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## A Qualitative Study to Explore Clinical Supervisors' Perceptions of How Personal Recovery Influences Their Supervision

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A Qualitative Study to Explore Clinical Supervisors' Perceptions of How Personal Recovery  
Influences Their Supervision

A Dissertation

Submitted to the Graduate Faculty of the  
University of New Orleans  
in partial fulfillment of the  
requirements for the degree of

Doctor of Philosophy  
in  
Counselor Education

By

Adrianne L. Trogden

B.A. Milligan College, 2002  
M.A. Indiana Wesleyan University, 2004

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## Dedication

I dedicate this dissertation to my parents, Jim and Kris Trogden.

Thank you for teaching me and always believing in me.

*I love you.*

And

Cortney Parsudi, my sister.

Thank you for fun adventures and being such a solid support.

*I love you.*

And

All those who have struggled with addiction and found recovery.

Thank you for instilling hope in those around you and inspiring me.

*I admire you.*

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## **Abstract**

Substance abuse counseling has many counselors and supervisors who are in recovery from a personal history of substance abuse. Approximately 37% of supervisors in the substance abuse field reported being in personal recovery (Eby, Burke, & Birkelbach, 2009). Little is known about how a clinical supervisor's personal recovery influences his or her clinical supervision. The purpose of this phenomenological research study was to investigate the perceived lived experiences of clinical supervisors' in recovery during the clinical supervision of substance abuse counselors working towards a license or credential in Louisiana. A qualitative phenomenological methodology, Interpretative Phenomenological Analysis (IPA) was used to analyze data from six clinical supervisors in recovery using semi-structured interviews. Themes emerged from the data, which resulted in 13 categories: 1) functions of supervision; 2) factors influencing the supervision relationship; 3) insight into addiction; 4) factors pertaining to self-disclosure; 5) managing dual relationships; 6) recovery isn't enough; 7) relapse potential and management; 8) stigma of addiction; 9) structure of supervision; 10) countertransference; 11) feelings about self-disclosure; 12) importance of self-care; and 13) supervisors need supervision and consultation. The categories provide increased understanding and insight into how recovery influences and were used in supervision by supervisors in recovery. Implications for supervisors in recovery, supervisees of supervisors in recovery, and clinical supervisor educators are also addressed.

**Key Words:** Substance Abuse Counseling; Addictions; Substance Abuse; Clinical Supervision; Supervisors in Recovery; Wounded Healer

## Chapter I

### Introduction

In this chapter, background information is presented on substance abuse counseling and clinical supervisors. A definition of the problem is stated along with the purpose of this qualitative study. The significance of the study is explained. The conceptual framework and an overview of the methodology are reviewed. The research questions are presented and the limitations and delimitations of this study are explored. Finally, definition of terms are provided.

### Overview

In 2016, an estimated 20.1 million persons aged 12 or older in the United States (7.5% of the population) were classified with substance use disorders based on criteria from the Diagnostic and Statistical Manual of Mental Disorders, 4<sup>th</sup> edition (DSM-IV, Substance Abuse and Mental Health Services Administration, SAMHSA, 2017). Over the course of 2016, only 1.4% of people sought substance abuse treatment at a specialty facility (SAMHSA, 2017). Of those individuals who sought treatment and maintained recovery, many also became substance abuse mental health professionals themselves and worked in treatment facilities. An estimated 30% to 50% of treatment professionals are *in recovery* (McGovern & Armstrong, 1987; Shipko & Stout, 1992; St. Germaine, 1996), a term identified primarily as total abstinence. Other professionals in the addiction field, such as counselors or supervisors of counselors are described as *nonrecovering* and identify as never having a substance abuse problem (Toriello & Leierer, 2005).

Counselors and supervisors of counselors in recovery are viewed as *wounded healers* due to the wounds of mental health and addiction they have experienced which has propelled them into the field of substance abuse treatment in the first place (Miller, Wagner, Britton, & Gridley,

1998). White (2000) commented that the wounds of addiction give counselors and supervisors greater insight into the challenges their clients face, but as suggested by Coleman and Colgan (1986); Nielsen (1987); and Preli, Protinsky, and Cross (1990), the wounds of addiction may leave counselors vulnerable to over identification with their clients. Counselors' over identification with clients can then create boundary issues, a concern that is already a challenge for individuals struggling with an addiction (Culbreth, 1999). Boundary issues typically result in ethical dilemmas in the counseling relationship.

Counselors in recovery may further their career and become clinical supervisors in recovery. Based on a self-report research study of clinical supervisors working in substance abuse programs, approximately 43% of counselors and 37% of supervisors reported being in recovery (Eby et al., 2009). Supervisors in the substance abuse field are responsible for supervising and training of new practitioners in the field, with some of those new practitioners in recovery themselves. Also, supervisors provide feedback, accountability, and endorsement of new practitioners for their professional credentials or licenses.

Each state in the United States has its own credential or licensure procedures for substance abuse counselors. In the state of Louisiana, practitioners who are working towards a substance abuse credential or license must be under the supervision of a clinical supervisor prior to becoming credentialed or licensed as substance abuse counselors. The Louisiana Addictive Disorders Regulatory Authority's (ADRA, 2016) has five credentialing levels for substance abuse counseling professionals, which include: 1) Addiction Treatment Assistant (ATA), 2) Counselor in Training (CIT), 3) Registered Addiction Counselor (RAC), 4) Certified Addiction Counselor (CAC), and 5) Licensed Addiction Counselor (LAC).



Clinical supervisors in recovery who supervise new practitioners working toward a credential or license in the substance abuse field are the identified population for the present study. In an effort to understand the unique experiences of clinical supervisors in recovery, I conducted a qualitative study using an Interpretive Phenomenological Analysis (IPA) approach. I investigated the lived experiences of clinical supervisors in recovery during their clinical supervision of substance abuse counselors working towards a substance abuse credential or license in Louisiana.

### **Purpose of the Study**

The purpose of this phenomenological study was to investigate the perceived lived experiences of clinical supervisors' in recovery during the clinical supervision of substance abuse counselors working towards a license or credential in Louisiana. Specifically, the aim of my study was to illicit meaning and understanding of clinical supervisors in personal recovery from past substance abuse. I investigated and interpreted how clinical supervisors' recovery status influences their clinical supervision with supervisees.

### **Significance of the Study**

Olmstead, Abraham, Martino, and Roman (2012) found that in the field of addiction counseling, competency-based supervision and quality of on-the-job training provided by supervisors of addiction counselors are lacking. One subgroup of clinical supervisors are those who are in personal recovery from substance abuse. Increased understanding of clinical supervisors who are in personal recovery from substance abuse and how their recovery status influences their supervision are needed. Awareness of the clinical supervision process for supervisors in recovery and the unique aspects that may influence their supervision process, could inform clinical supervision training programs regarding areas of focus for supervisor

competency. Additionally, this study could inform curriculum development in counselor education programs as well as educate trainers who provide training to clinical supervisors. Finally, this study has potential implications for employers who hire supervisors in recovery regarding training and competency needed to effectively supervise as a clinical supervisor in recovery (White, 2000 & 2008).

### **Conceptual Framework**

According to Glesne (2011), a conceptual framework shapes the context of the research questions and methods by providing a theoretical lens in which to view the results and implications of a study. Specific to my study, Miller et al. (1998) offered a theoretical framework for understanding the wounds of counselors while they are in training as mental health professionals. They proposed that the helping professions, like the addiction field, tend to attract individuals with wounds in their personal lives that propel them to want to help others by becoming mental health professionals. Vachon (2010) described the wounded healer as “someone who works with (heals) others and is informed by their own traumatic or difficult experiences (wounds) in the work that they do” (p. 55). According to Guggenbuhl-Craig (1999), the wounds of addiction assist counselors in recovery by relating to and treating their clients who are struggling with addiction.

Various theorists such as Rollo May (Remen, May, Young, & Berland, 1985), Sidney Jourard (1971), and Victor Frankl (1963) proposed that the concept of the wounded healer exists along a continuum rather than a dichotomy of wounded or not wounded. A healer may have no wounds (on one end of the continuum) to moderate wounds (in the middle of the continuum), to severe wounds (towards the other end of the continuum). The concept of the wounded healer or wounded counselor is not the degree of woundedness, but the ability of the wounded counselor

to draw from his or her own woundedness to help others (Frankl, 1963; Jourard, 1971; Remen et al., 1985). All of the authors agreed that counselors who have been wounded can transcend their personal pain, thereby bring compassionate healing to the therapeutic relationship (Cherniss, 1991; Hollis, 1989; Holmes, 1991; Kennedy, Kanthamani, & Palmer, 1994; Miller & Baldwin, 1987; Ryff & Keyes, 1995).

By using a continuum, Miller et al. (1998) posited that addiction wounds can be an asset as well as a vulnerability for counselors in recovery from substance abuse. Counselors' introspection that addresses their wounds can be encouraged by clinical supervisors, thus counselors can avoid vulnerability by re-experiencing their wounds during counseling practice. When counselors' wounds are addressed, the focus of counseling is on clients instead of counselors. An important distinction between wounded counselors and impaired counselors is that wounded counselors transcend their wounds to assist clients. Whereas, impaired counselors' wounds cause personal distress for them that adversely impacts clients (Jackson, 2001; Zerubavel & Wright, 2012). The American Counseling Association's (ACA) 2014 *Code of Ethics* defines counselor impairment as, "a significantly diminished capacity to perform professional functions" (p. 20). Wounded counselors thus have wounds that have healed sufficiently to practice responsibly, or the wounds are understood and processed enough to prevent interference with the therapeutic process of clients thereby avoiding counselor impairment (Zerubavel & Wright, 2012).

The concept of the wounded healer is particularly demonstrated in alcohol and drug addiction counseling. Since the beginning of Alcoholics Anonymous (A.A.) in the 1930s, the belief has been that the most effective substance abuse counselors are those counselors who have survived addiction themselves and thus become wounded healers (White, 2000). Those

counselors in recovery may advance to becoming clinical supervisors. Eby et al. (2009) indicated that 37% of substance abuse supervisors reported being in personal recovery from substance abuse, thereby demonstrating that a large segment of substance abuse clinical supervisors are wounded healers themselves. Zerubavel and Wright (2012) stated that research is lacking on how counselors' own recovery processes influence the therapeutic work they do with clients and how counselors who have wounds know they have healed to a sufficient degree in order to practice counseling responsibly.

The wounded healer concept can be extrapolated to clinical supervisors in personal recovery as there is no research on how clinical supervisors who have wounds know they have healed to a sufficient degree in order to supervise responsibly. The ambiguity of sufficient healing creates a potential ethical dilemma for both the wounded counselor and wounded supervisor in how completely the wounds must be healed in order to effectively counsel or supervise. The relative silence on whether the attributed wounds pertain to a potential stigma if disclosed and concern over being judged by colleagues regarding competency to practice results in secrecy, self-stigma, and shame for counselors and supervisors in recovery (Gil, 1988; Jackson, 2001; White, 2000; Zerubavel & Wright, 2012). However, substance abuse counseling is unique in that it is common and even preferred for counselors who are in recovery and who are wounded healers to self-disclose about their personal experiences (Jackson, 2001; White, 2000). My research study was framed theoretically within the context of the wounded healer, specific to clinical supervisors in recovery from substance abuse.

### **Problem Statement**

Research indicated that counselors in recovery were often promoted to a supervisor position based on seniority rather than skill, knowledge, training, or education; however, minimal

research exists on clinical supervisors in personal recovery from substance abuse (Culbreth & Cooper, 2008). Specifically, no research had been conducted on how personal recovery from substance abuse and the unique aspects of recovery influence clinical supervisors' styles of supervision. Little research or literature existed as to the phenomenon of clinical supervisors' experiences in recovery (Anderson, 2000; Culbreth, 1999; Sias, 2009). No literature was found on how clinical supervisors in recovery conduct supervision. Therefore, a gap in the current literature exists regarding clinical supervision of substance abuse counselors by clinical supervisors in recovery. Further research is needed on the experiences of clinical substance abuse counselors in recovery.

### **Overview of Methods and Research Questions**

The purpose of this phenomenological study was to investigate the lived experiences of clinical supervisors who are in recovery and who are supervising substance abuse counselors working towards licensure or credentials in Louisiana. A phenomenological approach was used to explore the universal essence or meaning of the phenomenon experienced by each individual participant. Semi-structured interviews were conducted to gain a deeper understanding of supervision experiences by recovering clinical supervisors who were supervising substance abuse counselors. IPA was the methodology of the study and provided a structure for gathering detailed descriptions of what were clinical supervisors in recovery personal experiences in their clinical supervision of supervisees working towards a Louisiana substance abuse license or credential.

**Research questions.** In a qualitative study, research questions are broad in nature and allow the researcher an opportunity to explore a topic in depth (Corbin & Strauss, 2008). A central research question is a guide for the entire research study and several subquestions were derived

from the main research question (Creswell, 2007). My central research question was, What are the lived experiences of clinical supervisors in recovery from past substance abuse when they are supervising supervisees working towards a Louisiana substance abuse license or credential? My three subquestions included the following:

1. How does clinical supervisors' recovery of substance abuse influence their clinical supervision with substance abuse counselors working towards a Louisiana substance abuse license or credential?
2. What are the advantages and challenges of being in recovery from substance abuse of clinical supervisors during clinical supervision with substance abuse counselors working towards a Louisiana substance abuse license or credential?
3. How are personal recovery experiences of clinical supervisors used in supervision with substance abuse counselors working towards a Louisiana substance abuse license or credential?

### **Limitations and Delimitations**

Several limitations existed in my study. One key limitation of my study was the potential biases regarding the researchers' own experiences as a clinical supervisor of substance abuse counselors. Creswell (2007) stated that managing biases is a necessary part of qualitative research. The use of bracketing, a codebook, and a peer debriefer were tools that I used to manage my researcher biases. Additionally, six participants were limited to clinical supervisors in personal recovery from substance abuse who supervise counselors working towards a substance abuse license or credential in Louisiana. According to Creswell (2007), qualitative research typically has small numbers of participants, and Smith, Flowers, and Larkin (2009) stated that IPA studies, in particular, use small sample sizes.

Due to the nature of inquiry, my study was delimited to six participants. The number of participants limit transferability to other clinical supervisors as qualitative research is difficult to transfer to other settings or groups (Creswell, 2007). The sample collected may not have been indicative of clinical supervisors in recovery as a whole in Louisiana. Therefore, a critique of my study was the limited transferability to a similar context such as mental health counseling supervisors in general. Additionally, the context of clinical substance abuse supervision in Louisiana could be very different from clinical substance abuse supervision contexts in other geographical regions.

### **Assumptions of the Study**

An assumption of my study was that an interaction existed between the participants' personal recovery and the clinical supervision they provided for counselors working towards a substance abuse credential or license in Louisiana. Secondly, the interview questions designed for my study were assumed to be valid and accurately depicted participants' perceptions of how their substance abuse recovery status influenced their clinical supervision with counselors working towards a substance abuse credential or license in Louisiana. A third assumption was that participants were honest in their answers during the interview process and that their perceptions were valuable.

### **Definition of Terms**

The following terms are relevant to my research study and the definitions are presented to assist the reader in fully understanding the meaning of the terms in the context of my study.

**Administrative supervision.** Administrative supervisors assist supervisees to function effectively within a larger organization focusing primarily on workplace performance, paperwork timeliness, and accountability to the organization (Bradley & Ladany, 2001).

**Credential.** Credential is defined as “certified documents showing that a person is entitled to credit or has a right to exercise official power” (Merriam-Webster, credential, n.d.)

**Clinical supervision.** Bernard and Goodyear (2004) defined clinical supervision as a relationship that, “is evaluative, extends over time, and has the simultaneous purposes of enhancing the professional function of the more junior person(s), monitoring the quality of professional services offered to the clients... and serving as a gatekeeper of those who are to enter the particular profession” (p. 8).

**Interpretative phenomenological analysis (IPA).** Smith (2004) introduced IPA as a phenomenological approach to qualitative health research. IPA provides a structure for the exploration of participants’ lived experiences in detail and what those experiences mean to participants.

**Nonrecovering.** Nonrecovering is a term used to describe counselors and supervisors who work in the addiction counseling field who do not identify as ever having a substance abuse problem (Toriello & Leierer, 2005).

**Phenomenology.** Creswell (2007) explained phenomenology research as the process of focusing on the meaning of lived experiences of persons experiencing a concept, structure, or phenomenon. The purpose of phenomenological research is to explore a phenomena as perceived by each individual and describe the commonalities of perceived experiences.

**Recovery.** Personal recovery is identified primarily as someone who has previously abused substances and has since stopped, maintaining a lifestyle of abstinence (Doukas & Cullen, 2009). Recovery was described by Laudet (2007) as an on-going state of personal growth that goes beyond just staying sober, which may include 12-step program involvement, ongoing counseling, support groups, or spiritual practices.



**Substance abuse.** The American Society of Addiction Medicine (ASAM, 2013) defined substance abuse as “harmful use of a specific psychoactive substance” (p. 411).

**Wounded healer.** People who are recovering from substance abuse are sometimes referred to as *ex-addicts* or *wounded healers* when they have sought a career in counseling after overcoming their own personal addiction and their intentions are to assist others in their own sobriety (White, 2000).

## **Chapter II**

### **Literature Review**

The purpose of this chapter is to review existing research and literature related to clinical supervision in substance abuse counseling and supervisors' substance abuse recovery status. The main topics from the literature will include a history of substance abuse counseling, counselors in recovery, wounded healers, unique aspects of recovering counselors, credentialing for substance abuse counselors in Louisiana, clinical supervision of substance abuse counselors, models of clinical supervision, credentialing of clinical supervisors, training of clinical supervisors, and unique aspects of recovering clinical supervisors.

#### **History of Substance Abuse Counseling**

Substance use has continued to thrive in the United States with an estimated 20.1 million persons in the United States aged 12 and older, in 2016, classified as having a substance use disorder based on criteria from the DSM-IV (SAMHSA, 2017). Only 1.4% of those classified with a substance use disorder sought treatment for their substance abuse (SAMHSA, 2017). Historically, many people who successfully completed substance abuse treatment became employed by the treatment program they attended effectively becoming a recovering substance abuse professional (White, 2000).

Approximately 43% of counselors and 37% of supervisors reported being in personal recovery from substance abuse (Eby et al., 2009). Historically, these statistics have been consistent over time as previous estimates ranged from 30 to 50% of substance abuse treatment professionals who were in recovery (McGovern & Armstrong, 1987; Shipko & Stout, 1992; St. Germaine, 1996). The Betty Ford Consensus Panel (2009) defined recovery as “a voluntarily maintained lifestyle comprised of sobriety, personal health and citizenship” (p. 1). Laudet

(2007) described recovery as an on-going state of personal growth that goes beyond just staying sober which can include involvement in a 12-step program, ongoing counseling, support groups, and/or spiritual practices. SAMHSA (2012) defined recovery of substance use as “A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential;” which includes having stable housing, addressing health issues, finding life purpose, and participating in a community of recovery supporters (p. 3). As such, counselors and supervisors in recovery espouse to Laudet’s (2007) definition of maintaining an on-going state of personal growth. In contrast, nonrecovering is a term used to describe counselors and supervisors who work in the addiction counseling field who do identify as never having a substance abuse problem (Toriello & Leierer, 2005).

Researchers agreed that multiple ways can be used to attain recovery and that recovery is more of a lifestyle rather than a particular treatment modality (Betty Ford Consensus Panel, 2009; Gockel & Russell, 2005; SAMHSA, 2012). Most researchers also agreed that *sobriety* is consistent with abstinence from alcohol and all illicit and non-prescribed drugs (Betty Ford Consensus Panel, 2009; SAMHSA, 2015). Although, caffeine and nicotine are typically not considered as violations of sobriety or recovery (Betty Ford Consensus Panel, 2009). One of the goals of recovery is for the substance user to become a contributing citizen in the community (i.e., *citizenship*) by developing pro-social behaviors and ceasing to participate in socially harmful behaviors (Betty Ford Consensus Panel, 2009; SAMHSA, 2012). The Betty Ford Consensus Panel (2009) identified three types of recovery. Early recovery from substance abuse is 1 to 12 months in a recovery-based lifestyle. Sustained recovery is 1 to 5 years and stable recovery is 5 or more years. Recovering persons may be at any stage of recovery and become a counselor, although state board credentialing regulations or organizations may stipulate a

particular length of time in recovery before a recovering person may become licensed or credentialed as a counselor (ADRA, 2016; SAMHSA, 2015).

Substance abuse treatment for counselors in personal recovery dates back to the late 18<sup>th</sup> and early 19<sup>th</sup> centuries when Native American tribes were using wounded healers to treat active alcoholics, and the American temperance movement used recovering alcoholics to carry the message of recovery through writings and public speaking (White, 2000). In the late 1800's, the American temperance movement led to the first addiction treatment centers and mutual aid societies, which included the American Association for the Cure of Inebriety and the first substance abuse research journal, *The Journal of Inebriety* (White, 1998, 2000). The debate between who is more qualified to treat substance abusers, recovering counselors or non-recovering counselors, dates back to the 19<sup>th</sup> century as well as similar arguments that are still heard today about which group (i.e., recovering or nonrecovering) is best in providing substance abuse treatment. As early as 1897, Dr. T.D. Crothers posited that being in personal recovery does not give an individual a credential to understand addiction and that physicians who are in personal recovery who treat active alcoholics are more vulnerable to relapse than nonrecovering physicians. Historically, on the other side of this debate were addiction treatment centers that hired *reformed men* from alcoholism to work in treatment facilities to help active alcoholics achieve recovery (White, 1998, 2000).

