Published in final edited form as:

J Subst Abuse Treat. 2013 February ; 44(2): 186–192. doi:10.1016/j.jsat.2012.05.001.

Mentoring support from clinical supervisors: Mentor motives and associations with counselor work-to-nonwork conflict¹

Tanja C. Laschober, Ph.D.^{*,1}, Lillian Turner de Tormes Eby, Ph.D.^{*,+}, and Katie Kinkade, B.A.⁺

^{*}Institute for Behavioral Research, University of Georgia, Athens, GA, 30602, USA

⁺Industrial and Organizational Psychology Program, University of Georgia, Athens, GA, 30602, USA

Abstract

Based on mentoring theory, social exchange theory, and theories of stress and coping, this study examined antecedents and consequences of the provision of mentoring support by clinical supervisors. Of particular interest is how the provision of mentoring support is further linked to counselor's experience of work-to-nonwork conflict. Survey data were collected in person in 2008 from 418 matched clinical supervisor-counselor dyads who worked in substance use disorder treatment programs across the U.S. Path analysis showed that clinical supervisors' evaluation of relational costs, relational benefits, and overall relationship quality with a particular counselor was related to the counselor's perception of the amount of mentoring support provided. In turn, perceived mentoring support was negatively related to both strain-based and time-based work-to-nonwork conflict among counselors. These findings suggest that counselors and clinical supervisors should be encouraged to build positive social exchanges to help reduce perceptions of counselor work-to-nonwork conflict.

Keywords

work-family; work-to-nonwork conflict; clinical supervision; mentoring

1. Introduction

Work-nonwork conflict can be defined as an imbalance and incompatibility between the demands and obligations at work and life outside of work (e.g., individual, family, community) (Greenhaus & Beutell, 1985). Work-nonwork conflict is negatively related to employees' psychological, physical, and mental well-being and positively related to organizational outcomes such as turnover and absenteeism (for a review, see Eby, Casper, Lockwood, Bordeaux, & Brinley, 2005). Moreover, work-nonwork conflict is a bi-directional construct: work can interfere with nonwork (e.g., stress experienced at work can spillover and create stress at home) and nonwork can interfere with work (e.g., caring for a

¹This research was supported in part by a grant from the National Institutes of Health (R01DA019460) awarded to Lillian T. Eby. The opinions expressed are those of the authors and not the granting agency.

© 2012 Elsevier Inc. All rights reserved.

^{*}Corresponding author. Tel.: 706-542-2174; Fax: 706-542-3275; tanja@uga.edu (T. C. Laschober).

Publisher's Disclaimer: This is a PDF file of an unedited manuscript that has been accepted for publication. As a service to our customers we are providing this early version of the manuscript. The manuscript will undergo copyediting, typesetting, and review of the resulting proof before it is published in its final citable form. Please note that during the production process errors may be discovered which could affect the content, and all legal disclaimers that apply to the journal pertain.

sick child can make one absent from work) (Netemeyer, Boles, & McMurrian, 1996). Given our interest in understanding how experiences in the work domain may lessen work-nonwork conflict, our focus is on work-to-nonwork conflict.

Owing to the growing recognition that work-to-nonwork conflict can be costly to organizations as well as damaging to employees and their families, research has examined work environment factors that may lessen the experience of work-to-nonwork conflict. One consistent finding is that supervisor social support can reduce employee work-to-nonwork conflict (Kossek, Pichler, Bodner, & Hammer, 2011). We also know that more specific forms of support tend to have stronger ameliorative effects than general measures of social support (Kossek et al.).

One specific form of workplace support is mentoring (Kram, 1985). In the substance abuse profession, the clinical supervision process is often referred to as a mentoring relationship (Powell & Brodsky, 2004). Like mentors in other settings, clinical supervisors are more experienced individuals who facilitate counselors' development by overseeing their work through the provision of job-related training, individualized feedback, and coaching (Powell & Brodsky). They also enhance counselors' professional identity and commitment to the agency in which they work by encouraging involvement in the profession and serving as a role model for professional conduct. Clinical supervisors facilitate personal development by acting as an empathetic sounding board, providing emotional support, fostering a relationship with the counselor that is open and trusting, and encouraging both vulnerability and independence (Powell & Brodsky). Research in other occupational contexts finds that those with a mentor tend to experience less work-family conflict (Nielson, Carlson, & Lankau, 2001) and report stronger perceptions of a family-friendly work climate (Foret & de Janasz, 2005). Therefore, we speculate that in the high stress environment of substance use disorder (SUD) treatment, mentoring support provided by clinical supervisors may help reduce work-to-nonwork conflict experienced by counselors.

While we know that supervisors can help reduce work-to-nonwork conflict, supervisory motives for providing such support remain largely unexplored. Drawing on principles of social exchange theory and relational mentoring we examine predictors of counselors' perceptions of mentoring support provided by clinical supervisors, using a matched sample of clinical supervisor-counselor dyads working in SUD treatment programs. We also examine whether counselors' perceptions of mentoring support are associated with lower reports of work-to-nonwork conflict, drawing on principles of stress and coping social support theory (Cohen & Wills, 1985; Lakey & Cohen, 2000).

