Engaging Conversations

Substance Use and Therapeutic Process

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Introduction

Grown ups are complicated creatures, full of quirks and secrets.

Roald Dahl

Purpose: Why read this guide?

The guide examines therapeutic process, the exchange between client and clinician through which the work happens. The focus is not so much on content — how to treat substance use or co-existing concerns — as on the relationship being formed, what helps and the challenges that arise.

This is the stuff we grapple with in the moment, in the room with the client. Where we're wondering how to connect, how to help and what just went wrong.

We wanted to get beneath the work, look at the underbelly and offer practical ideas and strategies to take into every therapeutic encounter. While this initial focus is on substance use, the intention was to create a resource that would be helpful in working with a wide range of complex issues.

We hope we have succeeded. The work you do matters. It helps real people change their lives for the better.

Content: What does guide cover?

To work in the treatment of alcohol and other drug (AOD) concerns is to work with everyone. Substance use is a behaviour chosen by many people from different walks of life, beliefs, struggles and hopes.

One of the challenges facing the AOD clinician is "How do I work on the substance use with *this* person?" when the client may be facing vastly different concerns than the people attending the appointment before or after.

One source of complexity arises when people are experiencing concurrent mental health concerns, whether they be commonly experienced symptoms of depression or anxiety through to less typical conditions such as borderline personality disorder or schizophrenia.

There has been a growing awareness over the last ten to fifteen years that we need to become more aware and skilled in working with clients with coexisting mental health and substance use concerns. This has led to a welcome increase in funding initiatives, skill development and manuals that aim to build the capacity of workers and services to provide more effective care for clients with multiple presenting issues. These resources have addressed various important aspect of the

work, ncluding service structure, screening and assessment tools, treatment modalities and collaboration with other services.

And yet in the face of so much knowledge, it is still not always easy to know what we need to do when we are there in the counselling room, sitting with that complexity and its many uncertainties.

This guide is intended to complement existing resources by offering some practical ideas about how to take some of the complexity of working with co-existing concerns into account when you are engaging clients and working out together how you could be most helpful to them.

Our hope is that this resource feels more like having a useful conversation with peers that offers good food-for-thought rather than a step by step 'How To' manual.

If we have learnt anything about therapeutic work, especially where there are multiple concerns, it's that the more we learn, the more we realise we don't know. It's more about approaching the conversation with an open mind, sitting with uncertainty and trying to do something useful together anyway.

The guide covers some of the key areas of therapeutic process:

- **The spirit of engagement**: The nature of the relationship being formed.
- **Therapeutic alliance**: The features of positive therapeutic relationships.
- **Assessment**: The relationship between assessment and the process of engagement, the tensions that arise and attending to complexity.
- **Formulation**: Making sense of the information gathered and developing strength-based understanding.
- **Treatment trajectory**: Locating the work in the bigger picture of the client's life.
- **Navigating complexity**: Qualities of the therapeutic relationship that offer guidance.
- **Working with the challenges**: Practical ideas for working with common challenges to therapeutic process.
- **Supervision and self care**: The importance of looking after both halves of the therapeutic relationship.

A core focus is the skill of formulation, making sense of what we have learned to inform and deepen the work. We offer some ideas and strategies to sift through the information we have gathered, including the Six P framework. The Six P's extend the well-known Four P (Predisposing, Precipitating, Perpetuating and Protective) to include our Personal reactions and Patterns we have observed. We also offer guiding principles for engaging in strength-based formulation — how to

develop our ideas about what is going on for the client in a way that honours them and inspires hope.

We also offer some ideas for working with common challenges that affect the relationship we form with the client and the work we are able to do:

- Complexity
- Avoidance
- Pessimism
- Impulsivity and impaired memory
- Difficulty with trust and intimacy
- Emotional extremes
- Hostility.

We are sure that every reader could contribute further insights and ideas that would make this an even better resource. We hope the guide sparks many stimulating conversations, as we have had in writing it, about the richness and challenges of the work we do.

Audience: Who is this guide for?

The main audience for this guide is the AOD worker whose role is primarily to work on substance use concerns. However, the ideas are not exclusive to the AOD field — indeed we hope clinicians in many other settings will find useful ideas they can apply in their own work.

The guide is not pitched at particular job descriptions or disciplines within the AOD sector, although it is written more with the counselling conversation in mind. Our aim was to focus on the process of the work where each reader can determine how relevant or transferable the ideas are to their own work setting.

To that end, we will use terms such as ‘clinician’ or ‘client’ throughout the guide with the appreciation these may not be the preferred or most ideal terms for many readers. They were chosen more for pragmatic simplicity but essentially we are considering how two people can come together in the AOD treatment setting to have respectful, useful conversations that matter.

Guiding principles: What approach does this guide take?

1. The aim was to consolidate a few core concepts into one accessible resource.
2. There is much more left out of this guide than was included. In offering something accessible and practical, we chose not to make it comprehensive.

3. The intention is to work effectively on substance use, by taking other complexities into account, rather than aim to provide fully integrated and simultaneous treatment for both the substance use and mental health concerns. The two are not mutually exclusive, or one necessarily superior to the other, but are separate approaches worthy of attention in their own right.

4. Good helping conversations happen in good helping relationships. Forming engaged relationships is sometimes challenging, with mental health concerns playing out in the relationship we are able to form with clients. This guide offers ideas on how to work with those processes as part of the work rather than being seen as an obstacle to the work.

5. Ultimately, our work is about assisting people to experience greater quality of life and making choices that are meaningful for them. We hope this resource offers a useful contribution to clinicians engaged in this process.

Engagement: The relationship is fundamental

If you talk to a man in a language he understands, that goes to his head. If you talk to him in his language, that goes to his heart.

Nelson Mandela

The spirit of engagement starts before we meet the client. It is embedded in how we see our role, our client and our beliefs about how change happens. Four qualities of a positive engagement are:

- Partnership
- Acceptance
- Compassion
- Evocation.

We know that without good engagement it is very difficult to do good work, and yet engaging one stranger after another in positive, supportive and productive relationships is no easy achievement. The treatment literature continually highlights the importance of clinician qualities and the importance of accurate empathy.

Some treatment approaches invite us to think deeply about our role, the way we think about the client and our purpose together. Strength-based approaches, such as Motivational Interviewing (MI), Solution-Focused Therapy, Acceptance and Commitment Therapy (ACT), Positive Psychology and Narrative Therapy, all highlight the importance of the spirit of engagement rather than just the content of treatment. Underpinning all of these approaches is a stance of faith, curiosity and respect.

This guide uses MI as the core framework for the spirit of engagement. This reflects both the recognised value of MI in treating substance use and the therapeutic orientation of the authors, but does not downplay or exclude the benefit of other approaches.

MI offers four key components to describe the spirit of engagement (Miller & Rollnick, 2012):

- Partnership

- Acceptance
- Compassion
- Evocation.

Partnership

The therapeutic relationship is essentially one of two equals coming together with two different roles. Our role is to provide structure, acting more as a guide than as an expert, while their role is to provide much of the content. In doing so, we not only engage their inner wisdom, we hope to empower them through not just our words but our actions: in stepping out of the expert role, we invite them to discover and reinforce their own expertise.

Acceptance

Flowing on from Carl Roger's notion of unconditional positive regard, the therapeutic role balances acceptance of the way things are with optimism that change is possible. Acceptance does not mean taking a position on what the person should or should not do. Four aspects of acceptance are:

- **Absolute worth**: The person is seen and valued separately from their problems or challenging behaviours. This quality reflects a humanist belief that all people are created equal and deserve to be treated with care and respect.

- **Affirmation**: The person is acknowledged and affirmed for who they are, their strengths, and values, not what they do or don't achieve.

- **Accurate empathy**: The clinician's role is to invest much, if not most, of their energy in trying to continually deepen their understanding of what is going on for the client rather than to interpret, fix or solve presenting concerns.

  In this sense, empathy is expressed through the continual, sustained use of the skill of reflective statements that attempt to capture the clinician's understanding of what the client is saying.

  The clinician never assumes that they have achieved full understanding, rather it is an ongoing desire to continue to deepen the understanding gained so far.

- **Autonomy**: Acceptance also includes a respect for the client's right to draw their own conclusions and make their own choices in life. We are not responsible for whether the person makes change or not — only they can make that decision for themselves.

While there may be times when the client experiences unwanted consequences for their choices, such as involuntary admission to a psychiatric ward, having children removed from their care or returning to prison, there is no sense of judgement that they have their own views and perspectives on what they believe they need or want in life. Autonomy is expressed through seeking permission (e.g. to raise a particular topic or offer information) and acknowledging the person's right to make their own choices.

Compassion

While few would question the importance of compassion in the therapeutic relationship, it may be challenging or difficult to sustain in some circumstances. Working with some clients may leave us feeling unsure, disrespected, unsafe or frustrated. The work may challenge or conflict with our own personal beliefs or values, making it hard to maintain positive, open attitudes or feelings toward all clients at all times. With loss of compassion comes impairment to the relationship and far greater risk the client will not feel safe or accepted enough to open up and truly engage in the work together.

Sometimes the work on engagement needs to happen between appointments, before we try to re-engage the client. We may need to examine our reactions, their source and how we may be able to regain an open mind and our compassion.

It can often be helpful to explore what is going on for us with a supportive colleague, who will listen and give you space to think without giving you advice. The following process may provide a useful structure:

- Talk for a few minutes about what is difficult or frustrating about working with this person. What do they do? How do you react?
- Then spend some time being curious about your own beliefs or values that may be contributing to your reaction. For example, you may value taking responsibility and this person seems to be wanting you to do everything for them, or you value respect and this person is treating you in what feels to be a very disrespectful way. What is it about this person or situation that's getting under your skin, when so many other challenging situations don't bother you so much?
- Then — and this might not be easy! — set a timer and talk about that person for three minutes where you only say positive things about them. This may help to free up new perspectives or soften the rift that may have developed between you. If it is difficult to find enough to say during the three minutes, the following may help:

    1. Return to the values discussed in the previous conversation. The same values may help you to find something to value or acknowledge about the other person. For example, if you

value respect, your wealth of experience in treating people with respect may help you out here.

2. The obituary: Imagine the client has passed away and you have been asked to speak at their funeral. What would you say? We know this is a time to highlight something we can honour in the other person, rather than the things that may have frustrated us.

   The exercise invites us to think more broadly than our working relationship. The same qualities that we may have found difficult may be the source of something to affirm. For example the person who was 'non compliant' could be seen as being independent or the person who comes across as blunt could be seen as assertive.

3. Client as child: Imagine the client as a child. What might life have been like for them? What forces outside their control may have shaped the behaviours that you are now finding difficult to deal with?

   If it remains difficult to reconnect and empathise with them, try to imagine the person as younger and younger — it may be easier to regain compassion by picturing them at the age of three than the age of fifteen or even eight.

4. Client at their best: Be curious to see what perspectives come to mind when we ask ourselves "What if this is the client at their best at this point in time?". This question invites us to think about the ways the difficult or challenging behaviour may reflect an attempt to show restraint rather than them fully giving in to their deeper urges.

   While this does not mean we condone aggression or disrespectful behaviour, it can be helpful to also pay attention to the degree to which the person is showing restraint or holding back an urge to express themselves in an even more confronting or challenging way.

- Based on the previous three conversations, you may then find it useful to answer the following questions to see if they help offer more clarity on what is going on and what might help:

  1. How might they be seeing the situation?
  2. What might they think the problem is from their point of view?
  3. How might they be feeling?
  4. What might be a positive quality or strength that they have?
  5. What might they value?
  6. What do you think you could do differently in the next appointment?

Evocation

You cannot teach a man anything; you can only help him find it within himself.

Galileo

Evocation is the process by which we draw out the client's own understanding, wisdom and meaning. Strength-based approaches assume that most of us know what is good for us and what we want, we just may be having difficulty accessing it, believing in ourselves, or finding the clarity and drive to pursue the changes that would work best for us.

The hope is to engage the client's own insights as much as possible, and for the clinician to only offer thoughts, information or ideas as a minor aspect of the work where possible. This approach communicates a fundamental respect and faith in the person that may help that person to see themselves with more hope and acceptance. It also improves the quality and relevance of anything we go on to discuss as it is based on their reality rather than what we might guess is going on.

Further, it is simply much easier for people to use what is already within them than to use something brand new offered by another person. The more the person is invited to consider their situation and piece together their own understanding of what is going on, what they want and what would be most helpful, the more likely they will feel ownership and a more profound connection to conclusions they draw and persist with the choices they make.

