Questions Asked During Live Webinar Broadcast on 8/24/2021

Successful Clinical Supervision with Therapists in Personal Recovery
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Might it be beneficial to have AA type meetings solely for clinicians, or beneficial being in general population? (I know there are AA meetings of lawyers, doctors etc.)?
A: That is a great point and question. We agree that recovery meetings specific to therapists, counselors, and/or addiction professionals are, or would be, beneficial. While we are confident that such meetings already exist in various communities, we are not aware of any in our area. As increasing numbers of people in personal recovery enter the helping professionals, having specialized meetings and communities, such as ones for physicians, lawyers, or nurses, would be a wonderful choice and resource for addiction professionals in recovery. Hopefully leaders in the community will advocate for creating more meetings. The COVID 19 pandemic led to innovations and expansions in offering recovery meetings online. That seems like a useful platform for offering meetings specific to counselors in recovery. Virtual meetings would allow such clinicians to be able to connect with a community (especially if they are in an area where they are not connected with other helping professionals who are also in recovery), and such meetings could augment or compliment other meetings they attend, especially if they find it challenging to attend local meetings in their communities given the nature of their work and the services they provide.

For clinicians in Al Anon and other support groups related to having a loved one in an AA or other support group, how might that effect or be utilized with supervisees in AA etc.?
A: Like most points, it seems important to acknowledge the potential advantages and disadvantages of such relationships. A provider or clinical supervisor who is part of a recovery community, such as Al Anon, has an advantage of being directly, intimately familiar with the dynamics of addiction. They also are familiar with the process of recovery and 12-step communities. This perspective can be helpful in working with clients addressing substance use and related issues, as well as supporting supervisees who are also providing such services. A supervisory relationship where the supervisor is part of Al Anon (for example) is supervising a colleague who is in their own personal recovery from active addiction (AA, NA, etc.) could have several beneficial aspects. Both understand addiction and recovery, not only professionally, but personally. They also both realize the importance of on-going recovery work and can encourage one another. However, problematic dynamics could arise, such as the focus of clinical supervision becoming more like a mutual support meeting, or personal therapy. There is also the potential for transference and conflict between the two. As with any ethical dilemmas or boundary challenges, and as we mentioned in the webinar, this does not automatically mean that all such relationships should be avoided. What it suggests is that all parties involved need to be aware of dynamics, intentionally attending to and deciding how best to respond to them and utilize on-going consultation and supervision when necessary.

I learned relapse is part of addiction management. How true is that?
A: Well, that is a great question, one that, while the topic has become less controversial in the past few decades, still brings with it a lot of debate and disagreement in our profession. Offer a panel on this topic at a professional conference, and it might start to resemble a professional wrestling match. Some in our field have historically suggested that focusing on relapse implies that relapse is natural, unavoidable, acceptable, and that talking about this topic in some way encourages people to relapse or gives them permission to do so. In our decades of working with people we have never encountered someone who needed our permission to return to use, or that something we said encouraged or necessitated a return to use for them. This is akin to saying that encouraging someone to discuss their suicidality makes it more likely that they will act on it. All available research suggests not only is that view...
How many years of experience should a supervisor have before they attempt to supervise/get a supervisor license?

A: That’s a great question. We don’t know. We are both social workers by profession, and we have been focusing on improving training for social work supervisors in our area. Currently in our state (Indiana) all that is required for someone to supervise another clinician towards licensure is that they must hold an independent clinical license in social work (in our state, it is the Licensed Clinical Social Worker, or LCSW). That requires at least two years of post-master’s degree full-time work under supervision and passing the state licensure exam. That’s it. Is that enough? Other professional organizations, credentialing bodies and states require more. Some states require that those who provide clinical supervision must complete required state-specific trainings and be registered with the licensure board to be an official supervisor. Like the challenge of trying to specify how many years one should have in recovery before working in the field, we caution against an overemphasis on time frames as the primary determining factor. We believe that the requirements for NAADAC’s National Clinical Supervision Endorsement (NCSE) through the National Certification Commission for Addiction Professionals (NCC AP) are good guidelines. Ultimately, we believe that three guiding recommendations are that someone who is in a clinical supervisor role should have a practice-based license or credential, receive supervision for their supervision, and complete supervision-specific continuing education. We have discovered that just because someone is an experienced clinician does not necessarily mean that they will be a good clinical supervisor, and that most people get promoted to supervisory roles based on their experience and time at the agency or in the profession as opposed to receiving or completing any formal education or training specific to clinical supervision. There is an entire literature base on clinical supervision, one that many new supervisors are unaware of or were not exposed to in their training programs. In addition to NAADAC monthly webinar topics that address clinical supervision, NAADAC also offers a specialty continuing education training series specific to clinical supervision.

