Mental Health of UK Hospitality Workers: Shame, Self-Criticism and Self-Reassurance

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Abstract

This study aimed to evaluate shame for mental health problems, and explore relationships between shame, self-criticism, self-reassurance, and mental health among UK hospitality workers, because this group of workers suffer from poor mental health yet report strong shame. An opportunity sample of 114 UK hospitality workers completed measures examining shame for mental health problems, self-criticism, self-reassurance, and mental health problems. A high proportion of workers scored over the midpoint in almost all the shame subscales. Shame, self-criticism, self-reassurance, and mental health were related to one another. External shame and self-criticism were positive predictors, and self-reassurance was a negative predictor for mental health problems. While self-criticism moderated the relationship between shame and mental health problems, self-reassurance did not. Online compassion training was recommended as it can reduce self-criticism and shame, can be undertaken without colleagues knowing and tailored to specific work patterns.

Keywords: mental health; mental health shame; mental health attitudes; self-criticism; self-reassurance; UK hospitality workers; emotional labor

Chinese translation required by the journal

英国酒店服务业从业者的身心健康

英国酒店服务业从业者的身心健康：羞愧，自我批评和自我肯定

摘要

本文旨在评估身心健康问题中的羞愧，并探索英国酒店服务行业从业者中所存在的羞愧，自我批评和自我肯定之间的关系，因为调查结果显示这组人群存在着很严重的身心健康问题以及很强烈的羞愧感。114 名英国酒店服务行业从业者参与了本次调研，评估了身心健康问题中的羞愧感，自我批评，自我肯定和身心健康问题。很高比例的从业者的评分都远高于几乎所有羞愧感分量表的中心点。 羞愧，自我批评，自我肯定和身心健康相互关联。外因羞愧感和自我批评是身心讲课问题的阳性预测分子，而自我肯定则是身心健康的阴性预测分子。自我批评对羞愧和身心健康问题之间的关系起到了调节作用，而自我肯定则不存在这样的调节作用。本文推荐网上慈悲培训，因为它可以降低自我批评和羞愧，同时它可以在其他同事不知情的情况下进行，并且可以根据不同的工作模式来制定特殊的培训内容。

关键词： 身心健康；身心羞愧；身心态度；自我批评； 自我肯定；英国酒店服务业从业者；情绪劳动

Introduction

Hospitality workers suffer from poor mental health: a survey of more than 1,100 UK employees found that 70% reported feeling overworked, and 45% have taken time off due to stress in their career (Davis, 2015). Depression is also prevalent among hospitality workers: depression in the food preparation and serving workers had the second highest prevalence rate of all US workers (Office of Applied Studies, 2007). Their mental health may be poor because of the workload, working hours, and fear of failure (Gilmour & Patten, 2007; Murray-Gibbons & Gibbons, 2007). Indeed, hospitality work is emotionally demanding; many hospitality workers have direct contact with customers, which requires providing quality service and real-time responses (Dann, 1990). They also have to deal with the 'jaycustomer' behavior, i.e., customer's thoughtless or abusive behavior, while maintaining a publicly observable, acceptable, emotional display (Harris & Reynolds, 2004). This 'emotional labor' (i.e., a type of labor that demands a worker to emphasize or suppress a certain feeling in order to maintain the agreeable mien to their customers; Hochschild, 1985) is one of the major causes of their occupational stress and burnout (Kogovsek & Kogovsek, 2014), and can cause mental health problems (Constanti & Gibbs, 2005). Customers' perception of surface acting (i.e., pretend emotional display), derived from emotional labor, was related to customers spending less money (Seger-Guttmann & Medler-Liraz, 2016). On the other hand, deep acting (i.e., genuine emotional display), the opposite of surface acting, can lead to better customer experience and more money being spent (Seger-Guttmann & Medler-Liraz, 2016; Yoo & Arnold, 2014). Additionally, working long and anti-social hours causes more depression than working regular hours (Gilmour & Patten, 2007). Indeed, depression is prevalent among hospitality workers (Office of Applied Studies, 2007); from 2004 to 2006, 10.3% and 8.1% of US workers in food preparation and serving-related

occupations (e.g. chefs, bartenders, hosts/hostesses) and hospitality office and administrative support workers (e.g., hotel, motel, and resort desk clerks), respectively, suffered from at least one major depressive episode in the prior year. Despite the severity of mental health difficulties in hospitality workers, effective solutions to prevent these difficulties have not been identified.

Negative Effects of Mental Health Problems

Although the process of defining mental health should be ongoing and constructive (O'Neal, 2003), a common definition is that it is a state of well-being in which you can cope with daily stresses or worries, and work productively and fruitfully (World Health Organization, 2016); hence, mental health problems hamper coping and affect thoughts, feelings, and behaviors (British Broadcasting Corporation, 2017). Mental distress hinders workers' creativity (Dunnagan, Peterson, & Haynes, 2001), and is likely to reduce their work activities (Gilmour & Patten, 2007). For example, depression limits productivity, and can cause disability, absenteeism, and premature retirement (Blackmore et al., 2007). Unsurprisingly, organizations where there are many employees who are mentally distressed, encounter a high turnover (International Labour Organization, 2010), costing the organizations substantially (Villanueva & Djurkovic, 2009). The costs of mental distress among UK workers (i.e., depression, anxiety, and stress) are estimated to be more than £10 billion (equating to 10 million working days) annually – 0.5% of GDP (Paton, 2007). The UK hospitality industry suffers from high levels of staff turnover (Lashley & Rowson, 2000) – more than 30% for managerial staff and 180% for general staff (Badger & Lashley, 2000). This yields extra costs; replacing an employee is estimated to be approximately £1,000 and replacing a manager can cost five times this amount (Lashley & Best, 2002). In order to counter this high turnover, recent hospitality studies (e.g., Jiang, Liu, McKay, Lee, & Mitchell, 2012; Karatepe & Karadas, 2012; Robinson, Kralj, Solnet, Goh, & Callan,

2014) have focused on job embeddedness - influencers of an employee staying in the job (Holtom, Mitchell, & Lee, 2006). Job embeddedness emphasizes the importance of employees' fit to the organization, the inks they have with it, and the consequences of leaving it: a literature review (Zhang, Fried, & Griffeth, 2012) and meta-analysis (Jiang et al., 2012) on job embeddedness highlighted these factors as crucial to employees' attachment to organization. Additionally, Robinson et al. (2014) suggested increasing hospitality workers' awareness of the perceived costs (materially and psychologically) of leaving the industry may reduce turnover. However, while this focus may help reduce turnover, it is unclear whether hospitality workers' poor mental health would concurrently improve. These approaches focus on the demands that workers face; it often difficult to changes these. An alternative approach is to focus on the coping resources that workers employ; given the mental health problems experienced and emotional labor that workers in the hospitality industry do this study aims to offer insights about mental health from an emotion regulation perspective.