1.1. Antecedents of Mentoring Support

What might motivate clinical supervisors to provide mentoring support to a particular SUD counselor? This is an important question to address empirically considering the daily challenges facing many clinical supervisors working in SUD treatment. This includes lower than average staff wages (Bureau of Labor Statistics, 2010), vast differences in counselor preparedness due to lack of uniform licensing and credentialing requirements (Culbreth, 1999; McCarty, 2002), high counselor turnover (Eby, Burk, & Maher, 2010; Johnson, Knudsen, & Roman, 2002; Knudsen, Johnson, & Roman, 2003), and high staff burnout rates (Garner, Knight, & Simpson, 2007; Lacoursiere, 2001). Amidst all of these challenges, clinical supervisors may have limited resources (e.g., time, energy, emotional capacity) to provide mentoring support to counselors.

Social exchange theory (Blau, 1964) provides one way to understand the conditions under which supervisors are likely to provide mentoring support to a particular counselor. The theory proposes that humans are rational beings who decide to act out of self-interest for the

purpose of maximizing rewards and minimizing costs (Sabatelli & Sheehan, 1993). Thus, according to social exchange theory, interactions between clinical supervisors and their assigned counselors are based on social economics and as such, supervisors will try to boost their wards and curtail the costs of providing mentoring support.

Rewards can either be gained at the time that mentoring support is provided (e.g., deriving personal satisfaction) or delayed until a future date (e.g., receiving recognition at a later time). The rewards associated with providing mentoring support can also be tangible (e.g., financial incentives, promotions) (Allen, Lentz, & Day, 2006; Kram, 1985) and intangible (e.g., met needs for affiliation, prestige) (Allen, Poteet, Russell, & Dobbins, 1997; Eby & Lockwood, 2005).

However, providing mentoring support can incur costs as well (Eby, Durley, Evans, & Ragins, 2008; Eby & Lockwood, 2005; Eby & McManus, 2004). Specific costs include experiencing problems relating to a counselor (e.g., conflicts, disagreements, personality clashes) and more serious relational problems such as breaches of trust, sabotage, jealousy, and competitiveness toward the mentor (Eby et al., 2008). The most important point, according to social exchange theory, however, is that clinical supervisors will be more likely to provide mentoring support when the perceived rewards are high and the perceived costs are low (Sabatelli & Sheehan, 1993).

Although social exchange theory is useful in understanding why clinical supervisors may provide mentoring support to counselors, not all relational behavior is governed by exchange norms. Communal motives operate in many high quality relationships (Clark & Mills, 1993). With this in mind, relational mentoring theory (Ragins, 2010) argues that relationship quality is important to consider alongside more traditional social exchange constructs to gain a more complete understanding of what happens in mentoring relationships. Moreover, by reflecting positive evaluative feelings about the counselor and relationship as a whole, perceived relationship quality represents something substantively different from the specific exchanges that take place within that relationship (Fletcher & Ragins, 2007; Ragins). Therefore, we also examine mentor reports of relationship quality as a predictor of the amount of mentoring support counselors receive. The argument is that mentors in higher quality relationships will be more motivated to provide mentoring support to counselors due to the mutuality, engagement, and positive affect that is generated in the relationship.

To date, no studies have examined the relationship between clinical supervisor motives for providing mentoring support to their SUD counselors. However, based on the tenets of social exchange theory and relational mentoring theory, we expect that clinical supervisors will consider relational rewards, relational costs, and relationship quality when making decisions about the amount of mentoring support to provide to counselors. Thus, we test the following hypotheses:

H1: Clinical supervisors' evaluation of the costs of their relationship with a specific counselor is negatively related to that counselor's perceptions of the amount of mentoring support provided.

H2: Clinical supervisors' evaluation of the benefits of their relationship with a specific counselor is positively related to that counselor's perceptions of the amount of mentoring support provided.

H3: Clinical supervisors' evaluation of the overall quality of the relationship with a specific counselor is positively related to that counselor's perceptions of the amount of mentoring support provided.

1.2. Consequences of Perceived Mentoring Support on Counselor Work-to-nonwork Conflict: Stress and Coping Social Support Theory

In addition to examining the relationship between the antecedents of clinical supervisor mentoring support, we investigate the consequences of mentoring support on counselor work-to-nonwork conflict using stress and coping social support theory (Cohen & Wills, 1985; Lakey & Cohen, 2000). Work-to-nonwork conflict is a specific form of stress that can manifest in strain-based conflict and time-based conflict. Strain-based work-to-nonwork conflict refers to strain reactions that are generated at work and then transferred to the nonwork domain (e.g., an argument with someone at work leads to feelings of anxiety once at home) (Greenhaus & Beutell, 1985). Time-based work-to-nonwork conflict refers to time demands in the work role that restrict the amount of time that can be spent in the nonwork role (e.g., overtime at work reduces the amount of time one can spend with family) (Greenhaus & Beutell).

According to stress and coping social support theory, support from others can reduce perceptions of stress. Support can either be actual supportive behavior received or perceived support. When people receive social support, coping is increased, which can reduce stress (Cohen & Wills, 1985; Viswesvaran, Sanchez, & Fisher, 1999). This is because when people perceive that social support is given or available, stressful situations are likely to be appraised as less stressful. Because mentoring has been conceptualized as a form of social support (Nelson & Quick, 1991; Sánchez, Reyes, & Singh, 2006), we expect that counselors who experience more mentoring support experience less stress in the form of work-to-nonwork conflict.

