Recognising and Managing Treatment Interfering Behaviours (TIB):

A Guide for Clinicians

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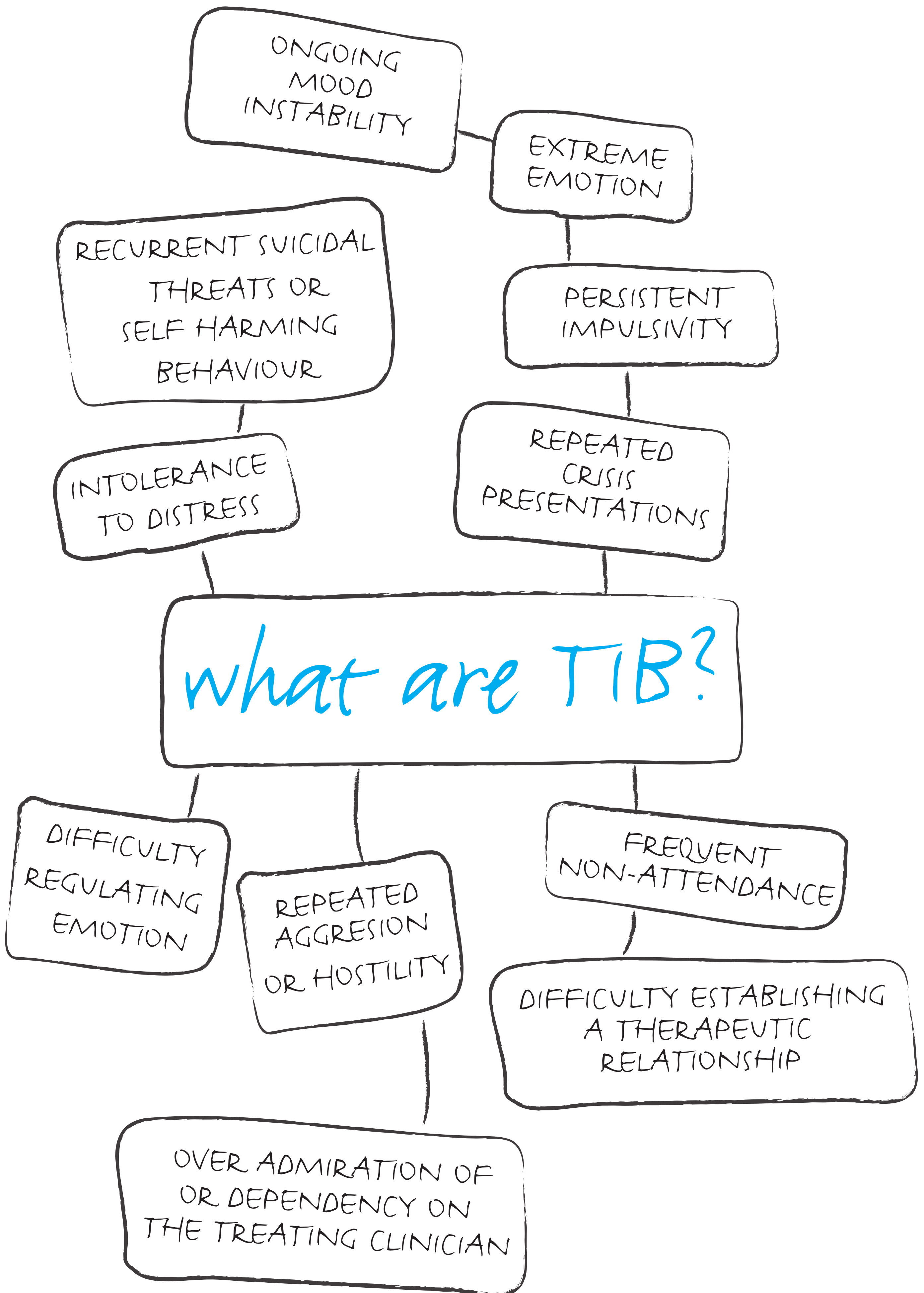
I pray to be like the ocean, with soft currents, maybe waves at times. More and more, I want the consistency rather than the highs and the lows. Drew Barrymore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"I do see counsellors but, sometimes it's a really bad idea to see a counsellor when you're not in the mood, 'cause they can get annoyed and give up on you. When I am feeling OK I don't want to have to talk about my using or why I use 'cause I just want to enjoy feeling OK...So yeah I do miss appointments but they also cancel on me at the last minute so I don't get what the big deal is. I mean sometimes they make you wait for ages but if I'm late I get my appointment cancelled. It's hypocritical". ***Mark, 34***

What Is Making Waves?

Making Waves is a program run at Turning Point Alcohol Drug Centre, Eastern Health, in partnership with Spectrum Personality Disorder Service of Victoria, which provides treatment to clients with substance use issues and Borderline Personality Disorder (BPD).

The Making Waves team have collaborated with Turning Point researchers to develop clinician resources that assist clinicians to recognise and manage behaviours that interfere with treatment retention for clients with Alcohol and Other Drug (AOD) issues, in order to ultimately promote recovery from AOD issues.

The Making Waves resources focus on psychosocial interventions and encompass:

1. Treatment content (i.e. the theoretical underpinnings of treatment; the strategies and behaviours targeted in treatment).
2. Treatment process (i.e. the interaction between client and clinician: the strength of engagement; the ability to work collaboratively on shared goals - 'the therapeutic alliance'; and the interpersonal relationship between client and clinician).

Effective psychosocial interventions require integration and successful application of both treatment content and process. Making Waves helps clinicians build on existing skills to manage the challenges inherent in TIB. It is those challenges that interfere with a positive therapeutic relationship, characterised by empathy, containment, compassion, collaboration, respect and optimism. In order to achieve this, mechanisms for open reflective practice are essential, together with an 'explanatory framework' to understand client's behaviours or interpersonal interactions that we find challenging. By promoting reflective practice, Making Waves hopes to encourage clinicians to sharpen their understanding of therapeutic processes, in order to respond adequately to interactions with clients that jeopardise treatment retention and ultimately recovery.

