI and BO in bank personnel (Kumar, 2017; Salami & Ajitoni, 2016) and in samples of nurses (Çam & Büyükbayram, 2015; Hong & Lee, 2016; Kaur et al., 2013). In a group of mental health counselors, EI was found to be negatively correlated with level of BO (Gutierrez & Mullen, 2016). One's knowledge, awareness, and ability related to EI appear to be aspects that can have a positive influence (Amir et al., 2019).

Purpose of the Study

The purpose of this study was to investigate the potential moderation value of EI in relationship to BO and CS of MHCMs working in an outpatient mental health facility with the intent to address a gap in the literature regarding BO and CS in relation to EI with MHCMs

working in an outpatient mental health facility. To date, there a scarce number of studies include the variables of BO, CS, and EI within the population of MHCMs, when compared to other mental health professionals, such as counselors. The differentiation between MHCMs and other mental health professionals can include level of education/training, salary, caseload sizes, and other factors that may influence outcomes. A study by Kraus and Stein (2012), the research indicated that MHCMs' perceptions of recovery-oriented services provided by community mental health centers improved aspects of job satisfaction and professional accomplishment, while diminishing components of BO. Although it has been found that these mental health facilities can be influential when it comes to bettering circumstances for their staffs, specifically MHCMs, there may be utility in identifying internal mechanisms that can provide similar, if not more value to MHCMs who experience harmful effects from their jobs. While MHCMs working with individuals living with severe mental illnesses (SMI) might experience certain levels of BO due to the unique demands of their work, as well as CS due to their professional dispositions and levels of fulfillment, EI may also play a role in influencing burnout and CS.

Research Questions

The following were the research questions for this study:

1. Is there a statistically significant relationship between CS and BO in a sample of MHCMs working in outpatient mental health facilities?
2. Does EI moderate the relationship between CS and BO in a sample of MHCMs working in outpatient mental health facilities?
3. Do characteristics such as age, level of education, gender, years of working experience in one's current role, and if one is satisfied with where they currently work have a statistically significant relationship with one's level of EI, CS, and/or BO?

Hypotheses

The following were the hypotheses for this study:

1. There will be a statistically significant negative relationship between CS and BO in MHCMs working in an outpatient mental health facility.
2. EI will be a statistically significant moderator in the relationship between CS and BO in MHCMs working in an outpatient mental health facility.
3. Demographic characteristics such as age, level of education, gender, years of working experience in one's current role, and if one is satisfied with where they currently work will have a statistically significant relationship with one's level of EI, CS, and/or BO.

Objectives

For this study, there were three core objectives. The first objective was to gather and analyze quantitative data on MHCM's levels of EI, BO, and CS. The second objective was to determine if there was a statistically significant relationship between CS and BO, as well as assess whether EI was a moderator of the relationship between CS and BO. The third objective was to determine whether there were any associations with discrepancies in levels of EI, BO, and CS due to demographic factors such as age, gender, level of education, years of working experience in one's current role, and if one is satisfied with where they currently work.

Research Design

This study involved the use of primary, quantitative data collected through surveys/assessments. There was a convenience sampling method employed to gather data. Emails were sent to potential participants who met criteria for the population sample. Inclusion criteria for the chosen population sample included those who were at least 18 years old, had a minimum of a bachelor's degree, and worked as an MHCM in an outpatient mental health

facility. After IRB approval, study surveys were sent to outpatient mental health facilities to obtain permission to conduct research with MHCM employees. The surveys/assessments were based on the following measurements: The Schutte Self Report Emotional Intelligence Test (SSEIT) (Schutte et al., 2009) and Professional Quality of Life (ProQOL) (Stamm, 2010).

Analysis

The study's analysis was conducted from three main processes, including a statistical power analysis, preliminary analyses, and primary analysis. The researcher used G*Power 3.1 (Faul et al., 2007) to determine the minimum number of participants required to achieve statistical power for this study. Preliminary analyses were run through SPSS (version 21.0) to test model assumptions of a hierarchical multiple linear regression analysis by determining linearity and homoscedasticity, normality, and multicollinearity. The primary analysis that was utilized was a two-step hierarchical multiple linear regression to calculate the level at which EI moderates the relationship between CS and BO in MHCMs working in an outpatient mental health facility. The relationship between CS and BO was also assessed. Furthermore, the relationships between certain demographics and the main constructs in this study were examined. An alpha level of .05 was used as the standard to which statistical significance was assessed.

Significance of the Study

The variables of BO and CS can impact how individuals interact with each other and affect the outcomes of those interactions (Kumar, 2017; Zeidner & Hadar, 2014). Further, EI might have an effect on both BO and CS. For instance, if an individual had the awareness and ability to identify their own emotions and those of others, it could assist them in managing challenging interpersonal situations, thus mitigating aspects related to BO. Moreover, enhanced EI could potentially provide individuals with a stronger connection to their coworkers and

consumers they serve, which may contribute to their overall CS. Theoretically speaking, if these occurrences are found to exist, agencies employing MHCMs, consumers, and, in general, society might benefit from this finding. Agencies employing MHCMs may recognize the value of EI and implement strategies and/or trainings to assist workers in enhancing EI, which could potentially reduce turnover and unnecessary expenditures. MHCMs might intentionally engage in practices to improve EI/CS and minimize BO to lead to a more rewarding and less taxing working experience. Consumers could benefit from higher quality and consistency of services rendered, bringing about healthier and more fulfilling lives. Society would benefit by having fewer individuals receiving poor mental health services that could cause regressive treatment outcomes, ultimately preventing these individuals from contributing as optimally to the social infrastructure.

Although some researchers have investigated mental health professionals, EI, and detrimental components, such as CF or BO (Rosenberg & Pace, 2006; Sprang et al., 2007; Zeidner et al., 2013), this study can address a gap in the literature regarding a lack of studies examining EI and its relation to BO and CS for MHCMs, specifically those working in an outpatient mental health facility. Based on the previous research regarding BO and its effects on healthcare professionals and services rendered, it will be beneficial to determine other variables that can assist with regulating any negative consequences. Results from this study may contribute to the literature by deepening areas of research that pertain to EI, CS, and BO. Other studies may be derived from this one that explore lived experiences and perspectives of MHCMs working in outpatient mental health facilities, thus providing more rich detail in a qualitative manner. For example, if data from this study suggest that there is a relationship between EI, CS, and BO in a sample of MHCMs working in outpatient mental health facilities, then researchers could explore

the nuances of contributing factors influencing these investigated variables. One example of these factors and their nuances could be how MHCMs' interactions, positive and negative, between consumers and other staff influence their experiences of CS and BO. Another example might be MHCMs' intentional use of aspects associated with EI to buffer the experiences of BO and/or improve level of CS.

This study may have implications for mental health professionals, particularly MHCMs. The MHCMs could learn more about how these constructs relate to their work roles and the individuals they serve. An improvement in knowledge can enable their ability to emphasize self-awareness, emotion management/regulation and their understanding of others' emotions, which could lead to a longer and more fruitful work life. Additionally, the effects stemming from the work of these MHCMs could also lead to better outcomes for consumers due to improved quality of services based on sustained continuity of care. Furthermore, students training to become mental health professionals can learn more about this topic and incorporate relevant findings, such as the impact of EI on CS and BO. They might do this by involving themselves in behaviors to stimulate EI to guide their professional development and preparation in providing services to consumers in the most ethical and sound manner.

Overview of Significant Constructs

Emotional Intelligence (EI)

The construct of EI has been extensively researched over the years. Nevertheless, several proponents have different definitions of EI. Some proponents utilize an ability-based approach to understanding EI, while others view EI as being a trait-based concept. Still, others see EI as a hybrid or mixed model between ability-based tendencies and personality traits. There are many nuances contrasting different paradigms of EI. In this study, Salovey and Mayer's (1990)

interpretation of EI will be applied. This model is comprised of three distinct components that include evaluation and expression of emotion (in oneself and others), managing emotions (in oneself and others), and utilizing emotions (Salovey & Mayer, 1990).

The Schutte Self-Report Emotional Intelligence Test (SSEIT)

The SSEIT is a 33-item instrument that utilizes a Likert-type scale (from strongly disagree to strongly agree) to evaluate responses associated with EI. This is a self-report tool that commonly takes about five minutes to complete (Schutte et al., 2009).

Burnout (BO)

The construct of BO was first described in the 1970s, but since then has changed in its characterization. There are numerous definitions that have been used to study the concept of BO. Due to the multitude of nuances proliferated, no consensus has been determined. One of the more well-known conceptualizations includes three components that encompass BO: emotional exhaustion, depersonalization, and minimized personal accomplishment (Maslach & Jackson, 1984). This study, however, will employ the conceptualization from Stamm (2010) that defined BO as a response of feeling overwhelmed, despondent, fatigued, frustrated, and detached resulting from occupational stressors, such as an overstraining workload or an unaccommodating work setting.

Compassion Satisfaction (CS)

Many individuals may experience CS in their professions. It can be particularly evident with staff working in helping professions. CS is defined as the contentment of professionals in helping roles that originates from positive interactions and experiences with other professional helpers and consumers (Stamm, 2010). Examples include having a working environment

conducive to healthy communication and interactions, noticing advancement of consumers' goals and treatment, and experiencing a sense of unity in the workplace (Kraus, 2005).

Professional Quality of Life (ProQOL) scale

The ProQOL is a 30-item tool that uses a Likert-type scale (never to very often) to measure variables such as CF (consisting of BO and secondary traumatic stress) and CS. This is a self-report measure that generally takes about five minutes to complete (Stamm, 2010). Each subscale within the instrument contains 10 items.

Definition of Terms

Burnout (BO). A response of feeling overwhelmed, despondent, fatigued, frustrated, and detached resulting from occupational stressors, such as an overstraining workload or an unaccommodating work setting (Stamm, 2010).

Caseload. The number of cases/consumers, which may fluctuate over time, that corresponds to what a case manager is professionally responsible for in helping to address needs and goals.

Case management. A service typically provided by case managers to assist consumers in obtaining and maintaining services. Case managers may monitor consumers' needs and goals, as well as link them with resources that can help with the attainment of mental health, social work, medical, educational, leisure, transportation, and occupational provisions (Mathematica, 2019).

Compassion satisfaction (CS). The level of one's contentment with their experiences helping others (Stamm, 2010).

Consumer. For the purposes of this study, a consumer will be defined as an individual with a serious mental illness and/or who has received services from the public mental health system due to a diagnosis of a mental health disorder (Substance Abuse and Mental Health Services Administration [SAMHSA], 2018).

Emotional intelligence (EI). A type of intelligence composed of three distinct components that include evaluation and expression of emotion (in oneself and others), managing emotions (in oneself and others), and utilizing emotions (Salovey & Mayer, 1990).

Mental Health Case Manager (MHCM). A mental health case manager will be defined as a staff member/mental health professional who provides case management services to consumers, including but not limited to assessment, planning, linkage to resources/services, monitoring, and advocacy (Joint Commission on Accreditation of Healthcare Organizations, 1979).

Outpatient mental health facility. A facility that mainly serves consumers with less than 24-hour mental health services for typically less than around three hours at each visit. The types of services may be individual, group, and/or family oriented within a clinic or related service site. There is usually a psychiatrist that undertakes the responsibility for all consumers and the course of the mental health treatment (Mathematica, 2019).

Serious mental illness (SMI). Serious mental illness is considered to be a dire impairment in behavioral, emotional, and/or mental functioning that inhibits an individual's ability to perform tasks as they would have previously been able to and negatively affects one or more life domains (National Institute of Mental Health [NIMH], 2019).

Overview of the Study

Chapter 1 presented an introductory explanation of related concepts, such as EI, BO, CS, and MHCMs. Chapter 2 consisted of a review of the relevant literature concerning aspects related to the study. In chapter 3, the methodology was outlined and described. Chapter 4 pertained to the results of the study. Lastly, chapter 5 included the discussion of the study's findings as well as implications, limitations, and recommendations for future research regarding the outcome of the study.

CHAPTER II: REVIEW OF THE LITERATURE

The primary motivations for this study were due to the current state of mental health provisions and the welfare of consumers, and the professional helpers providing services. This chapter will consist of an overview regarding relevant topics in this study. It will be comprised of mental health problems and trends, settings where mental health case managers (MHCMs) work as well as the challenges they encounter, the theoretical framework used in this study, and aspects of burnout (BO), compassion satisfaction (CS), and emotional intelligence (EI). I will review the major constructs operationalized for this study and express the potential implications of the contained variables.

Mental Health

Impact of Mental Health Problems

Serious mental illness (SMI) is a dire impairment in behavioral, emotional, and/or mental functioning that inhibits an individual's ability to perform tasks as they would have previously been able to and negatively affects one or more life domains (NIMH, 2019). Parabiaghi et al. (2006) previously reviewed the external and predictive validity of the SMI definition and determined support for its applicability. It is important to differentiate between SMI and other mental health issues that may be considered to be less severe. Therefore, throughout this study, there will be references to both.

Mental health problems can affect individuals, families, and communities. According to a report by the National Association of State Mental Health Program Directors (NASMHPD) individuals with SMI die 25 years earlier than their general population counterparts (Parks et al., 2006). The World Health Organization (WHO, 2014) estimated that people with SMI have a life expectancy that is diminished by 10 to 25 years. In terms of the impact mental health can have

on families, it has been calculated that 8.4 million Americans, at minimum, take care of an adult with either an emotional or mental health concern (National Alliance for Caregiving & AARP, 2015). At the national level, it was determined that SMI has led to fiscal losses amounting to $193.2 billion every year (Kessler et al., 2008). Moreover, in the U.S., one out of every 25 individuals experienced SMI in 2018 (SAMHSA, 2019). Globally, the cost for anxiety and depressive-related disorders accounts for approximately $1 trillion annually (Chisholm et al., 2016). Furthermore, 264 million people suffer from depression, the highest leading cause resulting in disabilities worldwide (GBD 2017 Disease and Injury Incidence and Prevalence Collaborators, 2018). These alarming figures show the urgent need for suitable and effective mental health provision by mental health professionals and the agencies they work in.

Researchers have questioned the monetary burden that mental health problems have on insurance, programs, and general infrastructures in place to assist people receiving mental health services. Charlson et al. (2014) found that adults and children under a Medicaid plan tended to have higher healthcare costs due to comorbidity. Rowan et al. (2019) corroborated these findings and added that adults with Medicaid had higher costs associated with whether they had an SMI and/or SMIs. Therefore, cost-effective measures are often highly valued and researched due to the major implications involved. Wells et al. (2018) reported that a combination of primary health and mental health care for consumers with SMI led to a reduction of hospital visits, length of time at a hospital, and in expenditures for paying parties. Newransky et al. (2019) also noted a decrease in psychiatric hospitalizations, time spent in psychiatric episodes, and costs in services rendered due to short-term crisis and transitional intervention. In another study, Brimblecombe et al. (2017) found that a youth-specific mental health service resulted in positive outcomes for adolescents and young adults, in terms of improving mental health wellness, occupational

attainment, and lowered potential expenses over a two-year treatment period. Still, other researchers are interested in learning more about the variables that influence one's choice and ability to receive mental health services. Jones et al. (2018) noted that persons seeking mental health services in an area with a low psychiatrist supply were more likely to not receive follow up care. The researchers posited that individuals with SMI were found to be more likely to seek and obtain treatment than those without SMI.

Persons' Experiences with Mental Health Disorders in Community Contexts

While previous studies have examined statistics related to the prevalence and financial costs of mental health issues, others have focused on the particular mental health disorders and experiences for consumers receiving mental health services. For example, a study reviewed several consumers with diagnoses such as schizophrenia, schizoaffective disorder, bipolar disorder, and other diagnoses, including substance use disorders, have benefitted by being in an assertive community treatment (ACT) program within a community mental health setting. These consumers had fewer readmissions into psychiatric hospitals as a result of them being in the ACT program (Udechuku et al., 2005).

O'Hare and Sherrer (2009) suggested that individuals with a prominent history of trauma may have complicated experiences as a result of their trauma, PTSD symptoms, and risky behaviors. These experiences can further exacerbate potential opportunities. Ruesch et al. (2004) posited that many persons with SMI generally are not gainfully employed. This may lead to diminished quality of life for these individuals. Barnes et al. (2012) surveyed individuals who have SMI (diagnoses such as schizophrenia, schizoaffective disorder, major depressive disorder, and bipolar disorder) and found that overall life satisfaction was correlated with fewer psychiatric symptoms and fewer medical problems. Other researchers concluded that mortality

was positively correlated with active daily living problems as well as problematic living conditions, employment status, and leisure activities in a population of individuals experiencing SMI (Hayes et al., 2012). Adan et al. (2017) determined that there were lowered levels of quality of life in a sample of consumers with comorbidity of SMI (diagnoses of schizophrenia, bipolar disorder, and major depressive disorder) and substance use disorders, as compared to population norms.

Although there may be negative factors affecting individuals with SMI, there are different causes that can lead to healthier outcomes. Some components that may be positive mediators for quality of life with individuals who experience SMI might include social competence, disability acceptance, and support from family and friends (Sanchez et al., 2019). Although many people with SMI may choose to take psychiatric medications, a major issue has been the medication nonadherence in terms of symptom management. For those who have initially chosen to take psychiatric mediations but then stopped, at times abruptly, there are several intentional and unintentional reasons for their nonadherence. These reasons can involve a lack of insight, substance abuse issues, medication side effects, a pessimistic disposition toward medications, and cognitive problems (Velligan et al., 2017).

Trends in Mental Health Provision

Throughout the past 50 to 60 years, scholars have studied and defined the recovery from SMI differently, moving from medically centered and outcome-based foci to a more consumer-oriented perspective (Henderson, 2010). The shift from institutionalization of many individuals experiencing SMI to community-based services has been monumental for promoting autonomy and active participation in one's recovery. However, Slade et al. (2008) point out an important distinction in how the term 'recovery' is used differently, depending on the context. The authors

note that ‘clinical recovery’ is the absence of symptomology and an enhancement in functionality, in terms of a return to previously held capabilities. The term ‘personal recovery’ is more aligned with definitions provided by persons who have lived with mental health illnesses and have obtained some type of mental health provision. Some particular themes that have emerged from an understanding of ‘personal recovery’ are meaning, identity, personal responsibility, spirituality, connection, empowerment, purpose, symptom management, stigma, and hope (as cited in Slade et al., 2008). Recovery is now widely seen as a personal and self-driven process that includes assistance from integrative supports (Lysaker & Roe, 2016).

Since the deinstitutionalized movement occurred, there have been various models, approaches, and priorities that mental health professionals such as MHCM’s have applied to address mental health problems. International trends regarding psychosocial rehabilitation (PSR) have changed the way that services are provided in many countries for individuals with SMI. The main objectives in PSR interventions include integrating collaboration between service providers and consumers as well as having personalized treatment goals for consumers that incorporate the totality of the individual receiving services, as opposed to only targeting specific symptoms they may be experiencing (as cited in Kramers-Olen, 2014).

The Integrated Recovery-oriented Model (IRM) is purported to allow for positive outcomes by improving accessibility to evidence-based psychosocial interventions or EBIs (Frost et al., 2017). Drake and Whitley (2014) emphasize that evidenced-based service provisions, like supported housing and supported employment, along with treatment approaches, such as shared decision making and peer support, can boost recovery for individuals with SMI. Other EBIs that are encouraged include life skills, supported education, consumer/family psychoeducation, cognitive remediation, motivational interviewing, various psychotherapies like cognitive

behavioral therapy (CBT), and supports such as ACT, early intervention programs for those experiencing psychosis, integrated assistance for people with comorbidity issues, and case management (Menear & Briand, 2014).

Indicative of PSR principles, the Collaborative Recovery Model (CRM) is a model used to work with individuals with SMI and is founded on the premise that these individuals have the wherewithal to lead lives filled with productivity and meaning, while simultaneously experiencing effects from their conditions (Slade et al., 2008). The CRM is sustained by respecting consumers' independence and working together on identifying needs, motivations, goal creation/progress, and homework/monitoring (Oades et al., 2005). In a study by Marshall et al. (2009), consumers perceived CRM to have positive effects on their recovery, in terms of them having higher completion rates of homework and believing their case managers to be supportive of their recovery journey. CRM principles have also been employed in an individual placement and support (IPS) program and a supported employment model, and were found to have beneficial results for consumers with regard to the length of their employment placements (Scanlan et al., 2019). Gibbons and Salkever (2019) reported that employment for individuals with SMI had positive effects on their mental health as well as their interactions with others.

Similar to the CRM, another recognized model is the Comprehensive Approach to Rehabilitation (CARe) methodology. The CARe methodology has evolved over the years since its inception in the 1980s and now includes aspects of individual recovery and a Strengths model of case management (as cited in Bitter et al., 2019). Adherents of this approach see the benefits in how they approach working with consumers, particularly after receiving training and guidance. Bitter et al. (2019) studied professionals who obtained such supports and found that these workers had an improved level of knowledge regarding CARe concepts and their scores

were higher than those in a control group. The authors go on to recommend that practitioners of this methodology continue to routinely take training and coaching that recognizes the specific challenges of these practices. In another study by Bitter et al. (2017), even with no apparent differences between the intervention and control groups, quality of life for consumers was assessed to be increased and unaddressed needs decreased when receiving CARe services.

The Illness Management and Recovery (IMR) approach is a structured form of psychosocial intervention used by clinicians to assist consumers dealing with issues related to SMI. There are five unique components that are applied within IMR that create a diminution in relapses and rehospitalizations through relapse prevention initiatives, increase comprehension regarding mental health illnesses by psychoeducation, foster medication acceptance and usage via behavior training, reduce the degree and affliction of symptoms with training in coping skills, and fortify social supports by means of social training (Egeland et al., 2017). The use of IMR has shown promising results in a variety of studies. Egeland et al. (2017) found significant positive changes in the ability of consumers to manage their illness and have better functioning, more hope, and fewer severe problems. In another study where IMR was infused within an ACT program, the researchers discovered a decrease in the number of hospitalizations as well as the total number of consumers hospitalized (Salyers et al., 2010). The researchers noted that clinicians teamed up with peer specialists, which offered a different take on the traditional strategy within IMR, to provide services within the ACT program.

For certain consumers who experience physical health and mental health symptoms, an adapted version of the IMR, called the Integrated Illness Management and Recovery (I-IMR) program, has been implemented. Mueser et al. (2012) determined that elderly consumers experiencing SMI and receiving I-IMR services were able to have more self-efficacy in their

own management of health issues, manage their psychiatric and physical conditions more effectively, and reach healthcare goals. Another adaptation of the IMR is the Wellness Management and Recovery (WMR) program. Users of the WMR follow a manual within a group-treatment context for the purposes of supporting recovery in people with SMI. Of note, sessions in WMR can be provided by peer specialists in conjunction with other employees of a mental health organization. A study by Lee et al. (2016) indicated that the outcome of a WMR program on individuals with SMI revealed fruitfulness, helping to reduce trauma-related symptoms and advance the improvement in their mental health.

The trauma-informed approach (TIA) to consumer care has become more commonplace within the last couple of decades (Knight, 2018). A prevailing notion regarding having a 'trauma informed' disposition is the change in thinking from "What is wrong with you?" to "What has happened to you?" (Sweeney et al., 2018, p. 319). This distinctive operational alteration gives consumers the ability to express their current struggles that have been influenced by past traumas (Knight, 2014). Five key pillars, including safety, trust, choice, collaboration, and empowerment have been seen as aspects of trauma-informed practice (Hickle, 2020). Knight (2018) expressed the need to understand the difference between trauma-informed practice and trauma-informed care, mentioning that the former is aligned with mental health interventions and the latter is aligned with how services are rendered to consumers via the organizational framework used by agencies.

Currier et al. (2017) commented on how trauma-informed care is not yet an empirical approach, but rather a conceptual measure taken by organizations to work with consumers in a more sensitive and humanistic manner. With that in mind, researchers have explored the utility of trauma-informed care as well as other relevant considerations for implementation. Kirst et al.

(2016) reviewed qualitative responses to their inquiries and found many insights from providers and consumers related to trauma-informed services. They discovered that providers called for more leadership, collaboration with other agencies, awareness of trauma, creation of a safe environment, focus on the consumer-provider relationship, and support for staff. Providers also shared challenges experienced such as a hesitancy to address issues of trauma, a lack of readily available services, and time-draining, overwhelming work. Consumers revealed positive views of the trauma-informed care such as believing they had gained applicable skills to address their traumas, their needs had been fulfilled, appreciation for the opportunities to share their experiences, and that their time with staff was seen as uplifting due to the staffs' benevolent attitude and how these qualities helped to create a therapeutic environment. Consumers' negative views included situations where providers were not willing to discuss traumatic instances that consumers had, that there were not enough trauma-informed programs or access, and that disruptive nature of other consumers could negatively affect their experiences of receiving services (Kirst et al., 2016). In another study, Hales et al. (2018) noticed that trauma-informed care seemingly had a positive impact on organizational proceedings and atmosphere, intra-agency staff working relations, consumer satisfaction, and a reduction in unexpected discharges. McDonald (2020) suggested that trauma-informed care could possibly improve service utilization, provision effectiveness, and general health while establishing a stronger connection between consumer and provider.

Strengths-based case management (SBCM) is another trend that has gathered momentum in the last couple of decades (Brun & Rapp, 2001; Gelkopf et al., 2016; Regis et al., 2020; Vanderplasschen et al., 2007). SBCM has been applied with individuals experiencing severe mental health concerns and/or substance abuse issues (Arnold et al., 2007). There are five

leading principles within SBCM: a focus during the assessment and planning phases consumers' internal resources; consumer discretion in their goal creation and looking for necessary resources; the working relationship between the consumer and the MHCM being valued as vital to progress; a perception of community as a useful resource as opposed to a hindrance; and case management in an involved, community-rooted method (Redko et al., 2007). Several influential elements of solution-focused therapy have been found in SBCM, such as the notion that everyone has abilities and can utilize autonomy, change is constant, consumers are their own experts, accentuating current and future circumstances, it is more beneficial to focus on solution-oriented discourse than problem-oriented discourse, and minor changes can lead to larger changes over time. Other specific interventions are operationalizing problems and goals as well as finding and enhancing solution habits (Greene et al., 2006). Blair et al. (2009) dichotomized the strengths-based approach with the pathology model of care, to show that the former is consumer-focused and is conducive in allowing consumers to examine and utilize their internal/external resources in accordance with their aims of achieving recovery. Moreover, research regarding the strengths-based approach has shown tangible, favorable outcomes for consumers' personal and inner experiences along with benefits to their societal affairs (Tse et al., 2016). Lindahl et al. (2012) reported that SBCM interventions had a positive impact, which contributed to no consumers dropping out during treatment. In a similar study with more participants, Gelkopf et al. (2016) concluded that SBCM promotes quality of life within intrapersonal and various other life domains, cultivates belief in one's ability, assists in meeting needs, and improves the quality of goal setting. Case managers have also been able to establish a solid working partnership with consumers while using SBCM, even after one session (Regis et al., 2020).

Summary

The available world data regarding the effects of mental health problems has substantiated serious consternation. Stakeholders have steadily become more aware of issues that are faced by those living with SMI and mental health concerns in general, further illuminated by the research. While societal perspectives and responses have changed in how provisions are viewed and offered, more focus can be given to the workers that serve individuals living with mental health issues. The next section presents content regarding MHCMs who are directly involved, often with the day-to-day functions, in consumers' lives where SMI is a prominent predicament.

Mental Health Case Managers

There are often scenarios where individuals require assistance in being connected to and managing physical and mental healthcare services. In many situations, MHCMs are considered to be frontline staff who meet with these potential and existing consumers who experience SMI, suggesting an immense importance regarding their professional involvement (Leutwyler et al., 2017). Generally speaking, MHCMs offer fundamental clinical services and organize resource attainment for consumers (Eack et al., 2009). Though there are several models of case management, MHCMs typically strive to help consumers create goals, solve problems, and make the most of available resources, while circumventing identifiable barriers and maintaining a working alliance (Ravitz et al., 2019).

Some MHCMs may work within private or public sectors, or non-government agencies (Lukersmith et al., 2016). Moreover, MHCMs' work can be in outpatient or inpatient settings, which could branch off into specific types of facilities. The particular facilities that MHCMs work at serve varying populations, such as youth, adult, geriatric, incarcerated, homeless, etc. In

many cases, MHCMs are employed within community-based settings that serve a multitude of populations concomitantly (Lukersmith et al., 2016). Consequently, MHCMs spend a portion of their time traveling to various locales (homes, offices, etc.) to provide services to consumers. The goal is to meet the needs of consumers. This means that MHCMs are actively flexible within the environments in which they work, and could be doing so individually or as a team with other professionals (Ivezic et al., 2010).

For decades, studies have shown MHCMs to be a crucial component in closing the gap between individuals seeking healthcare services and the acquisition of those provisions (O'Donnell et al., 2020). Griswold et al. (2005) found that MHCMs utilized effective intervention regarding linkage from inpatient psychiatric hospitalization to primary care within three months. The authors emphasize the significance of MHCMs, in that they are not only offering the information of the primary care provider to the consumer, but engaging in an ongoing process of educating, facilitating access to services and resources, and having routine contact through phone, home visits, and mobile outreach. There is evidence indicating that MHCMs can provide services which lead to an improvement in quality of life and consumer contentment within adult and youth populations (Arnold et al., 2007; Vanderplasschen et al., 2007). Several proponents have deemed the collaborative relationship between an MHCM and the consumer to be essential for a number of reasons (Kondrat & Teater, 2012). Hicks et al. (2012) reported that the improvement in alliance between an MHCM and the consumer had a positive impact on recovery outcomes. The frequency of MHCM visitations has also been associated with a decrease in psychiatric symptoms for consumers (Schneeberger et al., 2017). There are certain occasions where MHCMs are able to secure a robust working relationship with consumers after a single session, which may lead to positive overall results (Regis et al., 2020).

However, healthcare outcomes may not be the only benefits of case management. Research has shown that case management services are cost-effective by reducing healthcare costs and usage episodes, further highlighting the value of MHCMs (Chung, 2010; Gelkopf et al., 2016; Hudon et al., 2016).

Challenges for Mental Health Case Managers

Despite case management existing for over half a century, MHCMs face challenges in their work with consumers. The challenges MHCMs experience have an impact on their personal and professional lives as well as their quality of work with consumers (Morse et al., 2011). Ultimately, administrations and organizations are also negatively impacted, which leads to further complications (Sullivan et al., 2015).