Therapeutic alliance: The relationship is part of the work

I've learned that people will forget what you said, people will forget what you did, but people will never forget how you made them feel.

Maya Angelou

The therapeutic relationship offers more than an environment for positive change, it is an important part of the change process itself. Four essential components of the therapeutic alliance are:

- Effective communication
- Empathy
- Therapeutic values
- Agreement on focus and approach.

So having considered the spirit in which we meet with our clients, what of the relationship itself that we are trying to form? While many of the usual elements of human relationships exist within clinical work, the type of relationship we form is very specific, bound by clear principles and reflects the art of conscious responding rather than automatic reaction.

A helpful concept is that of the 'therapeutic alliance', which refers to "the quality and strength of the collaborative relationship between the client and therapist" (Norcross, 2011). The idea that the therapeutic relationship is fundamental in the change process has been recognised since the beginning of what we recognise as modern psychotherapy.

For example, Freud (1912) wrote about the therapeutic relationship from the point of view of transference and countertransference in psychoanalysis, while Rogers (1965) emphasised the role of 'unconditional positive regard' and 'accurate empathy' as key ingredients in humanistic counselling. Whilst their approaches were different, they and many other leading thinkers have observed that a positive therapeutic relationship is central to the change process.

Bordin (1979) suggested that the therapeutic alliance is made up of three core components:

- A positive affective bond between client and clinician
- Agreement on therapeutic goals
- Agreement on therapeutic strategies.

Research shows there is a strong link between a positive therapeutic alliance and more favourable outcomes for clients. Further, research shows that the quality of the relationship between the client and clinician is at least as important as the clients' presenting problems, qualities of the therapist and the type of therapy used.

While agreeing that the therapeutic alliance is fundamental, different theoretical orientations vary in the degree to which they understand the role of therapeutic alliance in facilitating change. To generalise, there are two main schools of thought:

1. The therapeutic relationship, assuming it is a positive one, is enough to assist the person to make changes to enable a more fulfilling and meaningful life.

2. The therapeutic relationship, assuming it is a positive one, is important but not sufficient to enable the client to make changes to have a more fulfilling and meaningful life. Other factors, including the development of new ways of thinking and new skills, are also considered essential in making and sustaining change.

Rather than advocate one approach over the other, we would invite clinicians to be curious about which approach fits best for each client. For example, the principles of MI suggest that skilful, accurate listening and empathy may be sufficient for many clients to reconnect with their own wisdom and they may not need technical assistance from the clinician in the form of information, advice or skill development. However, there may be times when the client and clinician both agree that specific interventions could be helpful to resource the client better to achieve their goals.

It is important to emphasise that there is no one kind of generic relationship that suits all kinds of clients and all kinds clinicians. Clinicians need understanding, skills and techniques to foster the types of relationships that maximise the outcomes for each client, whilst remaining genuine to themselves and the therapeutic process.

However, there are some guiding principles that can help to facilitate a positive therapeutic alliance. If we return to the definition of therapeutic alliance provided by Bordin (1979), one priority is to create a positive affective bond. Whilst there may be no definitive answer about how this might accurately and consistently be achieved, three key factors are:

- Effective communication skills
- Empathy
- Therapeutic values.

These three components will be discussed in more detail, along with the other components of therapeutic alliance — agreed goals and strategies. However, these will be broadened to the idea of an agreed understanding of the sense of focus and approach to be taken.

Effective communication

The single biggest problem in communication is the illusion that it has taken place.

George Bernard Shaw

Effective communication skills involve going beyond what is said to being able to observe and interpret the client's nonverbal and verbal messages: “What are the main messages here? What are they really telling me? How are they experiencing the situation?” The client also needs to be understood within the context of their life, particularly their immediate and broader social context.

The client’s perspective, 'blind spots' and biases need to be understood as they relate to the presenting concerns. And to understand these, we also need to be equally aware of our own perspective, blind spots and biases.

The clinician also needs to be able to communicate in a clear, sensitive and respectful manner, in a way that is responsive to the client’s own style of communication and comprehension. The heart of effective communication is not what is said or heard, but what is understood.

The skill of continually reflecting back our understanding protects against the risk of believing we have understood each other when we have brought our own meaning to what is being spoken about. Reflections allow us to check, clarify and deepen our understanding.

Empathy

We touched on the role of empathy in the spirit of engagement. Empathy has been defined in many ways, with the common themes being: listening to and understanding the experiences of another, being able to share the perspective of the other, refraining from judgement, and communicating understanding to the other.

At the heart of empathy is the aim to continually seek to understand the other person, with increasing depth and accuracy, while recognising it is impossible to ever achieve total understanding. In this way, empathy is a way of being in the relationship rather than a destination.

To take the concept further, empathy must be expressed. Our main skill for sharing the understanding we have developed is the skill of reflective listening. There are three main kinds of reflections in conversations about change:

- **Simple reflections** — where we repeat or paraphrase what the client has said. While it acknowledges that we were listening, simple reflections are limited by their lack of depth, can sound repetitive or 'parrot-like'.

- **Complex reflections** — where we state what we believe the client meant. Complex reflections require us to make an educated guess and so it is important they be expressed in an open way that allows the client to correct us when we get it wrong.

  Complex reflections include reflecting back emotion, strengths, values or themes that are consistent with what the client is telling us. These reflections allow the conversation to deepen and move into new or valuable territory.

- **Double-sided reflections** — where we reflect back both sides of the client's ambivalence in a neutral and non-judgemental way. For example, if we were working with a client who is expressing a desire for help but is also suspicious of our agenda or motives, we might gently reflect back something like "You would like some help with what you're going through and you're not yet sure if you can trust me." The aim is not to immediately resolve the dilemma, but to create a space where it can be discussed.

When we use reflections, we try to deepen our shared understanding by focussing on what the client has just said rather than broaden the conversation by asking for new content. Reflections are the core skill of an approach such as Rogerian client-centred counselling and Motivational Interviewing (MI) and may be thought of as empathy in action. In particular, reflections help us to:

- **Listen deeply** — if we know we need to frequently reflect back what we have understood the client to have said, it helps us to listen more attentively and carefully.

- **Validate** — the only way they can know that we were listening and that what they said was important is if we spend a moment reflecting on it.

- **Clarify** — the clinician has a chance to check if they understood, and the client has an opportunity to check if that is what they really meant.

- **Expand** — reflections invite the client to reflect more deeply on their current train of thought, offering an opportunity to take their own thinking further.

Therapeutic values

The values that the clinician holds and practices have a direct influence on the therapeutic outcomes. They provide the basis for a meaningful understanding of the relationship created between clinician and client and appear to be more important than individual clinician qualities.

Researchers have not been able to identify specific qualities that are necessary or sufficient for the clinician to be effective. This is not surprising if we accept that different clients benefit from different types of relationships. A more practical approach is to look at the values underpinning those qualities, such as:

- Respect
- Curiosity
- Strength-based focus
- Client empowerment
- Genuineness
- Professionalism.

While such values are important, they can be highly subjective and as open to bias or blind spots in our practice as any other part of the work. For example, using the values of empowerment or respect in a superficial way may miss opportunities to help the client to address the concerns that cause them shame or even pleasure in others' suffering.

Values exploration exercises such as the Values Card Sort (Miller, de Baca, Matthews, Wilbourne, 2001) were initially developed for the client to identify and reflect on core values. These tools can also be useful for clinicians to use periodically to reflect on their own values, motivations and areas where they may be experiencing alignment or conflict with others.

There will be times when our personal values do not match those of the client, or that they are behaving in a way that is at odds with our values and beliefs about the world. It may not always be possible to be truly non-judgemental, no matter how hard we try.

More important is that we then strive to be aware of those differences, and be open about them if needed, rather than impose our values on to the work. We need to keep a clear distinction between our therapeutic intent and our personal reactions — to be mindful of both, but also be careful not to let our reactions undermine the values that we work from.

Therapeutic work requires a commitment to be as true to the core therapeutic values as we can be, even though there may be times when it is difficult. Regular supervision provides the necessary space for reflection and feedback where we can review our practice and evaluate any drift away from our core values.

Agreement on focus and approach

A goal is not always meant to be reached, it often serves simply as something to aim at.

Bruce Lee

For a therapeutic alliance to be developed and sustained, the clinician also needs to facilitate a shared sense of focus and purpose. In order to do this, the conversation may:

- First broaden out to explore the range of what themes might be relevant
- Then narrow down to the area that would be most helpful or relevant to work on together.

Goal setting is a more detailed process where specific actions are identified and worked toward. Not all clients who are willing to work on a shared focus (e.g. discuss substance use) are ready to identify specific goals (e.g. cut down, quit or adopt harm minimisation strategies).

For some clients, goal setting can feel like they are being asked to commit to change before they are ready and express discomfort or agree to goals they are not yet committed to. The clinician needs to be skilled at developing as clear a sense of purpose as is possible, without pushing for more detail or commitment than the client is ready for.

Equally it is important that the client is involved in determining the approach taken and is able to make informed decisions about their care. While some clients may want detailed information about how the clinician works and others may require only minimal explanation, there needs to be a transparent process by which clients have an opportunity to understand the treatment options available and be involved in the choice of strategy. Possible areas for discussion might include:

- Estimated costs
- Estimated length of time available to work together
- Expectations of both the clinician and client
- Theoretical framework and client preferences
- Overview of the process — e.g. assessment, intervention, review and how completion is determined and managed
- Limits to confidentiality and how these limits will be handled.

This conversation also establishes a relationship style that values transparency and empowers the client, promoting their sense of control, responsibility, trust, collaboration and commitment.

A helpful place to start is to ask about previous experience of seeking help from support services and to find out what worked or didn't work for them. From there we can ask about any concerns they might have about how we might work with them and their hopes for how they would like to work together.

We can offer to give further explanation — for example, “Would it be helpful if I talked a bit about how work and what some of our options are?” We can then also encourage the client to let us know if they need more information later, for example, “If I’m doing something that doesn’t make sense or doesn’t feel right for you, please do let me know so we can have a chat about it and see if there is a better way to work together.”

It is also essential to build in an awareness of the end of treatment from the beginning. Clients need to know how long they can access the service and the limits of what is available. This helps you both to make better use of the time that is available and reduces the likelihood the client will feel let down or unprepared when the service must be reduced or ended.

It can be good practice to offer a specific period of care followed by a review to stay on track: “We typically work with people 3-6 months and you would be more than welcome to come in for that long if you decide it is helpful. We can start by meeting for four sessions and then review and see how it is going for you. How does that sound?”

Assessment: Deepening understanding

Believe those who are seeking the truth. Doubt those who find it.

André Gide

Assessment is an important opportunity for both client and clinician to deepen their understanding of what is going on. Intimate knowledge of the assessment process can help the clinician to keep the experience meaningful and conversational for the client. Key areas include:

- Agreement
- Content
- Source of information
- Skills.

Assessment is a gathering of data, a collection of little pieces of information about the person that come from many sources to build up as rich a picture as we can get on who this person is and what is going on for them. It is an act of respect and humanity, and honouring of the client to accept this is not a simple process.

No one piece of information is most important, rather it is about building up many little details to gain insight into their world, their needs and the best way to work together. The aim is not to reach a conclusion but to continually deepen our understanding.

Sometimes it can feel like the process of assessment may seem unnecessarily structured or unnatural and pulls us away from the process of engagement. Yet both assessment and engagement have the same fundamental objective — to understand, not make assumptions, and discover what would be the most useful way to support or treat the person at this point in their life. Making the assessment process comfortable for the other person can be an art form, particularly where there are opposing forces, such as issues of mistrust or pressing practical needs to be addressed.

What does the assessment process offer the clinician and client?

Assessment is an important and potentially exciting part of the work with the client. It is important because information gathered from the client during assessment forms the basis of a shared understanding between client and clinician about what is going on for the client. It is exciting because it is often a time of discovery for both the client and clinician.

Many clients find the experience of talking about themselves in the context of their lives, where they have been, where they are at right now and their hopes for their future, both enlightening and inspiring.

From the clinician's perspective, they are learning about a unique individual, their story, their way of being in the world and their hopes and dreams for their future. Through the assessment process, client and clinician can deepen their understanding of what is going on for the client and, ultimately, what might be helpful to them.

