RECOVERY AT WORK: THE RELATIONSHIP BETWEEN SOCIAL IDENTITY AND WORK ATTITUDES AMONG SUBSTANCE ABUSE COUNSELORS

by

SARA L. CURTIS

(Under the Direction of Lillian T. Eby)

ABSTRACT

The complex makeup of the substance abuse treatment workforce poses unique challenges to this field. One interesting dynamic is the high rate of counselors who are personally recovering from addictions. It was proposed that counselor recovery status would serve as an important factor in understanding work attitudes in this field. Based on social identity theory, it was expected that counselors in recovery would identify more with their profession and report higher professional and organizational commitment, job satisfaction, and lower turnover intentions. Data from a longitudinal study of substance abuse counselors from across the country were analyzed to see if recovery status is related to these work attitudes. The mediating role of professional commitment on the recovery status-- work attitudes relationship was also examined. Results show that counselor recovery status is directly related to professional commitment and indirectly related to the other three attitudes through its relationship with professional commitment.

INDEX WORDS: Social Identity Theory, Substance Abuse Treatment, Recovery, Work Attitudes, Professional Commitment

# RECOVERY AT WORK: THE RELATIONSHIP BETWEEN SOCIAL IDENTITY AND WORK ATTITUDES AMONG SUBSTANCE ABUSE COUNSELORS

by

SARA CURTIS

B. A., Milligan College, 2001

M.MFT., Abilene Christian University, 2003

A Thesis Submitted to the Graduate Faculty of The University of Georgia in Partial Fulfillment of the Requirements for the Degree

MASTER OF SCIENCE

ATHENS, GEORGIA

2009

# RECOVERY AT WORK: THE RELATIONSHIP BETWEEN SOCIAL IDENTITY AND WORK ATTITUDES AMONG SUBSTANCE ABUSE COUNSELORS

by

SARA L. CURTIS

Major Professor: Lillian T. Eby

Committee: Brian J. Hoffman
Charles E. Lance

Electronic Version Approved:

Maureen Grasso
Dean of the Graduate School
The University of Georgia
December 2009

# DEDICATION

In memory of Michael Johnson, a dear friend who will be greatly missed.

# ACKNOWLEDGEMENTS

There are many people who have supported me along the way. First and foremost, I want to thank my parents for their support and encouragement over the entire course of my life. You have always believed in me and helped me believe that I could do whatever I set my mind to.

I also want to thank the most amazing small group in the world—Amy, Heather, Jessica, Joan, Lydia, and Stephanie. You girls are always there for me with a word of encouragement, an uplifting prayer, or a much needed distraction. I'm not sure I could have made it through this year without you. Keep praying BIG!

There are several people in the Applied Psychology Program that deserve much thanks. I literally could not have done this project without the assistance and encouragement of Lillian Eby. Thank you for your support, guidance, and data! It has been such a great experience working with you. Additionally, I am indebted to my fellow students for all of the things I have learned from them. I'm honored to be able to study next to you.

Above all, I want to thank my Savior Jesus Christ for his grace and love no matter how badly I screw up. My success is all due to the blessings you have given me.

This research was supported in part by a grant from the National Institutes of Health (R01DA019460-02) awarded to Lillian T. Eby. The opinions expressed are those of the author and not the granting agency.

TABLE OF CONTENTS

Page

# LIST OF TABLES

Page

# LIST OF FIGURES

Page

# CHAPTER 1

## INTRODUCTION

The substance abuse treatment field faces many human resource management challenges due to the fact that clinicians have high caseloads, low pay, and often face both resistance to treatment and relapse among their clients. Perhaps because of these factors, the turnover rate among clinicians is high, estimated anywhere from 16% (McNulty, Oser, Johnson, Knudsen, & Roman, 2007) up to over 50% annually (McLellan, Carise, & Kleber, 2003). The substance abuse treatment workforce is also unique since many clinicians are in recovery from substance abuse themselves. Previous studies have found the percentage of counselors in recovery ranging from 37% (McNulty et al., 2007) to 57% (Knudsen, Ducharme, & Roman, 2006).

The substance abuse treatment field provides a unique opportunity for social and professional identities to align that does not exist in many other fields. The current study proposes that recovery status represents an important anchor for an individual's self-identity such that those who are in recovery will identify more with their profession, attach greater meaning to their tasks, and experience greater significance in their work than those who are not in recovery. This identification will foster professional commitment, and as a result, it is expected that substance abuse counselors who are personally in recovery will express higher job satisfaction, stronger organizational commitment, and lower turnover intentions than those who are not.

After a brief overview of two different theories of identity, I will discuss how the process of recovery provides a strong source of identity for those breaking free from an addiction. Then, the link between recovery status and working in the substance abuse treatment field will be

examined in order to explain how this individual difference may relate to the work attitudes of clinicians.

# CHAPTER 2

# LITERATURE REVIEW AND HYPOTHESES

## Social Identity

The idea that identity and self-concept are a result of social factors is the foundation for two different theories of identity: social identity theory (SIT), coming out of the social psychology field, and identity theory (IT), emerging from the field of sociology. Despite their near-identical names, there are differences between SIT and IT resulting from their different origins. A closer look at each theory's perspective on the source, mechanisms, and effects of identity will form the foundation for this study. In the present research we draw upon the unique contributions as well as the similarities between these two theories to make the connection between recovery status and work attitudes.

The idea that identity and self-concept are a result of social factors is the foundation of both SIT and IT. The premise of the theories is that the self is multifaceted and created by the interaction of the individual with society (Hogg, Terry, & White, 1995; Stets & Burke, 2000). People are not independent of the world around them but are instead shaped by the experiences and relationships they have. Identity formation, then, is based on a reflexive process of comparing one's self to others based on social categories or classifications.

Each theory has its own basis of classification. According to SIT, people classify themselves through the social groups with which they align (Hogg et al., 1995; Stets & Burke, 2000; Tajfel, 1974). In this sense, a social identity is "that part of an individual's self-concept which derives from his knowledge of his membership of a social group (or groups) together with

the emotional significance attached to that membership" (Tajfel, 1974, p. 69). It is the defining characteristics of the groups to which one belongs that provide an individual with a sense of self. In contrast to SIT, IT claims that it is the roles that people fill that provide identity rather than the groups to which they belong (Hogg et al., 1995; Stets & Burke, 2000). A role exists in relation to other roles. For instance, a doctor's identity is crafted by his or her relationship with patients just as a mother's role exists in relation to a child. It is through these relationships with others that a role crafts a social identity. These theories are not mutually exclusive, and a more realistic approach to this issue is that both groups and roles can provide important sources of identity (Hogg et al., 1995; Stets & Burke, 2000).

Individuals hold many roles and belong to many groups, often simultaneously. Each of these social factors can provide meaning, identity, and expectations for the individual. To manage the potential conflict resulting from multiple classifications, identity is dynamic and responsive to the context. At different times, different identities become more salient and have more influence over behavior. It is the salience of an identity rather than the existence of an identity that determines how one behaves. In SIT, the salience of a given identity is based on the value and status associated with that group or category (Hogg et al., 1995; Stets & Burke, 2000). In order to support current goals, categorizations that associate an individual with the most favorable group in a given context will be emphasized (Hogg et al., 1995; Stets & Burke, 2000). For example, while being a member of the football team may provide a sense of worth among other athletes, it may be an identity that is downplayed when at a party with a group of intellectuals. In that situation, the person may tend to act more out of his identity as a member of the debate team in order to gain esteem. In IT, salience is viewed as a function of the probability that a particular identity will be invoked in any given situation (Stryker & Serpe, 1994). This

probability is determined in part by a person's commitment to that role, and commitment is a function of the depth and breadth of the social ties that are predicated on that identity (Hogg et al., 1995; Stets & Burke, 2000; Stryker & Serpe, 1994). Therefore, the more a given aspect of the identity is entrenched in key social relationships, the more probable it is that that identity will be invoked, and the more salient and influential that identity will be for that individual. Identities are arranged in a hierarchy based on this probability, with higher probability identities being more salient and more self-defining.

Once an identity is established, it can influence behavior. It has been found that people behave according to the norms and expectations of the groups with which they strongly identify (Doosje, Ellemers, & Spears, 1999). To continue the example of the man at the party, because his debate team identity has been triggered, he is likely to adhere to the norms of that group by doing things such as pointing out weaknesses in another person's statements or citing facts from the news or research to support his own claims in order to appear knowledgeable and well read. Additionally, because the individual's identity is largely based on the group identity, the person is motivated to act in such a way that enhances the status of the group because this, in turn, also benefits the individual (Tajfel, 1974). When the group looks good, the individual looks good.