Theoretical Model

The three emotion regulatory systems (threat, drive, and soothing systems) of compassion focused therapy (CFT) aims to help mental health by reducing self-criticism and shame, and enhancing self-reassurance (Gilbert, 2009). In the soothing system, our parasympathetic nervous system, which modulates rest, acquiescence and digestion, is activated; we feel safe and content, which contributes to better mental well-being (Gilbert, 2009). Contrarily, high degrees of self-criticism and shame can activate our threat system, increasing feelings of anger, disgust, and anxiety; in order to survive, our sympathetic nervous system, which modulates threat responses including fight-or-flight, is activated (Gilbert, 2009). This can lead to mental health problems (Gilbert, 2009). The drive system runs by excitement and vitality, and seeks incentives and

resources (Gilbert, 2009). Continued activation of this system can also be problematic, as not achieving or acquiring what was desired can cause us to question our efficacy, increase self-criticism and cause depression (Gilbert, 2009). The usefulness of our soothing system can be further highlighted in the social contexts. Gilbert's social mentality theory (2000) claims that our internal system of social archetypical mentality leads us to feel and behave in a certain way to solve social problems crucial for our survival (e.g., care-seeking, caregiving). A social mentality helps us to form certain roles in relation with others, and to interpret the roles others are performing. Care-seeking and caregiving mentalities are activated in safe relationships with others (Gilbert, 2005): the care-seeking mentality expresses suffering and need for care, to which the caregiving mentality responds with caring emotions (Gilbert, 2005). Emotions derived from our soothing system, such as compassion and safety, are essential for us to create such supportive predictable networks (Gilbert, 2009). On the other hand, shame and self-criticism (evolved within the social rank mentality), pertinent to our threat and drive systems, work against forming supportive social networks, compromising our mental health (Gilbert, 2009). In conclusion, in order for us to achieve better mental well-being, self-reassurance is benignant as it relates to our soothing system, while self-criticism can be malignant as it activates our threat and drive systems (see Figure 1).

[Insert Figure 1 about here]

The relationships among mental health, shame, self-criticism, and self-reassurance have been identified in various populations including Japanese workers (Kotera, Gilbert, Asano, Ishimura & Sheffield, 2018d) and UK construction workers (Kotera, Green & Sheffield, 2019b). In Japanese workers, the best cross-sectional predictors of mental health difficulties were self-criticism and self-reassurance. In UK construction workers, the best cross-sectional predictor of

mental health difficulties was self-compassion (which has been related to self-reassurance). However, these relationships have not been explored in UK hospitality workers. In the current study we expect to see similar relationships: in bivariate correlations we anticipate relationships between self-criticism, self-reassurance and mental health difficulties; we anticipate that self-criticism and self-reassurance will independently predict mental health difficulties.

Low Help-Seeking and Mental Health Shame among UK Hospitality Workers

Despite the magnitude of mental health problems in the hospitality industry, the attitudes towards mental health problems among hospitality workers are in general negative; about half of UK hospitality workers would not reveal to anyone if they have mental health problems (Hospitality & Catering News, 2016). Further, 38% of them would not tell their boss that stress caused their absence, and 9% did not know how to cope with stress (Davis, 2015). Indeed, almost all the UK hospitality workers (90%) believe sensitivity to work stress can interrupt career progression, and 40% identify that the industry expectation - they should handle stress by themselves - causes stress (CV-Library, 2016). This was illustrated in a cross-industry comparison study about help-seeking in Hong Kong (Zhu, Tse, Goodyear-Smith, Yuen, & Wong, 2017): whilst the rates of depression and/or anxiety in hospitality workers was one of the highest (60%), the rate of seeking immediate help for depression and/or anxiety in hospitality workers was one of the lowest (21%). Many hospitality workers had a drinking problem (20%), but none indicated they intended to seek help. Additionally, migrant workers, which account for a quarter of UK hospitality workforce (Klynveld Peat Marwick Goerdeler, 2017), have reported for low help-seeking. Tse, Wong, and Kim's study of problem gambling in Asian immigrants (2004) highlighted low help-seeking of food industry and tourism workers; this may have been caused by the shame of being labelled as a problem gambler. Gleeson (2012) reported that Latino

migrant restaurant workers did not reveal their distress to others because of the perceived risk their employment would be terminated. These findings highlight the serious nature of non-disclosure as without awareness and willingness to discuss mental illness, workers are unlikely to obtain suitable treatment options (Corrigan, Druss, & Perlick, 2014).

Shame and stigma may contribute to mental health problems, because of taboos associated with mental health problems (Manson, 2012). Many employers in this industry have negative attitudes and misconceptions about mental health problems (Wildes, 2005; 2007). For example, employers are less likely to employ workers with depression than with diabetes, because of the latter are perceived to perform better (Glozier, 1998). In the hospitality industry, discussing mental health is taboo and stigmatizing (Glozier, 1998), and may lead to a sense of shame (Corrigan et al., 2014). One recent study explored shame about mental health problems in the UK hospitality workers (Kotera, Adhikari & Van Gordon, 2018a); however, the focus of that study was on work motivation, and its predictions for mental health problems. The mechanism of the relationship between shame and mental health problems in the UK hospitality workers has not been explored to date.

Shame affords a way of understanding the low help-seeking observed in hospitality workers and has been related to mental health problems. Generally, shame refers to painful negative self-evaluation, often derived from some social wrongdoing (Gilbert & Bailey, 2000). This study aimed to evaluate different dimensions of shame among UK hospitality workers, namely external, internal, and reflected shame, and relate it to mental health problems (i.e., mental health shame). In a general sense, external shame refers to how one perceives they are judged by others based on intrinsic features such as personality and appearance, while internal shame emerges when one internalizes external shame, entailing negative self-evaluation, because

of their intrinsic features (Gilbert & Bailey, 2000). External shame for mental health problems considers how others judge you for having a mental health problem: negative feelings derived from a perception that others are looking down on you and criticizing you. Internal shame for mental health problems focuses on one's negative evaluation of yourself, caused by internalization: how you negatively perceive yourself for having a mental health problem (Cook, 1996). Finally, reflected shame refers to the shame that you could bring to others or others could bring to you: you feel ashamed for having brought shame to your family because of your mental health problem, or you feel ashamed for your family member's mental health problems. Given the low levels of help-seeking in hospitality workers, we expect that a high proportion of them will score over the midpoint in the shame measure.