What Are Treatment Interfering Behaviours (TIB)?

In Dialectical Behaviour Therapy (DBT) for Borderline Personality Disorder (BPD), Linehan (1993) actively targets and reduces both therapist and patient behaviours that interfere with treatment efficacy. In Making Waves, TIB refers to any client or clinician behaviours, which may interfere with a client's potential to benefit from AOD treatment. TIB are repeated, ongoing or chronic in nature.

Some of the most common clinician TIB include stigma against working with clients who engage in particular behaviours (e.g. self-harm) or have a particular diagnosis (e.g. BPD); judgemental, non-empathic responses to clients due to *negative countertransference;* and the failure to embody hope that recovery is possible. In addition, some clinicians hold *positive countertransference* eg "I'll be the one that makes the difference...I'm the only one who really cares." Some of the most common TIB observed in clients include repeated presentations of verbal aggression, non-attendance, suicidal threats or self-harm.

Clinician and client TIB are often observed when working with personality disorders, such as BPD or Antisocial Personality Disorder (APSD), but can also occur in treatment for individuals in ongoing crisis or states of intoxication and withdrawal.

By their very nature, TIB make it very difficult to establish a therapeutic relationship, provide effective treatment, or advocate for a client. Research has shown that over 50% of clients presenting for AOD treatment are likely to display TIB.[1] Studies have demonstrated the stigma of working with people with BPD is greater than other psychiatric diagnoses.[2] Client TIB place enormous pressure on treating clinicians, teams, reception staff and other clients of a service and can contribute to clinician burnout. From the clients' perspective, clinician TIB can create a cycle of rejection from services and negatively impact their belief about whether treatment can help them and whether recovery is possible. At worst, clinician TIB may prevent an individual from being offered a service at all.

What Are Some Examples of Client TIB?

Frequent non-attendance; repeated crisis presentations; repeated aggression or hostility; recurrent suicidal threats or self-harming behaviour; ongoing mood instability; extreme emotion, intolerance to distress or difficulty regulating emotion; over admiration of or dependency on the treating clinician; persistent impulsivity; dramatic and histrionic behaviours; strategising for personal gain; deliberately or inadvertently disrupting the therapeutic relationship; difficulty establishing a collaborative therapeutic relationship.[3]

Why Should I Manage TIB?

Although there is limited research in the area, studies show that individuals with personality disorders are vulnerable and are at greater risk of harm than others seeking AOD treatment. They have higher levels of psychosocial impairment, more severe psychopathology, higher levels of AOD use, higher rates of relapse, greater risk of harm through needle sharing, overdose and sexual risk taking, and increased risk of self-harm and suicide. Not surprisingly, these individuals also have increased use of crisis and emergency services, more frequent use of multiple services at the one time, poorer treatment compliance and poorer treatment outcomes in general.

In spite of this bleak picture, the good news is that early studies have shown that although these clients remain at greater risk of harm, they do benefit from AOD treatment, as long as they remain in treatment. *What does this mean?* If we can minimise the impact of TIB, and retain clients in AOD treatment, they have a chance to recover from their AOD issues.

What's in This Making Waves Guide?

Making Waves for Clinicians is designed to help recognise and manage TIB by:

1. Giving clinicians and `an explanatory framework` to understand some of the common reasons people develop TIB;
2. Helping clinicians recognise and screen for TIB; and
3. Providing clinical tools to encourage reflective practice and minimise the impact of TIB on AOD treatment.
4. Giving AOD service managers and team leaders the opportunity to review and or implement protocols and clinical pathways to decrease the impact of TIB

Making Waves for Managers can be used by AOD service managers and team leaders to review or implement protocols and clinical pathways that assist their service to manage TIB.

All Making Waves resources are informed by the best available evidence based practice and have been reviewed by experts in the treatment of personality disorder and trialed by AOD clinicians in the field. This guide is not intended to replace clinical supervision or work in opposition to your organisation's current policies and procedures regarding client management.

This guide avoids using terminology about diagnoses and symptoms. While clients with TIB may meet the criteria for a personality disorder, such as BPD or ASPD, the purpose of this guide is to identify and address TIB, rather than diagnose a disorder.

Making waves for clinicians

How Do I Use Making Waves With My Clients?

Using the tools in Making Waves will not 'cure' an individual of their childhood trauma or attachment disorder, interpersonal difficulties or emotional dysregulation. For the most part, many TIB will continue until the individual reaches a point in their recovery journey where their AOD issues no longer prevent them from engaging in relationships and other meaningful life activities that rebuild their self-identity and relational capacity. Instead, these tools emphasise paying attention to treatment processes that will make your management of TIB, and ability to establish and maintain a therapeutic relationship, more effective.

This guide is intended to help you begin a conversation with your client about the possible origins of their TIB and how these might interfere with their AOD treatment. Identifying and discussing TIB with your client may improve engagement, retention and ultimately improve AOD treatment outcomes. By using this guide, you may:

1. Increase your client's insight into the development, triggers and consequences of their TIB.
2. Decrease shame, guilt or self-criticism about their TIB and provide options to do something different.
3. Set goals to address certain types of TIB or behaviours that cause problems in other areas of their life.
4. Assist them in their recovery journey.
5. Develop an 'explanatory framework' for TIB that you can draw upon while attempting to establish or maintain an effective therapeutic relationship.
6. Be encouraged or reminded to engage in reflective practice to respond adequately to TIB rather than to react to *negative countertransference.*

When Should I Use Making Waves?