Despite the differences between SIT and IT, there is a movement in the literature toward uniting these theories in order to get a more complete understanding of social identity (Hogg et al., 1995; Stets & Burke, 2000). It is the integration of these theories that provides an understanding of development and impact of a social identity. In short, social identity formation is the result of many influences, including social groups and roles, and it is responsive to the social context. Depending on the value of an identity, the number of relationships built around that identity, and situational cues, certain aspects of an individual's identity have more influence

over behavior and attitude than others. Because of the mutually reinforcing nature of these associations, social identities can satisfy some of the basic human desires to feel valuable and significant, further solidifying the value of that identity (Abrams & Hogg, 1990; Ashforth & Mael, 1989; Tajfel & Turner, 1986).

Traditionally, SIT has been used to explain group behavior and intergroup relations. However, its fundamental principles can be applied to other contexts including the organization (Ashforth & Mael, 1989; Van Dick, Wagner, Stellmacher, & Christ, 2004). In fact, it has been said that "social identity plays an important role in the organizational domain" (Van Dick, Wagner et al., 2004, p. 184). When applied to an organizational context, SIT predicts that the more one identifies as a member of an organizational group (e.g. work team, organization, occupation), the more their attitudes and behaviors will reflect that which is expected of a person in that group (Van Dick, Wagner, Stellmacher, Christ, & Tissington, 2005). The same can be said about a person's role (i.e. specific job) at work according to IT. Therefore, jobs, organizations, and occupations can serve as foundations for a social identity.

## Recovery and Identity

Recovery status is thought to be an important individual difference because of the unique social identities connected to addiction and recovery. These identities result from specific group and role associations associated with these ways of life (Denzin, 1987). The addicted identity is highly salient and often conflicts with other important identities one holds, such as father, employee, or community member (Denzin, 1987). Therefore, identity reformation is an essential component to recovering from an addiction (Cain, 1991; Kellogg, 1993; Koski-Jannnes, 2002). When individuals enter into substance abuse treatment, the hope is that their identity will be altered. Denzin (1987) describes recovery as a "study in adult socialization and identity

transformation, . . . the process by which the self of the person actively enters into the acquisition of new self-images, new languages of self, new relations with others, and new bonds or ties to the social order" (p. 19).

A closer look at the recovery process can shed light on the identity transformation process, but a prefatory note is in order. Much of the empirical research on recovery is based on alcoholism and Alcoholics Anonymous (A. A.). Not all people in recovery are recovering from an alcohol addiction or are members of A. A.. However, alcohol is the most common of all chemical dependencies, and the Twelve Steps treatment program originating from the A. A. tradition is highly prevalent among treatment programs (Bristow-Braitman, 1995). It is reported that 90-95% of substance abuse treatment programs base their program on the Twelve Steps model (Bristow-Braitman, 1995; Laudet, 2003). Therefore, research coming out of this specific area of substance abuse treatment is regarded as generalizable to the rest of the field.

As previously mentioned, a major aim of treatment is identity transformation. To illustrate this process, the transformation of an individual struggling with alcohol will be used. Reflecting the tenets of SIT, Denzin says, "the recovering self, like the alcoholic self, is a group and interactional phenomenon" (1987, p. 11). For many, a major source of this new self comes from the social forces at work within a Twelve Steps community. The Twelve Steps philosophy is designed to break down the old dysfunctional identity and create a dependence on and allegiance to the group that will become a new source of identity. It does this by functioning as a subculture with its own set of beliefs, assumptions, rituals, traditions, jargon, and norms that help regulate the formation of the new identity (Cain, 1991; Denzin, 1987). During the recovery process, the individual aligns him or herself more and more with A. A.. As the individual becomes more committed to the group, a social identity is created, and the attitudes, beliefs,

behaviors, and norms of the individual start to align with those of the group (Alcoholics Anonymous, 1953).

To deconstruct this process even further, recovery often involves two distinct identity transformations. The first transformation is from 'non-alcoholic drinker' to 'alcoholic' (Cain, 1991). The alcoholic identity, which involves admitting you have a problem with alcohol, is learned early on in the Twelve Steps process. The first step of A. A. requires abandoning what you thought to be true of yourself and coming to a new understanding of who you are and how you relate to the world (Alcoholics Anonymous, 1953). Once a person recognizes they need help, the real recovery process can begin. The challenge now is to develop a new identity that does not include drinking. Therefore, the second identity transformation is to that of a "recovering alcoholic." According to Cain, "the change that men and women of A. A. undergo is more than one of behavior—from drinking to not drinking. It is a transformation of identity, of how one understands oneself" (1991, p. 244). By changing an individual's identity rather than just their behavior, there is greater chance of sustained recovery.

While changing one's self-concept and identifying with the group is essential, it is not enough to sustain recovery according to most treatment philosophies. Successful recovery also requires the renegotiation of social relationships based on this new identity (Koski-Jannnes, 2002). Concurrent with identity reformation, important social ties are formed with others in the group and the recovery community at large. These relationships are vital for recovery according to the Twelve Steps philosophy (Alcoholics Anonymous, 1953). The fact that these new key relationships are centered on the recovering identity serves to increase the commitment to that identity. Relationships with people outside the recovery community, such as family, friends, and community members are also likely renegotiated as a result of the changes that come with

recovery. As the number of important social ties and different situations in which the recovering alcoholic identity is used increases, commitment to this identity increases. As explained by IT, as commitment increases, salience will increase as well. Therefore, this new identity becomes more salient as its influence extends beyond the recovery community into other realms of an individual's life (Denzin, 1987).

Looking back at the tenants of SIT and IT, we can see how recovery status can be an influential individual difference. Most, if not all, individuals who go through the recovery process will experience the identity transformation described above. Additionally, for recovering individuals who work in the substance abuse treatment field, the situational cues in the work environment will likely trigger this recovery identity. Interacting with substance abuse clients on a daily basis and walking with others through a process that is potentially very similar to their own experience will constantly remind them of their personal recovery, making that part of their identity more salient. Based on the recovery process, strong group identification, important social ties, situational cues, and the value of this identity, the recovery identity has the essential components to become a highly salient identity. As discussed previously, highly salient identities have a large impact on the behaviors and attitudes of the individual.

## Recovery and Work Attitudes

Due to the potential salience of the recovery identity and the high rate of substance abuse clinicians who are in recovery, differences based on clinician recovery status are of particular interest. Surprisingly, there has only been a small amount of research looking at differences between clinicians who are in recovery and those who are not. A review of the literature by Culbreth (2000) shows that most of these studies focused on criteria such as treatment effectiveness (from both the client's perspective as well as treatment outcome measures),

treatment methods, attitudes about addiction, clinical decision making, and personality. A search of PSYCINFO brought up a few additional studies looking at rates of relapse as well as differences in pay (Olmstead, Johnson, Roman, & Sindelar, 2007), supervision preferences (Culbreth, 1999) and attitudes about ethical issues (e.g. Hecksher, 2007; Hollander, Bauer, Herlihy, & McCollum, 2006). However, when recovery status has been studied in relation to work attitudes, it has been used as a control variable rather than a key predictor (Ducharme, Knudsen, & Roman, 2008). The aim of this study is to begin to fill this gap in the literature by testing for the direct effects of recovery status on work attitudes as well as a potential mediating mechanism for these relationships. Four of the most commonly studied work attitudes will be considered: organizational commitment, job satisfaction, turnover intentions, and professional commitment.

*Organizational commitment.* Over the several decades, the concept of work commitment has received considerable attention. It has been shown that commitment is multifaceted and there are distinctions between professional, organizational, and job commitment (Blau, 2000; Blau, Paul, & St. John, 1993; Meyer, Allen, & Smith, 1993). Organizational commitment has been defined as a bond or link between the individual and the organization (Mathieu & Zajac, 1990). It has been further divided into various types of commitment. The three main types of commitment are affective, continuance, and normative (Meyer et al., 1993). Affective commitment is a result of an emotional connection and a desire to stay connected to the target. It is generally thought to consist of three main factors: "a) a strong belief in and acceptance of the organization's goals and values; b) a willingness to exert considerable effort on behalf of the organization; and c) a strong desire to maintain membership in the organization" (Mowday, Porter, & Steers, 1982, p. 27). It is the most commonly studied form of commitment and has

been found to have the strongest relationship with outcome variables (Lee, Carswell, & Allen, 2000; Meyer et al., 1993). Continuance (also referred to as calculative) and normative commitment result from other psychological mechanisms such as sunk costs or adherence to social norms, respectively. Because it is the deep-level identification and connection with one's work that will be most effected by personal experience, this study will focus only on affective commitment.