Caseload size is one of the major occupational stressors that adds to the complex working circumstances for MHCMs. King (2009) found that larger caseload sizes were correlated with higher estimations of stress related to work and lower estimations of case manager self-efficacy. Caseload sizes may depend on the amount of MHCMs in a particular department as well as the number of consumers enrolled in services. For example, if there are a lack of MHCMs in a department and a high demand for services by consumers, then the expectation is that there will be higher caseloads. This reality for MHCMs effectively translates into more work with less time to complete it. Kraus and Stein (2012) explained that high caseloads, along with other factors such as large quantities of paperwork, a lack of sufficient funding and financial compensation, and the high volume of requests for services, add to the challenges that MHCMs encounter. Administrative tasks like surplus meetings, audits, compiling statistics, and report writing may increase the workload of MHCMs (Lukersmith et al., 2016).

Another challenge that tends to emerge for MHCMs is interacting with indifferent consumers or consumers who appear to "sabotage" treatment services (Stanhope et al., 2012). Certain consumers may engage in services initially, only to become ambivalent or irregular with their own appointments and then cease seeking services completely without providing notification to MHCMs, undercutting any progress made prior. The time, effort, and resources used to help a consumer achieve tangible and positive change that seems to disappear instantaneously can be yet another source of frustration for MHCMs (Stanhope et al., 2012). Consumers may enroll in services months or years later and end up falling into the same pattern of behavior. Furthermore, MHCM frustration can become exacerbated if this type of disengagement and reengagement occurs habitually.

Crisis situations can materialize quickly and sometimes without much warning. The onus is on MHCMs to respond effectively and expeditiously in addressing the emergent concern. With this reality, crises can engulf most of the workday for MHCMs, leading to a more demanding experience (Sullivan et al., 2015). The high level of stress that transpires from crises can drain an MHCM's energy (Kirst et al., 2016). On top of this, the MHCM may witness consumers go from a state of stability to a state of peril. These particular instances, happening across different timepoints with multiple consumers, seemingly compound over time. It is in this repeated nature that MHCMs can develop a sense of dismay (Sullivan et al., 2015).

Working with other staff in collaborative efforts to enhance service provision for consumers can be a positive learning experience for employees (Ivezic et al., 2010). However, there are times when conflict or issues may arise due to the communications between MHCMs and other team members. Stanhope and Matejkowski (2009) discovered that MHCM's experience frustration in working with other team members based on their interpersonal

dynamics and how it can affect the initial meeting with a consumer. Staff members certainly have invariably different personalities that may influence their synergy in how they are able to serve consumers. In the same study, the researchers found that MHCMs noticed other MHCMs having closer working relationships with consumers, which had a negative effect on their own work with those consumers, due to lacking the same understanding and solidarity. There can be situations where MHCMs have a different perspective from their coworkers regarding consumer care, which may change the approach that is taken in addressing treatment. This difference in perspectives has shown to be another cause for strain between coworkers (Stanhope & Matejkowski, 2009).

All of the previously mentioned challenges that MHCMs face are pressures that can lead to BO. It is well-documented that BO can bring about many undesirable consequences and is a worrisome problem for all stakeholders affected, be it staff, consumers, agencies, and/or the public (Morse et al., 2011). The BO that MHCMs experience as a derivative of workplace challenges seriously affects their physical, mental, and emotional capacities (Kraus & Stein, 2012). As a result, MHCMs may end up leaving their jobs, which develops into high turnover rates. These turnover rates can adversely affect consumer care, as new staff must be trained and may not possess the same level of skill, understanding, or expertise (Sullivan et al., 2015). There is also the aspect of consumers becoming acclimated to their new MHCM that may take time and impact their treatment progress. Furthermore, turnover rates produce costly expenditures for psychiatric mental health facilities which have employed these MHCMs (Selden, 2010). Each one of these occurrences functions as a step in a cyclical process that continues to impair MHCMs still working in their roles.

Summary

The previous studies support the notion that MHCMs are indispensable, as their role within different settings exemplifies their worth not only as a front-line team member, usually among interdisciplinary professionals, but one that assists consumers from their initial appointment in receiving services, to the coordination of services/resources, and eventually to discharge once goals/recovery have been achieved. Moreover, the evidence also shows propitious byproducts stemming from the efforts of these MHCMs. Even still, MHCMs experience numerous challenges that are problematic for them, can impede their work with consumers, and endanger consumer progress towards recovery. The following section offers the theoretical framework of this study.

Theoretical Framework: Transactional Model of Stress and Coping

Background/Definition

There are various theoretical perspectives in the research on stress and coping that have been postulated. Lazarus and Folkman (1984) provided one of the more prominent viewpoints reviewed that are utilized in contemporary literature. They posit their transactional model of stress and coping (TMSC) in which "psychological stress is 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" (Lazarus & Folkman, 1984, p. 19). This described relationship is characterized by processes of cognitive appraisals and coping.

Cognitive appraisal is seen as the "process of categorizing an encounter, and its various facets, with respect to its significance for well-being" (Lazarus & Folkman, 1984, p. 31). There are primary and secondary cognitive appraisals, as well as reappraisals (Lazarus & Folkman, 1984). Primary cognitive appraisals are mental evaluations of whether a situation/stimulus is

potentially troublesome or beneficial, currently or at some point in the future, and the particulars of how. Furthermore, there are three main kinds of primary appraisals: unrelated, positive, and stressful (Lazarus & Folkman, 1984). If a subjective confirmation of either of the last two perceptions is made, then the individual will classify the scenario in one of three ways- a threat, a challenge, or a loss (Berjot & Gillet, 2011). Loss is considered to be a type of destruction or a detriment that has previously occurred, while threat and challenge appraisals are viewed as historical events or expected ones (Berjot & Gillet, 2011). Moreover, a challenge can be viewed as a positive experience that may prime someone for growth or maturity (Berjot & Gillet, 2011).

Secondary appraisals are personal assessments of one's coping resources, whether physical, social, psychological, and/or material, and serve to understand whether these resources are adequate in managing the perceived stressors originating from the situation (Berjot & Gillet, 2011). Coping is defined as the "cognitive and behavioral efforts to master, reduce, or tolerate the internal and/or external demands that are created by the stressful transaction" (Folkman, 1984, p. 843). There are two varieties of coping, emotion-focused and problem-focused. Emotion-focused coping is employed for managing emotions during stress-inducing situations and problem-focused coping is used to address the specific components of the dilemma that begets stress (Folkman, 1984).

Reappraisals happen based on updated information that one receives from their environment, from their own responses to their environment, or due to mental coping exertions (Lazarus & Folkman, 1984). The nature of the dynamics is such that there is fluidity between the individual and their environment, meaning that as time and experiences or circumstances change, the perceptions of subjective stressors change correspondingly (Lazarus, 1999). Due to the constant plasticity in the relationship between person and milieu, there are also changes in how

one copes in relation to perceived stressors (Giacobbi et al., 2004). Positive reappraisals are essentially shifts in mental processes which contribute to one's ability to cope (Lazarus, 1993). People may engage in positive reappraisals during usage of emotion-focused coping that assists them in reassessing distressful cognitions to identify new, healthier thinking patterns (Matthieu & Ivanoff, 2006).

Relevance to MHCMs

Although MHCMs have a range of duties and experiences pertaining to their role, it would appear that the TMSC put forth by Lazarus and Folkman (1984) has applicability for a plethora of explanations. As illustrated beforehand, MHCMs can take on many burdens while carrying out their professional obligations that might lead them to experience a high level of stress. Based on their internal and external resources, MHCMs may attempt to contend with their work-related stressors, regardless of the prospect of a successful outcome. As indicated by previously conducted qualitative and quantitative research, MHCMs certainly have perspectives on their work with consumers as well as the factors that intermix and influence occupational prosperity (Kirst et al., 2016; Stanhope & Matejkowski, 2009; Sullivan et al., 2015).

Tennille et al. (2010) described MHCM experiences in which they were surprised to learn certain revealing information about consumers; however, this did not sway their work nor did it create a perspective of concern. This can be conceptualized as the MHCM filtering these experiences into the irrelevant type of primary cognitive appraisal, since it is not viewed as positive or stressful and did not create a perception of loss, challenge, or threat. In spite of difficulties faced by MHCMs, they have been able to learn from consumers' lives and find ways of appreciating their own lives more fully (Stein & Craft, 2006). This way of reevaluating one's life based on their work with consumers may be about confronting themselves in making

enriching personal changes, which can be understood as the positive aspect of the primary cognitive appraisal, albeit, categorized as a challenge. Another example of a positive, but challenging primary appraisal is when MHCMs see their work as having variety but know that they may encounter unforeseen situations that challenge them to respond accordingly (Sullivan et al., 2015). For primary cognitive appraisals that are regarded as stressful, MHCMs might perceive these situations to as a loss or threat. Crisis situations, increased caseloads, and an overabundance of paperwork are a few components that have been considered to be threats to MHCMs' mental and emotional stability (Kraus & Stein, 2012; Sullivan et al., 2015). Some MHCMs have experienced a loss of optimism, consideration, and motivation (Kraus & Stein, 2012; Morse et al., 2011; Stanhope et al., 2012). There could be MHCMs that do not see a conceivable change in circumstances. For instance, Freire et al. (2016) noted that some individuals might not recover from their losses due to the damage that has already taken place.

Secondary appraisals are evaluations of internal and external resource inventories. Indubitably, there are times when MHCMs take stock of available resources and determine that they are able to manage a situation satisfactorily, resulting in no negative aftermath. Nevertheless, some MHCMs engage in secondary appraisals and perceive the aforementioned work demands to exceed their own capacities to cope. Sullivan et al. (2015) expressed that MHCMs might develop BO at this point, which cascades other setbacks. To avoid adverse effects, MHCMs apply emotion-focused and problem-focused coping methods. Folkman (2010) described examples of emotion-focused coping including psychological distancing, positive reframing, and requesting emotional assistance. Productive coping can be achieved through positive reappraisals, which occur when a person perceives a previously stressful situation as less intimidating and notices a reduction in potency of any negative emotions (Ntoumanis et al.,

2009). Certain scenarios in which MHCMs witness or hear about traumatic events while working with consumers can cause undue stress. In these situations, MHCMs might elect to rationally distance themselves or intentionally change their outlook on the issue to be able to cope with the perceived stressor. Even still, MHCMs can look to supportive services in finding help. Morse et al. (2011) reviewed several studies and found that MHCMs have used cognitive-behavioral skills and strategies, meditation and mindfulness, and have participated in various trainings and programs to enhance coping competences. With this in mind, reappraisals seem to be an effective tool for MHCMs attempting to be more adaptive in their responses to workplace stressors. Perhaps more commonly utilized, MHCMs can cope with situations through problem-focused means such as identifying new resources for a consumer lacking healthcare, helping a consumer find a bus route, or assisting a consumer in deciding the best way to triage their needs based on level of urgency. According to Sullivan et al. (2015), MHCMs can derive a sense of joy and satisfaction from being able to use problem-solving skills to assist consumers in making progress.

Summary

The TMSC has been used with a range of populations and can be seen as a functional theoretical background for MHCMs. Primary appraisals, secondary appraisals, and reappraisals appear to align with how MHCMs operate and handle trying circumstances regarding their work with consumers. Not all similar situations are perceived the same; something seemingly ominous to one MHCM might be viewed as innocuous to another. While MHCMs experience situations where they perceive stress, they can actively reassess perceptible threats as less harmful entities and cope more effectively through emotion-focused tools. Still, certain emotion-focused options

may not work equivalently for all MHCMs, with the efficacy depending on the individual's perspective (Ntoumanis et al., 2009).

Burnout

Background/Definition

Nearly 50 years ago, Herbert Freudenberger and Christina Maslach were independently learning about and propagating the term "burnout" or BO, as it is referred to in this study. They both observed this described phenomenon in their work with others as well as in their talks with colleagues (Guzzi, 2019). Freudenberger believed BO was a state of "becoming exhausted by making excessive demands on energy, strength, or resources" (Freudenberger, 1974, p. 159). Maslach conceptualizes BO as a "psychological syndrome emerging as a prolonged response to chronic interpersonal stressors on the job" (Maslach, 2018, p. 11). According to Maslach, there are three main components to BO, which include emotional exhaustion, depersonalization, and a reduction in personal accomplishment (Maslach et al., 2001). Emotional exhaustion is seen when one has a loss of internal and emotional resources stemming from the demands of work and relational engagements in a work setting. Depersonalization is understood as a psychological detachment in which one intentionally distances themselves from consumers by viewing them as less intricate and distinctive, causing their interactions to become less humanized. A reduction in personal accomplishment is considered to be a diminished sense of effectiveness or achievement that emerges from an absence of useful resources and occurs either concurrently or sequentially with emotional exhaustion and depersonalization (Maslach et al., 2001). Since the well-known emergence of BO from the 1980s and 1990s, there have been variations in how it is defined and understood. Currently, there is no consensus on an operational definition for BO, as many

researchers have offered divergent takes on how this construct is described and in what contexts it is applicable (Guzzi, 2019).

Other proponents of state-based models of BO include Perlman and Hartman, Meier, Brill, Pines and Aronson, Farber, Figley, and Potter (Guzzi, 2019). Perlman and Hartman (1982) saw BO as a reaction to pervasive emotional strain that was comprised of exhaustion (physical and emotional), decreased job efficiency, and extreme depersonalization. Meier defined BO as a cognitive status "in which individuals expect little reward and considerable punishment from work because of a lack of valued reinforcement, controllable outcomes, or personal competence" (Meier, 1983, p. 899). Brill believed BO to be "an expectationally mediated, job-related, dysphoric and dysfunctional state in an individual without major psychopathology who has (1) functioned for a time at adequate performance and affective levels in the same job situation and who (2) will not recover to previous levels without outside help or environmental rearrangement" (Brill, 1984, p. 15). Pines and Aronson (1988) conceptualized BO as a condition that had aspects of exhaustion related to physical, mental, and emotional attributes. Farber operationally defined BO as a "work-related syndrome that stems from an individual's perception of a significant discrepancy between effort (input) and reward (output)" (Farber, 1990, p. 24). Figley (1995) viewed BO as a reduction in optimal functioning across seven domains (cognitive, emotional, behavioral, spiritual, interpersonal, psychosomatic, and work) that originated from persistent usage of empathy as well as work-related difficulties. Potter (1998) explicated BO as a loss of energy that has adverse consequences to one's drive and their capacity to use their skills. More recently, Stamm (2010) regarded BO as a response of feeling overwhelmed, despondent, fatigued, frustrated, and detached resulting from occupational stressors, such as an overstraining workload or an unaccommodating work setting. As one can

tell, several of these definitions of BO appear to have overlapping features but may not be considered exactly the same due to how they are presented and the nuances between each of them.

There are multiple instruments used to measure BO. Qiao and Schaufeli (2011) reviewed four of the most renowned and used instruments to measure BO for the purpose of determining convergent validity. In their study, they concluded that BO should be viewed as a multifaceted construct that is comprised of exhaustion and withdrawal components. The researchers examined the Maslach Burnout Inventory-General Survey (MBI-GS), the Burnout Measure (BM), the Shirom-Melamed Burnout Measure (SMBM), and the Oldenburg Burnout Inventory (OLBI). Initially, the MBI was used and rose to peak popularity in the 1990s. The MBI-GS, which also has a three-factor structure (exhaustion, cynicism, and reduced professional efficacy), was then created to address the possibility that BO occurred outside of human service professions (Qiao & Schaufeli, 2011). The OLBI is utilized for individuals in workplace settings and has two elements related to exhaustion and detachment. In the OLBI, exhaustion is made up of physical, emotional, and mental components; detachment is separating oneself from their work and having a negative disposition toward aspects related to their work (Qiao & Schaufeli, 2011). The BM instrument was originally created as a unidimensional measurement, not constrained to a specific context. However, several studies revealed an embedded three-factor setup that held three distinct but particularly correlated factors of demoralization, exhaustion, and loss of motive (Qiao & Schaufeli, 2011). The SMBM was founded based on Hobfoll's (1989) Conservation of Resources (COR) theory and helped to examine BO through its focus on exhaustion. The SMBM can also be utilized in a variety of settings and contains three separate subscales: physical fatigue, emotional exhaustion, and cognitive weariness (Qiao & Schaufeli, 2011).

Factors Related to Burnout

There is a plethora of factors related to BO within the literature, some considered to have positive or negative relationships with BO. These variables, in varying degrees, may be determinants or byproducts. Nuances of the effects on or from BO can depend on the setting, population, and other influential interrelated components.

One aspect that is often linked with BO in work settings is job stress. Levels of job stress are shown to be dynamic and ever-changing depending on numerous organizational facets. While job stress is typically a complicated issue, its outcomes on BO seem to be simple to understand. Abarghouei et al. (2016) found that job stress had a significant positive relationship with emotional exhaustion and depersonalization, concurrently having a significant negative relationship with personal accomplishment. The authors emphasized the negative and taxing effects that job stress has on healthcare employees. Job stress can also become exacerbated with a higher number of working hours, which may lead to other effects (Hatton et al., 1999). Wang et al. (2020) determined that work hours each day was significantly correlated with BO. The number of years one has worked in the same position has also predicted BO (Galek et al., 2011). In another study, Kim et al. (2020) reported that emotional dissonance has direct and indirect effects on BO, citing a significant positive relationship between both constructs. Lent and Schwartz (2012) discovered a personality aspect, neuroticism, to be strongly predictive of BO. Lower education levels, extended shift work, and job displeasure are amongst other components associated with BO (Fentie et al., 2021). Prada-Ospina (2019) recognized job dissatisfaction to have a positive correlation to BO. In an older study, work-home conflict as well as workload were also seen as predictors of BO (Langballe et al., 2010). Hansen et al. (2021) noted that administrative-related aspects such as a lack of systemic supports, lack of training/education,

lack of resources, increased tasks, and turnover rates contributed to staff BO. Theoretically, all of these internal and external sources could be combined for people in particular scenarios to ultimately worsen overall conditions.

Throughout the last decade, meta-analyses have been conducted to find variant associations with BO. A meta-analysis completed by Lim et al. (2010) revealed that level of education, work hours, and working in an agency as opposed to private practice were positively associated with emotional exhaustion, a component of BO. In contrast, age was determined to be a strong negative predictor of the emotional exhaustion and depersonalization aspects of BO. Moreover, age, years of experience, and level of education were positively correlated with personal accomplishment, another dimension often considered to be a part of BO. Interestingly, a meta-analysis by O'Connor et al. (2018) demonstrated that age had positive correlations with both depersonalization and personal accomplishment facets of BO. The authors also reported that workload and conflictual relationships with colleagues were occupational determinants for BO. Similarly, López-López et al. (2019) detected work overload and aggression issues between coworkers as contributors to the development of BO in their meta-analytic review. In a separate meta-analysis by Kim and Lambie (2018), the results showed large caseload sizes, lack of supervision, increased perceived stress, and completing unrelated job tasks as being variables correlated with higher levels of BO. A total of 77 studies were reviewed in the four previously referred meta-analyses.

Researchers have identified various protective factors that assist people in eschewing BO. For instance, personality traits such as grit are considered to have mitigating effects on BO, improving circumstances for individuals in continuously stress-inducing work environments (Cheema et al., 2020; Kim & Lambie, 2018; Moen & Olsen, 2020; Shakir et al., 2020).

Additionally, another personality trait, agreeableness, has been viewed as having an alleviating quality regarding BO (Lent & Schwartz, 2012). In a more recent study, Blanchard et al. (2021) suggested that EI had a negative correlation with BO. Kim et al. (2020) expressed that CS also had a negative relationship with BO. Other remediating factors related to BO include job satisfaction, sleep hours per day, and sleep quality (Wang et al., 2020). Social supports can also provide a buffer from the problems associated with BO (Galek et al., 2011). Kim and Lambie (2018) acknowledged that work support, supervision, higher levels of ego maturity, and task-aligned stress coping approaches serve as protective elements against BO. Furthermore, a sense of being treated fairly, clear understanding of role expectations, professional independence, and clinical supervision are extra protective factors found within the literature (O'Connor et al., 2018). The supervisory relationship and its supportive nature seem to counteract BO (Johnson et al., 2020; Yanchus et al., 2017).

Burnout in Helping Professions

The effects of BO on professional helpers are well-documented and have been of interest for many decades. Across numerous professions, the implications of BO are demonstrated to be pervasive and detrimental to the workers that offer services as well as to the individuals that receive those provisions. The experiences of workers in helping professions regarding BO are of importance to learn more about the aspects that cause dysfunction within organizations and the way their services are rendered.

Researchers have written about the effects of BO on hospital staff. Given the fast-paced nature and the environment these workers experience in their occupations, there may be little time to address concerns regarding BO. Patel et al. (2018) referred to work factors, organizational factors, and personal characteristics as some of the predominant causes of BO for

physicians. It has been estimated that one-fifth to one-third of resident physicians may experience BO (Nishimura et al., 2019). Huang et al. (2020) suggested that medical residents could benefit from lowered work-related burdens and more accessibility to resources. Yao et al. (2021) concluded that approximately 48.8% of doctors suffer from work-related BO. In another study, Al-Haddad et al. (2019) purported that almost 25% of physicians experienced high levels of BO. The consequences of BO within the physician population can include poorer health, lower quality patient care, and increased health care costs (Patel et al., 2018). Still, other staff working in hospitals are variably affected by BO. Manzano-Garcia and Ayala (2017) indicated that nurses working various shifts across multiple countries experience BO at different levels. The authors contend that individual factors such as socio-demographic characteristics, personality traits, and lifestyle and situational factors like organizational variables and working environment all contribute to BO in nurses. Wu et al. (2015) asserted that one of their most profound findings was regarding nurses' views that work togetherness in the workplace was a factor that led to lower levels of BO.

Workers in education-related jobs also experience BO. Specifically, primary/secondary school staff and academics in university settings encounter situations throughout their work settings which may result in BO. Marić et al. (2020) surveyed a sample of primary and secondary teachers and concluded that the experience of BO varied across regions where the teachers lived. Moreover, the researchers reported that older teachers tended to experience more emotional exhaustion. O'Brennan et al. (2017) suggested that school staff who do not have a sense of connectedness to their school communities tend to feel more BO than others who have robust relationships within the school system. Furthermore, school staff who had worked in their roles for four or more years tended to report BO. School staff with high self-efficacy in managing

stressors appear more likely to not experience as much BO as others who do not view themselves with as many applicable skills (Molero Jurado et al., 2019; O'Brennan et al., 2017). Maior et al. (2020) discussed that secondary school teachers tend to experience lower levels of depersonalization when they have more rational perspectives and are able to utilize social-emotional skills. Additionally, social-emotional abilities are negatively correlated with emotional exhaustion (Maior et al., 2020). Lei et al. (2020) noticed that academics in the university system faced teaching-research conflicts that increased the possibility of BO. The authors noted that internal psychological resources and perceived support from supervisors helped to assuage concerns associated with BO. Problems with coworkers, workload, and requests from students are found to be significantly and positively correlated with emotional exhaustion in university professors (Martini et al., 2019). Differences between aspects of BO in academic faculty have been identified. For example, clinical faculty, as compared with basic sciences faculty, have been evaluated at possessing more emotional exhaustion (Haghighinejad et al., 2021). In university female professors, higher scores on the emotional exhaustion dimension were witnessed, as compared to their male colleagues (Redondo-Flórez et al., 2020).

Mental health professionals work in a multitude of settings and have differing roles. However, contingent on particular contexts, they may experience BO in varying degrees and due to distinct reasons. Various researchers have written articles focusing on different individual populations, including counselors/therapists, psychologists, psychiatrists, social workers, case managers, clinical administrators/supervisors and other types of workers that are referred to under the umbrella term 'mental health professionals.' In accordance with Lent and Schwartz (2012), Somoray et al. (2017) discovered neuroticism within mental health professionals as a positive predictor of BO. According to Puig et al. (2012), mental health professionals

experiencing exhaustion from BO may not be engaging in wellness behaviors, such as eating healthily and exercising on a regular basis, which could further impair their well-being. These authors go on to suggest that mental health professionals engaging in these behaviors might start to feel incompetent and/or devalue their clients as a result of BO, leading to professional/personal problems that could become challenging to resolve. Based on a study by Ballenger-Browning et al. (2011), mental health professionals working more hours, treating more consumers, and working with more individuals diagnosed with personality disorders were more likely to have increased BO levels. Garcia et al. (2016) also found that treating consumers with diagnosed personality disorders was linked with a higher degree of BO. As age, years of working experience, and income increase, so too do levels of stress, disconnection, and emotional exhaustion in mental health professionals (Yang et al., 2016). Sofology et al. (2018) reported that for mental health professionals, years in one's role was predictive of emotional exhaustion. Craig and Sprang (2010) concluded that age and years of experience were positively correlated with BO. Intriguingly, Lanham et al. (2012) found that age was inversely related to emotional exhaustion. In a newer study, Somoray et al. (2017) assessed age to have a negative relationship with BO. In terms of contexts, Rosenberg and Pace (2006) concurred with other researchers that mental health professionals working in agency settings experience more BO than those working in private practice. For mental health professionals working in agency settings, a lack of control is considered to be one of the major factors associated with BO (Moreira & Lucca, 2020). This type of experience could be an antecedent to a worker wanting to leave their job. Understandably, turnover intention appears to be positively associated with emotional exhaustion (Yanchus et al., 2017).

Burnout in Mental Health Case Managers

The issue of BO in MHCMs is one of the foremost concerns. The problematic nature of circumstances which emerge can often seem to dictate changes in productivity, duration of employment, and personal/professional disposition for MHCMs. Notwithstanding, other work-related occurrences can complicate matters and appear to impact BO for MHCMs, creating a more dire situation for everyone involved.

Since the early 2000s, there was already a well-established understanding regarding the many focal issues faced by MHCMs (Gellis & Kim, 2004; Meldrum & Yellowlees, 2000). Some of these concerns included high job stress, perceived job pressures, and a lack of organizational assistance. Age appeared to be positively correlated with perceived lack of organizational assistance (Gellis & Kim, 2004). However, certain social networks and coping styles have been studied that find a negative relationship between them and BO (Haley-Lock, 2007; Patton & Goddard, 2006). As years progressed, other factors such as caseload size were assessed and found that higher caseloads were associated with more work-related stress and less individual effectiveness in an MHCM role (King, 2009). Acker (2010) noted the concern of BO and suggested that stakeholders such as policymakers, administrators, MHCMs, and consumers collaborate on how to improve the efficacy of service provisions concurrently with managing the caliber of professionalism and reasonable costs of services. Over the years, BO was seen as affecting MHCMs' health, their organizational commitment, and their work with consumers. Researchers have alluded to the overall effects that BO can have and how it may lead to MHCMs' health problems and a lack of desire to work at their agency, as well as the lessening of the quality of services they provide to consumers (Kraus & Stein, 2012; Lanham et al., 2012; Morse et al., 2011).

Ray et al. (2013) noted the importance of reviewing areas of work life (workload, control, reward, community, values, and fairness) and called for more approaches to improve circumstances for MHCMs and address factors that lead to BO. Reciprocal relations between MHCMs and the agencies they work for have been identified as continual issues, which harm the overall organizational health and the standard of services offered (Salyers et al., 2015; Sullivan et al., 2015). For instance, MHCMs experiencing BO may take more time off from work, perform their tasks poorly, and/or end up leaving their job, all of which contribute to negative effects on an organization through more workload, financial, and personnel implications (Sullivan et al., 2015). On the other hand, a lack of resources, training, supervision/support, and an inadequate working environment may be organizational variables that negatively affect MHCMs and lead to or exacerbate BO (Salyers et al., 2015; Sullivan et al., 2015). Of course, other work-related circumstances such as crises, consumer attitudes/behaviors, administrative duties, and coworker relations are variables to consider when examining BO for this population. Moreover, MHCMs' personal attitudes/dispositions can hinder their work with consumers, as the worker may be more susceptible to BO (Sullivan et al., 2015). Other effects that BO has on MHCMs include inhibiting workers' understandings of colleagues and consumers and diminishing the quality of the working milieu. Furthermore, increased demands such as expectations of higher productivity, workplace protocols, and budgetary constraints seem to contribute to BO (Eliacin et al., 2018). Au et al. (2018) suggested that appropriate training regarding staff roles and consumers circumstances, and support from supervisors/managers as well as other coworkers can lead to a lower risk of BO in MHCMs. Eliacin et al. (2018) corroborated these ideas by reporting that positive social connections within a working environment could minimize the possibility of BO. Aspects of rewards, recognition, job control, feedback, and participation can be considered as

potentially influential in reducing BO for MHCMs (Scanlan & Still, 2019). In a study by Milette-Winfree et al. (2019), it was determined that lower levels of BO among more experienced MHCMs with fewer consumers on their caseload was predictive of an increase in their administrations of a practical assessment. An inference could be made that MHCM and workload characteristics can be indicative of work-related outcomes.

Summary

The history of BO, as a researched construct, is one that can be considered as convoluted due to the sundry definitions that have been purported. At any rate, BO is widely understood to have negative consequences for those affected by it. As indicated, there are innumerable implications for professionals, including MHCMs, that continue to be studied for the purposes of understanding how, where, and to what measure BO is involved. One of the aims of this study is to broaden the literature and discourse by examining BO with MHCMs working in the particular settings of outpatient mental health facilities.

Compassion Satisfaction

Background/Definition

Beth Stamm introduced compassion satisfaction (CS) in 1993 in an assessment previously referred to as the "Compassion Fatigue Self Test" created by Charles Figley (Beebe, 2016). The assessment is now called the "The Professional Quality of Life Scale" or ProQOL and contains subscales of CS, and compassion fatigue (CF), comprised of BO and secondary traumatic stress (STS) (Beebe, 2016). The construct of CS has been predominantly viewed as an experience that helpers have in their work with other individuals. Stamm (2010) defined CS as the satisfaction one garners from the ability to perform their duties well, particularly through experiencing positivity while assisting others (such as consumers) and working with others (such

as coworkers). One may experience CS through their contributions to the wholesomeness of their work setting and/or improving circumstances for civilization (Stamm, 2010). Essentially, CS can be derived by one's perception of their professional capacity to be effectual at helping others (Stamm, 2010). To date, the definition proposed by Stamm (2010) for CS is the only conceptualization in scholarly work reviewed for this construct.

Factors Related to Compassion Satisfaction

In researching CS, there are a number of other variables that are also linked to this construct for a variety of reasons. Since CS is typically assessed with individuals in the helping professions, it follows that other factors that may impact this population's personal and professional experience, to be studied. Sodeke-Gregson et al. (2013) noted the importance of examining CS along with CF, STS, vicarious traumatization (VT), and BO.