Making Waves can be used by AOD clinicians at any time during treatment. It may be useful to review the principles in this guide before seeing a client whose referral information hints at the potential for TIB. Alternatively, if you feel you are constantly managing a client's crisis presentations but getting nowhere in terms of their AOD goals, the principles and tools in Making Waves may be helpful. Finally, if in your client work you feel stuck, frustrated, helpless, angry, burnt out, or are having difficulty establishing or maintaining a therapeutic relationship, then these tools may be useful.

Who Can Use Making Waves?

Making Waves has been written for AOD clinicians working as counsellors, case managers, key workers, and outreach workers. This guide assumes you have not had specialised training working with clients who have personality disorders. Yet, through your training and experience working as an AOD clinician it is likely that engaging clients in a therapeutic relationship is a natural part of your work.

"One day I had a fight with my girlfriend before I went in so I was pretty fired up, and they wouldn't have a bar of me. They told me I had to come back another day. So I did but after waiting for ages, with no one saying anything to me, I'd had enough. I blew up at the receptionist which I know was wrong but she should have told me or done something about it. I mean if it is so important for me to come in, it should be so important for him to keep my appointment. They act like they want to help you but they only do if you play by their rules". ***Andrew, 32***

Countertransference...What can I do?

Countertransference is a complex psychotherapeutic construct, which is best described as the emotional reactions stirred up in a clinician by a particular client. Negative countertransference is common when working with TIB. Working with clients with TIB requires many layers of support in order to prevent negative countertransference from adversely impacting AOD treatment. Some strategies to avoid negative countertransference include:

- regularly engaging in clinical supervision to discuss negative reactions
- sharing the responsibility of client management and encouraging transparency between clinicians
- seeking external secondary consultation when you feel stuck, angry, overwhelmed or helpless
- designing and implementing appropriate service policies and procedures around the management of difficult behaviours
- seeking help from managers when discharging or transferring a client once their treatment is no longer beneficial or safe
- receiving support and advice from your team around treatment planning, identifying blind sports, offering alternatives, validating your efforts, and holding hope for change.

Positive counterference can seem benign, but like negative counterference, if the clinician is unaware of these reactions it can contribute to unhelpful responses. Examples might include avoiding appropriate challenging of a client's TIB; arguing with the clinical team under the belief "you're the only one who understands and can advocate for your client."

A Little Bit of Theory - The AOD Use & TIB Relationship

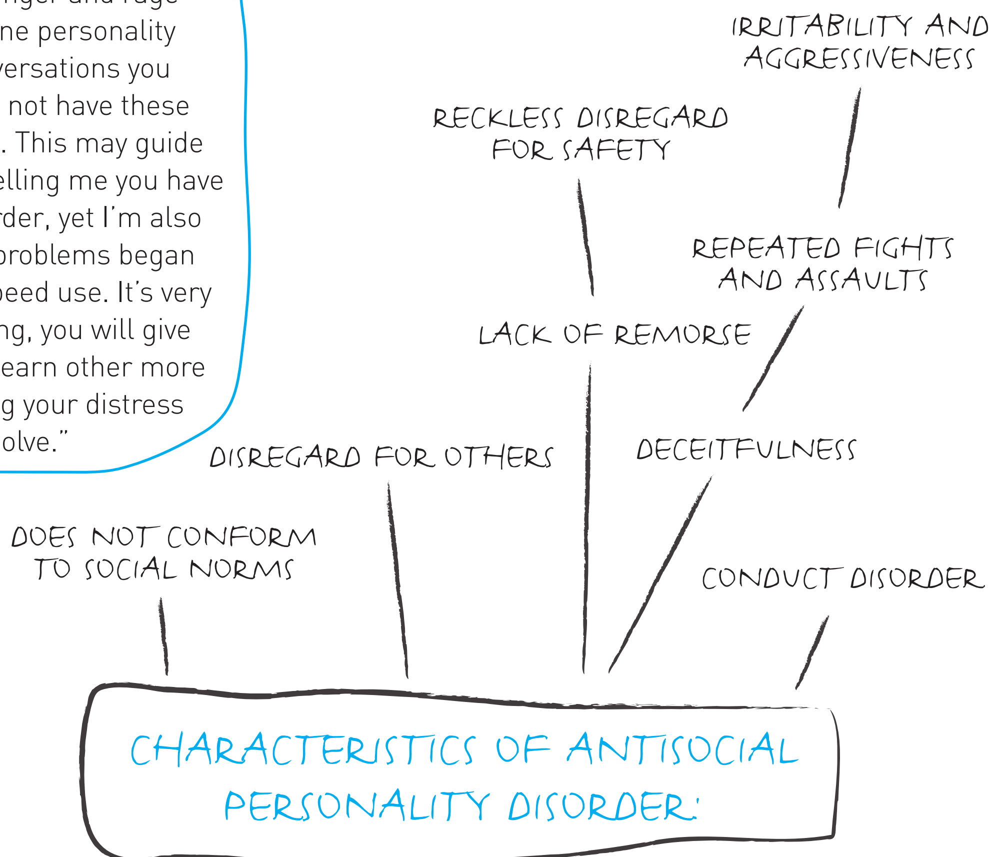
There are many explanations for the co-occurrence of AOD use and personality or behavioural problems that may manifest in TIB. The three main theoretical models are described below. These models are not mutually exclusive nor are they the only explanations for the relationship between TIB and AOD use. It is important that these models are not seen as 'truths' about the origins of behaviour.

1. Primary Substance Use Disorder – This model proposes that drug use causes personality and behavioural issues. It assumes that personality issues will resolve once drug use ceases.

Example: A client who is a heavy speed user might tell you that she is regularly experiencing extreme emotional highs and lows, including feelings of anger and rage and thinks she has borderline personality disorder. Through your conversations you may determine that she did not have these feelings before using speed. This may guide your approach, i.e."You're telling me you have borderline personality disorder, yet I'm also aware that your emotional problems began at the same time as your speed use. It's very possible that if you stop using, you will give yourself the opportunity to learn other more workable ways for managing your distress and your symptoms will resolve."

