

# JOURNAL

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### The Supervisor: An Historical Perspective <sup>1</sup>

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#### *Abstract*

The clinical supervisor in the drug/alcohol addiction treatment field takes many roles. Today, more than ever, those roles are needed to facilitate the field in maintaining its integrity and independence. Since the inception of Alcoholics Anonymous in 1935, the field has had the recovering alcoholic/addict as its mainstay. The recovery movement, as we know it today, is the result of the grass roots efforts and enthusiasm of recovering people. Today, as the field becomes increasingly legitimized through certification requirements and evidence based treatment interventions, the supervisor must bridge the gap between old and new. The supervisor must inspire a new generation of counselors who will keep the best from the past while integrating the new science of addiction treatment.

#### *Roles of the Clinical Supervisor in the Addictions Treatment Field: An Historical Perspective*

The 2010 clinical supervisor in the addiction treatment field stands at a crossroads of change. As change offers opportunities for growth and increased professionalism, change also creates new dangers as the field is increasingly integrated into medical and psychiatric systems of care. Some forecasters predict that the discrete field of drug and alcohol treatment may no longer exist in twenty years time (Powell, 2007). As the demographics of the culture continue to change with the aging of the baby boomers, a generation of leaders in "policy development, administration, clinical supervision, clinical practice, research, education and training" (White, 2006) is aging out of the field. New clinical practices are being implemented. Today's clinical supervisor is in the unique position of bridging the old with the new not only in terms of training new personnel but in terms of implementing a changing clinical paradigm. As the field becomes more and more legitimized through government regulations and public acceptance, it is conversely in danger of being swallowed up by the mental health and behavioral health fields. Historical challenges intersecting with contemporary challenges place today's clinical supervisor in a unique position. The supervisor must facilitate today's addiction counselors in bridging this divide in order to preserve the strengths that have evolved in drug and alcohol counseling over

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the past sixty-five years while integrating new evidence based practices into the field. The supervisor must be cognizant and respectful of and the field's rich history in order to bring today's practitioners into the modern paradigm. Without a skillful blending of the historical and the modern, the field as we know it, may not continue to exist.

The clinical supervisor's principle role in the addiction treatment milieu is to guide and support the direct service staff in providing quality rehabilitation services to clients. The supervisor's role within the organization evolved in tandem with the evolution of the treatment field. At any given point in history or any point in a supervisor's career, the supervisor could be a team member, teacher, consultant or mentor along with being an evaluator and program administrator. A supervisor rarely was or is the wearer of a single hat. The role of the clinical supervisor in the addiction treatment field is more complicated than that of the clinical supervisor in other types of mental health treatment modalities. The addiction treatment field was and continues to be a field that struggles with the moralistic prejudice of the greater society. The field had its beginnings in grass roots efforts originated from and staffed principally by individuals who themselves suffered from addictive disease. The field has been characterized by charismatic leaders who pioneered distinctive methods of addressing addictive disease and whose influence is still present in the modern addiction counselor. The field of addictive disease treatment today is a field that struggles to keep up with scientific advancements while at the same time dealing with the ever shrinking dollar. Burn-out in the field is pervasive and is in part due to the expectation that today's providers do more for less. Today's clinical supervisor, whether acting as a team member, teacher, consultant, mentor, evaluator or program administrator is charged with the unique job of bridging the old with the new and consequently helping preserve the discrete modality of addiction treatment. There are those who predict that the specialized field of addictive disease treatment could be swallowed up by the medical and mental health fields unless advancements are made in overcoming moralistic attitudes within society and in fully integrating new ideas and interventions into the field. The clinical supervisor is charged with teaching and mentoring both tenured counselors and those who are new to the field. In each case, a new clinical paradigm must either replace or be integrated with the old clinical paradigm.