CF has been defined as consisting of two components, STS and BO. STS may come from the listening to the accounts (secondary exposure) of individuals who have gone through highly stressful or traumatic situations (Stamm, 2010). Issues may come up that are related to PTSD-like symptoms, such as trouble sleeping, unwanted mental images, and avoiding cues that serve as reminders of the person's traumatic experience (Stamm, 2010). VT is a similar concept to STS and "refers to the cumulative transformative effect on the helper working with the survivors of traumatic life events" (Saakvitne & Pearlman, 1996, p. 31). In many cases, STS and VT are considered to be interchangeable (Stamm, 2010). The construct of BO can be correlated with feelings of hopelessness or helplessness and problems managing stressors in the workplace, which may lead to experiences of fatigue, irritability, and depression (Stamm, 2010). Both CF and BO are widely considered to have an inverse relationship with CS (Stamm, 2010).

There are other factors found in the literature in relational proximity to CS. Buceta et al. (2019) explored the constructs of adulthood attachment styles, self-compassion, caring satisfaction, and job satisfaction and their relationship to CS. There are four major adult attachment styles: secure attachment, preoccupied attachment, dismissive-avoidant attachment, and fearful-avoidant attachment (Bartholomew & Horowitz, 1991). Buceta et al. (2019) asserted the profound effect of how individuals' perceptions of others as well as how their self-view can affect their level of CS, hence the inquiry of adulthood attachment styles and self-compassion. Self-compassion is defined as compassion that is directed inwardly and is composed of three major qualities: kindness, a sense of common humanity, and mindfulness. This combination creates a disposition that exudes forgiveness, connectedness, and awareness of the present (Neff, 2003b; Salzberg 1997). Gilbert and Irons (2005) postulate that self-compassion augments well-being by lowering the self-criticism, insecure attachment, and defensiveness. Furthermore, self-compassion improves well-being by increasing feelings of safety, interconnectedness, and a sense of emotional balance (Gilbert & Irons, 2005). Self-compassion has been found to be negatively associated with maladaptive perfectionistic tendencies (Neff, 2003a). Therefore, when one with great self-compassion makes mistakes, they are less likely to be highly critical of themselves. Buceta et al. (2019) describe the positive influence of caring satisfaction on CS, among other variables that have a beneficial relationship with it. Buceta et al. (2019) also highlight job satisfaction, as a component that can have a valuable impact on CS. Tan (2013) examined Herzberg's two-factor theory regarding its relevance in modern-day work environments. Herzberg purported that internal and external factors could influence job satisfaction (as cited in Tan, 2013). These intrinsic and extrinsic motivators could play a role in improving one's job satisfaction and potentially their CS.

Compassion Satisfaction in the Helping Professions

Throughout the years, there has been an increase in studies evaluating CS for the helping professions. Individuals working in helping professions work in and come from a myriad of different professional backgrounds and settings. Therefore, this section will initially outline CS in more general helping professions, the shift focus to more specifically related to this study's population, MHCMs, which the next section will cover.

Yilmaz and Ustun (2018) reviewed several studies conducted with nurses and reaffirmed the inverse relationship between CS and CF/ BO. The authors further described the harmful effects of CF/ BO and urged for the improvement of CS through taking time for oneself, maintaining healthy professional boundaries, and educational assistance in the form of programs that teach about relaxation, coping, and communication skills. Zaidi et al. (2017) conducted a study with male rescuers (firefighters and paramedics) that revealed a moderate level of CS and BO, where the relationship between the two was negatively correlated. Stanfield and Baptist (2019) examined camp counselors' experiences and determined that regular interaction with self-care practices and management of stressors had a positive contribution to CS. Moreover, it was found that BO had a negative relationship with CS. In a study conducted with chaplains working for the Veterans Affairs (VA), outcomes indicated that chaplains typically have high levels of CS, but younger chaplains and those who had a lack of perceived collaboration and support from others within the organization had a higher likelihood of experiencing CF and BO (Yan & Beder, 2013). Similar to previously mentioned studies, Van Hook and Rothenberg (2009) found that younger age and female workers had characteristics associated with higher risk for BO and CF. The child welfare social workers who had increased levels of CS also had lower levels of CF/STS (Van Hook & Rothenberg, 2009). The study's participants provided recommendations

which may lead to improvements in circumstances that included more realistic workloads and greater support from administration (Van Hook & Rothenberg, 2009). Salloum et al. (2015) noted that there was a positive relationship between self-care practices and CS in child welfare workers. In another study, it was reported that self-other awareness, a mental aspect of empathy, was an indicator for improved CS among social workers (Wagaman et al., 2015). In a sample of critical care nurses, Sacco et al. (2015) determined that age had a positive relationship with CS, that is, older individuals would have greater scores on the CS subscale. The authors also found results that corroborated other studies, in their findings that females scored higher on CF scores than males; however, they cautioned the generalizability of these conclusions due to the small number of males in the study, compared with females. Other take-aways included the importance of managerial stability, environmental work changes, and proper acknowledgement of one's value as a worker as an influence on CS in employees (Sacco et al., 2015).

Sprang et al. (2007) surveyed 1,121 licensed or certified behavioral health service providers (psychologists, psychiatrists, social workers, marriage and family therapists, professional counselors, and drug and alcohol counselors) and examined levels of CF, CS, and BO. The authors found that counselors working in rural areas had higher levels of BO than those in different contexts and that specialized trauma training improved CS and elicited a reduction in CF and BO. Furthermore, females were at a higher risk of experiencing CF and BO, and psychiatrists tended to have greater levels of CF when compared to other mental health professionals (Sprang et al., 2007). In a similar study, Rossi et al. (2012) evaluated CF, CS, and BO in mental health workers from different service settings and discovered supporting evidence regarding psychiatrists and female workers having more CF and BO. Mental health social workers were also found to have higher scores regarding CF and BO. Again, CS was in a

negative relationship with CF and BO (Rossi et al., 2012). In an older study, Kraus (2005) identified self-care as being an associative factor that may have a positive influence on CS. Hyatt-Burkhart (2014) interviewed mental health workers with high levels of CS and observed their admissions of personal growth as a result of working with children who have been traumatized, admissions only given after expressing the many deleterious effects and focusing on the negative effects they have experienced as a result of their work with this population. It would seem that workers with high CS are able to be reflective with their work-related experiences, which reflection serves a greater purpose of mitigating negative effects.

Still, other studies have focused on different, yet equally intriguing elements that have implications for CS. Cetrano et al. (2017) explained that ergonomics such as time constraints were one of the highest predictors of BO with mental health professionals. They also discussed other major influences for CS, such as perceived need of training, perceived risks for the future, and perceived quality of meetings. Job complications, trust, and autonomy were among additional aspects that impacted CS (Cetrano et al., 2017). Samios (2017) concluded that mindfulness had an enhancing effect on CS with mental health professionals across a number of professions. Somoray et al. (2017) examined traits of personality and workplace belongingness as stimuli for CS in a sample of mental health workers. It was determined that neuroticism, a potentially problematic feature of one's personality, was negatively associated with CS. Furthermore, CS was strongly and positively correlated with workplace belongingness, suggesting that mental health workers who perceive supportive and valued dispositions from their coworkers and administration have a higher likelihood of finding satisfaction in their work as well as of avoiding BO throughout their professional functions (Somoray et al., 2017).

Compassion Satisfaction in Mental Health Case Managers

There are studies that have combined mental health professionals from different disciplines in the same study. However, the literature is deficient for CS specifically used with MHCMs being the primary population focus. Samios (2017) specified issues with cross-sectional research, as it may be difficult to make justified inferences in directional patterns of relationships. For instance, inconsistency between different mental health roles, in regard to education and training, could be a challenge in determining which variables truly had impactful outcomes for the study. Including mental health professionals from different roles and organizations can hinder generalizability to those organizations where these employees work (Ray et al., 2013). Nevertheless, there are limited studies with results specifying MHCM outcomes within a population of mental health professionals.

In one such comparative study where researchers examined differences between MHCMs and other mental health professionals, de Figueiredo et al. (2014) found that MHCMs were less familiar with terms such as CS and CF. The MHCMs also experienced less perceived benefit from supervision, which could ultimately impact their levels of CS. Moreover, these workers also believed that their caseload sizes and certain client factors, including the challenges of processing all their consumers' trauma-related narratives, negatively affected their CF, therefore potentially having an influence on their CS (de Figueiredo et al., 2014). Researchers have also had an interest in finding out if certain service-oriented frameworks have an impact on MHCMs and their CS. For instance, Mendenhall et al. (2019) identified a strengths model for youth consumers that had a positive effect on MHCM's CS over a six-month period.

Summary

There are several pertinent variables associated with CS that may have short and long-term implications for MHCMs. These implications may not only affect MHCMs but could also lead to issues within the organizations in which they work, as well as the services that are provided to communities. Overall, there is an identified need to further examine MHCMs in their work environments, including their experiences of CS (Mendenhall et al., 2019). For these reasons, the current study is intended to extend the contemporary literature by addressing the acknowledged gap.

Emotional Intelligence

Background/Definition

Proponents have developed, studied, and understood EI variably over the years. There are several different opinions on what EI is, how to define it, and how to measure it. As a result, multiple models of EI exist. Most models are categorized into one of three kinds: *ability EI, trait EI, and mixed EI.* Ability EI models are defined as being a form of intelligence comprised solely of cognitive abilities (Dhani & Sharma, 2016). Models of trait EI can be defined as "a constellation of emotion-related self-perceptions and dispositions located at the lower levels of personality hierarchies" (Petrides et al. 2007, p. 26), that also include aspects of assertiveness, happiness, self-esteem, and self-perceived ability to manage stress (Côté, 2014). Mixed models of EI contain a "combination of self-perceptions and dispositions with emotional abilities" (Côté, 2014, p. 462). These different types of EI are measured by various instruments. Within the literature, there are two distinct ways of arranging EI measures. The first method can be seen as the separation and uniqueness of ability EI assessments and trait EI assessments as two different appraisals (O'Connor et al., 2019). Expressly, ability EI instruments measure people's

understanding of emotions and their functioning (maximal performance scales), while trait EI instruments test for standard behaviors in emotion-specific situations (self-report scales). O'Connor et al. (2019) defined ability EI instruments as those that necessitate responses to emotion-related questions/problems which have correct or incorrect answers. The same authors defined trait EI instruments as those that require respondents to answer self-reported items to assess for EI and its components. Mixed EI instruments are measurements that evaluate an amalgamation of traits, social skills, and abilities that intersect with personality features. Moreover, when referring to EI, many scholars may signal to ability EI or trait EI (sometimes referred to as mixed EI). However, a secondary system is to view EI as having three particular "streams" (Ashkanasy & Daus, 2005). Stream one would be ability instruments that are derived from Mayer and Salovey's conceptualization and stream two are self-reported instruments that are also derived from Mayer and Salovey's conceptualization (O'Connor et al., 2019). Stream three is comprised of the "expanded models of emotional intelligence that encompass components not included in Salovey and Mayer's definition" (Ashkanasy & Daus, 2005, p. 443). Notably, streams two and three are generally categorized into "trait" instruments, which encompass most of the known EI questionnaires (O'Connor et al., 2019).

Initially, EI was championed by Salovey and Mayer (1990) and was introduced as the ability to cognitively process and manage emotional information for the purposes of intellectual and emotional development or maturity. In this model, it was suggested that EI can be acquired through learning and be improved on (Salovey & Mayer, 1990). Years later, the model was modified to define EI as four abilities (a four-branch model): perception of emotion, utilization of emotion to process thought, comprehension of emotion, and regulating emotion (Mayer & Salovey, 1997). This conceptualization is considered an ability model of EI. The Mayer-Salovey-

Caruso Emotional Intelligence Test (MSCEIT) is an instrument devised to assess EI founded on the ability model by Mayer and Salovey (Mayer et al., 2003). The responses scored on the MSCEIT are evaluated based on their level of accuracy (Mayer et al., 2008). As such, there are specific tasks used to assess ability within the branches of EI for this performance-based instrument (Dhani & Sharma, 2016). Moreover, the four-branch model by Salovey and Mayer as well as the MSCEIT are considered to be integrative paradigms, as opposed to specific-ability approaches (Mayer et al., 2008). Schutte et al. (2009) created the Schutte Self-Report Emotional Intelligence Test (SSEIT) to assess Mayer and Salovey's original model of EI. However, since it has self-report items, it is considered to be a trait EI instrument (O'Connor et al., 2019).

Another model of EI was developed by Daniel Goleman and was comprised of five aspects, including self-awareness, self-regulation, empathy, relationship management skills, and social awareness (Goleman, 1995). Goleman (1998) later expanded his theory of EI to be a combination of personal abilities and qualities, commonly referred to as a mixed model of EI. However, Goleman (2001) further reframed his conceptualization by having two domains of self (personal competence) and other (social competence) that broke down into self-awareness, self-management, social awareness, and relationship management (Kanesan & Fauzan, 2019). One of the more well-known measurements used to assess Goleman's mixed model of EI is the Emotional Competency Inventory (ECI). The ECI requires self-report and other-report (people who know the individual being assessed) for the completion of ratings regarding behaviorally related items associated with EI (Dhani & Sharma, 2016; Razzaq et al., 2016). A couple of other instruments used to measure EI based on Goleman's model include the Emotional Intelligence Appraisal (EIA), which is self and other reported, and the Work Profile Questionnaire-Emotional Intelligence Version (WPQei), which is self-reported (Dhani & Sharma, 2016).

Reuven Bar-On (1997) defined EI as "an array of noncognitive capabilities, competencies, and skills that influence one's ability to succeed in coping with environmental demands and pressures" (p. 14). It was comprised of five domains (intrapersonal skills, interpersonal skills, adaptability, stress management, and general mood) with 15 subscales (Neubauer & Freudenthaler, 2005). Bar-On's mixed model of EI was updated in 2000 and included 10 main facets of self-regard: emotional self-awareness, assertiveness, empathy, interpersonal relationship, stress tolerance, reality testing, impulse control, problem-solving, and flexibility (Neubauer & Freudenthaler, 2005). Reuven Bar-On emphasized that social intelligence and emotional intelligence are a part of the same classification (Powell et al., 2015). Bar-On (1997) also created the Emotional Quotient Inventory (EQ-i) as a self-report scale to assess a total EI or EQ score.

Petrides and Furnham defined their trait EI model as "a constellation of behavioral dispositions and self-perceptions concerning one's ability to recognize, process, and utilize emotion-laden information. It encompasses empathy, impulsivity, and assertiveness as well as elements of social intelligence and personal intelligence" (Petrides & Furnham, 2003, p. 278). Petrides (2009) explained that this trait model of EI contains 15 emotionally related components that span personality dimensions and are grouped within the four constucts of well-being, self-control, emotionality, and sociability. The Trait Emotional Intelligence Questionnaire (TEIQue) is a 153-item measure devised to assess trait EI associated with Petrides and Furnham's model via self-report (Petrides & Furnham, 2001). There is also a short-form version that is made up of 30 items (O'Connor et al., 2019).

As academics have demonstrated, many EI models have overlapping similarities as well as distinctive differences (Kewalramani et al., 2015). Cooper and Sawaf's (1998) Four

Cornerstone Model is considered to be a mixed model of EI. Emotional literacy, emotional fitness, emotional depth, and emotional alchemy are the four cornerstones that this model entails. The inventors of this model also created an 'EQ Map' that is a tool used to assess EI through this conceptualization (Kewalramani et al., 2015). Another mixed model of EI was developed by the Six Seconds group that has six central aspects with various subsections. The main tenets of this model include an improvement in self-awareness and recognition of feelings, controlling oneself and delaying gratification, socializing successfully, motivating oneself, building empathy and positiveness, and committing to honorable goals (Kewalramani et al., 2015). In addition to these lesser-known models of EI, there are other EI assessments less popularized, such as The Levels of Emotional Self Awareness Scale (LEAS), the Genos Emotional Intelligence Inventory (Genos EI), the Group Emotional Competence (GEC) Inventory, the Work Group Emotional Intelligence Profile (WEIP), and Wong's Emotional Intelligence Scale (WEIS) (Dhani & Sharma, 2016). As with varying EI models and corresponding measurements, it may make for misinterpretations when comparing results across studies, if done so haphazardly.

Factors Related to Emotional Intelligence

Researchers have studied factors regarding EI and found that there are implications for assorted life and work domains. For example, Brackett et al. (2011) noted mental health/well-being, social functioning, academic performance, workplace performance, and decision-making are correlated with EI. According to these researchers, EI and the skills associated with them can help to promote increased mental health and well-being, prosocial functioning, regulation of emotions to improve academic and workplace performance, and general decision-making abilities. Lin et al. (2016) also determined EI to be positively correlated with psychological well-being. Still, more researchers have examined EI related to various other constructs.

Another topic of interest has been the relationship between EI and empathy. Ioannidou and Konstantikaki (2008) asserted that EI can assist in maintaining emotional stability and the integrity of relationships. Moreover, they mentioned that empathy can be a crucial aspect of EI that brings about outcomes related to healing. In another study, Beauvais et al. (2017) found a significant relationship between EI and positive empathy. Mishra and Shrivastava (2018) claimed that EI can not only enhance one's aptitude in dealing with work obligations and stressors, but that it can lead to individuals having more empathy within their relationships. The same authors purported that self-awareness is necessary for the improvement of EI. Heffernan et al. (2010) examined the relationship between EI and self-compassion, while highlighting the importance that self-awareness has on this construct. Their study, it was found that there was a positive correlation between EI and self-compassion. Moreover, it was suggested that future research examine the benefits of improving EI.

In a recent study, Ain et al. (2021) extrapolated that there is a positive association between EI and grit, while also concluding that there is a positive relationship between EI and life satisfaction. Researchers claim that EI can be taught and learned, emphasizing the importance of developing programs that can address and improve EI via various approaches and activities (Ain et al., 2021; Lolaty et al., 2014). Bartz (2019) also studied EI and grit, citing the usefulness of both in positively transforming professional growth and development and determined that EI can assist the individual in achieving mental fortitude to progress in their professional endeavors. Magnano et al. (2015) also found that EI had a strong positive relationship with one's advancement, individual productivity, and achievement within an organizational context. Scholars have established that EI can have a role in improving resiliency in workers (Frajo-Apor et al., 2015; Magnano et al., 2015).

Researchers have investigated the associations between demographics and EI. Lolaty et al. (2014) noted that males had more EI as compared to females and single individuals had more interpersonal EI as compared to those who were married. In another study, Lekaviciene and Antiniene (2016) examined EI in relation to family psychosocial factors and described their impact on psychological climate in the family, the strength of an individual's relationship with their parents, and the subjective perception of family financial status as having a meaningful relationship with EI. The results indicated that psychological climate in the family (having positive feelings regarding family members), strong emotional connections with one's mother and/or father, and one's arbitrarily positive perspective of their own family's financial standing in relation to others are all contributive to higher levels of EI.

Other researchers have reviewed the link between assistive skills and EI to reveal interesting findings. Malekar and Mohanty (2009) found a positive impact that adaptability, inter/intrapersonal ability, and stress management had on EI. These results could shed more light onto the possibilities of enhancing EI. In a different study, Lolaty et al. (2014) discovered that EI had a positive influence on stress management. The outcomes of these studies exhibit the reciprocal nature that EI can have. For instance, it appears as if EI can be improved by certain skills, however, EI can also have an effect on skills. It has also been suggested that assessing for EI can lead to improved educational attainment, student growth, well-being, and mental capabilities (Sabbah et al., 2020).

Emotional Intelligence in the Helping Professions

Given the current state of research regarding EI, there is much interest in aspects of EI that can benefit individuals working in helping professions as well as what other variables interact with EI. It appears as if many research articles involving EI include populations such as

teachers, medical professionals, and mental health professionals. The research outcomes based on these studies serve as a basis for understanding if and how EI may be beneficial for relevant stakeholders.

Gawali (2012) surveyed over 400 teachers to find that EI had a positive relationship with robust mental health and adaptive coping skills. In a meta-analysis conducted by Puertas Molero et al. (2019), with studies including teachers between 2005-2017, it was concluded that EI can promote decision-making abilities and be a determinant of prosperity in education, namely through enhanced teaching practices and an improvement in health/well-being. Teachers often deal with the management of classrooms and students. Valente et al. (2018) noticed that teachers with higher levels of EI tended to have better management of discipline in their classrooms. EI has also been determined to have a positive correlation with teacher self-efficacy (Wu et al., 2019). Positive social interactions between teachers and their students can be amplified through skills associated with EI (Safina et al., 2020). It would seem that these social exchanges between teachers and their pupils may require adept communication and that skills related to EI can assist in this facilitation. Other researchers have placed paramount importance on the relationship between EI and how well teachers can complete their job duties. As such, Akhtar et al. (2020) noted a stark positive association between EI and performance levels in secondary school teachers. In terms of longevity, EI can also be a buffer to BO as well as have positive effects on work engagement and job satisfaction in the teacher population (D'Amico et al., 2020).

Nel et al. (2013) suggested that emotionally intelligent workers in a nursing environment are able to handle job-related stressors and experience less BO over time. In a different study, Năstasă and Fărcaş (2015) postulated that personal accomplishment is affected by the level of EI. Brennan (2017) posited that EI could assist in counteracting work-related stressors and

promoting wellbeing. Other studies have shown that doctors and nurses utilizing EI may have strong and trusting working relationships with their patients (Al Ubaidi, 2018; Carminati, 2021). Raghubir (2018) completed a meta-analysis of articles regarding the nursing profession published between 1990-2017 and reported that EI has the capacity to positively influence the well-being of nurses, their cognitive processes, the quality of patient care, and healthcare outcomes. Another meta-analysis pertaining to nurses by Noquez (2019) had similar findings, contending that EI had a positive impact on leadership, the work setting, and quality of care. The same meta-analysis revealed EI to protect against BO. Analogously, Soto-Rubio et al. (2020) deemed EI to be a protective component, reducing the effects of BO and other psychosomatic problems, while having a positive bearing on job satisfaction.

Powell et al. (2015) highlighted implications for mental health professionals regarding EI and other aspects. The authors cited EI as a factor that can improve health, spiritual well-being, and job satisfaction, and can reduce the potential for BO. In a study that included psychologists and therapists, Cascio et al. (2017) deduced that EI and BO had a negative relationship. As far as preventing deleterious effects stemming from workplace stress, mental health professionals may also become more resilient as a result of EI training and education (Cascio et al., 2017; Frajo-Apor et al., 2015; Lucero, 2021). Kabunga et al. (2020) urged for the investment and development of EI for psychotherapists to assist them in managing their own personal experiences. Mental health administrators consider EI to be a profound competency that can support workers in management and leadership positions (Saeed et al., 2017).

Emotional Intelligence in Mental Health Case Managers

Based on an extensive review of the extant literature, there is a dearth of articles specifically devoted to EI in MHCMs. However, as demonstrated, EI has been researched in

other diverse populations within the helping professions. This suggests, therefore, that EI could be presumed to be applicable to MHCMs for plenty of reasons.

Moffat (2014) underscored the value of EI skills within case management. Generally, professional helpers, including MHCMs, can benefit from employing EI in their work with consumers due to the nature of the interpersonal interactions that take place (Tandon et al., 2019). Some of the ways EI can contribute include strengthening the professional and consumer relationship, and enhancing staff empathy, teamwork, communication, stress management, career satisfaction, leadership, and organizational dedication (Andal, 2021). In public service workers, who may have similar working experiences to MHCMs, emotional regulation was found to have an inverse relationship with BO, while emotional self-awareness was positively correlated to job satisfaction (Lee, 2017). Students who possess components of EI, who might also eventually work in MHCM roles, may have solid leadership qualities and mental stability (Reshetnikov et al., 2020). Jenkins et al. (2020) also alluded to the usefulness of EI skills in the development of modern-day leaders. Proponents have assiduously advocated for organizations to provide opportunities of improving EI in service-oriented staff for the purposes of generating a more wholesome agency and enriched consumer-centered care (Hinds, 2017; Ogińska-Bulik, 2005; Rosenstein & Stark, 2015).

Summary

The concept of EI has an intriguingly similar history to BO, in that there have been multifarious originators, models, and measurements used to assess their facets and structures. Regardless of the multiplicities of definitions and instruments used to understand EI, it is apparent that there are significant factors related to this construct. Moreover, EI has been found to be valuable to those working in a diversified set of professions. However, irrespective of the

reviewed literature, there remains a comprehensive deficiency of studies involving EI and MHCMs. The current study intends to address these circumstances.

Conclusion

Emotional Intelligence Related to Compassion Satisfaction and Burnout

Knowing that CS has been found to have a negative relationship with BO, it may be important to determine influences that can improve CS and mitigate BO. Beauvais et al. (2017) studied registered nurses and found that higher levels of EI were associated with greater CS; EI was associated with lower levels of BO. In other studies, EI was also found to be inversely related to BO (Lin et al., 2016; Moon & Hur, 2011). Amir et al. (2019) noted that a lack of ability in managing negative emotions and scant insight regarding other's emotions can worsen the effects of factors linked to BO, such as CF. The construct of EI seems to have relevance with BO and CS regarding workplace effects and ways to address harmful outcomes. There may be potential for MHCMs to harness EI and utilize its benefits to ameliorate negative work-based experiences. Even so, there remains a paucity of research using the variables of CS, BO, and EI together for MHCMs. The apparent nature of the relationship between these variables rooted within this studied population can add to the existent literature.

CHAPTER III: METHODOLOGY

The intention of a moderation analysis is to determine if one variable influences the direction and strength of relationship between two other variables. The main aim of this study was to investigate the moderation value of emotional intelligence (EI) to the relationship between burnout (BO) and compassion satisfaction (CS) of mental health case managers (MHCMs) working in an outpatient mental health facility. In this chapter, I described the research methods I employed in conducting this study. The content is divided into the following sections: research questions, hypotheses, sampling procedure, collection of data, context of the study, instrumentation, selection of participants, measurement of constructs, data analyses, and delimitations and limitations.

Research Questions

The following were the research questions for this study:

1. Is there a statistically significant relationship between CS and BO in a sample of MHCMs working in outpatient mental health facilities?
2. Does EI moderate the relationship between CS and BO in MHCMs working in outpatient mental health facilities?
3. Do characteristics such as age, level of education, gender, years of working experience in one's current role, and if one is satisfied with where they currently work have a statistically significant relationship with one's level of EI, CS, and/or BO?

Hypotheses

The following were the hypotheses for this study:

1. There will be a statistically significant negative relationship between CS and BO in MHCMs working in an outpatient mental health facility.

2. EI will be a statistically significant moderator in the relationship between CS and BO in MHCMs working in an outpatient mental health facility.

3. Demographic characteristics such as age, level of education, gender, years of working experience in one's current role, and if one is satisfied with where they currently work will have a statistically significant relationship with one's level of EI, CS, and/or BO.

Sampling Procedure

Upon receiving institutional review board approval, I recruited participants using convenience sampling. I elected to use convenience sampling due to the practical and efficient benefits that it offers in collecting data from a population with similar characteristics. Since many of the prospective sites were at a considerable distance from the researcher's location, this was an appropriate approach. I sent emails containing study information to the administrations of the outpatient mental health facilities for them to review and approve before they sent out the information to their MHCMs who met my established inclusion criteria for solicitation of their participation in the study.

Collection of Data

I contacted the administration of several outpatient mental health facilities for permission to survey their MHCMs. Once permission was obtained, I sent the flyer/info sheet (via email in a Word document) to the administration of each research site. After the administrations approved the flyer/info sheet, they sent out the flyer/info sheet (via email) to study candidates. Candidates who were willing and interested in participating in the study were able to complete the survey. They were informed that participation was voluntary and that withdrawal was allowed at any point during the study without penalty. Candidates were able to contact me through my university email (listed in the flyer/info sheet), if they were interested in participating and had

any questions and/or concerns regarding the study details. The flyer/info sheet contained the recruitment script and the informed consent sheet and included study information, such as the level of risk, resources to outside assistance for purposes of mitigating any perceived harm (if requested), a request for involvement, a link to the Qualtrics electronic survey with the SSEIT (Schutte et al., 2009) (which typically takes about 5 minutes to complete) and the ProQOL (Stamm, 2010) (which typically takes about 10 minutes to complete) questionnaires, and instructions on how to complete the questionnaires. By opening the link in the flyer/info sheet, participants agreed to participate, and it indicated that they had read and accepted the conditions in the informed consent document. As an incentive for participation, those who completed the survey, including all questionnaires were eligible for and received an electronic Amazon gift card valued at $10.00, provided they entered an email address at the end of the survey. All electronic Amazon gift cards were emailed to eligible participants who entered an email address at the end of the survey, once all necessary data for the study was collected and the data collection period concluded.

Context of the Study

Inclusion criteria for MHCMs included that the individual was working in a full-time position at an outpatient mental health facility, was at least 18 years old, and had a minimum of a bachelor's degree. Exclusion criteria included any individuals in supervisor roles, those with any professional licenses, those under the age of 18, and those who had not worked past their initial training period after becoming hired as an MHCM. There were no specific exclusion criteria regarding gender and ethnicity. The outpatient mental health facility where participants were working were agencies that provided psychiatric services to individuals who attended appointments but were not required or expected to reside at the establishment to obtain said

services. The outpatient mental health facilities where participants were surveyed were at several sites throughout the state of Texas.

Selection of Participants

The recruitment script served as an introduction to the study and solicited participation in it. The informed consent included: the project title; introduction and purposes of the study; researchers involved in the study; description of the research study, its risks and benefits, and incentives; the process about potential new information emerging regarding the study that may affect participants' decisions to engage in the study; confidentiality; voluntary consent and withdrawal privileges; procedures for collection, storage, retention, and destruction of data obtained; individuals who may be contacted for more information pertaining to the study; community counseling resources to assist in mitigating any potential risk of harm incurred by participating in the study (if requested); and how to contact someone regarding questions or concerns about the researcher's compliance with research regulations. Demographic questions included inquiries about participants' employment positions and characteristics, such as their primary professional role (a response of "yes" is required to identify if the individual is working as a mental health case manager in an outpatient mental health facility), highest level of education (bachelor's, master's, doctorate), gender (female, male, transgender, other), age, ethnicity/race (Asian or Asian American, Black or African American, Hispanic or Latino/Latina/Latinx, multiple heritage, Native American/Alaska Native, Native Hawaiian/Pacific Islander, White or European American, or other), years of working experience in their current role, primary specialty area(s) (adult mental health, child and adolescent mental health, other), and if they were satisfied with where they currently worked. The 'other' choice

selection allowed for participants to specify their affiliation to any particular demographic item being asked of them in the email.