Shame, Self-Criticism, Self-Reassurance, and Mental Health

In the general population, shame is associated with a variety of mental health problems (Kim et al., 2011; Tangney & Dearing, 2002) such as depression (Alexander, Brewin, Vearnals, Wolff, & Leff, 1999; Cheung, Gilbert, & Irons, 2004; Matos, Pinto-Gouveia & Gomes, 2010), anxiety (Tangney, Wagner, & Gramzow, 1992), paranoia (Matos, Pinto-Gouveia, & Gilbert, 2013), post-traumatic stress disorder (Harman & Lee, 2010), eating disorders (Skårderud, 2007; Troop, Allan, Serpell, & Treasure, 2008), and personality disorders (Rüsch et al., 2007). Furthermore, shame in psychotherapists or clients can cause therapeutic rupture (i.e., degradation of the clinical relationship that dissatisfies clients; Gilbert & Leahy, 2007). These findings highlight strong relationships between shame and mental health problems.

Shame and mental health problems have both been related to self-criticism and self-reassurance (Gilbert, 2009; Gilbert et al., 2010; Kotera et al., 2018d). Self-criticism is commonly regarded as criticism of the self, aiming to protect it from feelings such as shame and anxiety,

while self-reassurance is defined as warmth, soothing, and liking directed to the self (Gilbert, 2009). Kotera, Green, and Sheffield (2018d) recently investigated these relationships among 87 UK social work students and found that shame about mental health problems and mental health were positively related to inadequate-self (i.e., one of the two forms of self-criticism, relating to a belief that one is not good enough; Gilbert, Clarke, Hempel, Miles, & Irons, 2004) and hated-self (the other form of self-criticism desiring to hurt the self; Gilbert et al., 2004), and negatively related to reassured-self (warmth and soothing to the self). Thus, how we treat ourselves mentally (i.e. self-criticism and self-reassurance) is important to our mental health. However, while shame was related to mental health problems in previous studies of workers, self-reassurance or self-compassion were stronger predictors of health problems (Kotera et al., 2018d; Kotera, Green & Sheffield, 2019).

In summary, previous research has identified that poor mental health of UK hospitality workers was a cause for concern, leading to high turnover and other organizational and individual problems. However, despite these negative impacts of poor mental health, hospitality workers' help-seeking has remained low, possibly due to its association with high shame about mental health problems. Further, recent occupational research identified that self-criticism and self-reassurance were important constructs for mental health and mental health shame. Aligned with the three emotion regulatory systems, self-criticism was positively associated with mental health problems and shame, while self-reassurance was negatively associated with them (Kotera, Green & Sheffield, 2019a; Kotera, Green & Sheffield, 2019b). However, these constructs have not comprehensively been explored in UK hospitality workers.

Accordingly, this study aimed to explore relationships among these variables: mental health problems, mental health shame, self-criticism, and self-reassurance. Examining these

relationships would help identify alternative targets and other solutions for their poor mental health. Further, shame about mental health problems may hinder hospitality workers' engagement with mental health training, limiting the positive training effects (Kotera et al., 2018d).

In order to examine the relationships between mental health, shame, self-criticism and self-reassurance among UK hospitality workers, this study examined the predictive power of shame, self-criticism, and self-reassurance variables on mental health problems. Additionally, this study explored whether self-criticism and self-reassurance would moderate the relationship between shame and mental health problems. Their depression, anxiety, and stress were evaluated, as these mental health problems are most common in both the general public and workforce (Davis, 2015; European Community, 2005; Miller, 1997; Office of Applied Studies, 2007) and are associated with shame (Cheung et al., 2004; Tangney et al., 1992).

H1: Shame is positively related to mental health problems (prediction).

H2: Self-criticism is positively related to mental health problems (prediction).

H3: Self-reassurance is negatively related to mental health problems (prediction).

H4: Self-criticism augments the relationship between shame and mental health problems (moderation).

H5: Self-reassurance weakens the relationship between shame and mental health problems (moderation).

Materials and Method

Participants

We used social media to recruit UK hospitality workers; participants were targeted from professional networks on Facebook and LinkedIn. One hundred and thirty workers agreed to participate; 114 UK hospitality workers (52 males, 62 females) completed all three measures, satisfying the required sample size (Faul, Erdfelder, Buchner, & Lang, 2009). Participants were 18 years of age or older and had more than one year of work experience in the UK hospitality industry. Both full-time and part-time workers were recruited (51% full-time, 49% part-time), as half of workers in this industry were part-time (People 1st, 2013a). The age range was 18–55 years (28.24 ± 8.37); 40% worked at a hotel, 32% at a restaurant, and the remaining 28% at other sites including pubs and in human resources. They reported working for 48.04 (SD 6.08) hours for full-timers and 22.07 (SD 10.16) hours for part-timers in an average week. Forty-eight percent have been working in hospitality for more than five years, 39% have been working for two to five years, and the remaining 13% have been working for less than two years.

Materials

Mental health shame was measured using the Attitudes Towards Mental Health Problems (ATMHP; Gilbert et al., 2007), a 35-item self-report instrument, consisting of four sections. The first section, eight items, measures shame-based negative attitudes towards mental health problems: how their community/family perceive mental health problems ('community attitude' and 'family attitude'; e.g., My community/family sees mental health problems as a personal weakness). The second section, comprising ten items, evaluates their external shame: how one feels their community/family would perceive *them* if they had a mental health problem ('community external shame' and 'family external shame'; e.g., I think my community/family would see me as inferior). The third section, five items, measures their internal shame: how they

perceive *themselves* if they had a mental health problem (e.g., I would blame myself for my problems). The final section has 12 items measuring two types of their reflected shame. Family-reflected shame considers how *one's family* would be perceived if one had a mental health problem (e.g., My family would be seen as inferior), and self-reflected shame considers fears of *reflected shame on themselves*, derived from a family member having a mental health problem (e.g., I would worry that others will look down on me). Participants respond each item on a four-point Likert scale (0 = 'Do not agree at all' to 3 = 'Completely agree'). All of the subscales have high internal consistency (α=.85-.97; Gilbert et al., 2007).

Mental health problems were examined using the Depression Anxiety and Stress Scale (DASS21), a shortened version of the DASS42 (Lovibond & Lovibond, 1995), comprising three subscales (seven items each, ordered sporadically): depression (e.g., I couldn't seem to experience any positive feeling at all), anxiety (e.g., I felt scared without any good reason) and stress (e.g., I tended to over-react to situations). A four-point Likert scale is used to mark how much each item applies to them in the past week (0 = 'Did not apply to me at all' to 3 = 'Applied to me very much, or most of the time'). The subscales of DASS21 have good reliability; α=.87-.94 (Antony, Bieling, Cox, Enns, & Swinson, 1998).