2. Primary Personality Model – This model focuses on personality characteristics and suggests certain characteristics create vulnerability to AOD use. It identifies three types of temperament that may be evident from an early age: intolerance to distress, impulsivity, and novelty/thrill seeking.

Example: Your client talks about his childhood at school or at home. Perhaps he says he got in trouble a lot. This gives you an opening to have a conversation about temperament and environment, i.e. - "It has been found that some kids are more vulnerable to using AOD, maybe because of genetics or family environment. For example, they were the kids on the playground who would try anything or the kids who were more sensitive. Tell me more about how you were as a kid. Does any of this sound like you"?



3. The Transactional Model – This model suggests that a mixture of biology and the environment explain the origins of certain personality characteristics. It adds 'bi-directionality'. In other words internal factors (genetics, temperament, psychology) and external (family, broader environment) have a reciprocal relationship, ie. they impact and interact with each other in both directions. The term 'poorness of fit' has been used to explain when the child and his/her environment co-create pathology.

Example: Your client says, "Oh you want to blame my mother". You have the opportunity to bring out a new tool, 'bi-directionality' (the reciprocal relationship between an individual and their environment). In other words you could talk about how sometimes a there is a 'poorness of fit' between a child and their family environment. For example a child who cries often or talks a lot, may be punished by one family and celebrated in another. You could then say to client, "this is not about looking for blame, but to have some understanding about what happened for you and how you got here, so you stop blaming yourself and we can start seeing what we can do differently".

A Little Bit More Theory - Some Core Concepts

The following concepts relating to the development of BPD can contribute to your 'explanatory framework' for client TIB , help you understand how TIB develop and make some sense of the struggles faced by clients with TIB. Incorporating these ideas into your work can assist with engagement and formulation and may assist in establishing and maintaining a therapeutic relationship with clients with a personality disorder. BPD is conceptualised as an attachment disorder where disturbances in a child's attachment to primary caregivers interact with other risk factors, such as childhood trauma and/or a vulnerable temperament, to play a central role in the development of BPD. There is a great deal of evidence exploring the impoverished emotional environment in which people with BPD are raised. It is clear that the entrenched, dysfunctional relational patterns evident in individuals with BPD are based on working models of attachment that have been established in childhood.[2]

Two further concepts have been proposed by Linehan to explain the development of BPD: *emotion dysregulation* and *the invalidating environment*. The interaction between these two concepts is central to Linehan's Biosocial Theory of Borderline Personality Disorder.[4]

Emotional Dysregulation is the inability to regulate emotions. Problems regulating emotion are thought to occur when an individual who has *emotional vulnerability* (i.e. a biological tendency to have an overly sensitive or reactive emotional system), does not learn adaptive strategies to modulate emotion throughout their development. Clients may experience emotional dysregulation as intense highs and lows that can feel intolerable and unrelenting. You may observe these clients have an intense emotional response to a situation and then have difficulty calming down, self-soothing or refocussing their attention. Often clients don't understand why this happens to them and it makes them feel "crazy" or "out of control". It is useful to start trying to explain the phenomenon and normalise that emotional dysregulation occurs when predisposed individuals do not learn ways to control emotion during development. It is common in people who have a trauma history and/or a history of an invalidating environment.

Example: It can be useful when trying to explain the concept of emotional dysregulation to a client for them to begin 'naming' or understanding their experience. Sometimes a metaphor can be helpful. For example: "some clients liken this intense emotional experience to a rough sea, what does it feel like for you?"

Invalidating Environment is one which is insensitive to a child's needs, and has a tendency to respond erratically and inappropriately to internal experiences, such as thoughts, feelings and sensations. This tendency is particularly damaging for a child with emotional vulnerability. In the most extreme cases, an invalidating environment is one where the child is abused or neglected. This fundamentally fractures the child's sense of who s/he is. Another form of invalidation is more subtle. It stems from a persistent negative response to a child's needs.

Example: A young child starts to try and describe what he's feeling, i.e. - "I'm cold, I'm hungry, I'm sad". If a parent repeatedly ignores or responds angrily or dismissively this might interfere with the child's capacity to understand his own feelings, sensations, urges. This can also affect the child's sense of who he is. As he grows up he will look to others to validate his experiences and even his sense of self. This is why you may hear a client say "I'm empty". There is a sense of needing others to fill what was never established in childhood.

Emotional vulnerability can manifest in intense anger and rage as readily as hopelessness and shame. Emotional vulnerability in this sense is about being 'hard wired' to be emotionally reactive, rather than emotionally helpless or defenceless. In many senses these individuals have enormous resilience, evolved over a life of frequent exposure to extreme emotion. This can be transformed as a strength, and used to develop responses to uncomfortable emotion that replace TIB and are more consistent with the individual's values and goals.

Recognising and Managing Client TIB

Even without specialist training in personality disorders, as an AOD clinician, you possess the core therapeutic skills required to engage and retain clients with TIB in treatment for their AOD issues, and develop an ongoing optimistic and trusting relationship. The first step is to recognise client TIB through screening and maintaining a list of unique *TIB Warning Signs.* (Your own TIB are best identified through mechanisms for reflective practice explored later in this guide).
Common interventions you are already practising can be expanded to manage TIB. These include: gathering and feeding back information in a non-judgmental way; validating and containing emotions; providing education; monitoring behaviour; harm reduction techniques and validating treatment progress.
Some additional clinical tools, which may be useful in managing your own TIB, are also included in this guide, such as: treatment agreements; assessing involvement, self-grounding, self-reflection and managing ongoing risk of self-harm.