The central element of organizational commitment is a personal identification with the organization (Meyer, Becker, & Vandenberghe, 2004; Wiener, 1982). Related to organizational commitment, organizational identification is the " extent to which one defines him or herself in terms of the work he or she does and the prototypical characteristics ascribed to individuals who do that work" (Mael & Ashforth, 1992, p. 106). It is often considered the perceptual-cognitive component of commitment (Ashforth & Mael, 1989). This identification results from a similarity of beliefs, attitudes, behavior, experiences, values, goals, as well as a common history (Ashforth & Mael, 1989; Van Dick, Christ et al., 2004). Counselors who are in recovery are more likely to experience this overlap due to these similarities, especially the similarity of goals and values. Helping people recover from addiction is the primary goal of treatment centers. As previously mentioned, people who are in recovery and living out the Twelfth Step value this objective as well. Therefore, there is congruence between the values of the organization and the values of the counselor who is in recovery. This satisfies the one of the key components of Mowday et al.'s (1982) conceptualization of affective organizational commitment. In sum, the shared values of an individual and an organization will foster identification which in turn leads to commitment. This connection between value congruence and affective organizational commitment has been

supported in the literature (Kristof-Brown, Zimmerman, & Johnson, 2005; Van Vuuren, Veldkamp, de Jong, & Seydel, 2008).

It is easy to see how the employing organization can be considered a social group with unique expectations, norms, attitudes, and values. As explained by SIT, as the individual identifies with the group, their commitment to that group increases (Ashforth & Mael, 1989; Hogg et al., 1995; Stets & Burke, 2000; Tajfel, 1974). Additionally, people tend to support institutions that embody salient aspects of their identity (Mael & Ashforth, 1992) because certain needs are met by being a part of a group (Tajfel, 1974).Therefore, it is proposed that:

*Hypothesis 1: Counselors who are personally in recovery will express higher affective organizational commitment than counselors who are not personally in recovery.*

*Job satisfaction.* The overlap between the Twelfth Step and treatment environments provides a context for increased job satisfaction through personal reward and increased tolerance. According to the A. A. philosophy, intrinsic satisfaction comes from living out the Twelfth Step. This final step of the A. A. process is commonly referred to as "carrying the message." It states, "having had a spiritual awakening as the result of these steps, we [try] to carry this message to alcoholics, and to practice these principles in all our affairs" (Alcoholics Anonymous, 1953, p. 109). A. A. goes on to claim that "practically every A. A. member declares that no satisfaction has been deeper and no joy greater than in a Twelfth Step job well done" (p. 113). Substance abuse counselors spend hours each day working with clients who are fighting the fight against addiction, helping them attain a life of recovery rather than addiction. In this way, working in the treatment field provides ample opportunity for someone in recovery to find satisfaction and joy in his or her work. Additionally, A. A. challenges its members to learn to be satisfied in serving others without requiring rewards or recognition (Alcoholics Anonymous,

1953). Therefore, it is proposed that there will be a significant relationship between recovery status and job satisfaction.

*Hypothesis 2: Counselors who are personally in recovery will report higher rates of job satisfaction than counselors who are not personally in recovery.*

*Turnover intentions.* As discussed previously, turnover is a major concern in the substance abuse treatment field with rates reported as high as 53% (McLellan et al., 2003). Turnover is costly to organizations and has numerous consequences for both the organization and the clients (Ducharme et al., 2008; McNulty et al., 2007; Van Dick, Christ et al., 2004). The few studies that have looked at turnover and recovery status have shown mixed results (Ducharme et al., 2008; Knudsen et al., 2006; McNulty et al., 2007). Going outside the substance abuse treatment field, investigations in the workplace have revealed that both organizational and occupational identification are negatively related to turnover intentions as well as actual turnover (Lee et al., 2000; Van Dick, Christ et al., 2004; Van Dick, Wagner et al., 2004; Van Dick et al., 2005; Wegge, Van Dick, Fisher, Wecking, & Moltzen, 2006). Therefore, if an employee's identity overlaps with their work, at either the job, organizational, or professional level, it is less likely that they will have thoughts of leaving their job. Therefore, the following hypothesis is offered:

*Hypothesis 3: Counselors who are personally in recovery will report lower turnover intentions than counselors who are not personally in recovery.*

*Professional commitment.* It seems that the potential for overlap between personal, organizational, and professional values and goals in this field is greater than in most, increasing the likelihood that clinicians in recovery may more strongly identify with their work. Even more than substance abuse counselors who are in recovery are expected to express commitment to

their organization, satisfaction with their jobs, and a desire to remain employed, it is thought that they will feel a strong sense of commitment to their profession. Professional commitment refers to "the strength of motivation to work in a chosen career role" (Hackett, Lapierre, & Hausdorf, 2001, p. 393). Like organizational commitment, professional commitment can be broken down into affective, continuance, and normative commitment. Again, this study will focus on affective commitment because it is the emotional connection that employees feel towards their occupation that is thought to be the most relevant. The terms professional commitment, occupational commitment, and career commitment are often used interchangeably despite their slightly different connotations. Because the substance abuse treatment field is a professional occupation with specialized training, certification, and a code of ethics, the term professional commitment is appropriate for this study (Lee et al., 2000; Loi, Hang-yue, & Foley, 2004).

In this context, the strong link between the individual's identity and the profession in which they work is most clearly seen in the Twelfth Step of A. A., as discussed previously. Helping others find freedom from addiction is a key goal of A. A. members. Since this is also the mission of the substance abuse treatment field, it seems reasonable to expect that counselors who are in recovery themselves will express a strong commitment to their profession. Based on this idea, it is proposed that recovery status is related to professional commitment.

*Hypothesis 4: Counselors who are personally in recovery will express higher affective professional commitment than counselors who are not personally in recovery.*

*Mediated Relationships.* In addition to professional commitment being directly related to recovery status, it is also believed to mediate the relationship between recovery status and the other work attitudes. A study by Loi et al. (2004) looked at professional identification in relation to job satisfaction and organizational commitment in a sample of lawyers. They also used social

identity theory to make the case that professions provide a strong target with which to identify with, and this identification has the potential to have a significant impact on work attitudes. They found that job satisfaction and organizational commitment were indeed significantly related to professional identification. Since professional identification is a component of professional commitment (Wiener, 1982), the work of Loi and colleagues provides a solid foundation for the argument that professional commitment will be related to the other work attitudes in this study.

There are several reasons to propose that professional commitment will serve as a mediator between recovery status and the other work attitudes. First, in professional occupations such as the one under investigation, it is often assumed that professional commitment typically precedes the other attitudes because of the training required to enter the field (Lee et al., 2000). A substance abuse counselor has already made a commitment to the profession by taking steps to get the necessary education and certification before joining an organization. This commitment, because it is based on strong value and goal congruence, is more likely to endure despite the fact that the counselor may not enjoy particular aspects of his or her job or organization.

Secondly, unlike previous generations, workers today have to deal with more changes in their work setting due to downsizing, mergers, and acquisitions. This turbulent work environment often means that people are unlikely to stay with the same organization their whole career, making occupations more stable than organizations or jobs (Lee et al., 2000; Van Vuuren et al., 2008). This is likely to result in people focusing on and committing to their profession more than to their organization (Lee et al., 2000). Organizations, then, become more of a means to fulfill their professional commitment than an end in themselves. Employees will commit to their organizations partly because they are committed to their profession. In this way, professional commitment is expected to partially mediate the relationship between counselor

recovery status and organizational commitment. Numerous studies have found a strong positive relationship between professional and organizational commitment (e.g. Blau et al., 1993; Hackett et al., 2001; Lee et al., 2000; Mathieu & Zajac, 1990; Meyer et al., 1993; Meyer, Stanley, Herscovitch, & Topolnytsky, 2002), yet factor analysis supports that they are distinct constructs (Blau et al., 1993; Blau, 1988). However, because there are numerous factors that can affect organizational commitment including job and organizational characteristics (Mathieu & Zajac, 1990), partial mediation is proposed.

*Hypothesis 5: Affective professional commitment will partially mediate the relationship between counselor recovery status and affective organizational commitment.*

The idea that professional commitment mediates the relationship between recovery status and job satisfaction is supported by the social identity literature. These theorists argue that having a strong identification with a group allows greater tolerance of negative events because they can be viewed as necessary obstacles in the pursuit of the larger goals (Van Dick, Christ et al., 2004). This mentality may allow those in recovery who have committed to the A. A. philosophy and the profession to find more satisfaction in a job that provides fewer opportunities for external rewards (Gallon, Gabriel, & Knudsen, 2003; Olmstead, Johnson, Roman, & Sindelar, 2007). Therefore, much of the influence of recovery status on job satisfaction may come from commitment to both the A. A. philosophy and the goals of the substance abuse treatment profession. For this reason, it is expected that professional commitment will partially mediate the relationship between recovery status and job satisfaction. However, since job satisfaction is a complex attitude influenced by various other factors, it is conceivable that there are other potential mediators related to recovery status (i.e. perceived employment alternatives). Therefore, only partial mediation is proposed.