The assessment process provides an opportunity for a client to feel accepted and cared for, 'warts and all', by another. Assessment is also collaboration in action, a demonstration by the clinician that they cannot assume anything about the client and are curious to know them as best they can before forming a clear idea of what treatment options may best fit the client's needs.

Assessment is an ongoing and dynamic process that continues throughout the therapeutic work. New information, or the reinterpretation of old information, can happen at any point in the process and lead to new developments, new understandings and new conversations.

The first step: The agreement

Any therapeutic undertaking, including assessment, requires a collaborative partnership between client and clinician. As outlined previously, clients need to know what they are consenting to, including the purpose of the assessment and any feedback or reporting requirements — for example, if a Community Corrections or Child Protection order is involved, the nature of the reporting requirements, frequency, level of detail required, what will happen if the clinician has concerns that need to be addressed.

It is also good practice to let the client know that they do not have to discuss anything they are not yet ready or willing to talk about, and to encourage them to tell you if you touch on something difficult for them. For example, there may be a history of trauma that the client finds too distressing to discuss, especially in a first or second appointment.

Whilst this conversation may sound formal, it can be done in a low key way. If the client agrees, the assessment is often best begun by simply asking the client to tell us about what has brought them in and what they hope to gain from treatment.

What goes into an assessment?

There are three broad aspects of an assessment. The first is the content, the information that needs to be gathered. The second is the how, the method of information gathering. The third is the process, the experience for the client and clinician of what and how the information is gathered.

In terms of the content, a good starting point is for the clinician to have in mind what information is needed by client and clinician to understand the client in the context of their life. Common areas include:

- How the client experienced growing up (family, friendships, education, relationships)
- Significant events in their life (e.g. traumas, achievements, loss)
- Medical issues (current and historical)
- Mental health (current and historical)
- Employment (current and historical)
- Accommodation and current living arrangements (e.g. where, who with, how it is going)
- AOD issues (current and historical)
- Current family composition (e.g. dependents, key relationships, significant losses)
- Risks of harm to self and other (e.g. what risks, to whom, under what circumstances)
- Challenges and therapeutic goals
- Values, strengths and resources.

There may be times when having a template of areas to cover may feel too structured or disrespectful to the uniqueness of each individual. However, if we have a good working knowledge of our assessment, we can learn much of what we hoped to ask from a more natural conversational style and clarify details as needed.

Sometimes there are very good reasons why a well-rounded, comprehensive assessment in not able to be completed at the beginning of treatment. For example, session time may be taken up with a current crisis in accommodation and a decision was made to focus on this rather than on asking about their history.

Knowing what is important to discuss with the client helps the clinician and client make considered decisions when deviations are required. A systematic approach also ensures that vital pieces of information are not overlooked, which may happen when:

- The clinician focuses on the ‘here and now’ with the client and did not ask about other important aspects of their lives.
- The client does not spontaneously identify other areas of their life as relevant and the clinician does not follow up.
- The assessment is unstructured and does not provide enough time for discussion of relevant themes or events.

- Competing demands or current crisis distract from a fuller and more comprehensive assessment being conducted.

In terms of the 'how' part of gathering information, there are many useful sources of information which should be considered and used in combination to ensure a well rounded, detailed and accurate picture of the client, including:

- The clinical interview
- Structured surveys and questionnaires
- Validated psychometric tests
- Personal reaction and feelings of the clinician (process data)
- File notes and reports
- Other clinicians
- Other staff (e.g. reception)
- Family members and significant others.

Each source of information has its own strengths and limitations, which is why a combination of approaches is best. A good assessment requires gathering information with the client about all facets of their life from a diverse range of sources.

Some information may become more important with certain clients. For example, we may need more comprehensive assessment on all levels where there is an indication of higher risk to self or others. Or we may want to rely less on self report and seek more corroborating information with clients with antisocial presentations or clients who are mandated to be there against their choice.

Due to time pressures it is sometimes very tempting to restrict the assessment of the client to just what the client says during the discussion, especially if the presenting issues seem straight forward and the person seems well engaged.

Yet there are several reasons why a client's self-report may not provide a complete or accurate reflection of their reality. Some of the reasons self-report may be a limited source of information include:

- Substance misuse can adversely affect people's memory which is an essential component of self-report.

- Substance misuse can affect people's perception of events.

- Some clients feel deeply embarrassed or ashamed about their substance use, or their experiences associated with substance misuse, and may minimise or avoid painful but important information.

- The person may be mandated to attend treatment and understandably wish to present themselves in a way that meets other needs, such as creating a favourable impression for court.

- Whether due to mental health symptoms, cognitive impairment or simply having differing views, the client may not be aware of relevant information or not perceive that information to be relevant.
- It may be extremely difficult for some people, particularly where there is a history of abuse or conflicted relationships, to provide the clinician with a full and accurate picture of themselves for fear of being vulnerable, rejected, exploited or exposed.

The information gathered from all aspects of the client's life and from a variety of sources is very much like collecting pieces of the puzzle of an individual's life. The hope is to put them together in a way that makes sense for the client and clinician, and guides a course of action geared towards improving the client's quality of life.

Assessment skills

Act like you've only got fifteen minutes, it'll take all day. Act like you've got all day, it might take fifteen minutes

Monty Roberts

The skills required to work with a client to enable an accurate and comprehensive assessment are not a distinct set of skills from those required to be a skilled clinician in the broader sense. What distinguishes this stage of the therapeutic process is the purpose for which these skills are used — to gather comprehensive and accurate information from a range of sources to inform the work.

Briefly, some of the broader essential skills and techniques that clinicians require to optimise the assessment process include the ability to:

- Establish and maintain a good therapeutic relationship.
- Keep focused on the agenda of the client.
- Support the client in the sharing of their story, particularly if it is painful.
- Assist the client to find hope and clarify their situation from their own understanding.
- Listen deeply for what is implied rather than just what is explicitly stated.
- Demonstrate an understanding of the client's beliefs, emotions and behaviours.
- Assist the client to identify and make meaningful connections between current concerns.
- Support the client to identify resources and strengths.

- Sensitively provide direct and honest feedback. Manage time in the session to ensure that enough time is allocated to various issues.
- To continue to participate in ongoing professional development to ensure knowledge, techniques and skills remain up to date.

If clients feel genuinely understood and valued, and if they have confidence in the clinician and the therapeutic process, then a good foundation has been laid for the work ahead.

In terms of content knowledge, specific knowledge is required for an accurate and comprehensive assessment to occur. Specific assessment content areas include:

- Knowledge of AOD screening tools.
    - What the screening tool is for.
    - How reliable and valid they are considered to be.
    - The strengths and limitations of the various tools.
- Knowledge of mental health conditions to be able to identify when a client has a co-occurring mental health problem and how to work with this to achieve positive outcomes for their AOD issues.
- Knowledge and skills in risk assessment.
- Knowledge of the stages of change model, which will be described in the next section, where the person is in this process, and how they typically makes difficult changes in their lives.
- An understanding of what broad domains in a client's life need to be explored to develop a comprehensive assessment.

Assessing complexity: What is important for treatment?

Sex, drugs, and insanity have always worked for me, but I wouldn't recommend them for everyone.

Hunter S Thompson

Given the prevalence of co-existing mental health concerns, it is important for the AOD clinician to be able to assess and respond to complexity. Familiarity with assessment content and process help to integrate assessment into the ongoing work. Four essential areas that complement the AOD assessment are:

- Mental health
- Risk
- Readiness for change
- Resources, strengths and values.

When working with complex presentations, the assessment may need to cover other areas of the person's experience more thoroughly. The two most common areas of mental health and risk are outlined here, as is the need to cover readiness to change and the client's resources, such as strengths and values.

However, there will be times when we come across presentations we are have not worked with before, and may need to seek guidance from someone who specialises in that area. For example, we may not have worked with people who grew up in a war zone, identify as transgender or have a history of anorexia.

It is important not to assume we know what to ask and how to take these unfamiliar aspects into account in the work. It is also good to get a sense of what specialist services might be available for the client and the circumstances under which a referral would be a viable option.

Mental health

Many clients presenting at AOD services have layers of serious challenges that impact adversely on their lives. These include relationship problems, accommodation issues, financial difficulties, employment problems and legal problems, to name a few. Mental health concerns are also very prevalent in this client group.

It is extremely important for AOD clinicians to be able to recognise co-existing mental health concerns as the combination of mental health and substance misuse problems has a significant impact on the treatment process and outcomes.

For clients with co-existing mental health issues, treatment needs differ compared to clients with substance misuse alone. Research shows that outcomes for these clients are much worse if their mental health needs are not addressed alongside their substance misuse issues. This includes a more complex recovery processes, greater levels of self harm and suicide, and higher number of hospital admissions.

Therefore it is important during the assessment process to determine whether there are any current significant mental health problems. If there are, and the presentation is serious or unfamiliar for the AOD clinician, further professional consultation may be necessary to determine the best way forward for the client, including referral options. This may include seeking permission from the client to speak with an existing or past mental health clinician or consultation with a dual diagnosis specialist.

Either way, the presence of mental health concerns increases the complexity of the work, as well as the likelihood further input from other professionals could be valuable, if only to check we are aware of all of the implications for the client or evaluate the most appropriate avenues for treatment.

How does having a mental illness affect therapeutic engagement and work?

Given the high prevalence of co-existing mental health and substance misuse problems, it is an essential skill that clinicians be able to recognise the presence of mental health issues and have an understanding of the likely effects on the therapeutic relationship and outcomes. This is particularly important when the focus of treatment is substance misuse issues rather than mental health per se.

Below are some common co-occurring mental health issues and just a few of the possible effects on the therapeutic relationship and outcomes. While this is not a comprehensive list, it gives an idea of how much we are trying to take into account when we are working on a specific behaviour, such as substance use.

- A client with depression may:
    - Recall historical information in a negative light, unduly biasing the quality of information obtained from the assessment.
    - Be inclined to interpret the clinician's comments as judgemental and critical of them.
    - Be inclined to dismiss positive feedback as inaccurate or superficial.
    - Miss appointments due to low motivation and energy.
    - Consider minor setbacks as major disasters and evidence that they are hopeless or a failure.
    - Feel particularly stuck in their ability to change, viewing their situation as hopeless.
    - Have difficulty recalling previous session content due to poorer memory associated with depression.
    - Consciously or unconsciously undermine their own therapeutic gains to maintain their more familiar negative self image.
- A client with anxiety may:
    - Have difficulty concentrating in session due to intrusive thoughts, agitation or distress.
    - Have difficulty being open or honest with a clinician for fear that the clinician will evaluate them negatively.
    - Have difficulty fully engaging in therapeutic conversations for fear that something may go wrong.
    - Miss appointments or avoid aspects of treatment due to anxious responses.
    - Be reluctant to reduce substance misuse even if it is their goal, for fear of being overwhelmed by their anxiety.
    - Replace substance misuse with other harmful strategies to avoid distress.
- A client with a history of trauma may:
    - Behave unpredictably in session as traumatic memories may be triggered.
    - Be hyper alert and extremely reactive to sudden noise or movement.
    - Dissociate or otherwise seem to lose touch with their usual awareness of what is going on around them.

- Want to avoid particular topics, making assessment and treatment more challenging.
- Have developed further symptoms of anxiety or depression.

- A client with psychotic symptoms may:
  - Find it difficult to attend to the conversation due to hallucinations or delusions.
  - Find it difficult to trust or be overly suspicious of the intention behind assessment questions.
  - Experience complex reflections as overly intrusive or mind reading.
  - Incorporate the clinician into delusional content.
  - Find it hard to engage with the full treatment process due to disorganised thinking.
  - Have difficulties with memory and motivation.
  - Have negative symptoms that appear similar, and are associated with similar difficulties, to depression.

- A client with a presentation consistent with personality disorder may:
  - Have difficulty being open with the clinician due to concerns about being perceived as weak, vulnerable, incapable or somehow thinking, feeling or doing things 'wrong'.
  - Be extra sensitive to clinician comments and perceive slights or insults when none were intended.
  - Be suspicious of the clinician's intentions or sincerity, and may have a history of unpleasant or ineffective encounters with previous workers.
  - Have difficulty focusing on therapeutic aims due to frequent crises that draw attention away from the intended issues, and the clinician may share in this difficulty.
  - Be highly attuned to the relationship being formed and respond in extreme or personal ways, such as idealising or disregarding the clinician.
  - Come to over-rely on the therapeutic relationship for meeting their needs if the relationship is perceived to be positive.
  - React with hostility if the relationship or clinician is perceived in a negative way.
  - Have unpredictable and seemingly uncontrollable bouts of emotion that cause significant distress and distract away from the therapeutic objectives.