Measurement of Constructs

The Professional Quality of Life (ProQOL 5) Scale

The ProQOL is a 30-item tool, which takes about five minutes to complete, that uses a Likert-type scale to measure responses (from never to very often). It has three subscales that have 10 items each, which include CS, secondary traumatic stress (STS), and BO. For the purposes of this study, only CS and BO will be used from the ProQOL. In a study by Geoffrion et al. (2019), results indicated support for convergent, discriminant, and construct validity (using a bifactor structure) of the ProQOL.

The total score for CS ranges from 10 to 50. The higher the score, the higher the probability that the individual receives a greater satisfaction regarding their effectiveness at performing duties in their job. Scores under 23 are considered to be low CS and associated with difficulties at work and/or factors that could otherwise negatively affect one's CS. Scores between 23 and 41 are considered moderate. Scores that are higher than 42 are considered to be a high level of CS (Stamm, 2010). The ProQOL has been utilized in several studies and found to have a Cronbach's alpha of 0.88 for the CS construct (Stamm, 2010). Some example items from the CS subscale include: "I am happy that I chose to do this work," "My work makes me feel satisfied," and "I believe I can make a difference through my work."

Similar to CS, BO also has scores that range from 10 to 50. The higher the scores for BO indicate a more severe level of BO. Scores that are 22 or under are considered to be a low level of BO. Scores that are between 23 and 41 are deemed to be moderate. Scores higher than 42 are regarded to be a high level of BO (Stamm, 2010). The Cronbach's alpha for BO was found to be

0.75 (Stamm, 2010). A few example items from the BO subscale include: “I feel connected to others,” “I have beliefs that sustain me,” and “I am the person I always wanted to be.”

The population that this instrument has been normed with has been individuals working in helping professions that deal with various crises. These individuals working in helping professions work in different roles, such as healthcare providers, social service workers, emergency responders, teachers, etc. (NCTSN, 2014). Advantages of using the ProQOL include that is that it has been a widely used assessment in reducing risk, building resilience, and early intervention. Furthermore, there are individual and group administrations of ProQOL that provide insight regarding tracking the degree of distress, individual changes over time, intervention results, and potential for cooperation, which may lead to organizational progress that can mitigate issues while working with trauma intervention (NCTSN, 2014).

The Schutte Self-Report Emotional Intelligence Test (SSEIT)

The SSEIT is a self-report instrument comprised of 33 items, which employs a Likert-type scale to assess responses related to EI (from strongly disagree to strongly agree). The four subscales identified are discernment of emotions, use of emotions, self-management of emotions, and management of others’ emotions. Scores range from 33 to 165, with higher totals denoting increased levels of EI attributes (Schutte et al., 2009). Average scores with many larger samples equal 124, with scores below 111 considered to be abnormally low and scores above 137 considered to be particularly high (Malouf, 2014). Internal consistency of Cronbach’s alpha for this instrument was found to be .90 (Schutte et al., 1998). The two-week test-retest reliability was determined to be at .78 for all scale scores (Schutte et al., 1998). Schutte et al. (1998) also found data to substantiate predictive and discriminant validity. Example items from the SSEIT

include: “I am aware of my emotions as I experience them,” “I have control over my emotions,” and “I am aware of the non-verbal messages other people send.”

The SSEIT has been used with various populations since its inception. Initially, this assessment was developed and used for the English language, with promising results from other studies for other languages (Schutte et al., 2009). The instrument was primarily used with adults, which has continued to be a prevalent occurrence over the years (Schutte et al., 1998). However, the SSEIT has also been determined to be psychometrically sound when used with adolescents from countries like Australia, Canada, and Malaysia (as cited in Schutte et al., 2009). An advantage of using the SSEIT may be in research endeavors with persons apt for introspection regarding their emotional capabilities (Schutte et al., 2009). Another advantage of the SSEIT is that it is one of the few free-to-use measures available that assesses EI (O’Connor et al., 2019). Additionally, the SSEIT is typically regarded as one of the more practical EI instruments as it contains 33 items and takes approximately five minutes for respondents to complete (Schutte et al., 2009). It is also recommended for researchers/practitioners to use trait EI measures, such as the SSEIT, when investigating behavioral proclivities and/or one’s confidence level in their emotional abilities (O’Connor et al., 2019).

Data Analysis

Statistical Power Analysis

Using the G*Power 3.1 statistical power analysis program (Faul et al., 2007), I conducted an a priori power analysis to establish the minimum number of participants needed to find statistical power for this research design at the .80 level given $\alpha = .05$. The results of this power analysis indicated a minimum sample size of 68 participants was required to detect a moderate effect of .15. Based on this finding, the sample of 73 MHCMs working in outpatient mental

health facilities used in the current study was enough to interpret relationships between the predictor and criterion variables.

Preliminary Analyses

I initially completed the data cleaning process before running data through SPSS (version 21.0). I computed descriptive statistics and alpha coefficients for each scale used in the study. I then reviewed data to determine if there were any outliers or extreme scores by viewing the Stem and Leaf Plots as well as performing a Mahalanobis distance test and Cook's distance test (Cook's D). Next, I tested the model assumptions associated with the hierarchical multiple linear regression analysis by examining multicollinearity, normality, linearity, and homoscedasticity. I assessed for multicollinearity by examining bivariate correlations and variance inflation factors. To assess for normality, I calculated a Kolmogorov-Smirnov goodness-of-fit test. To determine linearity and homoscedasticity, I evaluated the standardized residual plots. Following the conclusion of these analyses, the data was assessed for its appropriateness for purposes of analysis using hierarchical multiple linear regression.

Primary Analysis

The analysis selected for this study was a two-step hierarchical multiple linear regression and assessed the degree to which EI moderated the relationship between CS and BO among MHCMs working in an outpatient mental health facility. Hierarchical multiple regression analyses can be an appropriate selection and assist when examining the moderating effect of one variable (EI in this case) on the relationship of two other variables (in this case CS and BO) (Cramer, 2003). For the analysis conducted, an alpha level of .05 was utilized as the criterion by which statistical significance was established. This type of analysis provided information on the relationship between CS and BO as well as the potential predictability of EI as a factor in

affecting the relationship between CS and BO. Moreover, there was an inspection of correlation coefficients computed between several demographics and the main variables (CS, BO, and EI) used in this study.

Delimitations and Limitations

This study contained several delimitations to consider. For one, participants needed to be at least 18 years old of age. This delimitation is considered to be standard as MHCMs are not typically hired under the age of 18. Moreover, participants needed to hold, at minimum, a bachelor's degree, and work in a full-time position as an MHCM at an outpatient mental health facility. Again, these are typical requirements for outpatient mental health facilities that employ MHCMs. Other delimitations were that supervisors, part-time employees, and licensed staff were not included in this study. These delimitations are important to note due to the rationale that, while these types of employees may have similar duties and/or experiences that MHCMs would have, they would not fit the population's true characteristics, leading to a dilution in the accuracy of representation, due to varied responsibilities, decreased work durations, and/or differences in education/training.

One of the limitations of this study was that it was not an experimental design, meaning the participants were not randomly chosen or randomly allocated to a specific group. Moreover, the study included self-report measures to be completed by the participants. This was a limitation of the study, due to influences that may affect the outcome of the data collected, such as participants' introspective ability, interpretation of questions, honesty of responses, and potential biases in responses based on the researcher's previous interactions and working relationships with some of the participants. Another limitation identified was the use of one particular way of conceptualizing the constructs of EI, CS, and BO that may not completely cover the respective

phenomena, as it may be understood. All of these limitations should be considered when reviewing the results of this study, as they could lead to inaccurate depictions of the experiences examined.

CHAPTER IV: FINDINGS

The central goal of this research study was to appraise the moderation value of emotional intelligence (EI) to the relationship between burnout (BO) and compassion satisfaction (CS) of mental health case managers (MHCMs) working in an outpatient mental health facility. There was also an interest in the specific relationship between CS and BO as well as whether demographic characteristics had relationships with one's EI, CS, and/or BO. To accomplish these endeavors, I describe the results acquired from the following research questions:

1. Is there a statistically significant relationship between CS and BO in a sample of MHCMs working in outpatient mental health facilities?
2. Does EI moderate the relationship between CS and BO in MHCMs working in outpatient mental health facilities?
3. Do characteristics such as age, level of education, gender, ethnicity or race, years of working experience in one's current role, and if one is satisfied with where they currently work have a statistically significant relationship with one's level of EI, CS, and/or BO?

This study also contained three hypotheses related to the research questions. The following are the hypotheses that were tested in this study:

1. There will be a statistically significant negative relationship between CS and BO in MHCMs working in an outpatient mental health facility.
2. EI will be a statistically significant moderator in the relationship between CS and BO in MHCMs working in an outpatient mental health facility.
3. Demographic characteristics such as age, level of education, gender, years of working experience in one's current role, and if one is satisfied with where they currently work will have a statistically significant relationship with one's level of EI, CS, and/or BO.

Demographic Characteristics

The sample size of the study was 73 MHCMs from eight different outpatient mental health facilities. The descriptive statistics of the sample included age, gender, level of education, ethnicity/race, years of working experience in one's current role, if the MHCM was satisfied with where they were currently working, and the MHCM's primary specialty area. The total number of MHCMs invited to participate was not concluded due to the study sites not offering to disclose the total number of eligible MHCMs working at their agencies.

Out of the 73 MHCMs that completed the study, the sample was comprised of 82.2% (*n* = 60) females and 17.8% (*n* = 13) males. The age range for participants was between 23 and 67 years of age. There were 45.1% (*n* = 33) between the ages of 23 and 29. Between the ages of 30-39, there were 23.3% (*n* = 17). There were 13.7% (*n* = 10) between the ages of 40 and 47. There were also 13.7% (*n* = 10) between the ages of 50 and 58. The fewest participants were in the 61-67 age range, with 4.2% (*n* = 3). The following were the participants' self-reported data for ethnicity/race identity: Hispanic or Latino/Latina/Latinx accounted for 27.4% (*n* = 20), White or European American accounted for 46.6% (*n* = 34), Black or African American accounted for 15.1% (*n* = 11), and multiple heritage accounted for 10.9% (*n* = 8). There were 60.3% (*n* = 44) of respondents who held a bachelor's degree and 39.7% (*n* = 29) who held a master's degree. Regarding years of working experience, 19.2% (*n* = 14) of respondents that had worked for less than a year, 24.7% (*n* = 18) had worked for 1-2 years, 19.2% (*n* = 14) had worked for 2-3 years, 10.9% (*n* = 8) had worked for 4-5 years, and 26% (*n* = 19) had worked for over 5 years. For primary specialty, 63% (*n* = 46) of participants were working in adult mental health, 31.5% (*n* = 23) of participants were working in child and adolescent mental health, and 5.5% (*n* = 4) of participants were working in "Other" categories with two respondents working in both adult and

child/adolescent mental health and two other respondents working in a Mobile Crisis Outreach Team (MCOT). In terms of work satisfaction, 75.3% (n = 55) of respondents indicated being satisfied with where they were working, while 24.7% (n = 18) of respondents indicated that they were not satisfied with where they were working. See Table 1 for an itemization of these descriptive statistics.

Table 1

Descriptive Statistics for MHCMs

Demographics	**Range**	***n***	**% Total Sample**
Age	23-67	73	
Gender			
Male		13	17.8
Female		60	82.2
Ethnicity			
Hispanic or Latino/Latina/Latinx		20	27.4
White or European American		34	46.6
Black or African American		11	15.1
Multiple Heritage		8	10.9
Level of Education			
Bachelor's		44	60.3
Master's		29	39.7
Years of Working			

Experience in Current Role		
Less than 1	14	19.2
1-2	18	24.7
2-3	14	19.2
4-5	8	10.9
Over 5	19	26.0
Primary Specialty Area		
Adult Mental Health	46	63.0
Child/Adolescent Mental Health	23	31.5
Other (both Adult and Child/Adolescent Mental Health)	2	2.75
Other (MCOT)	2	2.75
Satisfied with Current Working Situation		
No	18	24.7
Yes	55	75.3

Preliminary Analyses

Data cleaning

Data cleaning is a process by which researchers identify, analyze, and ameliorate flawed data with the ambition of reducing any potential negative impact on study outcomes (Van den Broeck et al., 2005). Based on the G*Power 3.1 Statistical Power Analysis Program (Faul et al., 2007), and after I engaged in the data cleaning processes, I determined that I had solicited

adequate participation to estimate relationships between predictor and criterion variables. There were 85 questionnaires started, however, 73 of them were completed. The 12 that were not complete did not make it into the primary analysis phase due to missing several key items needed to acceptably make deductions and were deleted. As previously mentioned, a power analysis conducted showed a minimum sample size of 68 participants was required to find a moderate effect of .15. Therefore, the 73 participants that completed the study were found to be an acceptable quantity to continue the data analysis process. I downloaded the study data file from Qualtrics (questionnaire platform used) and opened it in the SPSS program. I continued the data cleaning process by erasing unnecessary info that was not pertinent to the study, such as beginning and end dates, progress, status, duration, recorded date, response ID, user language, and distribution channel. The IP addresses and locations of participants were not initially collected and did not need to be deleted, due to them not previously existing in the file. Once this process was done, I began and completed the procedure of reverse scoring relevant ProQOL items. After these efforts were concluded, I initiated the quantitative analysis.

Unusual and Influential Data

Outliers. Outliers are data points that are distant from general scores in a data set and can cause issues due to either missing significant findings or skewing actual results. Based on contextual indicators, researchers may choose to remove outliers to avoid problematic outcomes. However, Osborne and Waters (2002) stated that removing outliers is not always preferred. Yang and Berdine (2016) remarked that many researchers choose to preserve outliers, as they can be legitimate radical observations and result from the type of study conducted. Further, removing outliers can detract from the significance of the outcome related to the analysis (Cousineau & Chartier, 2010). To detect any potential outliers, I visually analyzed Stem and Leaf Plots, as well

as conducted a Mahalanobis distance test and a Cook's D test. Through an ocular analysis of the Stem and Leaf Plots, it was revealed that there were data points farther away than the general values for all of the responses from participant #64 regarding the study variables. Analysis of the Mahalanobis distance test displayed a p value of .00024 for participant #64. For the Mahalanobis distance test, p values less than .001 indicate an outlier (Leys et al., 2019). Cook's D was also computed, as it is another multivariate outlier detection method, and its score for participant #64 indicated .30. There are several methods of interpreting Cook's D. A rule-of-thumb is that any observation in a Cook's D test over 1.0 is excessive and would suggest there to be an outlier (Hair et al., 2009). Algur and Biradar (2017) stated that percentiles of over 50 shows there to be a highly influential point. Therefore, based on the cumulative results of the data analyses, I chose to retain the responses associated with participant #64 in the final data set and analysis.

Model assumptions

Four model assumptions are generally associated with hierarchical multiple linear regression analyses. These model assumptions include multicollinearity, normality, linearity, and homoscedasticity. The purpose for testing model assumptions is to identify whether there have been violations in the assumptions that could affect the interpretation of results in the study (Aljandali, 2017).

Multicollinearity. Multicollinearity can result from several similar variables that are treated and/or viewed as disparate variables, which can lead to negative effects for the inferences of the study outcomes in regression analyses (Pedhazur & Schmelkin, 1991). To assess for multicollinearity, I examined bivariate correlations and variance inflation factors (VIF). A VIF greater than 10 is generally seen as a violation in terms of the multicollinearity assumption

(Aljandali, 2017). For both CS and EI, VIF scores = 1.346, indicating an absence of robust multicollinearity.

Normality. Osborne and Waters (2002) discussed the importance of addressing the assumption of normality, as it assists in understanding if the variables in a study have normal dispersion. The authors expressed that abnormally distributed variables may end up warping relationships and significance analyses. To evaluate the assumption of normality, I computed a Kolmogorov-Smirnov goodness-of-fit test. Mishra et al. (2019) reported that if the outcome of the Kolmogorov-Smirnov test indicates significance, then the normality assumption would be violated, otherwise, a non-significant outcome would suggest the normality assumption to have been met. The numerical results of the Kolmogorov-Smirnov analysis conducted were significant for scores on my criterion variable, BO, $K\text{-}S(73) = .031$, $p < .05$. However, it is recognized that violations of the normality assumption do not typically cause perceptible effects on results derived from adequate sample sizes (Schmidt & Finan, 2018). Additionally, the computed statistic is considered to be conservative and the histograms appeared to be normal.

Linearity. To accurately ascertain the association between predictor and criterion variables in multiple regression studies, it is expected that this relationship exists in a linear form (Osborne & Waters, 2002). In reviewing linearity, I examined the scatterplot of scores between CS and BO and determined that there appeared to be a linear trend line. I then examined the scatterplot of scores between CS and EI and determined that there appeared to be a linear trend line. Lastly, I examined the scatterplot of scores between EI and BO and determined that there appeared to be a linear trend line. Based on the visual analysis of the data and the deductions made, I concluded that the linearity assumption had been met.

Homoscedasticity. Homoscedasticity occurs when the variation in scores from one variable are similarly observed in the denominations of other variables (Issa & Nadal, 2011). To address homoscedasticity, I completed a visual review of the residuals scatterplot. After inspection, I determined that there was a random scatter of the residuals, meaning the variance of residuals through the regression line was similar across the different predictor variables. Accordingly, the data was concluded to be homoscedastic.

Primary Analyses

I calculated the descriptive statistics for each measure that I used in this study. The descriptive statistics included the mean (*M*), the standard deviation (*SD*), a range of scores (low to high) (*R*) and the sample size (*n*). There were no missing values determined in the preliminary analysis, so the descriptive statistics are regarding the responses from the 73 participants who completed the study.

The ProQOL has two subscales that were used in this study, burnout (BO) and compassion satisfaction (CS). The values in this study for the BO subscale had a total raw mean score of 24.71 (*SD* = 5.96, *R* = 14-38). The values in this study for the CS subscale had a total raw mean score of 38.77 (*SD* = 6.14, *R* = 27-49). To provide some context, Abraham-Cook (2012) surveyed a sample of 111 teachers and found a total raw mean score of 24.45 (*SD* = 6.49) for BO and a total raw mean score of 39.24 (*SD* = 6.84) for CS, which is similar to the scores obtained in my study. However, in another study, Campbell (2013) found t-scores to be average for BO (49.80, *SD* = 7.67) and high for CS (57.25, *SD* = 7.57), within a sample of 362 mental health professionals that included 18 case managers. Moreover, these two authors did not provide the range of scores that were obtained. Stamm (2010) normed the ProQOL with individuals from helping professions and found average t-scores with males having a total mean

score of 48.99 (*SD* = 9.75) for the BO subscale and a total mean score of 49.01 (*SD* = 10.81) for the CS subscale. For females, there were also average t-scores with a total mean score of 50.37 (*SD* = 10.26) for the BO subscale and a total mean score of 50.14 (*SD* = 9.77) for the CS subscale. No ranges of scores were offered.

The SSEIT was used to measure emotional intelligence (EI). The values in this study for the EI variable had a total raw mean score of 126.82 (*SD* = 13.14, *R* = 98-156). For additional context, Young (2020) garnered responses associated with EI and found them to have a total raw mean score of 132.86 (*SD* = 14.94, *R* = 87-163) within a sample of 198 mental health leaders that worked in different behavioral health organizations. Schutte et al. (1998) normed the SSEIT with different groups that included psychotherapists, prisoners, clients who had abused substances, and university students. For males, the total raw mean score of EI was 124.78 (*SD* = 16.52). For females, the total raw mean score of EI was 130.94 (*SD* = 15.09). It was found that psychotherapists scored higher on the EI scale than the prisoners and clients who had abused substances (Schutte et al., 1998). No ranges of scores were offered. See Table 2 for an itemization of the descriptive statistics of scales used in this study.

Table 2

Descriptive Statistics of Main Variables

Variable	***M***	***SD***	**Range (low to high)**	***n***
Burnout	24.71	5.96	14-38	73
Compassion Satisfaction	38.77	6.14	27-49	73
Emotional Intelligence	126.82	13.14	98-156	73

Research Question/Hypothesis 1

To answer the first research question, I completed a bivariate correlation analysis for CS and BO. Additional bivariate correlation analyses were conducted to provide further insight, which showed the magnitude and directionality regarding the relationships between all main variables. Each of the Pearson correlations among the main variables are displayed in Table 3. These results support the first hypothesis in that there is a statistically significant relationship between CS and BO in a sample of MHCMs working in outpatient mental health facilities. Moreover, each of the dyadic correlations was found to be statistically significant at the .01 level. Therefore, it was concluded that the null hypothesis was accurately rejected. Pearson coefficient *r* values of ±0.1 indicate a small effect, ±0.3 indicate medium effect, and ±0.5 indicate a large effect (Cohen, 1988). However, the author notes for caution to be taken when interpreting results with these classifications and that researchers should incorporate an understanding of study outcomes in relation to relevant literature. The magnitude and direction of relationship between CS and BO was a strong and negative correlation, (r = -.68). Meaning that as scores of CS increased, the scores of BO decreased and vice a versa. The magnitude and direction of relationship between CS and EI was a strong and positive correlation, (r = .51). This meant that as scores of CS increased, the scores of EI also increased and vice a versa. The magnitude and direction of relationship between BO and EI was a moderate and negative correlation, (r = -.47). This signified that as scores of BO increased, the inverse happened to scores of EI and vice a versa.

Table 3

Pearson Correlations Among Main Variables

Variable	**1**	**2**	**3**

1. Burnout	--	**-.68	**-.47
2. Compassion Satisfaction		--	**.51
3. Emotional Intelligence			--

**significant at the .01 level (2-tailed)

Research Question/Hypothesis 2

To answer the second research question, a hierarchical regression analysis was processed to determine if EI moderates the relationship between CS and BO in MHCMs working in outpatient mental health facilities. The visual outcome of this analysis is captured in Table 4. The first block of the hierarchical design contained the denominations for CS. The second block contained the denominations for CS and EI. The third block contained denominations for CS, EI, and the interaction effect between CS and EI. For the interaction effect between CS and EI, $F(3,72) = 22.01$, $p = .246$, $R^2 = .489$. The EI variable was determined to not have statistically significant moderation value to the relationship between CS and BO in MHCMs working in outpatient mental health facilities. Therefore, hypothesis 2 was not supported by the results. All other relevant data regarding the hierarchical regression model is found in Table 4.

Table 4

Summary of Hierarchical Regression Model

Variable	***B***	***SE B***	**β**	***t***	***sr*²**	***F***	***R*²**
Model 1						59.62	.456
**CS	-.65	.08	-.67	-7.72	.46		

Model 2						32.16	.479
CS	-.57	.09	-.58	-5.87	.26		
EI	-.07	.04	-.17	-1.73	.02		
Model 3						22.01	.489
CS	-1.62	.90	-1.67	-1.25	.02		
EI	-.42	.29	-.92	-1.42	.01		
Interaction CSxEI	.00	.00	1.60	1.17	.01		

Note. ** = significant at the .01 level

Research Question/Hypothesis 3

To answer the third research question, I completed bivariate correlation analyses, which indicated the magnitude and directionality of the relationships between the main variables and demographic variables. Each of the Pearson correlations among the main variables and the demographic variables are displayed in Table 5. The demographics chosen to be run in the bivariate correlation analyses were selected due to similar demographics being observed in other studies and included age, years of working experience in one's current role, highest level of education, gender, and if one was satisfied with their current working situation. The correlations that indicated statistically significant relationships were BO and age, CS and age, and CS and work satisfaction. These results partially support the third hypothesis in that there are statistically significant relationships between three of the 15 dyads among main variables and selected demographics for MHCMs working in outpatient mental health facilities. The magnitude and direction of relationship between BO and age was a medium and negative correlation, (r = -.35). The higher one's age was, the lower their BO scores and vice a versa. The relationship between BO and age was found to be statistically significant at the .01 level. The magnitude and direction

of relationship between CS and age was a small and positive correlation, (r = .28), meaning that both CS and age moved in the same direction, both either increased or decreased concurrently. The relationship between CS and age was found to be statistically significant at the .05 level. The magnitude and direction of relationship between CS and if one was satisfied with where they were currently working was a medium and negative correlation, (r = -.33). This meant that there was an inverse relationship between CS and if one was satisfied with where they were currently working. In terms of coding, a '0' indicated that the MHCM was satisfied and a '1' indicated that they were not satisfied. In other words, as CS scores went up, then one was more satisfied with where they were currently working. If CS decreased, one was less satisfied with where they were currently working. The relationship between CS and if one was satisfied with where they were currently working was found to be statistically significant at the .01 level.

Table 5

Pearson Correlations Among Main Variables and Demographics

Variable	**Age**	**Exp**	**Edu**	**Gnd**	**Satis**
1. Burnout	**-.35	.03	-.20	-.08	.22
2. Compassion Satisfaction	*.28	-.10	.15	-.02	**-.33
3. Emotional Intelligence	.17	-.11	.10	-.04	-.19

Note. Exp = years of working experience in one's current role; Edu = level of education; Gnd = gender; Satis = one's satisfaction with where they currently work
*significant at the .05 level (2-tailed)
**significant at the .01 level (2-tailed)

Summary

This chapter offered the findings obtained from the data collection. The results were used to address the research questions and hypotheses. All the research questions were answered. The

outcomes showed that hypothesis one was fully supported, hypothesis two was not supported, and hypothesis three was partially supported. A detailed review of the study findings with implications and suggestions for future research will be provided in the next chapter.

CHAPTER V: DISCUSSION AND CONCLUSION

Introduction

The constructs of burnout (BO), compassion satisfaction (CS), and emotional intelligence (EI) examined in this quantitative study can help others to further understand their relation to mental health case managers (MHCMs) and how they interplay within this population. The main focus of this hierarchical regression analysis was to determine if EI moderates the relationship between CS and BO. Moreover, relationships between the main variables as well as between the variables and respondent demographics were evaluated. Findings from this study support previous studies and provide a foundation for future studies.

In this chapter, I offer an overall interpretation of this study's outcomes in relation to the literature review. I intend to provide an analysis that describes the gist of the results along with the value it has to MHCMs as well as other relevant stakeholders. I will detail conceivable implications and demonstrate how these extrapolations can be influential to MHCMs and administrators. Additionally, I will outline limitations that were found in this study and specify suggestions for future research. Lastly, I will underscore essential findings in the conclusion.

Discussion

Research Question/Hypothesis One

For research question one, I assessed the relationship between CS and BO in a sample of MHCMs working in an outpatient mental health facility. For hypothesis one, I predicted that there would be a statistically significant negative relationship between CS and BO. The results fully supported hypothesis one, showing a strong negative correlation between the two variables. In this sample, the mean scores of CS were on the higher end of moderate levels, while the mean scores for BO were on the lower end of moderate levels. Few other studies have included

MHCMs, however, comparable to the present study, Abraham-Cook (2012) noted that teachers had low-moderate BO mean scores and high-moderate mean scores of CS. Similarly, El-bar et al. (2013) identified about a third of physicians to have moderate levels of BO and close to 60% of physicians had moderate levels of CS. Somewhat similarly, Campbell (2013) reported that mental health professionals had high levels of CS and moderate levels of BO. These mental health professionals may have enjoyed certain aspects of their work with others more than MHCMs in the current study, while experiencing analogous levels of BO. In other studies, samples of child welfare case managers had high levels of BO and low levels of CS (Salloum et al., 2015; Salloum et al., 2018). This could indicate that MHCMs serving certain populations may deal with more particularly difficult challenges due to the consumers they serve. As it appears, the cited studies demonstrate the presence of CS and BO among a variety of workers and professions. The findings in the current study seem to corroborate the inverse relationship between CS and BO found in the mentioned studies within the literature review section. Thus, it might be inferred that CS may act as a counterweighing component in relation to BO. For example, if one has a solid degree of CS, then problems associated with BO might not be as burdensome due to the individual's attention being focused on their positive experiences of how well they are helping others. This could be helpful for MHCMs in stressful working situations where they may be at constant risk for BO. Previous studies indicated that CS has protective and amplifying influences on other variables. As expected, the outcome of a negative correlation between CS and BO indicated that a greater level of CS could possibly protect against BO effects. This finding is important to understand that CS may be useful for populations experiencing issues with BO. As such, CS could potentially be used and improved to combat against BO.

In this study, as individuals had higher levels of EI, they were also identified to have higher levels of CS. This may have been the case since one's ability to understand and recognize emotions may be related to one's ability to reflect on their contentment of how well they are able to help others. Academics have provided other evidence for favorable results associated with CS. For example, researchers found that nurses with lower levels of CS tend to be inclined to change from the unit they work in (Başoğul et al., 2021). This would seem to indicate that higher levels of CS could result in staff going through fewer departmental changes and being more content with their working situation. Further, Koutra et al. (2021) proposed that CS is a protective component, guarding against mental health professionals' adverse perspectives toward mental illnesses. Martin-Cuellar et al. (2021) suggested that a high level of CS can positively contribute to mental health clinicians' well-being. Furthermore, CS has been evaluated to have an inverse relationship with the imposter phenomenon, which could lead to greater confidence and better decisiveness regarding decision-making processes (Clark et al., 2021). With all the encouraging possibilities related to CS, scholars have urged for more research to find ways to enhance CS and protect against issues like BO (Kinman & Grant, 2020; Mendenhall et al., 2019; Towey-Swift & Whittington, 2021). The outcome of this research could result in MHCMs having longer employment durations, being more committed to their work, and having fewer work-related issues.

The problem of BO has not only caused major concern for those afflicted by it, but as well for individuals who have researched its effects. In this study, BO was observed to have a negative relationship with EI. It may be inferred that if one has a high degree of BO, then they could struggle to utilize skills related to EI. Jørgensen et al. (2021) identified higher scores regarding personal and work-related aspects of BO in mental health professionals than of client-

related BO, meaning that work sources unrelated to consumer interactions increased worker BO. The authors surmised that occupational and organizational factors are more impactful to workers, as opposed to those that stem from the challenges with the population served. Okuda et al. (2020) also determined that more stringent job pressures and less occupational support resulted in higher levels of BO. Job duties that are not related to a particular profession or role have been found to increase levels of BO (Okuda et al., 2020). On the contrary, professional identity can be inversely related to BO (Maor & Hemi, 2021). In another study, von Hippel et al. (2019) reported that since BO is associated with staff turnover and adverse workplace consequences, minimizing BO can reduce staff turnover and lower the rates of negative workplace results. The investigators also conveyed that mental health workers' perceptions that consumers are not improving or making progress in their recovery can contribute to their staff BO.