*Hypothesis 6: Affective professional commitment will partially mediate the relationship between counselor recovery status and job satisfaction.*

While the literature on recovery status and turnover intentions is limited and ambiguous, there is much more support for the connection between professional commitment and turnover intentions. Numerous studies have found that professional commitment is significantly negatively related to turnover intentions (Blau, 2000; Hackett et al., 2001; Lee et al., 2000; Meyer et al., 1993; Schmidt & Lee, 2008). This makes sense because the very nature of the construct of professional commitment is based on a desire to remain a member of the profession, and remaining in one's job is an easy way to do this. Substance abuse counselors who are personally in recovery are more likely to identify with their work and therefore want to remain in their job. It is important to note that the decision to leave an organization can be the result of factors related to the job or organization specifically rather than to the profession as a whole. Therefore, partial mediation is proposed.

*Hypothesis 7: Affective professional commitment will partially mediate the relationship between counselor recovery status and turnover intentions.*

In sum, it is hypothesized that counselor recovery status is directly related to organizational commitment, job satisfaction, turnover intentions, and professional commitment. Because of the potentially strong and stable identity connection to the profession of substance abuse treatment, it is expected that professional commitment will partially mediate the relationship between recovery status and the other three attitudes. Although causality cannot be determined from this research design, the work attitudes will be measured at two different points in time to strengthen the argument that affective professional commitment mediates the

relationship between recovery status and the other three attitudes. For a graphic representation of this model, see Figure 2.1.

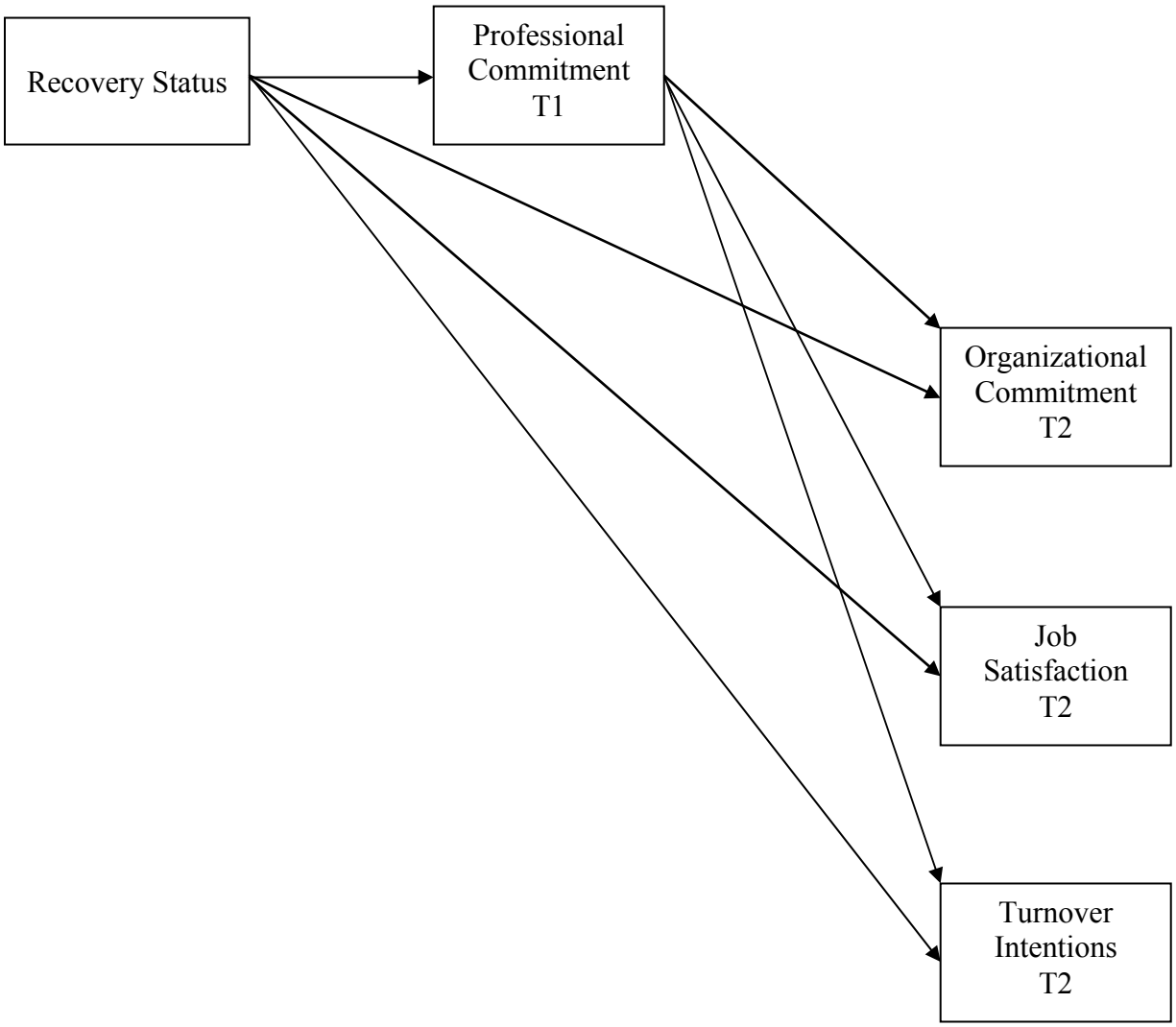


Figure 2.1

Hypothesized model of the relationship between recovery status and work attitudes.

# CHAPTER 3

# METHOD

## Sample and Procedure

The sample for this study came from counselors working at various Community Treatment Programs (CTPs) across the United States. A wide range of treatment programs was included in this study. Most of the treatment centers are accredited (70%), non-profit organizations (89%) that are not located on a hospital campus (82%). On average, the number of full-time counselors who carry a caseload employed by the CTPs was 56, with individual centers reporting between 8 and 225 counselors. Alcohol was the most commonly treated addiction (48% of clients), followed by marijuana (29%), heroin (24%) and cocaine (22%). The CTPs were compensated for their participation in the study.

Data were collected at two points in time, approximately one year apart. A researcher traveled to each location both times to administer the paper and pencil surveys. The survey took between an hour to an hour and a half to complete. The researcher gave a brief overview of the study and explained the survey process, stressing that participation was voluntary, and asked the participants to sign a consent form. To ensure confidentiality, the surveys were coded with numbers rather than names, and completed surveys were turned in directly to the researcher. CTP administration was not allowed access to completed surveys.

Usable longitudinal data were collected from 27 different treatment organizations. At time 1 (T1), 739 counselors took the survey (response rate of 81%), and one year later (T2), there were data from 658 counselors (response rate of 74%). Of those participants, there were 308

counselors who completed the surveys at both times. Eighteen of those cases were discarded because of contradictory responses on the recovery status question, leaving a final sample of 290 counselors.

While the specific responsibilities of a counselor vary from organization to organization, a typical substance abuse counselor performs various clinical and administrative tasks. A major part of their job is to counsel clients with addictions to various substances, both individually and in group settings. They are also responsible for the development, modification, and evaluation of treatment plans for these clients (O*NET, 2003). Participants were primarily female (62%) and Caucasian (58%). The average age at T1 was 44 years old with an average of just under ten years of experience in the field. At T1 counselors carried an average caseload of 27 clients and worked about 44 hours per week. At T2, the average case load was 28 and they reported working an average of 42 hours per week. The average annual salary was approximately $34,145 at T1 and $35,202 at T2. About half (55%) of the counselors held certifications or licensure in addiction treatment at T1, but that number increased to 62% at T2. Forty-four percent of the counselors were personally in recovery.

## Measures

*Recovery status*. A single-item yes/no question, “Are you personally in recovery?” was used to assess recovery status. Responses were coded 0 = no and 1 = yes. This question was asked at both T1 and T2.

*Professional commitment.* A modified version of Meyer et al.’s (1993) six-item measure of affective professional commitment was used to measure counselors’ emotional connection with their profession at T1 (see Appendix A). Meyer’s study focused on nursing, so where necessary, the word “nursing” was replaced with “the substance abuse profession.” A sample

item is, “I am enthusiastic about the substance abuse profession.” A five-point Likert-type scale was used (1 = strongly disagree; 5 = strongly agree). The coefficient alpha for this scale is .80.

*Organizational commitment.* Affective organizational commitment was measured at T2 with Meyer et al.’s (1993) six-item measure also using the same five-point scale as described above (see Appendix B). A sample item is, “This organization has a great deal of personal meaning to me.” The coefficient alpha is .85.

*Job satisfaction.* Smith’s (1976) six-item measure of intrinsic job satisfaction was used at T2 to assess the degree to which the counselors are happy or satisfied with their work (see Appendix C). A sample item is “The kind of work I do has a favorable influence on my overall attitude toward my job.” This scale also used a five-point scale (1 = strongly disagree; 5 = strongly agree) and has a coefficient alpha of .80.