In terms of the type of mentoring support that is most likely to reduce work-to-nonwork conflict, psychosocial mentoring support should be particularly important. This is because psychosocial mentoring support consists of friendship, role modeling, counseling, acceptance and confirmation, and advocacy. As such, it may help lessen the emotional toll of counseling patients, help counselors develop more effective coping strategies and increase their efficacy in dealing with difficult patients. In turn, this may reduce the spillover of work strain into the nonwork domain. Moreover, the highly personalized nature of psychosocial mentoring may manifest in greater care and concern for counselors' work-nonwork obligations, which in turn may afford counselors greater scheduling flexibility to meet nonwork demands. This has the potential to reduce perceptions of time-based work-to-nonwork conflict.

In summary, drawing on the principles of stress and coping social support theory, we expect the following:

H4: Counselors' perceptions of mentoring support from clinical supervisors are negatively related to their own strain-based work-to-nonwork conflict.

H5: Counselors' perceptions of mentoring support from clinical supervisors are negatively related to their own time-based work-to-nonwork conflict.

2. Materials and Methods

2.1. Study Design and Sample

We used data from the 2008 Managing Effective Relationships in Treatment Services (MERITS I) project. MERITS I is carried out by researchers affiliated with the University of Georgia for the purpose of investigating the experiences of clinical supervisors and counselors who work in diverse SUD treatment programs across the U.S. MERITS I is a national longitudinal project that is funded by the National Institute on Drug Abuse (NIDA). Twenty-six treatment organizations with a total of 104 locations that were affiliated with

NIDA's Clinical Trials Network (CTN) participated in Project MERITS I in 2008. The number of locations per organization varied from 1 to 11. The number of counselors as well as the number of supervisors per location ranged from 1-20. All procedures were approved by the Institutional Review Board at the University of Georgia.

Treatment organizations are defined as autonomous, free-standing operational units that are located in the community. That means that Veteran's Health Administration organizations, prison-based organizations, and driving-under-the-influence schools were excluded from participating. Treatment organizations received \$1,000 compensation in addition to \$50 per completed counselor survey and \$75 per completed clinical supervisor survey to offset the staff time required to collect the data during normal business hours.

According to administrator reports from each organization, the majority of treatment organizations were non-profit entities (88.5%), free-standing units not located on a hospital campus (92%), and accredited (72%). The vast majority of organizations offered in-patient services for both adults and adolescents (88.5%) and 82.6% adhered to an eclectic treatment modality rather than a primarily 12-step based modality. Further, treatment organizations employed an average of 10.65 ($SD = 10.95$; Range = 1-52) clinical supervisors and 56.33 ($SD = 45.93$; Range = 8-195) counselors. Finally, organizations were located across all major regions of the U.S. with 23.1% in the East, 11.5% in the Midwest, 26.9% in the South, and 38.5% in the West.

Survey data were obtained in person via paper-and-pencil surveys from 164 clinical supervisors and 418 of their SUD counselors who worked under their supervision. This yielded a sample size of 418 matched clinical supervisor-counselor dyads. To meet eligibility requirements, counselors had to have direct contact with patients in a therapeutic relationship. The majority of counselors were certified and/or licensed SUD professionals (54.4%), women (64.3%), non-Hispanic White (64.3%), held a master's degree or higher (52.2%), were not married (63.5%), and did not have children living at home (65.4%). In addition, the average counselor was 44.2 years old ($SD = 12.4$), worked 42.6 hours per week ($SD = 7.2$), and earned \$34,540 ($SD = \$9,780$) per year. Salaries varied by region where the organization was located with average counselor earnings of \$37,903 ($SD = 9,352$) reported in the Northeast, \$36,896 ($SD = 10,319$) in the Midwest, \$29,892 ($SD = 4,789$) in the Southeast, and \$34,893 ($SD = 10,865$) in the West. The participant response rate for counselors was 73%.

Clinical supervisors had to have written and/or face-to-face supervision with their counselors. On average, clinical supervisors completed performance appraisals on 2.5 counselors (range 1-8 counselors). Similar to counselors, the majority of supervisors were certified and/or licensed SUD professionals (78.3%), women (67.5%), non-Hispanic White (79.6%), held a master's degree or higher (75.1%), were not married (52.8%), and did not have children living at home (66.2%). In addition, the average clinical supervisor was 46.9 years old ($SD = 0.8$), worked 46.9 hours per week ($SD = 8.7$), and earned \$53,404 ($SD = \$16,132$) per year. Salaries also varied by region where the organization was located with average clinical supervisor earnings of \$56,472 ($SD = 10,464$) reported in the East, \$53,195 ($SD = 10,805$) in the Midwest, \$45,250 ($SD = 8,052$) in the South, and \$55,787 ($SD = 21,215$) in the West. The participant response rate for clinical supervisors was 91%.

Importantly, we note that organizational and SUD professional characteristics of the current sample are in general similar to research conducted using large, nationally representative samples. For instance, Montoya (2006) using data from the National Survey of Substance Abuse Treatment Services (N-SSATS) noted that 12% of their treatment programs were hospital-based (8% in our study) and 55% of clinicians were certified SUD professionals

(54.4% in our study). Knudsen et al. (2010) using data from the National Treatment Center Study (NTCS) showed that 13.80% of organizations operated for-profit (11.5% in our study) and 20.8% were hospital-based. Abraham et al. (2011), also using data from the NTCS, reported that 71.30% of centers were accredited (72% in our study).