Mental health professionals have been assessed to find that BO can lead to stigmatization attitudes and beliefs of mental health issues that can be detrimental to the consumers they serve (Lagunes-Cordoba et al., 2021). Consumers' ability to achieve recovery could be stunted due to this problem. As shown, BO can pose a threat to communities via agencies and workers, causing consumers and other stakeholders undue complications. Specifically, MHCMs working in agencies could feel intense levels of BO, which may generate poor working dispositions toward the consumers they serve, producing disconnection in working relations and inferior service provision.

Research Question/Hypothesis Two

For research question two, I evaluated EI to determine if it could moderate the relationship between CS and BO in MHCMs working in an outpatient mental health facility. For hypothesis two, I predicted EI would be a statistically significant moderator in the relationship

between CS and BO. The results indicated that hypothesis two was not supported. Contrastingly, others have also explored the impact that EI can have on different variables and found hopeful discoveries. For instance, researchers determined that EI moderated the relationship between the stress aspect of emerging adult responsibility and well-being (Marikutty & Joseph, 2016). The same researchers postulated that adolescents with high levels of EI were more likely to have less stress and better well-being. At the university level, EI moderated the relationship between coping self-efficacy and academic stress (Watson & Watson, 2016). Salami and Ajitoni (2016) posited that those with a high degree of EI can manage their emotions and sustain positive moods during stress-induced interactions. This skill can benefit individuals within social and professional contexts. García-Sancho et al. (2017) reported that ability EI was a moderator in lessening the effects of anger on physical aggression. As another example, Bibi et al. (2013) suggested that those with higher EI tended to display fewer negative workplace behaviors, such as deliberately doing work unsatisfactorily or having a surly attitude toward coworkers. It would seem that EI skills could reasonably help MHCMs deal with effects from BO. Moreover, EI skills may improve one's awareness of experiences and dispositions associated with CS.

As EI has been demonstrated to provide a protective buffer in several other studies, the lack of moderation value EI was found to have in this study could be attributed to various alternative factors that might have been more potent in their effects on MHCMs and therefore reduced the influence of EI. Outside forces or factors such as the COVID-19 pandemic, health problems, and/or organizational issues could have played a role in how MHCMs were able to use EI within their roles. It may even be inferred that the moderation strength of EI regarding the relationship between CS and BO was diluted by elements of personality/disposition, work milieu, workload, and unexpected externalities not assessed. It is also possible that the

conceptualization and measurement used to assess EI in this study could have caused the variance in expected EI moderation when compared to other studies. While there may be various explanations for the reason EI was not a moderator, it may also be important to consider the possibility that MHCMs did not have high enough levels of EI for the effects to be statistically significant on the relationship between CS and BO.

The predictive hierarchical regression model included three separate iterations. Results from model one indicated that the total score of CS estimating the predictor variable yielded a statistically significant outcome, as expected from prior studies. This explained approximately 45.6% of the change in CS scores in block one. Based on former studies referred to in the literature review, it was believed that models two and three would have statistically significant results due to the protective factor qualities that EI can have individually as well as the presumed protective factor quality that the interaction effect between CS and EI could have on BO. Unexpectedly, blocks two and three both did not have statistically significant results. It appears as if adding EI into models two and three resulted in nonsignificant findings, even with CS present in both iterations. However, while blocks two and three did not achieve statistical significance in the overall model, it may have been due to various other contributing factors inherent within the studied population and context, such as MHCMs' personal/professional features, work-related factors, and organizational influences. Interestingly, the nonsignificant occurrences in models two and three may also be attributed to how the instrument used to assess EI in this study is configured. For instance, varying EI measures may result in different outcomes when used with MHCMs due to differing psychometric properties that may account for the nuances observed.

The mean EI scores from participants in this study were about average compared to most large sample sizes (Malouf, 2014). As previously discussed, EI was determined to have a positive relationship with CS and a negative one with BO. If one has a high level of EI, then they may be more aware of their own emotions, thereafter able to recognize their satisfaction with how well they are helping others. Thus, someone with a greater level of EI could also have a greater level of CS. Similarly, if one is able to have a high degree of EI, then they might be able to manage their emotions effectively to avoid being affected by issues regarding BO. Therefore, one's EI could theoretically help them in mitigating stressful situations and consequently produce a low level of BO. Researchers have examined EI and shown how it can influence other constructs. Johnson and Blanchard (2016) purported that EI plays an important role in fostering mental health and is negatively associated with perceived stress levels and symptom reporting. While comparing experimental and control groups, Farej and Rezaee (2018) noticed stark discrepancies and alluded to the impact that EI can have on enhancing life expectancy as well as diminishing depressive symptoms. Sharp et al. (2019) posited that a high degree of EI was correlated with a decrease in stress and BO. These authors also noted that high levels of EI would be associated with leadership skills and improve job satisfaction. Perceived EI has been suggested to moderate work-related stressors on mental health (Pulido-Martos et al., 2016). Given the promising findings regarding EI, Baudry et al. (2018) called for more interventions to bolster EI capabilities pertaining to emotional profiles and particulars of individuals. In a recent study, Persich et al. (2021) evaluated the success of an online EI training program and found that it was effective in maintaining mental health fortitude, comparing scores from before the COVID-19 pandemic started to six months after it began. At any rate, it seems as though EI was not an influential moderator in the current study and may require further investigation.

Research Question/Hypothesis Three

For research question three, I was interested in determining if characteristics such as age, level of education, gender, ethnicity/race, years of working experience in one's current role, and if one was satisfied with where they were currently working had a statistically significant relationship with one's level of EI, CS, and/or BO. For hypothesis three, I predicted that each of these same characteristics would have a statistically significant relationship with one's level of EI, CS, and/or BO. The results indicated that hypothesis three was partially supported, being that three of the 15 dyadic variables were found to have statistically significant relationships. The data showed that age had a medium inverse association with BO, age had a small positive association with CS, and CS had a medium inverse association with one's satisfaction with where they were currently working. Essentially, as one's age increased, their BO decreased, and CS increased. Moreover, as participants' CS increased, so did their satisfaction with where they were currently working.

Akin to the current study, Salloum et al. (2015) found that age was inversely correlated with BO. In another study, Senreich et al. (2020) noted that age was positively related to CS, a finding corroborated in the current study. It could be surmised that as one ages, they might garner a deeper appreciation for their ability to help others in their work, enhancing their CS. Also rooted in the current study's outcomes, it stands to reason that if one's CS improves, their contentment with where they are currently working could be fortified, seeing as both aspects can feasibly inform one another. Based on the current study's results, it might also be deduced that as one ages, they may have learned more, matured further, and gained more skills to be able to withstand the pressures that contribute to BO. Notably, the statistically significant relationships between the mentioned demographics and the variables of CS and BO can add to the literature.

Implications

Implications for Mental Health Case Managers

On average, the sample of MHCMs in this study experienced high-moderate levels of CS, low-moderate levels of BO, and moderate levels of EI. In general, MHCMs may be able to see that these variables are relevant to their personal and professional experiences. For instance, MHCMs might want to learn ways to improve their CS for the purpose of reducing the risk of BO. A way to possibly increase CS would be for MHCMs to address the working alliance between themselves and the consumers they work with, as it may improve their ability to do their job and reduce consumers' issues and service episodes (Stergiopoulos et al., 2018). Many MHCMs can address the working alliance between themselves and consumers by being more aware of how their interactions affect consumers, having candid conversations about the status of their working alliance with consumers, being able to adapt their behaviors toward consumers to benefit the working alliance, and actively seeking training and supervision to better improve the way they work with consumers.

Researchers have previously discussed the harmful effects of BO on MHCMs and service delivery (Kraus & Stein, 2012; Morse et al., 2011). Regardless of the effects of BO, MHCMs can experience BO due to the nature of their work, as well as their responses to it. For example, even if certain work difficulties are present, MHCMs may interpret situations differently based on personal attitudes or perspectives. Consequently, it can be useful for MHCMs to examine their own beliefs regarding work circumstances. By doing this, MHCMs may be able to adjust their internal responses to external forces so that they can minimize the risk of BO.

The results from this study indicate that as MHCMs' EI levels increase, their BO levels decrease. While there are no claims of causality based on this study's results, MHCMs may want

to learn skills associated with EI to help address BO. Of course, MHCMs can also look to the relationship between CS and EI with hopes that increasing one or the other can have a positive effect on the interaction between the two variables. It can also be useful for MHCMs to obtain further training and support to enhance beneficial factors such as CS and EI, as training and consultations can lead to increased skills (Ravitz et al., 2019). Mendenhall et al. (2019) exhibited how a strengths-based, goal-directed model can assist MHCMs in performing more optimally in their jobs and in having a better professional quality of life. It appears as if a strengths-based goal-directed approach can be used to facilitate better service provision outcomes and have a positive influence on MHCMs' overall experience. Thus, MHCMs may be able to advocate for themselves within their agencies to promote the possibility of using such an approach to consumer care to improve their own overall CS. Due to the interactions between age/CS and age/BO, younger MHCMs may want to be more aware of susceptibilities to experiencing less CS and more BO. Moreover, MHCMs with less CS can be at risk to experience less satisfaction with their work situation. Workers who are unsatisfied with working conditions might end up leaving their jobs (Sullivan et al., 2015). This could forecast higher turnover rates within the outpatient mental health facilities where these MHCMs work. Overall, MHCMs can review these implications to find ways to boost their job experiences and circumvent harmful predicaments.

Implications for Administrators

Administrators may consider the importance of addressing CS, BO, and EI within MHCMs, as it could have consequences for their agencies, staff, consumers, and the public perception of their leadership. Since BO can possibly influence staff performance, staff health complications, turnover, and ultimately consumer outcomes, it would befit administrators to engage in efforts to develop individual and organizational strategies to diminish BO (Morse et

al., 2011). For instance, Kraus and Stein (2012) discovered that perceptions of using a recovery-oriented approach to delivering services related to MHCMs experiencing greater job satisfaction and lowered levels of BO. In other research, Bae et al. (2020) suggested that workers be encouraged to use EI as a skill and protective factor, as it could be used to enhance CS. Due to the current study's results, administrators may be justified in working on ways of increasing CS and EI in MHCMs. Even still, administrators can exhibit transformational leadership to motivate and support employees and contribute to procuring improvements in work-life equilibrium (Bae et al., 2020). Saeed et al. (2017) underscored several leadership competencies and values, such as integrity, fairness, vision, accountability, and quality focus that administrators can review and use in their supervisory work to assist MHCMs by promoting CS and creating counterbalances to diminish the risk of BO. Moreover, different effective practices and processes linked with hiring, support, and professional growth can subsequently lead to positive consumer outcomes (Sullivan et al., 2015). Administrators might also consider addressing additional factors such as offering routine and sufficient supervision, cultivating work setting/environment improvements, and providing trainings to enhance experiences for MHCMs. Conversano et al. (2020) noted that interventions and trainings related to mindfulness and compassion can promote awareness, self-compassion, and aspects regarding quality of life. In another study, Grant and Mandell (2016) suggested that administrators could offer trainings and workshops on understanding the purposes of boundaries and challenges with implementing them so that service providers can have strong working relationships with consumers. Based on the present study, there are approximately 25% of MHCMs experiencing a lack of satisfaction with their current working situation. Therefore, it would benefit administrators to identify the determinants leading to this occurrence, in hopes of remediating any controllable issues and retaining employees. This might be achieved through

engaging in internal research to better understand MHCMs and their experiences via quantitative, qualitative, and/or mixed methods analyses. While there may be inherent difficulties in collecting data from employees, administrators could contemplate hiring consultants to help identify deficient processes and offer recommendations to improve program procedures. Administrators investing in program evaluation can be educated through insightful findings that help them make critical decisions. Given the magnitude of induced stress that MHCMs encounter, it is incumbent on their organizational administrators to detect, resolve, and prevent foreseeable problems concerning staff and consumer relations.

Limitations and Suggestions for Future Research

A limitation to this study was that the research sites surveyed were scattered across the state of Texas. This may have caused weaker generalizations to be made due to the differences in service areas, cultures, and other peripheral factors. Another limitation was that the MHCMs surveyed were not required to have worked in their role for a minimum period of time, beyond their initial training period after being hired. Participants may have just received their caseload when completing the study and not have had various encounters with consumers prior. Therefore, their report of CS and BO within their MHCM role may not adequately depict the population's general realities. A final limitation acknowledged was regarding the lack of accounting for the potential influence of the COVID-19 pandemic on MHCMs and their circumstances related to CS, BO, and EI. Indeed, due to this study being conducted and participants surveyed between 2020 and 2021, it is possible that the COVID-19 pandemic affected the attempt to capture a genuine and characteristically accurate representation of MHCMs' personal and professional experiences.

One suggestion for future research is to examine the lived experiences of MHCMs working in an outpatient mental health facility regarding CS, BO, and EI. This kind of qualitative research may lead to further revelations that can offer additional insights about factors influencing MHCMs' experiences. An in-depth understanding of MHCMs' perspectives can perhaps assist researchers with learning about future investigatory directions to pursue. Further, studying personal characteristics; experiences in the work setting; and organizational, political, and societal contexts can provide a more thorough comprehension of workers (El-bar et al., 2013; Richards et al., 2021; Senreich et al., 2020; Wood et al., 2021; Yanchus et al., 2017). Inspecting safety issues within a work context via research can also precipitate crucial data-driven responses to interesting phenomena (Albutt et al., 2021).

Despite Mckinless (2020) recognizing the advantages of utilizing EI in stressful situations and Zeidner and Hadar (2014) noting that EI skills have been positively associated with CS, Towey-Swift and Whittington (2021) have cited the need for more research to look at the predictive factors of CS. With this information in mind, a research recommendation would be for researchers to identify aspects that can improve levels of CS and EI. It may also be valuable to find components that enhance the impact of these variables. Researchers could look at what factors strengthen the relationship between CS and EI, such as moderator variables. Furthermore, it may be worth further researching the exact reasons for the positive link between CS and EI, as these two variables have been shown to be independently beneficial.

Additional research endeavors could explore the possible explanations for differing levels of CS, BO, and EI between the present study and others conducted. For instance, the current study has shown moderate estimations of CS, BO, and EI within the sample of MHCMs. Yet, other studies have shown variations in scores of the appraisals of these constructs (Abraham-

Cook, 2012; Campbell, 2013; Lucero, 2021, Năstasă & Fărcaş, 2015; Sharp et al., 2019). However, much of the extant literature is missing these same variables with the MHCM population. Researchers using dissimilar conceptualizations and instruments for measuring the concepts of CS, BO, and EI could also be another reason for the discrepancy in outcomes. Still, differences between participants' personal and professional skills, dispositions, and experiences could account for a portion of the variance. Each of these types of possible explanations would be aspects for researchers to address in future studies.

Another research idea is to utilize other instruments in measuring CS, BO, and EI to determine convergent validity within MHCMs. The purpose of this kind of research would be to determine how related each of the measurements are to one another regarding the particular construct they are used to assess. Scholars could use data from a study of this nature to evaluate theoretically similar conceptions, possibly improving our knowledge of existing frameworks and allowing for better deductions to be made. While there is only one conceptualization and instrument used to measure CS at this time, there may be more to understand and gain by testing another iteration/measurement. There are, however, many versions of BO and EI, which can be variably measured. As an example, Qiao and Schaufeli (2011) analyzed the convergent validity of four well-known BO measures of a sample of Chinese nurses. Future studies with different conceptualizations and instruments to measure the three variables could be used to compare to the present study's outcomes.

A final recommendation is for scholars to examine and address/refine constructs which are erroneously described and create practical measurements to assess them. The way a construct is defined ultimately determines how it is understood and assessed. Therefore, inadequately defined constructs (e.g., descriptions that are more characteristically associated with other

constructs) can impair construct validity, leading to a disconnect between the operational definition and how it is measured. This can create difficulty in making accurate inferences based on study outcomes. Côté (2014) referred to the jingle fallacy and how several models of EI have been improperly labeled, thus creating conceptualizations that are definitionally diluted. Similarly, Bianchi et al. (2017) reviewed the MBI, used to measure BO, and noted several conceptual and operational issues including poor discriminant validity with depression. Furthermore, other researchers have observed comparable problems with the conceptualization of BO within the ProQOL's framework used in the current study (Heritage et al., 2018; Marks, 2016). As far as usability, Côté (2014) discussed many of the limitations regarding the MSCEIT used to measure EI. Additionally, due to the accessibility issues, number of items, and length of time needed to complete the measure, more pragmatic instruments may be used to measure EI instead of the MSCEIT. The SSEIT, used in this study to measure EI, has also been criticized as being inadequate in terms of measuring true EI ability (Côté, 2014). Generating and utilizing more sound and practical measures can contribute to easier and efficient processes regarding data collection, computing data, and interpreting study results.

Conclusion

Communities across the nation rely on services provided by MHCMs to improve the lives of many who suffer with mental health issues. This predictive quantitative study included BO, CS, and EI related to MHCMs working in outpatient mental health facilities. The results revealed that EI was not a moderator for the relationship between CS and BO. Nevertheless, statistically significant relationships were found between CS and BO, CS and EI, and EI and BO. Additionally, relationships between BO and age, CS and age, and CS and if one's satisfaction with where they were currently working were also determined to be statistically significant. The

results of this study have important implications for MHCMs and administrators at the personal and professional levels. Multiple limitations were observed in this study and results should be carefully considered. Several suggestions for future research have been offered regarding qualitative inquiry and aspects of comparing and improving conceptualizations and measurements associated with CS, BO, and EI. Outcomes from this study can inform and inspire stakeholders associated with the research population to identify ways to optimize CS and EI, while mitigating BO for MHCMs. The lasting consequences of these improvements can potentially increase MHCMs' longevity in their roles, enhance the services they offer, and enrich consumers' mental health. Additionally, healthier consumers could have a reduction in service episodes, leading to fewer expenditures and better resource reallocation. Overall, outpatient mental health facilities might have more stable and sustainable organizations, MHCMs might achieve a greater sense of fulfillment in their roles, and consumers may attain full personal recovery, which could all help to create flourishing communities around the nation.

REFERENCES

Abarghouei, M. R., Sorbi, M. H., Abarghouei, M., Bidaki, R., & Yazdanpoor, S. (2016). A study of job stress and burnout and related factors in the hospital personnel of Iran. *Electronic Physician, 8*(7), 2625-2632. https://doi.org/10.19082/2625

Abraham-Cook, S. (2012). *The prevalence and correlates of compassion fatigue, compassion satisfaction, and burnout among teachers working in high-poverty urban public schools* (Publication No. 3575412) [Doctoral dissertation, Seton Hall University]. ProQuest Dissertations and Theses Global. https://www-proquest com.manowar.tamucc.edu/pqdtglobal/docview/1461391768/450001B46F4F45A6PQ/1?ccountid=7084

Acker, G. M. (2010). The challenges in providing services to clients with mental illness: Managed care, burnout and somatic symptoms among social workers. *Community Mental Health Journal, 46*(6), 591-600. https://doi.org/10.1007/s10597-009-9269-5

Adan, A., Marquez-Arrico, J. E., & Gilchrist, G. (2017). Comparison of health-related quality of life among men with different co-existing severe mental disorders in treatment for substance use. *Health and Quality of Life Outcomes, 15*(1), 1-12. https://doi.org/10.1186/s12955-017-0781-y

Ain, N. U., Munir, M., & Suneel, I. (2021). Role of emotional intelligence and grit in life satisfaction. *Heliyon, 7*(4), 1-8. https://doi.org/10.1016/j.heliyon.2021.e06829

Akhtar, S., Shah, S. M., & Khan, M. S. (2020). Relationship between emotional intelligence and performance of secondary school teachers. *The Dialogue, 15*(1), 115-125.

Albutt, A., Berzins, K., Louch, G., & Baker, J. (2021). Health professionals' perspectives of safety issues in mental health services: A qualitative study. *International Journal of Mental Health Nursing, 30*(3), 798-810. https://doi.org/10.1111/inm.12838

Algur, S. P., & Biradar, J. G. (2017). Cook's distance and Mahalanobis distance outlier detection methods to identify review spam. *International Journal of Engineering and Computer Science, 6*, 21638-21649. https://doi.org/10.18535/ijecs/v6i6.16

Al-Haddad, A., Al-Omar, F., Al-Khaleel, A., & Al-Khalaf, A. (2019). Prevalence of burnout syndrome and its related risk factors among physicians working in primary health care centers of the ministry of health, Al Ahsa region, Saudi Arabia, 2018–2019. *Journal of Family Medicine and Primary Care, 9*(2), 571-579. https://doi.org/10.4103/jfmpc.jfmpc_743_19

Aljandali, A. (2017). *Multivariate Methods and Forecasting with IBM SPSS Statistics.* Springer International Publishing. https://doi.org/10.1007/978-3-319-56481-4

Al Ubaidi, B. A. (2018). Is emotional intelligence a need skill for health care provider? *Journal of Family Medicine and Disease Prevention*, *4*(1), 1-6. https://doi.org/10.23937/2469 5793/1510071

Amir, K., Betty, A., & Kenneth, A. M. (2019). Emotional intelligence as a predictor of compassion fatigue among mental health practitioners. *Open Access Library Journal*, *6*(5), 1-10. http://dx.doi.org/10.4236/oalib.1105410

Andal, S. (2021). Emotional intelligence among health care professionals. *Journal of Nursing and Health Science, 10*(1), 35-39. https://doi.org/10.9790/1959-1001023539

Arnold, E. M., Walsh, A. K., Oldham, M. S., & Rapp, C. A. (2007). Strengths-based case management: Implementation with high-risk youth. *Families in Society: The Journal of Contemporary Social Services, 88*(1), 86-94. https://doi.org/10.1606/1044-3894.3595

Ashkanasy, N. M., & Daus, C. S. (2005). Rumors of the death of emotional intelligence in organizational behavior are vastly exaggerated. *Journal of Organizational Behavior, 26*, 441–452. https://doi:10.1002/job.320

Au, M., Kehn, M., Ireys, H., Blyler, C., & Brown, J. (2018). Care coordinators in integrated care: Burnout risk, perceived supports, and job satisfaction. *American Journal of Preventive Medicine, 54*(6), 250-257. https://doi.org/10.1016/j.amepre.2018.01.044

Bae, J., Jennings, P. F., Hardeman, C. P., Kim, E., Lee, M., Littleton, T., & Saasa, S. (2020). Compassion satisfaction among social work practitioners: The role of work-life balance. *Journal of Social Service Research, 46*(3), 320-330. https://doi.org/10.1080/01488376.2019.1566195

Ballenger-Browning, K. K., Schmitz, K. J., Rothacker, J. A., Hammer, P. S., Webb-Murphy, J. A., & Johnson, D. C. (2011). Predictors of burnout among military mental health providers. *Military Medicine, 176*(3), 253-260. https://doi.org/10.1037/e717552011-002

Barnes, A. L., Murphy, M. E., Fowler, C. A., & Rempfer, M. V. (2012). Health-related quality of life and overall life satisfaction in people with serious mental illness. *Schizophrenia Research & Treatment*, 1-6. https://doi.org/10.1155/2012/245103

Bar-On, R. (1997). *The Emotional Quotient Inventory (EQ-i)*: *Technical manual*. Toronto, Canada: Multi-Health Systems.

Bartholomew, K., & Horowitz, L. M. (1991). Attachment styles among young adults: A test of a four-category model. *Journal of Personality and Social Psychology, 61*(2), 226-244. https://doi.org/10.1037/0022-3514.61.2.226

Bartz, D. E. (2019). Grit, emotional intelligence, and mindset: Three skill sets for fostering career advancement for organization members. *International Journal of Education and Human Developments, 5*(1), 1-6.

Başoğul, C., Baysan Arabaci, L., Mutlu Satıl, E., & Büyükbayram Aslan, A. (2021). Professional values and professional quality of life among mental health nurses: A cross-sectional study. *Nursing & Health Sciences, 23*(2), 362-371. https://doi.org/10.1111/nhs.12811

Baudry, A., Grynberg, D., Dassonneville, C., Lelorain, S., & Christophe, V. (2018). Sub dimensions of trait emotional intelligence and health: A critical and systematic review of the literature. *Scandinavian Journal of Psychology, 59*(2), 206-222. https://doi.org/10.1111/sjop.12424

Beauvais, A., Andreychik, M., & Henkel, L. (2017). The role of emotional intelligence and empathy in compassionate nursing care. *Mindfulness & Compassion, 2*(2), 92-100. https://doi.org/10.1016/j.mincom.2017.09.001

Beebe, J. (2016) *Compassion fatigue and compassion satisfaction: Experiences of helping professionals in the homeless workforce: A project based upon an investigation at Boston Healthcare for the homeless, Boston, Massachusetts* (Master's thesis). https://scholarworks.smith.edu/theses/1720

Berjot, S., & Gillet, N. (2011). Stress and coping with discrimination and stigmatization. *Frontiers in Psychology, 2*, 1-13. https://doi.org/10.3389/fpsyg.2011.00033

Bianchi, R., Schonfeld, I. S., & Laurent, E. (2017). Burnout: Moving beyond the status quo. *International Journal of Stress Management, 26*(1), 36-45. https://doi.org/10.1037/str0000088

Bibi, Z., Karim, J., & Din, S. (2013). Workplace incivility and counterproductive work behavior: Moderating role of emotional intelligence. *Pakistan Journal of Psychological Research, 28*(2), 317-334.

Bitter, N., Roeg, D., Van Assen, M., Van Nieuwenhuizen, C., & Van Weeghel, J. (2017). How effective is the comprehensive approach to rehabilitation (CARe) methodology? A cluster randomized control trial. *BMC Psychiatry, 17*(1), 1-11. http://dx.doi.org/10.1186/s12888017-1565-y

Bitter, N., Roeg, D., Van Nieuwenhuizen, C., & Van Weeghel, J. (2019). Training professionals in a recovery-oriented methodology: A mixed method evaluation. *Scandinavian Journal of Caring Sciences, 33*(2), 457-466. http://dx.doi.org/10.1111/scs.12644

Blair, K. D., Taylor, D. B., & Rivera, C. J. (2009). Strengths and stressors in a population of kinship caregivers: Implications for caseload management and administration. *Families in Society: The Journal of Contemporary Social Services, 90*(4), 431-438. https://doi.org/10.1606/1044-3894.3927

Blanchard, C., Kravets, V., Schenker, M., & Moore, T. (2021). Emotional intelligence, burnout, and professional fulfillment in clinical year medical students. *Medical Teacher, 43*(9), 1063-1069. https://doi.org/10.1080/0142159x.2021.1915468

Brackett, M. A., Rivers, S. E., & Salovey, P. (2011). Emotional intelligence: Implications for personal, social, academic, and workplace success. *Social and Personality Psychology Compass, 5*(1), 88-103. https://doi.org/10.1111/j.1751-9004.2010.00334.x

Brennan, E. J. (2017). Towards resilience and wellbeing in nurses. *British Journal of Nursing, 26*(1), 43-47. https://doi.org/10.12968/bjon.2017.26.1.43

Brill, P. (1984). The need for an operational definition of burnout. *Family Community Health, 6*(4), 12-24.

Brimblecombe, N., Knapp, M., Murguia, S., Mbeah-Bankas, H., Crane, S., Harris, A., … King, D. (2017). The role of youth mental health services in the treatment of young people with serious mental illness: 2-year outcomes and economic implications. *Early Intervention in Psychiatry*, *11*(5), 393-400. https://doi.org/10.1111/eip.12261

Brun, C., & Rapp, R. C. (2001) Strengths-based case management: Individuals' perspectives on strengths and the case manager relationship. *Social Work, 46*(3), 278-288. https://doi.org/10.1093/sw/46.3.278

Buceta, M. I., Bermejo, J. C., & Villacieros, M. (2019). Enhancer elements of compassion satisfaction in healthcare professionals. *Annals of Psychology*, *35*(2), 323-331. https://dx.doi.org/10.6018/analesps.35.2.345101

Çam, O., & Büyükbayram, A. (2015). The results of nurses' increasing emotional intelligence and resilience. *Journal of Psychiatric Nursing, 6*(3), 130-136. http://dx.doi.org/10.5505/phd.2015.96729

Campbell, J. (2013). *Prevalence of compassion fatigue and compassion satisfaction in mental health care professionals* (Publication No. 3557256) [Doctoral dissertation, Walden University]. ProQuest Dissertations and Theses Global. https://www-proquest com.manowar.tamucc.edu/pqdtglobal/docview/1341304831/4265F13A2639447EPQ/1?ccountid=7084

Carminati, L. (2021). Emotions, emotion management and emotional intelligence in the workplace: Healthcare professionals' experience in emotionally-charged situations. *Frontiers in Sociology, 6,* 1-5. https://doi.org/10.3389/fsoc.2021.640384

Cascio, M. I., Magnano, P., Parenti, I., & Plaia A. (2017). The role of emotional intelligence in health care professionals burnout. *International Journal of Healthcare and Medical Sciences, 3*(2), 8-16.

Cetrano, G., Tedeschi, F., Rabbi, L., Gosetti, G., Lora, A., Lamonaca, D…Amaddeo, F. (2017). How are compassion fatigue, burnout, and compassion satisfaction affected by quality of working life? Findings from a survey of mental health staff in Italy. *BMC Health Services Research, 17*(1), 1-11. https://doi.org/10.1186/s12913-017-2726-x

Charlson, M. E., Wells, M. T., Kanna, B., Dunn, V., & Michelen, W. (2014). Medicaid managed care: How to target efforts to reduce costs. *BMC Health Services Research, 14*(1), 1-8. https://doi.org/10.1186/1472-6963-14-461

Cheema, S. A., Sajid, A., & Hassan, A. (2020). The association of grit and burnout among gynecological post-graduate residents: A cross-sectional study. *Annals of King Edward Medical University, 26*(3), 462-467.

Chisholm, D., Sweeny, K., Sheehan, P., Rasmussen, B., Smit, F., Cuijpers, P., & Saxena, S. (2016). Scaling-up treatment of depression and anxiety: A global return on investment analysis. *Lancet Psychiatry, 3*(5), 415-424. https://doi.org/10.1016/s2215-0366(16)300244

Chung, D. W. (2010). Biomedical approach is not good enough for treating severe mental illness. *East Asian Arch Psychiatry, 20*(1), 4-5.