Self-criticism and self-reassurance were evaluated with the Forms of Self-Criticising/Attacking & Self-Reassuring Scale (FSCSR; Gilbert et al., 2004), 22 items exploring how people treat themselves internally when things go wrong for them. FSCSR consists of three components; two forms of self-criticism (inadequate-self and hated-self; nine and five items), and one form of self-reassurance (reassured-self; eight items). Inadequate-self relates to a sense of personal inadequacy (e.g., There is a part of me that puts me down.), hated-self to a desire to hurt or persecute the self (e.g., I have a sense of disgust with myself), and reassured-self to a

sense of self-support or compassion for the self (e.g., I find it easy to forgive myself). These three kinds of items are ordered sporadically. Each item is responded on a five-point Likert scale (0 = 'Not at all like me' to 4 = 'Extremely like me'). All the subscales have good reliability (α=.86-.90; Gilbert et al., 2004).

Procedure

After explaining the purpose of the study and consenting to participate to the study, the participants were sent links to the online scales. Once they have completed all three surveys, the debrief was sent to them. Ethics approval was obtained from the University's Research Ethics Committee.

The collected data was, first, screened for the outliers and parametric tests. Second, the rates of the UK hospitality workers who scored over the midpoint in the score range in each shame subscale were reported, in order to evaluate shame-based attitudes toward mental health problems. Third, multiple regression analyses were conducted to examine predictors of mental health problems (predictor variables being shame, self-criticism, and self-reassurance; H1-3). Lastly, moderation analyses were performed to examine the impact of self-criticism and self-reassurance on the relationship between shame and mental health problems (H4-5). IBM SPSS version 24.0 was used to test H1-3, and Process macro version 3 within SPSS was used to test H4-5 (Hayes, 2018).

No outliers were found. No common method bias and non-response bias were identified: the total variance for a single factor was below 50% (Podsakoff, MacKenzie & Podsakoff, 2003), and no significant differences in the scores between early responders and late responders (Miller & Smith, 1983). The Cronbach's alpha for all the subscales demonstrated high levels of internal consistency (>.80; Table 1). Because not all of the subscales were normally distributed (Shapiro-

Wilk's test; $p<.05$), data were transformed (square-root) to satisfy the assumption of normality. Multiple regression analyses were conducted to explore whether shame, self-criticism and self-reassurance would predict the degree of mental health problems in UK hospitality workers (H1-3). The mental health problems score was calculated by totaling the subscales of DASS21 (Lovibond & Lovibond, 1995). Lastly, based on our theoretical model, shame, self-criticism and self-reassurance, in addition to their interaction effects, were entered to predict mental health problems (H4-5), using the model 1 in the Process macro with 95% of confidence intervals and 5,000 bootstrap samples (Hayes, 2018). Shame was calculated by totaling the subscales of ATMHP (Gilbert et al., 2007; Kotera, et al., 2018d); self-criticism was calculated by summing the inadequate-self and hated-self subscales (Gilbert et al., 2004; Kotera et al., 2018d). To limit multicollinearity issues, the predictor variables were centered. The mediation analysis was conducted to evaluate regressions.

Results

Five subscales in the shame measure (ATMHP) out of seven had more than 50% of workers who scored over the midpoint in the score range, and in the remaining two subscales, the ratio was 49% (Table 1). Their community external shame, internal shame, and family-reflected shame had especially high proportions of workers scoring above the midpoint.

[Insert Table 1 about here]

Shame, Self-Criticism, and Self-Reassurance's Prediction of Mental Health Problems

Multiple regression analyses were conducted. ATMHP and FSCRS subscales were entered as predictor variables. Adjusted coefficient of determination (Adjusted R^2) was reported. Multicollinearity was not a concern (all the VIF values<5).

[Insert Table 2 about here]

The shame, self-criticism and self-reassurance measures predicted 87% of the variance in mental health problems, indicating a large effect size (Cohen, 1988). Among the mental health shame subscales, both types of external shame (community and family) were negative predictors of mental health problems, while the other subscales (community and family attitudes, internal shame, and reflected shame) did not predict the degree of mental health problems: H1 was partially supported.

Both types of self-criticism (inadequate-self and hated-self) were negative predictors of mental health problems: H2 was supported. Lastly, self-reassurance (reassured-self) was a positive predictor for mental health problems: H3 was supported (Table 2).

Impact of Self-Criticism and Self-Reassurance on Shame and Mental Health

Moderation analyses were conducted. The interaction effects of shame and self-criticism as predictors of mental health problems were significant (b=.10, t(110)=3.77, p<.001), which indicated that self-criticism moderated the effects of shame on mental health problems (F(3, 110)=224.31, p<.001) (Panel B in Figure 2). Three simple regression equations were calculated (Aiken & West, 1991) at different levels of self-criticism: (i) one standard deviation below the mean self-criticism score, (ii) the mean self-criticism score, and (iii) one standard deviation above the mean self-criticism score (Panel C in Figure 2). The interaction plot showed a positive enhancing effect of self-criticism: when self-criticism scores were high, the positive relationship between shame and mental health problems was strengthened. Simple slopes analyses showed that the relationship between shame and mental health problems was significant at each of the three levels of self-criticism: (i) low self-criticism (b=.09, t=2.37, p=.02), (ii) mean self-criticism (b=.19, t=5.26, p<.001), and (iii) high self-criticism (b=.29, t=5.85, p<.001). Further, Johnson-

Neyman technique identified that when self-criticism was higher than 1.86, shame and mental health problems were significantly related (b=.08, t=1.98, p=.05; Panel D in Figure 2). As self-criticism increased, the relationship between shame and mental health problems was enhanced with the highest self-criticism being 5.29 (b=.32, t=5.77, p<.001). On the other hand, although the overall model was significant (F(3, 110)=117.79, p<.001), there was no significant moderation effect of self-reassurance on the effects of shame on mental health problems: self-reassurance did not moderate the relationship between shame and mental health problems (b=.01, t=.24, p=.81; Panel E in Figure 2).

Lastly, mediation analysis was conducted to evaluate regression relationships among self-criticism, shame and mental health problems, using model 4 in the Process macro version 3 (parallel mediation model with 95% of confidence intervals and 5,000 bootstrap samples; Hayes, 2018). Shame was set as a predictor variable, mental health problems as an outcome variable, and self-criticism as a mediator variable. A model predicting self-criticism was significant F(1, 112)=252.18, p<.001, R^2=.69, and a model predicting mental health problems was also significant F(2, 111)=294.28, p<.001, R^2=.84.. Thus, H4 was supported, and H5 was rejected.

[Insert Figure 2 about here]

Discussion

This study evaluated the shame-based attitudes toward mental health problems among UK hospitality workers, and investigated relationships between their shame, self-criticism, self-reassurance and mental health. A high proportion of the UK hospitality workers reported shame about mental health problems; in particular, there were high levels of community external shame, internal shame, and family-reflected shame. External shame, self-criticism and self-reassurance

variables predicted the variances in mental health problems (H1-3). Finally, self-criticism moderated the relationship between shame and mental health problems, while self-reassurance did not (H4-5). We will discuss each finding in turn below.