The history of drug and alcohol treatment provides insights into the role of the clinical supervisor and the inherent challenges that exist within that role. From the charismatic leader, to the recovering supervisor, to the PhD professional the clinical supervisor in the addiction treatment field is grappling with a controversy as old as the field itself. Dating from the 18<sup>th</sup> Century, addiction counseling and treatment in America has involved controversy regarding the efficacy of the professional therapist as opposed to the recovered peer being best in the role of counselor. The inebriate homes and mutual aid societies of colonial America were founded and manned by the reformed temperance leaders of the day. At the same time, mainstream physicians and religious leaders formed the first addiction cure asylums and addiction cure missions. These early professionals were opposed to the reformed inebriate being involved in the rehabilitation of the alcoholic. In 1897, Dr. T. D. Crothers, Editor of the *Journal of Inebriety*, wrote that the reformed inebriates were incompetent by reason of organic defects of the higher mentality (White, 2006). In the early 19<sup>th</sup> Century, the Emmanuel Clinics, which integrated religion, psychology and medicine, were the first to use the lay therapist. Alcoholics Anonymous, formed in 1935, represents the most enduring use of peer support. AA spawned a proliferation

of recovery homes based on its principles. The most notable AA offshoot is the Minnesota Model which started in 1949 and continues today. The Minnesota Model used the “counselor on alcoholism” role. During the 1950’s and 60’s social model recovery homes and halfway houses sprung up and also made use of recovered counselors and administrators.

In 1958, Chuck Dederich, a recovered alcoholic and the original charismatic drug treatment leader, started Synanon, the first rehabilitation program dedicated to the drug addict. Synanon was staffed exclusively by ex-addicts who achieved recovery through the Synanon program. Dederich created the program based on his own recovery, his experiences taking LSD and principles of brain washing (Morantz, 2008). The program utilized “the game”, a form of attack against the individual which can be conceptualized as tearing the individual psyche down prior to brain washing the person into new ways of thinking. Synanon’s discovery that addicts soon relapsed when they left the program spurred the discontinuance of graduation from the Synanon program. Addicts were taught that they must stay in the program forever, away from society, in order to remain clean. Addicts who left the program were banished from Synanon and its members. Synanon was the forefather of the Therapeutic Community which began with Daytop Lodge in New York in 1957. Daytop was founded in response to the problem of the criminal addict. The program continued the “game”, but less so. The program relied heavily on the charismatic leader, confrontation in group therapy, role modeling by ex-addicts, work and a hierarchy of peers. Today, the Therapeutic Community continues as a treatment option both in and out of forensic settings. Delancy Street in San Francisco, though having graduations, also continues to offer the recovering addict a lifetime refuge from society. Community opposition to Daytop Lodge illustrated people’s aversion for addicts in their neighborhood. The “Not in My Backyard” (NIMBY) syndrome continues today illustrating the difficulty the addict may perceive in returning to society and their possible preference for peer support rather than professional intervention.

The 1970’s represented a significant change for the addictions rehabilitation field when massive increases in funding spurred development of a professional treatment industry. The “paraprofessional” of the 1970’s was rapidly required to model themselves after the professional therapist or social worker. Many states instituted educational and certification requirements for counselors. Personal recovery was de-emphasized and the percentage of recovering counselors declined. Recovering people, however, continued to take an active part in treatment programs in roles considered to be non-clinical (White, 2006). The field continued to benefit from increased professionalism during the 1980’s and 1990’s but the heyday of the funding of the 1970’s did not last. The push towards greater and greater professionalism has been affected by low levels of funding coupled with increasing credentialing standards.

Education and certification requirements vary from state to state so the levels of higher education among staff vary from state to state. The Pacific Southwest Addiction Technology Transfer Center conducted a 1994 survey in Arizona, California and New Mexico (as cited in the Coalition of Alcohol and Drug Associations, 1994) that found that 46% of counselors had education ranging from some college to an AA degree, 17% had a Bachelor’s degree and 28% had a Master’s degree. They found that 2/3 of the counselors were in recovery. Eby (as cited in SAMHSA Tip 52) found that non-recovering counselors report significantly lower job satisfaction

and commitment and higher turnover intentions than counselors in recovery. The 1994 survey found that client-centered and AA/12 Step approaches were the most frequently mentioned treatment model by both directors and staff. A 2007 nationwide survey of 348 drug abuse treatment units (of which 25% were associated with medical settings) revealed that 42% of the total counselor workforce held graduate degrees. The survey indicated that managers-supervisors advocated the use of evidence based practices while support staff were significantly less supportive of treatment innovations. Support staff, 24% of the workforce, were more likely to support confrontation and coercion. Support staff has more hours of direct contact with clients and present a significant roadblock to the success of the implementation of evidence-based practices (McCary, et al, 2007). Support staff, as well as counselors, needs to be trained in implementing the change of approach in the treatment of addicted people. Support staff are also likely to move up to counselor positions, sometimes before they become certified. For the clinical supervisor, the tension between professionalism and the history of grass roots peer support within the field of addictions treatment are core issues to be resolved in today's treatment program with today's treatment professionals and support staff.

