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# An Intern's Experience of Clinical Supervision in Group Work with Substance Abusers

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**Abstract:**

The author examines the role of clinical supervision, specifically supervision through Cognitive-Analytic Therapy (CAT), for social workers in understanding and managing countertransference and transference in their work with groups and individuals. By relating her own experience as a group work facilitator without CAT supervision and then under CAT supervision, the author concludes that CAT supervision benefits clinicians and facilitators by allowing them to identify their own countertransference and transference as well as that of their clients, helping them to avoid burnout and be more effective in their roles as clinicians.

Clinical supervision is a vital factor in healthy dynamics during group work. Group workers need a forum found in clinical supervision not only to understand the personalities, opinions, and behaviors of group members but also to process their own emotions, opinions, and behaviors stimulated by group members. Countertransference refers to the therapist's feelings, thoughts, and behaviors that occur in response to dynamics in the counseling relationship that stem from either the therapist's unresolved issues or from maladaptive behaviors elicited by the client (Gelso & Hayes, 2007). The concept of countertransference has been updated in the framework of Cognitive-Analytic Therapy. If countertransference and transference are not properly addressed in a clinical supervision forum, they can impede the group's process and goals. In addition, supervision is necessary for the worker's professional and personal health. This article describes the supervisory experience of a social work intern in the identification and management of transference and countertransference in group work with individuals dealing with substance abuse.

## The Significance of Clinical Supervision

The ability to identify, contextualize, and restructure countertransference experiences defines the line between ethical and non-ethical interaction for a professional committed to the implementation of theory and practice. Clinicians who lack effective clinical supervision could begin to dread personal interactions with clients because of anxiety about the clients and generalized feelings of distress,

anxiety, embarrassment, and desperation (Carsky, 2012, p. 76). Clinical supervision provides a framework by which transference and countertransference issues may be redirected into a strength-based, realistic discussion that supports various aims:

1. Personal and professional growth;
2. An honest reflection of self as well as self through the therapeutic process;
3. Positive therapeutic outcomes;
4. Establishing an operational definition of transference and countertransference;
5. Creating a baseline framework by which to assess and reassess client progress, goals, and action steps toward goals; and
6. A decreased likelihood of compassion fatigue and burnout (Carsky & Yeomans, 2012; Kavanagh, Spence, Wilson, & Crow, 2002).

## Cognitive-Analytic Therapy in Supervision

In order to accomplish the aforementioned tasks, clinical supervision must be implemented within the context of a structured technique rooted in theory. Cognitive-Analytic Therapy (CAT) is a practical method of brief context therapy that provides a good framework for clinical supervision. CAT supervision focuses on "increased self-awareness and understanding of the therapy process" (Marx, 2011, p. 416). Through examining "the many voices that are internalized from caregivers and the wider culture" (Marx, 2011, p. 403) in both the self and the client, the worker can identify, define, and manage transference and countertransference issues during individual and group therapeutic processes. CAT uses relational interaction to identify "cycles of repetitive patterns of thinking, activity, and evaluation that originally served to manage unbearable emotions" (Marx, 2011, p. 409). CAT also encourages supervisees towards reformulation, recognition, and revision of their own issues and cycles within the context of the therapeutic relationship. When applying this therapeutic technique to the clinical supervision process, clear contextual lines are drawn from the facilitator's being to the action or reaction of the client's being, thereby confronting counter/transference issues through clinical intervention.

## My Experience as a Social Work Supervisee

I will use my own experience as an example. Before entering the Springfield College Master's of Social Work (MSW) program, I had a five-year career as a Certified Alcohol and Drug Counselor (CADC). During that time, I lacked clinical supervision for approximately four years. During the first year without clinical supervision, I provided group counseling twice a week to approximately forty males diagnosed with substance dependence disorders within the structure of an inpatient therapeutic community. The work was difficult. Group members neither confronted nor supported each other. Clients would ask frivolous questions repeatedly simply to speak individually with me, because I was one of few women to which they had access. By the end of my second year as a practicing CADC, I became sluggish prior to each group. I suddenly felt tired and easily irritated. I found my clients to be annoying and developed a strong dislike toward many of them. I found them to be selfish, and the constant demand for instant gratification became an emotional strain. Compassion

