Chapter

Supervision of Substance Abuse Therapeutics Emphasizing the Discrimination Model of Supervision and Motivational Interview Practices

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Abstract

There is considerable pressure from varied sources to provide effective supervision to professionals who deliver therapeutic services to persons being treated for substance use disorders. The literature of supervision continues to evolve as the utility of supervision models and their applicability with substance abuse therapeutics are explored. Among the many models of supervision, Bernard's Discrimination Model of supervision is experiencing on-going development in the context of a variety of clinical services. The current chapter will describe how Bernard's model can be used effectively to enhance the supervision of substance abuse professionals as well as how further development of the model would enhance the approach. The Discrimination Model will be combined with existing literature of Motivational Interviewing approaches to describe key elements of effective clinical supervision with professionals delivering services in a complex and challenging industry.

Keywords: Discrimination model, motivational interviewing, supervision of substance use therapeutics

1. Introduction

Clinical supervision is indispensable to the professional development and well-being of therapists in all areas of mental health intervention.[1] Supervision is unavoidably a process that involves at least three participants: a Supervisor, a therapist, and at least one client. In most supervision cases, the supervisory activity attends to the work of the therapist with more than one client and each client then becomes part of this relationship triad (one triad for each client). Therapists must contend with challenges associated with patient difficulties and possess a great range of skills and knowledge to be successful. Besides the extensive array of personal and professional attributes necessary to promote therapeutic effectiveness in general, therapists must understand particular and unique patient concerns in the context in

[1] "Therapist" will be used interchangeably with comparable professional titles such as "counselor" and "service provider." No substantive difference is intended or implied.

which the therapist works. Intervention with patients with substance use disorder (SUD) requires a uniquely broad and complex body of knowledge as well as the ability to thrive under an emotionally charged set of stressors that are intrinsic to the treatment industry [1]. SUDs are serious and commonly long-term disorders that requires systematic and vigorous interdisciplinary intervention, education, and support [2]. As a result, successful work as a therapist with clients with SUDs requires skills associated with all types of psychological intervention as well as issues that are uniquely relevant to intervention with SUD patients [2].

In addition to the challenges of work with persons with SUDs, the treatment setting is further complicated by the fact that the professional background of SUD treatment providers is quite heterogeneous. While it may not be obvious to people outside the industry, SUD treatment professionals function in their roles on the basis of many different specific forms of professional training [2–5]. In fact, SUD treatment programs are unique within the spectrum of mental health services in that professionals within these programs are qualified to provide services even if they do not have a master's degree (e.g. [6]). While many jurisdictions have established certifications for SUD professionals, the variety of therapist backgrounds and characteristics is a reality that heightens the need for effective and persistent mentorship. Tatarsky [7] described the main components of intervention with SUDs. The author asserted that any supervision of SUD intervention must include how the therapist works with the therapeutic alliance, fosters corrective emotional experiences with the client, and how to teach of self-regulation. These challenges are considerable.

There are more than sufficient rational arguments for attending to the nature and quality of the supervision of SUD therapists. First, there is great variability in therapist training, so initial preparation to provide SUD treatment is critical. The range of issues that are essential to even beginning SUD treatment include skill with addiction processes, diagnostic concepts and practices, and methods of intervention. Next, these aforementioned basics that may be considered internal to treatment can be made more complicated by political realities. For example, there have been widely shifting attitudes in both public and professional circles about the status of persons with SUDs ("junkies," "addicts") throughout history [7]. The ethical and effective clinician will be sensitive to the varieties of client backgrounds and will use supervision as a part of on-going efforts to be expand these sensibilities. Such a clinician will refrain from a narrow view of patients and strive to build a therapeutic alliance in the context of the client's cultural context. These forces have real consequences for persons with SUDs that may become a focus in treatment. In addition to the initial considerations training, SUD therapists have considerable on-going training needs as they continue working in the field. For example, legal and ethical issues are persistent challenges that must be resolved. Adding to the demands already noted, the stress of continued work in the field places real demands on therapists, rendering continued emotional support essential. One can readily see how supervision may be essential to the well-being of clinicians and the utility of treatment efforts.

As already established, therapists and supervisors are called upon to function effectively in the context of differing demands for results, significant ethical, legal, and cultural consideration, gaps in training, increasing pressure to use empirically supported practices, differences pertaining to services being provided by persons with and without prior SUDs, and differing models for intervention [4]. As a result, the demand on SUD treatment supervisors is more complex and demanding than what might be found in other contexts. The question then arises about how to think of optimal clinical supervision. The Center for Substance Abuse Treatment [8] attempted to define effectively functioning clinical supervisors as those who are

knowledgeable about SUDs as well as all other areas of therapeutic practice. Much of this definition was grounded in technical skills of supervisors because of the complexities of clinical tasks for therapists. While this need for the highest quality supervision is seemingly irrefutable, there is a relative dearth of recent empirical literature to support this idea. There is some evidence to support the role of supervision in the job performance of therapists [5, 9]. Laschober and colleagues [2] reported the results of an investigation of the quality of counselor preparation as a function of supervision effectiveness. Harkening to the complexities of supervisory tasks, the authors confirmed the demands on practitioners and supervisors discussed above, and described the perceptions of SUD counselors in this regard. It is important to note that Laschober and her colleagues concluded that significant emphasis must be placed on the quality of the supervisory relationship. Their work was a survey design that lacked the elements necessary to infer causality between effective clinical supervision and the job performance of counselors, but it did support the link between supervisory skill and counselor outcomes. This remains an area in which experimental designs are still needed.