Later in the 1920's, the emergence of lay therapy began, where former patients in recovery from alcoholism were hired to work at substance abuse treatment facilities as mentors to patients currently in treatment at facilities (White, 2000). At that time, more standardization and specific therapeutic interventions were developed for counselors in personal recovery to use with individuals who were actively using substances (White, 2000). In 1935, the founding of A.A.

(1957) provided a long-term sobriety-based peer support structure that complimented professional treatment and expanded access to individuals in recovery across the United States. In the 1940's, A.A. was also incorporated into treatment facilities and was an integral part of a new approach to addiction treatment called the Minnesota Model of Chemical Dependency Treatment. This model used a multi-disciplinary team (i.e. physicians, nurses, psychologists, counselors, peer recovery specialists) inclusive of counselors in recovery. In the model, the treatment of alcoholism was seen as a primary disorder (White, 2000).

It was not until the 1970's and 1980's that addiction counseling began to be regarded as a profession with standards for training, codes of ethics, and certification or licensure for substance abuse counselors. Previous to the transition to professionalization, a person in recovery could transfer directly out of personal treatment for substance abuse to being a practicing counselor. Facilities employing counselors in recovery may have had training and supervision parameters, but no national standards or state standards and laws for the profession existed (White, 2000). More recently, in the 20<sup>th</sup> century, an increase has occurred regarding professionalization in the addiction field including most states in the United States requiring a license from a state regulatory board for addiction counselors, academic programs with addiction classes, and specialized training in addictions across healthcare professions (Rieckmann, Farentinos, Tillotson, Kocarnik, & McCarty, 2011).

### **Counselors in Recovery**

Since the beginning of A.A. in the 1930s, the most effective substance abuse counselors were believed to be individuals who survived addiction themselves (White, 2000). Substance abuse counselors who were in recovery themselves from addiction, thus endeavored to help others enter into recovery. Ham, LeMasson, and Hayes (2013) as well as White (2000) stated

that the wounds from the counselors' addictions fueled their desire to help clients in treatment overcome their own addictive wounds thus, they became wounded healers.

**Wounded healer.** The term *wounded healer* was developed and defined as “someone who works with (heals) others and is informed by their own traumatic or difficult experiences (wounds) in the work that they do” (Vachon, 2010, p. 55). The concept of wounded healer was first coined by Carl Jung (1951) in his description of the wounded healer archetype, which refers to the counselor's vulnerability due to his or her own personal wounds from painful life experiences. Guggenbuhl-Craig (1999) stated that people are both motivated to become counselors and strengthened in their capacity to empathize with others by the painful life experiences or wounds they received from their personal experiences. Guggenbuhl-Craig (1999) further postulated that power emerges from a healer's own woundedness. Wounds add to a healer's skill and insight to make him or her a more effective counselor (Wheeler, 2007). Wounded healers should not be seen as damaged people who are inferior in some way compared to others, but instead the term wounded healer is attributed to people who open themselves up to engaging in the practice of counseling because they have been wounded (Wheeler, 2007).

Miller et al. (1998) offered a framework for understanding the concept of the wounded healer. The authors proposed that the helping professions tend to attract individuals with wounds from their personal lives that propel them to want to help others professionally. White (2000) believed that the wounded healer is particularly demonstrated in alcohol and drug addiction counseling due to many counselors being in recovery from personal substance abuse. Although, as Zerubavel and Wright (2012) pointed out, in one sense, all counselors have had painful life experiences, have struggled with adversity, or have experienced various kinds of suffering, therefore have some degree of woundedness. Substance abuse counselors who have a personal

history of addiction, in particular, have unique wounds from their time in active addiction to draw from as counselors (White, 2000). The wounded healer paradigm suggests that the words *wounded* and *healer* can be represented as a duality rather than terms in conflict with one another (Zerubavel & Wright, 2012). The paradigm of the wounded healer suggests that it is the stimulation of the wounded healer duality for both the counselor and the client that constructively informs the healing process (Guggenbuhl-Craig, 1978).

Various theorists including Rollo May (Remen et al., 1985), Sidney Jourard (1971), and Victor Frankl (1963) proposed that the concept of the wounded healer exists along a continuum rather than a dichotomy. Woundedness lies on the continuum from no wound to severely wounded. The wounded healer paradigm focuses not on the degree of woundedness but on the ability to draw from one's woundedness to help heal others (Zerubavel & Wright, 2012). By using a continuum, Miller et al. (1998) posited that introspection can be encouraged by counselors and supervisors of counselors to address their wounds, thus avoid vulnerability to re-experiencing their wounds during the practice of counseling. Several authors agreed that a counselor can transcend personal pain, thereby bring compassionate healing to the therapeutic relationship (Cherniss, 1991; Hollis, 1989; Holmes, 1991; Kennedy et al., 1994; Miller & Baldwin, 1987; Ryff & Keyes, 1995).

An important distinction is that wounded healers are not impaired professionals. In ACA's 2014 *Code of Ethics*, counselor impairment is defined as, "a significantly diminished capacity to perform professional functions" (p. 20). Impaired professional indicates that the wounds of the therapist cause personal distress that adversely impacts clinical work with clients (Jackson, 2001; Zerubavel & Wright, 2012). Emerson and Markos (1996) listed several issues that can lead to counselor impairment such as counselor burnout, depression, temporary emotional imbalance or

disturbance, drug and alcohol abuse, sexual exploitation, over involvement with clients, and overwork. Conversely to impaired counselor, the wounded healer has wounds that have healed sufficiently to practice responsibly, or the wounds are understood and processed enough to prevent interference with the therapeutic process with clients (Zerubavel & Wright, 2012).

Zerubavel and Wright (2012) further posited that research is lacking related to how counselors' own recovery processes influence the therapeutic work they do with clients and how counselors know they have healed to a sufficient degree in order to practice responsibly. Furthermore, research does not exist regarding clinical supervisors in recovery from substance abuse healing to a sufficient degree in order to supervise responsibly. The ambiguity of sufficient healing creates an ethical dilemma for both the wounded healer and their supervisor. It is difficult at times to determine when someone moves from a wounded healer into being an impaired professional where they are unable to perform professional functions responsibly (Zerubavel & Wright, 2012). It is unclear how many times or to what degree a counselor makes mistakes in order to be an of impaired counselor aside from egregious acts such as having a sexual relationship with a client or coming to work intoxicated (Emerson & Markos, 1996). While egregious acts are easier to identify, the subtleties of a counselor's wounds that can lead to impairment are harder to see and require active engagement in the supervision process to identify and manage professionally (Zerubavel & Wright, 2012).

The relative silence on the topic of wounded healers in general for the counseling profession has been attributed to the wounds often pertaining to a potential stigma if disclosed and concern over being judged by colleagues regarding competency to practice resulting in secrecy, self-stigma, and shame (Gil, 1988; Jackson, 2001; White, 2000; Zerubavel & Wright, 2012). Substance abuse counseling is unique in that it is common and even preferred for the counselor



to have had a personal history of substance abuse in which they have overcome, thus becoming wounded healers (Jackson, 2001; White, 2000). Also, in the substance abuse field it is common for substance abuse counselor to share their personal history with clients (White, 2000).

**Unique aspects of recovering counselors.** Many people who seek treatment and maintain recovery from substance use addiction go on to become counselors and work in substance abuse treatment facilities (McGovern & Armstrong, 1987). However, professional concerns exist regarding recovering substance abuse counselors. They are more vulnerable to professional boundary violations due to the effects of former substance abuse and concerns with being raised in families with substance abuse problems who have poor family boundaries (Coleman & Colgan, 1986; Nielsen, 1987; Preli, Protinsky & Cross, 1990). As a result, counselors in recovery have reported struggles in preventing and managing dual relationships in their counseling settings (Doyle, 1997; Gallagher, 2010). Counselors' unresolved personal issues, personal crises, disregard for self-care, and loneliness can potentially cause harm to clients (Coleman & Schaefer, 1986).

According to Toriello and Benshoff (2003), although, dual relationships can present a challenge to substance abuse counselors, counselors' recovery status did not have an impact on their sensitivity to ethical dilemmas. However, St. Germaine (1997) found that the second most common ethical complaint cited by counseling licensure boards was the inability to clinically practice due to substance use or other mental or physical problems. For clinical supervisors, relapse among recovering substance abuse counselors is a concern, which is not a typical concern in supervising nonrecovering counselors (Center for Substance Abuse Treatment, CSAT, 2009; Culbreth & Borders, 1999; Jones, Sells & Reh fuss, 2009; White 2000). Regardless

of recovery status, supervisors of both recovering and nonrecovering counselors have a responsibility to be conscious of ways counselors may exploit clients to meet their own needs.

Substance abuse counselors in recovery often struggle when using self-disclosure and tend to disclose inappropriately or too frequently (Fulton, Hartwig, Ybanez-Llorente, & Schmidt, 2016). Recovering counselors are influenced by personal issues and are particularly vulnerable to imposing their personal experiences and beliefs on clients in an attempt to be helpful (Juhnke & Culbreth, 1994). Sweeney (1996) investigated the use of self-disclosure by recovering substance abuse counselors and found that counselors early in their careers disclosed more freely regarding their recovery status and what worked for them in their own recovery process, but became more conservative in self-disclosure as they gained experience in the field. While self-disclosure can benefit clients in certain circumstances, self-disclosure should be used selectively with clients based on clients' needs and their welfare should be at the forefront (Ham et al., 2013).

The ADRA (2016) specifies in its *Code of Ethics* that, "a person holding a practice credential shall not engage in activities that seek to meet the counselor's or specialists personal needs at the expense of a client" (p. 2). Sweeney (1996) noted that one participant in his study acknowledged her self-disclosures early in her career were self-serving and not based on her clients' needs. Powell and Brodsky (2004) also addressed self-disclosure in the Blended Model of supervision. They stated that a definitive answer does not always exist regarding self-disclosure, but they do encourage supervisors and counselors to explore ethical guidelines, assess their own needs, assess consequences, and consult with other professionals to avoid legal and ethical violations related to self-disclosure.

Research has also been conducted on the various differences between recovering and nonrecovering counselors. A recent study by Saarnio (2010) looked at the differences in personality traits or interpersonal functioning of counselors in personal recovery and nonrecovering counselors. Saarnio found that counselors with personal substance abuse recovery issues were less emotionally stable and conscientious than nonrecovering counselors. Although, Saarnio's research supported questionable emotional stability and conscientiousness of counselors in recovery; client treatment outcomes remained the same with recovering counselors and nonrecovering counselors. In two other studies, clients reported the same treatment outcome achievement with counselors in personal recovery as they did with nonrecovering counselors (Culbreth, 2000; Najavits, Crits-Christoph, & Dierberger, 2000). Unique insights that recovering substance abuse counselors bring to the counseling relationship are understanding ideas that are related to the culture of addiction, being able to be a role model for clients, having empathy for suffering, and bringing insight that is related to the 12-step fellowship involvement (McGovern & Armstrong, 1987; White, 2000).

When considering recovery versus nonrecovery counselors, one other large difference was the training and education received by each group. Nonrecovering counselors were more likely to have graduate degrees than recovering counselors (Culbreth, 1999; Saarnio, 2010). Additionally, nonrecovering counselors were more likely to use academic training and theory to treat clients, whereas recovering counselors have a tendency to use subjective personal recovery experiences along with theory and training (Argeriou & Manohar, 1978; Blum & Roman, 1985; Tournier, 1979, White 2000).

## **Credentialing for Substance Abuse Counselors in Louisiana**

Substance abuse counselors have also progressed in credentialing across the United States and can now get a credential or license in most states. According to ADRA (2016) in Louisiana, five levels of credentials are required for substance abuse professionals in Louisiana: 1) Addiction Treatment Assistant (ATA); 2) Counselor in Training (CIT); 3) Registered Addiction Counselor (RAC); 4) Certified Addiction Counselor (CAC); and 5) Licensed Addiction Counselor (LAC). Additionally, a Certified Clinical Supervisor (CCS) credential must be obtained by anyone supervising substance abuse professionals working toward the abovementioned credentials. All credentials require substance abuse professionals to be involved in supervision with a CCS until licensed as an LAC.

An individual may progress from ATA to CIT to RAC to CAC and finally to LAC, or he or she may start at any point depending on his or her level of education, field experience and successful completion of the competency exams. The ADRA uses eligibility requirements and competency-based tests at each level of certification, which are published by the International Credentialing and Reciprocity Consortium (IC&RC; IC&RC, 2016). The ADRA governs and issues all of the abovementioned credentials and substance abuse professionals are required to obtain continuing education in order to renew their credentials annually (ADRA, 2016).

The ATA credential is an entry-level credential that is renewed annually, but an individual does not have an independent right to practice, therefore he or she must work under a supervisor. To obtain an ATA credential, the ADRA requires the following: 1) 16 years of age or older; 2) legal resident of the United States; 3) in recovery from drugs, alcohol and gambling for at least six months, if applicable; 4) identification of a RAC, CAC or LAC to function as supervisor; 5) documentation of six hours of training in professional ethics; 6) documentation of training in

confidentiality, first aid, and CPR; 7) background check with written description of any felony convictions; 8) three written professional references; 9) copy of driver's license; 10) signed copy of the *ADRA Rules*, including the *ADRA Code of Ethics*; and 11) one-year supervisory plan signed by supervisor and applicant. The ATA is to function in a supportive role in a therapeutic environment directly supervised by a RAC, CAC or LAC (ADRA, 2016).

The CIT credential is also an entry-level credential that is renewed annually, but an individual does not have an independent right to practice credential, therefore he or she must work under a supervisor. To obtain a CIT credential, the ADRA requires the following: 1) 18 years of age or older; 2) legal resident of the United States; 3) in recovery from drugs, alcohol and gambling for at least two years, if applicable; 4) identified a CCS to function as supervisor; documented completion of at least 180 clock hours of substance abuse addiction specific education; 5) background check with written description of any felony convictions; 6) three written professional references; 7) copy of driver's license; 8) signed copy of the *ADRA Rules*, including the *ADRA Code of Ethics*; and 9) one-year supervisory plan signed by supervisor and applicant. The CIT is an entry-level credential for persons seeking to pursue the RAC, CAC and/or LAC credentials and may practice addiction counseling under the direct supervision of a CCS while gaining education and field experience for the higher-level credentials. CITs may practice independently with regular supervision of a CCS after completion of 300 hours of direct clinical supervision (ADRA, 2016).

The RAC credential is a step higher than the CIT and is a competency-based right to practice credential renewable every two years, but an individual still must practice under supervision. To obtain a RAC credential, the ADRA requires the following: 1) 21 years of age or older; 2) holds a high school diploma or high school diploma equivalent (GED); 3) legal

resident of the United States; 4) in recovery from drugs, alcohol and gambling for at least two years, if applicable; 5) identified a CCS to function as supervisor; 6) documented completion of at least 270 clock hours of education (180 hours of the 270 hours must be specific to substance abuse treatment, six hours in professional ethics, with the remaining 84 hours related); 7) successful completion of 6,000 hours of supervised work experience in the treatment of addictions supervised by a CCS; 8) background check with written description of any felony convictions; 9) three written professional references; 10) copy of driver's license; 11) a signed copy of the *ADRA Rules*, including *ADRA Code of Ethics*; and 12) demonstration of competence by passing a written exam. RACs may practice independently with regular supervision of a CCS (ADRA, 2016).

The CAC credential is a step higher than the RAC and is a competency-based right to practice credential renewable every two years, but an individual still must practice under supervision. To obtain a CAC credential, the ADRA requires the following: 1) 21 years of age or older; 2) holds a bachelor's degree from an accredited institution of higher education in a human services/behavioral science field; 3) legal resident of the United States; 4) in recovery from drugs, alcohol and gambling for at least two years, if applicable; 5) identified a CCS to function as supervisor; 6) documented completion of at least 270 clock hours of education (180 hours of the 270 hours must be specific to substance abuse treatment, six hours in professional ethics, with the remaining 84 hours related); 7) successful completion of 4,000 hours of supervised work experience in the treatment of addictions supervised by a CCS; 8) background check with written description of any felony convictions; 9) three written professional references; 10) copy of driver's license; 11) signed copy of the *ADRA Rules*, including *ADRA Code of Ethics*; and 12)

demonstration of competence by passing a written exam. CACs may practice independently with regular supervision of a CCS (ADRA, 2016).

The LAC credential is the highest credential available in Louisiana for a substance abuse counseling professional and has an independent right to practice credential renewable every two years. To obtain the LAC credential, the ADRA requires the following: 1) 21 years of age or older; 2) holds a master's or doctoral degree from an accredited institution of higher education in a human services/behavioral science field; 3) legal resident of the United States; 4) in recovery from drugs, alcohol and gambling for at least two years, if applicable; 5) documented completion of at least 270 clock hours of education (180 hours of the 270 hours must be specific to substance abuse treatment, six hours in professional ethics, with the remaining 84 hours related); 6) successful completion of 2,000 hours of supervised work experience in the treatment of addictions supervised by a CCS; 7) background check with written description of any felony convictions; 8) three written professional references; 9) copy of driver's license; 10) signed copy of the *ADRA Rules*, including *ADRA Code of Ethics*; and 11) demonstration of competence by passing a written exam. LACs may practice independently without supervision of a CCS (ADRA, 2016).

Once a professional has completed the abovementioned requirements of each credential level in Louisiana, he or she may submit an application to the ADRA. Professionals may also be dually licensed as an addiction professional and a licensed professional counselor, licensed social worker, or marriage and family therapist (ADRA, 2016).

## **Clinical Supervision of Substance Abuse Counselors**

Bernard and Goodyear (2004) offered the following definition for clinical supervision as a “relationship [that] is evaluative, extends over time, and has the simultaneous purposes of enhancing the professional function of the more junior person(s), monitoring the quality of professional services offered to the clients...and serving as a gatekeeper of those who are to enter the particular profession” (p. 8). Whereas, administrative supervision is defined as an individual who assists supervisees to function effectively in the larger organization focusing primarily on workplace performance, paperwork timeliness, and accountability to the organization (Bradley & Ladany, 2001).

Eby, Burke, and Birkelbach (2006) found that addiction counselors value the quality of the clinical supervisory relationship. Additionally, researchers found that addiction counselors with a favorable view of clinical supervision reported increased job satisfaction, commitment to their job and organization, less emotional exhaustion and burnout, and greater feelings of support and autonomy in their job functions (Eby et al., 2006; Knudsen, Ducharme, & Roman, 2008).

Culbreth (1999) surveyed 134 substance abuse counselors and found that participants indicated a high level of satisfaction in both clinical and administrative supervision with their overall supervisory experiences.

Mixed feelings occurred regarding substance abuse counselors who received supervision from a professional discipline that differed from the profession the counselors were working toward. Berger and Mizrahi (2001) identified concerns related to the effect of interprofessional supervision on the maintenance of professional identity and standards as well as quality of care for clients. For example, the authors found that supervision for social workers overall declined in the hospital setting and there was an increased use of interprofessional supervision in which



social workers were not supervised by other social workers, but were instead supervised by nurses, physicians, psychologists, or other mental health professionals. They found that supervision was done only as requested by the supervisee for individual supervision, and most supervision was done in the form of interdisciplinary team meetings. As a result, the professional identity of social workers and social work standards decreased due to other professionals having no knowledge or training in social work standards of care and professional identity. Additionally, client quality of care decreased due to the lack of supervision to reinforce standards of care.

**Models of clinical substance abuse supervision.** From SAMHSA's Center for Substance Abuse Treatment (2009), two models of clinical supervision explicitly recommended in their Treatment Improvement Protocol (TIP) 52 are Bernard and Goodyear's (2004) Discrimination Model and Powell and Brodsky's (2004) Blended Model.

***Discrimination model.*** Bernard and Goodyear's (2004) Discrimination Model incorporates three roles of a supervisor as teacher, counselor, and consultant. The supervisor roles of the counselor and teacher have clearly emerged in the research, but the consultant role has been more elusive although it is universally identified as a necessary role in the supervision process, Bernard and Goodyear (2004) stated that the consultant role is not as clearly defined in a universal way among supervisors, and therefore not as easy to identify in the context of research studies. In spite of an unclear definition, their supervision model remains one of the most widely used and empirically supported supervision models in the field of counseling (Borders & Brown, 2005).

According to Bernard and Goodyear (2004), the Discrimination Model has three skill areas of supervision that focus on intervention, conceptualization, and personalization. Intervention

skills include what the supervisor observes the supervisee doing in the counseling sessions. Conceptualization skills include how the supervisee is theorizing what is going on with the client and identification of the client's patterns of functioning. Personalization skills include how the supervisee utilizes their own personal style in therapy and the avoidance of countertransference. The supervisor may be a teacher at times instructing the supervisee on how to utilize a particular intervention, a counselor at times helping the supervisee process personal issues that may be impacting his or her work with a client, and a consultant who at times offers various options for the supervisee to consider.