Assessing and responding to mental health concerns

Although AOD work is a specialist area in its own right, we cannot afford to ignore our clients' mental health as it is a core influence on their experience of themselves and their world. Co-existing mental health and substance use concerns also tend to influence the other in their development, severity, circumstances of relapse and response to treatment. Focusing on the substance use and ignoring mental health concerns is likely to mean the work on the substance use will be less effective.

Every AOD worker realistically needs training in mental health conditions and, given the complexity of the field, ongoing professional development and supervision throughout the duration of our work in the sector. There is always more to learn.

A specific skill that is very useful in checking in with how a client is going is the Mental State Examination (MSE). Briefly, the MSE is designed to obtain information that provides an insight into the client's mental experiences and behaviours, at the time of the session. It is based on both observations of the client made by the clinician as well as inquiry into the client's thoughts, feelings and behaviours. It is not diagnostic, but can be used as a guide to determine whether a specialist assessment is warranted. There are eight broad areas covered, each with their subcomponents:

- Appearance and behaviour
- Speech
- Mood and affect
- Form of thought
- Content of thought
- Perception
- Sensory awareness and cognition
- Insight.

It is important AOD clinicians have a sound understanding of the MSE and the basic concepts to identify signs and symptoms of underlying mental health concerns, or to monitor how a client with a known condition is going.

Information about how to conduct the MSE and how to make sense of the responses is readily available in standard mental health text-books and online. However, it is preferable to learn about the MSE from an experienced mental health clinician in a skill-development workshop.

The MSE can help inform the clinician's views and discussion with the client about whether:

- Continuing to engage in therapeutic work is suitable at that moment.
- Additional support of a GP, other helping professional or consultation would be beneficial.

- The client may benefit from further psychiatric assessment and intervention before focusing on the AOD work.

As people's mental health fluctuates and the MSE is focused on capturing what is going on for the person 'in the moment', it is best do the MSE at regular intervals to see how they are going and check if symptoms are getting better or worse. As with other assessments, this does not need to be intrusive or time-consuming. Rather, it involves careful observation of the client and asking about particular topics that need not be out of place in a regular session.

For example, we can ask low key questions to enquire about mood, such as "I am interested to know more about how you have been feeling over these last few weeks?" or "How are you feeling today?" We can check in with thought content with a simple question such as "What kinds of things have been on your mind lately?" Similarly the skills you use in other areas of your work are highly relevant here too, such as validating the client's feelings and experiences, active listening, showing empathy and clarifying comments.

Where there are alcohol and other drug issues, consideration needs to be given to factors that may affect the presentation in session, such as when the client last used a substance, whether the client is currently intoxicated or experiencing withdrawal symptoms and whether there is any acquired brain injury from substance use or associated life events. If a client is heavily intoxicated or experiencing withdrawal symptoms, an MSE may have limited value but may still provide a brief snapshot to guide how we respond to the client in the moment.

Sometimes checking with the MSE will highlight concerns that may require immediate action. In these circumstances it is important to inform a line manager or supervisor of the situation and follow your organisation's policies and procedures, as well as your professional ethical obligations.

If the concerns arising are about risk to self or another, and the client is known to their local Clinical Mental Health Service, then it is advisable to contact their case manager or duty worker with your concerns. If the client is not engaged with their local Clinical Mental Health Service then they may need to be encouraged to go the nearest emergency department or their general practitioner. Ideally, we should try to discuss our concerns prior to contact so the GP or emergency department is informed and ready to handle the situation in the most helpful way for the client.

In the situation where the client declines to seek additional help and the clinician is concerned about their risk to self or other, then it may be the case that police or other emergency services become involved. In these cases breaches of confidentiality are protected by legislation. In all of these situations, careful documentation outlining actions taken and reasons underpinning them should be made, preferably including consultation with a line manager or supervisor who supported the course of action taken.

If concerns arise from the MSE that are not urgent but important, and the client is engaged with their local Clinical Mental Health Service, it is a good idea to contact the case manager or duty

worker to discuss the issues further. If the client is not involved with Clinical Mental Health Services, then a referral to their general practitioner for further assessment may be appropriate.

Many regions have specialist dual diagnosis workers whose role is to help build the capacity of AOD and mental health services to recognise and respond effectively to people with co-occurring mental health and substance use concerns. Such workers may be able to offer consultation and advice where there are challenges in providing treatment or in linking a client into a service that can provide a needed treatment.

Risk assessment

A very important component of any AOD assessment includes an assessment of risk. Risk is an extremely broad term, and in a general sense it means the probability of a particular outcome, usually adverse. For example, the risk of losing access to children, substance-related health problems or becoming homeless.

Assessment is an opportunity to check in with the client's level of risk, with an attention to two different key dimensions — the degree of likelihood of harm and the degree of possible severity or impact of harm. Different settings and client groups will affect the risks that are seen to be most prevalent, and there will be times when it becomes important to consider the welfare and wellbeing of others, such as dependent children.

Two very specific kinds of risk, however, are essential to monitor — risk to self and risk to other. This makes sense, given the severity of possible outcome and importance of protecting and preserving human life.

Sadly, we work with groups of people where suicide, self-harm and violence are far more likely than within the general population. Therefore, it is essential that risks to self and others are routinely assessed with every client at numerous intervals throughout the therapeutic contact.

Having said that, assessment of risk to self and other can feel like a daunting therapeutic undertaking. Some clinicians describe the experience as anxiety provoking, uncomfortable, intense or intrusive. It is often these aspects of our work that follow us home or play on our minds, leaving us wondering if we have done enough or missed something.

One common concern associated with risk assessment is whether asking about risk increases a client's level of risk by 'putting ideas into their head'. Research has clearly shown that this is not the case. Asking about suicidal or homicidal thoughts or intentions will not cause someone without these thoughts or intentions to become suicidal or homicidal. Rather, more harm may be done by not asking these questions and therefore not supporting the client to identify meaningful alternative actions or actively manage their risk.

One of the best ways to manage these experiences is to become very practiced and familiar with assessing risk. One aspect of this is to become familiar with the content of risk assessment: being confident that the important questions are being asked in each of the two risk areas. The other aspect is familiarity with the process: how to ask the questions so that the conversation continues to flow and the client continues to feel cared for.

Where risks are identified but not imminent, it is helpful to think ahead and imagine the scenarios in which risks may escalate and the ways they may be expressed. Knowing something of the client's 'risk signature' can then assist you, the client and significant others to develop practical risk management plans for both mild and severe elevation of risk. These plans should be clearly documented on file for easy access. Plans might include nature of risk and to whom, strategies the client agreed to implement, key people to contact and their roles, and detailed crisis management plans for high levels of risk.

If you assess the client's risk of suicide or homicide to be high and imminent, the guidance is the same as for concerns arising from conducting the MSE but with increased urgency and careful attention. In short:

- Discuss your concerns with the client in a supportive and matter of fact way and keep them informed as much as is reasonable on any actions you are taking in response to the identified risk, unless doing so may increase the risk to you or others.
- Your line manager should be informed of the situation and action taken in accordance with your organisation's policies and procedures and your professional ethical obligations.
- If the you have an additional supervisor, you may wish to share the concerns with them for further guidance and support.
- If the client is known to their local Clinical Mental Health Service, the case manager or duty worker needs to be informed of the elevated risk.
- If the client is not engaged with their local Clinical Mental Health Service then they may need to be encouraged to seek urgent care from the nearest emergency department or general practitioner. To give the client the best chance of receiving the care they require, it can help for the clinician to phone ahead so the service can be alert to the client's attendance and needs.
- If the client declines to seek additional help and you are concerned about their risk to self or other, then police or other emergency services may need to become involved.
- All steps taken must be carefully documented, including the conversations with the client and other professionals, conclusions and their rationale, and the actions taken.
- Seek support and increase self care behaviours, as high risk situations are stressful for all concerned.

The reality of working in the AOD area is that self-harm, suicide and violence towards others does occur and that an investigation following these tragic events also occurs. The purpose of these investigations is to identify systemic weaknesses with a view to strengthening them.

However, these investigations are often experienced as extremely stressful for the clinicians involved and having detailed documentation of the risk assessments and outcomes is of great benefit both for the investigation and for the clinician. Each clinician should be fully aware of their organisation's policy and procedure in relation to risk to self and other, as well as their professional obligations, in the event that a high risk situation is identified.

Formal training in assessing risk to self and other is highly recommended and should be refreshed at regular intervals to ensure risk assessment practices are sharp and up to date. Fortunately, there are many training courses around that support workers to develop up their knowledge and skills in this area.

Supervision and secondary consultation also provide a valuable opportunity to address risk assessment issues and it is highly recommended that both of these avenues are pursued until the clinician feels competent in risk assessment. Regardless of experience, supervision and secondary consultation should again be sought when elevated risk is identified to ensure the best course of action is selected under the circumstances.

The importance of being competent in the area of risk assessment cannot be overstated, as the objective of any clinician must be to preserve life. We also need to be mindful of the fact that we are not mind readers or fortune tellers. Sometimes clients choose to withhold information or a situation dramatically alters from one session to the next.

A broad and comprehensive assessment based on a variety of sources, with frequent risk assessment, reduces the chances of serious risks to self and others going undetected but sometimes bad outcomes occur despite good practices. Good supervision is essential when distressing events occur to our clients or those around them. This work affects us and it won't help anyone if we become another casualty of the pain within our client's lives.

Assessing change process and readiness

Treatment essentially involves inviting the client to do something different so that things be different in their life. That is not to say external forces or biology do not have an influence, but the focus of therapeutic work is essentially the task of trying to find meaningful change that is within the control of the client.

We all have ideas about how change is supposed to happen. It can be very helpful to assess the client's expectations about change, and their expectations of themselves in the change process.

Equally it can be valuable to get a sense of how they see our role and how they think we may help or hinder the process.

- How do they perceive change?
- How do they expect change to happen?
- What do they expect will happen if they did make change?
- How are they attempting change?
- How have they attempted change in the past?
- How they successfully made change in the past?
- How do they want to attempt change this time?
- What challenges do they anticipate?
- What they think might help to protect their attempts to change?

A starting point is to get a sense of where they are in relation to both making change and engaging in treatment. Prochaska and DiClemente (1982) offered a now well-known framework for identifying readiness for change, which included the following stages:

- **Precontemplation**: The person does not see the reason or need for change.
- **Contemplation**: The person sees benefits or possibility of change but has not made a decision to change.
- **Determination**: The person has decided to change and is working out how best to go about it.
- **Action**: The person has started the change.
- **Maintenance**: The person is keeping the change going.
- **Lapse**: The person has had a set back and has returned in some way to previous behaviours.

It can also be useful to get a sense of how the person is *feeling* about change:

- **No intention**: The person may feel resolved, resigned, rebellious or relaxed about not making change.
- **Ambivalence**: The person feels pulled in two directions, with no clear sense which way they will go yet.
- **Possibility of change**: The person feels curious or interested in change but is not yet certain what they want to do.
- **Commitment to change**: The person feels resolved that change is the best option, and they may also feel excitement or apprehension.
- **Action**: The person feels ready and able *enough* to take a step.

Naturally someone may fluctuate in and out of different stages in the change process, but may be more strongly in one than another at any given moment. They may also be at different points for different changes. For example, they may ambivalent about changing their substance use but open to working on their depression. Or they may be committed to changing their substance use but ambivalent about engaging in treatment with an AOD service to do so.

If we can determine where the person is in relation to making change, we are then better able to align what we're doing with where they are at and what they are ready for. Our aim is only ever to see if they may be able to move into the next stage, while never expecting that they will or even should.

There is no right or wrong place to be in the change process, it is more a case of observing where they are and meeting them there. We only move on to the next stage if the person is ready. Working with change is a bit like gardening — we do the thing that is most needed at that point in the growing cycle. If we are at the beginning, we might start by simply enriching the soil and see how that goes. It's not a time for planting, pruning or harvesting.

Assessing resources, strengths and values

Of equal importance to assessing problems and opportunities for treatment, we need to assess for resources. What's going well? What are they good at? What supports do they have? What motivates them? Who is important to them? What makes them feel good about themselves? What opportunities do they have? What does 'quality of life' mean to them? In particular, we want to ask what are their core strengths, values and hopes.