A high proportion of the participants reported that they feel shame about mental health problems, especially community external shame (i.e., how their colleagues see them), internal shame (i.e., how they see themselves), and family-reflected shame (i.e., how their mental health problems would shame their family). The high community external shame and internal shame may relate to aspects of the industry culture: working long and anti-social hours under pressure is standard in this industry (Manson, 2012). This is in line with Shame Resilience Theory (SRT), which considers professional identity as one possible trigger of shame (Brown, 2006). Employees are expected to function well and maintain their professional display, while dealing with pressure. Those high standards and expectations might cause them to have strong shame for having mental health problems, as they may perceive they are failing to meet standards and expectations of their profession (Tarrier, Wells, & Haddock, 1998). As suggested in SRT, supporting workers' resilience and compassion may reduce their shame (Brown, 2006).

Another possible explanation concerns recruitment and retention and, accordingly the characteristics of the workforce. Retention is a continual problem because the hospitality industry employs a great number of young and mobile working population, which, in turn, is associated with a high turnover (Wildes, 2007). In Wildes' study (2005) about 70% of hospitality workers reported intending to leave the industry within two years. Furthermore, precarious employment, which entails less control of work processes, lower income, and less benefits than other types of employment, is a notable characteristic of this industry (Seifert & Messing, 2006), causing mental distress (De Cuyper et al., 2008). The hospitality industry appears unattractive to

many job-seekers because of long, anti-social working hours, low pay, unstable, seasonal employment, and low job status (Wildes, 2005). This suggests that individuals, who have been through several recruitment processes, where their confidence is compromised, apply for jobs in this industry. Therefore, they may be more self-critical and not reassure themselves (Stoeber, Hutchfield, & Wood, 2008). In future, it would be useful to compare data with other UK working populations in different stages of the job cycle to examine this possibility. Longitudinal data are also needed to fully understand the temporal nature of these relationships.

The high family-reflected shame may imply their family-work conflict, which has been increasingly paid attention to (Zhao, Mattila, & Ngan, 2014). This will be discussed further with the results of our regression analyses. Multiple regression analyses revealed shame, self-criticism and self-reassurance predicted the levels of mental health problems to a great degree. Additionally, external shame, self-criticism, and reassured-self were predictors of mental health problems. Increasing awareness of mental health problems among workers, especially managers, has been highlighted as a solution to mental health problems at workplace (Kline & Sussman, 2000). About 65% of the UK hospitality workers believe their employer would look down on the employees who are stressed, and 61% of them feel their manager does not offer support for their stress at work (CV-Library, 2016). The findings of this study suggest that it may be important to be more aware of those predictors of mental health problems. For example, hospitality workers' family-work conflict has been highlighted recently (Zhao et al., 2014), which may help explain why community and family external shame were predictors. Because of the industry standard of working long and anti-social hours, hospitality workers' work-life may interrupt with their family-life and cause mental distress (Zhao et al., 2014). One could argue that because they have already sacrificed their family-life, they are sensitive to add extra burden to their family, thus

increasing familial shame, while coping with emotional labor at work. Recently many innovative companies provide care for employees' families (Chaturvedi, Sathyanarayanan, & Sengupta, 2015), and UK hospitality industry may also benefit from such initiatives (more details discussed in the practical implications). Self-criticism and self-reassurance being predictors suggests that providing compassion training to help workers reduce self-criticism and strengthen self-reassurance may be useful (Gilbert, 2009). Considering the hospitality workers' various working patterns, online compassion training, undertaken independently (without being seen by their colleagues), would be appropriate (Rao & Kemper, 2017). Such an alternative approach to the mental health of hospitality workers would be worth exploring, because they may not engage with traditional mental health training because of their shame.

Indirect approaches to mental health have been examined recently: the planned breather leisure coping, where an individual proactively plans leisure activities to distract themselves from stress (Tsaur & Tang, 2012) or aesthetically-pleasant workplace (Kirillova, Fu & Kucukusta, 2018) was considered. Although these strategies and factors were deemed conducive to mental health, arranging them can take a relatively long time and high cost. In contrast, targeting shame and self-criticism can be achieved continuously in the workplace over a shorter time. For example, enhancing awareness of mental health may help hospitality workers reduce shame about mental health problems (Evans-Lacko et al., 2013). A three-hour training about stress management significantly improved young chefs' ability to talk about their distress with others including their supervisors (Pidd, Roche, & Fischer, 2015). A six-hour training aiming to i) improve social interaction, ii) promote a healthy work environment, and iii) destigmatize help-seeking for mental distress, reduced mental health shame to facilitate positive behaviors among restaurant workers (Bray, Galvin, & Clu, 2011).

Finally, moderation analyses revealed that self-criticism moderated the relationship between shame and mental health problems, while self-reassurance did not. The positive relationship between shame and mental health problems was enhanced by the stronger self-criticism. While previous findings suggested that self-criticism moderated effects on mental health (e.g., Cheraghian et al., 2016), findings from the present study, which considered shame for mental health problems, provides novel insights. Self-criticism may be detrimental for hospitality workers' mental wellbeing and can suggest an alternative solution for their poor mental health. Targeting reduction of self-criticism, more specifically the feelings of inadequacy and hate for oneself, may have great impacts on their mental health. Compassion training to reduce shame and self-criticism may be beneficial. For example, an American IT company employed monthly, one-hour compassion training for six months that mitigated depression (Fredrickson et al., 2008). As noted above, online compassion training may be helpful, as it can be undertaken anytime they can and without their colleagues' knowledge (Rao & Kemper, 2017). The effects of such training on self-criticism, shame, and mental health should be examined in UK hospitality workers. Lastly, a campaign may be effective to increase awareness about mental health problems. In the UK, for example, the 'Time to Change' social marketing campaign to encourage positive mental health behaviors has been successful to reduce mental health shame (Evans-Lacko et al., 2013). Hospitality workers should consider how to utilize this type of campaign.

Self-reassurance did not moderate the relationship between shame and mental health, contrary to our hypothesis and previous findings (e.g., Kyeong, 2013). As discussed earlier, this may illustrate people's stronger tendency to react to the negative (Gilbert, 2009), and the industry standard to deal with emotional challenges (Manson, 2012): maintaining the standard

may be taken for granted, while violating it may cause self-criticism. Further, submissive compassion (i.e., care for customers is motivated by being liked or valued; Catarino, Gilbert, McEwan & Baião, 2014) may help interpret the no moderation of self-reassurance. Many hospitality workers do not feel confident and self-reassured (Wilde, 2005); therefore, their motivation to help their customers may be derived from low self-reassurance, which may not impact the relationship between shame and mental health problems. Future research needs to explore their motivation for service behaviors.