The Discrimination Model is discriminatory as the supervisor tailors supervision responses to situations based on the needs of the supervisee. The supervisor judges the skills of the supervisee and then decides what role is most appropriate to use to accomplishing the goals of supervision. Bernard and Goodyear's model allows the supervisor flexibility between roles to meet the needs of the supervisee. In any given supervision session, the supervisor may utilize all three roles depending on what issues are presented by the supervisee. Their model has been described as "one of the best known models of supervision" (Borders & Brown, 2005, p. 7). Since the model's inception, considerable empirical attention has been received by the model and it is among the most researched models of supervision in the mental health field resulting in numerous research study findings (e.g., Goodyear, Abadie, & Efros, 1984; Goodyear & Robyak, 1982; Lazovsky & Shimoni, 2007; Putney, Worthington, & McCullough, 1992; Stenack & Dye, 1982, 1983).

***Blended model.*** The second supervision model recommended by SAMHSA is Powell and Brodsky's (2004) Blended Model. It is the only supervision model specifically designed for substance abuse counseling supervision. The Blended Model is adapted from Stoltenberg,

McNeill and Delworth's (1998) Integrated Development Model (IDM) for supervising counselors. Counselors progress through three primary developmental levels as they gain competency in eight domain areas. Stoltenberg et al. (1998) asserted that supervisors move through the same three primary developmental levels as they gain experience in supervising. The supervision process focuses on moving the supervisee from a Level 1 counselor to a Level 3 counselor, which was adapted from Stoltenberg and Delworth's (1987) three stage model of counselor development. A Level 1 counselor is considered an entry-level counselor who is dependent on the supervisor, lacking in self-awareness, having rigid thinking patterns, frequently anxiety-ridden, and enthusiastic about work. Supervision at this developmental stage focuses on basic counseling skills, praise and encouragement, introduction to ambiguity and conflict, strength identification and risk-taking encouragement; all done in the context of a supervisee's learning style. Level 2 counselors are beginning a journey of skill development and often struggle with how to effectively help clients who have difficult problems. Counselors may struggle when disillusioned that they cannot help everyone, and begin searching for their own professional identity and autonomy. Supervision at this developmental stage focuses on providing support and safety for a supervisee to process their struggles, provide less instruction and more modeling opportunities, and encourage critical thinking. Level 3 counselors are more mature and comfortable in their role as counselors and focus on autonomy and establishing a personal style of counseling through self-awareness and self-care. Supervision at this final developmental stage focuses on encouraging autonomy and shifting to a more consultative relationship.

The Blended Model expands on IDM incorporating 13 dimensions that define the nature of supervision with three levels of counselor development (Powell & Brodsky, 2004). Supervisees

mature along a continuum in each dimension and the supervisor is seen primarily as a guide in the growth process. Powell and Brodsky (2004) described the three stages as embedded within 13 dimensions that define the nature of supervision: 1) influential, 2) symbolic, 3) structural, 4) explicative, 5) counselor in treatment, 6) information gathering, 7) jurisdictional, 8) relationship, 9) strategy, 10) journey, 11) internalization, 12) listening, and 13) questioning. Each dimension views the supervisee's development related to his or her developmental level and integrates the spiritual aspects of change by having the supervisor take a holistic approach to the supervisee's development by encouraging collaboration between the supervisor and supervisee. Powell and Brodsky (2004) outlined qualities of contemplative supervision by putting emphasis on the supervision alliance and the supervisor as a reflective practitioner. The supervisor should have a deeper self-awareness and a personal-spiritual disciplines that include practices such as stillness, meditation and reflection.

In Powell and Brodsky's (2004) model, emphasis is placed on integration of the spiritual aspects of change in a supervisee. They coined the term contemplative supervision to describe the integration of spirituality. Their Blended Model of supervision is based on the substance abuse treatment approaches that integrate the 12-step recovery program with the idea that substance abuse is a pervasive disease. Spirituality is seen as the impetus for change in the client as in the 12-step program, therefore the spirituality component is also a change agent for the supervisee during the supervision process.

In a research study by Anderson (2000), the IDM was applied specifically to the supervision of substance abuse counselors and found that the three overriding structures of IDM (e.g. self and other awareness, motivation, and autonomy) fit well into the process of supervision for substance abuse counselors. Anderson stated that substance abuse counselors who are in

personal recovery needed sufficient self-awareness to ensure his or her own recovery issues do not adversely affect client welfare as suggested in IDM's structure of self and other awareness. Additionally, recovering substance abuse counselors need to examine their own motivation for entering the field of substance abuse counseling and differentiate their participation in community recovery activities from their practice of counseling. Finally, Anderson stated that autonomy is as important in substance abuse counseling as it is in other types of counseling and the supervisor must assist the supervisee in moving towards greater autonomy.

### **Credentialing of Clinical Supervisors**

Licensing and certification boards in the field of substance abuse in many states require little to no education or training in clinical supervision for an individual to be approved as a supervisor (Hoge, Migdole, Farkas, Ponce, & Hunnicut, 2011). In Louisiana, professionals become supervisors through two pathways. One pathway is when a supervisor obtains a promotion or position in an agency setting typically based on seniority rather than credentials (Culbreth & Cooper, 2008; Hoge et al., 2011). In mental health agencies and health care organizations, many supervisors are promoted to their supervisor position based on seniority rather than skill, knowledge, training, or education (Culbreth & Cooper, 2008). Additionally, supervisors working in agencies and health care organizations typically are not required to be approved as a supervisor from a licensing board, but instead are only required to have an independent license in the mental health field (Culbreth & Cooper, 2008). However, clinical supervisors who take only the first pathway cannot supervise practitioners seeking licensure in such fields as substance abuse, social work, or counseling.

A second pathway to becoming a supervisor is by obtaining a supervision credential such as in Louisiana (e.g. Certified Clinical Supervisor, CCS; Licensed Professional Counselor

Supervisor, LPC-S; Licensed Clinical Social Worker Board-Approved Clinical Supervisor, LCSW-BACS). To obtain a CCS, the ADRA (2016) requires the following: 1) at least 21 years of age; 2) possess and maintain an LAC, CAC, RAC credential or other qualified mental health professional credential with a current and valid addiction add-on certificate; 3) legal resident of the United States; 4) not in violation of any ethical standard subscribed to by the ADRA or corresponding Board; 5) not been a substance abuser or compulsive gambler for at least two years; 6) not been convicted of a felony; 7) successfully completed 10,000 hours (5 full time years) of work experience in the treatment of people with addictive disorders, with 4,000 of 10,000 hours having been in a supervisory position; and 8) successfully completed 90 total clock hours of education approved by the ADRA. 30 hours of the 90 hours must be specific to the first five clinical supervision domains with a minimum of four hours in each domain with the remaining 60 hours being specific to addiction treatment.

To obtain a board-approved LPC supervisor credential (LPC-S) in Louisiana, the Licensed Professional Counselors Board of Examiners (LPC Board, 2016) requires the following: 1) current, active Louisiana license as a Licensed Professional Counselor (LPC); 2) practiced mental health counseling for five years with two of the five years post LPC licensure; and 3) successfully completed training in supervision through graduate-level academic training or a professional training program approved by the Licensed Professional Counselors Board of Examiners. To obtain a board-approved social work supervisor, the Louisiana State Board of Social Work Examiners (LABSWE, 2016) requires the following: 1) current and active Louisiana license as a Licensed Clinical Social Worker; 2) successfully completed a 6.5 hour social work supervisor training; 3) successfully completed a social work board orientation training; and 4) two letters of recommendation from colleagues in the field of social work.

## **Training of Clinical Supervisors**

A few models of supervision training and education specific to substance abuse supervision are available from the Addiction Technology Transfer Center (ATTC) and the Distance Learning Center for Addiction Studies (DCLAS) which are based on the Discrimination Model (Bernard & Goodyear, 2004) and the Blended Model (Powell & Brodsky, 2004) of supervision. For example, from the ATTC, the Northwest Frontier Addiction Technology Transfer Center (NFATTC) offers a week-long intensive training on the basic skills of clinical supervision (Lindbloom, Ten Eyck, Gallon, & Porter, 2009). A participant manual is available online for the training; however, NFATTC recommends the training be completed in-person. The training model includes lecture, demonstration, discussion, and group and individual supervision exercises completed in a classroom setting. The course assumes some knowledge of supervision by attendees and is designed for supervisors already practicing as clinical supervisors, but does not include administrative supervision information. The primary objectives of the course are understanding the clinical supervision tasks, giving feedback appropriately, creating a learning plan for supervisees, and understanding and assessing competencies in addiction counseling (Lindbloom et al., 2009).

Another widely used clinical supervision course entitled *Clinical Supervision in Alcohol and Drug Abuse Counseling: Principles, Models, Methods* was developed by David Powell and DCLAS (2011). This course is based on Powell and Brodsky's (2004) book *Clinical Supervision in Alcohol and Drug Abuse Counseling*. The course takes 30 hours to complete online and meets the requirements for the Certified Clinical Supervisor (CCS) credential offered by the International Credentialing and Reciprocity Consortium (IC&RC, 2016). The certification for addiction counseling clinical supervisors, CCS is recognized by many state licensure boards,

including Louisiana, (DLCAS, 2011). Learning in this course is based on five domains: 1) counselor development, 2) professional and ethical standards, 3) program development and quality assurance, 4) performance evaluation, and 5) administration.

The course includes the role of administrative supervisor and clinical supervisor as many supervisors in substance abuse agencies function in both roles simultaneously (Powell & Brodsky, 2004). Training in Powell and Brodsky's (2004) model focuses on using a developmental model of supervision that is inclusive of the supervisee's experience in the field and stage of professional development advocating for the supervisee requiring a different approach from the supervisor as they advance through their career (Kipnis, Lincourt, & Killar, 2009). Kipnis et al. (2009) stated that supervisors using a developmental approach to supervision need to use an educational approach toward supervisees who are early in their career and move to an egalitarian approach as supervisees increase in autonomy. Supervisors learn how to progress through the stages with their supervisees using the developmental model outlined by Powell and Brodsky (2004) that includes spiritual development, emotional growth, and encouragement of self-awareness of both the supervisor and supervisee (DCLAS, 2011; Kipnis et al., 2009).

Substance abuse counselors require effective and ethical supervision as well as training in evidence-based practices (EBPs) to competently provide services that will result in positive client outcomes (Fulton et al., 2016; Olmstead et al., 2012; Powell & Brodsky, 2004). A large number of substance abuse counselors enter the field without formal graduate training (Laschober, de Tormes Eby, & Sauer, 2013) and particularly lack substance-use specific training (Knudsen, Gallon, & Gabriel, 2006). Great variability occurs in training of counselors and supervisors in the substance abuse field because substance abuse treatment is one of the few



mental health care areas where counselors without at least a master's degree, licensure, or certification can engage in client care (Laschober et al, 2013; Powell & Brodsky, 2004). Olmstead et al. (2012) found that competency-based supervision and quality on-the-job training were lacking. Thus, supervisors are often filling in the gaps of substance abuse counselors' education and training (West & Hamm, 2012).

When training substance abuse counselors, a primary task of clinical supervisors is gatekeeping for the profession, including ensuring counselor competence through ongoing and consistent evaluation and remediation (Schmidt, Ybanez-Llorente, & Lamb, 2013; West & Hamm, 2012). Ethical gatekeeping involves verifying that supervisees are aware of expectations and given opportunities to correct any deficiencies (Fulton et al., 2016). Many substance abuse clinical supervisors also maintain a caseload along with their supervisory duties (Fulton et al., 2016). They may be reluctant to follow the necessary steps to satisfy gatekeeping responsibilities due to lack of time, energy, or lack of knowledge (Culbreth & Cooper, 2008; Powell & Brodsky, 2004; West & Hamm, 2012). Additionally, supervisors who have incompetent supervisees fear confronting or challenging supervisees because of potential complaints or legal action that is alleged against supervisors (Kerl & Eichler, 2005). These challenges and fears can result in less effective clinical supervision, thus lessened supervisee competence and reduced positive client outcomes (Fulton et al., 2016). Substance abuse clinical supervisors need to be prepared to respond effectively to ethical concerns (Powell & Brodsky, 2004) because the rate of ethical violations may be highest among substance abuse counselors (Gallagher, 2009, 2010). In a nationwide study of 33,000 certified addictions counselors, St. Germaine (1997) found that common ethical complaints against substance abuse counselors

included sexual relationship with a current or former client; impairment conducting job duties related to drugs, alcohol, or other conditions; practicing without a certificate; and breaching confidentiality.

Clinical supervisors are responsible for mentoring supervisees through ethical dilemmas, particularly supervisees with a personal recovery history who have increased exposure to ethical violations, such as dual relationships (Taleff, 2010). For example, supervisees have the potential for blurred boundaries if they attend and participate in 12-step meetings for their own personal recovery where clients may attend (Gallagher, 2010; Hecksher, 2007). Additionally, supervisees may have personal relationships with others who have substance abuse problems and who may eventually seek counseling at an agency where supervisees work (Hecksher, 2007; Taleff, 2010). Clinical supervisors' guidance is vital in navigating these complex dual relationships and supervisors are responsible for ensuring that supervisees are aware of the risks of dual relationships and boundary issues (CSAT, 2009).

Substance abuse counselors in recovery often struggle with issues such as using self-disclosure appropriately and imposing personal issues and beliefs on clients in an attempt to be helpful (Fulton et al., 2016; Juhnke & Culbreth, 1994). Substance abuse clinical supervisors therefore have a responsibility to address self-disclosure in clinical supervision, particularly for supervisees in personal recovery as they tend to use personal stories and experiences in their counseling practice (Fulton et al., 2016). For example, Ham et al. (2013) conducted a qualitative study of 10 long-term recovering counselors with some formal training in counseling and found that most participants utilized excessive self-disclosure and relied on self-disclosure as the main technique in counseling. In their study, many of the counselors reported that they lacked

education, training, and adequate supervision, thus they relied on self-disclosure as their main counseling technique (Ham et al., 2013).

Because supervisees may use excessive self-disclosure, substance abuse clinical supervisors should engage in direct observation of their supervisees, and not rely only on supervisee self-report. According to Fulton et al. (2016) and Borders and Brown (2005), if verbal reports are the sole supervision method supervisees use, supervisees may not disclose problematic behaviors in supervision due to lack of their self-awareness, minimization, or omission of disclosure.

Clinical supervisors can encourage formal education; advocate for training in EBPs; utilize a supervision model; and provide education of counseling theories, skills, and resources to develop competence and professionalism in their supervisees (Fulton et al., 2016).

### **Unique Aspects of Recovering Clinical Supervisors**

Eby et al. (2009) found that approximately 37% of supervisors reported being in personal recovery from substance abuse. Culbreth and Cooper (2008) found that supervisors in recovery were likely to have more experience as counselors and less experience in the role of supervisors. Additionally, they found that supervisors in recovery were often promoted to that position based on seniority rather than skill, knowledge, training, or education. More experience as a supervisor was correlated to overall self-efficacy of the supervisor. Supervisors who had a longer length of time as a counselor felt more confident in their role as supervisors. Supervisors with more training or mentoring as supervisors also had increased self-efficacy as compared to supervisors with little or no training. Additionally, supervisors' feelings of effectiveness in their role as supervisors were found to increase over time as they were in the supervisor role (Culbreth & Cooper, 2008).

Borders and Brown (2005) noted concerns with supervisors being promoted on seniority due to the complex process of supervision and multiple responsibilities of supervisors related to promoting professional and ethical competence of supervisees. Culbreth (1999) found that many supervisors who supervise addiction counselors are undertrained and overworked. He found that many supervisors lack a graduate education and never receive formal training in supervision (Culbreth, 1999). Furthermore, little is known about how substance abuse supervisors conduct supervision (Schmidt et al., 2013). Lesser education, lack of professional supervision resources, inexperience and/or lack training in supervision may lead supervisors to rely more heavily on their own experiences as supervisors rather than on professionally endorsed supervision practices, which could lessen the quality of supervision they provide (Borders & Brown, 2005).

Concerns about the preparedness of substance abuse counselor supervisors are exacerbated by continued reports of ethical infractions committed by substance abuse counselors (St. Germaine, 1997). Clinical supervisors need to be aware of common ethical infractions and address these issues in supervision because substance abuse counselors are more likely to commit an ethical violation than other mental health professionals (Gallagher, 2009 & 2010). Also, supervisors in the addiction field typically utilize less effective supervision strategies, such as self-report, and often do not incorporate strategies that are likely to promote supervisee competence, such as reviewing audio/video-recordings of sessions and/or live supervision (Durham, 2003). As a result of being overwhelmed, managing a caseload, and lacking supervisor training; substance abuse supervisors may not provide effective supervision and may unknowingly overlook the needs of supervisees (Schmidt et al., 2013). The lack of education and training among substance abuse supervisors also suggested that they may be uncomfortable with gatekeeping and inconsistently fulfill the gatekeeping duties of supervisors (Schmidt et al.,

2013). A recently developed tool entitled the Supervisor Evaluation of Professional and Ethical Competence for Substance Abuse Counselors (SPEC-SAC) is available to help substance abuse counselor supervisors address the ethical and professional competence of supervisees to guide supervisors in giving evaluative feedback to supervisees in their development as counselors (Schmidt et al., 2013). While the SPEC-SAC was developed based on SAMHSA's Tap 21 and evaluation forms from other disciplines, it has not been assessed for efficacy and needs further research to provide reliability and validity (Schmidt et al., 2013).

### **Summary**

The majority of literature reviewed placed a heavy emphasis on counselors in recovery from personal substance abuse and their unique struggles related to working with clients, indicating the need for effective clinical supervision. The literature was limited on clinical supervisors in personal recovery from substance abuse, however, concerns regarding training and preparation of clinical supervisors in addiction counseling were found. Limited research also existed regarding the training models and educational programs used to train clinical supervisors in addiction counseling primarily focusing on Powell and Brodsky's (2004) Blended Model. Much remains to be studied, understood, and clarified, including, but not limited to the value of clinical supervisors' personal recovery experience and how personal recovery is used effectively in clinical supervision. In order to do so, a better understanding of how clinical supervisors' personal recovery from substance abuse influences their supervision practice is essential.

## **Chapter III**

### **Methodology**

The purpose of this chapter is to describe the research design and methodology utilized in the present study. This chapter includes the following sections: research questions, research design, participants, data collection methods, data analysis, role of the researcher, data analysis, validation procedures, and summary.

The purpose of this phenomenological study was to investigate the perceived lived experiences of clinical supervisors' in recovery during the clinical supervision of substance abuse counselors working towards a license or credential in Louisiana. Specifically, the aim of my study was to illicit meaning and understanding of supervisors in personal recovery from past substance abuse and to describe, investigate, and interpret how their recovery status influenced their clinical supervision with supervisees.

#### **Research Questions**

In a qualitative study, research questions are broad in nature to allow the researcher an opportunity to explore a topic in depth (Corbin & Strauss, 2008). A central research question is a guide for the entire research study and several sub-questions are derived from the main research question (Creswell, 2007). My central research question was, What are the lived experiences of clinical supervisors in recovery from past substance abuse when they are supervising supervisees working towards a Louisiana substance abuse license or credential? My three sub-questions included the following:

1. How does clinical supervisors' recovery of substance abuse influence their clinical supervision with substance abuse counselors working towards a Louisiana substance abuse license or credential?

2. What are the advantages and challenges of being in recovery from substance abuse of clinical supervisors during clinical supervision with substance abuse counselors working towards a Louisiana substance abuse license or credential?
3. How are personal recovery experiences of clinical supervisors used in supervision with substance abuse counselors working towards a Louisiana substance abuse license or credential?

### **Research Design**

Creswell (2007) explained phenomenology as focusing on the meaning of lived experiences of persons going through a particular experience, structure, or phenomenon. The purpose of phenomenological research is to explore a phenomena as perceived by individuals and describe what their individual experiences all have in common as related to the phenomena. One hallmark of phenomenology is to describe the universal essence or meaning of the phenomenon experienced by each individual participant.

One method of phenomenological research is Interpretative Phenomenological Analysis (IPA; Smith, 2004). IPA was the specific analysis used for my research study. IPA provided a structure for exploration of participants' lived experiences in detail and what those experiences mean to participants. Smith (2004) further described IPA as idiographic, inductive, and interrogative. IPA's idiographic nature is exhibited through the examination of one case in detail until obtaining a level of closure, then moving to the next case. Once each case is analyzed individually, then a cross-analysis is done to identify themes across cases. Due to the detailed analysis process of IPA, a small sample size of three to six participants is suggested (Smith, Flowers & Larkin, 2009).