Strengths go beyond skills. They are those personal qualities we draw on in everyday and exceptional circumstances, such as courage, flexibility, determination and creativity. Strengths are separate from the purpose for which they are used; to survive ten years of heavy heroin use a person may draw on many strengths to do dangerous or even destructive behaviours. Those very qualities are the same ones that may help them to face the significant challenge of overcoming addiction, long standing habits and a way of life.

Values go beyond likes. They are the core of who we are, what is important to us and gives other aspects of life its meaning. Values are fundamental and yet can be hard to articulate, and may have become hard to access in the face of ongoing or chronic adversity. Values exploration exercises such as the Values Card Sort (Miller, de Baca, Matthews & Wilbourne, 2001) may be helpful in clarifying and strengthening the person's relationship with these driving forces.

Hopes go beyond goals. What kind of a life do they want? What kind of life would be worth putting in the hard work of making change without guarantee of succeeding? What is it they want to be different in their life as a result of treatment or making change?

Formulation: What do we make of the information we have?

You never really understand a person until you consider things from his point of view... Until you climb inside of his skin and walk around in it.

Harper Lee

Formulation is an attempt to develop a more coherent understanding of what is going on for the client. Different theoretical models approach formulation differently but share the common aim of focusing the work. As a starting point, information can be structured around the Six P's:

- Predisposing factors
- Precipitating factors
- Perpetuating factors
- Protective factors
- Personal reactions
- Patterns.

Assessment is only one part of the process. The skill of formulation is one way that we try to make sense of the information we have gathered. And yet there are very diverse ideas about what we mean by formulation, let alone how we might do it. The only thing we do seem to agree on is that there is no one agreed understanding and that it is typically under-taught and under-utilised as a valuable tool of clinical work.

Eells (2007) defines formulation as "a hypothesis about the causes, precipitants, and maintaining factors of a person's psychological, interpersonal, and behavioural problems" that serves to organise the information, make sense of inconsistencies, provide guidance for treatment, deepen empathy and alert the clinician to challenges that may arise in treatment.

Eells further highlights some of the tensions facing clinicians in engaging in the formulation process:

- **Immediacy vs comprehensiveness**: We need to find a balance between being practical and being thorough.
- **Complexity vs simplicity**: We need sufficient detail to be meaningful, but not so much that it is inaccessible.
- **Clinician bias vs objectivity**: We need to take into account that clinicians' judgements are notoriously flawed but more objective, consensus based methods are prohibitively expensive, if even possible.
- **Observation vs inference**: We need to find a balance between observable description and inference of unverifiable psychological processes by ensuring a clear link between the observation and the more tentative inference.
- **Individual vs general**: We need to be aware and make decisions about the degree to which the ideas proposed are unique to the individual or relate to broader theories and understanding of human behaviour.

This section offers an opportunity to consider the formulation process and its possible relevance. It is recommended that anyone interested in developing skills in formulation seeks out further reading and supervision from a skilled clinician, and receives regular and constructive feedback on their use of the skills.

Different approaches to formulation

The method and purpose of the formulation process is heavily influenced by a clinician's preferred theoretical orientation regarding the information seen to have the most importance and the conclusions that may be drawn.

If you have a particular therapeutic orientation that guides your work, it can be useful to be clear on the underpinning principles and way sources of information are weighted differently from other approaches.

For example, psychodynamic and attachment approaches tend to place a great deal of weight on early childhood experience of parental relationships and their implications for the interpersonal style of the older adult. Psychodynamic theory may then include more focus more on unconscious processes and defences, while attachment theorists may look for patterns in the relationship styles that continue to be played out in adult relationships.

Cognitive Behavioural Therapy (CBT) tends to place more emphasis on the learning and reinforcement processes that shape or maintain thoughts, feelings and behaviours. Schema Therapy looks for patterns of both relating and beliefs that now shape the adult responses to the world.

Humanist therapies would approach formulation with great caution, if at all, preferring to work more with making sense of the moment than creating a global picture. Motivational Interviewing, based in humanist tradition, tends not to dwell on historical information or causes of current difficulties, preferring to use the time to explore the person's current relationship with their dilemma, the possibility of change and what would be a truly meaningful next step for them.

Mindfulness-based approaches equally spend less time on the history or the specific cause of the concerns. Instead the focus is more on attending to here and now sensations and reactions to be able to live more fully in the present. Narrative therapy comes from a more post-modern perspective that believes there is no one objective 'truth' and instead seeks to help people to rewrite their stories.

What each approach has in common, however, is the importance of trying to understand the client's experience in a way that could help lead to positive change, even though they may differ radically on the ideas of how that change may best occur.

For our purpose, formulation is an informed understanding of the challenges the person is facing and offers some clarity on a next step they could take toward a more positive future. At its best, formulation synthesises a large amount of information into a brief, working summary of what is going on for the person that both validates that their suffering is genuine and inspires hope that life could improve.

The six Ps

The formulation takes information gathered through the assessment and each encounter with the client and tries to make some sense of it. Formulation is a learned skill and one that is hard to master without coaching and supervision from a skilled practitioner.

Underpinning most approaches to formulation is the idea that we want to look both to the present and the past for sources of understanding. Different theoretical models may value certain kinds of information more highly than others, and draw on vastly different assumptions, but the core sources remain similar.

The 'Four P's' approach to formulation captures the core kinds of information most approaches draw on:

- **Predisposing**: The long term vulnerabilities arising from genetics, development and early life experiences
- **Precipitating**: The triggers and factors that contribute to the current concerns emerging
- **Perpetuating**: The factors that contribute to the concerns continuing

- **Protective**: The strengths, resources and other factors that contribute to resilience, or contribute to the concerns not escalating further or reducing.

Each of these can be further broken down into type:

- **Biological**: genetic, organic or acquired
- **Psychological**: learning and reinforcement processes that shape our behaviours, thoughts, feelings and adaptation to stress
- **Familial**: Family relationships, dynamics and events
- **Social**: Broader social relationships, dynamics and events.

The Four P's give us a useful framework but we need to be clear it is not in itself a formulation. Rather, it is a process of sorting out the data so we can look at the picture more clearly. It is what we do with the information that guides the formulation process.

Put altogether, the Four P's create a table of information that may be relevant to the presenting issues. The structure helps us to think about the client in a more systematic way. It may then allow us to see patterns or themes emerge that might be useful in our work with the client.

It may also highlight areas of the client's life or experience that we do not yet know about that may be useful to explore further with the client. However, by itself it doesn't give us much guidance on how to make sense of the information.

So what how might we use the Four P's to provide more structure for the information we have? Let's take the example of the following 31 year old male client who:

- Is mandated to attend AOD counselling as part of his corrections order
- Presents with alcohol dependence and regular amphetamine use
- Demonstrates a moderate level of verbal hostility with no physical aggression
- Clearly expresses that he does not want to attend counselling and thinks it is a waste of his time
- Has engaged enough to offer personal information during the assessment process, but we do not feel we have a strong working alliance as yet.

We can combine his self reported information with details from his referral report and conversations with his Corrections Officer into the Four P framework to see if it helps provide more clarity in the situation.

It can also be a useful step to engage in a practical task such as this to sit back and gain more objectivity if we have been finding it difficult to engage with the client or manage our own natural reactions to the way he communicates with us.

The four P's

Four Ps	Predisposing	Precipitating	Perpetuating	Protective
Biological	History of alcohol use in family.	Sensation seeking. Starts to get withdrawal symptoms.	Enjoys feelings of intoxication. Avoidance of withdrawal symptoms.	Relatively healthy, liver function in normal range, no diseases from shared needles.
Psychological	Heavily critised by father for being weak. Beliefs about male identity. Life should be exciting and fun.	Feeling vulnerable and inadequate. Wanting to reassert masculinity. Feelings of boredom.	Intermittent but on-going feelings of vulnerability. Substance misuse relieves boredom. Substance misuse feels good.	No concurrent major mental health problems. No suicidal ideation.
Familial	Father very aggressive. Father abused substances. Other brother also has problems with alcohol.	Family gatherings, conflict in family.	Beliefs about masculine identity within family. Family patterns and habits.	Mother does not have substance abuse problems and encourages him to cut down.
Social	History of friendships with others who abuse substances. Need for a sense of belonging and 'mateship'.	Spending time with friends. Feelings of boredom.	Sense of belonging. Feelings of excitement.	New girlfriend does not abuse substances.

While not explicit in all models of formulation, we could add a fifth P: Personal. This category offers an opportunity to capture our personal observations and reactions that may in some way provide an insight into the client's world and experiences.

- What is my impression of this person? Who do they remind me of? Why?
- What is my impression of how the work is going?
- What bigger patterns am I beginning to notice across sessions?
- What am I sensing or feeling in response to this person? E.g. anxiety, affection, threat, anger, boredom, respect, confusion, frustration, desire, judgement.
- How is this different from how I typically feel?
- Does this offer any insight into how the client is feeling? E.g. I feel confused or threatened because the client feels confused or threatened.
- What is the urge that comes with these feelings? E.g. avoid, punish, protect or switch off?
- What is different in how I work with this person compared to my 'usual' practice?

- Do others feel this way?
- Are there any patterns in the way I and others respond to the client?
- Might these feelings help inform what their experience of the world and relating to people may be like?

The 5th P: Personal reactions

Personal	**Impression**	**Feeling**	**Urge**	**Possible relevance**
As a person	He seems to have a high need for dominance.	I don't like him.	I don't want to keep working with him.	He may often have the experience of people not liking him or wanting to withdraw.
As a client	He seems arrogant and hostile with fleeting moments of vulnerability.	I feel intimidated by him.	I want to passify him and avoid any confrontation.	He needs a high level of control and will be very sensitive to any comments or feedback I give him.
Our work together	Our sessions are feeling blocked, superficial and ineffective.	I feel frustrated and stuck.	I want to give up and conclude that he is not able or willing at this point to make change.	He feels ambivalent, frustrated.

While we need to be very careful that our reactions may be reflecting our own needs, biases or patterns, they can be a useful source of information to consider. This is not something to judge, even if the reaction is more negative, just something to notice and be curious about whether our feelings add any deeper insight to what is going on for the client.

It can help to ask what the person actively seeks out and what they don't. For simplicity, we can think of this as what they approach or avoid, although this does not suggest any value or judgement is being made, just an observation. We can look for patterns in their life in general, in their substance use and with us.

Where substance use is involved, we can specifically look at the role of the drug in this pattern. What does the drug help the person to experience, or experience more of? What does the drug help the person to avoid or experience less of?

We can also be curious about what the person approaches or avoids in their relationship with us. What do we have a lot of in our interactions? Where does the client seem most comfortable? What do we have little of in our interactions? What doesn't seem to interest them? What seems

uncomfortable for them? We can then look at these observations to discover if there are any common patterns or differences that might be of interest.

The sixth P: Patterns

Patterns	Approaches	Avoids
In general	Excitement, high risk situations, novelty.	Boredom, stability, 'mainstream', intimacy.
Substance use	Confidence, energy, excitement, feeling very masculine, belonging.	Boredom, withdrawals.
With me	Dominant, wants to be in control.	Letting his guard down, feelings of vulnerability.

While the Six Ps have not in themselves explained anything, the process can offer a valuable opportunity to reflect on the work and what might be the most helpful thing to do next. A summary of the Six Ps can be found in Appendix 1.

Using the formulation process to focus

As we have already discussed, the aim of the formulation process is not necessarily to 'get it right' or even complete. Undoubtably, a well-crafted formulation that meaningfully accounts for much of the presenting information with few unanswered questions can be valuable. However the process of developing the formulation is in itself helpful for both clinician and client.

The very act of trying to develop a formulation can help the clinician to focus their thoughts and find a way to articulate complexities that may at first be difficult to describe with clarity. The steps of formulation help take the mass of data of assessment and give it structure by asking the clinician to think through:

- What have I learned?
- How might these different details fit together?
- What is the most central issue we could address together?
- What could the client work on in treatment and beyond for the greatest benefit?
- How can we explain our ideas in a way that expresses compassion and hope?

This process provides the possibility of good answers but, perhaps more importantly, can raise even better questions for both the clinician and the client. For example, the clinician may discover that they had not explored a topic that proves to be quite illuminating or productive. In trying to fit

the pieces together, it encourages us to continually deepen our understanding and communicates they are worth taking the time to get to know and think about.

Rather than finalise a process, formulation may provide new avenues to explore in the work, supervision, secondary consultation and further reading to deepen understanding of both the presenting concerns and the best approach to treatment.