Clark, P., Holden, C., Russell, M., & Downs, H. (2021). The impostor phenomenon in mental health professionals: Relationships among compassion fatigue, burnout, and compassion satisfaction. *Contemporary Family Therapy*, 1-13. https://doi.org/10.1007/s10591-021 09580-y

Cohen, J. (1988). *Statistical power analysis for the behavioral sciences* (2nd ed.). Hillsdale, NJ: Erlbaum.

Collins, S., & Long, A. (2003). Too tired to care? The psychological effects of working with trauma. *Journal of Psychiatric and Mental Health Nursing, 10*(1), 17-27. http://dx.doi.org/10.1046/j.1365-2850.2003.00526.x

Conversano, C., Ciacchini, R., Orrù, G., Di Giuseppe, M., Gemignani, A., & Poli, A. (2020). Mindfulness, compassion, and self-compassion among health care professionals: What's new? A systematic review. *Frontiers in Psychology*, *11*, 1-21. https://doi.org/10.3389/fpsyg.2020.01683

Cooper, R. K., & Sawaf, A. (1998). *Executive EQ emotional intelligence in leadership and organization*. Berkley Publishing Group.

Côté, S. (2014). Emotional intelligence in organizations. *The Annual Review of Organizational Psychology and Organizational Behavior*, *1*(4), 459-488. https://doi.org/10.1146/annurev orgpsych-031413-091233

Cousineau, D., & Chartier, S. (2010). Outliers detection and treatment: A review. *International Journal of Psychological Research, 3*(1), 58-67. http://dx.doi.org/10.21500/20112084.844

Craig, C. D., & Sprang, G. (2010). Compassion satisfaction, compassion fatigue, and burnout in a national sample of trauma treatment therapists. *Anxiety, Stress & Coping*, *23*(3), 319 -339. https://doi.org/10.1080/10615800903085818

Cramer, D. (2003). *Advanced quantitative data analysis: Understanding social research*. Philadelphia, PA: Open University Press.

Currier, J. M., Stefurak, T., Carroll, T. D., & Shatto, E. H. (2017). Applying trauma-informed care to community-based mental health services for military veterans. *Best Practices in Mental Health: An International Journal, 13*(1), 47-64.

D'Amico, A., Geraci, A., & Tarantino, C. (2020). The relationship between perceived emotional intelligence, work engagement, job satisfaction, and burnout in Italian school teachers. *Psychological Topics, 29*(1), 63-84. https://doi.org/10.31820/pt.29.1.4

de Figueiredo, S., Yetwin, A., Sherer, S., Radzik, M., & Iverson, E. (2014). A cross-disciplinary comparison of perceptions of compassion fatigue and satisfaction among service providers of highly traumatized children and adolescents. *Traumatology, 20*(4), 286-295. https://doi.org/10.1037/h0099833

Dhani, P., Sharma, T. (2016). Emotional Intelligence: History, models, and measures. *International Journal of Science Technology and Management, 5*(7), 189-201.

Drake, R. E., & Whitley, R. (2014). Recovery and severe mental illness: Description and analysis. *The Canadian Journal of Psychiatry, 59*(5), 236-242. https://doi.org/10.1177/070674371405900502

Eack, S. M., Greeno, C. G., Christian-Michaels, S., Dennis, A., & Anderson, C. M. (2009). Case managers' perspectives on what they need to do their job. *Psychiatric Rehabilitation Journal, 32*(4), 309-312. https://doi.org/10.2975/32.4.2009.309.312

Egeland, K. M., Ruud, T., Ogden, T., Fardig, R., Lindstrom, J. C., & Heiervang, K. S. (2017). How to implement illness management and recovery (IMR) in mental health services settings: Evaluation of the implementation strategy. *International Journal of Mental Health Systems, 11*(1), 1-10. http://dx.doi.org/10.1186/s13033-017-0120-z

El-bar, N., Levy, A., Wald, H. S., & Biderman, A. (2013). Compassion fatigue, burnout and compassion satisfaction among family physicians in the Negev area- A cross-sectional study. *Israel Journal of Health Policy Research, 2*(1). https://doi.org/10.1186/2045-4015 2-31

Eliacin, J., Flanagan, M., Monroe-DeVita, M., Wasmuth, S., Salyers, M. P., & Rollins, A. L. (2018). Social capital and burnout among mental healthcare providers. *Journal of Mental Health*, *27*(5), 388-394. https://doi.org/10.1080/09638237.2017.1417570

Farber, B. (1990). Burnout in psychotherapists: Incidence, types, and trends. *Psychotherapy in Private Practice, 8*, 35-44.

Farej, F., & Rezaee, A. M. (2018). The effect of emotional intelligence on self-esteem, mental health, quality of life, social skills, and self-efficacy of working child mothers. *Indian Journal of Positive Psychology*, *9*(4), 451-454.

Faul, F., Erdfelder, E., Lang, A.G., & Buchner, A. (2007). G*Power 3: A flexible power analysis program for the social, behavioral, and biomedical sciences. *Behavior Research Methods, 39*(2), 175-191. https://doi.org/10.3758/BF03193146

Fentie, E. T., Daba Wami, S., & Guyasa Kabito, G. (2021). Prevalence of burnout syndrome and associated factors among health care workers at public hospitals in Addis Ababa, Ethiopia: Results from a cross-sectional study. *International Journal of Mental Health*, 1 -13. https://doi.org/10.1080/00207411.2021.1946904

Figley, C. (1995). Compassion fatigue as secondary traumatic stress disorder: An overview. In C.R. Figley (Ed.) *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized*. New York: Brunner-Routledge.

Folkman, S. (1984). Personal control and stress and coping processes: A theoretical analysis. *Journal of Personality and Social Psychology, 46*(4), 839-852. https://doi.org/10.1037/0022-3514.46.4.839

Folkman, S. (2010). *Stress, health, and coping: Synthesis, commentary, and future directions*. Oxford University Press.

Frajo-Apor, B., Pardeller, S., Kemmler, G., & Hofer, A. (2015). Emotional intelligence and resilience in mental health professionals caring for patients with serious mental illness. *Psychology, Health & Medicine, 21*(6), 755-761. https://doi.org/10.1080/13548506.2015.1120325

Freire, C., Ferradás, M. D., Valle, A., Núñez, J. C., & Vallejo, G. (2016). Profiles of psychological well-being and coping strategies among university students. *Frontiers in Psychology, 7*, 1-11. https://doi.org/10.3389/fpsyg.2016.01554

Freudenberger, H. J. (1974). Staff burn-out. *Journal of Social Issues, 30*, 159-165.

Frost, B. G., Tirupati, S., Johnston, S., Turrell, M., Lewin, T. J., Sly, K. A., & Conrad, A. M. (2017). An integrated recovery-oriented model (IRM) for mental health services: Evolution and challenges. *BMC Psychiatry, 17*(1), 1-17. https://doi.org/10.1186/s12888016-1164-3

Galek, K., Flannelly, K. J., Greene, P. B., & Kudler, T. (2011). Burnout, secondary traumatic stress, and social support. *Pastoral Psychology, 60*(5), 633-649. https://doi.org/10.1007/s11089-011-0346-7

Garcia, H. A., McGeary, C. A., Finley, E. P., McGeary, D. D., Ketchum, N. S., & Peterson, A. L. (2016). The influence of trauma and patient characteristics on provider burnout in VA post-traumatic stress disorder specialty programmes. *Psychology and Psychotherapy: Theory, Research and Practice, 89*(1), 66-81. https://doi.org/10.1111/papt.12057

García-Sancho, E., Dhont, K., Salguero, J. M., & Fernández-Berrocal, P. (2017). The personality basis of aggression: The mediating role of anger and the moderating role of emotional intelligence. *Scandinavian Journal of Psychology*, *58*(4), 333-340. https://doi.org/10.1111/sjop.12367

Gawali, K. C. (2012). Relationship between emotional intelligence and coping among college teachers. *Journal of Psychosocial Research, 7*(1), 25–32.

GBD 2017 Disease and Injury Incidence and Prevalence Collaborators. (2018). Global, regional, and national incidence, prevalence, and years lived with disability for 354 diseases and injuries for 195 countries and territories, 1990-2017: A systemic analysis for the Global Burden of Disease Study 2017. *The Lancet, 392,* 1789-1858.

Gelkopf, M., Lapid, L., Werbeloff, N., Levine, S. Z., Telem, A., Zisman-Ilani, Y., & Roe, D. (2016). A strengths-based case management service for people with serious mental illness in Israel: A randomized controlled trial. *Psychiatry Research, 241*, 182-189. https://doi.org/10.1016/j.psychres.2016.04.106

Gellis, Z. D., & Chun Kim, J. (2004). Predictors of depressive mood, occupational stress, and propensity to leave in older and younger mental health case managers. *CommunityMental Health Journal, 40*(5), 407-421. https://doi.org/10.1023/b:comh.0000040655.09817.e8

Geoffrion, S., Lamothe, J., Morizot, J., & Giguere, C. (2019). Construct validity of the professional quality of life (ProQOL) scale in a sample of child protection workers. *Journal of Traumatic Stress*, 32(4), 566-576. https://doi.org/10.1002/jts.22410

Giacobbi, P. R., Lynn, T. K., Wetherington, J. M., Jenkins, J., Bodendorf, M., & Langley, B. (2004). Stress and coping during the transition to university for first-year female athletes. *The Sport Psychologist*, *18*(1), 1-20. https://doi.org/10.1123/tsp.18.1.1

Gibbons, B. J., & Salkever, D. S. (2019). Working with a severe mental illness: Estimating the causal effects of employment on mental health status and total mental health costs. *Administration and Policy in Mental Health and Mental Health Services Research, 46*(4), 474-487. http://dx.doi.org/10.1007/s10488-019-00926-1

Gilbert, P., & Irons, C. (2005). Focused therapies and compassionate mind training for shame and self-attacking. In P. Gilbert (Ed.), *Compassion: Conceptualizations, research and use in psychotherapy*. London: Routledge.

Goleman, D. (1995). *Emotional intelligence*. New York, NY: Bantam.

Goleman, D. (1998). *Working with emotional intelligence*. New York, NY: Bantam.

Goleman, D. (2001). An EI-based theory of performance. In C. Cherniss & D. Goleman (Eds.), *The emotionally intelligent workplace: How to select for, measure, and improve emotional intelligence in individuals, groups, and organizations* (pp. 27-44). San Francisco, CA: Jossey-Bass.

Grant, J. G., & Mandell, D. (2016). Boundaries and relationships between service users and service providers in community mental health services. *Social Work in Mental Health, 14*(6), 696-713. https://doi.org/10.1080/15332985.2015.1137258

Greene, G. J., Kondrat, D. C., Lee, M. Y., Clement, J., Siebert, H., Mentzer, R. A., & Pinnell, S. R. (2006). A solution-focused approach to case management and recovery with consumers who have a severe mental disability. *Families in Society: The Journal of Contemporary Social Services, 87*(3), 339-350. https://doi.org/10.1606/1044-3894.3538

Griswold, K. S., Servoss, T. J., Leonard, K. E., Pastore, P. A., Smith, S. J., Wagner, C., … Thrist, M. (2005). Connections to primary medical care after psychiatric crisis. *Journal of the American Board of Family Medicine, 18*(3), 166-172. https://doi.org/10.3122/jabfm.18.3.166

Gutierrez, D., & Mullen, P. R. (2016). Emotional intelligence and the counselor: Examining the relationship of trait emotional intelligence to counselor burnout. *Journal of Mental Health Counseling, 38*(3), 187-200. https://doi.org/10.17744/mehc.38.3.01

Guzzi, D. A. (2019). *Redefining burnout: Exploring common conceptualizations and the neurophysiology of chronic stress to establish an integrated allostatic model.* [Doctoral dissertation, National Louis University]. ProQuest Dissertations and Theses Global. https://digitalcommons.nl.edu/diss/374

Haghighinejad, H., Jafari, P., Rezaie, M., Farrokhi, M., Jafari, M., & Ramzi, M. (2021). Burnout comparison between clinical and basic sciences faculty of a medical school and evaluation of related factors. *Iranian Journal of Psychiatry, 16*(4), 399-408. https://doi.org/10.18502/ijps.v16i4.7227

Hair, J. F., Black, W. C., Babin, B. J., & Anderson, R. E. (2009). *Multivariate data analysis* (7th ed.). Pearson.

Hales, T. W., Green, S. A., Bissonette, S., Warden, A., Diebold, J., Koury, S. P., & Nochajski. T. H. (2018). Trauma-informed care outcome study. *Research on Social Work Practice, 29*(5), 529-539. https://doi.org/10.1177/1049731518766618

Haley-Lock, A. (2007). Up close and personal: Employee networks and job satisfaction in a human service context. *Social Service Review, 81*(4), 683-707. https://doi.org/10.1086/522218

Hansen, N., Jensen, K., MacNiven, I., Pollock, N., D'Hont, T., & Chatwood, S. (2021). Exploring the impact of rural health system factors on physician burnout: A mixed methods study in Northern Canada. *BMC Health Services Research, 21*(1). https://doi.org/10.1186/s12913-021-06899-y

Hatton, C., Emerson, E., Rivers, M., Mason, H., Mason, L., Swarbrick, R., Kiernan, C., Reeves, D., & Alborz, A. (1999). Factors associated with staff stress and work satisfaction in services for people with intellectual disability. *Journal of Intellectual Disability Research, 43*(4), 253-267. https://doi.org/10.1046/j.1365-2788.1999.00208.x

Hayes, R. D., Chang, C., Fernandes, A. C., Begum, A., To, D., Broadbent, M., … Stewart, R. (2012). Functional status and all-cause mortality in serious mental illness. *PLoS ONE, 7*(9), 1-9. https://doi.org/10.1371/journal.pone.0044613

Heffernan, M., Quinn Griffin, M. T., McNulty, S. R., & Fitzpatrick, J. J. (2010). Self-compassion and emotional intelligence in nurses. *International Journal of Nursing Practice, 16*(4), 366-373. https://doi.org/10.1111/j.1440-172x.2010.01853.x

Henderson, A. R. (2010). A substantive theory of recovery from the effects of severe persistent mental illness. *International Journal of Social Psychiatry, 57*(6), 564-573. https://doi.org/10.1177/0020764010374417

Heritage, B., Rees, C. S., & Hegney, D. G. (2018). The ProQOL-21: A revised version of the professional quality of life (ProQOL) scale based on Rasch analysis. *PLOS ONE, 13*(2), 1-20. https://doi.org/10.1371/journal.pone.0193478

Hickle, K. (2020). Introducing a trauma-informed capability approach in youth services. *Children & Society, 34*(6), 537-551. https://doi.org/10.1111/chso.12388

Hicks, A. L., Deane, F. P., & Crowe, T. P. (2012). Change in working alliance and recovery in severe mental illness: An exploratory study. *Journal of Mental Health, 21*(2), 127-134. https://doi.org/10.3109/09638237.2011.621469

Hinds, J. A. (2017). Leading transformation in healthcare and the role of emotional intelligence. *Journal of Neurology & Neurophysiology, 8*(4), 1-3. https://doi.org/10.4172/2155 9562.1000441

Hobfoll, S. E. (1989). Conservation of resources: A new attempt at conceptualizing stress. *American Psychologist, 44*, 513–524.

Hong, E., & Lee, Y. S. (2016). The mediating effect of emotional intelligence between emotional labor, job stress, burnout and nurses' turnover intention. *International Journal of Nursing Practice, 22*(6), 625-632. https://doi.org/10.1111/ijn.12493

Huang, L., Caspari, J. H., Sun, X., Thai, J., Li, Y., Chen, F., & Zhao, X. (2020). Risk and protective factors for burnout among physicians from standardized residency training programs in Shanghai: A cross-sectional study. *BMC Health Services Research, 20*(1), 1 -12. https://doi.org/10.1186/s12913-020-05816-z

Hudon, C., Chouinard, M., Lamber, M., Dufour, I., & Krieg, C. (2016). Effectiveness of case management interventions for frequent users of healthcare services: A scoping review. *BMJ Open, 6*(9), 1-8. https://doi.org/10.1136/bmjopen-2016-012353

Hyatt-Burkhart, D. (2014). The experience of vicarious posttraumatic growth in mental health workers. *Journal of Loss and Trauma, 19*(5), 452-461. https://doi.org/10.1080/15325024.2013.797268

Ioannidou, F., & Konstantikaki, V. (2008). Empathy and emotional intelligence: What is it really about? *International Journal of Caring Sciences, 1*(3), 118-123.

Issa, MA., & Nadal, K. L. (2011). *Encyclopedia of Child Behavior and Development* (2011 ed.). Springer, Boston, MA. https://doi.org/10.1007/978-0-387-79061-9

Ivezic, S. S., Muzinic, L., & Filipac, V. (2010). Case management – A pillar of community psychiatry. *Psychiatria Danubina, 22*(1), 28-33.

Jenkins, G. T., Shafer, M. S., & Janich, N. (2020). Critical issues in leadership development for peer support specialists. *Community Mental Health Journal, 56*(6), 1085-1094. https://doi.org/10.1007/s10597-020-00569-9

Johnson, S. K., & Blanchard, A. (2016). Emotional intelligence and mental health: Stress and symptom reporting pathways. *Journal of Mental Health Counseling, 38*(1), 79-92. https://doi.org/10.17744/mehc.38.1.06

Johnson, J., Corker, C., & O'Conner, D. B. (2020). Burnout in psychological therapists: A cross sectional study investigating the role of supervisory relationship quality. *Clinical Psychologist, 24*(3), 223-235. https://doi.org/10.1111/cp.12206

Joint Commission on Accreditation of Healthcare Organizations. (1979). *Principals of accreditation of community mental health service programs.* Oakbrook Terrace, IL: Joint Commission on Accreditation of Hospitals, 1979.

Jones, J. M., Ali, M. M., Mutter, R., Henke, R. M., Gokhale, M., Marder, W., & Mark, T. (2018). Factors that affect choice of mental health provider and receipt of outpatient mental

health treatment. *The Journal of Behavioral Health Services & Research, 45*(4), 614-626. https://doi.org/10.1007/s11414-017-9575-6

Jørgensen, R., Christensen, A., Pristed, S. G., Jepsen, I., & Telléus, G. K. (2021). Burnout in mental health care professionals working with inpatients in open or closed wards in psychiatric hospitals. *Issues in Mental Health Nursing, 42*(11), 1030-1037. https://doi.org/10.1080/01612840.2021.1931582

Kabunga, A., Anyolitho, M. K., & Betty, A. (2020). Emotional intelligence and compassion fatigue among psychotherapists in selected districts of northern Uganda. *South African Journal of Psychology, 50*(3), 359-370. https://doi.org/10.1177/0081246319889174

Kanesan, P., & Fauzan, N. (2019). Models of emotional intelligence: A review. *E-Bangi Journal, 16*(7), 1-9.

Kaur, D., Sambasivan, M., & Kumar, N. (2013). Effect of spiritual intelligence, emotional intelligence, psychological ownership and burnout on caring behavior of nurses: A cross sectional study. *Journal of Clinical Nursing, 22*(21-22), 3192-3202. https://doi.org/10.1111/jocn.12386

Kessler, R. C., Heeringa, S., Lakoma, M. D., Petukhova, M., Rupp, A. E., Schoenbaum, M., … Zaslavsky, A. M. (2008). Individual and societal effects of mental disorders on earnings in the United States: Results from the national comorbidity survey replication. *The American Journal of Psychiatry, 165*(6), 703-711. https://doi.org/10.1176/appi.ajp.2008.08010126

Kewalramani, S., Agrawal, M., & Rastogi, M. R. (2015). Models of emotional intelligence: Similarities and discrepancies. *Indian Journal of Positive Psychology, 6*(2), 178-181. https://doi.org/10.15614/ijpp%2F2015%2Fv6i2%2F73844

Kim, H. J., Ha, J. H., & Jue, J. (2020). Compassion satisfaction and fatigue, emotional dissonance, and burnout in therapists in rehabilitation hospitals. *Psychology, 11*(1), 190 -203. https://doi.org/10.4236/psych.2020.111013

Kim, N., & Lambie, G. W. (2018). Burnout and implications for professional school counselors. *The Professional Counselor, 8*(3), 277-294. https://doi.org/10.15241/nk.8.3.277

King, R. (2009). Caseload management, work-related stress and case manager self-efficacy among Victorian mental health case managers. *Australian and New Zealand Journal of Psychiatry, 43*(5), 453-459. https://doi.org/10.1080/00048670902817661

Kinman, G., & Grant, L. (2020). Emotional demands, compassion and mental health in social workers. *Occupational Medicine, 70*(2), 89-94. https://doi.org/10.1093/occmed/kqz144

Kirst, M., Aery, A., Matheson, F. I., & Stergiopoulos, V. (2016). Provider and consumer perceptions of trauma informed practices and services for substance use and mental health problems. *International Journal of Mental Health and Addiction, 15*(3), 514-528. https://doi.org/10.1007/s11469-016-9693-z

Knight, C. (2014). Trauma-informed social work practice: Practice considerations and challenges. *Clinical Social Work Journal, 43*(1), 25-37. https://doi.org/10.1007/s10615 014-0481-6

Knight, C. (2018). Trauma informed practice and care: Implications for field instruction. *Clinical Social Work Journal, 47*(1), 79-89. https://doi.org/10.1007/s10615-018-0661-x

Kondrat, D. C., & Teater, B. (2012). The looking-glass self: Looking at relationship as the mechanism of change in case management of persons with severe mental illness. *Families in Society: The Journal of Contemporary Social Services, 93*(4), 271-278. https://doi.org/10.1606/1044-3894.4237

Koutra, K., Mavroeides, G., & Triliva, S. (2021). Mental health professionals' attitudes towards people with severe mental illness: Are they related to professional quality of life? *Community Mental Health Journal*, 1-12. https://doi.org/10.1007/s10597-021-00874-x

Kramers-Olen, A. L. (2014). Psychosocial rehabilitation and chronic mental illness: International trends and South African issues. *South African Journal of Psychology, 44*(4), 498-513. https://doi.org/10.1177/0081246314553339

Kraus, V. I. (2005). Relationship between self-care and compassion satisfaction, compassion fatigue, and burnout among mental health professionals working with adolescent sex offenders. *Counseling and Clinical Psychology Journal, 2*(1), 81-88.

Kraus, S. W., & Stein, C. H. (2012). Recovery-oriented services for individuals with mental health illness and case managers' experience of professional burnout. *Community Mental Health Journal, 49*(1), 7-13. https://doi.org/10.1007/s10597-012-9505-2

Kumar, R. (2017). Burnout in relation to emotional intelligence among bank personnel. *Indian Journal of Health and Well-being, 8*(11), 1401-1403.

Lagunes-Cordoba, E., Davalos, A., Fresan-Orellana, A., Jarrett, M., Gonzalez-Olvera, J., Thornicroft, G., & Henderson, C. (2021). Mental health service users' perceptions of stigma, from the general population and from mental health professionals in Mexico: A qualitative study. *Community Mental Health Journal, 57*(5), 985-993. https://doi.org/10.1007/s10597-020-00706-4

Langballe, E. M., Innstrand, S. T., Aasland, O. G., & Falkum, E. (2010). The predictive value of individual factors, work-related factors, and work-home interaction on burnout in female and male physicians: A longitudinal study. *Stress and Health, 27*(1), 73-87. https://doi.org/10.1002/smi.1321

Lanham, M., Rye, M., Rimsky, L., & Weill, S. (2012). How gratitude relates to burnout and job satisfaction in mental health professionals. *Journal of Mental Health Counseling, 34*(4), 341-354. https://doi.org/10.17744/mehc.34.4.w35q80w11kgpqn26

Lazarus, R. S. (1993). Coping theory and research: Past, present, and future. *Psychosomatic Medicine, 55*(3), 234-247. https://doi.org/10.1097/00006842-199305000-00002

Lazarus, R. S. (1999). *Stress and emotion: A new synthesis.* New York: Springer.

Lazarus, R. S., & Folkman, S. (1984). *Stress, appraisal, and coping.* New York: Springer.

Lee, H. J. (2017). How emotional intelligence relates to job satisfaction and burnout in public service jobs. *International Review of Administrative Sciences, 84*(4), 729-745. https://doi.org/10.1177/0020852316670489

Lee, A., Bullock, W. A., & Hoy, J. (2016). Trauma symptoms, recovery, and participation in the wellness management and recovery (WMR) program. *American Journal of Psychiatric Rehabilitation, 19*(2), 75-96. http://dx.doi.org/10.1080/15487768.2016.1162755

Lei, W., Li, J., Li, Y., Castaño, G., Yang, M., & Zou, B. (2020). The boundary conditions under which teaching–research conflict leads to university teachers' job burnout. *Studies in Higher Education, 46*(2), 406-422. https://doi.org/10.1080/03075079.2020.1811218

Lekaviciene, R., & Antiniene, D. (2016). High emotional intelligence: Family psychosocial factors. *Procedia- Social and Behavioral Sciences, 217*, 609-617. https://doi.org/10.1016/j.sbspro.2016.02.066

Lent, J., & Schwartz, R. C. (2012). The impact of work setting, demographic characteristics, and personality factors related to burnout among professional counselors. *Journal of Mental Health Counseling, 34*(4), 355-372. http://dx.doi.org/10.17744/mehc.34.4.e3k8u2k552515166

Leutwyler, H., Hubbard, E., & Zahnd, E. (2017). Case management helps prevent criminal justice recidivism for people with serious mental illness. *International Journal of Prisoner Health, 13*(3/4), 168-172. https://doi.org/10.1108/ijph-06-2016-0021

Leys, C., Delacre, M., Mora, Y. L., Lakens, D., & Ley, C. (2019). How to classify, detect, and manage univariate and multivariate outliers, with emphasis on pre-registration. *International Review of Social Psychology, 32*(1), 1-10. https://doi.org/10.5334/irsp.289

Lim, N., Kim, E. K., Kim, H., Yang, E., & Lee, S. M. (2010). Individual and work-related factors influencing burnout of mental health professionals: A meta-analysis. *Journal of Employment Counseling, 47*(2), 86-96. https://doi.org/10.1002/j.2161 1920.2010.tb00093.x

Lin, D. T., Liebert, C. A., Tran, J., Lau, J. N., & Salles, A. (2016). Emotional intelligence as a predictor of resident well-being. *Journal of the American College of Surgeons, 223*(2), 352-358. https://doi.org/10.1016/j.jamcollsurg.2016.04.044

Lindahl, M. L., Berglund, M., & Tonnesen, H. (2012). Case management in aftercare of involuntarily committed patients with substance abuse. A randomized trial. *Nordic Journal of Psychiatry, 67*(3), 197-203. https://doi.org/10.3109/08039488.2012.704068

Lolaty, H. A., Tirgari, A., & Fard, J. H. (2014). Emotional intelligence and related factors in medical sciences students of an Iranian university. *Iranian Journal of Nursing and Midwifery Research, 19*(2), 203-207.

López-López, I. M., Gómez-Urquiza, J. L., Cañadas, G. R., De la Fuente, E. I., Albendín-García, L., & Cañadas-De la Fuente, G. A. (2019). Prevalence of burnout in mental health nurses

and related factors: A systematic review and meta-analysis. *International Journal of Mental Health Nursing*, *28*(5), 1035-1044. https://doi.org/10.1111/inm.12606

Lucero, S. S. (2021). Emotional intelligence, resilience, and coping strategies of the helping professionals. *International Journal of Multidisciplinary Research and Publications, 3*(11), 58-74.

Lukersmith, S., Millington, M., & Salvador-Carulla, L. (2016). What is case management? A scoping and mapping review. *International Journal of Integrated Care, 16*(4), 1-13. http://dx.doi.org/10.5334/ijic.2477

Lysaker, P. H., & Roe, D. (2016). Integrative psychotherapy for schizophrenia: Its potential for a central role in recovery oriented treatment. *Journal of Clinical Psychology*, *72*(2), 117-122. https://doi.org/10.1002/jclp.22246

Magnano, P., Craparo, G., & Paolillo, A. (2015). Resilience and emotional intelligence: Which role in achievement motivation. *International Journal of Psychological Research*, *9*(1), 9-20. https://doi.org/10.21500/20112084.2096

Maior, E., Dobrean, A., & Pasarelu, C. (2020). Teacher rationality, social-emotional competencies and basic needs satisfaction: Competencies and basic needs satisfaction: direct and indirect effects on teacher burnout. *Journal of Evidence-Based Psychotherapies, 20*(1), 135-152. https://doi.org/10.24193/jebp.2020.1.8

Malekar, S., & Mohanty, R. (2009). Factors affecting emotional intelligence: An empirical study for some school students in India. *International Journal of Management in Education, 3*(1), 8-28. https://doi.org/10.1504/ijmie.2009.023085

Malouf, J. (2014). *How can we measure emotional intelligence?* https://blog.une.edu.au/usingpsychology/2014/04/27/how-can-we-measure-emotional intelligence/comment-page-1/

Manzano-García, G., & Ayala, J. (2017). Insufficiently studied factors related to burnout in nursing: Results from an e-Delphi study. *PLOS ONE, 12*(4), 1-20. https://doi.org/10.1371/journal.pone.0175352

Maor, R., & Hemi, A. (2021). Relationships between role stress, professional identity, and burnout among contemporary school counselors. *Psychology in the Schools, 58,* 1597 -1610. https://doi.org/10.1002/pits.22518

Marić, N., Mandić-Rajčević, S., Maksimović, N., & Bulat, P. (2020). Professional stress and burnout syndrome in teachers: Are there differences among the Republic of Srpska regions? Scripta Medica, 52(1), 28-37. https://doi.org/10.5937/scriptamed52-29174

Marikutty, P. J., & Joseph, M. I. (2016). Effects of emotional intelligence on stress, psychological well-being, and academic achievement of adolescents. *Indian Journal of Health and Wellbeing, 7*(7), 699-702.