2.2. Measures

Supervisors' evaluation of the relational costs associated with providing mentoring support to their counselors was measured using two scales: destructive relationship patterns (15 items) and interpersonal problems (12 items). These scales have been developed based on three separate studies that examined content-related validity, factor structure via confirmatory factor analysis, and criterion-related validity (Eby et al., 2008). An example item of the destructive relationship pattern scale is, "This counselor tries to damage my reputation at work." An example item from the interpersonal problems scale is, "This counselor and I have conflicting personalities." The scale was created by calculating the mean across the 27 items (see Table 1 for coefficient alpha). Response options were reported on a Likert-type scale and ranged from 1 = *strongly disagree* to 5 = *strongly agree*.

Supervisors' evaluation of the relational benefits associated with giving mentoring support to the counselor was assessed with a modified version of Ragins and Scandura's (1999) scale. The scale focuses on mentoring as a rewarding experience (7 items; e.g., "Serving as a clinical supervisor to this counselor is one of the most positive experiences of my career."), as improving one's own job performance (6 items; e.g., "Providing clinical supervision to this counselor has a positive impact on my job."), and as creating a loyal base of support from the counselor (2 items; e.g., "This counselor is a trusted ally."). The scale showed construct validity evidence in the form of exploratory factor analysis, has been used in dozens of studies on mentor's perspective on mentoring relationships, and has demonstrated associations with other constructs as predicted by theory (e.g., see Eby et al., 2008). The scale was created by calculating the mean across the 15 items (see Table 1 for coefficient alpha). Response options were reported on a Likert-type scale and ranged from 1 = *strongly disagree* to 5 = *strongly agree*.

Supervisors' evaluation of the overall relationship quality with the counselor was assessed using Allen and Eby's (2003) 4-item measure. This measure was developed using confirmatory factor analysis and has been used extensively in research on mentoring. An example item is, "The relationship between this counselor and I is very effective." Response options were reported on a Likert-type scale and ranged from 1 = *strongly disagree* to 5 = *strongly agree* (see Table 1 for coefficient alpha).

Counselors' perceptions of mentoring support received was measured with a shortened version of Ragins and McFarlin's (1990) scale, which is one of the most widely used and psychometrically sound measure of psychosocial support that addresses friendship (3 items; e.g., "My clinical supervisor is someone I can trust."), role modeling (3 items; e.g., "My clinical supervisor serves as a role model for me."), counseling (3 items; e.g., "My clinical supervisor guides my professional development), acceptance and confirmation (3 items; e.g., "My clinical supervisor accepts me as a competent professional."), and advocacy (2 items; e.g., "My clinical supervisor forwards my suggestions to decision-makers within the organization."). The scale was created by calculating the mean across the 14 items (see Table 1 for coefficient alpha). Response options were reported on a Likert-type scale and ranged from 1 = *strongly disagree* to 5 = *strongly agree*.

Counselors' work-to-nonwork conflict was measured with two scales—strain-based work-to-nonwork conflict (3 items) and time-based work-to-nonwork conflict (3 items) (Carlson, Kacmar, & Williams, 2000). These scales are among the most extensively used in published

research and provide evidence of content adequacy, dimensionality, reliability, factor structure invariance, and construct validity. An example item of strain-based conflict is, "When I get home from work I am often too frazzled to participate in nonwork activities." An example item of time-based conflict is, "My work keeps me from my nonwork activities more than I would like." Response options for both scales were reported on a Likert-type scale and ranged from 1 = *strongly disagree* to 5 = *strongly agree* (see Table 1 for coefficient alphas).

Separate *control variables* were included to test hypotheses 1-3 and hypotheses 4 and 5. Previous research finds a significant association between more frequent contact and perceptions of mentoring (Arnold & Johnson, 1997; Lankau & Scandura, 2002; Parise & Forret, 2008). Therefore, in the models predicting perceptions of mentoring support, we controlled for clinical supervisor reports on the mean number of hours spent supervising (interacting with and providing feedback) the counselor and the number of years supervising the counselor. In models predicting counselor perceptions of work-to-nonwork conflict, three control variables were included: counselor gender (0=*male*, 1 = *female*), presence of children living at home (0=*no*, 1 = *yes*), and marital status (0=*single*, 1 = *married or cohabiting*). In an extensive review of the work-family literature, Eby et al. (2005) found differences in work-nonwork conflict between men and women, parents and non-parents, and married and single adults.

2.3. Data Analyses

Descriptive statistics were first calculated for all variables. Correlations were then run to examine relationships among all study variables (see Table 1 for descriptive statistics, intercorrelations, and coefficient alphas). Path analysis with mixed-method models was used to test the hypotheses shown graphically in Figure 1. Path analysis is an extension of multiple regression and is used to obtain estimates of the significance and magnitude of hypothesized causal paths between variables (see Pedhazur, 1997 for a detailed explanation). Path models differ from structural equation models in a few important ways. First, with path analysis there are only observed (manifest) variables whereas in structural equations models latent variables are used to test the hypothesized model. Second, with path analysis there is no estimation of a measurement model. Third, path analysis consists of a series of separate regression equations where parameters (paths) are estimated for each variable in the model only taking into account direct effects. In other words, path analysis does not consider (or estimate) intercorrelations among all model variables.