In itself this is part of treatment rather than a prelude to it — a process of exploration and enquiry that may provide a place for the client to find new clarity and energy for what they want to do next. We are also modelling a reflective process that may itself be helpful for clients to use for this or future dilemmas.

Above all do no harm

Already we can get the sense that this process is fraught with the potential for the formulation process to introduce new problems to the work. Research already suggests that clinicians' judgement is a valuable and yet flawed and biased tool that needs to be used with healthy caution.

A significant risk we all face is that of interpretative bias or inaccuracy on the part of the clinician and mistake formulation for fact — the risk that 'if it feels like it is true it must be true'. There is strong evidence that clinicians tend to over-estimate the accuracy of their intuition and once satisfied with an explanation tend to stop looking for competing or better hypotheses. The formulation may seem logical but fails to accurately capture what is actually going on for the client.

Another significant risk is to over-focus on the problems and develop a formulation that may hold some degree of 'truth' but be so negative or pathology-based it is unable to inspire hope in the client that things could improve with time and well-spent effort. Likewise, we may err on the side of trying to be too comprehensive, again capturing some degree on 'truth' but in such a way it feels heavy and overwhelming for the client.

Formulation is a process to cohere and focus the work to increase the capacity for positive change to occur. If the best formulation we can develop does not do that, it is not sufficiently developed and should not be used to guide the work. It either needs to be abandoned or set aside until further information or understanding comes to light.

Conversely, formulation may be a useful process to use when the usual flow of treatment doesn't seem to be working or the complexity makes it difficult to know where to start. The end result may not be a complete or usable formulation, but the process may have been very helpful in structuring thinking and offering fresh perspectives or ideas.

Naturally it is our duty to minimise the risk of these biases. A starting point is for the clinician to be curious and aware of their own biases that have been shaped by their personal experiences,

cultural norms, professional training and the organisation within which they work. While we cannot make these biases go away, we can be increasingly aware that they exist and to continually seek information that disproves our viewpoint as much as seek information that may support it.

While there are many models of formulation available, the approach taken here is strength-based and speculative. We believe a good formulation should not only capture the difficulties the client is experiencing but also inspire hope and is only ever a guess that could be proven wrong at any point.

Principles of strength-based formulation

One sees great things from the valley, only small things from the peak.

G.K. Chesterton

Strength-based formulation is not about focussing on problems, but about understanding what might help improve the person's situation and inspire hope. Five core principles guide the process of an understanding of what is going on for the client that:

- Honours the client's dignity and humanity
- Makes sense of a diverse range presenting concerns or symptoms
- Locates the problem in changeable behaviour rather than the person
- Provides a direction for what could help
- Is only ever speculation and is never assumed to be fact.

A good place to start is to take a strengths-based approach to formulation as a way of trying to make more sense of both what is going on for the client and what might be helpful for them to invest their energy in to enhance their well-being.

The principles outlined in this section are incorporated into many approaches to formulation to varying degrees. In highlighting the importance of these principles, however, our intention is to highlight an approach that minimises the risk of creating formulations that are ineffective or harmful, and maximise the benefit for the client and the work we do together.

A good formulation can be like discovering a map when we are in difficult or unfamiliar terrain. It shows us where we have come from and suggests a path to place where we may feel better about ourselves and the life we are living.

A strength-based formulation is one that:

- Honours the client's dignity and humanity
- Makes sense of a diverse range presenting concerns or symptoms
- Locates the problem in changeable behaviour rather than the person
- Provides a direction for what could help
- Is only ever speculation and is never assumed to be fact.

Honours the client's dignity and humanity

At the heart of strength-based formulation lies compassion — a genuine desire to understand another human being and care for their well-being. Formulation is an opportunity to sit back and reflect on the whole person, rather than just focus on what hurts or is causing problems.

This begins with the premise that everyone has equal worth as human beings. There are no 'good' or 'bad' people, just people trying to get by as best they can given their life experiences and expectations of themselves and the world. That does not mean that 'bad behaviour' is condoned, rather it is seen as just that — behaviour with adverse or unacceptable consequences that may need to be addressed. We try to look at everything with curiosity, even when it is confronting.

A strength-based formulation has the potential to be healing in its own right rather than just as a prelude to treatment. It provides an opportunity to reflect deeply on everything you have learned about the client in a way that possibly few, if any, other people in their life do. By itself, this can be empowering, a demonstration of your belief in them and your commitment to their care.

Further, the formulation may be a starting point for the client to come to see themselves with fresh eyes and be able to treat themselves with more compassion, acceptance and hope. That alone can also be transforming.

Given the speculative nature of formulation, we have a great deal of choice about what we include or exclude and there will many different opinions as to what constitutes a 'successful' outcome.

A good rule of thumb is to ask yourself, "How would I feel if someone said this to me to describe my life?" If we might feel diminished, criticised, disheartened or angry, it probably won't make someone else feel any better either. Formulation is an opportunity to reflect on the person with honour and dignity, so that they may be able to embrace themselves and approach their future with both acceptance and optimism.

In summary:

- A good formulation comes from an attitude of intense curiosity and respect.
- A formulation is only of value if it has the potential to inspire hope.
- A formulation is not complete until sharing it feels like an act of kindness.

Make sense of a diverse range of presenting concerns or symptoms

To the man who only has a hammer, everything he encounters begins to look like a nail.

Abraham Maslow

One powerful opportunity provided by the process of formulation is to consider the range of concerns a client is facing and look for common underlying patterns or causes.

The hope is to identify something fundamental that is affecting the person across different areas of their life, where the presenting concerns are seen more as symptoms of the one core source rather than a string of separate problems.

One benefit is to simplify our understanding of 'what is not working' to something more manageable and focussed. When faced with ten seemingly separate problems it can be hard to know where to direct our efforts and we may find ourselves doing a little on everything and feeling like not much is changing.

Another benefit is to maximise the value of any effort put toward making change. For example, working on this one concern may not solve everything, but a carefully chosen focus may lead to improvements across a range of different life domains.

This is not to say that there is only one core problem underlying complex concerns or that every problem is under the client's control. Rather, if we can find a theme that is common across several area of their life, the person could put their effort into one change that leads to significant improvement, rather than split their energy or find it hard to work out priorities.

We see this where people are successfully guided by a core question or philosophy. For example, when faced with a dilemma, some people will come back to a fundamental question: "Will this contribute to my overall happiness or well-being?" or "What response will help me to be a good parent for my children?"

Another benefit of finding an underlying common concern is that it can help create more coherence across what might otherwise be seen as disconnected conversations. It's normal for people seeking help to have a number of problems on their mind. Conversations may bounce from one topic to another or plans for the next session become sidelined by a new crisis or source of distress. It can be easy for both client and clinician to feel like the topics are important but little is being achieved.

Developing a formulation invites us to go beneath the detail and ask, "What do these different stories have in common? Can we find something more central that connects them together to work on?"

Once we have a formulation that the client believes is meaningful and relevant for them, this can also help create coherence across diverse topics by highlighting the elements relating back to core concerns and using each example as a way to work further on that issue.

This can reduce the tension often experienced by both clients and clinicians on where best to focus the work — to pull back from immediate concerns can feel invalidating or unhelpful and yet to only work on immediate concerns can feel reactive and ineffective. Formulation can help to bring the two aims back together, acknowledging the immediate concern while continuing to bring attention back to ongoing themes.

So how do we find this needle in the haystack? A great place to start is by asking the client whether they have ideas about common themes they have noticed running through their lives.

- What thoughts have you had on what these different concerns have in common?
- What themes have you noticed?
- If you were to say one thing was the root cause of all these different concerns, what ideas come to mind?
- If someone who really cares about you was describing you, how might they explain the connection between these different concerns?

It can also help to start at the other end of the question and take two of the most common beliefs that lead to a thousand little actions that may cause problems for us in the long run:

- I'm bad (I believe or fear myself to be inadequate, unlovable, flawed, broken, dangerous, etc)
- The world is bad (I believe or fear other people are inadequate, unloving, deceptive, selfish, dangerous, etc).

A lot of us hold something of these two concerns to greater or lesser degrees. They are a normal part of the human condition and in smaller doses can even promote quite positive responses — a healthy note of caution, humility or concern for others' feelings.

In larger doses, however, they tend to elicit feelings of vulnerability or threat. The way we manage these feelings may bring relief in the immediate term but may create new problems in the longer term.

Another approach is to ask whether the person is over-using certain strategies that may be very functional or even necessary in smaller quantities but used to excess are contributing to problems.

For example, avoiding the things that cause us distress is a good strategy in many circumstances. But if we over-use avoidance, we may find it hard to learn to deal with those things and the distress may even get worse. We may also end up inadvertently avoiding many of the things that make us feel good in life.

Or if we over-rely on being independent and strong may mean we find it hard to learn to sit with the vulnerability that we experience in our lives. It can be helpful to ask:

- How does this person manage feelings of vulnerability or threat?
- How do these strategies work for them in the short term? What are the longer term consequences of these strategies?
- How do those strategies relate to the presenting problems?

While none of these questions may give you 'the' formulation, they are a good starting point and may help to discover ideas or guesses that can be tentatively checked out with the client. The aim is not to 'get it right' but to have meaningful discussions that help both of you to deepen your understanding and clarify where to go next in the process.

In summary:

- Go beyond the immediate concerns to the bigger picture.
- Try to simplify multiple problems to a more fundamental source.
- Honour both past coping and capacity for change.

Locate the problem in changeable behaviour rather than the person

While it can be helpful to understand why someone has the difficulties that they present with, we are more concerned with helping them to make effective change that improves things. The ideas arising from the previous process are not sufficient or helpful if they just give the person cause to feel worse about themselves or helpless about the future.

It may be accurate to state that a person has a persistent fear that they are inadequate or worthless. We know this is a common human experience. And yet, stated as such, it gives that person little to work with. If anything it would most likely be taken as another reason to feel worse.

A guess about what might be underlying the person's concerns is just the beginning of the formulation process. And formulation is just one part of the therapeutic process.

It is our responsibility to then think about their concerns in behavioural terms that supports the person's optimism that they can do something about their situation. What is it that they do that might be creating a self-fulfilling prophecy? What are they doing that they could be doing differently?

This is in no way an avenue to 'blame' the client for what they are experiencing. On the contrary, the aim is to place the power squarely back in their own hands so that they can make informed choices about what they want to do next.

Nor is it a denial that other people and events outside of their control may have had a significant impact on what is going on for them. Rather it is about discovering the aspects of their situation that they do have control over, rather than those they don't.

For example, a client's difficulties may stem from childhood abuse, which she could not prevent, and where she experienced great trauma. She cannot change that it occurred or that it affected her deeply — traumatic response is largely a normal reaction to an abnormal situation. Maybe her life spun out of control, maybe she held things together. Either way she has been badly hurt by the actions of another human being. Regaining a sense of control over her present, however, is probably one of the most powerful things she could attempt to do.

In summary:

- Knowing what is wrong is not enough.
- Long held or subconscious beliefs have a habit of proving themselves right.
- Things must be different to feel different.
- No matter how much others or history may have contributed to the problem, the starting point for change must be ourselves and what lies under our control.

Provide direction for what could help

The bad things, don't do them.

The good things, try to do them.

To purify, subdue your own mind.

That is the teaching of all buddhas.

Thich Nhat Hanh

The problem needs to be located not only in behaviour, but behaviour that is open to change through conscious, focussed effort. Ideally, the behaviour is simple to describe because if it is something fundamental, it will most likely be hard to change. One behaviour change done one hundred times may go far further than one hundred different single changes.

To change long standing habits is to change a way of being, where automatic reactions become new conscious choices. That takes time and practice. And there needs to be a clarity about what to invest that kind of energy in and why it might be helpful.

That is not to say that attempting to change several things at once is necessarily undesirable, but for a formulation to be most helpful it distills the possible changes into a more fundamental principle that can be applied over and over in a wide range of situations.

We see the value of this in approaches like Alcoholics Anonymous. While AA might not be for everyone, part of the movement's success is the clear, unwavering focus on one central goal:

abstinence from alcohol. In not continually debating with ourselves about our focus, we free up so much more energy to find a way of working toward it.

Given the speculative nature of formulation, it isn't possible to 'know' for sure that the understanding you have developed together is the best one or the most accurate. Our best guess could be proven wrong at any moment.

