Quality of clinical supervision and counselor emotional exhaustion: The potential mediating roles of organizational and occupational commitment

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A B S T R A C T

Counselor emotional exhaustion has negative implications for treatment organizations as well as the health of counselors. Quality clinical supervision is protective against emotional exhaustion, but research on the mediating mechanisms between supervision and exhaustion is limited. Drawing upon data from 934 counselors affiliated with treatment programs in the National Institute on Drug Abuse's Clinical Trials Network (CTN), this study examined commitment to the treatment organization and commitment to the counseling occupation as potential mediators of the relationship between quality clinical supervision and emotional exhaustion. The final ordinary least squares (OLS) regression model, which accounted for the nesting of counselors within treatment organizations, indicated that these two types of commitment were plausible mediators of the association between clinical supervision and exhaustion. Higher quality clinical supervision was strongly correlated with commitment to the treatment organization as well as commitment to the occupation of SUD counseling. These findings suggest that quality clinical supervision has the potential to yield important benefits for counselor well-being by strengthening ties to both their employing organization as well the larger treatment field, but longitudinal research is needed to establish these causal relationships.

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1. Introduction

Burnout has been established as a chronic issue affecting individual and organizational performance in human services (Morse, Salyers, Rollins, Monroe-Devita, & Pfahler, in press; Paris & Hoge, 2010), especially among those engaged in treating substance use disorders (SUDs) (Broome, Knight, Flynn, & Edwards, 2009; Vilardaga et al., 2011). It is among several critical issues affecting this workforce that are cited as affecting its stability, and thus in need of further study (Abt Associates, 2006; The Annapolis Coalition on the Behavioral Health Workforce, 2007). Burnout is a concept that has substantial face validity across many settings of jobs and careers involving repeated role performances. It has been widely studied across multiple occupations, and repeatedly is found to have several distinct dimensions. Within studies of human service workers, emotional exhaustion, or the affective perception that one's emotional resources have been completely expended, has been identified as the most salient component of burnout (Maslach, Schaufeli, & Leiter, 2001; Schaufeli & Taris, 2005).

Workplace supervision clearly affects many dimensions of employees' attitudes and feelings toward their jobs. Within the counseling occupations, a unique form of supervision combines both ongoing direction and evaluation of performance with various forms of job-specific mentoring and training (Powell & Brodsky, 2004). Clinical supervision embeds both organizational and occupational components, with the supervisor representing both the broader performance goals of the organization and a base of experience in the unique skills and core techniques of the occupation, generally at a level that exceeds those of the individuals being supervised (Laschober, de Tormes Eby, & Kinkade, in press). While employees in many organizational settings experience both supervision and mentoring, its formalized combination into a single role has a unique presence in behavioral health treatment organizations.

Not surprisingly, clinical supervision has been cited as a potential buffer against a variety of negative job experiences, implying that such supervision can provide significant support and serve as a source of intrapersonal conflict resolution for direct human service providers (Edwards et al., 2006; Roche, Todd, & O'Connor, 2007). The extent to which this buffering occurs is likely a function of the quality of clinical supervision provided. In this paper, we examine the relationship between the quality of clinical supervision and SUD counselor emotional exhaustion. We elaborate our prior work on this question

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by examining whether counselors' organizational and occupational commitment (which parallel the two functions of clinical supervision) plausibly mediate this relationship.

Preventing or reducing burnout is a managerial challenge. For organizations, emotional exhaustion is costly because it reduces employee job performance (Cropanzano, Rupp, & Byrne, 2003; Wright & Cropanzano, 1998) and increases employee absenteeism (Anagnos-topoulos & Niakas, 2010; Bekker, Croon, & Bressers, 2005; Toppinen-Tanner, Ojajarvi, Vaananen, Kalimo, & Jappinen, 2005). It is linked to other withdrawal behaviors, such as turnover (Cropanzano et al., 2003; Lee & Ashforth, 1996). For employees, emotional exhaustion is detrimental to both physical well-being and quality of life. Prospective studies have documented relationships between emotional exhaustion and the onset of physical health conditions, including type 2 diabetes (Melamed, Shirom, Toker, & Shapira, 2006), cardiovascular disease (Melamed, Shirom, Toker, Berliner, & Shapira, 2006), and musculoskeletal pain (Armon, Melamed, Shirom, & Shapira, 2010). Emotional exhaustion is negatively associated with life satisfaction (Burke & Greenglass, 1995; Demerouti, Bakker, Nachreiner, & Schaufeli, 2000).