Team Approach – Not Individual

Treatment of clients with TIB should be collaborative, between the client, clinician, treatment team, and when possible external supports and services. Individual clinicians should never be solely responsible for a client's care when complexity is evident.
A team approach is essential to manage countertransference, encourage transparent treatment planning, identify treatment 'blind spots', offer support, brainstorm alternatives and encourage reflective practice. There should be a multi-disciplinary team attached to the client's treatment plan. Each clinician is responsible for their role which includes at minimum: understanding the client's TIBs; attempting to engage the client in treatment; effective and frequent communication with the members of the treatment team; and reflective clinical practice to identify and manage countertransference issues as they surface.

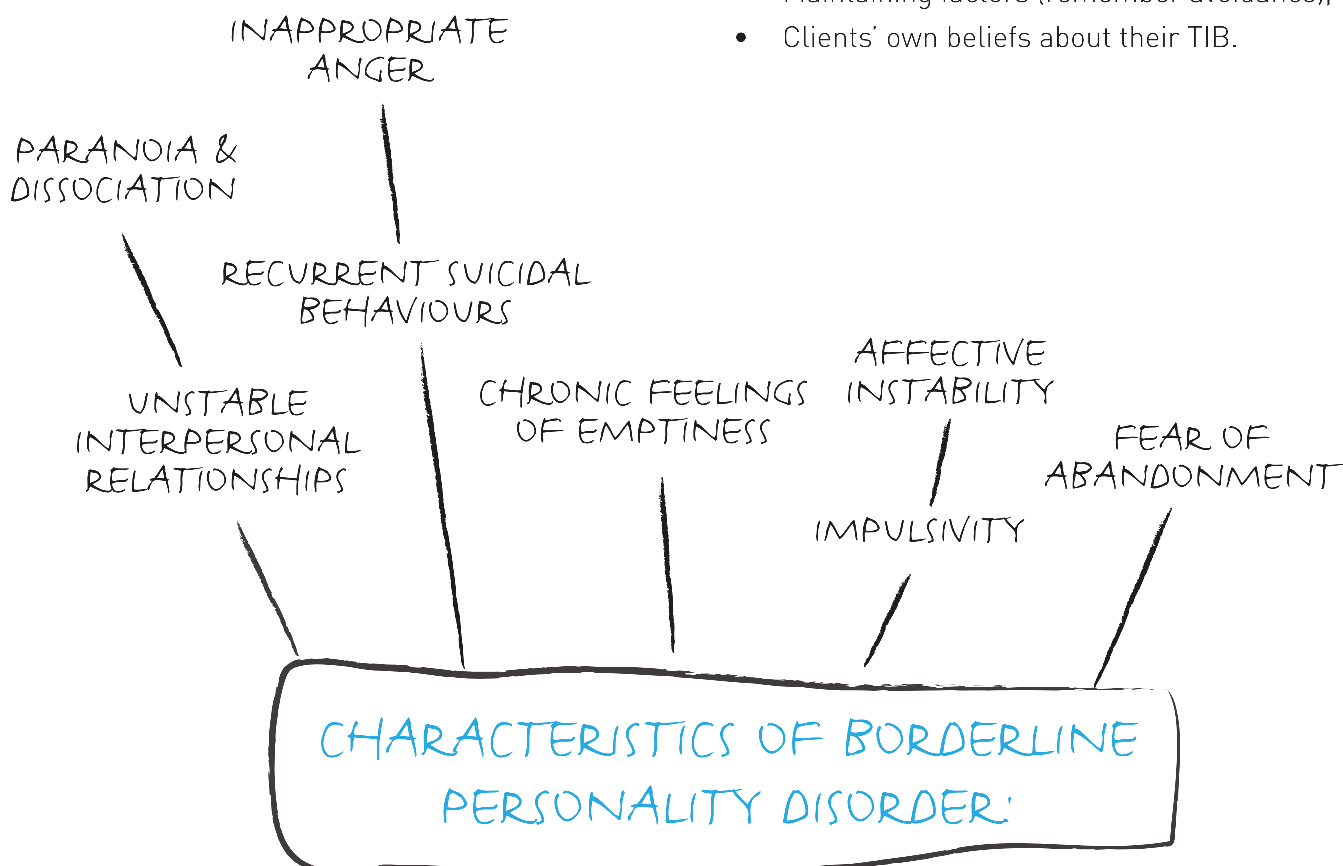
How do I Recognise TIB?

There should always be two objectives in an AOD assessment: gather the most relevant information and get the client back for the next meeting. Clients with TIB often present many challenges during assessments, i.e. a chaotic presentation, a poor historian, a lack of motivation and difficulty with engagement. It is useful to keep these objectives in mind and alter your strategy accordingly. If a client states "I've given all this information before" it would be useful to get a written release of information agreement and obtain the facts from another source. Then you could use the assessment time to understand the client's experience and develop theories about what might be driving their TIB. *The best thing you can do initially is give the client hope that this time, treatment might be different.*

Screening and Assessment

There are seven shaded 'flags' (shown above) that identify possible client TIB or warning signs. These 'flags' are only intended for screening and encourage you to assess client TIB more comprehensively. Like any problem behaviour targeted for treatment, an assessment of TIB should cover the hallmarks of a good behavioural assessment, including:

- A good description of the TIB. For example, where do they occur? When? With whom? How often? How disruptive are they? What are the triggers of the TIB? What are the consequences?
- An understanding of how the TIB developed. When did it begin? What were the predisposing factors? How have these changed over time?
- Contexts and modulating factors,
- Maintaining factors (remember avoidance),
- Clients' own beliefs about their TIB.



Multiple Agency Flag - Call a Case Conference
When there are three or more services involved in a clients' care – organise a CASE CONFERENCE.

Before Case Conference
1. Discuss objectives and develop a strategy within team
2. Make sure GP is invited
3. Discuss level of client's involvement and knowledge of meeting.

During Case Conference
1. Ensure someone is facilitator and note taker
2. Clarify roles for each service provider – who is doing what? (and has done what?)
3. Share treatment plans and goals
4. Identify points of intersection and conflict in the goals.
5. Discuss successes and challenges
6. Minimise the chance of undermining other clinicians' treatment plans.
7 Ensure client's strengths are highlighted
8 Appoint a case co-ordinator – who is responsible for communication and scheduling the next case conference and the minutes?