The inductive process of data gathering is evident in IPA through the construction of a broad research question in order to obtain expansive data, rather than attempting to negate a specific hypothesis (Smith et al., 2009). A broad question also allows for flexible data collection and analysis techniques in order to account for new information gathered throughout the research process. Finally, IPA is interrogative in its desire to make contributions to the field of psychology through interrogating existing research. Although IPA involves in-depth analysis of a small number of cases, the results are discussed with existing psychological literature. The results of IPA do not simply stand on their own, but also compare existing literature to the research findings (Smith et al., 2009).

IPA was an appropriate methodology for my study as I sought to understand how in substance abuse settings clinical supervisors perceived and made meaning of their personal recovery from substance abuse within the context of their clinical supervision of substance abuse counselors. For the present study, IPA was used to explore the lived experiences of clinical supervisors in recovery from past substance abuse and how their personal recovery influenced their clinical supervision of substance abuse counselors working towards a substance abuse license or credential.

## **Participants**

Substance abuse counseling supervision is a field in which minimal research exists on how recovery status of clinical supervisors influences their supervision process when supervising counselors.

**Sample size and criteria.** For my research study, I gathered information from six clinical supervisors. The four criteria used for participation in my study was that a clinical supervisor must have been: (a) working in a substance abuse agency who self-identify as being in personal



recovery from past substance abuse for two years or longer, (b) supervising a counselor who is working toward license or credential as a substance abuse counselor, (c) licensed as a Licensed Professional Counselor (LPC), Licensed Social Worker (Licensed Master Social Worker or Licensed Clinical Social Worker), or Licensed Addiction Counselor (LAC) in Louisiana, and (d) supervising as a clinical supervisor for two years or longer.

### **Data Collection Methods**

The most common data collection method for IPA is semi-structured interviews (Roberts, 2013). Smith and Eatough (2007) acknowledged that one-on-one interviews are preferred for IPA as they allow the researcher to obtain in-depth descriptions of a phenomena and the flexibility to modify follow-up questions based on participants' responses. IPA has been used in a variety of health-related research studies aimed at understanding the lived experience and personal meaning of illnesses (Roberts, 2013; Smith & Eatough, 2007; Smith, 2011).

**Sampling procedures.** Using a convenience sample, six participants were identified by contacting administrators of substance abuse treatment programs and mental health programs in Louisiana. I asked administrators if they had clinical supervisors working at their agencies who were in personal recovery from past substance abuse and who were supervising a substance abuse counselor working towards a substance abuse license or credential. In addition, I obtained a mailing list of supervisors holding a supervisor credential through ADRA and those supervisors were contacted via telephone or e-mail to request participation. Once participants were identified, I used a script to follow-up by a telephone call or e-mail to discuss the research study and scheduled a time to conduct the initial interviews (see Appendix A).

Prior to beginning my research study, approval was obtained from the University of New Orleans Institutional Review Board (IRB). Confidentiality was ensured through the following:

(a) all information was stored on a computer program with password protection in a locked office; (b) all research participants were assigned a pseudonym to protect their identity; (c) all written information, including informed consent forms, were kept in a locked file cabinet in a locked office; and (d) all audiotape recordings were kept in the same locked cabinet in the locked office.

The data collection method I used was semi-structured face-to-face interviews with each participant and written artifacts as available, such as related employee documentation regarding requirements of the professional position (e.g., employee guidelines, statement of practice) (Roberts, 2013; Smith & Eatough, 2007). Semi-structured, in-depth interviews lasting approximately 1 to 1.5 hours were utilized to gain an understanding of participants' experiences and perceptions of their supervision process. Interviews were audiotaped in a confidential location of the participants' choosing, typically an office or home.

Informed consent for research participation and audiotaping was obtained from each participant (see Appendix B). I explained the purpose of the study and confidentiality to each participant. A Pre-interview Demographic Questionnaire was attached to the informed consent for each participant to complete prior to the initial face-to-face interview consisting of two definitions (i.e., clinical supervision and administrative supervision) and 17 questions pertaining to the following: (1) age, (2) ethnicity (i.e., African American/African/Black/Caribbean, Asian/Pacific Islander, Caucasian, Hispanic/Latino, Native American, other), (3) educational level (i.e., high school/GED, Associate, Bachelor, Master, Ph.D.), (4) employment status (i.e., full-time, part-time, contractor, other), (5) credentials (i.e., LPC, LMSW, LCSW, LMFT, LAC, CAC, RAC, CCS, other), (6) primary work setting (i.e., type of agency/facility/practice), (7) job position (i.e., counselor, supervisor, clinical director, other), (8) years working in the field of

counseling, (9) years as a clinical supervisor, (10) how supervision is conducted and how often meet for supervision (i.e., individually, groups, staff meetings, other), (11) number of supervisees, (12) type of supervisor training received (i.e., completed a supervisor training course, completed hours of experience, took an examination, other, no training completed), (13) type of license or credential supervisees are pursuing (i.e., LPC, LMSW, LCSW, LMFT, LAC, CAC, RAC, CIT, ATA, other), (14) years in recovery, (15) substances abused in past (i.e., alcohol, marijuana, opiates, benzodiazepines, barbiturates, cocaine/crack, hallucinogens, steroids, other), (16) how they entered recovery (i.e., criminal justice involvement, self-motivated, prompting of loved one(s), prompting of medical provider, prompting of higher power, other) , and (17) type of treatment or intervention personally received (i.e., 12-step meetings, inpatient/residential, halfway house/transitional living, intensive outpatient program (IOP), group counseling, individual counseling, other) (see Appendix C).

To establish rapport, I provided participants with the interview questions I developed prior to the interview via e-mail to allow participants to become familiar with my research topic (see Appendix D). Because I did semi-structured interviews, the order of the questions as listed in the appendix did not always occur. As suggested by Creswell (2007), I used other questions surrounding my research topic. All interview questions were based on experiences related to clinical supervision of substance use counselors and supervisors' personal recovery. I discussed all questions with my dissertation chair and a peer debriefer to eliminate possible biases and disclosed my own personal experiences related to the subject matter. I had the debriefer sign a confidentiality agreement regarding all discussions related to my research study (see Appendix E). A second follow-up contact via e-mail occurred to conduct the member check in which I provided each participant a copy of his or her transcript and the themes from my data analysis

from the transcript to verify and clarify all information collected. No further meetings were scheduled with participants. All interviews were transcribed for organization and analysis purposes.

### **Role of the Researcher**

In a qualitative research design, researchers utilize themselves as the instrument tool in data collection. They collect data through interviewing research participants, observing participants in a particular environment, and reviewing related documents (Creswell, 2007). Researchers have several responsibilities in the interview process which include building rapport with participants, developing an interview framework, exploring issues, and assisting research participants in self-exploration and expression of their experiences (Sixsmith & Sixsmith, 1987). Participants should feel comfortable when sharing personal experiences and related information in an atmosphere of trust.

Also, researchers need to be self-aware of his or her personal biases and experiences. In the IPA approach that I used, the researcher plays an active role in the interview data collection process. Because of the level of engagement with participants in the IPA model, personal experiences and biases must be acknowledged throughout the research process. Shank (2006) suggested that researcher bias has the potential to put the research at risk by providing poor reliability and validity. Since researchers are the instruments of qualitative research, they must be aware of biases, assumptions, and beliefs about the research topic (Corbin & Strauss, 2008).

My biases began with my first experience working as a substance abuse counselor during my graduate practicum and internships at Indiana Wesleyan University in 2001 and 2002. I completed one practicum and two internships at facilities providing both mental health and substance abuse counseling. I found myself working with a variety of professionals in these

environments, but primarily with professional counselors with master's degrees. I completed one short internship experience with a counselor who did not have a master's degree, but had training as a substance abuse professional. I noticed that this counselor had a different type of relationship with clients utilizing many of his own personal experiences with substance abuse and recovery in his counseling activities. This was a positive experience for me as I noted how easy the clients opened up about their substance abuse struggles after hearing the counselor's personal story of substance abuse, which was different than my previous experiences with other counselors. I did not have another experience with a substance abuse professional until 2007 when I began working as a counselor and supervisor in New Orleans. As I began supervising addiction counselors at a substance abuse counseling agency, I began to notice substance abuse professionals interacting with clients in the same way as my previous internship experience in 2002. Through the process of supervising substance abuse professionals, I found that I was dealing frequently with topics such as boundaries of counselors with clients, inappropriate self-disclosure, and dual relationships with clients. I noticed that these topics arose more frequently in supervision with substance abuse professionals than it did with master's level counselors from mental health counseling disciplines. I began to question the influence of a counselor's recovery status in being an effective counselor and ultimately wondering how a recovering supervisor would deal with these topics in supervision. I worked with a recovering supervisor at the same agency and found that supervisor to exhibit the same types of behaviors I noticed in substance abuse counselors I was supervising. I turned to empirical research and found very little on the topic of substance abuse counselor supervision.

My first bias was that the recovery status of the supervisor influenced the clinical supervision process with recovering counselors and supervisors. I also believed that recovering supervisors

may be modeling diffused boundaries to their supervisees as a result of their own personal history of substance abuse. My bias was that a connection existed between the recovery status of supervisors and the influence that their recovery status had on their ability to conduct clinical supervision and that recovering supervisors modeled diffused boundaries to their supervisees.

To monitor my biases, I utilized bracketing, which involves separating out the ideas emerging from each transcribed interview in order to allow new themes to emerge in subsequent transcriptions (Morrow, 2005; Smith et al., 2009). The specific bracketing method that I used was engaging in dialogue with a colleague who was my peer debriefer throughout my research process to bring out any preconceptions or biases that I had. I used a confidentiality agreement that the debriefer signed agreeing to protect the content of the participants' transcriptions (see Appendix E).

### **Data Analysis**

The goal of IPA is to understand the meaning or essence of participants' lived experiences (Smith, 2004). The researcher's goal is to understand how participants make sense and meaning of their lived experiences. Through thorough analysis of each interview separately and then across interviews and related documents, the researcher is able to find the meaning or essence of participants' experiences (Smith et al., 2009).

**Method of analysis.** I used a six-step analysis process developed by Smith et al. (2009) to thoroughly analyze the data. Prior to the data analysis, I transcribed all initial interviews and printed them out in order to make notes and review transcripts as well as all of the artifacts collected from each participant. In accordance with the IPA model, each case was thoroughly analyzed one after the other until all cases were analyzed individually and saturation was achieved. According to Creswell (2007), saturation is achieved when the researcher no longer

finds new information that adds to their understanding of the data. Smith et al. (2009) recommended a sample size of six participants as sufficient for a good IPA study to achieve detailed analysis of each case and saturation of data across categories.

The first step included reading and re-reading each transcription in order to immerse oneself in the data and ensure that each participant is the focus of attention to manage any possible researcher biases (Smith et al., 2009). The re-reading of a transcript allows the researcher to fully engage with the data and begin to gain an understanding of each participant's viewpoint. I read the transcript of each participant along with any related artifact documents before moving to the next participant.

The second step involved taking initial notes from the transcripts or related artifacts of any words or phrases that stood out in the documents and making notes in the margins of the documents. Notations included descriptive, linguistic, and conceptual comments. The researcher is to maintain an open mind and notate anything of interest to gain a clearer understanding of how participants use language and views the world around them (Smith et al., 2009).

The third step involved developing emergent themes. According to Smith et al. (2009), "The main task in turning notes into themes involves an attempt to produce a concise and pithy statement of what was important in the various comments attached to a piece of transcript" (p. 1,892). The researcher attempts to manage the large amount of detail from the second step and begin theme identification through mapping interrelationships, connections, and patterns in the notations (Smith et al., 2009). I underlined and highlighted emerging themes in different colors for each participants' transcript and related artifact documents. I then pulled all identified excerpts of one color and typed them out on slips of paper to look for commonalities among the

themes. I ultimately created a table of emerging themes from each color-coding and underlined sections with contextual excerpts from each transcript or related artifact.

The fourth step leads the researcher to search for connections among emerging themes and how themes fit together. Smith et al. (2009) encouraged researchers to keep an open mind during this stage of analysis and explore themes for abstraction, subsumption, polarization, contextualization, numeration, and function based on the research questions to bring themes together and analyze interrelationships. As suggested by Smith et al. (2009), I maintained a research process diary to track my process of data analysis and how I came to the theme connections. I used the typed slips of paper and table created in step three to search for themes and patterns and notated in a third table column commonalities with contextual examples.

The fifth step leads the researcher to analyze the next case or transcript in accordance with steps one through four. Finally, the last step involves looking for common categories across all of the themes and cases. Once each case has been independently analyzed, the researcher seeks theme commonalities among all cases and interrelationships across cases to create categories. According to Smith et al. (2009), step six is where interpretations can be made regarding theme meanings across cases to create the final categories. I used a table of emergent themes from each individual case and compared one to another in order to identify patterns and interrelationships across cases that resulted in categories. Additionally, I used participant verbatim quotes or related artifact quotes as examples or descriptors for theme and category clarification.

### **Validation Procedures**

In order to demonstrate the academic rigor of a qualitative research project, the expectation is that the final study assures a level of trustworthiness or validity (Bloomberg & Volpe, 2016). Bloomberg and Volpe (2016) further articulated that the elements of credibility, dependability,



and transferability compose the concept of trustworthiness. Creswell (2007) listed eight varying strategies (i.e. prolonged engagement and observation; triangulation; peer review; negative case analysis; clarifying researcher bias; member checking; rich, thick descriptions; and external audits) when discussing validity in qualitative research and recommended that qualitative researchers use at least two of them in any study. Creswell (2007) concluded that validation strategies are vital to check the accuracy of findings in a research project. I used triangulation, member checking, clarifying researcher bias, external audits, and using rich, thick descriptions of data.

**Trackable variance.** King and Horrocks (2010) identified the use of trackable variance in qualitative research to account for variabilities that may be ascribed to a particular source (e.g., error, reality shifts, better insights, etc.). Trackable variance can be accounted for by providing documentation or a running account of the inquiry process during the study. Trackable variance was part of the validation procedures for my study to ensure the data was reliable, valid, and accurate. Particularly, the use of an auditor to double-check coding of the researcher accounts for trackable variance and was also a validation strategy for my study.

In the present study, I utilized several procedures to ensure trackable variance of my data: a) transcript checking, b) use of a codebook, c) use of an auditor, and d) double-checking each transcription (Gibbs, 2007; LeCompte & Schensul, 2010). Transcript checking involved examining each transcript to ensure accuracy of the transcription by listening to the tape and reading through the written transcription. Use of a codebook included consistently using a system of coding throughout the coding process to ensure coding accuracy and trackable variance. I used an auditor who checked for accuracy of the research findings and I double-checked each transcription against the codebook to ensure accuracy and reliable findings.

Creswell (2007) stated that auditing the research process in qualitative research is a way to establish dependability and confirmability of the data. I had the auditor sign a confidentiality agreement regarding all discussions and documents related to my research study (see Appendix D).

**Credibility.** Credibility speaks to the validity of the research conducted in that the participants being studied endorse the interpretation of the researcher (King & Horrocks, 2010). Creswell (2009) identified strategies for checking the accuracy of research findings that I will utilize in my study: a) personal bias clarification, b) member checking, and c) triangulation.

Throughout my study, I clarified my personal biases by consulting with my dissertation chair and peer debriefer. I clarified my biases by making them known to my chair and peer debriefer which also have been described in my dissertation. I consulted with them throughout the research process to ensure that my biases did not skew the research findings. Secondly, member checks were conducted by sending each participant an e-mail in which I provided each participant the themes found from his or her transcript. Participants were given the opportunity to provide feedback on the preliminary findings and clarify any misinterpretation of data. Finally, triangulation was utilized with multiple sources of data (i.e. interview transcripts, my field notes, related artifact documents).

## **Summary**

The purpose of my phenomenological study was to investigate the perceptions of substance abuse clinical supervisors' recovery status in the clinical supervision of substance abuse counselors who were working towards a Louisiana license or credential in substance abuse. I used IPA and semi-structured interviews to illicit meaning and understanding of six supervisors who were in personal recovery from substance abuse. IPA was used to identify emerging themes

and ultimately lead to patterns, descriptions, and interpretations grouped into categories that described participants' lived experiences.

## **Chapter IV**

### **Results**

The purpose of this study was to investigate the perceived lived experiences of clinical supervisors' in recovery during the clinical supervision of substance abuse counselors working towards a license or credential in Louisiana. In this chapter, data analysis procedures are discussed, demographic information about the participants is provided, participants are introduced, the results are presented, and finally, the research questions are reviewed and answered with data collected from the interviews.

#### **Data Analysis Procedures**

According to IPA method, I conducted and recorded open-ended, semi-structured interviews with six participants on their experiences and perceptions of their supervision process. Next, I completed six stages of data analysis for the purpose of answering the primary and secondary research questions. In the first stage, I performed four steps to identify themes and analyze data: (1) I read each interview transcript several times to immerse myself in the data; (2) I took initial notes from the transcripts and related artifacts; (3) I coded the data and analyzed emerging themes; and (4) I included as themes the emerging themes that were coded three or more times, which were strongly emphasized by a participant to develop the codebook. In the second stage, I completed member checks by sending each participant a copy of her or his interview transcript and the themes identified to ensure accuracy. I compared and contrasted new data received from the member checks into additional themes. Third, I performed two steps for the peer review audit: (1) themes from each transcript was sent to my peer auditor for review to ensure accuracy of my interpretation, and (2) new or different interpretations received from the peer auditor were included in the analysis and the themes. Fourth, I performed three steps to develop categories

from the themes across participants' interviews: (1) I cross-analyzed and identified patterns that linked all themes to develop categories; (2) I analyzed individual participants' transcripts as a collective; and (3) I included new or different interpretations from the cross-analysis of the combined data. Fifth, I performed four steps to answer each of the research questions: (1) I reviewed each of the research questions; (2) I analyzed the categories to ensure they answered the broad research question; (3) I identified categories that supported the specific research questions; and (4) I provided quotes that supported the categories across the data. Finally, I maintained communication with a peer debriefer throughout the data analysis process in order to manage bias and maintain integrity of the data analysis process.

## **Participants**

**Demographics.** A total of six participants were interviewed, all of whom were clinical supervisors in recovery supervising counselors working toward a substance abuse professional license or credential in Louisiana. Descriptions of the participants at the time of the interview and a brief account of their recovery and supervision experiences are given to provide context for the data. Pseudonyms were applied to all participants for confidentiality. Participants' ages ranged from 52 to 68 ( $M = 57$ ). Four participants were female, and two were male. Four participants were Caucasian, one was Mid-Asian/Eurasian, and one was African American. Three participants completed a master's degree, one a bachelor's degree, and three completed an associate's degree. Five participants were employed full-time and one was employed part-time. Four participants were Licensed Addiction Counselors (LAC), one was a Licensed Professional Counselor (LPC), and one was dually-licensed as a LAC and LPC. Four participants were Certified Clinical Supervisors (CCS) in addition to their licenses. Four participants had additional credentials: three were Certified Compulsive Gambling Counselors (CCGC) and two

were Certified Co-Occurring Disorder Professional Diplomats (CCDP-D). Four participants primarily worked in residential substance abuse treatment facilities and two worked in a criminal justice outpatient setting. Two participants had substance abuse outpatient programs that were attached to the residential programs at their place of employment. Three participants primarily saw clients in their job positions, two had dual-roles as a clinical director/executive director along with seeing clients, and one had a primarily administrative role in management. Participants' years in the field of substance abuse counseling ranged from 7 to 37 years ( $M = 24$ ) (see Table 1).

Table 1

*Participants' Personal Demographics*

	John	Jolie	Earlisha	Michelle	Ben	Jan
Demographics						
Age	52	55	56	59	68	53
Gender	Male	Female	Female	Female	Male	Female
Ethnicity	African American	Caucasian	Caucasian	Caucasian	Eurasian	Caucasian
Education	Associate	Master	Master	Bachelor	Associate	Master
Employment Status	Full Time	Full Time	Full Time	Full Time	Part Time	Full Time
Credentials	LAC CCS CCGC	LPC LAC CCS	LPC	LAC CCS CCDP-D	LAC CCS CCGC	LAC CCGC CCDP-DW
Primary Work Setting	Residential & Out Patient program	Residential program	Residential program	Criminal Justice	Criminal Justice	Residential & Out Patient program
Job Position	Executive Director	Clinical Director	Clinical Manager	Counselor	Counselor	Executive Director
Client Caseload	No	Yes	Yes	Yes	Yes	Yes
Years in Field	28	10	7	28	37	32

**Personal recovery demographics.** Participants' length of time in personal recovery from substance abuse ranged from 12 to 38 years ( $M = 27$ ). One participant reported one relapse of alcohol 4 years ago. Participants' reported that they abused two to seven substances in the past. All six participants reported abusing alcohol, five abused cocaine, four marijuana, three LSD/PCP, and two opiates. Two participants reported entering recovery due to criminal justice involvement, three were prompted by family members or family did an intervention to get participants into treatment, one was self-motivated, and one was motivated by her higher power. Five participants reported attending 12-step meetings as a part of their treatment, four completed inpatient hospital treatment for at least 28 days, and one participant completed residential treatment for several months. One participant reported only participating in 12-step meetings with no other form of treatment. Four participants reported participating in individual counseling after completing inpatient or residential treatment programs and two participants participated in an aftercare program for one to two years that was associated with an inpatient or residential program they initially entered for treatment (see Table 2).