As just described, there is real importance to the development of a strong supervisory alliance. This reality has been echoed in many works in the field (e.g. [10, 11]). This connection has been discussed in the literature of both the supervision of mental health and SUD clinicians. The supervisory alliance is a medium for social influence in a critical professional area [12, 13]. The working alliance in supervision is most commonly defined as a supportive relationship that includes three components: agreement on goals, agreement on tasks to pursue the goals, and the bond that develops between the supervisor and therapist. [14–16]. There are some reports of research that suggest that the alliance and the associated mentoring are a distinct predictor of therapist proficiency relative to technical proficiency of the supervisor [2].

2. The discrimination model

There is undisputed importance to the identification, examination, and application of effective and appropriate models for clinical work. This is also true for clinical supervision for SUDs. Optimal supervision requires a keen sense for the wide range of difficulties of the therapist, and models of supervision can hasten and sharpen the processes by which supervisors identify and work with training needs. Suitable models of supervision may function as a guard against toxic fluctuations in the strategies used by supervisors [11].

2.1 Development and concept of the discrimination model

In 1979, Bernard introduced the "Discrimination Model" (DM) of supervisor training, at least partly in response to confusion in the literature about the significance of supervision, a dearth of literature regarding the training of supervisors, and a wish to promote an effective training model that addresses the processes of supervision. The majority of the following description comes directly from Bernard's 1979 seminal paper [17]. The model has been applied in a number of subsequent works that highlight its applicability [18–22]. The discrimination model is named as such because its main function is to provide the supervisor with a variety of approaches that they may apply within a given situation at their discretion without the limitations of theory. In the discrimination model, the supervisor must identify the area of skill or behavior with which the counselor most requires assistance at a particular time (process, conceptualization, or personalization), and

then subsequently assume one of three roles (teacher, counselor, or consultant) by which to provide said assistance. The variety of combinations that result from this process grant the supervisor with nine possible approaches to a given situation, allowing for the maximization of effective communication between the supervisor and the counselor. It is important to explicate these approaches as prelude to the discussion of integration with other supervisory skills.

The ultimate goal of supervisor training is to provide counselors with the necessary skills for successful intervention. Bernard divides these necessary skills into three major categories: process skills, conceptualization skills, and personalization skills. At any given time, a counselor may be exhibiting behaviors that relate to these skill categories, and the discrimination model assists the supervisor in identifying the nature of the trainee behavior for supervisory intervention. "Process" behaviors are those which relate to the conduct of the session, such as effectively opening and closing the session, implementing different intervention techniques, or encouraging communication with nonverbal cues. Process behaviors indicate to the client that the counseling has begun and how it is progressing. Counselor-trainees typically learn these skills early in their training, though they may also be skill areas that evolve throughout their career. A counselor-trainee who struggles in this area may incorrectly implement a specific technique, have difficulty maintaining a robust working alliance, or fail to effectively communicate with the client. When evaluating and assisting counselors with the development of process skills within the discrimination model, the supervisor is to focus on how these skills and techniques are executed, as opposed to whether or not they are the appropriate skills to apply within the given situation. "Conceptualization" behaviors are skills which pertain to comprehension, analysis, recognizing themes or patterns, and deciding which strategies and techniques would be most effectively applied to help the client achieve their goals. Since these behaviors take place primarily as cognitive functions, they are more difficult for a supervisor to observe within the session. Conceptualization should occur both within the session and between sessions. It is possible for a counselor the struggle with, say, recognizing patterns within the client during the session, but easily do so when writing a case report of the same client. Therefore, it is important for a supervisor to differentiate between these two areas of conceptualization and determine where the counselor-trainee is struggling in order to maximize effectiveness of supervision. Lastly, "personalization" skills are the counselor's ability to maintain professionalism, take responsibility and authority within their position as counselor, use their inner experience as professional guidance, accept challenges, feedback, or criticism from the client, avoid projecting personal beliefs and values onto the client, and maintain a basic, fundamental respect for the client. Development of these skills requires a willingness for personal growth within the counselor. Because the advancement of personalization skills requires the counselor to identify personal flaws and biases that inhibit their ability to be objective toward the client, such advancement is simultaneously emotionally difficult and perpetually necessary in all counselors. It is important the supervisor treats the learning of personalization skills as not a sign of personal shortcoming in the counselor, but as being equivalent to learning any process or conceptualization skills. The ability of the counselor to possess adequate skills in each of these three areas of behavior is vital to the success of intervention. The discrimination model aims to train both the counselor and the supervisor to recognize which areas specific behaviors pertain to and better understand where issues arise.