Can you explain the dynamics of a workspace where some counselors disclose, and some don’t and how that impacts effective relationships with clients?

A: It is a challenging dynamic to navigate. Having a workforce or treatment team where some workers are in personal recovery while others are not can create some issues. There can be a tendency, if clients are aware, for clients to ignore and reject workers that they know are not in recovery and to gravitate towards the workers they know who are, thus undermining the efficacy of those providers who are not. “How can they help me—they’re not in recovery”. However, the opposite can also occur. Clients might be more suspicious towards or critical of workers in recovery. They might believe that such workers will violate their anonymity in recovery communities, or that they are not able to professionally help them. “How can they help me—they’re in recovery and just another addict like me.” Even between colleagues this can create a collaborative or competitive environment. Workers in recovery might be able to help educate their colleagues who are not to better understand the dynamics of addiction and recovery. However, workers in recovery might mistakenly see themselves as more uniquely able to help clients, or workers not in recovery might see their colleagues who are as vulnerable or biased. The most general approach we have seen in such settings and treatment teams is to decide that providers will not share their personal recovery status, whatever it is. We are not suggesting that this is the correct or best approach. Ultimately, as mentioned previously, such situations are not a dichotomy with a clear right or correct choice. What is most important is that the agency and team acknowledge and intentionally attend to the dynamic and decide how best to respond, while utilizing on-going consultation and supervision when necessary.
What is a suggested clean for counselors?

A: The wording of the question makes it challenging to know just what is being asked. We are assuming that the question is asking, “how should clean be defined or determined for addiction professionals generally, and specifically for ones in personal recovery?” That is a great question, and another one that raises a lot of disagreement and debate. First, we are going to use the terms sober and abstinent as opposed to clean. While some might choose to use that word (and anyone is free to do so), we do not use the term clean because we believe it can be stigmatizing. It suggests that any substance use, or use with some frequency or amount, makes one dirty, and it is not far of a jump from there to then (even if it is unintentional) come to see substance use as bad and the people who use substances as bad. This moral evaluation is understandable, and many people hold it personally or adopt it out of possibly their affiliation with or participation in a chosen wisdom or faith community. We do not believe that this is generally a helpful perspective, and especially not a good professional perspective. We also avoid referring to drug screens that test positive for the presence of a drug(s) and testing dirty. This creates the same perspective as mentioned previously. When someone’s drug screen registers positive for the presence of a drug(s), then it is just that-a positive test. When someone uses drugs, it does not make them dirty, it means they have used drugs. Not using does not make someone clean in any type of professionally meaningful way (though we realize people in certain recovery or faith communities might decide or find it useful to use such terminology and ideology-they are free to do so, we just do not see any professional utility in doing so). While there are differences in definitions, in general abstinence is defined as abstaining from, i.e., not using. This is often differentiated from being sober, which is often defined as not only maintaining abstinence, but working an intentional and on-going recovery program that leads to personal transformation. Many people in recovery believe that simply not using is not enough, that people must engage in some type of curative process or program.

This then brings up a general question: should all addiction professionals, regardless of their personal recovery status, be expected to maintain abstinence from substance use? There is a lot of debate about that. It seems reasonable to suggest that professionals working to help people address the role of substances in their lives, their use, and its consequences would be well served by choosing to remain abstinent themselves. However, is this necessary, or even professionally or legally enforceable? It does not seem practical or workable to expect or demand that everyone working in a position must completely abstain from all use to work in the profession and to be considered competent. There are oncologists, cardiologists, and even pulmonologists who smoke. There are doctors who are obese and consume high caloric diets. Obviously, one could suggest, without disagreement from us, that it would be better and healthier for these professionals to not choose to engage in such behaviors, but if they do, does that mean that they should no longer be able to identify as physicians and practice medicine? In general, we believe that it is a reasonable and a good choice for addiction professionals to choose not to use, however we are not prepared to suggest that it should be expected or mandatory to say that someone working in the addiction professions must maintain complete and on-going abstinence to be considered a competent professional in good standing.