*Turnover intentions.* The measure of turnover intentions was based on Adams and Beehr’s (1998) scale (see Appendix D). This three-item scale measures the extent to which one is considering leaving their current job. Turnover intentions were measured at T2. A sample item is “I often think about quitting my job.” A five-point Likert-type scale was used (1 = strongly disagree; 5 = strongly agree). Higher scores indicate greater intentions to quit. The coefficient alpha for this scale is .93.

*Controls.* There are numerous other variables that could influence the work attitudes examined in the present study. The first set of control variables to be considered are demographics that may serve as the basis of alternate salient social identities. This includes variables such as gender, race, marital status, and parental status. Secondly, previous research has found significant differences between counselors who are in recovery and those who are not. Counselors in recovery from their own addictions are less likely to have professional training or

graduate degrees (Culbreth, 2000; Culbreth & Borders, 1998; Hecksher, 2007; Valle, 1979), get paid less (Olmstead et al., 2007), and are older (Culbreth & Borders, 1999). Therefore, education level, current salary, and age will also be considered as potential control variables. Finally, two other variables, role overload and positive affect, were measured because it was thought might have a significant impact on the work attitudes. Substance abuse counselors traditionally carry high caseloads. Counselors who feel that their caseload is too high may be less satisfied with their work and less committed to it. Due to this potential relationship with the criteria, a three-item measure of role overload was used (see Appendix E; Cammann, Finchman, Jenkins, & Klesh, 1979). It is possible that the work attitudes, particularly job satisfaction, might be inflated due to the dispositional effects of positive affect (Brief & Weiss, 2002; Judge & Larsen, 2001). The PANAS scale (Watson, Clark, & Tellegen, 1988) was used to measure dispositional positive affect (see Appendix F). The control variables were measured at both times. Professional commitment was controlled with variables from T1 whereas job satisfaction, organizational commitment, and turnover intentions were controlled with variables from T2.

# CHAPTER 4

# RESULTS

## Analyses

Data analysis began by examining the zero-order correlations between the variables of interest (see Table 4.1 for correlations between key variables). First, the correlations between the potential control variables and the four criteria, organizational commitment, job satisfaction, turnover intentions, and professional commitment, were considered. In order to preserve power and avoid over-inflated results from the inclusion of a large number of superfluous, unrelated variables, only the control variables that were significantly related to the specific criterion variable were used as controls in each analysis (Neter & Wasserman, 1990). Based on these correlations, the following control variables were used: for affective professional commitment (T1), positive affect; for job satisfaction (T2), age, role overload, and positive affect; for affective organizational commitment (T2), age, role overload, positive affect, and education level; for turnover intentions (T2), age, role overload, positive affect, and education level. To factor out these control variables, the attitude variable was regressed on the relevant controls, and the unstandardized residual was saved to be used in all future analyses. Therefore, when any of the four work attitudes are referenced in the context of analyses, it is the residual of that variable with the variance accounted for by the control variables factored out that is being used.

The first set of hypothesized relationships is the direct relationships between counselor recovery status and the four work attitudes. To test the direct effects proposed in Hypotheses 1-4, the residualized work attitude criteria were each regressed on recovery status (see Table 4.2).

Contrary to prediction, recovery status was not significantly related to job satisfaction (β = -.02), affective organizational commitment (β = -.03), or turnover intentions (β = .04). Therefore, Hypotheses 1-3 were not supported. The standardized regression coefficient between recovery status and affective professional commitment was significant (β = .15, $p < .05$), supporting Hypothesis 4. Affective professional commitment was the only criteria significantly predicted by recovery status.

Although there were no direct effects between counselor recovery status and affective organizational commitment, job satisfaction, and turnover intentions, it is still possible that there are indirect effects. A direct relationship between the independent variable and the dependent variables is often thought of as necessary for testing mediation based on the Baron and Kenny method (1986), but it has been shown that this requirement is not necessary and may even be problematic in relatively small sample sizes when there is full mediation (LeBreton, Wu, & Bing, 2009). Therefore, since testing for mediation is not predicated on a significant relationship between recovery status and the work attitudes of interest, Hypotheses 5-7 could still be tested.

The first step for testing for mediation is to establish a link between recovery status and the mediator, affective professional commitment. As reported above, the regression coefficient for affective professional commitment regressed on recovery status was .15 ($p < .05$). This relationship is significant, so the first condition for mediation is satisfied.

The second step is to establish the relationship between the mediator and the three remaining work attitudes. To test this, multiple regression was used. Affective organizational commitment was regressed on recovery status and affective professional commitment simultaneously, and this was repeated for job satisfaction and turnover intentions. The standardized regression coefficients indicate whether or not affective professional commitment

was a significant predictor of the dependent variables controlling for recovery status. Affective professional commitment was found to be a significant predictor of all three work attitudes: job satisfaction ($\beta = .27$, $p < .001$), affective organizational commitment ($\beta = .25$, $p < .001$), and turnover intentions ($\beta = -.24$, $p < .001$) (see Table 4.3).

The final step in this analysis is to determine if affective professional commitment partially or fully mediates the effects of recovery status on job satisfaction, organizational commitment, and turnover intentions. In order to test this, the regression coefficient for recovery status from the previous step was examined. If this coefficient is significant, it is an indication of partial mediation; however, if it is not significant, full mediation is indicated. In all three analyses, the regression coefficients for recovery status were not significant (see Table 4.3) indicating that affective professional commitment fully mediates the relationship between counselor recovery status and job satisfaction, affective organizational commitment, and turnover intentions. Therefore, even though there is sufficient evidence of mediation, Hypotheses 5-7, which predicted partial mediation, were not supported.

Table 4.1

*Means, Standard Deviations, and Correlations of Study Variables*

| | Mean | SD | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|---|---|
| 1. Recovery[a] | .44 | .50 | -- | | | | |
| 2. APC[b] T1 | 4.21 | .62 | .17* | -- | | | |
| 3. Job Sat. T2 | 3.94 | .65 | .02 | .30* | -- | | |
| 4. AOC[c] T2 | 3.16 | .84 | .08 | .26* | .49* | -- | |
| 5. TOI[d] T2 | 2.90 | 1.30 | -.10 | -.20* | -.52* | -.65* | -- |

*Note. N ranges from 255 – 275.*

[a]Recovery status coded 0 = not in recovery, 1 = in recovery. [b]APC = affective professional commitment. [c]AOC = affective organizational commitment. [d]TOI = turnover intentions.

*$p < .01$.

Table 4.2

*Summary of Regression Analyses of Direct Effects of Recovery Status on Work Attitudes*

| Variable[a] | B | Std. Error B | β | F (df) | $R^2$ |
|---|---|---|---|---|---|
| APC[b] T1 | .17 | .07 | .15* | 6.10* (1, 273) | .02 |
| Job Sat. T2 | -.02 | .07 | -.02 | .13 (1, 272) | .00 |
| AOC[b] T2 | -.05 | .10 | -.03 | .31 (1, 263) | .00 |
| TOI[d] T2 | .10 | .14 | .04 | .45 (1, 261) | .00 |

*Note.* [a]All variables are in their residualized form after being controlled. [b]APC = affective professional commitment. [c]AOC = affective organizational commitment. [d]TOI = turnover intentions.

*$p < .05$.

Table 4.3

*Summary of Regression Analyses Testing for Mediating Effects of Affective Professional Commitment Between Recovery Status and Work Attitudes*

| Variable[a] | B | Std. Error B | β | *F (df)* | $R^2$ |
|---|---|---|---|---|---|
| Job satisfaction T2 | | | | 9.46** (2, 259) | .07 |
| Recovery status | -.06 | .07 | -.06 | | |
| APC T1 | .24 | .06 | .27** | | |
| Org. commitment T2 | | | | 8.26** (2, 254) | .06 |
| Recovery status | -.11 | .10 | -.07 | | |
| APC T1 | .33 | .08 | .25** | | |
| Turnover intentions T2 | | | | 7.67* (2, 252) | .06 |
| Recovery status | .18 | .14 | .08 | | |
| APC T1 | -.47 | .12 | -.24** | | |

*Note.* [a]All variables are in their residualized form after being controlled.

*$p < .01$. **$p < .001$.

# CHAPTER 5

# DISCUSSION

## Theoretical Implications

The purpose of this study was to examine the influence of substance abuse counselors' personal recovery status on their attitudes towards their work. It contributes to the literature by integrating two traditionally independent lines of research, social identity and work attitudes, in a setting where neither are often studied, substance abuse treatment. This study sought to determine if counselors who have been through the recovery process themselves might identify more with their work and therefore report more positive attitudes than counselors who are not in recovery. There are valuable implications from this research.