As the supervisor is able to recognize an issue as falling into one of these three areas, the supervisor must determine the best approach with which to present instruction. Bernard identifies three possible approaches or roles the supervisor may take on in order to do so: teacher, counselor, or consultant. When taking on the

"teacher" role, the supervisor's goal is to impart knowledge and information to the counselor-trainee. This might include, but not be limited to, introducing relevant professional literature or directly explaining a concept or technique. Within the "counselor" role, the supervisor works with the personal needs of the counselor, helping them to overcome personal or emotional barriers that inhibit their development as a counselor. While maintaining appropriate professional boundaries, the supervisor evokes the inner subjective experience to facility the trainee having the most fluid and adaptative access to this part of their reaction and approach to a client. Lastly, when taking the role of "consultant," the supervisor acts less authoritatively, engaging in reciprocal dialog and offering suggestions and discussions of professional and case material in order to come to solutions or more advanced understanding in the trainee. It is deeply important that the supervisor chooses their role based on the needs of the counselor within the situation. The model does not work if the supervisor chooses a role because it is most comfortable or natural to their disposition.

2.2 Application of the discrimination model

Bernard [23] saw supervision as an activity that emerged more from the training of therapists than the nature of therapy relationships despite the fact that many models of supervision closely followed models of psychotherapy. Given the above-noted significance of mentorship in supervision the skilled and purposeful application of the seemingly simple discrimination model may be critical. It is important, then, to consider how the DM is used.

The discrimination model offers an array of approaches that a supervisor can employ by first identifying the skill type within which an issue occurs, and then assuming the role which they feel is best fit for the situation. For example, a counselor-trainee may approach the supervisor expressing that they wish to use a technique that they have not learned with a client. This would be an instance of building process skills, and the supervisor may take on the role of "teacher", providing the counselor-trainee with resources and information on how to use the desired technique. In another instance, the supervisor may notice that the counselor-trainee is more hesitant to work with clients of the opposite gender, an issue which relates to the counselor-trainee's personalization skills. Here, the supervisor might choose to take on the role of counselor and attempt to help the counselor-trainee understand what aspects of their own world view may be contributing to this bias. Although it may be tempting to associate specific supervisor roles with specific skill areas, such as, for example, assuming the development of process skills always necessitates the teacher role, it is important to remember that any combination may occur. The discrimination model is most effective when the supervisor's approach is selected based solely on the circumstances of the given situation.

Use of the supervisor role from the DM is based on the real needs of the supervisee and this may not be directly evidenced by the manifest nature of the dilemma as just described. For example, when confronting ethical, legal, and professional issues in SUD treatment, the trainee may have a lack of information for which they need instruction, a need for help considering alternatives about which they are already familiar, or more personal assistance working through more subjective blocks to effective and appropriate application of relevant standards. Thus, the supervisor must develop an appreciate the dynamics of a supervisees dilemma before adopting the teacher, consultant, or counselor role with a specific dilemma.

The complex skill needs of the therapist in SUD treatment may make the simple structure of the DM a useful framework for the consideration of the areas of supervision that merit the greatest focus. Given the extent and nature of the complexities

of the SUD diagnosis and treatment planning, conceptual problems are readily encountered. Between diagnostic categories, complexities of treatment planning, and implementation of a treatment program, the therapist has a significant array of ideas to consider and integrate. In addition, the SUD treatment environment can be highly evocative for the professional therapy environment, and it is natural for an inexperienced therapist could need support and counsel with the emotional components of the work. Finally, SUD treatment can be very difficult to implement, and the process tasks of a therapist can be very important to address to maximize the likelihood of proper treatment implementation.

Specific settings can further highlight the utility of the DM. Byrne and Sias [24] reported on the application of the DM model to supervision of direct care professionals in adolescent residential treatment programs. In particular, they focused on therapist intentionality, flexibility, and professionalism as target themes for supervision activities. The authors highlighted how the conceptualization role could be tailored to the exact needs of the trainees. With widely varying amounts of experience and training, the therapist would have differing needs for how to understand clinical situations. In addition, careful focus on conceptualization allows the supervisor to be responsive to the different needs while allowing for team collaboration in shared understanding of clinical dilemmas. This focus enhanced the effectiveness of the therapists. Their effectiveness was further enhanced by a suitable attention to personalization. By encouraging the therapist to employ their own personal style to interventions and being careful of their own reactions in an evocative environment, focus could remain on planned interventions without the interference of unmodulated therapist emotions.