fatigue had consumed me cognitively, physically, and emotionally. Transference issues were relatively ignored unless they became blatant. Subtle issues, such as clients' reluctance to speak in group due to fears of a lack of confidentiality, or their difficulty accepting direction from a relatively young female, were difficult to identify. My desire to instill hope morphed first into pity for, then quickly disdain for my clients, yet I yearned for them to want more from life and to have increased faith in their abilities. The addiction clinicians, nurses, case managers, and managers within my agency exhibited the same symptoms because they also lacked clinical supervision.

During the fourth year of my employment and second year of graduate school, I engaged in a first-year internship via the Springfield College MSW program. My field instructor was trained in CAT. I found that my supervision not only helped me in my internship, but also gave me a new perspective on my concurrent work as a group substance abuse counselor. In the context of clinical supervision using CAT, I was able to expose subconscious dialogue as well as associated emotions. Through this relationship, I identified my negative thoughts and emotions as well as their causes, and I was able to identify specific catalysts for toxic emotions and ways of thinking. For example, I had been harboring feelings of disrespect and resentment due to the gawking I experienced as a female in a male correctional facility. In the context of structured clinical supervision, I was able to identify countertransference issues specifically toward Black males: I was frustrated by what I perceived to be their willingness and weakness to fall into the trap of oppression and cultural genocide through actions that led to their incarceration. I became able, during group sessions of up to 25 clients, to separate my countertransference issues from each client's transference issues. Engaged in a theoretical and practical framework informed by assessment, I was able to separate the transference experiences of one group member from the other instead of grouping such experiences to fit my personal context.

This form of clinical supervision provided a platform to ask questions about observed behavior in the context of applied theories and thereby to inform assessment, reassessment, and effective treatment planning for my clients through an enhanced understanding of myself. I was systematically diverted from fatigue and overgeneralization toward the identification of my own emotive and cognitive processes during group sessions and later individual sessions. I learned to express my reaction to specific situations that arose from client discussion, to draw direct lines to my perception of life as well as to how my development formulated such a perception. I was then able to identify specific behaviors, vocalizations, and patterns of narrative that were impeding the therapeutic process as well as those patterns that seemed to positively enhance the therapeutic process. Through CAT supervision, a strength-based process that developed operational definitions of transference, countertransference, clinical supervision, and self-care during therapeutic interventions, I was actually learning the following lessons:

1. how to practice my craft;
2. how to utilize concepts learned in academia and apply them to practice; and
3. how to use my being in the context of a helping professional.

I was rejuvenated within three sessions. I became enthused by group work and its dynamics. I was able to refocus on the intervention I was providing rather than on my concept of how others should live and how quickly they should change. I realized that I could have become less helpful to my clients and myself by being unavailable to my clients' needs while attending to my own desires and expectations. Clinical supervision utilizing the CAT structure assisted my ability to become re-enthused through a deeper understanding of myself and my true passion for process in therapy and in life.

## Conclusion

In my experience, clinical supervision has often been neglected for professionals who intervene in the lives of others. According to Hofsess (2010), "The concept of countertransference is generally considered to be important in counseling because therapists who lack knowledge of the concept may unwittingly sabotage an otherwise successful treatment" (p. 52). I have witnessed and experienced the phenomenon loosely termed burnout; I have lived compassion fatigue. The foundation provided in my internship's clinical supervision allowed me to resume my professional and social commitment. Clinical supervision rejuvenated me and awakened parts of me that I had forgotten or of which I had not previously been aware. Clinical supervision is not an option for helping professionals; it is a necessary form of self-care for persons providing any form of clinical intervention. Clinical supervision, therefore, should be mandatory for all professionals providing intervention in the lives of others, in order to decrease the likelihood of self-harm and subsequent harm to persons seeking professional support.

## References


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