Limitations and Future Research

There were several limitations in this study. First, opportunity sampling might have limited the generalizability of the findings of this study, although the part-time/full-time workers split is representative of the industry demography. Second, the sample size was relatively small, limiting the findings' reliability. Third, their scores in the mental health shame scale (ATMHP) should be compared with other UK industries or hospitality industry in other countries, in order to make meaningful comparisons Fourth, specificities of hospitality workers were not discussed in-depth. Fifth, social desirability bias might have been present using self-report measures to evaluate mental health issues, limiting the accuracy (Latkin, Edwards, Davey-Rothwell & Tobin, 2017). Sixth, as this study aimed to offer psychological insights, structural factors that can cause mental distress in hospitality workers were not examined but are job demands and structures are worthy of investigation as workers' resources are not unlimited (Gilmour & Patten, 2007; Murray-Gibbons & Gibbons, 2007). Lastly, this study did not elucidate the causal direction of these effects. Longitudinal data will help appraise the temporal patterning of the observed relationships and may help with the development of interventions that would increase our understanding of causality.

Conclusion

We evaluated the levels of shame for mental health problems, and explored relationships between shame, self-criticism, self-reassurance, and mental health among 114 UK hospitality workers. Our findings/contributions were i) a high proportion of workers reported shame about mental health problems, ii) external shame, self-criticism, and self-reassurance were predictors for mental health problems, and iii) self-criticism moderated the relationship between shame and mental health problems. Contrary to our theoretical model, based on the emotion regulatory systems, self-reassurance did not moderate the relationship between shame and mental health problems (i.e., how reassuring they were towards themselves did not impact on the positive relationship between mental health shame and mental health problems). These findings can offer additional values to research in UK hospitality industry, highlighting the characteristics of this industry culture. No moderation of self-reassurance may be related to their industry's standards, which expect them to deal with their emotional distress internally, while maintaining a professional attitude and displays that requires emotional labor. When employees fail in their emotional labor, they may feel shame and criticize themselves, while when they succeed, it may be taken for granted. Moreover, the UK hospitality workers' low shame resilience or submissive compassion may help explain these findings. Future research needs to explore these constructs to elucidate shame and mental health of this population group. Considering their high shame and diverse work patterns, along with structural changes that decrease the emotional demands on employees, online compassion training is recommended to reduce their self-criticism and shame.

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Tables and Figures for Self-criticism as a Moderator Between Shame and Mental Health in UK Hospitality Workers

Figure 1. The present study's theoretical model based on the three emotion regulatory systems

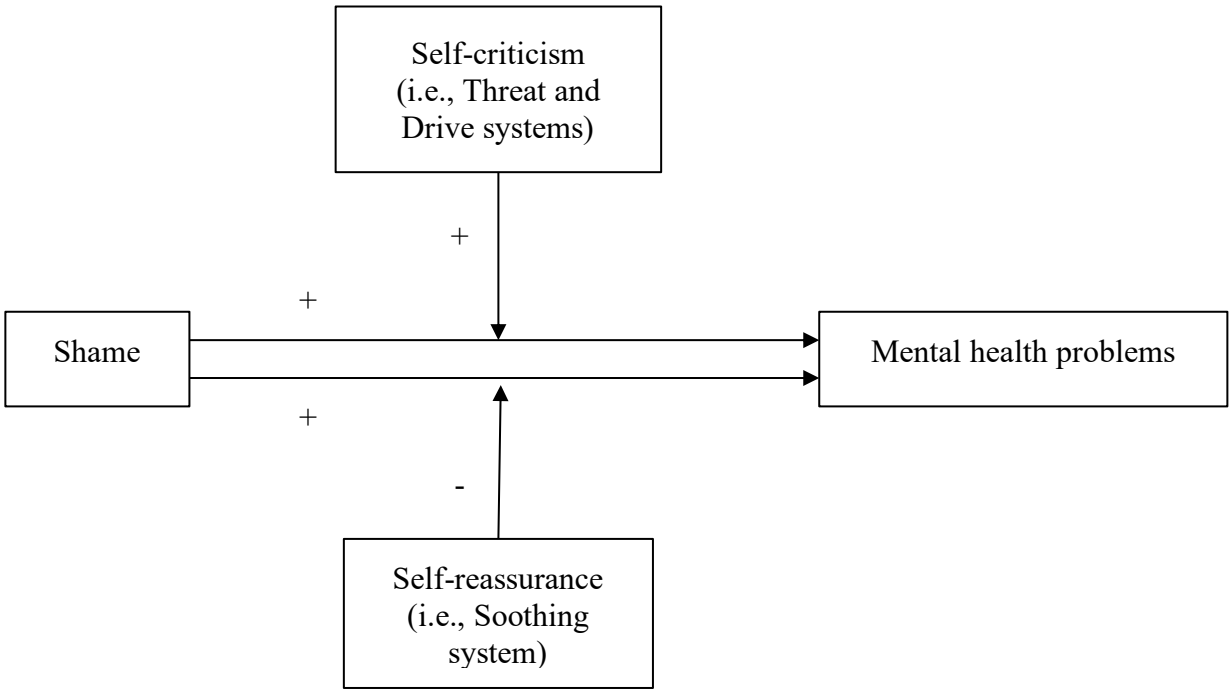


Table 1. Descriptive statistics of the shame (ATMHP), mental health (DASS21), self-criticism and self-reassurance (FSCRS) measures among UK hospitality workers (n=114)

Scale	Measured construct	Subscale (Range)	M	SD	α	% over midpoint
Attitudes Towards Mental Health Problems	Mental health shame	CA (0-12)	5.97	2.82	.82	49
		FA (0-12)	5.57	3.50	.86	49
		CES (0-15)	8.37	3.57	.84	70
		FES (0-15)	7.43	4.59	.91	61
		IS (0-15)	8.39	3.43	.84	66
		FRS (0-21)	11.15	5.42	.89	67
		SRS (0-15)	7.22	4.27	.91	57
Depression Anxiety and Stress Scale 21	Mental health problems	Dep (0-42)	15.06	9.56	.92	
		Anx (0-42)	10.39	5.89	.86	
		Strs (0-42)	11.96	5.06	.89	
Forms of Self-Criticising/Attacking & Self-Reassuring Scale	Self-criticism	ISelf (0-36)	22.81	8.12	.92	
		HSelf (0-20)	10.04	6.16	.91	
	Self-reassurance	RSelf (0-32)	16.86	6.93	.80	