A Word on Avoidance. One of the hallmarks of personality disorder is chronic avoidance. Remember, personality disorders are characterised by pervasive and rigid patterns of thinking and behaving that create their own vicious circle of behaviour. Most short-term cognitive and behavioural interventions, like relapse prevention, assume clients have access to thoughts and feelings after some education and coaching from their AOD clinician. In many personality disorders, however, feelings and thoughts are avoided, e.g. 'blocked out' because they are overwhelming or uncomfortable. This avoidance may be a common cause of feeling 'stuck' in treatment. Seek advice from your supervisor, consult an expert or put this clinical issue to your team to help you come up with alternative ways to overcome avoidance.

How Do I Manage TIB? What next?

Two Helpful Strategies to Use with Your Clients.

If three or more of the warning signs listed are identified, there are many strategies you can use in your session. It is not within the scope of Making Waves to address all types of TIB, but the following strategies and tools may assist you to manage common types of TIB. See the reading list at the end of this guide for more ideas about other strategies.

Education: Sometimes it may be useful to educate a client about TIB. A script such as the one below can be presented. Some clinicians find it easy to introduce new material to a client, however for many, this brings normal anxiety. It can be useful to practice communicating the ideas out loud first to yourself, then to another, or into a digital recorder. Having rehearsed it will enable you to feel more natural when speaking with clients.

Example: "While we've been talking I've noticed a few things you've said that can sometimes indicate that treatment might be difficult. People may start treatment, hoping to [improve their lives/get court off their back/save a relationship/avoid feeling bad] but either [drop out early/have intense emotions/have too many life crises/have mental health symptoms/get so hopeless they become suicidal.] When this happens the person may feel they 'failed' or 'treatment failed them'. I try to work with them to see if they are vulnerable to behaviours that interfere with treatment. Then we try to do something about them from the beginning so it makes it easier for them to meet their goals. I can either give you a little explanation to help make sense of your experience or I can talk to you about how to help you get back here for your next appointment. What do you think? How does this sound?"

Now use your clinical instincts. How did the person respond? Were they apathetic, interested, or curious? Use this moment to be curious yourself. Why? What might be happening? Are they demoralised, frustrated, confused? Is this common? Some clinicians get anxious ("I'm not doing this right" or "another therapist would do this better"), this is common but unhelpful. Remember you are not trying to 'fix' a client's struggles or ensure success. You are simply looking for barriers to engagement. This allows for normalising dialogue with the client and your team.

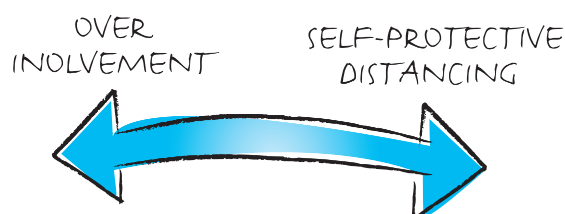
Values: In some circumstances it might be useful to discuss values. How does AOD use or TIB interfere with the client's values? Values work can be a useful engagement strategy but it is not easy to do. People with long histories of AOD use have often made multiple choices that are not in line with their own values (which may include being loving, productive or fun). Therefore talking about these things might be difficult and cause sadness for the client. A useful start is to ask why they want to change AOD use. You might hear a hidden value about health, family or freedom.

Example: Questions such as these might be helpful: "Deep down inside, what is important to you? What do you want your life to stand for? If I was to see you with your children what would I see happening? What characteristics in others do you admire? It also might be useful to say something like this: "Lots of treatment programs focus on goals, and goals are important, but then people feel like they've failed if they didn't meet their goals. The good news about values is we can more easily look at some steps you can take to feel like you're living more in line with your values, even if you don't always feel like you're meeting your goals."

Six Helpful Clinical Tools

TOOL 1: *Assessing Involvement*

It can be incredibly hard for clinicians when working with a client with TIB to develop a collaborative, respectful, therapeutic relationship that offers containment and upholds appropriate clinical boundaries. The literature suggests that clinicians working with clients with TIB will fall somewhere on a continuum of clinical involvement[5]. Some clinicians may recognise the client's vulnerabilities and past traumas and become overly 'caught up' with the client. An indication of this is when your team member is over identifying with the client's vulnerabilities and ignoring the client's strengths. Other clinicians are ever mindful of the need to maintain strict boundaries to avoid client's becoming overly dependent on them. In this case your team member may have unrealistic expectations for the client's potential to change.



Adapted from Powell, 2004.

Each end of the continuum can impact and/or interfere with treatment success. It is important to reflect on your clinical style and determine where you generally fall in this continuum. It is a useful concept to reflect on when there is opposing opinion about treatment strategies within a clinical team. See if discussing this idea with your supervisor or treatment team makes a difference in clinical practice.

TOOL 2: Treatment Agreements

Treatment agreements can be useful with clients that have TIB, especially if done with consideration and reflection. A treatment agreement, unlike contracting or informed consent, is an agreement between you and your client about the expectations of each other during the course of treatment. This indicates both you and the client share the responsibility for treatment. Together, you and the client should identify the goals, purpose and practical arrangements of treatment.[6] ***Treatment agreements should not be seen as punishment for poor behaviour. They should be an opportunity to elicit commitment, as well as establishing clear expectations and boundaries.*** You should be prepared to discuss what s/he will be doing as well. For example if the client's issue is anger, the therapist might include a statement in the agreement such as "I will respond respectfully but firmly when the issue of anger at the clinician surfaces in the session."

How do I write a treatment agreement?