Table 2

*Participants' Personal Recovery Demographics*

	John	Jolie	Earlisha	Michelle	Ben	Jan
Personal Recovery						
Years in personal recovery	29	15.5	12	31	38	34
Substances abused	1. Alcohol 2. Marijuana 3. Cocaine	1. Alcohol 2. Cocaine 3. Opiates	1. Alcohol 2. Cocaine	1. Alcohol 2. Marijuana 3. Barbiturates 4. Cocaine 5. LSD/PCP 6. Amphetamine 7. Muscle Relaxers	1. Alcohol 2. Marijuana 3. Opiates 4. Benzos 5. Barbiturate 6. Cocaine 7. LSD/PCP	1. Alcohol 2. Marijuana 3. LSD/PCP 4. Diet Pills
Ways entered recovery	Criminal justice Family intervention	Criminal justice	Prompting of higher power	Self-motivated	Suicide Attempt Family intervention	Self-motivated Prompting of loved ones
Type of treatment received	12-step Inpatient 2-year aftercare	Residential Halfway house IOP Individual Counseling	12-step	12-step Inpatient Group & Individual Counseling 1-yr aftercare	12-step Inpatient Halfway House Group & Individual Counseling	12-step Inpatient Individual Counseling

**Supervision demographics.** Participants' years as a clinical supervisor ranged from 2 to 35 years ( $M = 16$ ). All six participants completed hours of experience in order to become a clinical supervisor, four participants completed a supervision training course, and three completed an exam. The number of counselors that each participant supervised at the time of the interviews ranged from 1 to 7 supervisees ( $M = 6$ ). All six participants were supervising counselors working towards substance abuse professional credentials. All six participants were supervising at least one supervisee working towards a license as an addiction counselor (LAC), three were supervising supervisees working towards a Certified Addiction Counselor (CAC), and two were supervising supervisees working towards a Registered Addiction Counselor (RAC) credential.



Three participants also were supervising counselors working towards a license as a professional counselor (LPC) or a social worker (LMSW). Five participants used multiple modalities to conduct clinical supervision including individual supervision, group supervision, and staff meetings. All six participants conducted individual supervision at least two times per month with supervisees. Three participants conducted group supervision at least one time per week. One participant used individual supervision sessions as their only modality (see Table 3).

Table 3

*Participants' Supervision Demographics*

	John	Jolie	Earlisha	Michelle	Ben	Jan
Supervision						
Years as clinical supervisor	19	4	2	9	35	28
Types of supervisor training completed	Course Experience Hours Exam	Course Experience Hours	Experience Hours	Course Experience Hours Exam	Courses (4) Experience Hours Exam	Course Extra experience
Number of supervisees	2	7	2	1	3	5
Supervisee credentials working towards	LAC CAC	LPC LAC CAC RAC	LPC LMSW LAC	LPC LAC	LAC CAC	LPC LAC LMSW RAC
Supervision modalities	Individual 2x/month Staff meetings	Individual 1x/week Group 1x/month Staff meetings	Individual 1x/month Staff meetings	Individual 1x/week	Individual 1x/week Group 2-3x week Staff meetings In-service trainings	Individual 1x/week Group 2x/month Staff meetings

**Participants' Self-descriptions**

Self-descriptions of all six participants are provided, which include demeanor during the interviews and substance abuse and supervision history.

**John.** John was jovial during the interview. He described getting a driving while intoxicated (DWI) and a possession of cocaine charge, which led to his family doing an intervention. He ultimately attended a 28-day inpatient substance abuse treatment program. He started in the field of counseling as an “aftercare counselor” at the hospital where he became sober several months earlier. He said it was “probably six or eight months sober, and me and another clinician would go over and just do aftercare” groups on the weekend. “It wasn’t until maybe a year or year and a half later where I actually began working as a counselor-in-training.” He spent most of his counseling career working in hospital or residential facilities. He described how he “didn’t get a lot of good administrative training,” but he “got some great clinical supervision” over the years. He described getting a job as a program manager several years into his career “because the assumption is if you can clinically supervise other people, you can run a program and it’s not true.” He described consulting with program managers at other facilities and “got a lot of information on how to put together a program...so, that’s how I learned from getting dumped in the grease.” He expressed his desire to translate that learning to his supervisees. He stated that he does not carry a caseload of clients in his current position where his primary role is a supervisor.

**Jolie.** Jolie appeared frustrated at the beginning of the interview when the interview was interrupted by one of her supervisees who needed assistance with a client issue. Despite this interruption, the rest of the interview went smoothly and Jolie was forthcoming about her experiences and views about substance abuse. Jolie reported she entered recovery as a result of involvement with the criminal justice system where she attended a residential program for four months and lived in a halfway house for seven months. She was one of the participants who had the least amount of experience as a clinical supervisor, four years. She described her first job in

the counseling field as an “admin/intake person” for a residential program. She recalled a clinical supervisor who she had who “would talk about their personal life a lot...not related to supervision...and I remember being annoyed by that” and “so, I try to remember that when I’m supervising.” She maintains a caseload of clients in her current role as a supervisor, thus she spoke about both roles of counselor and supervisor during the interview. She expressed self-doubt as a supervisor when she said, “Sometimes I wonder...if I didn’t self-disclose, would I be any good?”

**Earlisha.** When I interviewed Earlisha, she was eager to talk about her experiences as a supervisor. She was the participant with the least amount of experience as a supervisor, 2 years of experience. She also maintains a caseload of clients along with her supervisory duties. She entered recovery at the prompting of her higher power and attended 12-step meetings to “get sober.” She was the only participant who did not attend formal treatment or counseling services. She described relapsing on alcohol as a clinician and administrative supervisor several years ago. “I lost my position as a counselor for a little bit. I started over basically.” She said that she lost standing at work and her “self-esteem,” but gained “insight that I didn’t have prior...I was pretty critical of folks who came in and relapsed” before she had her own relapse. She described her internal struggle and self-consciousness around co-workers as “sometimes, if I’m off, having a bad day, or a bad couple of days...in my mind I wonder if they think I’m using”...and that’s just in my head...that’s where I go.”

**Michelle.** Michelle appeared nervous at the beginning of the interview, but seemed to relax as the interview progressed. She maintains a caseload of clients in addition to her supervisory duties. She supervises the least amount of supervisees compared to the rest of the participants with only one supervisee at the time of the interview. She described being self-motivated to

enter treatment and completed an inpatient/residential program. She described being supervised early in her career by a psychologist who “helped me tremendously because I had this tendency to...I think from being in recovery and having this confrontive, got to tell people about themselves kind of attitude.” The psychologist helped her “to balance looking for what’s right with the person and looking for the strengths in the person.” She described a central focus she has in supervision that is to “really take care of yourself ... even if I’m working with someone who’s not in recovery because people who are drawn to this field often ... want to help others, take care of others and forget to take care of themselves.”

**Ben.** I conducted the interview with Ben over the telephone because scheduling did not allow me to travel to meet with him in person. Ben was soft-spoken during the interview, but was forthcoming about his experiences and views. Ben maintains a caseload of clients in addition to his supervisory duties. He described getting committed to a hospital after “my dad caught me with a pistol in my mouth” where he completed several months of inpatient treatment followed by six months in a halfway house. He described his experiences working with supervisees as being “a really positive, supportive relationship...educational in nature and a couple of them have been pretty intensely personal.” He emphasized the importance of a supervisor in maintaining a relationship with a supervisee because it “has to do with my own stuff with...transference and countertransference. The same thing happens with supervisees as it does with clients. I’ve got to have somebody to...help me bounce that around.”

**Jan.** Jan was jovial and eager to talk about her experiences with supervision. She stated at the beginning of the interview “there was such a part of me that, when I was looking at these questions, that I kind of struggled with...well I don’t think it matters. I don’t think that being in recovery makes a better addiction counselor.” She further expressed frustration with “very, very

unhealthy, messy counselors who are in recovery” who did “way too much self-disclosure...it was inappropriate” which was a “big part of...why I did decide to supervise people.” She stated she “felt like I could challenge that with people” and encourage them to look beyond their recovery status to “be skilled” clinicians. Jan was self-motivated and her father also prompted her to enter treatment as she was a member of Alcoholics Anonymous. She started attending 12-step meetings, then completed inpatient treatment followed by individual counseling off and on. Jan maintains a private practice in addition to her work as a supervisor.

### **Data Analysis and Reduction**

**Cross-analysis.** I analyzed each participant’s transcript and artifacts individually and a total of 62 themes emerged. I conducted a cross-analysis of the 62 themes that resulted in 13 categories: (1) Functions of supervision by six participants, (2) Factors influencing the supervision relationship by six participants, (3) Insight into addiction by six participants, (4) Factors pertaining to self-disclosure with five participants, (5) Managing dual relationships by five participants, (6) Recovery isn’t enough by five participants, (7) Relapse potential and management by five participants, (8) Stigma of addiction by five participants, (9) Structure of supervision by four participants, (10) Countertransference by four participants, (11) Feelings about self-disclosure by four participants, (12) Importance of self-care by four participants, and (13) Supervisors need supervision and consultation by three participants (see Table 4). I then compared the 13 categories by participants to ensure they fit with the transcribed interviews. In each category summary, I included quotes that support each category based on if participants’ responses were reflected for a specific category.

**Category 1: Functions of supervision.** *Functions of Supervision* was developed from the cross-analysis of themes as the first category, in which six participants responded. Five

participants; John, Michelle, Ben, Jolie, and Jan described one major function of supervision as supervisee skill development. Earlisha differed from the other participants in that she focused on the importance of the supervisor modeling appropriate behavior to supervisees as a major function of supervision. John explained that “Supervision for me ... is about training and development ... whether it’s getting the counselor prepared for licensing examinations or for a clinical environment.” Ben suggested that a function of supervision was “building a relationship with the intention of transmitting skills.” Jolie focused on the function of “the ability to be able to teach someone and mentor them” and added, “I have to teach them to fish” so they can do things on their own. Michelle focused on “helping them be the best clinician and understand the core functions” of addiction counseling and assist them in knowing “the responsibility they have to themselves and their clients, and modeling those things to them.” Jan was along the same lines, but added the evaluative nature of supervision when she stated that, “Supervision is about mentoring, evaluation, and guiding skill development [and] ... challenge supervisees to be better.”

***Category 2: Factors influencing the supervision relationship.*** The second category that was developed from the cross-analysis of the themes was *Factors of Influencing the Supervision Relationship*, in which six participants responded. For two of the six participants’ responses to Category 2; Earlisha and Jan stated that managing their own personal biases was an important factor in the supervision relationship, which could have negative impacts on the relationship if unchecked. Earlisha described how having a bias towards clients who had relapsed could be a factor to consider in supervision. “I had a hard time with ... the counselors that I was supervising that [I was] sorry for them or ... wanting me to coddle them” when they were working with a client that relapsed.” She stated that her own relapse “was really, really eye opening” and “now I

can address this calmly and ... show the counselors how to act and how to react to these folks, and how to guide them in what to do.” Jan described a factor that impacted supervision was that “sometimes I’ve bumped up against counselors who are prejudiced against me because of their own take on addiction and recovery.” She described that “it’s like they don’t respect me the same” because they found out that she was in recovery. She stated that “it ended up being a good learning tool” for supervisees, which did not negatively impact the supervision relationship.

Additionally, Ben, Jolie, and Jan identified management of supervisees who are “know it alls” as a potential challenging factor in the supervision relationship. Ben described how supervisees in recovery who were a challenge to work with in supervision because they “believe that they already know everything they need to know to be an addiction counselor” because they are in recovery. He stated that he “had a lady that wanted to engage in the process” of supervision who he told to “get a copy of TAP 21” and she “kind of blew me off,” so “I ended that relationship there as far as supervision.” Jolie stated “there are some [supervisees] that are not open-minded, that are hard to work with.” Jan stated that “it’s really hard to evaluate people ... when I know they think they’re good, but they’re not ... it looks like it breaks their heart” when she does an evaluation with them.

Ben, John, and Michelle also pointed out that factor that influences the supervision relationship is supervisees who have a higher level of education than their supervisors and may not respect their supervisors as much. Ben described a situation where he was frustrated with a supervisee who had a master’s degree. He said “when I talk to him [supervisee] about the competencies, he always kind of gives me a little feedback and I’d like to just kind of step on him sometimes.” Ben stated that the supervisee was “already qualified” with a master’s degree, and therefore, “already knows everything” in order to be an addiction counselor. Michelle stated

that she has “had a couple people who I supervised ... who said that I’d be more credible if I got my master’s degree.”

**Category 3: *Insight into addiction.*** The third category that was developed from the cross-analysis of the themes was *Insight into Addiction*, in which six participants responded. All six participants expressed their own insight into addiction because they were in recovery as a primary benefit of being a supervisor in recovery. For instance, Jolie stated that “I have an eye for manipulation because I was a master manipulator” as a client and “so I get to teach them [supervisees] that” from “just remembering some of the stuff I did” as a client. Michelle said what has been helpful when working with supervisees is to “have someone be honest with them about what their experience was as a client or a patient” in order to give supervisees the client perspective in treatment as she had experienced as a client. John stated that within his insight in addition, he “can offer a personal experience ... whether it’s an experience in active addiction or my experience related to treatment and recovery that can assist” a supervisee with understanding the process. Earlisha agreed that she encourages her supervisees to “come to [her] with questions about recovery, or sobriety, or relapse” in order to help them understand the process of addiction and recovery from her own experiences.

Three participants, John, Jan, and Ben specifically emphasized that their supervisees need an appreciation of the experience of addiction and recovery. John and Jan both stated that they encourage supervisees to attend 12-step meetings if they are not in recovery themselves. John said he “encouraged our clinical staff...part of their supervision is to attend 12-step meetings ... you can’t really understand something unless you’ve been there.” Jan said he will “invite [supervisees] if [they’ve] never been to AA, [they] need to go to an AA meeting.” Ben tells his supervisees “if you’re not in recovery, then you need to have some experience with abstinence”



and asks them to give something up for 30 days to “have an appreciation of the experience.”

Ben stated that “Learning that can come from a personal experience ... in a lot more solid way than just somebody talking to you about it.”

***Category 4: Factors pertaining to self-disclosure.*** The fourth category that was developed from the cross-analysis of the themes was *Factors Pertaining to Self-Disclosure*, in which five participants (i.e., Ben, Jolie, Michelle, Earlisha, and Jan) responded. All five participants’ reported that their use of self-disclosure was impacted by various factors, both positively and negatively. However, the greatest focus was on using self-disclosure with intention and knowing your audience when self-disclosing. Jolie stated that she tries to avoid “talking about personal stuff” in supervision because she had a previous supervisor who “would talk about their personal life a lot, not related to supervision” and she felt it was inappropriate. Ben described one interaction with a woman working with him at a hospital who “challenged me several times” and would “get a little haughty with me occasionally,” but he “never did disclose to her that I was in recovery” as her supervisor because “it had no purpose” and “in her eyes it may have diminished my role as her program supervisor.” Michelle echoed Ben’s sentiment when she stated that she would not disclose to “someone that I felt didn’t value my experience in recovery.” Jolie and Earlisha both stated the importance of knowing your audience when you choose to self-disclose. Jolie described a time when she disclosed her personal story to a group of people where she talked “about being a heroin addict ... I used heroin IV,” then she noticed the audience’s facial reactions when “all of a sudden I realize that, yeah probably shouldn’t be telling this story.” Earlisha also stated that she has “learned to tone things down, you know and be discreet, selective about what I share” with supervisees and other people. Jan expressed frustration with “very, very unhealthy, messy counselors who are in recovery” that did “way too much self-

disclosure ... it was inappropriate,” which was a “big part of ... why I did decide to supervise people.”

**Category 5: *Managing dual relationships*.** The fifth category that was developed from the cross-analysis of the themes was *Managing Dual relationships*, in which five participants (i.e., Earlisha, Jan, John, Ben and Michelle) responded. Every participant except one specifically addressed managing dual relationships as a challenge for supervisors in recovery. Earlisha reflected that she struggled initially when supervising people because she “couldn’t figure out what hat [she] was suppose to wear” and struggled to be a member of the recovery community as well as a counselor and supervisor. Jan stated that she wanted “to be careful of my dual piece with them [supervisees],” so “a lot of times I’ll just remain quiet.” If she saw a supervisee at a 12-step meeting “then [she] might address it in supervision the next time [she saw] them”. A written artifact that John, Ben, and Michelle stated they use in supervision to is the ADRA *Code of Ethics*. It states that the supervisor “shall avoid all dual relationships with the counselor in training [supervisee] that may interfere with the supervisor’s professional judgment or exploit the counselor in training [supervisee].” Additionally, after their treatment for substance abuse both John and Michelle worked at the same treatment facility that they were treated. Michelle stated that when she went to work at the treatment facility, one of her previous counselors as a client “ended up being my boss” and they “had [her treatment] record destroyed so that no one that [she] worked with saw [her treatment] record.”

**Category 6: *Recovery isn’t enough*.** The sixth category that was developed from the cross-analysis of the themes was *Recovery isn’t Enough*, in which five participants (i.e., Jan, John, Michelle, Earlisha, and Jolie) responded. All five participants emphasized that a counselor needs more than just being in recovery to be a good counselor and that skills are required to be

effective. For Jan, “it seemed natural since I was in recovery, to go with substance abuse” as an area of focus in counseling, however, recovery is not enough. She said a counselor “has to be skilled.” She recalled being “talked to at length about, my recovery has nothing to do with my counseling, and then eventually, it has nothing to do with my supervision other than taking care of myself like any other person should do.” She stated that she “felt like [she] could challenge that with people” and encourage them to look beyond their recovery status to “be skilled” clinicians. John expressed a similar sentiment that “when it comes to working with supervisees ... my focus is always going to be best practices ... based on our supervision plan” regardless of the supervisee being in recovery or not. From the supervisor perspective, Michelle stated that “you have to use other supervision skills besides your personal story” to be an effective counselor. Jolie and Earlisha agreed that a counselor needs more skills than recovery to be effective.

***Category 7: Relapse potential and management.*** The seventh category that was developed from the cross-analysis of the themes was *Relapse Potential and Management*, in which five participants (i.e., John, Earlisha, Ben, John, and Jan) responded. Two participants specifically addressed their personal relapse potential and three other participants addressed providing accountability features in the supervision relationship for supervisees in recovery. John and Earlisha both addressed their own personal relapse potential and management. John shared an experience where he personally was tempted to drink alcohol after being in recovery for 20 years while being the director of a treatment center. He shared that he was on a cruise with his girlfriend and was on the main deck alone where he was “looking at the huge bar ... and there was way more stuff that I’d ever seen or tried before ... and a brief thought – as big as this ship is, I could sneak a drink and hide from my girlfriend long enough so she wouldn’t know it.” He

stated that “It scared me half to death” and reflected on how close he was to a relapse. Earlisha relapsed after nine years in recovery and reflected that her supervisor prior to her relapse “noticed some differences in me but he didn’t ask me ... that was a boundary he didn’t want to cross.” She further reflected that she did not think it would have made a difference if her supervisor had asked “but at least it would have been an opportunity for me to say I needed help.” Ben, John, Earlisha, Jan, and Jolie all stated that they continue to attend 12-step meetings in their community in order to maintain their own recovery and encourage supervisees in recovery to do the same. John advocated for organizations having good “HR policies and standards” for employees regarding illicit drug use and committing crimes that can be reinforced by supervisors regardless of recovery status as long as the employee “has no level of impairment and it doesn’t violate policy.” Jan stated that her own recovery has made her “more attuned to addictions in supervisees” and she is able to “identify when a supervisee in recovery is on a slippery slope” possibly headed toward a relapse. Ben stated that he uses supervision as “accountability for supervisees in recovery.” He specifically asks supervisees about their recovery in supervision.

**Category 8: Stigma of addiction.** The eighth category that was developed from the cross-analysis of the themes was *Stigma of Addiction*, in which five participants (i.e., Michelle, Earlisha, Ben, John, and Jan) responded. Five participants were strong in their views about the stigma of addiction following them in their professional lives and work with supervisees. Michelle stated that she believes “people ... disregard people in recovery ... and not respect my opinions, many just discount the whole recovery piece like it’s not relevant.” Earlisha expressed insecurity when coming back to work as a supervisor after her relapse because of a possible stigma. She “felt a little awkward because just coming from a relapse and I don’t have much

ground to stand on to talk about recovery to [supervisees].” She also expressed paranoia that colleagues were “wondering if I was using because I had a bad day” at work or that another counselor “resented me ... thinking I was getting special treatment because I was in recovery” even though “that was never written or said anywhere ... but I did feel ... that I was being slighted.” Ben, John, and Jan agreed that they experienced feeling de-valued and discriminated against in their workplace for being in recovery.