The DM can also magnify the impact of specialized or advanced supervisory functions. The prospect of the "parallel process" in supervision is also a challenge to supervision that is such an example for the DM. The idea of a parallel process began in psychodynamic writings as a replication of the therapy relationship and supervision outside of the awareness of the participants [25]. The concept was not initially named in the seminal literature, but the parallel process concept received increasing attention and has evolved into a well-articulated principle. The parallel process notion was clarified extensively in the literature, beginning with Doehrman's [26] work. Doehrman's work was a landmark contribution in identifying issues of power, control, dependency, intimacy, and judgment as manifest in the parallel process of supervision [27]. The concept of the parallel process began to receive successful empirical examination in subsequent decades [28]. The parallel process is now clarified as a set of sometimes parallel phenomena between the supervision relationship and the treatment relationship. Many authors now recognize the phenomenon with or without the psychodynamic trappings and independent of theoretical orientations.

2.3 Limitations of the discrimination model

With any clinical approach there are limitations that may be anticipated. For now, we will consider limitations of the DM that are associated with the application of the model. Some approaches to, activities of, and contexts for supervision are inconsistent with parts of the nine "cells" in the model. The cells of the model have to be applied in a manner that is optimally targeted to the specific milieu. Therapists in such a context must learn about the significance of supervision, the responsibilities and functions of supervisors, and the responsibilities of therapists in the supervisory conditions. For example, quick application of supervision that occurs in front of clients can be corrosive to the delicate work that needs to happen within the supervision. This could easily complicate the delivery of group services in the

SUD treatment context. In addition, the model does not prescribe exact approaches for exact situations and has not been empirically investigated for doing so. As a result, the model is useful for considering possible approaches and enjoys some rich descriptions of its application, but the DM is not yet supported by well-designed empirical work.

The model does not appear to provide a locus for what may be considered "external" or "political" considerations or when disciplinary action is in the offing. There are a number of possible components that fit in this area of concern. First, if supervision needs to turn to issues of therapist accountability, it is not clear what supervisory function is invoked. That is, when there are deficiencies in practical dimensions of a therapist's work and development efforts seem to have been exhausted, the preferred cells in the DM are not clear. Perhaps obviously, the counselor would not be the preferred role. It is possible that the consultant role could be invoked, particularly in situations in which the therapist was bringing some of the issues to the table on their own. In the end, however, if discussions of objective components of performance or considerations of job action were imperative, the DM may be irrelevant or at least not instructive.

A political consideration might be the career development of the therapist. It is quite appropriate for such discussions to be some part of supervision and mentorship, but the DM might not be helpful. One might argue that the consultant role would be useful in general professional mentorship, but this has not been suggested or discussed in the literature [29].

A final limitation of note was raised by the work of Crunk and Barden [18] who began a discussion of the relative lack of research into the integration of the discrimination model with other supervisory factors. In particular, their work integrated the "common factors" of supervision that by themselves have already received such robust support [30]. Their preliminary efforts are a part of future developments that are spawned by the discrimination model but are yet to be realized.

3. Motivational interviewing

3.1 Development and concepts

This chapter is based on the notion that Motivational Interviewing (MI: [31]) is a highly useful approach to treatment *and* supervision and with SUD patients and therapists in particular. MI was originally designed to assist with persons suffering from mental health conditions whose difficulties seemed particularly challenging because of internal conflict about treatment and behavior change. The applicability of MI to SUD treatment was readily made when MI was introduced, and its widespread utility has been reflected in the literature since then [32]. After introducing and describing MI, the discussion will turn to an integration of MI concepts and methods with the DM to maximize supervisory effectiveness.

MI is a technique which focuses on working with the client to uncover motivation for change that is already posited as being present within the client. The goal of MI is to use the client's own desires and feelings in order to overcome resistance to change which would otherwise inhibit the therapeutic process [33]. MI develops many of its key goals and practices based upon Rogers' [34] necessary and sufficient conditions for constructive personality change. Rogers proposes six conditions which must be met in order for personality change to occur within the therapeutic setting.

The first and most basic of these conditions is that two people must be in psychological contact. In other words, there must be some sort of relationship between the counselor and the client of which both parties are aware. Conditions 2–6 relate to the nature of this relationship. The second condition is that the client must be in some state of incongruity. Within this state of incongruity, the client is experiencing a disconnect between their perceived self and their actual behaviors and experience. This idea relates closely with Festinger's theory of cognitive dissonance, a principle which is also frequently employed within MI [35]. Rogers' third condition for change is that the counselor is consistent and genuine within their relationship with the client. The counselor must be aware and accepting of their own feelings within the relationship, and must not attempt to act in any way that is disingenuous or performative. The fourth condition requires the counselor to experience unconditional positive regard toward the client. The counselor must aim to be accepting of all of the client's experiences or statements, without the presence of judgment or persuasion. The fifth condition proposes that the counselor must hold an empathetic understanding of the client's internal perception of their own experiences, and effectively communicate this understanding to the client. It is important not only that the counselor is able to understand the client's experiences as if they themselves were experiencing them from the client's perspective, but that the client feels understood as a result of this. Lastly, Rogers' sixth condition for change is that the client is aware of the unconditional positive regard, acceptance, and empathy which the counselor feels toward them.