The key finding from this study is that recovery status does in fact play an important role in the work attitudes of substance abuse counselors. Counselors who are personally in recovery report significantly higher levels of affective commitment to the profession. This strong emotional connection implies that they identify with their profession, are motivated to work in this field, and believe that their role in the profession is important to their self-image (Hackett et al., 2001; Meyer et al., 1993). It is through this commitment to the field of substance abuse treatment that counselors in recovery experience higher levels of job satisfaction and organizational commitment and report lower intentions to leave their jobs. While previous research has considered that recovery status may play an important role in clinical outcomes such as treatment approaches, client recovery rates, and attitudes toward supervision (Culbreth, 1999, 2000; Culbreth & Borders, 1998, 1999), this study shows that recovery status is important to

consider in our understanding of the work attitudes of those employed in the substance abuse treatment profession.

Beyond this central finding, it is valuable to take a closer look at the other findings and consider why the results were not as expected. A careful examination of the relationships involved in this study provides ample suggestions for future research in this area.

It was hypothesized that recovery status would be directly related to all four work attitudes due to a strong social identity. Surprisingly, recovery status was not significantly related to affective organizational commitment, job satisfaction, or turnover intentions. While recovery status is significantly related to one's attitude about the profession, it may be too distal to have a strong direct effect on attitudes and evaluations about a person's specific job or organization. It may be that these attitudes are influenced much more directly by job and organizational factors that are more proximal. Previous research has found many antecedents to job satisfaction, organizational commitment, and turnover intentions. These antecedents tend to be more directly related to the specific context and include situational, stress-related, and other work attitudes. Situational factors found to predict these attitudes include the physical and emotional demands of the job, the amount of social contact, autonomy, task variety, feedback, and control (Griffeth, Hom, & Gaertner, 2000; Judge, Locke, Durham, & Kluger, 1998; Parker, Wall, & Cordery, 2001). Another category of predictors is stress-related factors including role overload, role ambiguity and role conflict (Griffeth et al., 2000; Mathieu & Zajac, 1990). Additionally, it has been shown that other work-related attitudes such as perceived organizational support (Allen, Shore, & Griffeth, 2003; Rhoades & Eisenberger, 2002) and procedural and distributive justice (Colquitt, Conlon, Wesson, Porter, & Yee Ng, 2001) can influence the attitudes of interest in this study. All of these antecedents exist at the job or organizational level, making them more

proximal than a recovery-based social identity to job satisfaction, organizational commitment, and turnover intentions. While recovery status may be too distal to influence these attitudes directly, but through its influence on commitment to the profession, an indirect relationship was supported.

The second focus of this study was to investigate a mechanism through which counselor recovery status might be influencing work attitudes. Hypotheses 5-7 addressed whether or not affective professional commitment mediates the relationship between recovery status and affective organizational commitment, job satisfaction, and turnover intentions. It was found that recovery status significantly predicts professional commitment, and in turn commitment to the profession predicts the other three work attitudes. Therefore, the role of affective professional commitment as a mediator is more robust than was expected. This appears to be a key driver of the other work attitudes, especially in regards to clinician recovery status.

While the causality of these relationships cannot be determined due to the non-experimental design of this study, causal inferences about the relationships between these variables are strengthened on the basis of three factors: 1) the temporal precedence of recovery status, 2) the use of longitudinal data with professional commitment being measured a year before the other variables, and 3) the theoretical claim that professional commitment precedes and is more stable than other work attitudes (Lee et al., 2000). It has been argued that professional commitment is more stable than organizational commitment, especially in today's labor market that is laden with downsizing, mergers, and frequent job changes (Lee et al., 2000). Once a commitment to the profession is established, it can then influence their attitudes about the job and organization in which they find themselves employed. It may be that they are not

particularly committed to their specific organization or job, but because these contexts serve as a function to enact their commitment to the profession, they remain in their jobs (Lee et al., 2000).

## Practical Implications

There are practical applications of the finding that affective professional commitment mediates the relationship between recovery status and work attitudes. Understanding why employees do their work is of strategic importance to organizations. A study by Van Vuuren et al. (2008) found that organizational values and value congruence are strong motivators of behavior and commitment. In the substance abuse treatment profession, the values of the profession are overt. For counselors who are personally in recovery who hold strong personal values regarding the Twelfth Step and helping others find recovery, it is easy for them to see the overlap of their personal values with those of the profession. This identification then leads to commitment which has positive benefits for the organization. To maximize the positive results of having high levels of professional commitment, Lee et al. (2000) argue that organizations concerned with retention of employees should implement strategies for building and enhancing professional identification. They suggest practices such as offering professionally valued rewards and activities. In the substance abuse treatment field, this could include educational and training benefits and support to attend professional conferences. These types of programs will help to enhance the counselors' professional identification and commitment, which can in turn lead to increased job satisfaction and decreased turnover.

If it is true that identification with the values and goals of the profession has positive results, then it is likely that organizations will benefit by increasing any counselor's awareness of the congruence between their personal values and those of the organization. Organizations that want to increase job satisfaction and organizational commitment and lower their rates of

voluntary turnover should present an image of the organization that allows employees to identify with common goals, values, and mission (Van Dick, Christ et al., 2004; Van Vuuren et al., 2008). This could be done by creating a mission or vision statement for the organization based on values that are important to the counselors, such as helping hurting people find freedom from addiction. By integrating this vision into routine communications and human resource practices like training and performance appraisal, employees will better be able to identity with their work and strengthen their professional and organizational identification (Lee et al., 2000).

These suggestions, based on the idea that a strong social identity is related to occupational and organizational outcomes, can extend beyond the substance abuse treatment field. Other organizations that have a strong value-base, such as religious or charity organizations, are prime contexts for strong professional and organizational commitment. Organizations like these may benefit from emphasizing those facets of their organization that will connect with the individual's personal identity. People want to feel that their work is significant and meaningful (Hackman & Oldham, 1976), and appealing to their personal values and helping them identify with their work is one good way to develop this. The results of the current study can serve as the springboard for future studies looking at social identification and the organization.

## Limitations and Future Research

As in all research, this study has its limitations. One limitation of this study has to do with the construct of identity. The theoretical foundation for this study was that counselors who are personally in recovery will have a highly salient identity based on their recovery experience. It is possible that some people may be in recovery but that this part of their lives does not impact their identity in a way that would influence their attitudes towards their job. It is also possible

that counselors who are not in recovery themselves but have a close friend or family member who has struggled with an addiction may have a deep-level identification with their work. As a result, it is possible that the single item measure of recovery status does not adequately tap into how strongly a person in recovery identifies with this part of their life. However, the recovery literature makes a very strong case that there is a significant transformation of identity that occurs during the recovery process (Cain, 1991; Denzin, 1987; Kellogg, 1993). It is safe to assume, then, that most, if not all, counselors who are in recovery identify in some way with their recovery. An interesting future study would be to measure the degree to which a person identifies with his or her own recovery and with the profession as well as any experience of recovery among family or close friends to gain a better understanding about how identification plays a part in the relationship between recovery status and work attitudes.

The decision to use longitudinal data strengthened the design of this study, but it also decreased the sample size. At both times of data collection, data from well over 600 counselors were collected and could have been used to study these relationships. Deciding to use only data from those counselors who took the survey at both times in order to strengthen causal inferences reduced the sample size by over half. However, when the same analyses were run on the full sample from time 1 (N = 695), results were essentially the same.

Another limitation arising from the longitudinal nature of the study is attrition resulting in range restriction. It is entirely possible that those participants who had lower job satisfaction, organizational commitment, and professional commitment and higher turnover intentions at T1 may have left the organization. A one-way ANOVA was conducted to determine if there were differences in work attitudes between those participants who took the survey at both times and those who only took the survey at T1. Results indicate that there were indeed significant

differences on three of the four work attitudes in the expected direction. Counselors who did not participate at T2 reported significantly lower affective professional commitment ($F = 5.70$, $p < .05$), lower affective organizational commitment ($F = 4.87$, $p < .05$), and higher turnover intentions ($F = 19.34$, $p < .001$). Therefore, it is possible that there is some range restriction in the sample because those with more negative job attitudes were more likely to not participate at T2 for whatever reason. However, as mentioned before, the analyses were run on the full sample from T1 and the results were the same, indicating that whatever attrition may have occurred did not significantly affect the substantive relationships examined in the present study.