**Category 9: Structure of supervision.** The ninth category that was developed from the cross-analysis of the themes was *Structure of Supervision*, in which four participants (i.e., Ben, John, Jolie, and Earlisha) responded. All four participants stated that they used evidence-based practices to structure supervision and documented supervision in accordance with licensure or certification requirements from state boards. Ben recommended structuring supervision around “TAP 21 and the competencies.” He listed several books he used to help him with supervision or that he recommends supervisees to read. Ben further explained that he is, “pretty strict in, in my supervision about... when people are in recovery to follow that developmental model, so I ... don't get too deep too fast.” John stated that he takes supervisees through “a specific supervision plan to make sure that these folks are adequately prepared,” which is based on SAMHSA’s TAP 21. He also stated that he “gets them familiar with our core functions and global criteria” of addiction counseling. Jolie and Earlisha both stated they follow a learning plan that they develop with the supervisee and turn into the ADRA annually which outlines objectives for each month and principle methods to be used for teaching and correcting deficiencies.

Written artifacts also contributed to the *Structure of Supervision*, category 9, which provided data specifically related to the structure and documentation of supervision. Earlisha provided a copy of her job description and documentation template that she uses in supervision with

supervisees, which outlines what a supervisor needs regarding “a working knowledge of the 12-Step Principles and how treatment is administered in conjunction with 12-Step recovery.” Also, she must “provide onsite clinical supervision of any paraprofessional or inexperienced professional” at a minimum of once month. The supervision documentation form that Earlisha provided included issues discussed in supervision, plan of action to address issues, and tasks assigned to supervisees. Jolie, John, Ben, Jan, and Michelle stated that they use the ADRA standard contract that is signed by the supervisor and supervisee, then submitted to the ADRA as their supervision contract. The ADRA standard contract includes the ADRA *Code of Ethics* that is signed by the supervisee and a *Clinical Supervisor Professional Affidavit* that is signed by the supervisor. The *Clinical Supervisor Professional Affidavit* outlines the duties of the supervisor including: avoiding dual relationships with supervisees that compromise professional judgment or exploit the supervisee, informing the supervisee about the process of supervision, and engaging the supervisee in examining any issues that might affect supervision.

**Category 10: Countertransference.** The tenth category that was developed from the cross-analysis of the themes was *Countertransference*, in which four participants (i.e., Jolie, Earlisha, Ben, and Michelle) responded. All four participants cited countertransference as a major concern for them in supervision and a source of internal struggle. Jolie stated that she constantly struggles with countertransference because “I remember what it was like to be a client.” She sometimes struggles with supervisees who want to be punitive and “kick people out” of treatment for “acting out” which she remembers doing as a client. “I probably should’ve gotten kicked out a thousand times,” she stated, but she was never kicked out. Earlisha agreed that she struggles with wanting “to fix” clients and doesn’t always allow her supervisees to work with clients on their own without intervening. Ben stated that “the reason I maintain a relationship

with a supervisor [myself] has to do with my own stuff, you know, transference and countertransference.” He has a supervisor that will “tell me the truth” because “my problem is that I don’t recognize [countertransference and transference] early enough.” Michelle agreed that she has “countertransference and sometimes [she needs a] nudge in one direction or another” from a supervisor.

**Category 11: Feelings about self-disclosure.** The eleventh category that was developed from the cross-analysis of the themes was *Feelings about Self-Disclosure*, in which four participants (i.e., Michelle, Ben, Jan, and Earlisha) responded. The participants expressed feelings both positive and negative about self-disclosure. However, they primarily expressed positive feelings about self-disclosure when strengthening their relationships with supervisees. For instance, Michelle stated that when talking about disclosing her recovery status to a supervisee, “I really do think that it helps build rapport with people when you let yourself be vulnerable.” Ben stated that he uses self-disclosure “to enhance what’s going on, so I think the effect is positive ... and there’s a level of candor ... all it does is strengthen the relationship.” Jan agreed that disclosing that she is in recovery has strengthened her relationships with supervisees.

Negative feelings about self-disclosure particularly pertained to not taking into account the receptivity of the individual who is being disclosed to and regretting self-disclosure as a result. Earlisha described how a supervisee looked when she disclosed information about her relapse to the supervisee. She said, “I could see the look on her face and I went, “Oh no, dang!”...it took me a little bit to get her trust back” after that disclosure. She said she regretted “telling her ... because then that led her to think that I was deceiving her for several months prior to my relapse.” Ben described disclosing to a training group that he was in recovery and how “it kind

of shut down some of the interaction with several of the people in the workshop [and] ... it dampened the interaction” and “I regret doing that one.”

**Category 12: Importance of self-care.** The twelfth category that was developed from the cross-analysis of the themes was *Factors Importance of Self-Care*, in which four participants (i.e., Ben, Michelle, Earlisha, and Jan) responded. All four participants agreed that self-care was an important topic to address in supervision as well as something to be actively engaged in as a supervisor in recovery. Ben stated the he suffers “from the same things I warn others about” and “I can get so wrapped up in my work that I neglect my own personal recovery.” He described a situation that was “the most severe time” when he “hadn’t gone to an AA meeting in like three weeks” and had “a sponsor in name only.” He admitted that he tried to use “those supervisee relationships to ... get ... some of that support that I need to maintain my own stuff.” Michelle agreed that “you’ve gotta take care of yourself” and “then you risk relapse if you’re not taking care of yourself” as a supervisor or a supervisee. Earlisha stated that she makes sure to ask supervisees if they “Are ... taking care of ... self?” Jan agreed that she asks her supervisees regularly about self-care.

**Category 13: Supervisors need supervision and consultation.** The thirteenth category that was developed from the cross-analysis of the themes was *Supervisors Need Supervision and Consultation*, in which three participants responded. Although the need for supervisors to have supervision and consultation was directly discussed by only three participants; Jolie, Ben and Jan, their focus was strong. Ben stated that “the reason I maintain a relationship with a supervisor has to do with my own stuff” because his expectations of supervisees tends to be high and “the relationship gets foggy” so “my supervisor keeps an eye on me.” Jolie described a time when she was able to consult with a supervisee’s “licensure supervisor about some stuff that was



going on” and they “worked with [the supervisee] together ... and I think she’s [the supervisee] doing great.” Jan expressed a similar sentiment when she said, “I still have people I call ... if I get kind of stuck on something that I think I don’t know how to help them with this.”

Table 4

*Cross-Analyses of Themes Resulting in 13 Categories for Six Participants*

Category	Theme Total	John	Jolie	Earlisha	Michelle	Ben	Jan
Functions of Supervision	6	X	X	X	X	X	X
Factors Influencing the Supervision Relationship	6	X	X	X	X	X	X
Insight into Addiction	6	X	X	X	X	X	X
Factors Pertaining to Self-Disclosure	5		X	X	X	X	X
Managing Dual Relationships	5	X		X	X	X	X
Recovery Isn’t Enough	5	X	X	X	X		X
Relapse Potential and Management	5	X	X	X		X	X
Stigma of Addiction	5	X		X	X	X	X
Structure of Supervision	4	X	X	X		X	
Countertransference	4		X	X	X	X	
Feelings about Self-Disclosure	4			X	X	X	X
Importance of Self-Care	4			X	X	X	X
Supervisors Need Supervision/ Consultation	3		X			X	X
Total Categories = 13		8	9	12	10	12	11

## Findings by Research Questions

The process of collecting and analyzing data was conducted with the goal of answering the central research question, What are the lived experiences of clinical supervisors in recovery from past substance abuse when they are supervising supervisees working towards a Louisiana substance abuse license or credential? Although the 13 categories were interrelated and had

overlap to some degree, 11 categories specifically described participants' lived experiences for the central research question and were linked to each of the three research sub-questions. The remaining two categories were treated as additional reflections about the Clinical Supervision Framework (see Figure 1).

**Research sub-question one.** How does clinical supervisors' recovery of substance abuse influence their clinical supervision with substance abuse counselors working towards a Louisiana substance abuse license or credential? Research sub-question one included four categories that reflect the *Influences of Recovery Experiences in Supervision* of clinical supervisors: 1) Category 2. Factors Influencing the Supervision Relationship, 2) Category 6. Recovery Isn't Enough, 3) Category 11. Feelings About Self-disclosure, and 4), Category 12. Importance of Self-care. One or two examples of each category are included for clarity of how clinical supervisors perceived their recovery of substance abuse influenced their clinical supervision in the following ways:

**Category 2.** For *Factors Influencing the Supervision Relationship*, Earlisha described how she, "had a hard time with...the counselors that I was supervising that were sorry for [clients] or...wanting me to coddle them [supervisees]" when her supervisees were working with a client that relapsed. She stated that her own relapse "was really, really eye opening" and "now I can address [a relapse] calmly and...show the counselors how to act and how to react to these folks, and how to guide them in what to do" with a client that relapsed.

**Category 6.** For *Recovery Isn't Enough*, Jan described how a counselor needs more than just being in recovery to be a good counselor and that skills are required in order to be effective. She stated that "it seemed natural since I was in recovery, to go with substance abuse" as an area of focus in counseling, however, recovery isn't enough and a counselor "has to be skilled." She recalled being "talked to at length about, my recovery has nothing to do with my counseling, and

then eventually, it has nothing to do with my supervision other than taking care of myself like any other person should do.” She expressed frustration with “very, very unhealthy, messy counselors who are in recovery” that did “way too much self-disclosure...it was inappropriate” which was a “big part of...why I did decide to supervise people.” She stated that she “felt like [she] could challenge that with people” and encourage them to look beyond their recovery status to “be skilled” clinicians.

**Category 11.** For *Feelings About Self-disclosure*, Michelle stated that when talking about disclosing her recovery status to a supervisee, “I really do think that it helps build rapport with people when you let yourself be vulnerable.” Ben stated that he uses self-disclosure “to enhance what’s going on, so I think the effect is positive...and there’s a level of candor...all it does is strengthen the relationship.”

**Category 12.** For *Importance of Self-care*, Ben stated, “I suffer from the same things I warn others about” and “I can get so wrapped up in my work that I neglect my own personal recovery...that's happened a couple of times...more early on than, than later.” He stated, “the most severe that it ever was...I hadn't gone to meeting in like three weeks and... I had a sponsor in name only” so, “I tried to use those supervisee relationships to get that ... Some of that support that I need to maintain my own stuff... which is not a good thing...not for anybody.”

**Research sub-question two.** What are the advantages and challenges of being in recovery from substance abuse of clinical supervisors during clinical supervision with substance abuse counselors working towards a Louisiana substance abuse license or credential? Research question two also included four categories that reflected the *Advantages and Challenges for Clinical Supervisors in Recovery*: 1) Category 3. Insight into Addiction, 2) Category 5. Managing Dual Relationships, and 3) Category 8. Stigma of Addiction, and 4) Category 10.

Countertransference. One or two examples of each category are included for clarity of how clinical supervisors perceived the advantages and challenges of being in recovery from substance abuse in the following ways:

**Category 3.** For *Insight Into Addiction*, Jolie stated that “I have an eye for manipulation because I was a master manipulator” as a client and “so I get to teach them [supervisees] that” from “just remembering some of the stuff I did” as a client. Michelle stated that it has been helpful in working with supervisees to “have someone be honest with them about what their experience was as a client or a patient” in order to give supervisees a client’s perspective of treatment.

**Category 5.** For *Managing Dual Relationships*, Earlisha reflected that she struggled initially when supervising people because “I couldn’t figure out what hat [she] was suppose to wear” and struggled to be a member of the recovery community as well as a counselor and supervisor. Jan stated, “I want to be careful of my dual piece with them,” so “a lot of times I’ll just remain quiet” if she sees a supervisee at a 12-step meeting “and then I might address it in supervision the next time I see them” to see how that person felt about seeing her there.

**Category 8.** For *Stigma of Addiction*, Michelle stated, “There are people who ... would disregard people in recovery ... and not respect my opinions ... many just discount the whole recovery piece like it’s not relevant.” Earlisha expressed paranoia when coming back to work as a supervisor after her relapse because she felt colleagues were “wondering if I was using because I had a bad day” or that another counselor “resented me ... thinking I was getting special treatment because I was in recovery.”

**Category 10.** For *Countertransference*, Jolie stated that she constantly struggles with countertransference because “I remember what it was like to be a client.” She sometimes

struggles with supervisees who want to be punitive and “kick people out” of treatment for “acting out” which she remembers doing as a client. “I probably should’ve gotten kicked out a thousand times,” she stated, but she was never kicked out. Ben stated that “the reason I maintain a relationship with a supervisor [myself] has to do with my own stuff, you know, transference and countertransference.” He has a supervisor that will “tell [him] the truth” because “my problem is that I don’t recognize [countertransference and transference] early enough.”

**Research sub-question three.** How are personal recovery experiences of clinical supervisors used in supervision with substance abuse counselors working towards a Louisiana substance abuse license or credential? Research question three included three categories reflected on the *Use of Recovery Experiences in Supervision*: 1) Category 4. Factors pertaining to self-disclosure, 2) Category 7. Relapse Potential and Management, 3) Category 13. Supervisors Need Supervision and Consultation. One or two examples of each category are included for clarity of how clinical supervisors in recovery perceived they used personal recovery experiences in the following ways:

**Category 4.** For *Factors Pertaining to Self-disclosure*, Jolie stated that she uses self-disclosure “to explain what a client might be experiencing, and to share with them what it was like to be addicted, from an inside look...I remember certain things that my counselor did that were extremely important and touching...so I get to share that with [supervisees].”

**Category 7.** For *Relapse Potential and Management*, Jan stated that her own recovery has made her “more attuned to addictions in supervisees” and able to “identify when a supervisee in recovery is on a slippery slope” possibly headed toward a relapse. Ben stated he uses supervision as “accountability for supervisees in recovery” and specifically asks supervisees about their recovery in supervision.

**Category 13.** For *Supervisors Need Supervision and Consultation*, Ben stated that his expectations of supervisees tends to be high and “the relationship gets foggy [so] my supervisor keeps an eye on me.” Jan expressed a similar sentiment when she said, “I still have people I call ... if I get kind of stuck on something that I think I don’t know how to help [supervisees] with.”

**Additional reflections.** Two categories reflected the *Clinical Supervision Framework* used by supervisors in recovery; 1) Category 1. Functions of Supervision and 2) Category 9. Structure of Supervision, which provided additional reflections for clinical supervisors in recovery.

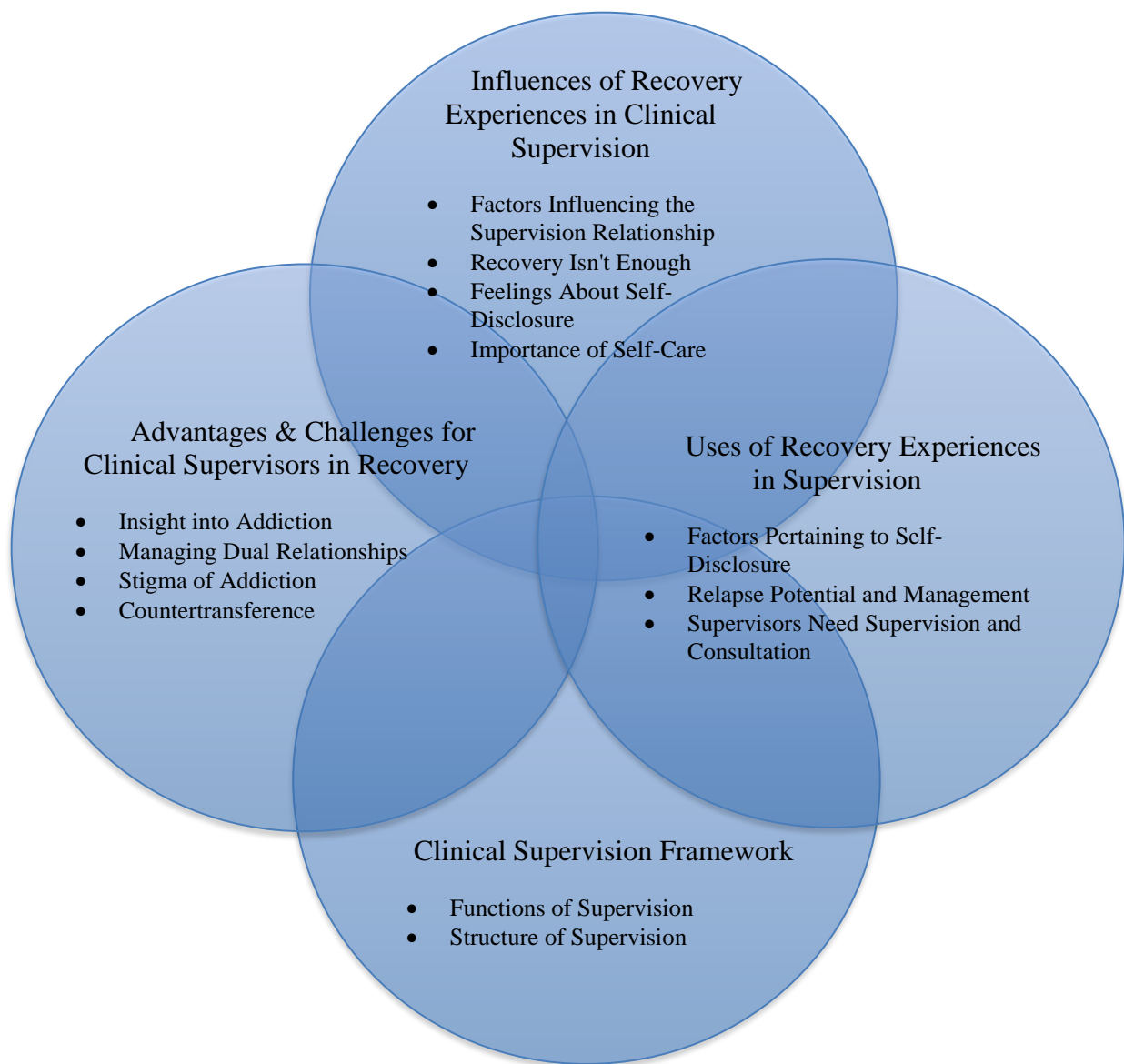
**Category 1.** For *Functions of Supervision*, John explained that “supervision for me ... is about training and development ... whether it’s getting the counselor prepared for licensing examinations or for a clinical environment.” Ben suggested that a function of supervision was “building a relationship with the intention of transmitting skills.” Jan was along the same lines, but described the evaluative nature of supervision when she stated that, “Supervision is about mentoring, evaluation, and guiding skill development [to] ... challenge supervisees to be better.”

**Category 9.** For *Structure of Supervision*, Ben recommended structuring supervision around “TAP 21 and the competencies.” He listed several books he used to help him with supervision or that he recommends supervisees to read. Ben further explained that he is, “pretty strict in, in my supervision about... when people are in recovery to follow that developmental model, so I ... don't get too deep too fast.” John stated that he takes supervisees through “a specific supervision plan to make sure that these folks are adequately prepared,” which is based on SAMHSA’s TAP 21. He also stated that he “gets them familiar with our core functions and global criteria” of addiction counseling. Jolie and Earlisha both stated they follow a learning plan that they develop with a supervisee and turn into the ADRA annually which outlines objectives for each month and principle methods to be used for teaching and correcting deficiencies. Earlisha provided a copy

documents she uses in supervision. Jolie, John, Ben, Jan, and Michelle use ADRA's standard contract for their supervision contract.

Figure 1

*Visual Depiction of the 13 Categories*



*Figure 1.* A visual depiction is provided of the 13 categories with the overlapping relationships to each other into four areas.

### **Summary of Peer Auditor Procedure**

A master's level counselor who demonstrated understanding of the research procedure and the coding method of qualitative analysis reviewed all of the interview transcripts and reviewed a written summary of the analysis of the data. The peer auditor was utilized to determine if the development of themes and categories appeared accurate. The peer auditor and I discussed the research questions, rationale for the theme and category development, and the research topic. Recommendations were made by the peer auditor that helped me focus on the emphasis each participant gave to a specific emerging theme and additional themes she saw emerging that resulted in the overall categories, which I then included in data analysis.

### **Conclusion**

In this chapter, I presented a detailed description of the themes that emerged from the individual interviews of the research participants. I conducted an analysis of themes for each participant and a cross-analysis of the themes into 13 categories. I then provided quotes that support the categories. Next, I reviewed the research questions, identified the categories that answered the research questions, and presented the quotes that support the categories. Finally, I provided a summary of the peer auditor process.



## **Chapter V**

### **Discussion**

The purpose of this study was to investigate the perceived lived experiences of clinical supervisors' in recovery during the clinical supervision of substance abuse counselors working towards a license or credential in Louisiana. In this chapter, the philosophical foundation of the study is described and findings are discussed as related to previous research, and presented in an order that encourages understanding of the data. In addition, implications for counselors are discussed and the limitations and delimitations of the study are reviewed. Recommendations for future research are listed and my personal reflection as the researcher are included.

#### **Philosophic Foundation**

The purpose of this phenomenological study was to investigate the perceived lived experiences of clinical supervisors' in recovery during the clinical supervision of substance abuse counselors working towards a license or credential in Louisiana. Within the philosophical context of my research study framed in a wounded healer theoretical framework, the wounds of addiction of clinical supervisors who are in recovery may inform the clinical supervision field in a similar fashion as wounded counselors in recovery using personal experiences of addiction in their treatment of clients struggling with addiction.