Intoxication is as ancient as man and has always been a part of the human experience (Walton, 2002). Human beings have used plants and alcohol for the purpose of intoxication since time immemorial. So much so that the psychopharmacologist, Ronald K. Siegel, considers the strength of the human desire for intoxication as a natural part of our biology and as the "fourth drive" following the human drives for food, sleep and sex (Siegel, 2005). Siegel's drive theory notwithstanding, for as long as humans have used intoxicating substances they have also had a love/hate relationship with those substances. The earliest record of a prohibitionist teaching is from 2000 B.C. by an Egyptian priest who writes to his pupil, "I, thy superior, forbid thee to go to the taverns. Thou art degraded like beasts" (Montagu, A., retrieved 12/29/09).

This love/hate relationship has been particularly true throughout United States history. Benjamin Rush, one of the founding fathers, labeled alcoholism as a disease in 1785 yet the temperance movement flourished during the nineteenth century, narcotics were criminalized by the Harrison Act in 1914 and the Volstead Act made alcohol illegal in the United States from 1919-1933. Despite the disease concept, intemperate users of alcohol and users of narcotics have traditionally been labeled as weak willed and immoral. Because of societal beliefs, the addict and the alcoholic have been considered to be untreatable or not deserving of treatment. Freud, who described his own love affair with cocaine as "exhilaration and lasting euphoria" (Jones, 1981) nonetheless wrote that drug addicts were not suitable for psychoanalysis because every backsliding or difficulty in therapy led to further recourse to the drug (Byck, 1974). Many professionals both in and out of the addiction field accept the updated disease concept which states that addiction is a physiological brain disease that is chronic and, if left untreated, fatal. They accept that behavioral and medical treatments which are effective in treating other chronic disorders can be as effective in treating chemical dependency (McLellan, Lewis, O'Brien & Kleber, 2000). However, some professionals both in and out of the addiction field continue to view the addict/ alcoholic as a criminal acting purely out of choice. A 1983 review documented widespread negativity towards addicted individuals by treatment providers (Imhof, Hirsch & Terenzi) and in 1995 Imhof asserted that the medical field continued to hold negative attitudes toward the alcohol abuser. Professional psychiatrists, psychologists and medical providers'

attitudes have remained consistent with Freud's point of view until fairly recently. The clinical supervisor needs to be aware of lingering attitudes in professionals, both in and out of the addiction field and communicate that to those being supervised. As a consultant, the supervisor can offer suggestions on how to deal with lingering negativity toward the addict. The clinical supervisor works in a field that has been traditionally stigmatized and underfunded. Attitudes resulting in a lack of compassion and a subsequent lack of funding prevail to the present day despite efforts by researchers and treatment providers to convince the public otherwise. Clinical supervisors must first convince counselors and support staff to adopt new attitudes and utilize evidence-based, compassionate, practices before society at large will fully accept new ways of looking at the addict. Treatment services are moving away from the paradigm of the client fitting to the program and towards a new paradigm where the program fits itself to the needs of the client. The old paradigm often required strict treatment compliance from the client while the new paradigm is viewing addiction as a chronic, relapsing disease that requires keeping clients involved in on-going recovery using a system of care which utilizes modalities chosen to meet the client where the client is at the time. This involves use of evidence based approaches, service retention, constant re-engagement and individualized treatment plans (White, et al, retrieved 12/29/09). It also involves focused energy by the clinical supervisor to teach and institute the new paradigm.