This study serves to break the surface of the role of clinician recovery status in relationship to workplace attitudes. In addition to the suggestions offered previously, there is a myriad of research that can be done to contribute to the findings of this study. This study focused on affective commitment to both the profession and the organization, but it is possible that other forms of commitment might be related to recovery status. Continuance commitment is a form of commitment based on the costs associated with leaving (Mathieu & Zajec, 1990). It can result from a lack of perceived alternatives, sunk costs, or other perceived sacrifices that would result from leaving the organization or profession (Meyer et al., 2002). It may also be that counselors who are in recovery may feel that they have fewer career alternatives and so they stay in the substance abuse field. Normative commitment is based on a sense of obligation grounded in social norms (Meyer et al., 2002). Counselors in recovery may feel obligated to work in the substance abuse treatment field out of an obligation to the substance abuse treatment community as a way to show gratitude for their own recovery. At the organization level, counselors who are in recovery may feel indebted to their organization for taking a chance on them and giving them a job. These feelings of obligation may tie the person to the profession or the organization even if

he or she is not emotionally connected, as in affective commitment. Therefore, this line of research could be expanded to the other types of commitment, looking to see if there are differential relationships with these different forms of commitment.

While there was support for the mediating role of affective professional commitment, there are other mechanisms that may serve to mediate the relationship between recovery status and work attitudes. One such mechanism may be perceived job alternatives. Counselors who are in recovery tend to be less educated (Culbreth, 2000) and therefore may perceive that they have fewer career alternatives compared to counselors who are not in recovery who are more likely to have professional degrees. Not believing that they could find another comparable job might lead them to view their current job more favorably and be less likely to leave. The influential role of perceived alternatives is especially supported in the turnover literature (Lee, Mitchell, Wise, & Fireman, 1996). Future research should examine the mediating role of perceived employment alternatives.

## Conclusion

Based on the findings of this study, it is clear that clinician recovery status should be considered in future work in the substance abuse treatment field. Culbreth and colleagues (Culbreth, 1999, 2000; Culbreth & Borders, 1998, 1999) have laid the foundation by studying recovery status in more clinical matters, but this study shows that the impact of recovery status extends beyond treatment itself. Counselors who are personally in recovery are more committed to their profession than counselors who are not, and this professional commitment is related to higher levels of satisfaction with their jobs, higher affective commitment to the organization, and lower intentions to leave the organization. The recovery identity can be a powerful one.

Recovering from an addiction is a personal accomplishment that extends down into the core of an individual and can affect all aspects of their life, and its influence should not be overlooked.

# REFERENCES

Abrams, D., & Hogg, M. A. (1990). An introduction to the social identity approach. In D. Abrams & M. A. Hogg (Eds.), *Social Identity Theory: Constructive and Critical Advances* (pp. 1-9). New York: Springer-Verlag.

Adams, G. A., & Beehr, T. A. (1998). Turnover and retirement: A comparison of their similarities and differences. *Personnel Psychology, 51*(3), 643-665.

Allen, D. G., Shore, L. M., & Griffeth, R. W. (2003). The role of perceived organizational support and supportive human resource practices in the turnover process. *Journal of Management, 29*(1), 99-118.

Alcoholics Anonymous (1953). *Twelve Steps and Twelve Traditions*. New York: Alcoholics Anonymous World Services, Inc.

Ashforth, B. E., & Mael, F. (1989). Social identity theory and the organization. *Academy of Management Review, 14*(1), 20-39.

Baron, R. M., & Kenny, D. A. (1986). The moderator-mediator variable distinction in social psychological research: Conceptual, strategic, and statistical considerations. *Journal of Personality and Social Psychology, 51*, 1173-1182.

Blau, G. (2000). Job, organizational, and professional context antecedents as predictors of intent for interrole work transitions. *Journal of Vocational Behavior, 56*(3), 330-345.

Blau, G., Paul, A., & St. John, N. (1993). On developing a general index of work commitment. *Journal of Vocational Behavior, 42*(3), 298-314.

Blau, G. J. (1988). Further exploring the meaning and measurement of career commitment. *Journal of Vocational Behavior, 32*(3), 284-297.

Brief, A. P., & Weiss, H. M. (2002). Organizational behavior: Affect in the workplace. *Annual Review of Psychology, 53*, 279-307.

Bristow-Braitman, A. (1995). Addiction recovery: 12-step programs and cognitive-behavioral psychology. *Journal of Counseling & Development, 73*(4), 414-418.

Cain, C. (1991). Personal stories: Identity acquisition and self-understanding in Alcoholics Anonymous. *Ethos, 19*(2), 210-253.

Cammann, C., Finchman, M., Jenkins, D., & Klesh, J. (1979). The Michigan Organizational Assessment Questionnaire. Unpublished Manuscript. University of Michigan.

Colquitt, J. A., Conlon, D. E., Wesson, M. J., Porter, C., & Yee Ng, K. (2001). Justice at the millennium: A meta-analytic review of 25 years of organizational justice research. *Journal of Applied Psychology, 86*, 425-445.

Culbreth, J. R. (1999). Clinical supervision of substance abuse counselors: Current and preferred practices. *Journal of Addictions & Offender Counseling, 20*(1), 15-25.

Culbreth, J. R. (2000). Substance abuse counselors with and without a personal history of chemical dependency: A review of the literature. *Alcoholism Treatment Quarterly, 18*(2), 67-82.

Culbreth, J. R., & Borders, L. D. (1998). Perceptions of the supervisory relationship: A preliminary qualitative study of recovering and nonrecovering substance abuse counselors. *Journal of Substance Abuse Treatment, 15*(4), 345-352.

Culbreth, J. R., & Borders, L. D. (1999). Perceptions of the supervisory relationship: Recovering and nonrecovering substance abuse counselors. *Journal of Counseling & Development, 77*(3), 330-338.

Denzin, N. K. (1987). *The Recovering Alcoholic*. Newbury Park, CA: Sage.

Doosje, B., Ellemers, N., & Spears, R. (1999). Commitment and Intergroup Behavior. In N. Ellemers, R. Spears & B. Doosje (Eds.), *Social Identity: Context, Commitment, Content* (pp. 84-106). Oxford: Blackwell.

Ducharme, L. J., Knudsen, H. K., & Roman, P. M. (2008). Emotional exhaustion and turnover intention in human service occupations: The protective role of coworker support. *Sociological Spectrum, 28*(1), 81-104.

Griffeth, R. W., Hom, P. W., & Gaertner, S. (2000). A meta-analysis of antecedents and correlates of employee turnover: Update, moderator tests, and research implications for the next millennium. *Journal of Management, 26*, 463-488.

Hackett, R. D., Lapierre, L. M., & Hausdorf, P. A. (2001). Understanding the links between work commitment constructs. *Journal of Vocational Behavior, 58*(3), 392-413.

Hackman, J. R., & Oldham, G. R. (1976). Motivation through the design of work: Test of a theory. *Organizational Behavior & Human Performance, 16*(2), 250-279.

Hecksher, D. (2007). Former substance users working as counselors: A dual relationship. *Substance Use & Misuse, 42*(8), 1253-1268.

Hogg, M. A., Terry, D. J., & White, K. M. (1995). A tale of two theories: A critical comparison of identity theory with social identity theory. *Social Psychology Quarterly, 58*(4), 255-269.

Hollander, J. K., Bauer, S., Herlihy, B., & McCollum, V. (2006). Beliefs of board certified substance abuse counselors regarding multiple relationships. *Journal of Mental Health Counseling, 28*(1), 84-94.

Judge, T. A., & Larsen, R. J. (2001). Dispositional affect and job satisfaction: A review and theoretical extension. *Organizational Behavior and Human Decision Processes, 86*(1), 67-98.

Judge, T. A., Locke, E. A., Durham, C. C., & Kluger, A. N. (1998). Dispositional effects on job and life satisfaction: The role of core evaluations. *Journal of Applied Psychology, 83*(1), 17-34.

Kellogg, S. (1993). Identity and recovery. *Psychotherapy: Theory, Research, Practice, Training, 30*(2), 235-244.

Knudsen, H. K., Ducharme, L. J., & Roman, P. M. (2006). Counselor emotional exhaustion and turnover intention in therapeutic communities. *Journal of Substance Abuse Treatment, 31*(2), 173-180.

Koski-Jannnes, A. (2002). Social and personal identity projects in the recovery from addictive behaviours. *Addiction Research & Theory, 10*(2), 183-202.

Kristof-Brown, A. L., Zimmerman, R. D., & Johnson, E. C. (2005). Consequences of individual's fit at work: A meta-analysis of person-job, person-organization, person-group, and person-supervisor fit. *Personnel Psychology, 58*(2), 281-342.

Laudet, A. B. (2003). Attitudes and beliefs about 12-step groups among addiction treatment clients and clinicians: Toward identifying obstacles to participation. *Substance Use & Misuse, 38*(14), 2017-2047.

LeBreton, J. M., Wu, J., & Bing, M. N. (2009). The truth(s) on testing for mediation in the social and organizational sciences. In C. E. Lance & R. J. Vandenberg (Eds.), *Statistical and Methodological Myths and Urban Legends: Received Doctrine, Verity, and Fable in Organizational and Social Research* (pp. 107-141). New York: Routledge.