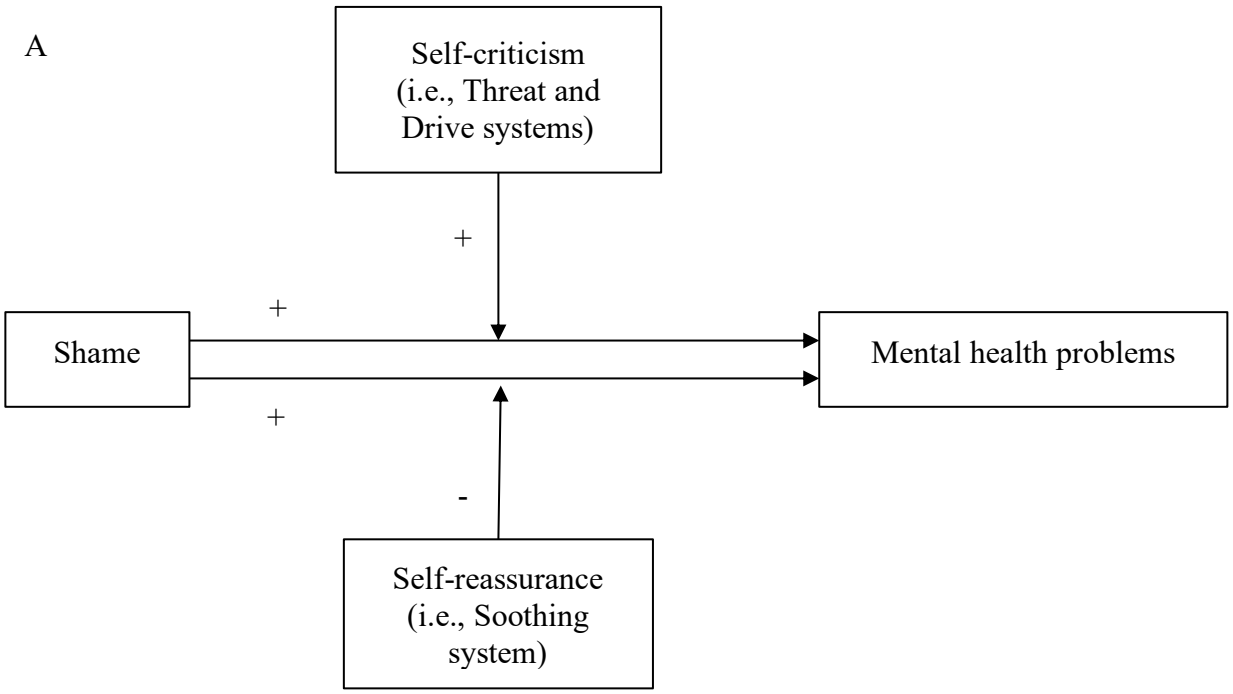
CA=Community Attitudes; FA=Family Attitudes; CES=Community External Shame; FES=Family External Shame; IS=Internal Shame; FRS=Family-Reflected Shame; SRS=Self-Reflected Shame; Dep=Depression; Anx=Anxiety; Strs=Stress; ISelf=Inadequate-Self; HSelf=Hated-Self; RSelf=Reassured-Self.

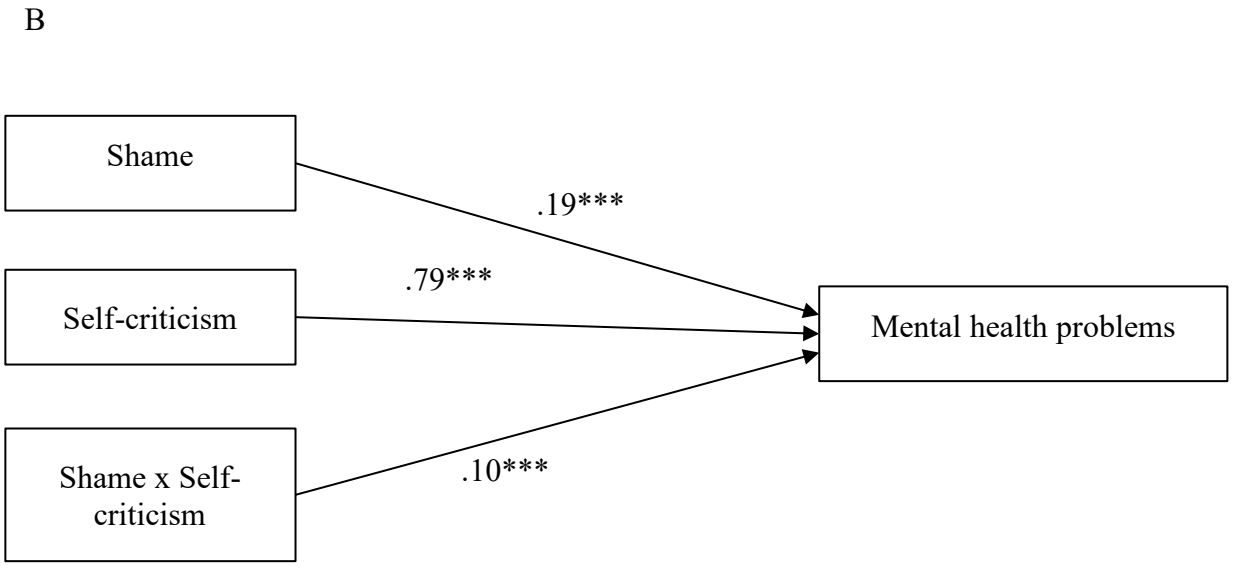
Table 2. Multiple regression: Mental health problems (DASS21) for shame (ATMHP), self-criticism and self-reassurance (FSCRS) in UK hospitality workers (n=114)

	Mental Health Problems		
	B	SE_B	β
Community Attitudes	.10	.08	.08
Family Attitudes	.10	.08	.10
Community External Shame	-.16	.07	-.13*
Family External Shame	.16	.07	.19*
Internal Shame	-.02	.07	-.01
Family-Reflected Shame	.12	.06	.11
Self-Reflected Shame	-.01	.06	-.01
Inadequate-Self	.29	.07	.28**
Hated-Self	.22	.06	.30**
Reassured-Self	-.18	.05	-.15**
Adj. R^2	.87		

Outcome variable = Mental health problems. B=unstandardized regression coefficient; SE_B=standard error of the coefficient; β=standardized coefficient; $^{*}p<.05$; $^{**}p<.01$.

Figure 2. Moderation of the effect of self-criticism and self-reassurance on mental health problems by shame: conceptual diagram (panel A), statistical diagram for self-criticism (panel B and C) and self-reassurance (panel D).