The love/hate relationship that America has with intoxicants is emphasized by society's rampant approval of and use of chemical agents from coffee and alcohol to pharmaceutical drugs. Certain types of use are incorporated into the fabric of our society and condoned but other types of use are marginalized and punished. Many substances including opium, cocaine, heroin, amphetamine and LSD were initially lauded and widely used but the substances were subsequently banned and users ostracized. The current state regarding the use of cigarettes in today's culture provides an astute comparison. Thirty years ago, smoking was accepted and was as ubiquitous as coffee. Today, the substance is banned in many public places and its users are stigmatized. Cigarette addicts are beginning to be seen as morally weak and self-willed. Moderate use of alcohol is an acceptable, even encouraged, practice in American culture but those who overindulge are stigmatized and rejected by society. Today's society hides many narcotic addicts who have been made so by the medical establishment but the suffering individual is often rejected by the very doctors who enabled their addictions. The opiate addict who uses pharmaceuticals is soon forced to resort to street drugs and to seek treatment in methadone clinics. Users of illegal substances have learned society's message that pain should be medicated. Many, if not most, of these users are suffering from severe sociological and psychological pain for which society has little or no compassion. In each case, the cigarette addicts, alcoholics and junkies have first been encouraged to use their substance of choice but then have been abandoned and blamed. Today's clinical supervisor is challenged to mentor recovering as well as non-recovering staff who have been subject to society's negative attitudes and who may have internalized those attitudes. During the course of providing treatment, blaming and ostracizing behaviors by counselors, who are often themselves recovering, may illuminate their own internalized hate toward the victims of addiction. Those who have been victimized by society's scorn can develop traits as a result of that victimization such as self-denigration or identification with the aggressor (Allport, 1954). Non recovering counselors may find it hard to understand and be compassionate regarding the client's inability to exert rational

control over their addiction (White, et al, retrieved 12/29/09). Unacknowledged attitudes in counselors present an issue of which the clinical supervisor needs to be aware. Today's more compassionate approaches to treatment may be unconsciously sabotaged by counselors who have interjected society's negative attitudes toward the addict.

Because of financial constraints, many clinical supervisors are also team members who must fill in for absent staff or even carry their own caseload. Being in this position merges boundaries and makes the objectivity of the supervisor difficult. Another boundary problem involves the clinical supervisor who is also an administrator and whose evaluation of the staff is not only educational but also used to evaluate the supervisee as an employee. The clinical supervisor must respond to competing demands for time. If the supervisor is called to provide direct services or to be responsible for administrative tasks, meetings and paperwork, supervision can fall into a lower priority category than is clinically appropriate. To be a proper mentor and teacher the clinical supervisor needs to put direct client services as the number one priority. Often, financial considerations interfere with that priority and undermine the supervisor's role as teacher and mentor. Supervisors and programs face a liability if the supervisor is unaware of what is going on between the client and the counselor and malpractice occurs (Durham, Retrieved 12/1/09).

The historically low wages that exist in the field of chemical dependency treatment make developing and retaining both supervisors and counselors an on-going difficulty within the field. The clinical supervisor, as teacher and mentor, is the link between change and staff retention within the field. The clinical supervisor can inspire supervisees to commit themselves to the field. Through the supervisor, the supervisee can experience the field as dynamic and life changing for clients. The supervisee can be inspired to look into the future and see the possibilities that the field holds for the committed professional. This aspect of the supervisor's role is particularly important today. Many in the field today are the baby boomers who are reaching retire age and who are looking to pass the torch to a younger generation of addiction treatment professionals. The excitement and commitment that those workers have brought to the field through the history of grass roots action needs to be passed on and integrated with evidence based scientific innovations. The clinical supervisor is charged with the task of helping create a new workforce that will keep the field empowered into the 21<sup>st</sup> Century.

The supervisor needs to be aware of and sensitive to the forces and long history that hold the status quo in place in addictions treatment. Education level and certification requirements are not uniform from State to State which makes service positions held by recovering counselors variable but still pervasive. The number of Masters level counselors vary from State to State. Masters level counselors who commit to the field are usually in recovery (Milne-Glasser, 2007) and have developed attitudes based upon their own recoveries. Masters level individuals may enter the field at a supervisory level. This can create a situation where the supervisor is out of step with line staff. Some staff can be hostile but many staff are eager to learn new techniques and philosophies. Because of force of habit they might, however, have difficulty integrating the new information into what they actually do.