Miller and Rollnick [31] described four general concepts that were important for the implementation of MI. These were 1) express empathy, 2) develop discrepancy, and 3) roll with resistance, and 4) support self-efficacy. It is important to clarify these foundational elements and recall that these factors are central to the conditions in the relationship and may underlie and/or precede a variety of other interventions. First, motivational interviewing includes the expression of reflective listening to communicate understanding of what a client is saying. The second component is the cultivation of the client experience of any inconsistency between the client's most cherished values and their recent behavior. The third element of MI is the practice of understanding and tolerating a client's resistance to change in contrast with a more confrontational stance with forces that seem to interfere with change. Finally, MI encourages clients to believe that wished-for change can happen.

3.2 Application of motivational interviewing for supervision

Clarke and Giordano [33] articulated a compelling case for the applicability of MI in supervision. This relevance is rooted in the fundamentally essential nature of the relationship in therapy *and* supervision. Bordin [14] described the working alliance in supervision in part by applying therapeutic principles to supervision. He stated that a working alliance in supervision included shared goals, mutual understanding of the work to be done, and a constructive timbre of the working bond as foundational themes. Clarke and Giordano extended Bordin's supervisory alliance notion to include a greater range of supervision complexities. A significant part of this development was to highlight the difficulties associated with conditions in which Bordin's three conditions of the alliance were awry any way. In particular, difficulties with any of the three areas of the working alliance in supervision can promote anxiety and resistance in the therapist to learning and change. The presence of such conflict, then, highlights the need for supervisory methods that address the resistance. As discussed when MI was defined above, the principles and practices of MI are well-suited to such situations. As a result, there is a call to clarify the usefulness of MI in supervision.

Because of the paucity of relevant literature, it is instructive to review Clarke and Giordano's description of supervisory components that foster anxiety and resistance in the therapist and how the key features of MI can enhance a response. As they noted, while MI has expanded rapidly in the development of therapeutic approaches, most of the work related to MI and supervision has been to clarify how to conduct supervision of therapists' MI work rather than using MI in supervision itself. This is a key distinction, and a notable exception to the relative neglect of MI as a supervisory method was Madson et al.' [4] consideration of a MI model of supervision in the context of SUD treatment.

In most supervisory contexts, it is likely that a supervisor may serve at different times as a teacher, consultant, and supporter. We will soon turn to a consideration of these roles from the DM perspective, but it is instructive to talk about the supervisory roles from an MI perspective first. As has been discussed, supervision is an intervention that is based on a relationship in which a more advanced professional provides the necessary activities to a less experienced professional for the sake of maximizing client welfare, increasing therapist competence and promoting their ongoing development [23]. In discussing the contribution of MI to the supervision of SUD treatment, Madson and his colleagues [4] stated that"a supervisor may adopt roles as educator, consultant, supporter, and evaluator" (p. 350). Here is clear groundwork for the upcoming discussion of using MI and DM jointly.

3.3 Limitation of motivational interviewing

MI is widely characterized by well specified theory and technique [36]. MI has also been afforded a wide range of training resources and increasing empirical support for the efficacy of those efforts. At the same time, there is some increasing concern about the ability to evaluate MI and transfer it among settings because of inconsistencies in practice and the ongoing changes to the underlying theory that have been articulated [37]. Scholarship of MI needs to become more transparent so that developments are better examined, replicated, and advanced [38]. Such enhanced scholarship will also solidify the impact of clinical trials and the resulting guidance for practitioners.

There is still a lack of knowledge about the exact connection between the activities of MI and the outcomes that are associated with it [39]. There are a number of hypothesized mechanisms for this connection, but the specific action is not known. The relationship is considered to be an important part of how MI in addition to the technical advantage of altering the inner dialog of clients [40]. It is also possible that the investment of a client in behavioral changes could be enhanced by reducing the client talk that reinforces the persistence of old patterns [41].

4. The discrimination model and motivational interviewing in supervision

It is argued here that these two models for different kinds of intervention contexts may be considered in an integrated fashion to enhance the supervision of the treatment of substance use disorders. As previously discussed, Bernard's Discrimination Model (DM: [17]) was developed as an atheoretical guide for supervisors in the decision to adopt different roles or approaches to issues manifest in supervision. In the context of teaching, consulting, or counseling roles, flexible and intentional approaches are available in any given situation [41]. In the DM, three possible supervisor roles are employed in conjunction with three possible areas of trainee concern. So, the supervisor may work from flexible roles to address

the conduct of intervention, understanding of clinical dynamics, and optimizing the presence of the person of the therapist.