Considering the nested structure of the data (i.e., counselors within supervisors within organizations), we examined intraclass correlation coefficients (ICCs) to determine whether mixed-model statistical methods rather than standard multiple regressions are required to analyze the data. ICCs for supervisor nesting were .09 for counselor strain-based work-to-nonwork conflict, .16 for counselor time-based work-to-nonwork conflict, and .18 for counselor perceived supervisor mentoring support. ICCs for organization nesting were .03 for counselor strain-based work-to-nonwork conflict, .12 for counselor time-based work-to-nonwork conflict, and .11 for counselor perceived supervisor mentoring support. Because generally accepted rules indicate that ICCs greater than .10 suggest a fair amount of clustering, we used mixed-models for the path analysis to account for the nested structure of the data (counselors within supervisors within organizations).

Hypotheses 1 to 3 were tested by entering supervisor relation costs, relational benefits, relationship quality, and two control variables (supervisor reports of the number of hours spent supervising the counselor per week and the number of years supervising the counselor) at the same time in the mixed-model predicting counselor perceived supervisor mentoring support. Hypotheses 4 and 5 were tested by entering counselor perceived supervisor

mentoring support and three control variables (counselor gender, marital status, and presence of children) at the same time in the mixed-model predicting counselor strain-based work-to-nonwork conflict and the mixed-model predicting counselor time-based work-to-nonwork conflict.

Finally, we conducted post-hoc tests using general linear models with the lsmeans option to provide an in-depth description and comparison of the subscales that were used to create the overall measures of mentor costs, mentor benefits, and counselor mentoring support. These additional analyses allowed us to statistically examine the types of greatest mean costs and mean benefits that mentors report as well as the types of greatest mean mentoring support counselors report receiving from clinical supervisors.

3. Results

The results of the path analysis are shown in Figure 1. Hypothesis 1 was supported. As clinical supervisors reported greater costs in the mentoring relationship, counselors reported receiving significantly less mentoring support, which confirmed our first hypothesis ($B = -.39$, $SE = .09$, $F = 18.01$, $p < .001$). Hypothesis 2 was also supported. As clinical supervisors reported greater benefits in the relationship with their counselor, counselors reported receiving significantly more mentoring support ($B = .18$, $SE = .09$, $F = 4.41$, $p < .05$). Finally, in support of hypothesis 3, as clinical supervisors reported higher overall relationship quality, counselors reported receiving more mentoring support ($B = .24$, $SE = .09$, $F = 7.30$, $p < .01$). The control variables were not significantly related to counselors' perceived supervisor mentoring support ($B = .01$, $SE = .01$, $F = .59$, $p > .05$ for hours spent supervising counselor; $B = -.01$, $SE = .02$, $F = .15$, $p > .05$ for years supervising counselor).

Supporting hypothesis 4, when counselors reported more mentoring support, strain-based work-to-nonwork conflict was significantly lower ($B = -.18$, $SE = .06$, $F = 9.49$, $p < .05$). Counselors' gender, marital status, and number of children were not significantly related to their strain-based work-to-nonwork conflict ($B = .05$, $SE = .12$, $F = .17$, $p > .05$; $B = -.20$, $SE = .12$, $F = 2.85$, $p > .05$; $B = -.11$, $SE = .12$, $F = .74$, $p > .05$, respectively).

Hypothesis 5 was supported. When counselors reported more mentoring support, time-based work-to-nonwork conflict was significantly lower ($B = -.18$, $SE = .06$, $F = 9.48$, $p < .01$). Counselors' gender, marital status, and number of children were not significantly related to their time-based work-to-nonwork conflict ($B = -.10$, $SE = .11$, $F = .77$, $p > .05$; $B = -.17$, $SE = .11$, $F = 2.40$, $p > .05$; $B = -.20$, $SE = .12$, $F = 2.86$, $p > .05$, respectively).

3.1. Post-Hoc Analysis

To gain a better understanding of the types of costs and benefits that clinical supervisors might perceive as most important for mentoring motivation, we further examined the two subscales of mentor costs (destructive relationship patterns, interpersonal problems) and the three subscales of mentor benefits (rewarding experience, improved job performance, counselor loyalty). There were no significant differences in cost perceptions [$F(1,417) = 1.59$, $p = .207$] between destructive relationship patterns ($M = 1.71$, $SD = .65$) and interpersonal problems ($M = 1.77$, $SD = .63$). However, with regards to benefits, we found significant differences among the three subscales [$F(2, 416) = 26.15$, $p < .0001$]. Counselor loyalty had a significantly higher mean ($M = 3.66$, $SD = .90$) than rewarding experience ($M = 3.37$, $SD = .76$) and improved job performance ($M = 3.28$, $SD = .74$). No significant differences were found between the latter two subscales.

Further, we examined the five subscales of counselors' perceived received mentoring support to try to understand the types of support that might matter most to counselors and

found significant differences among the five subscales [$F(4,414) = 34.95, p < .0001$]. Perceptions of acceptance and confirmation from the supervisor received the highest and a significantly different mean ($M = 3.99, SD = .88$) compared to friendship ($M = 3.68, SD = 1.10$), advocacy ($M = 3.41, SD = 1.03$), role modeling ($M = 3.32, SD = 1.15$), and counseling ($M = 3.26, SD = 1.09$). Moreover, the friendship mean was significantly higher than advocacy, role modeling, and counseling means. The advocacy mean was also significantly higher than the counseling mean.

4. Discussion

The primary purpose of this study was to examine the antecedents of mentoring support as provided by clinical supervisors to help fill the gap on research on supervisor-supervisee interactions. The secondary purpose was to assess the consequences of counselors' perceptions of mentoring support on their work-to-nonwork conflict. As hypothesized, counselors reported receiving more mentoring support when clinical supervisors believed that there were fewer relational costs, greater relational benefits, and that there was higher overall relationship quality. In turn, and also as hypothesized, counselors who reported more mentoring support experienced less strain-based and less time-based work-to-nonwork conflict.