The second question concerns addiction professionals in personal recovery: should addiction professionals in personal recovery be expected professionally to maintain complete an on-going abstinence? This question seems at first like it has an obvious answer, but it a bit more complicated than that. There is an assumption in our profession (one that we both endorse, and which guides our clinical services with individuals) that complete and on-going abstinence from all addictive substances or processes is the best treatment target. Most recovery communities, especially 12-step based ones, hold the “abstinence best and only” position as well. Some even suggest that this is the only acceptable or viable choice, especially for individuals who would identify as being an “addict” or having a diagnosis of substance use disorder moderate to severe (or the more historical distinction of dependence). That is our general approach as well; in services we advocate for abstinence, especially for those whose use displays characteristics of dependence and/or addiction. However, it is also important to note that this is another on-going debate whether someone needs to maintain complete and on-going abstinence. Some suggest that modifying use, such as reducing its frequency or amounts, to reduce or avoid recurrent negative consequences is an acceptable positive treatment outcome (it also should be noted that this is the standard for most all outcome research in our field-while treatment programs might demand complete and on-going abstinence, almost no outcome studies define success as that in determining the benefits of the intervention). There is also an assumption (again one with which we agree and incorporate into our services), that in addition to maintaining abstinence those in recovery need to
attend on-going recovery meetings. Again, this is a great practice, but is it necessary? That is another on-going debate.

This brings us back to addiction professionals in personal recovery. We believe that the best priorities and choices for such individuals are to maintain complete, on-going abstinence and to continue to participate in active recovery activities and communities. However, this raises two points that could arise in supervision. What if someone who historically and currently identifies as being in recovery decides not to attend traditional meetings and engage in typical recovery activities? From a professional perspective, and not personal perspectives or the perspective of traditional recovery communities, we do not believe that addiction professionals in recovery can be expected or required to engage in certain activities or practices, such as going to meetings. It is up to each counselor to decide how to maintain their abstinence and recovery, however they define that. For some, and likely even most, that will involve on-going attendance of and participation in traditional recovery communities. However, we believe that this cannot be mandated and that it is up to the professional to engage in the activities and communities that help them maintain abstinence and sobriety. What if addiction professionals who historically or currently identify or have identified as being in recovery end up using? How should that be handled? We would return then to the before mentioned point about use among addiction professionals in general. Our ethical codes only stipulate that professionals are expected to adhere to relevant agency policies (which might address use) and laws, and that we are to avoid practicing while impaired, especially since doing so can endanger recipients of services. Nowhere in the codes, for anyone, does it say that someone must not use at all, even if they currently or historically have been in recovery. Again, we think that counselors with a history of addiction and recovery returning to use is likely to be a catastrophic and destructive professional and personal decision. Still, it is theirs to make, and it seems that supervisors and the profession can only respond with any authority if, and almost certainly when, their use reaches a place where it either violates laws or leads to practicing in an impaired manner.

We have raised a lot of questions and points for consideration here. Ultimately, we would answer the question in the following ways. We believe that addiction professionals make a constructive and effective choice when they choose to maintain abstinence, and this is especially true for professionals in personal recovery. Addiction professionals in personal recovery are also well served by maintaining an active, on-going connection to and participation with a recovery program as part of their professional self-care. While these priorities and decisions can be considered ideal or preferable, they cannot be enforced in any reasonable way by an employer, professional organization, or regulatory board. The best that any such entities can do is to set standards that are consistent with laws, including not using when doing so is illegal, or when it leads to professional impairment.

In relationship to the first question of having professionals attend their own AA meetings, wouldn't a meeting that includes persons who are clinicians with clients for different socioeconomic and educational status help empower others to see that addiction can affect everyone?

A: This is a good question and great point, one without a definitive answer. As we mentioned in the webinar, we believe that clinicians in recovery attending meetings with clients can be encouraging and empowering, and that was affirmed by the experiences of the participants in or research. The two guiding questions for such an inquiry seem to be, what type of community are we hoping to create, and how are we hopeful that such a community will be uniquely helpful? This is an on-going consideration when developing any type of group—how homogeneous or heterogeneous should members of the group be? It is important to consider the relative advantages and disadvantages of each. Groups that include people from multiple backgrounds and with diverse characteristics (ex. age, ethnicity, gender, socioeconomic and educational status, etc.) have several advantages. They help to normalize and universalize the struggle, showing that anyone can be impacted by it regardless of their identity or heritage. They also provide a diversity and variety of perspectives, suggestions, and resources. However, some might find it hard to connect with others in the group whose identities or backgrounds seem so different from their own. Groups with a more specific or narrow focus, such as gender-specific recovery meetings, etc. might allow members to acknowledge and address needs or issues that are more unique or specific to certain communities. Such issues may either be ignored, or even criticized or dismissed, in broader, generalized groups. Specialized communities can create a space for acknowledging and valuing those unique experiences. It also might be easier for some people to connect with a specialized community that more reflects their experiences. Our suggestion is twofold. First, we suggest that both types of communities are necessary and beneficial, so it should not be an either/or and that people should explore both. Second, we advocate for a menu of options and a variety of resources for those recovering
from addiction. For us what is important is that people find what helps them to heal. That is not going to be the same for everyone, so it is our commitment and responsibility as a profession to continue to develop and expand the services and resources that we offer.