#### **Research Findings Related to Literature**

From the present research study, conceptual findings are discussed based in the research questions and supporting quotes in four overall areas: 1) Influences of Recovery Experiences in Clinical Supervision, 2) Advantages and Disadvantages for Clinical Supervisors in Recovery, 3) Uses of Recovery Experiences in Clinical Supervision, and 4) Clinical Supervision Framework.

**Influences of recovery experiences in supervision.** Several influences of recovery experiences of the six clinical supervisors in the present study were described. Two clinical supervisors believed that managing their own personal biases was an important factor in the supervision relationship. The Blended Model of supervision confirms that self-awareness of both supervisor and supervisees are important to the process of supervision (Powell & Brodsky, 2004). In the present study, clinical supervisors described how having a bias towards clients who had relapsed could be a factor to consider in supervision and that their own relapse can be an eye opening recovery experience. They also believe how important it is for clinical supervisors to address relapse situations calmly and how supervisors should guide supervisees in how to handle such situations.

Additionally, clinical supervisors in the present study pointed out the influences that the supervision relationship has when supervisees who have a higher level of education than their supervisors may not respect their supervisors. One supervisor described how her supervisee felt that she needed a master's degree to be credible in the counseling field. The idea that educational level influencing the supervision relationship was concurrent with Culbreth (1999) and Saarnio's (2010) findings that nonrecovering counselors were more likely to have graduate degrees than recovering counselors (Culbreth, 1999; Saarnio, 2010). As a result of the lack of formal training, knowledge in the area of supervision theory and technique was lacking for recovering supervisors (Culbreth & Cooper, 2008).

Culbreth and Cooper (2008) found supervisors' feelings of effectiveness in their role as supervisors increased over time as they were in the supervisor role, which seemed to be true for Jolie and Earlisha, who had the least amount of experience as supervisors and expressed more insecurity in their role as supervisors' than the other supervisors in the present study. For

example, Earlisha stated, “Sometimes I’m afraid that I don’t have control enough to prevent an event, like when this [client] got in trouble ... I have to stop this ... and I can’t do that especially with my supervisee’s around.” Other supervisors described struggling with insecurity early in their careers that dissipated over the course of their career experience. John described how he “learned over the years. I asked a lot of questions.” Jolie and Earlisha also had the least amount of years in recovery, whereas the other supervisors had 29 years or more in recovery. The supervisors with a longer time in recovery such as Ben and Jan described a continuous process of personal and professional growth which agreed with Laudet’s (2007) comment that confidence increases in the role as a supervisor. According to Culbreth and Cooper (2008), supervisors who had a longer length of time as a counselor felt more confident in their role as supervisors. Additionally, clinical supervisors in the present study were consistent with Culbreth and Cooper’s (2008) findings in that they had significant time of approximately 24 years in the field of counseling and four out of the six clinical supervisors felt more confident in their role as a clinical supervisor later in their careers.

Five out of the six clinical supervisors in the present study agreed that being in recovery was not enough to be an effective counselor. They emphasized the importance of teaching their supervisees specific counseling skills and professional behaviors that should occur in counseling settings and in supervision. For Jan, “recovery isn’t enough.” A counselor “has to be skilled.” She recalled being “talked to at length about, my recovery has nothing to do with my counseling, and then eventually, it has nothing to do with my supervision other than taking care of myself like any other person should do.” She expressed feeling frustrated with “very, very unhealthy, messy counselors who are in recovery” that did “way too much self-disclosure ... it was inappropriate” which was a “big part of ... why I did decide to supervise people.” She stated

that she “felt like [she] could challenge that with people” and encourage them to look beyond their recovery status to “be skilled” clinicians. The literature supported the clinical supervisors’ viewpoint that skills beyond self-disclosure of recovery are important to be addressed in supervision (Fulton et al., 2016; Juhnke & Culbreth, 1994; Powell & Brodsky, 2004). Because many substance abuse counselors lack formal education such as a master’s degree in a mental health discipline, as suggested by Juhnke and Culbreth (1994) clinical supervisor should provide a strong educational component to clinical supervision in order to ensure a minimal level of skill and competency in supervisees. Additionally, Powell and Brodsky (2004) stated that clinical supervision should include educating supervisees on the 12 core functions of substance abuse counseling (e.g. screening, intake, orientation, assessment, counseling, case management, treatment planning, consultation, crisis intervention, client education, referral, report and record keeping), affective qualities (e.g. empathy, unconditional positive regard, genuineness, respect, potency, immediacy, concreteness, congruence), helping skills (e.g. attending, paraphrasing, probing, reflection of feelings, summarizing, confrontation, self-disclosure, interpreting), transference and countertransference, physical contact with clients, and sexual misconduct.

In the present study, most clinical supervisors reflected that they frequently used self-disclosure in clinical supervision as a way to educate supervisees as well as strengthen the relationship with supervisees. Because the substance abuse counseling field began as a peer led movement of people in recovery helping others gain recovery, the history of substance abuse training laid a framework of self-disclosure being used as a sharing of one’s own recovery experiences to help others who are struggling with an addiction (White, 2000). Although the field of substance abuse counseling has grown and professionalized which includes credentialing and licensing in each state, substance abuse counselors have continued to rely on self-disclosure

in counseling sessions for several reasons (i.e., lack of education, training, and adequate supervision) instead of using counseling skills and theories that have been provided and based in research (Ham et al., 2013). In the same way as counselors in recovery use self-disclosure as a primary method in counseling (Fulton et al., 2016), clinical supervisors in the present study also described using self-disclosure as a primary method when supervising supervisees in clinical supervision. In the infancy of the field of supervision in substance abuse counseling, supervision was often in the form of senior level counselors using their own recovery experiences to supervise and give direction to junior level counselors (Juhnke & Culbreth, 1994). In the present study, Michelle stated that when talking about disclosing her recovery status to a supervisee, “I really do think that it helps build rapport with people when you let yourself be vulnerable.” Ben stated that he uses self-disclosure “to enhance what’s going on, so I think the effect is positive ... and there’s a level of candor ... all it does is strengthen the relationship.”

Also, clinical supervisors’ negative feelings about self-disclosure specifically pertained to not taking into account the receptivity of the individual who is being disclosed to and regretting self-disclosure as a result. Juhnke and Culbreth cautioned that recovering counselors and supervisors are particularly vulnerable to imposing their personal beliefs and experiences on clients and supervisees, and clients’ or supervisees’ negative response or relapse may trigger responses in recovering helpers such as loss of empathy or reduction in patience that may negatively impact the relationship. As wounded healers, clinical supervisors’ addiction wounds can be an asset as well as a vulnerability (Miller et al., 1998). The concept of the wounded healer is not the degree of woundedness, but the ability of the wounded healer to draw from his or her own woundedness to help others (Frankl, 1963; Jourard, 1971; Remen et al., 1985). Earlisha described how a supervisee looked when she disclosed information about her relapse to

the supervisee. She said, “I could see the look on her face and I went, “Oh no, dang!”... it took me a little bit to get her trust back” after that disclosure. She said she regretted “telling her ... because then that led her to think that I was deceiving her for several months prior to my relapse.” Several researchers agreed that substance abuse counselors in recovery often struggle with using self-disclosure appropriately (Fulton et al., 2016; Juhnke & Culbreth, 1994). Also, Ham et al.’s (2013) found that some counselors learned over years in the field to use less self-disclosure overall and when they did self-disclose, they used short disclosures instead of long stories in order to be more purposeful. All the clinical supervisors in the present study are also substance abuse counselors, thus they struggled at times with appropriately self-disclosing which agreed with other researchers (Fulton et al., 2016; Gallaher, 2010; Ham et al., 2013). The researchers believed that inappropriate self-disclosure can lead to blurred boundaries with supervisees, dual relationships, and ethical concerns which negatively impact the supervision relationship by taking the focus off of supervisee development.

**Advantages and challenges for clinical supervisors in recovery.** In the present study, all of the clinical supervisors perceived their recovery of substance abuse presented several advantages in their clinical supervision. They stated that their personal recovery allowed them to have insight into what is an addiction and that their recovery experiences helped them talk to supervisees about clients’ perspectives when they are in treatment. According to Guggenbuhl-Craig (1999), the wounds of addiction assist counselors in recovery by relating to and treating their clients who are struggling with addiction. Although the literature is lacking related to clinical supervisors in recovery, counselors in recovery were found to bring unique insights into the counseling relationship; such as their understanding of ideas that are related to the culture of addiction, being able to be a role model for clients, having empathy for suffering that occurs with

additions, and bringing insight into the 12-step fellowship involvement (McGovern & Armstrong, 1987; White, 2000). The attributes of counselors in recovery that were reported in the research were confirmed by the clinical supervisors in the present research study regarding clinical supervisors' supervision of supervisees. Michelle agreed that it was helpful in work with supervisees to "have someone be honest with them about what their experience was as a client or a patient." Since A.A. began in the 1930s, there has been a prevalent belief that the most effective substance abuse counselors are those who have personally survived addiction, thus becoming wounded healers (white, 2000). John, Jan, and Ben all specifically emphasized that because they have had a personal experience with addiction, their supervisees need an appreciation of the experience of addiction. As Jan stated, "you can't really understand something unless you've been there." Therefore, Jan and John encouraged supervisees to attend 12-step meetings and Ben encouraged supervisees to abstain from something for 30-days in order to have some experience with abstinence if supervisees are not already in personal recovery from substance abuse. Many substance abuse counseling professionals believe that an individual must be in personal recovery in order to provide effective treatment to clients who are abusing substances and who attend a 12-step meeting or abstain from something to be empathic and understanding of the recovery process (Powell & Brodsky, 2004).

All clinical supervisors in the present study described challenges in clinical supervision for recovering clinical supervisors. As persons in recovery, the supervisors all described boundary issues as challenges in supervision particularly dual relationships and countertransference. Earlisha reflected that she struggled initially when supervising people because she "couldn't figure out what hat [she] was suppose to wear" and struggled to be a member of the recovery community as well as a counselor and supervisor. Jan stated that she wanted "to be careful of

my dual piece with them [supervisees],” so “a lot of times I’ll just remain quiet.” If she saw a supervisee at a 12-step meeting “then [she] might address it in supervision the next time [she would] see them” to see how they felt about seeing her there. Gallagher (2010) and Hecksher (2007) advised that supervisees have the potential for blurred boundaries if they attend and participate in 12-step meetings for their own personal recovery where clients may attend and can be expanded to include supervisors. The ADRA *Code of Ethics* that most of the clinical supervisors in the present study use with supervisees when working toward a substance abuse credential in Louisiana includes that the supervisor “shall avoid all dual relationships with the counselor in training [supervisee] that may interfere with the supervisor’s professional judgment or exploit the counselor in training [supervisee].” Jan stated, “I know that they might struggle, so I just take on the piece that it’s my responsibility to make this as easy for them as it can be” when supervisees see her at 12-step meetings. Also, Jan’s handling of the dual relationship is consistent with CSAT (2009) and the ADRA *Code of Ethics*. Clinical supervisors’ guidance is vital in navigating these complex dual relationships and supervisors are responsible for ensuring that supervisees are aware of the risks of dual relationships and boundary issues (CSAT, 2009).

Regarding countertransference, Jolie described how she constantly struggles with remembering “what it was like to be a client” and supervising supervisees who want to be punitive and “kick people out” of treatment for “acting out” which she remembers doing as a client. “I probably should’ve gotten kicked out a thousand times,” she stated, but she was never kicked out. Ben stated that he has a supervisor that will “tell [him] the truth” because “my problem is that I don’t recognize [countertransference and transference] early enough.” Michelle agreed that she has “countertransference and sometimes [she needs a] nudge in one direction or another” from a supervisor. Similar with supervisors who have personal issues that could occur



in supervision, Juhnke and Culbreth (1994) cautioned recovering counselors about the influences that can occur regarding personal recovery issues which can make them particularly vulnerable to imposing their personal experiences and beliefs on clients and supervisees in an attempt to be helpful. Powell and Brodsky (2004) encouraged clinical supervisors to acknowledge and briefly process supervisees' reactions to clients that indicate countertransference and to refer supervisees to therapy if countertransference is long-standing or deep-seated.

Five clinical supervisors in the present study were strong in their views about the stigma of addiction following them in their professional lives and when they work with supervisees.

Michelle stated, "There are people who ... disregard people in recovery ... many just discount the whole recovery piece like it's not relevant." Jan described how "sometimes I've bumped up against counselors who are prejudiced against me because of their own take on addiction and recovery." She said that "it's like they don't respect me the same." Although substance abuse counseling is unique in that it is common and even preferred for counselors to have a personal history of substance abuse in which they have overcome (Jackson, 2001; White, 2000), the literature confirmed that disclosing personal wounds pertaining to a potential stigma, such as a relapse, can lead to concerns over being judged by colleagues regarding competency which can result in secrecy, self-stigma, and shame (Gil, 1988; Jackson, 2001; White, 2000; Zerubavel & Wright, 2012). For example Earlisha expressed insecurity when coming back to work as a supervisor after her relapse because she "felt a little awkward ... and I don't have much ground to stand on to talk about recovery to you [supervisees]." She also expressed paranoia that colleagues were "wondering if I was using because I had a bad day" at work or that another counselor "resented me ... thinking I was getting special treatment because I was in recovery." The clinical supervisors in the present study agreed that they learned over time to be very

selective about whom they disclose to regarding their recovery status as a result of feeling stigmatized in the workplace. Additionally, there is no research on how clinical supervisors who have wounds know they have healed to a sufficient degree in order to supervise responsibly. Zerubavel and Wright (2012) suggested that the subtleties of a counselor's, and therefore a supervisor's, wounds that can lead to impairment are harder to see and require active engagement in the supervision process to identify and manage professionally. Therefore, it is important for the clinical supervisor to maintain a relationship with his or her own clinical supervisor as well as engage in self-care to maintain effective management of personal wounds from addiction.

Clinical supervisors emphasized self-care for themselves and supervisees as important to maintaining a healthy supervision relationship. Ben stated, "I suffer from the same things I warn others about" and "I can get so wrapped up in my work that I neglect my own personal recovery." He stated, "the most severe that it ever was ... I hadn't gone to meeting in like three weeks and ... I had a sponsor in name only" so, "I tried to use those supervisee relationships to get that ... which is not a good thing." Powell and Brodsky's (2004) Blended Model also emphasized that the supervisor should have a deeper self-awareness and maintain their own self-care practices as they encourage their supervisees to do the same.

**Uses of recovery experiences in clinical supervision.** In the present study, self-disclosure was a major factor in clinical supervision as reported by several of the supervisors. Earlisha and Jolie both reported regretting self-disclosures early in their careers as clinical supervisors and how they learned to be more selective when self-disclosing as a result of negative experiences when they self-disclosed. According to White (2000), professionals in recovery draw from their own personal experiences in counseling or supervision, however, a major factor is that

professionals in recovery often struggle when using self-disclosure and they tend to disclose inappropriately or too frequently (Fulton et al., 2016). Earlisha described how inappropriate self-disclosure can happen when she disclosed information about her relapse to a supervisee. She said, “I could see the look on her face and I went, “Oh no, dang!”...it took me a little bit to get her trust back.” Earlisha has “learned to tone things down..., [and be] selective about what I share” with supervisees and other people. Jolie described a time where she disclosed to a group of people “about being a heroin addict ...” and she noticed the audience’s facial reactions when “all of a sudden I realize that, yeah probably shouldn't be telling this story.” Her reflection is consistent with Sweeney’s (1996) study where he found that counselors who were early in their careers disclosed more freely what helped them in their own recovery process, but they became more conservative with self-disclosure as they gained experience in the field. Jolie and Earlisha are both early in their careers as clinical supervisors (i.e., under 4 years). Jan, Ben and John had 19 years or more as clinical supervisors and expressed the need to be intentional with self-disclosure, which is consistent with Ham et al.’s (2013) assertion that self-disclosure is a factor in counseling that should be used selectively with clients based on clients’ needs and welfare. Accordingly, clinical supervisors should use self-disclosure selectively with supervisees based on supervisees’ needs and welfare.

In the present study, clinical supervisors described reasons for using personal recovery experiences in clinical supervision as primarily enhancing the supervision relationship, providing insight into addiction, and managing potential relapses. Jolie stated, “I have an eye for manipulation because I was a master manipulator” as a client and “so I get to teach [supervisees] that” from “just remembering some of the stuff I did” as a client. “I’m like oh my God, I’m telling them too many stories, so I got to watch that sometimes. But if it’s a really good story that

will really help them” then she uses it in supervision. The literature is relatively silent on these specific uses of recovery experiences in supervision, however, Borders and Brown (2005) expressed concerns that substance abuse supervisors rely more heavily on their own experiences rather than on professionally endorsed supervision practices, which could lessen the quality of supervision they provide. They attributed substance abuse supervisors relying on their own experiences because of lesser education, lack of professional supervision resources, and inexperience and/or lack of training in supervision.

Managing relapse was discussed by clinical supervisors in the present study as influencing the supervision relationship in two ways: (1) helping the supervisor to hold supervisees in recovery accountable and (2) training the supervisees how to appropriately handle client relapses based on the supervisor’s own relapse. Ben stated he uses supervision as “accountability for supervisees in recovery” and specifically asks supervisees about their recovery in supervision. Jan stated her own recovery made her “more attuned to addictions in supervisees” and able to “identify when a supervisee in recovery is on a slippery slope” towards relapse. The literature was consistent with clinical supervisors’ viewpoints in the present study in that supervisors should be concerned about relapse among supervisees in recovery and encourage supervisees to practice self-care (CSAT, 2009; Culbreth & Borders, 1999; Jones, Sells & Reh fuss, 2009; White, 2000).

Since clinical supervisors in recovery have personal wounds from addiction and research does not exist regarding clinical supervisors in recovery healing to a sufficient degree in order to supervise professionally, how recovery can be appropriately used in the context of clinical supervision is unclear. However, Zerubavel and Wright (2012) stated that the subtleties of a counselor’s wounds can lead to impairment and require active engagement of the counselor in

the supervision process to identify and manage appropriately. Supervisors in recovery are also counselors who could need and require supervision or consultation themselves to manage their own wounds in order that the supervision relationship is not compromised. Ben and Jan agreed that supervision and consultation were important for clinical supervisors in recovery. Ben stated that his expectations of supervisees tends to be high and “the relationship gets foggy” so “my supervisor keeps an eye on me.” Jan expressed a similar sentiment when she said, “I still have people I call ... if I get kind of stuck on something that I think I don’t know how to help [supervisees] with this.”

**Clinical supervision framework.** Functions of supervision and the structure of supervision provided insight into the supervision framework that clinical supervisors in the present study used to guide their supervision process with supervisees. In the supervision framework, Jan included the evaluative nature of supervision. She said, “Supervision is about mentoring, evaluation, and guiding skill development...to challenge supervisees to be better.” Jan said it was a challenge to evaluate people who are “unhealthy ... because personally they’re so messed up, or they have absolutely no willingness to learn the skill.” “It’s really hard to evaluate people when I sit down and do paperwork with them, when I know they think they’re good, but they’re not.” Jan’s feelings of discomfort around the evaluative nature of supervision is in line with Schmidt et al.’s (2013) suggestion that substance abuse supervisors may be uncomfortable with gatekeeping and inconsistent in fulfilling the gatekeeping duties of supervisors. Jan’s comments spoke to the discomfort with evaluation that could negatively influence supervisors who may avoid evaluation or minimize supervisees’ challenges in their work with clients.

The majority of the clinical supervisors in the present study completed a training course, an examination, and experiential hours to become clinical supervisors. The supervisors deviated

from Culbreth's (2008) findings that most clinical supervisors received little training as supervisors. In the present study, clinical supervisors stated that they used evidence-based practices to structure supervision and documented supervision in accordance with licensure or certification requirements from state boards. Ben recommended structuring supervision around "TAP 21 and the competencies" and he uses books as sources to help him with supervision or he recommends supervisees to read professional books. Ben further explained that he is, "pretty strict in my supervision about... when people are in recovery to follow that developmental model, so I...don't get too deep too fast." John stated that he takes supervisees through "a specific supervision plan to make sure that these folks are adequately prepared" which is based on SAMHSA's TAP 21. He also stated that he "gets them familiar with our core functions and global criteria" of addiction counseling. Laschober et al. (2013) and Powell and Brodsky (2004) found great variability in training of substance abuse counselors because substance abuse treatment is one of the few mental health care areas where counselors without at least a master's degree, licensure, or certification can engage in client care, thus the burden of training is placed on clinical supervisors. The academic training variability was demonstrated in my study as three clinical supervisors had master's degrees, one had a bachelor's degree, and two had associate's degrees. The majority of clinical supervisors had multiple professional credentials or licenses that required additional experience and training. Additionally, three supervisors were Certified Clinical Supervisors (CCS) that required specific training as in Powell and Brodsky's (2004) Blended Model as well as supervised experience (ADRA, 2016).