This chapter contends that the DM can be productively integrated with the principles and practices of Motivational Interviewing (MI) to even further strengthen the supervision of the treatment of SUDs. MI was developed with an emphasis on four basic principles for intervention in treatment and supervision [31]. Briefly, MI includes the expression of understanding, the cultivation of the awareness of tension between actions and values, gentleness with expressions of resistance to change, and support for the experience of what is possible. The four basic principles and practices in MI are designed to work with a therapist (in supervision) or a client (in treatment for SUDs) include attitudes about emotional, cognitive, and behavioral aspects of experience. Challenging these attitudes from different positions is essential for the effectiveness of interventions.

4.1 Joint implementation of MI and DM

The best use of DM and MI is grounded in the common factors of psychotherapy. While there is little literature that describes the common factors in supervision [23], the common factors have been suggested as an important dimension of any form of supervision. In fact, it has been suggested that DM be expanded into a "Common Factors DM" [18]. Full treatment of the Common Factors DM is beyond the scope of this chapter, but the application of common factors to DM shows the significance of the common factors when it is combined with a supervisory approach (DM) that is so widely associated with effective supervision. The *integration* of DM and MI actually depends on the common factors. First, Bernard clearly recommended that the supervisor give careful consideration of exact supervisee needs and adopting interventions that match them carefully [17]. This attention requires the supervisory conditions that are fostered through the common factors. Therefore, when examining *any* dilemma faced in supervision, it is important to consider the exact nature of the dilemma, the subjective reaction of the supervisee, the extent to which the supervisee harbors adequate knowledge, and to the extent to which the supervisee can serve as their own expert in a particular matter (tenets of the DM).

One can readily see that in the exploration of these supervisory themes, the common factors quickly rise to the surface. The exploration of supervisory dilemmas must be conducted with empathy for the conditions of treatment relationship as well as the individual experience of the supervisee. Adding MI to the work *also* begins with the reflection of empathy by the supervisor encourages the expression of the therapist and facilitates the assessment and associated of supervisory work. The accuracy of the supervisory assessment and the effectiveness of the MI interventions are also promoted by a supervisory stance that refrains from evaluating or judging the therapist as they work to express and resolve their dilemma. Finally, it is critical that the supervisor conduct the assessment and supervisory interventions in a manner that is genuine. As MI is applied to supervision in this way, one can see some ways that MI works naturally with the DM.

The integration of MI and DM may be illustrated at the abstract level by examining the 9-cell Discrimination model grid presented by Bernard in her seminal work [17] accompanied by MI concepts. **Figure 1** shows the DM grid first advanced by Bernard with three columns for the supervisor roles (teacher, counselor, consultant) and three rows for the therapy functions that may be a supervisory focus (process, conceptualization, personalization). Each cell is populated by an index number for the list sample activities that represent one of the MI basic activities as implemented in that particular cell.

	Supervisor Role			
Therapeutic function		Teacher	Counselor	Consultant
	Process	1	2	3
	Conceptualization	4	5	6
	Personalization	7	8	9

Figure 1.
Integrative examples of motivational interviewing functions in the discrimination model context.

What follows are indexed examples of SUD treatment supervision activities for each of the nine cells of the DM (with a sample MI function):

1. The supervisor is concerned about the extent to which the therapist feels capable of enduring the vicissitudes of the SUD treatment relationship. The supervisor provides instruction to the therapist about the typical elements of the treatment process. (fostering therapist self-efficacy)

2. The therapist has been enduring a particularly challenging treatment relationship, so the supervisor provides time for the therapist to express some conflicted and negative therapist feelings that have accumulated and not been expressed through the SUD treatment. (rolling with the resistance)

3. The therapist has been very confused about some of the ways that their client has been behaving, particularly in relation to some of the more difficult aspects of therapy. The supervisor helps the therapist by discussing clinical data combined with knowledge of recovery processes (addressing incongruities).

4. The young therapist is not very sure about how to understand recovery processes, so the supervisor provides instruction in what is known about recovery from conditions such as those face by the client. This includes attention to stages of change and how those are resisted naturally (roll with resistance)

5. The therapist is so angry with the client's public SUD-related behavior that the supervisor feels that the therapist understanding of the client's condition has become cloudy. The supervisor knows that it is important for the therapist to feel calmer and so spends time listening to the therapist's pain for the sake of clarifying her/his thinking (being in contact)

6. The therapist has become slightly disorganized in presenting treatment activities to the client. The supervisor spends some time helping the therapist re-organize SUD treatment goals and objectives because it appears that the therapist has lost some sense of feeling able to plan treatment effectively (support self-efficacy).

7. The therapist has felt very concerned and sad for some developments with her/his SUD patient. The supervisor listens very carefully for the personal impact of this development and treatment (being in contact).

8. The patient in SUD treatment has been vigorously blaming the therapist for their problems with the probation department. This has had little emotional impact on the therapist and the therapist her/his indifference disturbing. The therapist thinks that she/he should be upset by this intense blame. The therapist evokes the experience of the therapist to help sort out feelings that might be interfering with acceptance of a natural reaction (highlighting incongruities)

9. The supervisor shows compassion and flexibility with the therapist need to discuss techniques of various types. The therapist feels that they are going through a time of professional growth and transition and are reviewing a lot of different elements of the SUD treatment that they provide. (being in contact).