Powell (2007) stated that only 50% of counselors were currently certified in the specialty field of

drug and alcohol addiction counselors. In California, it has only been during the last five years that substance abuse counselors have been required to earn professional certification through education and supervised experience. Regardless of education level when beginning employment, any new staff member who has direct client contact is given 5 years to become certified. This policy guarantees an influx of recovering people who may or may not have educational qualifications at the time of hire. In spite of certification requirements, education levels of counselors can be low. Many enter certification programs with a high school diploma or GED. Many also enter with experience and pre-conceived notions drawn from several years participating in 12 Step Recovery Programs. Many current counselors and supervisors represent the group that has worked in the field for many years and were grandfathered into certification. Educational variables, coupled with the fact that programs have often developed policies and procedures over the course of decades, makes the job of the clinical supervisor difficult. The teacher who is also a mentor must be able to demonstrate success with new practices. New evidence based practices and changing philosophies compete with the time-worn practices of 12 Step Recovery programs and long-standing treatment programs. The disparity between new scientific evidence and personal and program beliefs create sometimes passionate disagreements among program staff. Reconciling beliefs and research is critical to clinical supervision (White, et al, retrieved 12/12/09). Counselors who have previously relied on a program menu of interventions and bottom lines need sensitive teaching and evaluating from the clinical supervisor to become adept and comfortable with the new paradigm.

Carl Jung first used the term wounded healer (Jung, 1951). Jung drew on the archetype Chiron, the Greek healer, to hypothesize that the best healer is the one who has suffered soul disease. In 1938, when Bill Wilson and Dr. Bob Smith started Alcoholics Anonymous they used principles from Carl Jung and from the Oxford Group, a Christian Evangelical organization. The concept of one alcoholic helping another surely extrapolates from Jung's wounded healer. Recovering counselors within the addiction treatment field are wounded healers which creates inherent difficulties. The field of chemical dependency treatment is notorious for staff burn-out. Burn-out is a major factor contributing to high staff turnover in today's treatment programs and contributes to the current labor shortage in the field. Recovering counselors are prone to compassion fatigue due to a heightened sensitivity to the issues surrounding addiction, particularly if the counselor has a history of trauma and abuse (O'Mara. 2006).

The non-recovering counselor can also be subject to compassion fatigue based on their own psychological makeup and personality. Organizational demands resulting from staff shortages and diminishing resources can exacerbate compassion fatigue and produce full blown burn-out in counselors. Counselors may then be frequently absent from work and develop a cynical, hopeless attitudes. Burn-out begets more burn-out in other counselors as counselors begin to contribute less and less to the treatment team.

It is the job of the clinical supervisor as a mentor to model good self-care as well as to be alert to signs of burn-out in staff. The supervisor must consult with the supervisee on a regular basis in regard to self-care and signs of burn-out. Relapse among recovering staff is always a possibility to which a supervisor needs to be attuned. Unfortunately, there is a lack of consistent guidelines regarding lengths of sobriety for recovering counselors and inherent difficulty in

monitoring the recovery status of a supervisee. Anyone who has worked in the field for any length of time has witnessed the chaos caused by the relapsing staff member. Intervening in this type of situation is an ethical minefield for the clinical supervisor who most likely would need to consult regarding the correct course of action to take. A study on complications in the supervision process found that the number one ethical concern of supervisors was working with an incompetent or impaired supervisee (DeTrude, 2001).

The clinical supervisor is charged with teaching ethics and monitoring their supervisees in that regard. The four areas of biomedical ethics are autonomy, beneficence, non-maleficence and justice (Durham, retrieved 12/1/09). The new clinical paradigm which encourages as much autonomy by the client as possible may clash with the old paradigm in which the counselor makes decisions for the client. The clinical supervisor must be wary of the counselor who revels in the role of the charismatic leader and help that supervisee find satisfaction in seeing the client learning to be autonomous. Beneficence in the form of hope and encouragement comes naturally to most counselors. However, counselors may veer off track when the hope and encouragement is conditional and does not have room for the chronicity of the disease. Again, the old may clash with the new in this regard. Counselors need to be constantly aware of laws and codes that prescribe the ethics in the field. The clinical supervisor needs to make supervisees aware of where and how these laws and codes may be violated. Confidentiality, as it relates to 12 Step meetings is a particularly tricky issue for recovering staff. Many agencies have rules as to where and how a recovering staff member may participate in meetings. Non-maleficence, do no harm, is a fertile area for ethical dilemmas. There are many ways of relating to clients in the old paradigm is now unacceptable. Counselors may have a hard time seeing or have a hard time accepting the clinical changes that require less invasive, more accepting approaches to interacting with clients. Taking stage of change into account when evaluating how a counselor interacts with a client is a new way of thinking that may not come easily to counselors who have been working in the field for many years. The clinical supervisor as teacher and evaluator must sensitively bring all staff into the new paradigm in regards to ethics. Counselors must first recognize ethical dilemmas and then be helped to formulate ethical decision making skills. The clinical supervisor might find it particularly helpful to form and maintain an ethically based relationship with the supervisee which can then be replicated by the supervisee with his/her clients. Instituting changes in approach must be made very sensitively with an eye to not disrespecting the counselor's good intentions.