Therefore it is also helpful to think of the changeable behaviour being identified as a 'next step' or stepping stone. Of all the changes they could invest in right now, we are trying to identify something that is:

- Realistic
- Meaningful
- Would have benefits in more than one problem or domain in their life
- Would leave them in a stronger position to pursue future change
- Has minimal risk of harm.

Ideally it is a change that the person is both willing to attempt and would be a good stepping stone to future change. Sometimes the change is as concrete as 'ceasing or reducing substance use'. This one change may have significant benefits across their life, they have a history of success and are ready to try again. In this case we may have no desire to complicate the picture by looking for deeper concerns or chronic patterns.

However, sometimes it is not so straight forward and the substance use may be more intricately tied up with other deeper concerns. This is where deeper speculation may be of more value.

Of all the things the person could invest their energy in, what has a high chance of being of practical benefit, maybe even liberating for them? For example, it may be helpful to improve the ability to:

- Sit with uncomfortable emotions and resist the urge to engage in old habits
- Soothe high levels of distress or arousal
- Connect more meaningfully with others
- Take regular small risks to open up a more rewarding life
- Say no or effectively express needs that would normally be unsaid or suppressed
- Respectfully express needs that would normally be imposed or expressed aggressively
- Be kinder to oneself
- Be kinder to others.

The change just needs to be a logical 'next step'. It may not in itself dramatically improve the person's life or make the problems go away, but is at least opening up the potential for further change and is going in the right direction.

Again, it can help to approach the question of which behaviour to work on from the other end — the desired benefit of making change. We seldom go wrong increasing the following in our lives:

- Being kinder or more accepting of oneself
- Developing more positive, engaged relationships with others
- Reducing sources of new stress or conflict
- Developing greater capacity to tolerate and manage uncomfortable emotions.

If one of these areas resonates more than the others as a good place to start, we can track back and be curious what they are currently doing that minimises their capacity to experience these and what practical steps may help to increase them.

Another key concern at this stage is "What are they ready for?" It is one thing to identify a change that may be useful, quite another to feel ready or confident to attempt it — particularly if it is the very thing they have difficulty doing.

It is critical that this process be collaborative, driven more by curiosity than conviction about what might be helpful. The guiding principles of an approach such as MI may help navigate the difficult terrain of converting desire for change into a realistic plan that is trialled with focussed effort.

In summary:

- The change should be simple because changing is not.
- Look for change that is a good 'next step' and a stepping stone to future change.
- Change that builds emotional resilience, self worth or a stronger network of supportive relationships will increase capacity for future change.

Maintain curiosity and speculation

Thinking is more interesting than knowing, but less interesting than looking.

Goethe

A formulation never crosses the line into fact. It is, and will always be, guess work that might be proven wrong at any moment. The best formulations are the beginning of a good conversation, not the end of one.

Always assume you do not have all the facts and never will. Always wonder if the client has withheld a bombshell that would totally, utterly change your beliefs about what is going on for them. And assume that they may never tell you in the duration of your work together. Uncertainty is a given, not an obstacle.

Formulation requires us to be disciplined — to keep an open mind, be curious and not make assumptions. It is the art of asking good questions and sometimes we are fortunate to find useful answers. The scientific method is a good analogy:

- Every answer is a question until there are no more questions
- The best hypothesis is just waiting for a better hypothesis to come along.

The formulation process can also be grounding for the clinician working with complex issues as it helps us to:

- Keep wanting to learn more
- Try to understand rather than be right
- Be less likely to mistake speculation for fact
- Question our assumptions
- Look for what we don't see
- Listen deeply.

And test, test, test your guesses continually. What might be a better explanation? Does it explain all of the details? If not, why not? Try like mad to prove yourself wrong until you think there is no aspects of the client's presentation that are not consistent with the theory. And then question it all over again.

In summary:

- You are always missing information that might change your mind.
- Formulations are helpful guesses, not facts.

Applying the principles: Formulation in practice

A child of five could understand this. Send someone to fetch a child of five.

Groucho Marx

Applying the principles of formulation is a skill that takes time, practice and feedback from an experienced supervisor. It is more art than science. The ideas that emerge from the formulation process:

- Are the beginning of good conversations not the end of them
- Should be offered only after seeking permission
- Need to be shared sensitively and with an air of wondering
- Contribute to the treatment process rather than dominate it.

The components of a strength-based formulation outline our intention, not our method. Finding the method that allows you to develop formulations that are consistent with our intention is not clear cut, and is often a personal one.

At this point, the process of formulation is more art than science. In this section we will talk through some principles of moving from the data to a more coherent hypothesis, however there is no clearly prescribed practice that will get you there as yet. Formulation is a path of curious enquiry rather than a formula.

Let's take an example of a 50 year old male client who is drinking heavily. He presents with symptoms of anxiety and depression, is socially isolated and has a history of only a few brief, unsuccessful relationships. He lives alone and has been employed for many years in the same relatively low paying job that he finds unstimulating and doesn't enjoy.

He describes himself as shy and appears quite anxious. He has missed several sessions and worries that he is wasting the counsellor's time but states he wants to continue because he is miserable with his life and wants things to change.

We could list the problems he is experiencing:

- Alcohol dependence
- Depression
- Poor history of attachments
- Social isolation
- Social anxiety
- Impoverished lifestyle.

We could go on. When we list the problems it can be hard to know where to start. Of course we would want to ask him what he wanted, what he thought was the priority and what he was ready to work on.

But looking at it from a theoretical perspective, what is the best place to start? Take on all of them at once? Take them in turn? In which case, in which order? Choose two or three, in which case which ones?

Our training or role may invite us to focus on particular areas more than others. As a AOD worker we will probably want to start with the alcohol use. As a psychologist, we may be most interested in his mental health and history of relationships. As a social worker, we may want to focus on his isolation and accessing the practical supports that could be helpful. An occupational therapist may be wanting to know more about how he spends his time and what could give his life more satisfaction or meaning.

It can also be easy to find ourselves in circular thinking:

> *Why is he drinking too much?*
> *He's depressed.*
> *Why is he depressed?*
> *He's lonely.*
> *Why is he lonely?*
> *He's depressed.*
> *Why is he depressed?*
> *He's drinking too much.*
> *Why is he drinking too much?*
> *He's lonely.*

Or we can find ourselves in thinking that seems to close down possibilities:

> *Why is he drinking too much? He's depressed. Why is he depressed? He has depression.*

So let's apply the principles of strength-based formulation and see if it helps to open up any possibilities.

Make sense of a diverse range of presenting concerns or symptoms

It's possible that the list of problems might be symptoms or consequences for something more fundamental. We can see here that a good assessment process will be valuable in going beyond the presenting issues to find a new perspective that could be of value to the client to consider.

If we found a common thread across the alcohol use, depression, social isolation and unsatisfying lifestyle, it may help to simplify and focus the work and give the client more hope.

We can collate the data we have gathered and start by using the Six P's framework. The approach may not capture everything that is going on for this man, but it might help us to sift through what we have learned for meaningful patterns or themes.

The sorting process itself can be as helpful as the end result, and may highlight key areas that have not yet been explored. Then once the information is collated, we can look for themes or key words that seem to stand out.

Structuring the information: The Six Ps

Four Ps	**Predisposing**	**Precipitating**	**Perpetuating**	**Protective**
Biological	History of anxiety in family.	Tendency to quick anxiety response.	Alcohol eases anxiety in short term.	Relatively healthy, liver function in normal range.
Psychological	Parents very critical and he never felt he could please them.	Learned to avoid risk, possibility of failure.	Few experiences of positive relationships or success.	Some depression, but no suicidal ideation.
Familial	High tension and dissatisfaction in family upbringing.	Two brothers also have problems with alcohol.	Ongoing criticism, feels like 'the black sheep'.	Sister tries to keep him connected to the family.
Social	Shy, nervous, uncomfortable with others, history of few strong relationships.	Sensitive, easily hurt in relationships.	Isolated, few friends who also drink heavily. Perceives his job as unsatisfying with low status.	Sometimes attends AA and feels he is not alone. Shy but pleasant manner.

Personal	**Impression**	**Feeling**	**Urge**	**Possible relevance**
As a person	He seems nice.	I like him.	I want to keep working with him.	His sister and AA members like him and want to help.
As a client	He seems vulnerable, sensitive, easily hurt.	I feel worried and protective.	I want to go very slowly and gently in treatment, and give him lots of reassurance.	He approaches change very slowly and cautiously.
Our work together	Our sessions are feeling repetitive and ineffective.	I feel frustrated and stuck.	I feel caught between wanting to go deeper and keep it safe.	He feels frustrated and stuck too.

Patterns	**Approaches**	**Avoids**
In general	Safety, low risk, familiar situations even though they feel repetitive and unstimulating.	Risk, discomfort, situations out of his comfort zone where he might fail or feel out of control. Conflict, criticism.
Substance use	Soothing & relief.	Feeling lonely, stuck, miserable .
With me	Friendly, wants to please, offers positive comments and feedback.	Conflict, negative feedback, expressing frustration at lack of progress.

Another useful strategy is to use the Mind of a Five Year Old technique. Young children have a robust curiosity for nearly everything around them and are seldom satisfied with our initial explanations. This technique simply invites us to pose ourselves questions and respond to every answer with “but why?” until we feel we can’t go any further. This curiosity-based approach takes each answer as the beginning of the next question. For example:

> *Why is he drinking? He is depressed.*
> *Why is he depressed? His life seems to be depressing.*
> *Why is his life depressing? There seem to be few sources of pleasure or fulfilment.*
> *Why are there few sources of pleasure? Maybe he doesn’t seek them out.*
> *Why might that be? There is a risk of failing or getting hurt.*
> *Why might that be? Failing or getting hurt is bad.*
> *Why might that be? It would prove his fear that somehow he’s an inadequate person.*

The strategy may not in itself answer our questions but may help push our thinking further.

Locating problems in changeable behaviour

If our formulation is to be helpful, it makes sense of the presenting issues in terms of factors that are under the client's control. That is not to say that other factors have not been important or continue to play a role. For example, he cannot change the fact that his childhood was very stressful or that he may have a biological predisposition toward anxiety.

So if we look at the investigations above, we might guess that a common factor underlying several things that makes this man unhappy is to do with the way he protects himself from feeling vulnerable.

One strategy he seems to use, and perhaps overuse, is to act with caution and keep things safe. This may include avoiding certain situations or feelings, especially where there is a perceived risk of feeling uncomfortable or getting something 'wrong'. If it were true, it wouldn't be so helpful to simply suggest he tries to avoid avoidance. After all, it is very likely to be helping him in many ways and could be a very well-practiced response.

It may then be helpful to think what role this approach plays in his life:

> *How might the caution be helping him? Reduce feelings of anxiety and vulnerability, prevent a predicted negative experience, protect himself from feeling worthless.*
>
> *How might caution not be helping him? Also avoids positive experiences, doesn't develop a greater capacity to sit with anxiety or vulnerability, comfort zone remains small and unsatisfying.*

From there we could we translate 'over use of caution' into something behavioural and not so clinical that we could check out with him. For example, it might be easier to talk about him tending to stay inside his comfort zone or feeling uncomfortable with things that feel risky.

Provides a direction for what could help

If the client sees relevance in the idea and believes it does indeed relate to several presenting issues, the question becomes one of exploring what it would take to be able to pull back a little on a useful strategy that is being over used. This may also lead to discussion of what it might take to regain more balance in the approaches he uses, such as also increasing the ability to take small meaningful risks that might slowly begin to open up his world a little more.

This idea can be further extended to an exploration of values, where one value has become dominant — perhaps a value of caution, safety or security — and could be softened by bringing attention and curiosity to other core values, such as courage, adventure or stimulation. Rather

than compete, there is rich ground to be explored in how these values relate and enhance each other in working out what feels like a good, realistic next step for the client.

Note that the original hypothesis that there may be a fear of inadequacy that is simply used to inform the process, and is then left behind rather than be the focus, as it is a negatively framed concept with little practical hope embedded within it.

If the aim of the work was then to do counselling around his alcohol use, the idea of learning to build up distress tolerance could be very helpful in managing cravings while learning to take a series of small but consistent risks would be helpful in both attempting change and relapse planning.

How to introduce and discuss the formulation process in conversation

As already discussed, the formulation is the beginning of a conversation rather than the end of a process. The ideas generated by the formulation need to be carefully thought through to ensure respectful and productive use of the time spent together with the client.

It is important to have reached a point where the ideas within the formulation could inspire hope rather than simply describe a problem. As such, formulation as fuel for enquiry, not answers.