4.1. Antecedents of Clinical Supervisor Mentoring Support

This study extends the literature on mentoring support by applying the principles of social exchange theory (Blau, 1964; Sabatelli & Sheehan, 1993) and relational mentoring (Fletcher & Ragins, 2007; Ragins, 2010) to explore the antecedents of providing mentoring support from the supervisor's perspective. Our results suggest that clinical supervisors are evaluating the costs and benefits of providing mentoring support to their counselors along with the overall relationship they have with their counselors. In turn, these relational perceptions predict the amount of mentoring support supervisors ultimately provide to counselors. When the clinical supervisor perceives high costs associated with providing support to a particular counselor, that counselor perceives lower levels of mentoring support.

By contrast, when a clinical supervisor perceives more benefits from a particular clinical supervisory relationship, their counselor perceives more mentoring support. These results imply that social economics are at work: clinical supervisors are assessing the potential positive or negative impact that providing mentoring support will have on them, and this may drive mentoring behavior aimed at their counselors. Given the many benefits that result from supervisory mentoring support, it is critically important for researchers and practitioners to know what may increase or decrease the likelihood for clinical supervisors to give such support. Additional research aimed at understanding supervisory motives will help address why a supervisor may or may not be engaging in supportive behavior with a particular counselor.

In an attempt to better understand the overall pattern of costs and benefits as mentoring motives for supervisors, we found in post-hoc analyses that regarding costs, destructive relationship patterns and interpersonal problems were perceived similarly. However, regarding benefits, clinical supervisors appear to place a greater emphasis on counselors' loyalty as a motive for providing mentoring support compared to mentoring being a rewarding experience and mentoring improving their own job performance. Thus, it may be that fostering loyalty-related aspects such as trust, allegiance, and fidelity between supervisor and counselor helps to increase mentoring support.

4.2. Consequences of Clinical Supervisor Mentoring Support

This study also demonstrates that counselors who perceive more mentoring support from their clinical supervisor tend to report less work-to-nonwork conflict. This extends existing research on mentoring by finding that it is not just the presence of a mentor that is related to less work-family conflict (Nielson et al., 2001) but also the amount of mentoring support that is provided if one has a mentor.

In an attempt to also understand the most important aspects of counselors' perceptions of mentoring support that are linked to work-to-nonwork conflict, we found in post-hoc analyses of the subscales that acceptance and confirmation from the supervisor as well as friendship with the supervisor appear to be most important compared to role modeling, counseling, and advocating. It may be that feelings of being personally valued as an employee as well as a friend helps counselors build positive perceptions that spillover into the nonwork domain more so than perceptions of mentoring support that is more geared toward professional development.

4.3. Practical Implications, Limitations, and Conclusion

Because research has demonstrated negative consequences associated with work-to-nonwork conflict (Eby et al., 2005), our finding of lower nonwork conflict when counselors perceive higher levels of clinical supervisor mentoring support suggests an important point of intervention to potentially reduce counselor work-nonwork conflict. To this end, we offer several practical implications for organizations, supervisors, and counselors all centered on the importance of increasing the positive social exchanges and relational mentoring between clinical supervisors and counselors. First, organizations can help supervisors increase their perceptions of benefits related to working with particular counselors, improve their relationship with counselors, and decrease the relational costs of providing mentoring support. This can be accomplished by providing training on interpersonal competence, relationship building skills, and conflict resolution assistance. In addition, organizations can consider selecting clinical supervisors into management based on interpersonal and leadership skills rather than just technical skills, and encouraging training or continuing education opportunities that will help supervisors hone their leadership and mentoring skills. Second, supervisors and counselors can be encouraged to reflect on their attitudes, reactions, and behaviors toward others with whom they perceive negative interactions. Mediation may further help improve the supervisor-supervisee relationship when the dyad cannot work through their issues. Supervisors can also promote mentorship support by having an "open door policy" so employees feel comfortable approaching them with personal and professional concerns, provide a family friendly environment, be sensitive to nonwork responsibilities, and allow flexible scheduling.

Limitations of our study should be taken into consideration when interpreting and generalizing the findings. We restricted our exploration of antecedents of mentoring support to clinical supervisors' evaluations of a particular relationship with a counselor. Other research has found that more stable individual differences on the part of the mentor may also influence mentoring provided. This includes general motives for mentoring others (Allen, 2003) as well as mentor personality characteristics, locus of control, and upward striving (Allen et al., 1997). Future research is needed to examine both relationship-specific motives (e.g., specific costs and benefits) as well as general motives for mentoring (e.g., self-focused versus other-focused motives; Allen) in order to gain a more comprehensive understanding of the motives for providing mentoring support to counselors. In terms of antecedents of mentoring support, it is likely that relational costs, relational benefits, and relationship quality are related in more complex ways than are depicted in Figure 1. Because no published research has examined these constructs in relation to one another, we have no

empirical research to use as a guide to hypothesize more nuanced effects. Moreover, the cross-sectional nature of our data gives us pause to propose that relational costs and benefits predict relationship quality or vice versa. This represents an important avenue for future research.