We have previously examined emotional exhaustion in the context of clinical supervision and perceptions of organizational justice (Knudsen, Ducharme, & Roman, 2006, 2008). Our interest in clinical supervision was influenced by observing the unique demands and features of this form of supervision as well as research linking supervisor–employee relations to affective perceptions of the workplace (Allen & Eby, 2003; Eisenberger, Stinglhamber, Vandenberghe, Sucharski, & Rhoades, 2002; Stinglhamber & Vandenberge, 2003). Studies of nurses had shown a negative association between clinical supervision and emotional exhaustion (Brunero & Stein-Parbury, 2008; Edwards et al., 2006; Gonge & Buus, 2011), but there had been little research regarding SUD counseling. We initially found a strong negative association between clinical supervision and counselors' self-reported emotional exhaustion, such that more positive appraisals of one's clinical supervisor were associated with lower levels of emotional exhaustion (Knudsen et al., 2008). However, this relationship was mediated by counselors' perceptions regarding organizational justice and job autonomy. The relationships between clinical supervision and these perceptions regarding counselors' jobs and the larger organization were consistent with other studies showing that employees' appraisals about their employer are often inferred from the quality of their relationship with their supervisor (Eisenberger et al., 2002; Maertz, Griffeth, Campbell, & Allen, 2007).

To expand upon our previous work, in this study we consider whether organizational commitment and occupational commitment may also mediate of the relationship between clinical supervision and emotional exhaustion. As described by Meyer, Allen, and Smith (1993), these two types of commitment have three main dimensions: affective commitment (i.e., strong emotional ties), continuance commitment (i.e., ties based on the high costs of changing employers or occupations), and normative commitment (i.e., ties based on a sense of moral obligation).

We focus on the affective dimension of these two types of commitment for two reasons. First, a meta-analysis has shown that work experiences are generally associated with affective organizational commitment, but not the other dimensions (Meyer, Stanley, Herscovitch, & Topolnytsky, 2002). These meta-analytic results suggest that clinical supervision is likely to be relevant for affective commitment but not continuance commitment or normative commitment. Second, affective commitment is associated with organizationally relevant outcomes like turnover, absenteeism and job performance as well as employee well-being (Meyer et al., 2002), suggesting that it is likely to be associated with emotional exhaustion. In addition to a potential role as a mediator, organizational commitment is significant in its own right. Recent research has demonstrated an association between affective organizational

commitment and intentions to leave the field of SUD treatment (Rothrauff, Abraham, Bride, & Roman, 2011), so organizational commitment may have implications beyond the staffing needs of specific SUD treatment programs to the overall size, and hence, capacity of the treatment workforce.

While counselors' organizational commitment has important consequences for SUD treatment organizations and the larger field, counselors' occupational commitment has considerable significance for maintaining workforce capacity. Occupational commitment is distinct from organizational commitment in its emphasis on the ways that employees construct meaningful identities and develop emotional connections based on their membership within a given occupation (Blau, 1985, 1988). Notably, affective occupational commitment is associated with intentions to leave a given occupation (Blau & Holladay, 2006; Chang, Chi, & Miao, 2007), which is why it is a particularly significant construct to consider when examining the SUD treatment workforce.

To date, there have been few studies of the intersections of clinical supervision, commitment, and emotional exhaustion for SUD counselors. Using data collected from SUD counselors working in programs with the National Institute on Drug Abuse's (NIDA) Clinical Trials Network (CTN), our study has two aims. First, we seek to replicate our previous finding regarding the relationship between clinical supervision and emotional exhaustion. Then, we test the hypothesis that organizational and occupational commitment are plausible mediators of the association between clinical supervision and emotional exhaustion.

2. Methods

2.1. Data collection

Data from counselors were collected as part of a larger study of innovation adoption and health services delivery within community treatment programs (CTPs) affiliated with NIDA's CTN. In 2008–2009, research staff scheduled face-to-face interviews with program administrators and/or clinical directors of the CTN's CTPs (Roman, Abraham, Rothrauff, & Knudsen, 2010). To be eligible, CTPs were required to offer either methadone maintenance within an opioid treatment program (OTP) or a level of substance abuse treatment that was, at a minimum, equivalent to the American Society of Addiction Medicine (ASAM) definition of level-1 outpatient services (Mee-Lee, Gartner, Miller, Shulman, & Wilford, 1996). Treatment organizations varied in their available levels of care; some only offered outpatient care, others specialized in residential services, and many offered a mixture of outpatient and residential treatment. Some organizations were housed in a single site, while others consisted of multiple treatment centers, defined as organizational units with autonomous administrators who held discretionary control over their unit's budget. Units that did not deliver treatment (e.g., those limited to intake/assessment, transitional housing, prevention services) were not eligible for the study. Telephone screening identified 238 eligible CTPs. Administrators and/or clinical directors of 198 CTPs participated in face-to-face interviews (response rate = 84.7%), and $150 was donated to participating CTPs.

At the end of these interviews, participants were asked to provide e-mail addresses of counselors working within the CTP who currently carried a caseload of SUD clients. Counselors were e-mailed an invitation to participate in an online survey. Prior to beginning the online survey, counselors were asked to provide informed consent. If counselors preferred to complete a paper-and-pencil questionnaire, the paper version was mailed to them with two consent forms and a postage-paid envelope. A total of 1502 counselors were invited to complete the survey, with 934 counselors deciding to participate (response rate = 62.2%). Counselors who participated received a $50 honorarium. These research