Reliance on the old paradigm was often fueled by counter-transference issues of which the counselor was unaware. Today's clinical supervisor must train the supervisee to expect, recognize and appropriately address transference and counter-transference issues.

The client's transference issues are usually well defined. The client loves the counselor or hates the counselor, or both on alternating days. The counselor's countertransference reactions to the client are more complicated. The counselor may enjoy the pedestal the client erects and the feeling of competence it bestows but alternately will bristle with anger when the pedestal is abruptly removed. The clinical supervisor needs to be alert to the client's splitting and the counselor's resultant countertransference. Sometimes, it is difficult to convince a counselor that the client's idealization and devaluation really have nothing to do with the counselor. When the

client stirs the counselor's desire to rescue or stirs the counselor's desire to recoil, the clinical supervisor must teach the counselor to focus instead on the why. Why did this happen? What internal conflicts, affects and anxieties caused this? (Kraft Goin, 1998). Without the supervisor's intervention, this type of situation can escalate to staff-wide splitting with some staff on the side of the client and some against the client. This type of splitting happened commonly in the old paradigm. Addiction counselors also may need to be convinced that expressing sympathy or congratulations represents countertransference. Albanese and Shaffer (2003) suggest that rather than sympathy or congratulations, the counselor should ask questions such as "When did you decide?" "How did you decide?" or "What is that going to be like for you?" This approach takes the counselor's reaction out of the client's purview and minimizes the possibility of the client trying to please or disappoint the counselor. The clinical supervisor needs to be sensitive to the counselor's desire to act as a cheerleader or a sympathizer and provide more appropriate clinical responses.

Despite the fact that the counselor's interpersonal skills in session are correlated with greater therapeutic effectiveness (Luborsky, McLellan, Woody & O'Brien, 1985), many counselors have tended to blame the client for treatment failures. Staff may reject difficult clients and label them beyond help. The close connection between pathology and unlikability in the client may stir the counselor with powerful negative feelings that the counselor may project onto the client. (Bursztajn, Gutheil & Brodsky, retrieved 12/5/09). Winnicott's *Hate in the counter-transference* (1949) suggested that the therapist could have a natural and normal reaction to working with a psychotic patient and that reaction might be hate. Winnicott stated, "Apart from psycho-analytic treatment, the management of a psychotic is bound to be irksome". Convincing the drug treatment counselor that hate can be a normal reaction to the client and that treatment can progress nevertheless is a tricky job for the clinical supervisor. In the old paradigm, countertransference hate was routinely projected onto the client with resultant practices such as "attack therapy" groups held to allow the community to blame and shame the client. Rule infractions prompted sometimes lengthy, abusive consequences. Banishment was considered an appropriate consequence for clients choosing to leave treatment and premature discharge due to rule infractions was commonplace. Most programs no longer employ those interventions, but the attitude of wanting to punish the client can persist. Dietz (as cited in Pirzada Sattar, Pinals & Gutheil, 2002) recommended that if forensic psychiatrists notice that they are becoming "aroused, attracted, afraid or angry" that most probably is due to countertransference. Treatment professionals need to be trained by the clinical supervisor to consistently draw the same conclusions. Counselors who repress and deny countertransference hate may consciously or unconsciously act out their hate and rage. Maltzberger and Buie (as cited in Albanese & Shaffer, 2003) break down countertransference hate into malice, aversion and a mixture of the two. Malice stimulates disgust and punishment. Malice can allow the counselor to maintain the relationship with the client but aversion tempts the counselor to abandon the client. Clients who stimulate malicious or aversive reactions in counselors can be driven from treatment. The clinical supervisor should be sensitive to this possibility and work with the counselor to avoid it. Counselors need to be taught to recognize countertransference hate and the resultant malice and aversion it can engender.