Another limitation of our study is the use of a cross-sectional design, which limits our interpretation to the relationship between clinical supervisors' evaluation of costs, benefits, and overall relationship quality and counselors' perception of their supervisors' mentoring support. This is true despite the use of strong theoretical linkages that support the use of path analysis. Longitudinal studies will provide insights into the direction of the influence of antecedents of mentoring support on reducing work-to-nonwork conflict as well as an understanding of changes in perceived mentoring support and work-to-nonwork conflict.

In conclusion, our findings support previous research in fields outside of SUD treatment suggesting that greater clinical supervisor support is related to lower work-to-nonwork conflict among supervisees. In addition, clinical supervisors' motives such as mentoring costs, benefits, and relationship quality for providing counselor mentoring support are linked to work-to-nonwork conflict. This finding suggests that it is important to not only consider the type and extent of support that is given to counselors, but also supervisors' motives for providing mentoring support. Counselors and clinical supervisors should be made aware of and encouraged to create positive social exchanges, foster quality relationships, and promote mentoring support to help address and reduce counselors' work-to-nonwork conflict, likely increase well-being, and possibly promote positive outcomes for organizations such as reduced turnover and improved performance.

References

- Abraham AJ, Knudsen HK, Roman PM. A longitudinal examination of alcohol pharmacotherapy adoption in substance use disorder treatment programs: Patterns of sustainability and discontinuation. *Journal of Studies on Alcohol and Drugs*. 2011; 72:669–677. [PubMed: 21683049]
- Allen TD. Mentoring others: A dispositional and motivational approach. *Journal of Vocational Behavior*. 2003; 62:134–154.
- Allen TD, Eby LT. Relationship effectiveness for mentors: Factors associated with learning and quality. *Journal of Management*. 2003; 29:465–486.
- Allen TD, Lentz E, Day R. Career success outcomes associated with mentoring others: A comparison of mentors and nonmentors. *Journal of Career Development*. 2006; 32:272–285.
- Allen TD, Poteet ML, Russell JEA, Dobbins GH. A field study of factors related to supervisors' willingness to mentor others. *Journal of Vocational Behavior*. 1997; 50:1–22.
- Arnold J, Johnson K. Mentoring in early career. *Human Resource Management Journal*. 1997; 7:61–70.
- Blau, P. *Exchange and power in social life*. New York: Wiley; 1964.
- Bureau of Labor Statistics, U.S. Department of Labor. *Occupational Outlook Handbook*, 2010-11 Edition, Counselors. 2010. Retrieved April 15, 2012, from <http://www.bls.gov/oco/ocos067.htm>
- Carlson DS, Kacmar KM, Williams LJ. Construction and initial validation of a multidimensional measure of work–family conflict. *Journal of Vocational Behavior*. 2000; 56:249–276.
- Clark MS, Mills J. The difference between communal and exchange relationships. *Personality and Social Psychology Bulletin*. 1993; 19:684–691.
- Cohen S, Wills TA. Stress, social support, and the buffering hypothesis. *Psychological Bulletin*. 1985; 98:310–357. [PubMed: 3901065]
- Culbreth JR. Clinical supervision of substance abuse counselors: Current and preferred practices. *Journal of Addictions and Offender Counseling*. 1999; 20:15–25.

- Eby LT, Burk H, Maher CP. How serious of a problem is staff turnover in substance abuse treatment? A longitudinal study of actual turnover. *Journal of Substance Abuse Treatment*. 2010; 39:264–271. [PubMed: 20675097]
- Eby LT, Casper W, Lockwood A, Bordeaux C, Brinley A. Work and family research in IO/OB: Content analysis and review of the literature (1980-2002). *Journal of Vocational Behavior*, Monograph. 2005; 66:124–197.
- Eby LT, Durley J, Evans SC, Ragins BR. Mentors' perceptions of negative mentoring experiences: Scale development and nomological validation. *Journal of Applied Psychology*. 2008; 93:358–373. [PubMed: 18361638]
- Eby LT, Lockwood A. Protégés and mentors' reactions to participating in formal mentoring programs: A qualitative investigation. *Journal of Vocational Behavior*. 2005; 67:441–458.
- Eby LT, McManus SE. The protégé's role in negative mentoring experiences. *Journal of Vocational Behavior*. 2004; 65:255–275.
- Fletcher, JK.; Ragins, BR. Stone Center Relational Cultural Theory: A window on relational mentoring. In: Ragins, BR.; Kram, KE., editors. *The handbook of mentoring at work: Theory, research and practice*. Thousand Oaks: Sage; 2007. p. 373-399.
- Foret M, de Janasz S. Perceptions of an organization's culture for work and family: Do mentors make a difference? *Career Development International*. 2005; 10:478–492.
- Garner BR, Knight K, Simpson DD. Burnout among corrections-based drug treatment staff: Impact of individual and organizational factors. *International Journal of Offender Therapy and Comparative Criminology*. 2007; 51:510–522. [PubMed: 17615435]
- Greenhaus JH, Beutell NJ. Sources of conflict between work and family roles. *Academy of Management Review*. 1985; 10:76–88.
- Johnson JA, Knudsen H, Roman PM. Counselor turnover in private facilities. *Frontlines: Linking Alcohol Services Research & Practice*. 2002; 5:8.
- Knudsen HK, Johnson JA, Roman P. Retaining counseling staff at substance abuse treatment centers: Effects of management practices. *Journal of Substance Abuse Treatment*. 2003; 24:129–135. [PubMed: 12745030]
- Knudsen HK, Studts JL, Boyd S, Roman PM. Structural and cultural barriers to the adoption of smoking cessation services in addiction treatment organizations. *Journal of Addictive Diseases*. 2010; 29:294–305. [PubMed: 20635279]
- Kossek EE, Pichler S, Bodner T, Hammer LB. Workplace social support and work-family conflict: A meta-analysis clarifying the influence of general and work-family specific supervisor and organizational support. *Personnel Psychology*. 2011; 64:289–313. [PubMed: 21691415]
- Kram, KE. *Mentoring at work*. Glenview, IL: Scott, Foresman; 1985.
- Lacoursiere RB. "Burnout" and substance user treatment: The phenomenon and the administrator-clinician's experience. *Substance Use and Misuse*. 2001; 36:1839–1874. [PubMed: 11795582]
- Lakey, B.; Cohen, S. Social support theory and measurement. In: Cohen, S.; Underwood, L.; Gottlieb, B., editors. *Measuring and intervening in social support*. New York: Oxford University Press; 2000. p. 29-52.
- Lankau MJ, Scandura TA. An investigation of personal learning in mentoring relationships: Content, antecedents and consequences. *Academy of Management Journal*. 2002; 45:779–790.
- McCarty, D. *Frontlines*. Washington, DC: Academy Health; 2002. The alcohol and drug abuse treatment workforce; p. 1-2.
- Montoya ID. Differences in drug treatment services based on profit status. *Journal of Psychoactive Drugs*. 2006; 38:219–228. [PubMed: 17165364]
- Nelson DL, Quick JC. Social support and newcomer adjustment in organizations: Attachment theory at work? *Journal Of Organizational Behavior*. 1991; 12(6):543–554.
- Netemeyer RG, Boles JS, McMurrian R. Development and validation of work-family conflict and family-work conflict scales. *Journal of Applied Psychology*. 1996; 81:400–410.
- Nielson TR, Carlson DS, Lankau MJ. The supportive mentor as a means of reducing the work-family conflict. *Journal of Vocational Behavior*. 2001; 59:364–381.