The treatment agreement might start very simply and progress over time. For example, at first it might be as basic as agreeing on the minimum number of sessions (i.e. 2-4) that a client is expected to attend and what you and your client will do to ensure the commitment is met. As the client gains skills, the agreement may become more involved in terms of what she is capable of doing to support her own treatment and manage TIB. You should collaboratively identify potential TIB and outline how these will be managed, what actions you and the client will take when TIB surface. You should be mindful of establishing agreements to which clients are unable to adhere and setting the client up for treatment failure. You should also prepare for the end of treatment in your treatment agreement. Prepare for both treatment ending once goals are achieved or setting the stage for a discussion about what to do when treatment doesn't go as planned. See the section on Saying Goodbye for more ideas.

TOOL 3: Self-Grounding

Most clinicians pride themselves on responding to clients in a non-judgemental way. Yet unfortunately, many clients with TIB can directly or indirectly incite negative responses and countertransference from clinicians. Learning how to respond to TIB effectively is one of the most difficult, but important, skills to master as an AOD clinician.

In other words, in your clinical career it is essential to find ways to 'stay grounded'. This might mean using your team to normalise your reactions so they don't interfere with your work. Or seeking clinical supervision openly and honestly about your negative responses. Remember your negative reactions are valid pieces of clinical information. The sign of an experienced clinician is not getting rid of those responses, but being curious and non-judgemental about their origins and knowing how to use them effectively in your work with your clients.

TOOL 4: Self-Reflection

Clients with TIB offer an important opportunity to improve your own capacity for clinical reflection. After sessions you might start to notice your reactions, i.e. – questioning your own skill or devaluing the client. Your awareness of these responses is particularly important as it can negatively impact treatment outcomes if ignored. You are responsible for self-reflection. A concept that might be helpful is that 'you play your own side of the tennis net to the best of your ability' and then you can leave the rest to the client. It has been suggested that the impact of both the client and clinician's early parental relationships can have an effect on treatment outcome.[7] Please reflect on your part in any treatment episode with clients that have TIB.

Tool 5: Dropping the Anchor

When working with client's TIB it is likely you will encounter some of the most challenging clinical issues, such as self-harm and suicidal intent. It is important to remember that suicidality and self-harm are the client's best attempt at addressing intense pain, unmet needs or ambivalence about life. In adherence with your service's clinical policies on suicide and risk management it is important to assess risk, refer appropriately to crisis assessment teams within mental health, put in place a crisis management plan, get support from your supervisor and openly discuss these clients with the treatment team. Self-management during crises is just as important for a clinician. First, remember to ground yourself (try using *Dropping the Anchor* below) when you are faced with this presentation. Remember there are actions you can take, but ultimately our clients are responsible for their decisions. In an immediate crisis presentation an intervention called *Dropping the Anchor* can be a useful addition to your crisis management plan.[8] If the client describes their emotional distress as an "internal storm that is fierce and relentless", you could ask if the client is willing to try and 'drop anchor' or find some grounding in this emotional storm. If the analogy of dropping anchor doesn't resonate with you or your client, explore other analogies about grounding.

TOOL 6: The Three I's – Describe the Pain

A second intervention that might be useful can follow *Dropping the Anchor.* If the client was able to acknowledge even a small difference in the level of distress after *Dropping the Anchor* you have room for a new dialogue about the client's pain. When clients are chronically suicidal, a helpful construct might be the Three I's:[9] intolerable, interminable (never-ending) and inescapable. These are ways to describe the client's pain. When you begin to have a framework for a discussion about pain it allows clients to have an open and honest conversation about why suicide is seen as the only solution. A discussion of the Three I's can facilitate the identification of times when this wasn't the case or when they were more able to manage pain. Obviously all these interventions should be discussed with supervisors and your team. But these strategies may assist you feel a bit more equipped when facing these challenges.

Dropping the Anchor:
You could use the following as a script:

1. Ground your feet in the floor and feel the floor beneath your feet
2. Notice your body in the chair and how you feel sitting
3. Look around the room and notice what you can see
4. Notice what you can hear
5. Notice what they are doing, notice that you and I are in the room together talking
6. Now see if you can breathe down into your feet that are planted on the floor
7. Notice your thoughts keep trying to pull you away, but see if you can just notice that and stay in the room with me
8. Notice the room around you and us being here together
9. Now notice if there is even a slight difference between now and when we began

Deliberate Self-Harm

Just as you would with AOD it can be useful to review the *triggers* and *consequences* of Deliberate Self-Harm (DSH) actions. It is important that you discuss DSH incidents after they occur, asking the client to describe step-by-step the events leading to DSH and then consequences after the behaviour. You can do this by examining the external and internal triggers such as situational experiences as well as thoughts and feelings, a sense of release, and shame, etc. The goal is to begin to increase the client's insight into the motivations behind self-harm. Once the client is able to identify high-risk situations, they can be avoided or managed effectively. Examination of the consequences of DSH, such as increased self hatred, shame, and negative responses from family and friends can assist the client in understanding the impact of their DSH. It is important to note clients might not want to stop the self-harm behaviour, because just like AOD use, it serves a function. If appropriate, this might be a chance to see if self-harm moves a client towards or away from living within their values. With self-harm it is important to *validate* the effective management of distress. Successful attempts by the client to manage intense emotions or stressful experiences without engaging in self-harm should be reinforced as this is a big success. See the Making Waves resource *An Introduction to Managing Deliberate Self-harm: A Guide for AOD Clinicians* for more information on self-harm behaviours.

How to deal with "Manipulation" and "Splitting"

Manipulation and splitting are often terms that are misused when discussing clients struggling with TIB. They have become a clinical shortcut to explain challenging behaviour. For example, when a client starts yelling in the waiting room that their doctor doesn't care and isn't helping her, it is hard not to feel personally attacked and it becomes difficult to be objective. Yet it is important to separate the function of this action from terms like "manipulating us to get pills" or "she's trying to split us". If instead, this behaviour is discussed as the client's TIB, it separates it from both the client and the service. As discussed above the client likely struggles with regulating emotion and uses a variety of strategies including yelling and demanding. The term manipulation does not convey the complexities of the client's experience. She is doing the best she can, these strategies have likely been the only way she's found to either get her needs met or find a way to "feel better". Review the theory section of this guide or look into the further reading sections of Making Waves to assist you in developing a sophisticated 'explanatory framework' for these behaviours which can guide appropriate clinical responses.