## **Implications**

**Implications for clinical supervisors in recovery.** A review of the literature revealed scant research on the perceptions of supervisors regarding the influence of their recovery during

supervision. The present qualitative study provided insight into clinical supervisors' perceptions, which may contribute to a better understanding of clinical supervision for substance abuse counselors, and facilitate more effective clinical supervision for substance abuse counselors. The first implication in my study is that clinical supervisors may benefit from using a supervision model with supervisees that includes competencies in substance abuse counseling to ensure that supervisees develop appropriate counseling skills beyond self-disclosure of their own recovery if they are in personal recovery. A second implication derived for clinical supervisors in recovery is increased insight into the risks and benefits of using self-disclosure in supervision. In the present study, the clinical supervisors emphasized the need to "know your audience" when self-disclosing and make sure that self-disclosure is appropriate and beneficial to the environment and individual supervisees. A third implication is increasing the awareness of clinical supervisors in recovery regarding the stigma of addiction in the workplace as well as within the supervision relationship. A fourth implication is increasing supervisors' awareness about countertransference and dual relationships as well as the need to address various situations that might include countertransference in supervision with supervisees, particularly if supervisees are in recovery and may encounter a supervisor at a 12-step meeting in the community. Finally, the last implication is the awareness of clinical supervisors in recovery of their own self-care and need for continuous monitoring of how to ensure that they are not meeting their own needs in the supervision relationship.

**Implications for supervisees of clinical supervisors in recovery.** A review of the literature revealed that supervisees valued the quality of the clinical supervisory relationship, and addiction counselors with a favorable view of clinical supervision reported increased job satisfaction, commitment to their job and organization, less emotional exhaustion and burnout,

and great feelings of support and autonomy in their job functions (Eby et al., 2006; Knudsen et al., 2008). An implication in the present study for clinical supervisors is that supervisees can benefit from additional training and formal education to gain a solid foundation of counseling skills. A second implication is that supervisees should be aware of and willing to reflect of how boundary issues, countertransference, and dual relationships can occur in supervision which could influence the supervision relationship with supervisors.

**Implications for clinical supervisor educators.** A review of the literature revealed that substance abuse clinical supervisors progress through stages of development which includes self-awareness for both supervisors and supervisees (DCLAS, 2011; Kipnis et al., 2009). The first implication found from the present study is linked to the developmental approach in clinical supervision. Using a developmental approach with supervisors and supervisees could provide insight into the use of recovery in clinical supervision and contribute to a better understanding of the training areas needed specifically for substance abuse clinical supervisors in recovery that could facilitate effective training for supervision. A second implication is for educators of clinical supervisors who may benefit from the present research findings regarding how much self-disclosure is being used by supervisors in recovery during clinical supervision. Training programs may benefit from evaluating their current training on self-disclosure as well as the risks and benefits of self-disclosure in clinical supervision. A third implication is increasing elements in training programs regarding managing boundaries, particularly around countertransference and dual relationships with supervisees and supervisors. A fourth implication is assisting clinical supervisors in managing their own self-care, including how to manage a relapse if the supervisor or supervisee relapses. The fifth implication is that educators of clinical supervisors could benefit from knowing that clinical supervisors in recovery may be uncomfortable with evaluating



supervisees and may need extra training or support in gatekeeping for the profession. The final implication is that beginning supervisors in recovery need more training and support to be effective considering that recovering supervisors are less likely to have experience in the supervisory role and beginning supervisors in recovery are likely to have deficits as a supervisor (Culbreth & Cooper, 2008).

### **Limitations and Delimitations**

In the present research study, several potential limitations exist. The first potential limitation was the possibility of my researcher bias. I am a clinical supervisor of substance abuse counselors, thus my interpretations may have been influenced by my experience throughout my research. The second potential limitation was that the clinical supervisors were limited to supervisors in personal recovery from substance abuse who supervise counselors working towards a substance abuse license or credential in Louisiana. The limited number of clinical supervisors in my study do not allow for transferability to other clinical supervisors in similar or different contexts. Additionally, the context of clinical substance abuse supervision in Louisiana may be very different from the context of clinical substance abuse supervision in other geographical regions. The third potential limitation was that the clinical supervisors were in personal recovery from substance abuse and their own biases may have impacted the findings of my study. The fourth potential limitation was the homogeneity of the clinical supervisors; the majority of participants were Caucasian and female; thus racial, ethnic, and cultural factors were not addressed. The fifth potential limitation was the age and length of recovery of the participants. All participants were over the age of 50 and had over 10 years of recovery; thus participants were not new to the profession. Clinical supervisors who are younger in age and/or have less work experience in substance abuse counseling may have different experiences.

Despite the existence of limitations in the present research, the findings are important regarding perceptions of clinical supervisors in recovery and their use of their recovery experiences in clinical supervision, a topic that has not been addressed in the literature.

### **Recommendations for Future Research**

A need for research continues in the need to understand clinical supervisors in recovery from personal substance abuse and how they use personal recovery in supervision. The present research study examined six clinical supervisors' perceptions of how their personal recovery influences the supervision they provide to counselors working towards a substance abuse credential in Louisiana. Compared to clinical supervision disciplines in similar professions, very few studies focus on the influence of the supervisor's recovery status on supervision. The field of addictions would benefit from more studies that examine the impact or influence of the supervisor's recovery status on supervision as well as research that investigates the similarities and differences between clinical supervisors in recovery and nonrecovering supervisors. Additionally, research is needed regarding supervisees' perceptions of how recovery is used or influences supervision from clinical supervisors in recovery. A review of the literature revealed that research does not exist regarding clinical supervisors in recovery from substance abuse healing to a sufficient degree in order to supervise responsibly. The lack of information about healing from the wounds of addiction related to clinical supervisors in recovery indicates there is a need for more research in this area.

### **Personal Reflection**

Reflecting on my experience as a researcher, my duty was to remain as unbiased as possible, and follow the established procedures for collecting and interpreting data. I made every effort to conduct myself in an ethical and professional manner throughout the course of the research

study. I was more impacted by the research process than I anticipated. Specifically, reading and rereading the transcriptions of the interviews permitted me to hear the challenges and achievements of each of the six participants as well as the group as a whole. I was challenged to remain objective when reading about the stigma of addiction that is still so present in society today. I was honored to hear and share the personal stories of the participants. I believe that they are truly exceptional clinical supervisors in recovery who overcame addiction in their own lives and have committed themselves to shaping the next generation of substance abuse counselors through their experiences and wisdom. Their journey through addiction and recovery empowered them to embark on a life-changing path of healing that led them to pass on their experiences, strengths, as well as hope for others to find recovery from addiction. I admire their courage and determination to recover and share their life experiences with others. I truly hope that my research study will be a voice for clinical supervisors in recovery that will advance the field of clinical supervision for substance abuse counselors. It has been a privilege to get to know John, Jolie, Earlisha, Michelle, Ben, and Jan. Their willingness to share about themselves in light of the stigma of addiction they each personally experienced is greatly appreciated.

## **Conclusion**

In conclusion, I presented in the present chapter the philosophic foundations for my research study and discussion of the existing literature to provide the context to examine the findings in my research study. Also, I discussed the findings my research as they answered four major areas. Finally, I presented the limitations, implications, recommendations for future research, and my personal reflection.

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**Appendix A**  
**Script for Recruiting Participants**

## Appendix A

### Script for Recruiting Participants

My name is Adrienne Trogden and I am conducting research on the experiences of clinical supervisors in recovery from substance abuse. I am a doctoral candidate in counselor education at the University of New Orleans. The study that you are being asked to participate in involves my dissertation research, entitled *Clinical Supervisors' Perceptions of How Personal Recovery Influences Their Supervision*.

The purpose of this study is to explore the lived experiences of clinical supervisors in recovery from substance abuse. I hope to gain a better understanding of the supervision experiences of clinical supervisors in recovery from substance abuse and the meaning behind their lived experiences.

Upon verbal agreement from you, we can set up the face-to-face interview based on your convenience. After reading and the consent form, you will be asked to fill out a short Pre-Interview Demographic Questionnaire describing your personal characteristics. You will then be asked to agree to be interviewed. Several weeks after the interview, you will be asked to review the researcher's analysis of your interview and provide feedback. The research will require the following time commitment from you:

- 1) Estimated time to complete the short questionnaire is 1-2 minutes (administered on one occasion)
- 2) Estimated time to complete the interview is approximately 1-1.5 hours
- 3) Estimated time to review the transcript of the interview and my research analysis of the interview is approximately 15 minutes
- 4) Estimated total time commitment for this research study is approximately 2 hours
- 5) You will be audiotaped during the interview.

Before you can participate in this research study, you must affirm that you meet the following participant criteria:

- (a) Working as a clinical supervisor in a mental health agency.
- (b) Working in a substance abuse agency who self-identifies as being in personal recovery from past substance abuse for two years or longer;
- (c) Supervising a counselor who is working toward license or credential as a substance abuse counselor;
- (d) Licensed as a Licensed Professional Counselor (LPC), Licensed Social Worker (Licensed Master Social Worker or Licensed Clinical Social Worker), or Licensed Addiction Counselor (LAC) in Louisiana; and
- (e) Supervising as a clinical supervisor for two years or longer.
- (f) Agree that I can use your information in the research study.

Prior to agreeing to participate in the study and when we meet for the interview, I will read the consent form with you so you clearly understand the conditions of participation in this study. If

you choose to participate, your information will be held confidential and you will be assigned a pseudonym to protect your identity.

Here is my contact information for your reference:

Adrienne Trogden, CCS, LAC, ADS, LPC-S

Doctoral Candidate

Counselor Education

504-994-0881, e-mail: [atrogden@uno.edu](mailto:atrogden@uno.edu)

The contact information for my dissertation committee chair and principle investigator is Roxane L. Dufrene, PhD, LPC-S, LMFT, NCC

Associate Professor

Educational Leadership, Counseling, and Foundations

University of New Orleans

504-280-7434, e-mail: [rdufren1@uno.edu](mailto:rdufren1@uno.edu)

If you have any questions about your rights as a participant in this research, or if you feel you have been placed at risk, you can contact Dr. Ann O'Hanlon at the University of New Orleans at (504) 280-3990.

You are encouraged to ask questions if any of the information is unclear. Do you have any questions or concerns at this time about the research study?

Thank you for your time and consideration.

**Appendix B**  
**Informed Consent**

## Appendix B

### Informed Consent

1. Title of Research Study: Clinical Supervisors' Perceptions of How Personal Recovery Influences Their Supervision.

2. Principle Investigator: Roxane Dufrene, PhD, LPC-S, LMFT, NCC  
Associate Professor  
Educational Leadership, Counseling, and Foundations  
University of New Orleans  
504-280-7434, e-mail: [rdufren1@uno.edu](mailto:rdufren1@uno.edu)

3. Co-Investigator: Adrianne Trogden, CCS, LAC, ADS, LPC-S  
Doctoral Candidate  
Counselor Education  
504-994-0881, e-mail: [atrogden@uno.edu](mailto:atrogden@uno.edu)

Adrianne Trogden, a doctoral student at the University of New Orleans and her faculty supervisor, Dr. Roxane L. Dufrene, are requesting your participation in a research study entitled *Clinical Supervisors' Perceptions of How Personal Recovery Influences Their Supervision*.

4. Purpose of the Research: Little is known about the perceptions of how supervisors in personal recovery from substance abuse use their recovery experiences in supervision. The purpose of this study is to investigate the perceived influence of a supervisor's recovery status in the clinical supervision of substance abuse counselors working towards licensure.

5. Procedures for this Research: Participants will be asked to complete a one to one and a half hour interview with the co-investigator, in which you will be asked to discuss your experiences related to using your personal recovery within your clinical supervision role. The interview will be conducted in a setting that offers privacy, is conducive for digital recording, and is convenience and accessible to you. Such settings may include a library meeting room, your home, or your office. Interview locations will be made with your convenience in mind at the time of scheduling. The interviews will be digitally recorded. Participants will be contacted a second time in a manner that is acceptable to you (telephone, postal mail, or email) and asked to provide either verbal (telephone) or written (postal mail or email) responses to my research analysis of your interview.

6. Potential Risks or Discomforts: Participants may experience negative emotions and/or discomfort when talking about experiences during the course of this study. If you wish to discuss these or any other discomforts you may experience, you may call the co-investigator listed in item 2 of this consent form to obtain referral sources for counseling in your area if needed, such as calling 211 or 504-994-0881 to obtain resources in your area. You may request a break during the interview if you feel you need one. You may also choose not to answer any questions that you do not wish to answer, and you may withdraw any and all answers either during or after the interview. You may withdraw from the study at any time without consequence.

7. Potential Benefits to You or Others: Participation in this research may give you an opportunity to voice your concerns, opinions, thoughts, and ideas about your experiences using personal recovery in clinical supervision. It is hoped that results will assist in the education and understanding of how personal recovery can influence the supervision process for other supervisors, educators and trainers.

8. Alternative Procedures: There are no alternative procedures to this research. Your participation is entirely voluntary and you may withdraw consent and terminate participation at any time without consequence.

9. Protection of Confidentiality: Participants' identity will be kept confidential and will be maintained with an identifying pseudonym of your choosing. You will be asked to use this name (not your real name) to identify your responses to interview questions and to be used in any resulting publications. All identifying information will be stored separate from the information collected for added security. Digitally recorded interviews will be transcribed into Microsoft Word documents and saved with a password. Recordings and transcripts will be kept in a locked cabinet accessible only to the investigator and co-investigator. Recordings will be destroyed upon completion of data analysis and transcripts will be destroyed three years later. The researcher will use only a landline to obtain or provide information that may include sensitive or personal data. Likewise, either HIPAA compliant email or postal mail will be used to send information that contains sensitive or personal information. Your identity will be protected in the reporting of aggregate data only to any publication. Although every effort will be made to ensure confidentiality, absolute anonymity cannot be guaranteed.

10. Signatures: If you have any questions about your rights as a participant in this research, or if you feel you have been placed at risk, you can contact Dr. Ann O'Hanlon at the University of New Orleans at (504) 280-3990.

I have been fully informed of the above-described procedure with its possible benefits and risks. I have read and understand the consent form and desire of my own free will to participate in this study. By agreeing to participate, I have given my permission for participation in this study.

## **Appendix C**

### **Pre-Interview Demographic Questionnaire**

## Appendix C

### Pre-Interview Demographic Questionnaire

For the purposes of this research study, the following definitions are provided.

**Clinical Supervision:** “The clinical supervision relationship is evaluative, extends over time, and has the simultaneous purposes of enhancing the professional function of the more junior person(s), monitoring the quality of professional services offered to the clients...and serving as a gatekeeper of those who are to enter the particular profession” (Bernard & Goodyear, 2004, p. 8).

**Administrative Supervision:** The administrative supervision is a relationship that assist supervisees to function effectively within the larger organization focusing primarily on workplace performance, paperwork timeliness and accountability to the organization (Bradley & Ladany, 2001).

Please provide the following information for each item.

1. Age \_\_\_\_\_
2. Ethnicity
  - a. African American/African/Black/Caribbean
  - b. Asian/Pacific Islander
  - c. Caucasian
  - d. Hispanic/Latino
  - e. Native American
  - f. Other\_\_\_\_\_
3. Highest Educational Degree Achieved
  - a. High School/GED
  - b. Associate
  - c. Bachelor
  - d. Master
  - e. Ph.D.
4. Employment Status
  - a. Full-time
  - b. Part-time
  - c. Contractor
  - d. Other\_\_\_\_\_
5. Credentials
  - a. LPC
  - b. LMSW
  - c. LCSW
  - d. LMFT



- e. LAC
  - f. CAC
  - g. RAC
  - h. CCS
  - i. Other\_\_\_\_\_
6. Primary work setting where you are conducting clinical supervision with a substance abuse counselor working toward a Louisiana substance abuse license or credential?
- a. Type of Agency/Facility/Practice \_\_\_\_\_
7. What is your present job position?
- a. Counselor
  - b. Supervisor
  - c. Clinical Director
  - d. Other
8. How many months/years have you been working in the field of counseling? \_\_\_\_\_
9. How many months/years have you been a clinical supervisor? \_\_\_\_\_
10. How do you conduct supervision?
- a. Individually  
How often do you meet?\_\_\_\_\_
  - b. Groups  
How often do you meet?\_\_\_\_\_
  - c. Staff Meetings  
How often do you meet?\_\_\_\_\_
  - d. Other \_\_\_\_\_  
How often do you meet?\_\_\_\_\_
11. How many substance abuse counselors working towards a Louisiana substance abuse license or credential do you supervise?
12. What types of training have you completed to become a clinical supervisor?
- a. Took a supervision training course
  - b. Completed hours of experience
  - c. Took a written examination
  - d. Other\_\_\_\_\_
  - e. No training completed
13. What type of license or credential is your supervisee(s) working towards
- a. LPC
  - b. LMSW
  - c. LCSW
  - d. LMFT
  - e. LAC

- f. CAC
- g. RAC
- h. CIT
- i. ATA
- j. Other \_\_\_\_\_

14. How long have you been in personal recovery from substance abuse?

15. What substances did you previously abuse?

- a. Alcohol
- b. Marijuana
- c. Opiates
- d. Benzodiazepines
- e. Barbiturates
- f. Cocaine/Crack
- g. Hallucinogens
- h. Steroids
- i. Other \_\_\_\_\_

16. How did you enter recovery?

- a. Criminal justice involvement
- b. Self-motivated
- c. Prompting of loved one(s)
- d. Prompting of medical provider
- e. Prompting of higher power
- f. Other \_\_\_\_\_

17. What type of treatment/intervention did you receive? (choose all that apply)

- a. 12-steps Meetings
- b. Inpatient/Residential
- c. Halfway House/Transitional Living
- d. Intensive Outpatient Program (IOP)
- e. Group Counseling
- f. Individual Counseling
- g. Other \_\_\_\_\_

**Appendix D**  
**Interview Questions**

## **Appendix D**

### **Interview Questions**

1. What is supervision to you?
2. What was supervision like for you?
3. How has your recovery status informed your clinical supervision of substance abuse counselors?
4. What are the advantages of being a clinical supervisor in personal recovery from substance abuse?
5. What are the challenges of being a clinical supervisor in personal recovery from substance abuse?
6. How might you supervise counselors in recovery themselves differently than non-recovering counselors?
7. Have you used self-disclosure of your personal history of addiction with supervisees, and if you have, in what ways and why?
8. How has your self-disclosure affected supervision?
9. Are there times when you have chosen not to use self-disclosure or times when you regret using self-disclosure? Describe these situations.
10. What was your supervision like? Who did you have as a supervisor?

## **Appendix E**

### **Peer Debriefers and Auditor Confidentiality Agreement**

## Appendix E

### Peer Debriefing and Auditor Confidentiality Agreement

It is understood and agreed to that the below identified discloser of confidential information may provide certain information that is and must be kept confidential. To ensure the protection of such information, and to preserve any confidentiality necessary under HIPAA and research participant confidentiality, it is agreed that:

1. The confidential information to be disclosed can be described as and includes: Research participant demographic information, written transcriptions of interviews conducted with participants, and categories and themes identified in transcriptions.
2. The recipient agrees not to disclose the confidential information obtained from the discloser to anyone unless required to do so by law.
3. This agreement states the entire agreement between the parties concerning the disclosure of confidential information. Any addition or modification to this agreement must be made in writing and signed by the parties.
4. If any of the provisions of this agreement are found to be unenforceable, the remainder shall be enforced as fully as possible and the unenforceable provision(s) shall be deemed modified to the limited extent required to permit enforcement of the agreement as a whole.

**WHEREFORE**, the parties acknowledge that they have read and understand this agreement and voluntarily accept the duties and obligations set forth herein.

Recipient of Confidential Information:

Name (Print or Type):

Signature:

Date:

Discloser of Confidential Information:

Name (Print or Type):

Signature:

Date:

## **Appendix F**

### **Institutional Review Board Letter of Approval 05/2017**

**University Committee for the Protection  
of Human Subjects in Research  
University of New Orleans**

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*Campus Correspondence*

**Principal Investigator:** Roxane Dufrene

**Co-Investigator:** Adrienne Trogden

**Date:** May 4, 2017

**Protocol Title:** A Qualitative Study to Explore Clinical Supervisors' Perceptions of How Personal Recovery Influences Their Supervision

**IRB#:** 03May17

The IRB has deemed that the research and procedures are compliant with the University of New Orleans and federal guidelines. The above referenced human subjects protocol has been reviewed and approved using expedited procedures (under 45 CFR 46.116(a) category (7)).

Approval is only valid for one year from the approval date. Any changes to the procedures or protocols must be reviewed and approved by the IRB prior to implementation. Use the IRB number listed on this letter in all future correspondence regarding this proposal.

If an adverse, unforeseen event occurs (e.g., physical, social, or emotional harm), you are required to inform the IRB as soon as possible after the event.

Best wishes on your project!

Sincerely,

A handwritten signature in blue ink, appearing to read "R. D. Laird".

Robert D. Laird, Ph.D., Chair  
UNO Committee for the Protection of Human Subjects in Research



## Vita

Adrienne Trogden was born in Indianapolis, Indiana. She obtained a bachelor degree in elementary education from Milligan College in 2002 and a master's degree from Indiana Wesleyan University in 2004. In 2010, she joined the University of New Orleans graduate program to pursue a Ph.D. in counselor education. She is currently a Licensed Professional Counselor and Licensed Addiction Counselor.