The originators of MI were clear about the important principles for intervention [40]. As noted above, the MI components that are central to this discussion are well matched to the common factors and the specific techniques associated with DM. For example, genuineness in the supervisory stance is a fundamental dimension of a working alliance and a major component of the common factors approach; genuineness is also a central tenet of MI. As previously noted, the conditions of the working alliance is associated with supervision outcomes. The optimal timing of feedback is best realized when the supervisor and trainee agree that the supervisory climate reflects the mutual trust and respect that are hallmarks of a strong alliance. Feedback is also made more useful when the trainee has had an opportunity to fully discuss their perspective on the supervisory dilemma; this is a common activity that maintains the supervisory alliance. The quantity of feedback is critical in providing the optimal balance of frustration and support for a supervisee. As has often been suggested, the specificity and concreteness of observations made in the feedback can enhance the receptivity of the trainee to the information and its eventual utility. Finally, it is important to close a difficult discussion with reflections on the trainee's experience of the feedback and its discussion. This final suggestion is critical to the continued largess of the supervisory alliance. It is an opportunity review the feedback process, revise the process for future discussions, and to renew shared goals and values for the continued supervision.

4.2 Examples of supervision of SUD treatment using MI & DM

Madsen and his colleagues claimed that MI is useful in a number of situations that are unique to the supervision of SUD treatment [4]. This chapter argues that the DM *adds* to the MI approach and will now expand some of Madsen's examples to illustrate the synergy that is possible with the combined application of these two approaches. It is beyond the scope of this chapter to fully explicate all possible details of the integration of these two useful models, but the discussion of some key issues in the supervision of the treatment of SUDs can be very useful and lead to further experimentation by experienced supervisors. Some basic examples of the integration are presented in the prior section and we now turn to more extensive examples.

Madsen and colleagues [4] claimed that supervision of SUD treatment from an MI perspective is most likely to include critical functions in three particular situations that are likely to be a part of the treatment of SUDs. While the exact function of the supervision may be discussed from a variety of perspectives, these situations *are* critical in the treatment of SUDs in general. Madsen's common SUD treatment scenarios include 1) when it appears that a client has lied to a therapist, 2) when a therapist is unsure of how to properly maintain privacy with the

treatment, and 3) the optimal procedures for working with recidivism. When a client has lied to a therapist in a manner that is challenging to a therapist, this can be evocative to the therapist, disrupt treatment success, and present specific dimensions which may call for different types of clinical approaches. The assessment of supervisee needs when she/he has been lied to begins in a careful understanding from the supervisor of the supervisee's description of their dilemma. In such a discussion, the supervisor will use MI concepts to develop and express understanding of conflicts in the supervisee and their experience of the dilemma. It is likely that the supervisee with have a variety of conflicting thoughts and feelings. Given the nature of this supervisory condition, the DM provides a window on the nature of the clinical dilemmas and supervisee turmoil without making assumptions about the therapeutic situation. With these complex understanding, the supervisor develops an opinion about the extent to which the supervisee needs help with the conduct of the session, how to understand the session, or how to work with their own reaction. During this process, the supervisor will cultivate an awareness of any conflict that exists within the supervisee that contributes to the expressed dilemma. This awareness contributes to the understanding of the locus of the dilemma (process, personalization, conceptualization) and the nature of any resistance experienced in the supervisee. Adopting the suitable role (DM: teacher, consultant, counselor), the supervisor can then begin to consider supervisory interventions in a strategic manner. One possible version of this scenario is that the therapist has been emotionally hurt by the betrayal by the client that is embedded in the patient's deception. However, the therapist feels restricted in their ability to fully experience and work with the nature of this reaction as well as feeling constricted in their ability to use their feelings to shape interventions. This supervisor could readily begin in the counselor role from an MI approach to assist the therapist with the richness and spontaneity of their reaction until its toxic quality has dissipated. The supervision then can shift to a consultant role regarding the therapy process and assist the therapist to consider possible interventions while instilling optimism regarding their potential success as a therapist at this juncture. As this unfolds, the supervisee is naturally encouraged to experience the optimism that characterizes the last step of MI. While this description of the process associated with deception from a client with an SUD has been necessarily brief, one can readily see how DM and MI readily work together and with the common factors to bring greater focus an optimal strategy to the supervisory encounter.