- Parise MR, Forret ML. Formal mentoring programs: The relationship of program design and support to mentors' perceptions of benefits and costs. *Journal of Vocational Behavior*. 2008; 72:225–240.
- Pedhazur, EJ. Multiple regression in behavioral research Explanation and prediction. 3. Orlando, FL: Harcourt Brace College Publishers; 1997.
- Powell, DJ.; Brodsky, A. Clinical supervision in alcohol and drug abuse counseling: Principles, models, methods. San Francisco: Jossey-Bass; 2004.
- Ragins, BR. Relational mentoring: A positive approach to mentoring at work. In: Cameron, K.; Spreitzer, G., editors. *The Handbook of Positive Organizational Scholarship*. New York: Oxford University Press; 2010. p. 519-536.
- Ragins BR, McFarlin DB. Perceptions of mentor roles in cross-gender mentoring relationships. *Journal of Vocational Behavior*. 1990; 37:321–339.
- Ragins BR, Scandura TA. Burden or blessing? Expected costs and benefits of being a mentor. *Journal of Organizational Behavior*. 1999; 20:493–509.
- Sabatelli, RM.; Sheehan, CL. Exchange and resource theories. In: Boss, PG.; Doherty, WJ.; LaRossa, R.; Schumm, WR.; Steinmetz, SK., editors. *Sourcebook of family theories and methods: A contextual approach*. New York: Plenum Press; 1993. p. 385-411.
- Sánchez B, Reyes O, Singh J. A qualitative examination of the relationships that serve a mentoring function for Mexican American older adolescents. *Cultural Diversity and Ethnic Minority Psychology*. 2006; 12(4):615–631.10.1037/1099-9809.12.4.615 [PubMed: 17087524]
- Viswesvaran C, Sanchez JI, Fisher J. The role of social support in the process of work stress: A meta-analysis. *Journal of Vocational Behavior*. 1999; 54:314–334.

Figure 1.
Path Analysis Results

Table 1

Descriptive Statistics of and Correlations among Study Variables

	1.	2.	3.	4.	5.	6.	7.	8.	9.	10.	11.
1. Counselor strain-based conflict	.92	.67***	-.16**	.08	.01	-.02	.03	-.10*	-.07	-.00	-.06
2. Counselor time-based conflict		.90	-.15**	.11*	-.01	-.08	-.04	-.09	-.11*	-.01	-.14**
3. Counselor mentoringsupport			.97	-.39***	.35***	.42***	-.04	.00	.04	.08	.02
4. Supervisor relational costs				.96	-.43***	-.61***	-.04	.03	-.01	.04	-.02
5. Supervisor relational benefits					.94	.64***	.01	.01	.06	.10*	-.03
6. Supervisor relationship quality						.92	-.04	.08	-.03	.15**	.10*
7. Counselor female							----	-.16**	.06	-.02	-.14**
8. Counselor married								----	.19***	.03	.07
9. Counselor number of children									----	.03	-.00
10. Supervisor hours of supervision										----	.13**
11. Supervisor supervision/years											----
Mean	2.81	2.77	3.54	1.74	3.39	3.96	.64	.43	.31	6.11	2.15
Standard Deviation	1.15	1.13	.94	.61	.68	.72	.48	.50	.46	6.02	2.48

Note. Coefficient Alphas for each measure, where appropriate, are listed along the diagonal.

* $p < .05$;

**

$p < .01$;

$p < .001$;