Counselors may tend toward defensiveness to cover inherent feelings of inadequacy in

performing an ever more complicated job with a minimal of training and education. Providers are currently expected to provide services that are “developmentally appropriate, gender specific, family centered, culturally competent, trauma-informed, strengths-based and evidence-based (to name just a few)” (White, et al, retrieved 12/29/09). The provider must be able to recognize the symptoms of mental health diagnoses, communicable diseases and other health complications that may occur with addiction. The provider needs to make appropriate referrals and, in addition, the provider should be familiar with the local medical and mental health system in order to help the client access services. Helping client access entitlement programs in order to pay for services is also part of the job description. It is no wonder that the clinical supervisor and the counselor may be subject to feelings of overwhelm. Counselors who are feeling overwhelmed will tend to revert to older, more comfortable stances when interacting with clients. The clinical supervisor as consultant must guide and inform the supervisee while keeping a close eye on signs of overwhelm.

A common intervention used by the overwhelmed counselor is the use of excessive self-disclosure. The use of self-disclosure, because it is a central concept in 12 Step recovery programs, needs to be constantly monitored by the clinical supervisor. Some supervisors, in fostering increased professionalism, choose to ask their supervisee's to minimize the use of self-disclosure. Over-identification with the client can be seen as a form of counter-transference where the counselor responds to the client as if the client is the counselor's former, addicted, self. This can lead to the counselor assuming that what worked for them should work for the client. The counselor, in this instance, is not meeting the client where they are but rather where the counselor imagines them to be. The counselor may become co-dependent with the client and focus more on nurturing the client than helping the client challenge their dysfunctional ways of thinking and acting. The counselor may be preoccupied with the client liking them or with the client being successful and validating them. This type of countertransference renders the counselor helpless to tolerate the client's process. The clinical supervisor should be constantly alert for over-identification and the resultant attitudes it engenders. Working with counselors to develop unconditional positive regard for clients without the countertransference leading to codependency is a balancing act for the clinical supervisor.

As is true in any clinical field, the roles demanded of the clinical supervisor in the addiction treatment field are many and varied. The complexity, however, is exacerbated in the addiction treatment field due to a unique intersection between the old and the new. As older, tenured workers are aging out of the field, a new generation of workers is entering the field. An old treatment paradigm involving charismatic leaders and 12 Step concepts is giving way to a new paradigm that treats addiction as the chronic, relapsing disease that it is. Change always breeds tension and the tensions that today's clinical supervisor contends with are daunting. The age-old differences between recovering and non-recovering staff further complicate the changes. Today's addiction treatment programs are working hard to preserve the love and enthusiasm of the grass roots efforts that started in 1935 with Alcoholics Anonymous and to integrate the exciting innovations of evidence based clinical practices and scientific, brain based information to the field. The clinical supervisor, as team member, teacher, consultant, mentor, evaluator and program administrator is at the vanguard of the revolution happening in addiction treatment today.

The clinical supervisor's relationship with the supervisee should provide an example of the appropriate client/counselor relationship. The supervisor need always be cognizant of the power differential that exists in the supervisor/supervisee relationship in order to avoid the abuse of power. The supervisor is a team member, teacher, consultant, mentor, evaluator and often a program administrator. The supervisee holds the same roles in relation to clients. The supervisor needs to always role model appropriate boundaries with the supervisee. As the supervisor takes stage of change and the desires of the supervisee into account in the supervising relationship, the supervisee will emulate the same inherent respect for clients in the counseling relationship. The old paradigm focused on hope and the joy of recovery while the new paradigm focuses on process and respect for the strengths of the individual. Through the supervisor/supervisee relationship today's clinical supervisor can illustrate how seamlessly the old and the new can operate in the treatment environment and thus inspire a new generation of treatment professionals to keep the field alive and vibrant.

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