Lee, K., Carswell, J. J., & Allen, N. J. (2000). A meta-analytic review of occupational commitment: Relations with person- and work-related variables. *Journal of Applied Psychology, 85*(5), 799-811.

Lee, T. W., Mitchell, T. R., Wise, L., & Fireman, S. (1996). An unfolding model of voluntary employee turnover. *Academy of Management Journal, 39*, 5-36.

Loi, R., Hang-yue, N., & Foley, S. (2004). The effect of professional identification on job attitudes: A study of lawyers in Hong Kong. *Organizational Analysis, 12*(2), 109-128.

Mael, F., & Ashforth, B. E. (1992). Alumni and their alma mater: A partial test of the reformulated model of organizational identification. *Journal of Organizational Behavior, 13*(2), 103-123.

Mathieu, J. E., & Zajac, D. M. (1990). A review and meta-analysis of the antecedents, correlates, and consequences of organizational commitment. *Psychological Bulletin, 108*(2), 171-194.

McLellan, A. T., Carise, D., & Kleber, H. D. (2003). Can the national addiction treatment infrastructure support the public's demand for quality care? *Journal of Substance Abuse Treatment, 25*(2), 117-121.

McNulty, T. L., Oser, C. B., Johnson, J. A., Knudsen, H. K., & Roman, P. M. (2007). Counselor turnover in substance abuse treatment centers: An organizational-level analysis. *Sociological Inquiry, 77*(2), 166-193.

Meyer, J. P., Allen, N. J., & Smith, C. A. (1993). Commitment to organizations and occupations: Extension and test of a three-component conceptualization. *Journal of Applied Psychology, 78*(4), 538-551.

Meyer, J. P., Becker, T. E., & Vandenberghe, C. (2004). Employee commitment and motivation: A conceptual analysis and integrative model. *Journal of Applied Psychology, 89*, 991-1007.

Meyer, J. P., Stanley, D. J., Herscovitch, L., & Topolnytsky, L. (2002). Affective, continuance, and normative commitment to the organization: A meta-analysis of antecedents, correlates, and consequences. *Journal of Vocational Behavior, 61*(1), 20-52.

Mowday, R. T., Porter, L. W., & Steers, R. M. (1982). *Employee-Organizational Linkages*. New York: Academic Press.

Neter, J., & Wasserman, W. (1990). *Applied linear statistical models: Regression, analysis of variance, and experimental designs.* Homewood, IL: Irwin.

Olmstead, T. A., Johnson, J. A., Roman, P. M., & Sindelar, J. L. (2007). Why are recovering substance abuse counselors paid less? *Substance Abuse, 28*(1), 31-44.

Parker, S. K., Wall, T. D., & Cordery, J. L. (2001). Future work design research and practice: Towards an elaborated model of work design. *Journal of Occupational and Organizational Psychology, 74*, 413-440.

Rhoades, L., & Eisenberger, R. (2002). Perceived organizational support: A review of the literature. *Journal of Applied Psychology, 87*(4), 698-714.

Schmidt, J. A., & Lee, K. (2008). Voluntary retirement and organizational turnover intentions: The differential associations with work and non-work commitment constructs. *Journal of Business and Psychology, 22*(4), 297-309.

Smith, J. F. (1976). Index of organizational reactions (IOR). *JSAS Catalog of Selected Documents in Psychology, 6*(54), No 1265.

Stets, J. E., & Burke, P. J. (2000). Identity theory and social identity theory. *Social Psychology Quarterly, 63*(3), 224-237.

Stryker, S., & Serpe, R. T. (1994). Identity salience and psychological centrality: Equivalent, overlapping, or complementary concepts? *Social Psychology Quarterly, 57*(1), 16-35.

Tajfel, H. (1974). Social identity and intergroup behaviour. *Social Science Information/sur les sciences sociales, 13*(2), 65-93.

Tajfel, H., & Turner, J. C. (1986). The Social Identity Theory of Intergroup Behavior. In S. Worchel & W. G. Austin (Eds.), *Psychology of Intergroup Relations* (2nd ed., pp. 7-24). Chicago: Nelson-Hall Publishers.

Valle, S. K. (1979). *Alcoholism counseling: Issues for an emerging profession*. Springfield, IL: Thomas.

Van Dick, R., Christ, O., Stellmacher, J., Wagner, U., Ahlswede, O., Grubba, C., et al. (2004). Should I Stay or Should I Go? Explaining Turnover Intentions with Organizational Identification and Job Satisfaction. *British Journal of Management, 15*(4), 351-360.

Van Dick, R., Wagner, U., Stellmacher, J., & Christ, O. (2004). The utility of a broader conceptualization of organizational identification: Which aspects really matter? *Journal of Occupational and Organizational Psychology, 77*(2), 171-191.

Van Dick, R., Wagner, U., Stellmacher, J., Christ, O., & Tissington, P. A. (2005). To Be(long) or Not to Be(long): Social Identification in Organizational Contexts. *Genetic, Social, and General Psychology Monographs, 131*(3), 189-218.

Van Vuuren, M., Veldkamp, B. P., de Jong, M. D. T., & Seydel, E. R. (2008). Why work? Aligning foci and dimensions of commitment along the axes of the competing values framework. *Personnel Review, 37*(1), 47-65.

Watson, D., Clark, L. A., & Tellegen, A. (1988). Development and validation of brief measures of positive and negative affect: The PANAS scales. *Journal of Personality and Social Psychology, 54*(6), 1063-1070.

Wegge, J., Van Dick, R., Fisher, G. K., Wecking, C., & Moltzen, K. (2006). Work motivation, organizational identification, and well-being in call centre work. *Work & Stress, 20*(1), 60-83.

Wiener, Y. (1982). Commitment in Organizations: A Normative View. *Academy of Management Review, 7*(3), 418-428.

# APPENDIX A

## AFFECTIVE PROFESSIONAL COMMITMENT SCALE

*Please answer the following questions using the scale:*

*SD=Strongly Disagree, D=Disagree, N=Neither Agree nor Disagree, A=Agree, SA=Strongly Agree*

___ My profession is important to my self-image.

___ I regret having entered the substance abuse profession.*

___ I am proud to be in the substance abuse profession.

___ I dislike being a substance abuse professional.*

___ I do not identify with the substance abuse profession.*

___ I am enthusiastic about the substance abuse profession.

*Items marked with an asterisk are reverse scored.

# APPENDIX B

## AFFECTIVE ORGANIZATIONAL COMMITMENT SCALE

*Please answer the following questions using the scale:*

*SD=Strongly Disagree, D=Disagree, N=Neither Agree nor Disagree, A=Agree, SA=Strongly Agree*

___ I would be very happy to spend the rest of my career with this organization.

___ I really feel as if this organization's problems are my own.

___ I do not feel a strong sense of belonging to this organization.*

___ I do not feel emotionally attached to this organization.*

___ I do not feel like part of the family at this organization.*

___ This organization has a great deal of personal meaning to me.

*Items marked with an asterisk are reverse scored.

# APPENDIX C

## JOB SATISFACTION SCALE

*Please answer the following questions using the scale:*

*SD=Strongly Disagree, D=Disagree, N=Neither Agree nor Disagree, A=Agree, SA=Strongly Agree*

___ When I finish a day's work, I almost always feel like I have accomplished something worthwhile.

___ The kind of work I do has a favorable influence on my overall attitude toward my job.

___ I enjoy nearly all the things I do in my job.

___ Nearly all of the work I do stirs up real enthusiasm on my part.

___ I really don't like the kind of work that I do.*

___ Work like mine discourages me from doing my best.*

*Items marked with an asterisk are reverse scored.

# APPENDIX D

## TURNOVER INTENTION SCALE

*Please answer the following questions using the scale:*

*SD=Strongly Disagree, D=Disagree, N=Neither Agree nor Disagree, A=Agree, SA=Strongly Agree*

___ It is likely that I will actively look for a new job in the next year.

___ I often think about quitting my job.

___ I will probably look for a new job in the next year.

# APPENDIX E

## ROLE OVERLOAD SCALE

*Please answer the following questions using the scale:*

*SD=Strongly Disagree, D=Disagree, N=Neither Agree nor Disagree, A=Agree, SA=Strongly Agree*

___ I have too much work to do to do everything well.

___ The amount of work I am asked to do is fair. *

___ I never seem to have enough time to get everything done.

*Item marked with an asterisk is reverse scored.

# APPENDIX F

## POSITIVE AFFECTIVITY SCALE

*These items ask you to report on how you typically feel on a daily basis. This is how you feel on the average. Indication how often you feel this way, by writing one number in the blank to the left of each item.*

*Use the scale: 1=Almost Never, 2=Seldom, 3=Sometimes, 4=Often, 5=Almost Always*

___ Interested

___ Excited

___ Strong

___ Enthusiastic

___ Proud

___ Alert

___ Inspired

___ Determined

___ Attentive

___ Active