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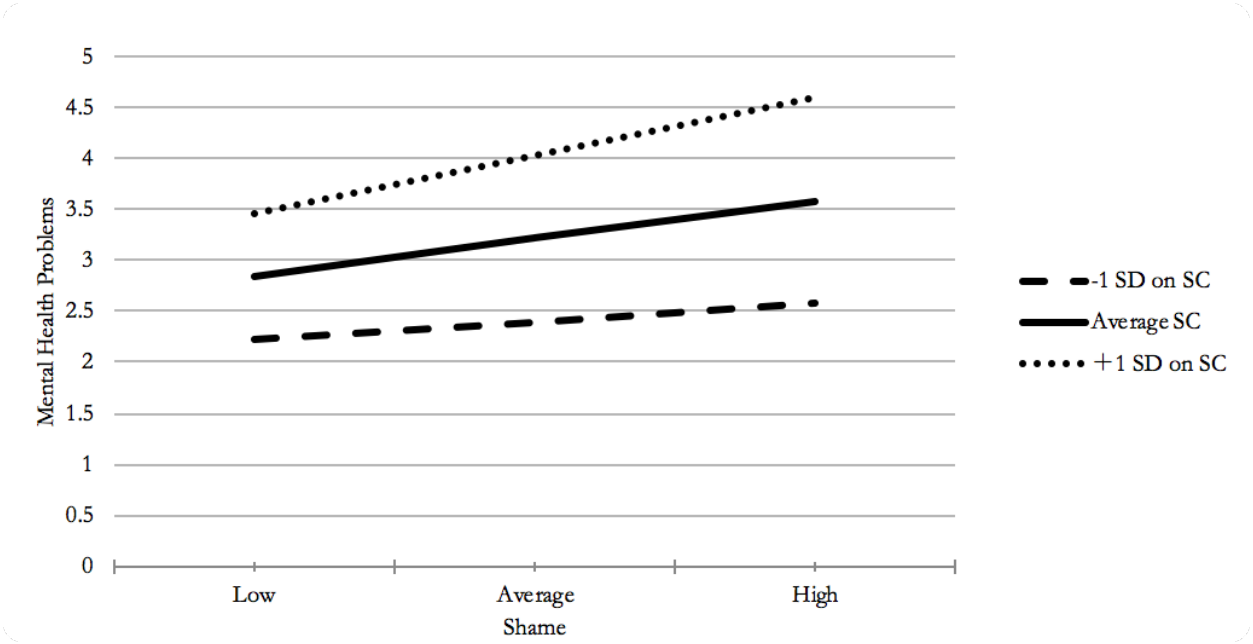

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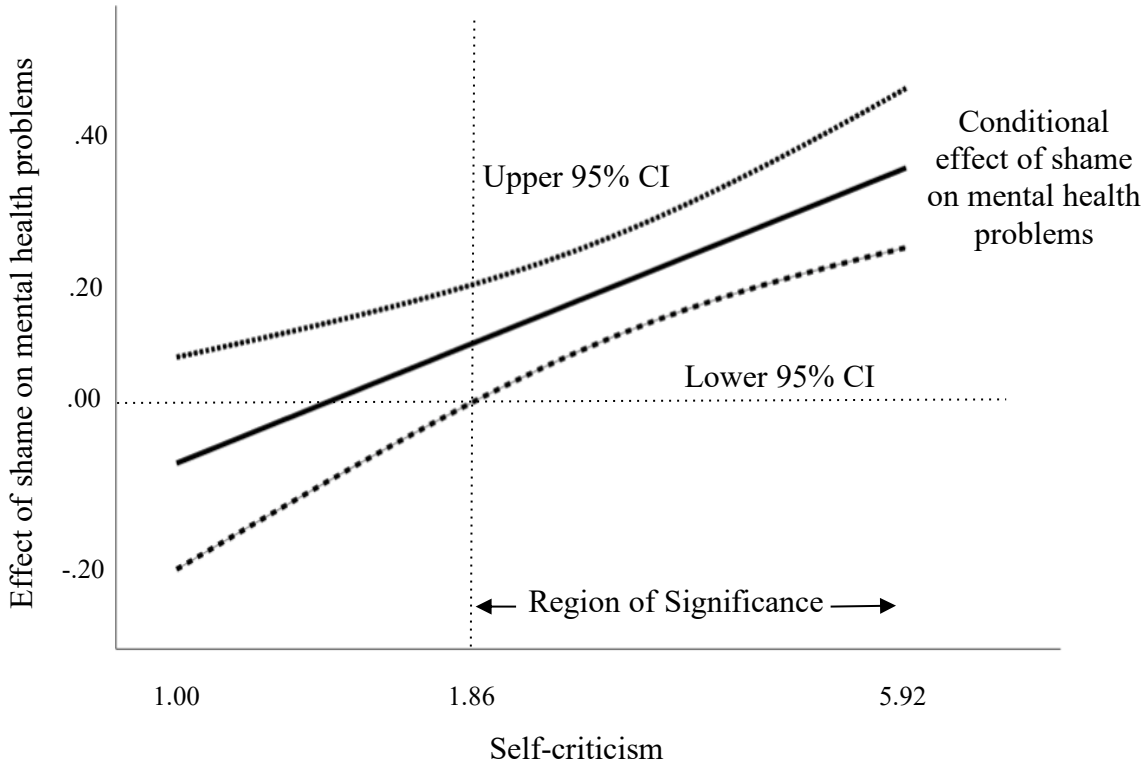

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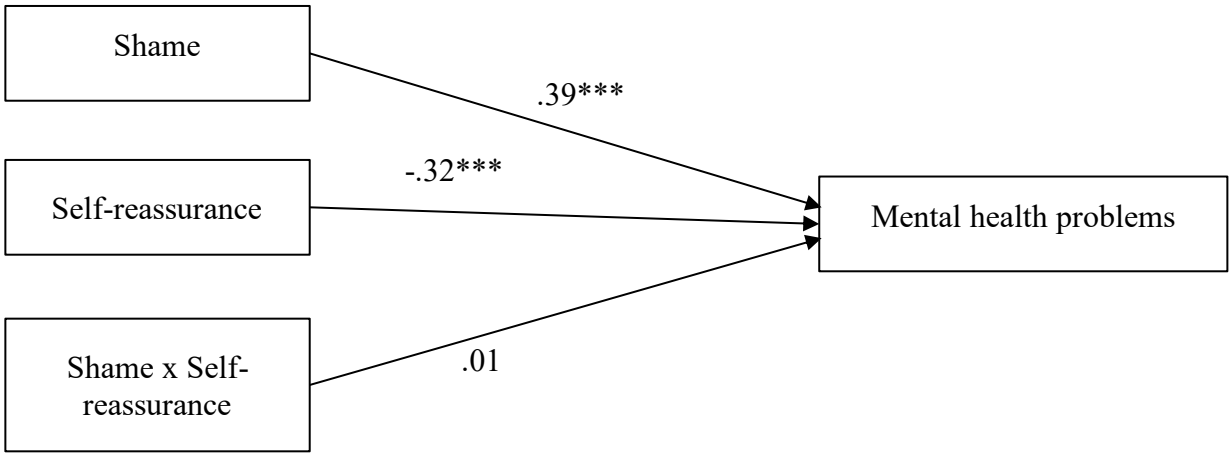

Figure 3. Mediation analysis: Shame predicting mental health problems through self-criticism (95% of confidence intervals and 5,000 bootstrap samples)