Marks, M. (2016). *Re-conceptualizing compassion fatigue: A confirmatory factor analysis.* [Master's thesis, University of Central Florida]. STARS. Electronic Theses and Dissertations, 2004-2019. https://stars.library.ucf.edu/etd/5278

Marshall, S. L., Oades, L. G., Crowe, T. P. (2009). Mental health consumers' perceptions of receiving recovery-focused services. *Journal of Evaluation in Clinical Practice, 15*(4), 654-659. https://doi.org/10.1111/j.1365-2753.2008.01070.x

Martin-Cuellar, A., Lardier, D. T., & Atencio, D. J. (2021). Therapist mindfulness and subjective vitality: The role of psychological wellbeing and compassion satisfaction. *Journal of Mental Health, 30*(1), 113-120. https://doi.org/10.1080/09638237.2019.1644491

Martini, M., Guidetti, G., Viotti, S., Loera, B., & Converso, D. (2019). Sometimes it drains, sometimes it sustains: The dual role of the relationship with students for university professors. *BioMed Research International, 2019*, 1-8. https://doi.org/10.1155/2019/9875090

Maslach, C. (2018). Job burnout in professional and economic contexts. In A. A. Ariyanto, H. Muluk, P. Newcombe, F.P. Piercy, E.K. Poerwandari, and S.H.R. Suradijono (Eds.), *Diversity in Unity: Perspectives from Psychology and Behavioral Sciences* (pp. 11-15). London: Routledge.

Maslach, C., & Jackson, S. E. (1984). Burnout in organizational settings. *Applied Social Psychology Annual,* 5, 133-153. https://www.academia.edu/28591664/BURNOUT_IN_ORGANIZATIONAL_SETTINS

Maslach, C., & Jackson, S. E. (1986). *Maslach burnout inventory manual* (2nd edn.). Palo Alto, CA: Consulting Psychologists Press.

Maslach, C., & Jackson, S. E. (1996). *Maslach burnout inventory-human services survey.* Mountain View, CA: CGG, Inc.

Maslach, C., Schaufeli, W., & Leiter, M. (2001). Job burnout. *Annual Review of Psychology*, *52*, 397-422.

Mathematica Policy Research. (2019). National Mental Health Services Survey (N-MHSS). https://info.nmhss.org/Definitions/index.asp

Mattieu, M. M., & Ivanoff, A. (2006). Using stress, appraisal, and coping theories in clinical practice: Assessments of coping strategies after disasters. *Brief Treatment and Crisis Intervention, 6*(4), 337-348. https://doi.org/10.1093/brief-treatment/mhl009

Mayer, J. D., Roberts, R. D., and Barsade, S. G. (2008). Human abilities: Emotional intelligence. *Annual Review of Psychology, 59,* 507-536. https://doi:10.1146/annurev.psych.59.103006.093646

Mayer, J. D., & Salovey, P. (1997). What is emotional intelligence? In P. Salovey & D. Sluyter (Eds.), *Emotional development and emotional intelligence: Educational implications* (pp. 3-31). New York: Basic Books.

Mayer, J. D., Salovey, P., & Caruso, D. R. (2002). *Mayer-Salovey-Caruso Emotional Intelligence Test (MSCEIT) item booklet, version 2.0.* Toronto, Ontario, Canada: MHS.

Mayer, J. D., Salovey, P., Caruso, D. R., & Sitarenios, G. (2003). Measuring emotional intelligence with the MSCEIT V2.0. *Emotion, 3*(1), 97-105. http://dx.doi.org/10.1037/15283542.3.1.97

McDonald, J. (2020). "It's fine; I'm fine": Considerations for trauma-informed healthcare practices. *Journal of Aggression, Maltreatment & Trauma, 29*(4), 385-399. https://doi.org/10.1080/10926771.2019.1710641

McKinless, E. (2020). Impact of stress on nurses working in the district nursing service. *British Journal of Community Nursing, 25*(11), 555-561. https://doi.org/10.12968/bjcn.2020.25.11.555

Meier, S. T. (1983). Toward a theory of burnout. *Human Relations, 6,* 899-910.

Meldrum, L., & Yellowlees, P. (2000). The measurement of a case manager's workload burden. *Australian & New Zealand Journal of Psychiatry, 34*(4), 658-663. https://doi.org/10.1080/j.1440-1614.2000.00760.x

Menear, M., & Briand, C. (2014). Implementing a continuum of evidenced-based psychosocial interventions for people with severe mental illness: Part 1-Review of major initiatives and implementation strategies. The *Canadian Journal of Psychiatry*, *59*(4), 178-186. https://doi.org/10.1177/070674371405900402

Mendenhall, A. N., Grube, W., & Jung, E. (2019). Implementing strengths model for youth in community mental health: Impact on case managers' professional quality of life. *Children and Youth Services Review, 102*, 1-6. https://doi.org/10.1016/j.childyouth.2019.04.020

Milette-Winfree, M., Nakamura, B. J., Kotte, A., & Higa-McMillan, C. (2019). Multilevel predictors of case managers' assessment administration behavior in a precursor to a measurement feedback system. *Administration and Policy in Mental Health and Mental Health Services Research, 46*(5), 636-648. https://doi.org/10.1007/s10488-019-00941-2

Mishra, P., Pandey, C. M., Singh, U., Gupta, A., Sahu, C., & Keshri, A. (2019). Descriptive statistics and normality tests for statistical data. *Annals of Cardiac Anaesthesia*, *22*(1), 67-72. https://doi.org/10.4103/aca.ACA_157_18

Mishra, P., & Shrivastava, D. (2018). A study of the factors of emotional intelligence, determining the performance of management teachers. *Journal of Business and Management, 20*(2), 26-39. https://doi:10.9790/487X-2002012639

Moen, F., & Olsen, M. (2020). Grit: A unique protective factor of coaches well-being and burnout? *New Ideas in Psychology, 59*, 1-6. https://doi.org/10.1016/j.newideapsych.2020.100794

Moffat, M. (2014). Reducing moral distress in case managers. *Professional Case Management, 19*(4), 173-186. https://doi.org/10.1097/ncm.0000000000000039

Molero Jurado, M. D., Pérez-Fuentes, M. D., Atria, L., Oropesa Ruiz, N. F., & Gázquez Linares, J. J. (2019). Burnout, perceived efficacy, and job satisfaction: Perception of the educational context in high school teachers. *BioMed Research International, 2019*, 1-10. https://doi.org/10.1155/2019/1021408

Moon, T. W., & Hur, W. (2011). Emotional intelligence, emotional exhaustion, and job performance. *Social Behavior and Personality, 39*(8), 1087-1096. http://dx.doi.org/10.2224/sbp.2011.39.8.1087

Moreira, A. S., & Lucca, S. R. (2020). Psychosocial factors and burnout syndrome among mental health professionals. *Revista Latino-Americana de Enfermagem, 28*, 1-11. https://doi.org/10.1590/1518-8345.4175.3336

Morse, G., Salyers, M. P., Rollins, A. L., Monroe-DeVita, M., & Pfahler, C. (2011). Burnout in mental health services: A review of the problem and its remediation. *Administration and Policy in Mental Health and Mental Health Services Research, 39*(5), 341-352. http://dx.doi.org/10.1007/s10488-011-0352-1

Mueser, K. T., Bartels, S. J., Santos, M., Pratt, S. I., & Riera, E. G. (2012). Integrated illness management recovery: A program for integrating physical and psychiatric illness self-management in older persons with severe mental illness. *American Journal of Psychiatric Rehabilitation, 15*(2), 131-156. http://dx.doi.org/10.1080/15487768.2012.679558

Năstasă, L., & Fărcaş, A. D. (2015). The effect of emotional intelligence on burnout in healthcare professionals. *Procedia- Social and Behavioral Sciences, 187,* 78-82. https://doi.org/10.1016/j.sbspro.2015.03.015

National Alliance for Caregiving and the AARP Public Policy Institute. Caregiving in the U.S. 2015 Report. 2015. https://www.caregiving.org/research/caregivingusa/

National Institute of Mental Health (NIMH). (2019). Mental illness. https://www.nimh.nih.gov/health/statistics/mental-illness.shtml

Neff, K. D. (2003a). The development and validation of a scale to measure self-compassion. *Self and Identity, 2*(3), 223-250. https://doi.org/10.1080/15298860309027

Neff, K. D. (2003b). Self-compassion: An alternative conceptualization of a healthy attitude toward oneself. *Self and Identity, 2*(2), 85-101. https://doi.org/10.1080/15298860309032

Nel, J. A., Jonker, C. S., & Rabie, T. (2013). Emotional intelligence and wellness among employees working in the nursing environment. *Journal of Psychology in Africa, 23*(2), 195-203. https://doi.org/10.1080/14330237.2013.10820615

Neubauer, A. C., & Freudenthaler, H. H. (2005). Models of Emotional Intelligence. In R. Schulze & R. D. Roberts (Eds.), *Emotional intelligence: An international handbook* (pp. 31–50). Hogrefe & Huber Publishers.

Newransky, C. M., Monti, K., & Lombe, M. (2019). Addressing the treatment gap for individuals with serious mental illness: Can a short-term crisis and transitional intervention impact psychiatric and medical service utilization? *Best Practices in Mental Health, 15*(1), 1-19.

Nishimura, Y., Miyoshi, T., Obika, M., Ogawa, H., Kataoka, H., & Otsuka, F. (2019). Factors related to burnout in resident physicians in Japan. *International Journal of Medical Education, 10,* 129-135. https://doi.org/10.5116/ijme.5caf.53ad

Noquez, A. (2019). Emotional intelligence in nurses and emerging trends: An integrative literature review. *International Journal of Nursing*, *6*(1), 12-18. https://doi.org/10.15640/ijn.v6n1a2

Ntoumanis, N., Edmunds, J., Duda, J. L. (2009). Understanding the coping process from a self-determination theory perspective. *British Journal of Health Psychology*, *14*(2), 249-260. https://doi.org/10.1348/135910708x349352

Oades, L., Deane, F., Crowe, T., Lambert, G. W., Kavanagh, D., & Lloyd, C. (2005). Collaborative recovery: An integrative model for working with individuals who experience chronic and recurring mental illness. *Australasian Psychiatry, 13*(3), 279-284. https://doi.org/10.1111/j.1440-1665.2005.02202.x

O'Brennan, L., Pas, E., & Bradshaw, C. (2017). Multilevel examination of burnout among high school staff: Importance of staff and school factors. *School Psychology Review*, *46*(2), 165-176. https://doi.org/10.17105/spr-2015-0019.v46-2

O'Connor, P. J., Hill, A., Kaya, M., & Martin, B. (2019). The measurement of emotional intelligence: A critical review of the literature and recommendations for researchers and practitioners. *Frontiers in Psychology*, *10*, 1-19. https://doi.org/10.3389/fpsyg.2019.01116

O'Connor, K., Muller Neff, D., & Pitman, S. (2018). Burnout in mental health professionals: A systematic review and meta-analysis of prevalence and determinants. *European Psychiatry, 53,* 74-99. https://doi.org/10.1016/j.eurpsy.2018.06.003

O'Donnell, R., Savaglio, M., Vicary, D., & Skouteris, H. (2020). Effect of community mental health care programs in Australia: A systematic review. *Australian Journal of Primary Health, 26*(6), 443-451. https://doi.org/10.1071/py20147

Ogińska-Bulik, N. (2005). Emotional intelligence in the workplace: Exploring its effects on occupational stress and health outcomes in human service workers. *International Journal of Occupational Medicine and Environmental Health, 18*(2), 167-175.

O'Hare, T., & Sherrer, M. V. (2009). Lifetime traumatic events and high-risk behaviors as predictors of PTSD symptoms in people with severe mental illnesses. *Social Work Research, 33*(4), 209-218. https://doi.org/10.1093/swr/33.4.209

Okuda, Y., Iwasaki, S., Deguchi, Y., Nitta, T., Mitake, T., Sakaguchi, A., Niki, A., & Inoue, K. (2020). Burnout and occupational stressors among non-medical occupational health staff. *Occupational Medicine, 70*(1), 45-51. https://doi.org/10.1093/occmed/kqz160

Osborne, J. W., & Waters, E. (2002). Four assumptions of multiple regression that researchers should always test. *Practical Assessment, Research, and Evaluation, 8*(8), 1-5. https://doi.org/10.7275/r222-hv23

Parabiaghi, A., Bonetto, C., Ruggeri, M., Lasalvia, A., & Morven, L. (2006). Severe and persistent mental illness: A useful definition for prioritizing community-based mental health service interventions. *Social Psychiatry, 41*(6), 457-463. https://doi.org/10.1007/s00127-006-0048-0

Parks, J., Svendsen, D., Singer, P., Foti, M. E. (2006). *Morbidity and mortality in people with serious mental illness.* Alexandria, VA: National Association of State Mental Health Program Directors Medical Directors Counsel; 2006.

https://www.nasmhpd.org/sites/default/files/Mortality%20and%20Morbidity%20Final%0Report%208.18.08.pdf

Patel, R., Bachu, R., Adikey, A., Malik, M., & Shah, M. (2018). Factors related to physician burnout and its consequences: A review. *Behavioral Sciences*, *8*(11), 1-7. https://doi.org/10.3390/bs8110098

Patton, W., & Goddard, R. (2006). Coping with stress in the Australian job network: Gender differences. *Journal of Employment Counseling, 43*(3), 135-144. https://doi.org/10.1002/j.2161-1920.2006.tb00013.x

Pedhazur, E. J., & Schmelkin, L. P. (1991). *Measurement, design, and analysis: An integrated approach.* Hillsdale, NJ: Lawrence Erlbaum Associates. http://dx.doi.org/10.4324/9780203726389

Perlman, B. & Hartman, E. A. (1982). Burnout: Summary and future research. *Human Relations, 35*(4), 283-305.

Persich, M. R., Smith, R., Cloonan, S. A., Woods-Lubbert, R., Strong, M., & Killgore, W. D. (2021). Emotional intelligence training as a protective factor for mental health during the COVID-19 pandemic. *Depression and Anxiety, 38*(10), 1018-1025. https://doi.org/10.1002/da.23202

Petrides, K. V. (2009). Psychometric properties of the Trait Emotional Intelligence Questionnaire (TEIQue). In C. Stough, D. H. Saklofske, & J. D. Parker (Eds.), *Assessing emotional intelligence. Theory, research, and applications* (pp. 85-101). Boston, MA: Springer.

Petrides, K. V., & Furnham, A. (2001). Trait emotional intelligence: Psychometric investigation with reference to established trait taxonomies. *European Journal of Personality, 15*, 425 -448.

Petrides, K. V., & Furnham, A. (2003). Trait emotional intelligence: Behavioural validation in two studies of emotion recognition and reactivity to mood induction. *European Journal of Personality, 17*, 39-57.

Petrides, K. V., Pérez-González, J. C., Furnham, A. (2007). On the criterion and incremental validity of trait emotional intelligence. *Cognition & Emotion, 21*(1), 26-55. https://doi.org/10.1080/02699930601038912

Pines, A. M. & Aronson, E. (1988). *Career burnout: Causes and cures*. New York: Free Press.

Potter, B. A. (1998). *Overcoming job burnout, How to renew enthusiasm for work*. Berkeley, California: Ronin Pub., Inc.

Powell, K. R., Mabry, J. L., & Mixer, S. J. (2015). Emotional intelligence: A critical evaluation of the literature with implications for mental health nursing leadership. *Issues in Mental Health Nursing, 36*(5), 346-356. https://doi.org/10.3109/01612840.2014.994079

Prada-Ospina, R. (2019). Social psychological factors and their relation to work-related stress as generating effect of burnout. *Interdisciplinaria: Revista de Psicología y Ciencias Afines, 36*(2), 39-53. https://doi.org/10.16888/interd.2019.36.2.3

Puertas Molero, P., Zurita Ortega, F., Ubago Jiménez, J. L., & González Valero, G. (2019). Influence of emotional intelligence and burnout syndrome on teachers well-being: A systematic review. *Social Sciences, 8*(6), 185. https://doi.org/10.3390/socsci8060185

Puig, A., Baggs, A., Mixon, K., Park, Y. M., Kim, B. Y., & Lee, S. M. (2012). Relationship between job burnout and personal wellness in mental health professionals. *Journal of*

Employment Counseling, *49*(3), 98-109. https://doi.org/10.1002/j.2161 1920.2012.00010.x

Pulido-Martos, M., Lopez-Zafra, E., Estévez-López, F., & Augusto-Landa, J. M. (2016). The moderator role of perceived emotional intelligence in the relationship between sources of stress and mental health in teachers. *The Spanish Journal of Psychology, 19*, 1-10. https://doi.org/10.1017/sjp.2016.8

Qiao, H., & Schaufeli, W. B. (2011). The convergent validity of four burnout measures in a Chinese sample: A confirmatory factor-analytic approach. *Applied Psychology: An International Review*, *60*(1), 87-111. https://doi.org/10.1111/j.1464-0597.2010.00428.x

Raghubir, A. E. (2018). Emotional intelligence in professional nursing practice: A concept review using Rodgers's evolutionary analysis approach. *International Journal of Nursing Sciences, 5*(2), 126-130. https://doi.org/10.1016/j.ijnss.2018.03.004

Ravitz, P., Berkhout, S., Lawson, A., Kay, T., & Meikle, S. (2019). Integrating evidence supported psychotherapy principles in mental health case management: A capacity building pilot. *The Canadian Journal of Psychiatry, 64*(12), 855-862. https://doi.org/10.1177/0706743719877031

Ray, S. L., Wong, C., White, D., & Heaslip, K. (2013). Compassion satisfaction, compassion fatigue, work life conditions, and burnout among frontline mental health care professionals. *Traumatology, 19*(4), 255-267. https://doi.org/10.1177/1534765612471144

Razzaq, F., Zadeh, Z. F., & Aftab, F. (2016). A theoretical evaluation of four influential models of emotional intelligence. *Bahria Journal of Professional Psychology, 15*(2), 39-62.

Redko, C., Rapp, R. C., Elms, C., Snyder, M., & Carlson, R. G. (2007). Understanding the working alliance between persons with substance abuse problems and strengths-based

case managers. *Journal of Psychoactive Drugs, 39*(3), 241-250. https://doi.org/10.1080/02791072.2007.10400610

Redondo-Flórez, L., Tornero-Aguilera, J. F., Ramos-Campo, D. J., & Clemente-Suárez, V. J. (2020). Gender differences in stress- and burnout-related factors of university professors. *BioMed Research International, 2020*, 1-9. https://doi.org/10.1155/2020/6687358

Regis, A., Meyers-Ohki, S. E., Mennenga, S. E., Greco, P. P., Glisker, R., Kolaric, R., McCormack, R. P., Rapp, R. C., & Bogenschutz, M. P. (2020). Implementation of strength-based case management for opioid-dependent patients presenting in medical emergency departments: Rationale and study design of a randomized trial. *Trials, 21*(1), 1-14. https://doi.org/10.1186/s13063-020-04684-6

Reshetnikov, V. A., Tvorogova, N. D., Hersonskiy, I. I., Sokolov, N. A., Petrunin, A. D., & Drobyshev, D. A. (2020). Leadership and emotional intelligence: Current trends in public health professionals training. *Frontiers in Public Health, 7*(413), 1-7. https://doi.org/10.3389/fpubh.2019.00413

Richards, A. E., Curley, K. L., Zhang, N., Bendok, B. R., Zimmerman, R. S., Patel, N. P., Kalani, M. A., Lyons, M. K., & Neal, M. T. (2021). Burnout and emotional intelligence in neurosurgical advanced practice providers across the United States: A cross-sectional analysis. *World Neurosurgery, 155*, 335-344. https://doi.org/10.1016/j.wneu.2021.08.066

Rosenberg, T., & Pace, M. (2006). Burnout among mental health professionals: Special considerations for the marriage and family therapist. *Journal of Marital and Family Therapy*, *32*(1), 87-99. https://doi.org/10.1111/j.1752-0606.2006.tb01590.x

Rosenstein, A. H., & Stark, D. (2015). Emotional intelligence: A critical tool to understand and improve behaviors that impact patient care. *Journal of Psychology and Clinical Psychiatry, 2*(1), 1-4. https://doi.org/10.15406/jpcpy.2015.02.00066

Rossi, A., Cetrano, G., Pertile, R., Rabbi, L., Donisi, V., Grigoletti, L., … Amaddeo, F. (2012). Burnout, compassion fatigue, and compassion satisfaction among staff in community based mental health services. *Psychiatry Research, 200*(2-3), 933-938. https://doi.org/10.1016/j.psychres.2012.12.017

Rowan, P., Begley, C., Fu, S., Turibekov, B., & Morgan, R. (2019). Impact of serious mental illness on Medicaid and other public healthcare costs in Texas. *Administration and Policy in Mental Health and Mental Health Services Research, 46*(4), 498-506. https://doi.org/10.1007/s10488-019-00929-y

Ruesch, P., Graf, J., Meyer, P. C., Rossler, W., & Hell, D. (2004). Occupation, social support and quality of life in persons with schizophrenic or affective disorders. *Social Psychiatry and Psychiatric Epidemiology, 39*(9), 686-694. https://doi.org/10.1007/s00127-004-0812y

Saakvitne, K. W., & Pearlman, L. A. (1996). *Transforming the pain: A workbook on vicarious traumatization.* New York: W.W. Norton & Company.

Sabbah, I. M., Sabbah, H., Khamis, R., Berbari, R., Sabbah, S., Badran, S., & Droubi, N. (2020). Factors associated with the emotional intelligence among youth University students. *European Journal of Clinical Medicine, 1*(1). https://doi.org/10.24018/clinicmed.2020.1.1.3

Sacco, T. L., Ciurzynski, S. M., Harvey, M. E., & Ingersoll, G. L. (2015). Compassion satisfaction and compassion fatigue among critical care nurses. *Critical Care Nurse, 35*(4), 32-44. https://doi.org/10.4037/ccn2015392

Saeed, S. A., Silver, S., Buwalda, V. J., Khin, E. K., Petit, J. R., Mohyuddin, F., Weinberg, P., Merlino, J. P., Lekwauwa, N., & Levin, S. (2017). Psychiatric management, administration, and leadership: A continuum or distinct concepts? *Psychiatric Quarterly, 89*(2), 315-328. https://doi.org/10.1007/s11126-017-9536-5

Safina, A. M., Arifullina, R. U., Ganieva, A. M., & Katushenko, O. A. (2020). Emotional intelligence in teachers' activities. *Journal of History Culture and Art Research, 9*(2), 61-71. https://dx.doi.org/10.7596/taksad.v9i2.2677

Salami, S. O., & Ajitoni, S. O. (2016). Job characteristics and burnout: The moderating roles of emotional intelligence, motivation and pay among bank employees. *International Journal of Psychology, 51*(5), 375-382. https://doi.org/10.1002/ijop.12180

Salloum, A., Choi, M. J., & Stover, C. S. (2018). Development of a trauma-informed self-care measure with child welfare workers. *Children and Youth Services Review, 93*, 108-116. https://doi.org/10.1016/j.childyouth.2018.07.008

Salloum, A., Kondrat, D. C., Johnco, C., & Olson, K. R. (2015). The role of self-care on compassion satisfaction, burnout and secondary trauma among child welfare workers. *Children and Youth Services Review, 49*, 54-61. https://doi.org/10.1016/j.childyouth.2014.12.023

Salovey, P., & Mayer, J. D. (1990). Emotional intelligence. *Imagination, Cognition and Personality, 9*(3), 185-211. http://dx.doi.org/10.2190/DUGG-P24E-52WK-6CDG

Salyers, M. P., Fukui, S., Rollins, A. L., Firmin, R., Gearhart, T., Noll, J. P., Williams, S., & Davis, C. J. (2015). Burnout and self-reported quality of care in community mental health. *Administration and Policy in Mental Health and Mental Health Services Research, 42*(1), 61-69. https://doi.org/10.1007/s10488-014-0544-6

Salyers, M. P., McGuire, A. B., Rollings, A. L., Bond, G. R., Mueser, K. T., & Macy, V. R. (2010). Integrating assertive community treatment and illness management and recovery for consumers with severe mental illness. *Community Mental Health Journal, 46*(4), 319-329. http://dx.doi.org/10.1007/s10597-009-9284-6

Salzberg, S. (1997). *A heart as wide as the world*. Boston: Shambhala.

Samios, C. (2017). Burnout and psychological adjustment in mental health workers in rural Australia: The roles of mindfulness and compassion satisfaction. *Mindfulness, 9*(4), 1088-1099. https://doi.org/10.1007/s12671-017-0844-5

Sanchez, J., Muller, V., Chan, F., Brooks, J. M., Iwanaga, K., Tu, W., … Crespo-Jones, M. (2019). Personal and environmental contextual factors as mediators between functional disability and quality of life in adults with serious mental illness: A cross-sectional analysis. *Quality of Life Research, 28*(2), 441-450. https://doi.org/10.1007/s11136-018-2006-1

Scanlan, J. N., & Still, M. (2019). Relationships between burnout, turnover intention, job satisfaction, job demands and job resources for mental health personnel in an Australian mental health service. *BMC Health Services Research, 19*(1), 1-11. https://doi.org/10.1186/s12913-018-3841-z

Scanlan, J. N., Feder, K., Ennals, P., & Hancock, N. (2019). Outcomes of an individual placement and support programme incorporating principles of the collaborative recovery

model. *Australian Occupational Therapy Journal, 66*(4), 519-529. https://doi.org/10.1111/1440-1630.12580

Schmidt, A. F., & Finan, C. (2018). Linear regression and the normality assumption. *Journal of Clinical Epidemiology, 98*, 146-151. https://doi.org/10.1016/j.jclinepi.2017.12.006

Schneeberger, A. R., Huber, C. G., Lang, U. E., Muenzenmaier, K. H., Castille, D., Jaeger, M., Seixas, A., Sowislo, J., & Link, B. G. (2017). Effects of assisted outpatient treatment and health care services on psychotic symptoms. *Social Science & Medicine, 175*, 152-160. https://doi.org/10.1016/j.socscimed.2017.01.007

Schutte, N. S., Malouff, J. M., & Bhullar, N. (2009). The assessing emotions scale. C. Stough, D. Saklofske & J. Parker (Eds.), *The assessment of emotional intelligence*. New York: Springer Publishing, 119-135. http://dx.doi.org/10.1007/978-0-387-88370-0_7

Schutte, N. S., Malouff, J. M., Hall, L. E., Haggerty, D. J., Cooper, J. T., Golden, C. J., & Dornheim, L. (1998). Development and validation of a measure of emotional intelligence. *Personality and Individual Difference, 25*(2), 167-177. http://dx.doi.org/10.1016/S0191-8869(98)00001-4

Selden, D. (2010). The effects of staff turnover on psychiatric rehabilitation programs. *Psychiatric Rehabilitation Journal, 34*(1), 71-73. http://dx.doi.org/10.2975/34.1.2010.71.73

Senreich, E., Straussner, S. L., & Steen, J. (2020). The work experiences of social workers: Factors impacting compassion satisfaction and workplace stress. *Journal of Social Service Research, 46*(1), 93-109. https://doi.org/10.1080/01488376.2018.1528491

Shakir, H. J., Cappuzzo, J. M., Shallwani, H., Kwasnicki, A., Bullis, C., Wang, J., Hess, R. M., & Levy, E. I. (2020). Relationship of grit and resilience to burnout among U.S.

neurosurgery residents. *World Neurosurgery, 134*, 224-236. https://doi.org/10.1016/j.wneu.2019.10.043

Sharp, G., Bourke, L., & Rickard, M. J. (2019). Review of emotional intelligence in health care: An introduction to emotional intelligence for surgeons. *ANZ Journal of Surgery, 90*(4), 433-440. https://doi.org/10.1111/ans.15671

Shkoler, O., & Tziner, A. (2017). The mediating and moderating role of burnout and emotional intelligence in the relationship between organizational justice and work misbehavior. *Journal of Work and Organizational Psychology, 33*(2), 157-164. http://dx.doi.org/10.1016/j.rpto.2017.05.002

Slade, M., Amering, M., & Oades, L. G. (2008). Recovery: An international perspective. *Epidemiology and Psychiatric Sciences, 17*(2), 128-137. http://dx.doi.org/10.1017/S1121189X00002827

Sodeke-Gregson, E. A., Holttum, S., & Billings, J. (2013). Compassion satisfaction, burnout, and secondary traumatic stress in UK therapists who work with adult trauma clients. *European Journal of Psychotraumatology, 4*(1), 1-10. http://dx.doi.org/10.3402/ejpt.v4i0.21869

Sofology, M., Efstratopoulou, M., & Dunn, T. (2018). Predicting burnout syndrome in Greek mental health professionals. *Journal of Social Service Research, 45*(1), 142-149. https://doi.org/10.1080/01488376.2018.1480556

Somoray, K., Shakespeare-Finch, J., & Armstrong, D. (2017). The impact of personality and workplace belongingness on mental health workers' professional quality of life. *Australian Psychologist, 52*(1), 52-60. http://dx.doi.org/10.1111/ap.12182

Soto-Rubio, A., Giménez-Espert, M. D., & Prado-Gascó, V. (2020). Effect of emotional intelligence and psychosocial risks on burnout, job satisfaction, and nurses' health during the COVID-19 pandemic. *International Journal of Environmental Research and Public Health, 17*(21), 1-14. https://doi.org/10.3390/ijerph17217998

Sprang, G., Clark, J. J., & Whitt-Woosley, A. (2007). Compassion fatigue, compassion satisfaction, and burnout: Factors impacting a professional's quality of life. *Journal of Loss & Trauma, 12*(3), 259-280. http://dx.doi.org/10.1080/15325020701238093

Stamm, B. H. (2009). *Professional quality of life: Compassion satisfaction and fatigue subscales, R-III (ProQOL)*. https://proqol.org/ProQol_Test.html

Stamm, B. H. (2010). *Professional quality of life-5: Compassion satisfaction, burnout & and compassion fatigue/secondary trauma subscales (ProQOL-5)*. https://proqol.org/ProQol_Test.html

Stanfield, H. M., & Baptist, J. (2019). Compassion satisfaction among camp counselors: A pilot study. *Journal of Experiential Education, 42*(2), 121-139. http://dx.doi.org/10.1177/1053825918824617

Stanhope, V., & Matejkowski, J. (2009). Understanding the role of individual consumer-provider relationships within assertive community treatment. *Community Mental Health Journal, 46*(4), 309-318. https://doi.org/10.1007/s10597-009-9219-2

Stanhope, V., Tiderington, E., Henwood, B., & Padgett, D. K. (2012). Understanding how case managers use 'sabotage' as a frame for clinically difficult situations. *Clinical Social Work Journal, 40*(2), 261-267. https://doi.org/10.1007/s10615-012-0385-2

Stein, C. H., & Craft, S. A. (2006). Case managers' experiences of personal growth: Learning from consumers. *Community Mental Health Journal, 43*(2), 183-195. https://doi.org/10.1007/s10597-006-9068-1

Stergiopoulos, V., Gozdzik, A., Nisenbaum, R., Durbin, J., Hwang, S. W., O'Campo, P., Tepper, J., & Wasylenki, D. (2018). Bridging hospital and community care for homeless adults with mental health needs: Outcomes of a brief interdisciplinary intervention. *The Canadian Journal of Psychiatry*, *63*(11), 774-784. https://doi.org/10.1177/0706743718772539

Substance Abuse and Mental Health Services Administration (SAMHSA). (2018). Statewide Consumer Network Program. https://www.samhsa.gov/grants/grantannouncements/sm18-008

Substance Abuse and Mental Health Services Administration (SAMHSA). (2019). *Key substance use and mental health indicators in the United States: Results from the 2018 National Survey on Drug Use and Health* (HHS Publication No. PEP19-5068, NSDUH Series H 54). Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. https://www.samhsa.gov/data/

Sullivan, P. W., Kondrat, D. C., & Floyd, D. (2015). The pleasures and pain of mental health case management. *Social Work in Mental Health, 13*(4), 349-364. http://dx.doi.org/10.1080/15332985.2014.955942

Sweeney, A., Filson, B., Kennedy, A., Collinson, L., & Gillard, S. (2018). A paradigm shift: Relationships in trauma-informed mental health services. *BJPsych Advances, 24*(5), 319-333. https://doi.org/10.1192/bja.2018.29

Tan, S. K. (2013). Herzberg's two-factor theory on work motivation: Does it work for today's environment? *Global Journal of Commerce & Management Perspective, 2*(5), 18-22.