Saying Goodbye – As important as Engagement!

Whenever possible, termination of treatment should always be carefully planned. Even if termination occurs in the context of breaching the treatment agreement, a well planned ending can make the difference between consolidating therapy gains and spoiling the whole experience. Termination is best discussed at the beginning of treatment when agreeing on a collaborative plan for treatment (see section on Treatment Agreements). Ideally terminations occur when the client meets their goals for AOD treatment but sometimes treatment stalls, hits a plateau or other work is to be done outside your area of expertise. Whenever possible you should aim for a collaborative discussion about the process of termination. Clients with TIB often have complex histories of abuse and abandonment so preparation is paramount to success. Remember to use supervision and support during treatment termination.

The last session: The final session should only be about termination with no new material added. Many clients with TIB will find this exceptionally challenging. Your work is to gently link anything new discussed to the process of closure. Linking new material to treatment successes and achievements is a good strategy to maintain closure while reinforcing and celebrating treatment gains.

I'm not afraid of storms, for I'm learning how to sail my ship.

Louisa May Alcott

Making waves for managers

Making Waves promotes the introduction and consolidation of mechanisms to support reflective practice in all AOD services. The balance between supporting reflective practice and implementing clear and appropriate service procedures to support clinicians to continue to work effectively with clients who present with TIB is a challenge identified by all managers and clinicians who took part in the project. In particular, procedures around the management of self-harm and suicidal intent, which go beyond a CATT team or mental health service referral, were identified as essential. Supervision models which include internal clinical supervision, peer supervision and externally facilitated group supervision for teams were all raised as essential undertakings in the Reference Group and clinician pilot for Making Waves. In spite of the unanimous enthusiasm for these supervision models, it was recognised that finding the time for reflective practice was challenging, when the 'real' client work continued to be counted as face to face sessions. It was noted that supervision is not currently funded within the sector.

Checklist: Policies to Support Your Service in the Management of TIB

- Ensure your service has an up to date procedure and clinical protocol for the management of risk of self-harm and suicide, including when to refer to your area mental health service, hospital psychiatric triage or Crisis Assessment and Treatment Team (CATT). Ensure that this procedure also includes achievable suicide management plans to be implemented within your service for times when a client is suicidal, but assessed by mental health services as not meeting their intake criteria. A clear message to your staff that a whole of service response is to be initiated when management of a suicidal client is required will ensure clinicians do not manage such circumstances in isolation and without following service protocols.
- Ensure your service has an up to date procedure for the management of risk of harm to others, verbal aggression and threats of harm, including when to call the police. Pre-emptive aggression management is more effective than reactive, so ensure that intake procedures and treatment planning include contingencies for clients who have a repeated history of aggression. For example, try including verbal aggression management strategies in a treatment agreement, writing a 'waiting room plan' with clients who struggle with frustration tolerance and structuring treatment so that the client has every opportunity to build a collaborative relationship with someone in the service and honour their treatment agreement. Too often, clients are set up for failure. Aggression management training is essential for all your staff, including reception and support staff.
- Ensure your AOD clinicians are not working in isolation: support the appropriate forums for clinical supervision, transparent treatment planning, team review of clients and access to external consultation services.
- Ensure your service has a policy or clinical guidelines about when it is appropriate to terminate the treatment of a client, when it is no longer safe for the treating clinician, other staff or the client themselves.
- Consider the complexities and potential conflicts of interest apparent in combined line management and clinical supervision arrangements. If unavoidable, give your team the opportunity to examine clinical process outside of a line management relationship, free from performance management. Supporting regular forums for peer supervision or less frequent externally facilitated group supervision may help overcome some of these conflicts.

Policies, procedures and clinical protocols for managing TIB can be written in consultation with specialists or experts in working with clients with personality disorder.
A relationship characterised by mutual respect and goodwill with your local area mental health team manager is essential. Whether informal relationships are built around co-management of clients or a formal memorandum of understanding is written between the two services, effective collaboration is essential to good management of clients with TIB.

Good Luck!

Making Waves acknowledges that the group of principles and tools in this guide are small steps toward addressing the complex service system issues which contribute to negative responses of people with personality disorders who are struggling with AOD issues. Although the complexity of the service system is overwhelming, Making Waves hopes to help clinicians manage their own and client TIB, which may interfere with a client's potential to benefit from AOD treatment. In spite of the complexity, people in recovery from AOD issues readily identify the individuals who did not give up on them and did not lose hope that recovery was possible during their recovery journey.

Further Reading

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2 Beatson J, Rao S, Watson C. Borderline Personality Disorder: Towards Effective Treatment. Melbourne: Australian Postgraduate Medicine; 2010.
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7 Bateman AW, Tyrer P. Services for personality disorder: Organisation for inclusion. Advances in Psychiatric Treatment. 2004;10(6):425-33.
8 Harris R. ACT Made Simple. An easy-to-read primer on Acceptance and Committment Therapy. Oakland: New Harbinger; 2009.
9 Chiles J, Strosahl K. Manual for the assessment and treatment of suicidal patients. Washington DC: American Psychiatric Publishing; 2005.

"I don't really get why I should see a counsellor all the time. When I need help I call them ...otherwise I'll end up seeing someone at the hospital anyway. I mean if I knew I was going to need them beforehand I would make an appointment. But I can't predict that I am going to need someone on Thursday cause centre-link is going to stuff up my payments and my boyfriend picks a fight with me. I am not wasting my time going in if there is no reason". ***Felicity, 26***