In the second common scenario, the therapist is presented with privacy in SUD treatment that be challenging to therapists at all levels. A hypothetical situation helps illustrate the use of DM an MI together in dealing with a thorny privacy matter. A loved one of a person in SUD treatment has called the therapist to advise the therapist that the patient has succeeded in eluding detection of their continued use of psychoactive substances. The loved one wants to know what the patient has really told the therapist about their current level of adaptation. The loved one suspects that the client has less than candid or potentially misleading to the therapist. On one hand, the therapist believes that the family of the patient could be very instrumental in assisting with the progress of the patient. This could be particularly true if the family knew about the nature of the patient's real struggles in treatment and could respond accordingly. Since there are legal and ethical prohibitions against the therapist disclosing such information outside the treatment relationship, the therapist is frustrated that what is perceived to be a tool for treatment is not available. This may be compounded by the reluctance of the patient to be forthcoming with loved ones because of a host of factors associated with SUD and recovery. The frustration of the therapist can interfere with the spontaneous generation and implementation of effective and appropriate viable treatment approaches

because of this conflict, so the dilemma clearly merits supervisory attention. The development of the supervisory themes should progress much as described in the prior scenario. The empathic stance of the supervisor assists in the process of open communication by the therapist and allows supervisor understanding of the dilemma. This can bring to light the impediments to clear clinical thinking as well as a greater understanding of the ways in which the therapist is tempted to behave in ways that are inconsistent with prevailing professional standards. This segment of the work which is promoted by the principles of MI allows for clarification of the focus of therapeutic the supervisory attention (concerning therapy process, therapist reaction, or therapist conceptualization of the treatment dilemma). Further exploration assists the supervisor in considering the most likely supervisory role to promote the desired educational effect (teacher, consultant, counselor). It is likely in this scenario that there are a variety of alternatives in the treatment that could respond to in some fashion to the prompting of the loved one without violating professional standards regarding privacy. However, such alternatives require careful consideration of the complex factors that converge on this dilemma and the proper DM role and focus can be brought to bear through MI methods as the painful and complicated dilemmas as sorted. As a result, the supervisor might be well advised to adopt more than one of the DM rolls in order to thoroughly provide the supervisory influence needed.

A final scenario to be considered is the somewhat common but regrettable circumstance of the SUD patient relapsing to substance use during the course of treatment. Despite the fact that such an occurrence is not particularly uncommon, its occurrence can be particularly difficult for early career therapists and an occasion for which heightened supervision can be critical for therapists at any level. The relapse of a patient can suggest failure to a therapist and be discouraging in the context of the therapist's considerable investment in learning to be a therapist and believing deeply in the importance of the work. This sensation can also be enhanced by their sentiments and perceptions associated with the work with a particular patient. Therapist responses to patient relapse can also be exacerbated by the therapist's reaction to treatment approaches espoused by the facility in which they work and the therapist's knowledge of treatment approaches in general. Given the possible emotionality and professional complexity of responding to a relapse, the initial assessment conducted by the supervisor as described in the prior two scenarios may garner even more importance and sensitivity. Despite these challenges, the principles that have already been described remain relevant in this particular treatment possibility. The supervisor is advised to listen carefully to how the dilemma uniquely impacts the therapist and the nature of the clinical restriction that follows. The integration of DM and MI can be particularly noticeable in this scenario because the patient relapse is not the end of the possibilities for the patient or for the treatment. The therapist's perception of the situation may be aggravated by policies and procedures of a treating facility and relevant legal situations for the patient, but it is unlikely that the long-term considerations are determined by a single relapse. As a result of the complexity of this dilemma, the supervisor must take care at the assessment phase to interact with the therapist in a way that helps the therapist come to an understanding of the supervisory goals and methods around this specific therapeutic occurrence.

5. Discussion

This chapter has described the Discrimination Model of Supervision, the Motivational Interviewing approach to intervention, and how the two may be

considered together in the context of the common factors of supervision as a way to promote the most sensitive and powerful supervision of the therapy of SUDs. MI was originally designed as a foundation for clinical work in which the service recipient was in conflict about change. After widespread and dissemination and some empirical support, MI was extended into the realm of supervision. The DM has been discussed and applied widely and appears to enjoy considerable clinical utility. Unfortunately, there is a paucity of empirical support for the structure of efficacy of the model. With the well-supported context of the common factors, this chapter has argued that MI and DM are significant contributions to the supervision of treatment of SUDs. Abstract considerations of combining the perspectives were followed by practical examples that demonstrated how these ideas could be integrated in practice.

Since this is one of the first attempts to integrate these two strong traditions, there is no empirical support for any of the intuitively plausible suggestions made in this work. As already noted, this further extends areas of clinical practice, such as the DM, for which there is a dearth of empirical support. Empirical support for these ideas will require difficult research designs with carefully delineated controls and predictions. In addition, employment of these methods will continue to evolve in parallel with any research efforts. Clearly this is an area of supervision practice in early stages. However, given the pressure on SUD treatment resources, supervision of such work should be supported through the continued promotion of clinical practice, cultivation of enhanced supervisory methods, and extensive research. The research must pursue support for the efficacy of supervision that uses DM and MI in combination in general as well as in specific conditions of SUD treatment.

Conflict of interest

The authors have no conflict of interest, financial or otherwise.

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