Tandon, P., Chauhan, R. K., & Chaturvedi, V. (2019). Impact of emotional intelligence on healthcare on healthcare providers. *International Journal of Mechanical Engineering and Technology, 10*(1), 667-676. https://iaeme.com/Home/issue/IJMET?Volume=10&Issue=1

Tennille, J., Solomon, P., & Blank, M. (2010). Case managers discovering what recovery means through an HIV prevention intervention. *Community Mental Health Journal, 46*(5), 486 493. https://doi.org/10.1007/s10597-010-9326-0

The National Child Traumatic Stress Network (NCTSN). (2014, June 16). Professional Quality of Life Scale-5. https://www.nctsn.org/measures/professional quality life-scale-5

Towey-Swift, K., & Whittington, R. (2021). Person-job congruence, compassion and recovery attitude in community mental health teams. *Journal of Mental Health, 30*(4), 431-439. https://doi.org/10.1080/09638237.2019.1608931

Tse, S., Tsoi, E. W., Hamilton, B., O'Hagan, M., Shepherd, G., Slade, M., Whitley, R., Petrakis, M. (2016). Uses of strength-based interventions for people with serious mental illness: A critical review. *International Journal of Social Psychiatry, 62*(3), 281-291. https://doi.org/10.1177/0020764015623970

Udechuku, A., Olver, J., Hallam, K., Blyth, F., Leslie, M., Nasso, M., … Burrows, G. (2005). Assertive community treatment of the mentally ill: Service model and effectiveness. *Australasian Psychiatry, 13*(2), 129-134. https://doi.org/10.1080/j.1440 1665.2005.02175.x

Valente, S., Monteiro, A. P., & Lourenço, A. A. (2018). The relationship between teachers' emotional intelligence and classroom discipline management. *Psychology in the Schools, 56*(5), 741-750. https://doi.org/10.1002/pits.22218

Van den Broeck, J., Cunningham, S., Eeckels, R., & Herbst, K. (2005). Data cleaning: Detecting, diagnosing, and editing data abnormalities. *PLoS Medicine, 2*(10), 966-970. https://doi.org/10.1371/journal.pmed.0020267

Vanderplasschen, W., Wolf, J., Rapp, R. C., & Broekaert, E. (2007). Effectiveness of different models of case management for substance-abusing populations. *Journal of Psychoactive Drugs, 39*(1), 81-95. https://doi.org/10.1080/02791072.2007.10399867

Van Hook, M. P., & Rothenberg, M. (2009). Quality of life and compassion satisfaction/fatigue and burnout in child welfare workers: A study of the child welfare workers in community based care organizations in central Florida. *Social Work & Christianity, 36*(1), 36-54.

Velligan, D. I., Sajatovic, M., Hatch, A., Kramata, P., & Docherty, J. P. (2017). Why do psychiatric patients stop antipsychotic medication? A systemic review of reasons for nonadherence to medication in patients with serious mental illness. *Patient Preference and Adherence, 11*, 449-468. https://doi.org/10.2147/ppa.s124658

von Hippel, C., Brener, L., Rose, G., & von Hippel, W. (2019). Perceived inability to help is associated with client-related burnout and negative work outcomes among community mental health workers. *Health & Social Care in the Community, 27*(6), 1507-1514. https://doi.org/10.1111/hsc.12821

Wagaman, A. M., Geiger, J. M., Shockley, C., & Segal, E. A. (2015). The role of empathy in burnout, compassion satisfaction, and secondary traumatic stress among social workers. *Social Work, 60*(3), 201-209. https://doi.org/10.1093/sw/swv014

Wang, J., Okoli, C. T., He, H., Feng, F., Li, J., Zhuang, L., & Lin, M. (2020). Factors associated with compassion satisfaction, burnout, and secondary traumatic stress among Chinese nurses in tertiary hospitals: A cross-sectional study. *International Journal of Nursing Studies, 102*, 1-8. https://doi.org/10.1016/j.ijnurstu.2019.103472

Watson, J. C., & Watson, A. A. (2016). Coping self-efficacy and academic stress among Hispanic first-year college students: The moderating role of emotional intelligence. *Journal of College Counseling, 19*(3), 218-230. https://doi.org/10.1002/jocc.12045

Wells, R., Kite, B., Breckenridge, E., & Sunbury, T. (2018). Community mental health center integrated care outcomes. *Psychiatric Quarterly, 89*(4), 969-982. http://dx.doi.org/10.1007/s11126-018-9594-3

Wood, S., Seevak, E., Bhatia, U., McBain, R., & Nadkarni, A. (2021). "I will not step back": A qualitative study of lay mental health workers' experiences in India. *Administration and Policy in Mental Health and Mental Health Services Research, 48*(4), 695-706. https://doi.org/10.1007/s10488-020-01102-6

World Health Organization. (2014). Information sheet: Premature death among people with severe mental disorders. World Health Organization. http://www.who.int/mental_health/management/info_sheet.pdf

Wu, Y., Lian, K., Hong, P., Liu, S., Lin, R., & Lian, R. (2019). Teachers' emotional intelligence and self-efficacy: Mediating role of teaching performance. *Social Behavior and Personality: an international journal, 47*(3), 1-10. https://doi.org/10.2224/sbp.7869

Wu, S., Singh-Carlson, S., Odell, A., Reynolds, G., & Su, Y. (2015). Compassion fatigue, burnout, and compassion satisfaction among oncology nurses in the United States and

Canada. *Oncology Nursing Forum, 43*(4), 161-169. https://doi.org/10.1188/16.onf.e161-e169

Yan, G. W., & Beder, J. (2013). Professional quality of life and associated factors among VHA chaplains. *Military Medicine, 178*(6), 638-645. https://doi.org/10.7205/milmed-d-13-00021

Yanchus, N. J., Periard, D., & Osatuke, K. (2017). Further examination of predictors of turnover intention among mental health professionals. *Journal of Psychiatric and Mental Health Nursing, 24*(1), 41-56. https://doi.org/10.1111/jpm.12354

Yang, S., & Berdine, G. (2016). Outliers. *The Southwest Respiratory and Critical Care Chronicles, 4*(13), 52-56. https://doi.org/10.12746/swrccc2016.0413.178

Yang, S., Meredith, P., & Khan, A. (2016). Is mindfulness associated with stress and burnout among mental health professionals in Singapore? *Psychology, Health & Medicine, 22*(6), 673-679. https://doi.org/10.1080/13548506.2016.1220595

Yao, L. M., Hung, C. S., Ain, S. N., Pui, E., & Lee, O. C. (2021). Prevalence of burnout syndrome and its associated factors among doctors in Sabah, Malaysia. *Psychology, Health & Medicine*, 1-8. https://doi.org/10.1080/13548506.2021.1891265

Yilmaz, G., & Ustun, B. (2018). Professional quality of life in nurses: Compassion satisfaction and compassion fatigue. *Journal of Psychiatric Nursing, 9*, 205-211. https://doi.org/10.14744/phd.2018.86648

Young, J. D. (2020). *Emotional intelligence of leaders within behavioral health organizations* (Publication No. 28093256) [Doctoral dissertation, The Chicago School of Professional Psychology]. ProQuest Dissertations and Theses Global.

https://www.proquest.com/openview/1b58d05fa764e6417e788130944eb830/1?pq-origsite=gscholar&cbl=18750&diss=y

Zaidi, S. M. I. H., Yaqoob, N., & Husnain, S. (2017). Compassion satisfaction, secondary traumatic stress and burnout among rescuers. *Journal of Postgraduate Institute*, *31*(3), 314-318.

Zeidner, M., & Hadar, D. (2014). Some individual difference predictors of professional well-being and satisfaction of health professionals. *Personality and Individual Differences, 65*, 91-95. http://dx.doi.org/10.1016/j.paid.2014.01.032

Zeidner, M., Hadar, D., Matthews, G., & Roberts, R. D. (2013). Personal factors related to compassion fatigue in health professionals. *Anxiety, Stress & Coping*, *26*(6), 595-609. https://doi.org/10.1080/10615806.2013.777045

APPENDIX A:
IRB APPROVAL LETTER, INFORMATION SHEET, AND RECRUITMENT SCRIPT

TEXAS A&M UNIVERSITY
CORPUS CHRISTI

OFFICE OF RESEARCH COMPLIANCE
Division of Research and Innovation
6300 OCEAN DRIVE, UNIT 5844
CORPUS CHRISTI, TEXAS 78412
O 361.825.2497

Human Subjects Protection Program | Institutional Review Board

DATE: June 11, 2020

TO: Michelle Hollenbaugh

CC: Benjamin Robertson

FROM: Office of Research Compliance

SUBJECT: Exempt Determination

On June 11, 2020, the Texas A&M University-Corpus Christi Institutional Review Board reviewed the following submission:

Type of Review:	Exempt
Title:	The Relationship between Emotional Intelligence, Burnout, and Compassion Satisfaction of Mental Health Case Managers Working in an Outpatient Mental Health Facility
Principal Investigator:	Michelle Hollenbaugh
IRB ID:	TAMU-CC-IRB-2020-05-048
Funding Source:	None
Documents Reviewed:	BRobertson Dissertation IRB Information SheetFlyer for Dissertation Assessing Emotions Scale (1) Assessing Emotions Scale Chapter published manuscript version ProQOLManual; PermissionToUseProQOL SSEIT Permission Letters of support CITI and CVs

Texas A&M University-Corpus Christi Institutional Review Board reviewed the project and based on the information provided has determined the research meets exempt category: 45 CFR 46.104(d)(2) (Research involving use of educational tests, survey procedures, interview procedures or observation of public behavior).

Therefore, this project has been determined to be exempt from IRB review. You may proceed with this project.

Reminder of Investigator Responsibilities: As principal investigator, you must ensure:

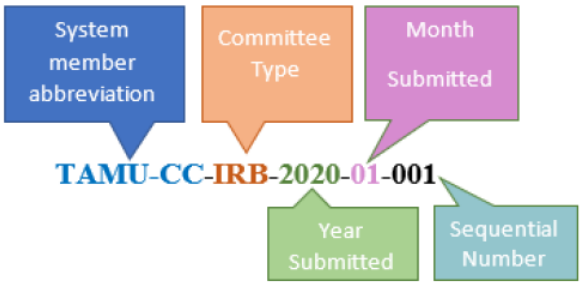
1. **Informed Consent: Ensure informed consent processes are followed** and information presented enables individuals to voluntarily decide whether to participate in research.
2. **Amendments:** This determination applies only to the activities described in the IRB submission and does not apply should any changes be made. **Any planned changes require an amendment** to be submitted to the IRB to ensure that the research continues to meet criteria for exemption. The Amendment must be approved before being implemented.
3. **Completion Report: Upon completion of the research project (including data analysis and final written papers), a Completion Report must be submitted**.
4. **Records Retention: All research related records must be retained for three (3) years** beyond the completion date of the study in a secure location. At a minimum these documents

include: the research protocol, all questionnaires, survey instruments, interview questions and/or data collection instruments associated with this research protocol, recruiting or advertising materials, any consent forms or information sheets given to participants, all correspondence to or from the IRB or Office of Research Compliance, and any other pertinent documents.

5. **Adverse Events:** Adverse events must be reported to the Research Compliance Office immediately.
6. **Post-approval monitoring:** Requested materials for post-approval monitoring must be provided by dates requested.

New IRB Number Format: In anticipation of software implementation in 2020, you have received an IRB number in the new format.

New IRB Number Format Explained



Please do not hesitate to contact the Office of Research Compliance with any questions at irb@tamucc.edu or 361-825-2892.

Respectfully,

Rebecca Ballard, JD, MA, CIP

Digitally signed by Rebecca Ballard, JD, MA, CIP
Date: 2020.06.11 13:43:31 -05'00'

Office of Research Compliance

INFORMATION SHEET

The Relationship between Emotional Intelligence, Burnout, and Compassion Satisfaction of Mental Health Case Managers Working in an Outpatient Mental Health Facility

Introduction

Hello, my name is Benjamin Robertson. I am a doctoral candidate at Texas A&M University-Corpus Christi (TAMUCC). I am planning on conducting a research study for my dissertation. I'm interested in learning about the relationship between emotional intelligence, compassion satisfaction, and burnout of mental health case managers working in an outpatient mental health facility. The purpose of this form is to serve as a research flyer and provide you information to help to make the decision on whether to participate in this research study. Thank you very much for your time and consideration.

Why is this research being done?

The goal of this research study is to understand the relationships between emotional intelligence, compassion satisfaction, and burnout in mental health case managers working in an outpatient mental health facility. Specifically, this study seeks to determine if, and to what degree, emotional intelligence moderates the relationship between compassion satisfaction and burnout in the selected population.

Who can be in this study?

We are asking you to be a part of this research study because you may meet participant criteria as a mental health case manager working in an outpatient mental health facility. To be eligible to be in this study, you must:

- Be 18 years old or older
- Have a minimum of a bachelor's degree
- Currently work as a mental health case manager in an outpatient mental health facility
- Have worked past your initial training (orientation/introductory) period after becoming hired as a mental health case manager
- NOT currently possess any professional licenses (e.g., LPC, LMFT, LCDC, etc.)

What will I be asked to do?

Being in this study involves completing a demographic survey and two questionnaires: (1) ProQOL assesses for burnout and compassion satisfaction and (2) SSEIT assesses for emotional intelligence. If you agree to be in this study, you will be in this study for approximately 15-20 minutes.

If you choose to be in this study, the following things will happen:

- Your participation will involve reading the study information and answering questions about your demographics which should take about 5 minutes

- You will be asked to answer several items on the Qualtrics website regarding two questionnaires, which in total should take about 10-15 minutes

What are the risks involved in this study?

This research involves minimal risks or risks that are no more than what you may experience in everyday life. The main risk may include:

- Perceived psychological distress- To address any perceived psychological distress, counseling resources will be provided if requested.
- Perceived pressure to conform- To address any perceived pressure to conform, potential participants are encouraged to answer with the utmost honesty and are informed that others will not be notified of their responses
- Perceived pressure to participate- To address any perceived pressure to participate, participants are informed that their involvement is voluntary, and they are able to withdraw at any time without penalty.
- Potential breaches of confidentiality- To address any potential breaches of confidentiality, participants will be assigned numbers in order to maintain confidentiality throughout the duration of this study.
- Your participation will involve collecting information about you. There is a slight risk of loss of confidentiality. Your confidentiality will be protected to the greatest extent possible. You do not have to give any information to the study that you do not want to give.
- Some questions/items may be embarrassing or uncomfortable to answer. Sample questions/items that you may be asked are: “My work makes me feel satisfied”; “I am aware of my emotions as I experience them”; “I like to share my emotions with others.” You do not have to answers questions you do not want to.

What are the alternatives to being in this study?
Instead of being in this study, you may choose not to be in the research study.

What are the possible benefits of this study?
There may be no direct benefit to you from being in this research study. By being in this study, you may help researchers learn more about the impact that the studied variables have on mental health case managers and the services they provide to the community.

What will I receive if I am in the study?

You will be eligible to receive one Amazon electronic gift card valued at $10.00, if you complete this study. You will be asked to enter your email address in Qualtrics to be sent the Amazon electronic gift card after the study concludes.

Do I have to participate?
No. **Being in a research study is voluntary.** If you choose not to participate, there will be no penalty or loss of benefits to which you are otherwise entitled.

What if I change my mind?
You may quit at any time. There will be no penalty or loss of benefits to which you are otherwise entitled.

You may decide not to participate or quit at any time without your current or future relations with Texas A&M University-Corpus Christi or any cooperating institution being affected.

What about protecting my information?
This study is confidential.

When information collected about you includes identifiers (such as an email address) the study can involve confidential information. You will be prompted to add your email address at the end of the study, if you are interested in an Amazon electronic gift card valued at $10.00.

Your information will be protected by:

- All research records will be kept securely.
- Research records will be seen only by authorized research team members.
- We will share your information only when we must, will only share the information that is needed, and will ask anyone who receives it from us to protect your privacy.
- No identifiers linking you to this study will be included in any report that might be published or presentation.

Once data analysis is complete, your identifiers will be removed from the research data. Your information collected as part of this research, even after identifiers are removed, will not be used or distributed for future research studies.

Who can I contact with questions about the research?
Dr. Michelle Hollenbaugh is in charge of this research study. You may contact Dr. Michelle Hollenbaugh at michelle.hollenbaugh@tamucc.edu with questions at any time during the study.

You may also email Benjamin Robertson at brobertson2@islander.tamucc.edu with any questions you may have.

Who can I contact about my rights as a research participant?

You may also call Texas A&M University-Corpus Christi Institutional Review Board (IRB) with questions or complaints about this study at irb@tamucc.edu or 361-825-2497. The IRB is a

committee of faculty members, statisticians, researchers, community advocates, and others that ensures that a research study is ethical and that the rights of study participants are protected.

CONSENT TO PARTICIPATE

To participate in this research study, click the following link to begin fill out the survey(s).
https://qtrial2018q2az1.az1.qualtrics.com/jfe/form/SV_4ZrfN3ZCq3Fg4nj
By opening the provided link, you are agreeing to participate in the study. By participating in this study, you are also certifying that you are 18 years of age or older, have a minimum of a bachelor's degree, currently work as a mental health case manager in an outpatient mental health facility, have worked past your initial training (orientation/introductory) period after becoming hired as a mental health case manager, and do not currently possess any professional licenses (e.g., LPC, LMFT, LCDC, etc.).

If you do not agree to participate in the research study, please ignore this request and exit this screen/do not fill out the form/survey(s).

RECRUITMENT SCRIPT

To whom it may concern,

Hello, my name is Benjamin Robertson. I am a doctoral candidate at Texas A&M University-Corpus Christi (TAMUCC). I am planning on conducting a research study for my dissertation. I'm interested in learning about the relationship between emotional intelligence, compassion satisfaction, and burnout in mental health case managers working in an outpatient mental health facility. You are receiving this message because you may meet participant criteria for this study. I have attached the informed consent with more information on this study and how you can be a part of it. I would greatly appreciate your participation in this project. Please take a look at the informed consent and let me know if you have interest in contributing to this endeavor. Thank you very much for your time.

Kindly,

Benjamin Robertson, M.Ed., LPC, LCDC, NCC

APPENDIX B:
DEMOGRAPHIC FORM

Please respond to the following demographic questions about yourself.

Q1 Are you a mental health case manager who engages in direct consumer care as your primary professional role, working in an outpatient mental health facility?

☐ Yes (1)

☐ No (2)

If No is selected, then skip to the end of the survey

Q2 What is your highest level of education?

☐ Bachelor's (1)

☐ Master's (2)

☐ Doctorate (3)

Q3 Gender (check all that applies)

☐ Female (1)

☐ Male (2)

☐ Transgender (3)

☐ Other (please specify): (4) _____

Q4 Please indicate your exact age (in years):

Q5 Please indicate your ethnicity or racial identity (check all that apply):

☐ Asian or Asian American (1)

☐ Black or African American (2)

☐ Hispanic or Latino/Latina/Latinx (3)

☐ Multiple Heritage (4)

☐ Native American/Alaska Native (5)

☐ Native Hawaiian/Pacific Islander (6)

☐ White or European American (7)

☐ Other (please specify): (8) _____

Q6 Indicate your time, in years, of experience working in your current mental health case manager role:

Q7 Please indicate your primary specialty area(s). Check all that apply.

☐ Adult mental health (1)

☐ Child and adolescent mental health (2)

☐ Other (please specify): (3) _____

Q8 Are you satisfied (contented, pleased) with where you work?

☐ Yes (1)

☐ No (2)

APPENDIX C
PROQOL PERMISSION AND SCALE

PO **ProQOL Office** Inbox - TAMUCC December 27, 2019 at 4:29 PM

Permission to Use ProQOL

To: Benjamin Robertson

Reply-To: ProQOL Office

Thank you for your interest in the ProQOL.

The ProQOL measure may be freely copied and used, without individualized permission from the ProQOL office, as long as:
(a) You credit The Center for Victims of Torture and provide a link to www.ProQOL.org;
(b) It is not sold; and
(c) No changes are made, other than creating or using a translation, and/or replacing "[helper]" with a more specific term such as "nurse."

Because you have agreed that your use of the ProQOL follows the above criteria, the ProQOL Office at the Center for Victims of Torture grants you permission to use the ProQOL. Your recorded request is attached here as a PDF.

If you have any questions or comments, you can contact us at proqol@cvt.org. Note that unfortunately our capacity is quite limited, as this is a volunteer-run effort, but we will do what we can to respond within a couple of weeks.

Thank you!

The ProQOL Office
at The Center for Victims of Torture

proqol@cvt.org PermissionToUseProQOL.pdf

Permission to Use the ProQOL

Thank you for your interest in using the Professional Quality of Life Measure (ProQOL). Please share the following information with us to obtain permission to use the measure:

Please provide your contact information:

Email Address

brobertson2@islander.tamucc.edu

Name

Benjamin Robertson

Organization Name, if applicable

Country

United States

Please tell us briefly about your project:

I am planning on conducting a study (for dissertation) on emotional intelligence, compassion satisfaction, and burnout with mental health case managers working in an outpatient mental health facility.

What is the population you will be using the ProQOL with?

Mental health case managers working in an outpatient mental health facility.

In what language/s do you plan to use the ProQOL?

Listed here are the languages in which the ProQOL is currently available (see https://proqol.org/ProQol_Test.html). If you wish to use a language not listed here, please select "Other" and specify which language/s.

English

The ProQOL measure may be freely copied and used, without individualized permission from the ProQOL office, as long as:

- **You credit The Center for Victims of Torture and provide a link to www.ProQOL.org;**
- **It is not sold; and**
- **No changes are made, other than creating or using a translation, and/or replacing "[helper]" with a more specific term such as "nurse."**

Note that the following situations are acceptable:

- **You can reformat the ProQOL, including putting it in a virtual format**
- **You can use the ProQOL as part of work you are paid to do, such as at a training: you just cannot sell the measure itself**

Does your use of the ProQOL abide by the three criteria listed above? (If yes, you are free to use the ProQOL immediately upon submitting this form. If not, the ProQOL office will be in contact in order to establish your permission to use the measure.)

Yes

Thank you for your interest in the ProQOL! We hope that you find it useful. You will receive an email from the ProQOL office that records your answers to these questions and provides your permission to use the ProQOL.

We invite any comments from you about the ProQOL and the experience of using it at proqol@cvt.org. Please also contact us if you have any questions about using the ProQOL, even if you noted them on this form. Note that unfortunately, our capacity is quite limited so we may not be able to respond to your note: however, we greatly appreciate your engagement.

SECTION 8: THE PROQOL TEST AND HANDOUT
PROFESSIONAL QUALITY OF LIFE SCALE (PROQOL)

COMPASSION SATISFACTION AND COMPASSION FATIGUE
(PROQOL) VERSION 5 (2009)

When you *[help]* people you have direct contact with their lives. As you may have found, your compassion for those you *[help]* can affect you in positive and negative ways. Below are some questions about your experiences, both positive and negative, as a *[helper]*. Consider each of the following questions about you and your current work situation. Select the number that honestly reflects how frequently you experienced these things in the *last 30 days*.

1=Never 2=Rarely 3=Sometimes 4=Often 5=Very Often

1. I am happy.
2. I am preoccupied with more than one person I *[help]*.
3. I get satisfaction from being able to *[help]* people.
4. I feel connected to others.
5. I jump or am startled by unexpected sounds.
6. I feel invigorated after working with those I *[help]*.
7. I find it difficult to separate my personal life from my life as a *[helper]*.
8. I am not as productive at work because I am losing sleep over traumatic experiences of a person I *[help]*.
9. I think that I might have been affected by the traumatic stress of those I *[help]*.
10. I feel trapped by my job as a *[helper]*.
11. Because of my *[helping]*, I have felt "on edge" about various things.
12. I like my work as a *[helper]*.
13. I feel depressed because of the traumatic experiences of the people I *[help]*.
14. I feel as though I am experiencing the trauma of someone I have *[helped]*.
15. I have beliefs that sustain me.

16. I am pleased with how I am able to keep up with *[helping]* techniques and protocols.

17. I am the person I always wanted to be.

18. My work makes me feel satisfied.

19. I feel worn out because of my work as a *[helper]*.

20. I have happy thoughts and feelings about those I *[help]* and how I could help them.

21. I feel overwhelmed because my case [work] load seems endless.

22. I believe I can make a difference through my work.

23. I avoid certain activities or situations because they remind me of frightening experiences of the people I *[help]*.

24. I am proud of what I can do to *[help]*.

25. As a result of my *[helping]*, I have intrusive, frightening thoughts.

26. I feel "bogged down" by the system.

27. I have thoughts that I am a "success" as a *[helper]*.

28. I can't recall important parts of my work with trauma victims.

29. I am a very caring person.

30. I am happy that I chose to do this work.

APPENDIX D
SSEIT PERMISSION AND SCALE

NS **Nicola Schutte** June 2, 2020 at 8:47 PM

RE: Emotional Intelligence

To: Robertson, Benjamin

Thank you for your message.

Please find attached the manuscript copy of a published chapter that provides more information, including the scale and scoring instructions.

Kind regards, Nicola Schutte

-----Original Message-----
From: Robertson, Benjamin <brobertson2@islander.tamucc.edu>
Sent: Wednesday, 3 June 2020 4:49 AM
To: Nicola Schutte <nschutte@une.edu.au>
Subject: Emotional Intelligence

Good afternoon,

My name is Benjamin Robertson and I am a doctoral candidate at Texas A&M University-Corpus Christi (TAMUCC). I am working on my dissertation and am studying emotional intelligence, compassion satisfaction and burnout in mental health case managers working in an outpatient mental health facility. I am using the ProQOL for compassion satisfaction and burnout. I would like to inquire about The Schutte Self Report Emotional Intelligence Test (SSEIT) and the possibility of using your survey in my dissertation. If you could please provide me more information. Thank you very much for your time, Dr. Schutte.

Kindly,

Benjamin Robertson, M.Ed., LPC, LCDC, NCC

Assessing Emotio...ion.pdf

The Assessing Emotions Scale

Directions: Each of the following items asks you about your emotions or reactions associated with emotions. After deciding whether a statement is generally true for you, use the 5-point scale to respond to the statement. Please circle the "1" if you strongly disagree that this is like you, the "2" if you somewhat disagree that this is like you, "3" if you neither agree nor disagree that this is like you, the "4" if you somewhat agree that this is like you, and the "5" if you strongly agree that this is like you.

There are no right or wrong answers. Please give the response that best describes you.

1 = strongly disagree
2 = somewhat disagree
3 = neither agree nor disagree
4 = somewhat agree
5 = strongly agree

1.	I know when to speak about my personal problems to others.	1	2	3	4	5
2.	When I am faced with obstacles, I remember times I faced similar obstacles and overcame them.	1	2	3	4	5
3.	I expect that I will do well on most things I try.	1	2	3	4	5
4.	Other people find it easy to confide in me.	1	2	3	4	5
5.	I find it hard to understand the non-verbal messages of other people.	1	2	3	4	5
6.	Some of the major events of my life have led me to re-evaluate what is important and not important.	1	2	3	4	5
7.	When my mood changes, I see new possibilities.	1	2	3	4	5
8.	Emotions are one of the things that make my life worth living.	1	2	3	4	5
9.	I am aware of my emotions as I experience them.	1	2	3	4	5
10.	I expect good things to happen.	1	2	3	4	5
11.	I like to share my emotions with others.	1	2	3	4	5
12.	When I experience a positive emotion, I know how to make it last.	1	2	3	4	5
13.	I arrange events others enjoy.	1	2	3	4	5
14.	I seek out activities that make me happy.	1	2	3	4	5
15.	I am aware of the non-verbal messages I send to others.	1	2	3	4	5
16.	I present myself in a way that makes a good impression on others.	1	2	3	4	5
17.	When I am in a positive mood, solving problems is easy for me.	1	2	3	4	5

18.	By looking at their facial expressions, I recognize the emotions people are experiencing.	1	2	3	4	5
19.	I know why my emotions change.	1	2	3	4	5
20.	When I am in a positive mood, I am able to come up with new ideas.	1	2	3	4	5
21.	I have control over my emotions.	1	2	3	4	5
22.	I easily recognize my emotions as I experience them.	1	2	3	4	5
23.	I motivate myself by imagining a good outcome to tasks I take on.	1	2	3	4	5
24.	I compliment others when they have done something well.	1	2	3	4	5
25.	I am aware of the non-verbal messages other people send.	1	2	3	4	5
26.	When another person tells me about an important event in his or her life, I almost feel as though I experienced this event myself.	1	2	3	4	5
27.	When I feel a change in emotions, I tend to come up with new ideas	1	2	3	4	5
28.	When I am faced with a challenge, I give up because I believe I will fail.	1	2	3	4	5
29.	I know what other people are feeling just by looking at them.	1	2	3	4	5
30.	I help other people feel better when they are down.	1	2	3	4	5
31.	I use good moods to help myself keep trying in the face of obstacles.	1	2	3	4	5
32.	I can tell how people are feeling by listening to the tone of their voice.	1	2	3	4	5
33.	It is difficult for me to understand why people feel the way they do.	1	2	3	4	5