- First we need to have developed a strong sense of engagement.
- Prior to offering a formulation for consideration, it is helpful to test out small, safe elements of the bigger concept to see how the client responds both to feedback in general and your ideas in particular.
- Place the conversation within a broader process of affirming and validating the person.
- Seek permission to offer ideas for consideration.
- Use every day language the client will relate to.
- Normalise the idea that we develop ways of being and responding that served a purpose at some stage, even if they are now no longer as helpful.
- Suggest that this may be more a time to adjust and fine tune these patterns rather than needing to make a complete change.
- Offer ideas as just that — wonderings you would like to check out with them rather than interpretations or facts.
- Gently guide away from explanations that locate the problem within the person's character or diminish confidence that any change is possible (e.g. "I'm lazy, weak or no good").

- Show curiosity in their perspective and be guided by their thoughts and reactions as to where to go next in developing a shared understanding of what is going on.

For example, we could raise the ideas from our formulation process in a quite low key way:

> *I've been thinking about a range of things we have discussed and I'm wondering if there is a common thread running through them. I might be on the wrong track but would it be OK if I shared an idea I had with you?*
>
> *[He gives permission]*
>
> *You've described yourself as a fairly cautious person and that's been very helpful to you in dealing with some difficult experiences. Now that you're looking at making some more changes in your life, I'm wondering if it's worth talking a bit more about that. For example, if you're concerned things might go wrong, it might be tempting to want to stay inside your comfort zone and not take that risk. Does that seem at all familiar to you?*
>
> *[Clinician and client discuss this idea and what it feels like from the client's perspective]*
>
> *Would it be OK if we talked about how that might relate to some of the concerns that brought you in here? It could give us a clearer idea on what would help make a difference for you.*
>
> *[He agrees]*
>
> *It's such a natural thing to want to play it safe, particularly as you said you've had some pretty tough knocks in life, particularly when you were growing up. I'm just wondering if it's now protecting you from some good experiences as well and whether this might be a time to see if its possible to just make a few little adjustments so you get a bit more balance. How does it feel for you?*
>
> *[Clinician and client might then explore the idea in more depth, being curious if the idea fits, if it is helpful and if it helps shed light on what the client is interested to consider or try in making change]*

It is vital that the client is partner in this process. If a client disagrees with ideas we may offer, find out more about out how they see it instead. The aim is to find a shared way of looking at what is going on, rather than to gain their agreement that your initial ideas were right.

There is a delicate balance to be maintained at times between validating and agreeing, exploring and leading, finding new perspectives and disagreeing. The aim is to find hope and direction, while capturing the realistic challenges facing them.

Treatment trajectory: Where are we in the work?

Nature does not hurry, yet everything is accomplished.

Lao Tzu

The treatment trajectory is way of conceptualising the broader process of healing and work a person engages in over their life time. It asks us to consider:

- Where are we in the bigger picture?
- How can our work together best fit with what the person is ready for?
- How can we support the work they have already done?
- What can we do that would help prepare them for the next stage?

A useful concept is the 'treatment trajectory'. We can think about the course of the healing process over difference time scales:

- Across a session
- Across a course of treatment
- Across a lifetime.

The first two time scales inherently involve us, the clinician: What can we do in the time we have together? We think about our role, our resources, our training, our service structure. While these questions are important they can sometime restrict our focus to what is within our capacity as a clinician and as a service.

The treatment trajectory is something bigger, where the focus is squarely on the person and the course of healing a person may experience over months, years or even a lifetime. Rather than ask "What can we offer?" the question becomes more "Where are they in the course of healing and what do they need next?"

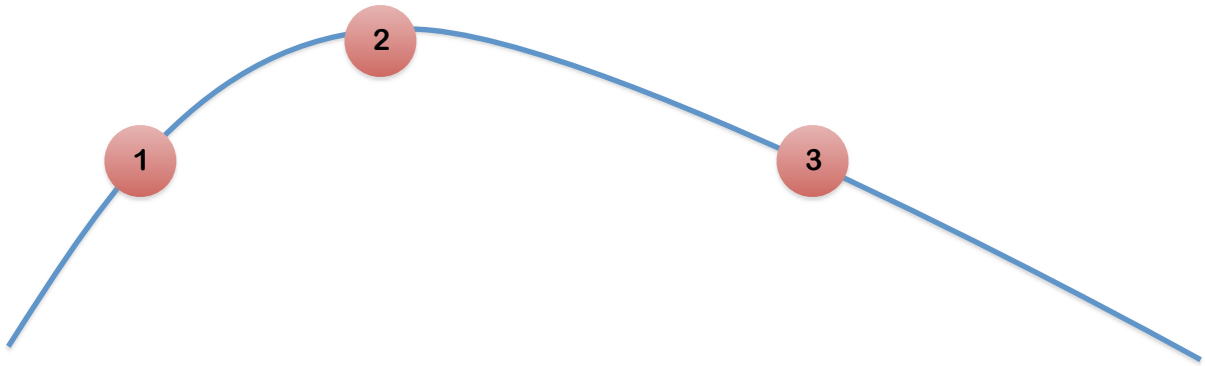
This question applies as equally to the work we do together as to the possible referrals we could make. Well-intended efforts to support clients has sometimes resulted in something closer to

Snow White and the Seven Referrals, where the client finds it hard to keep track of what each worker is doing and how it all fits together.

A useful mantra is ‘just because we can, doesn’t mean we should‘. All treatment and referral options should be carefully chosen based on what would be most helpful for this person at *this* point in time. Sometimes a well-chosen, small step sets the person up to be better able to make use of other resources later.

Applying the idea of treatment trajectory to the work

While everyone’s trajectory is different, we could take the example of someone who has experienced a significant trauma. The curved line on the next page represents the intensity of work they are doing on processing and recovering from the traumatic event. The numbered circles represent three different points where we may meet them in a AOD setting.



The treatment trajectory

At point one, the person is building up to some intensive work on the traumatic experience. At point two they are at their most ready to process the trauma. At point three a great deal of work has already been done in processing the trauma.

While as AOD workers we may never be the clinician who provides trauma counselling, it is important to get a sense of where the client is in relation to working through their trauma as a guide for what the person needs from us.

Pre trauma work

If we met the client at point one, it may be premature to advocate or encourage them to address their trauma as they are not yet ready. Instead, we may be trying to work out what we could do together that might help prepare them for addressing their trauma at a later stage.

We would want to be alert to signs of hyperarousal to be careful not to inadvertently overwhelm the client with exposure to trauma related material that they are not yet ready to deal with. In this sense we may need to act as the brake and accelerator pedals for the session, helping to moderate arousal and de-escalate flooding responses. It may not yet be possible for the person to aim toward being drug free (although this is entirely dependent on the person in question) as being sober may increase their traumatic response.

In terms of what we can do, this may be a time to look at the substance use and try to work on reducing the extremes, the risks and the greatest harm. This may be a good time to gently work on building up skills in emotional regulation. Assisting the client to develop their capacity to tolerate emotional distress and self soothe would be extremely helpful in both managing cravings and increase the chance the person may feel strong or equipped enough to attempt trauma work at a later stage.

During the trauma work

If we met the client at point two, we may initially be facilitating a safe and appropriate referral for treatment for the trauma as the person is now feeling far more ready to look at this difficult content.

If the person is already engaged in working on the trauma, the AOD work should ideally build on that work and use concepts that are consistent with the other treatment. This is not a time to overload a client with treatment models that seem incompatible or at odds with each other. This may be a time to gain permission to consult the trauma counsellor so that the three of you can work out the best way to all work from the same page.

The focus of the work at point two may be around risk management and dealing with strong cravings that arise in response to looking at the trauma. Our work may feel more like we are helping the person to stay focussed and feel contained enough to do the emotional work that they need to do.

After the trauma work

If we met the client at point three our work may feel more like consolidation, where we will be guided by the client as to what they need most to maintain the progress already made. Ideally, any work we do together will build on the ideas and strategies that worked best in the trauma work, rather than introduce entirely new or potentially incompatible frameworks.

This may be a time for intensive work on the substance use now that the underlying trauma has been addressed to some degree and they are now ready to let go of a significant coping mechanism that got them through. Perhaps the major work on the substances has already occurred and the focus is more on relapse prevention and strengthening alternate ways to manage feelings and feel good.

While the particular choices may differ from person to person, the principles remain the same. The challenge for the clinician is to look beyond the current work to help the client determine what is the most helpful next step for them.

Effective relationships: Navigating complexity in treatment

The meeting of two personalities is like the contact of two chemical substances: if there is any reaction, both are transformed.

C.G. Jung

Forming and maintaining authentic therapeutic relationships is a difficult task that requires us to be very self aware. Four grounding concepts can help anchor the work and offer guidance:

- Deep listening
- Boundaries
- Consistency
- Neutrality.

This work is challenging. It often feels like we don't have enough time or resources to support clients to make change. In addition, some of the challenges clients experience play out in our work with them.

For example, the person who is uncomfortable with conflict in their own life is likely to find it hard to tell us when we are doing something that upsets or annoys them. The person who uses aggression to meet their needs is likely to display some of that aggression toward us. When there is a co-existing mental health concern, it is highly likely there will be further challenges in engaging or supporting the person to make positive changes.

While our main focus remains the substance use, the nature of co-occurring conditions will influence how we are able to work with the client. The aim is to attend to the ways in which interpersonal processes may have an impact on the therapeutic conversation and how to incorporate that within the work rather than see it as an obstacle to the work.

This is not to say that this is the ideal way to 'treat' co-existing substance use and mental health concerns. On the contrary, there is considerable literature on the benefits of integrated care. Mueser et al (2003), for example, describe the benefits and weaknesses of three approaches:

- **Sequential care**: One condition is treated, then the other.
- **Parallel care**: Both conditions are treated at the same time.
- **Integrated care**: Both conditions are treated in a co-ordinated way that takes each other into account, either by the one clinician or by more than one clinician working in close collaboration.

However, truly integrated care may not be an option without sufficient training, supervision or ability to provide such care in that service setting. Yet in all of our work, we have a capacity to take the mental health concerns into account and minimise the risk of fragmented treatment that ultimately fails to provide adequate care to clients living with complexity.

In research into young people's experience of dual diagnosis services, the frustration of poorly integrated care is a common theme, as well as the importance of genuine, empathic relationships where the young person felt heard, understood and not judged (Russell & Evans, 2009).

It can sometimes feel like the mental health concerns are introducing new obstacles into the work; it can be tempting to find ourselves saying things like "If only they would attend treatment consistently, I would be able to work so much better with them".

And yet much of what we may view as obstacles to working on the substance use issues may be very much a part of why the person is experiencing problematic substance use in the first place.

Our challenge is to find a way to incorporate the whole person into the work, including those aspects that may seem difficult or confronting or belong to a different treatment modality.

For example, two of the most common concerns presenting with clients attending AOD services are depression and anxiety, both being common causes and effects of substance misuse. Rather than examine depression and anxiety themselves, it is useful to look at the way they may affect the work.

For example with depression, it is common for the clinician to face a seemingly unyielding pessimism or negative expectations. With anxiety, it is common for avoidance to be heavily utilised as a strategy to manage distress and discomfort and may well be used when facing challenges in addressing the substance use or in the treatment process as well.

A starting point is to look underneath the presenting difficult behaviour to understand what is driving it. There are many possible reasons that could lead to the same observable behaviour or challenging presentation.

Gaining as deep and objective an understanding of the nature of the concern is the key to informing how we might best think about it in a way that most respects the client and the clinician, and discover the most therapeutically beneficial way to respond.

As part of this process, it is also important to understand what is situationally specific and what might be a more pervasive pattern in the client's life that may underlie the substance misuse itself.

For example, the unique nature and demands of the therapeutic relationship may elicit responses that are not so common in other areas of the client's life. For example, the client may be reacting to the intensity of the therapeutic process of two strangers coming together to discuss highly personal and sensitive material, the difference in power, imbalance of control, and possible implications for the client, particularly those who are mandated to attend. Or they just might be having a reaction to us as a person.

On the other hand, the therapeutic relationship may act as a microcosm of the client's relational world where the patterns and responses they use and elicit in their everyday life may well be expressed during the duration of treatment.

The aim is to be curious about these challenges and what they may mean for the client, and to find a way of accommodating them into the work, rather than see them as an obstacle to the work.

Indeed they may even be a core part of what is going on for the client and why they are using substances in the way that they do. The hope is to find a way of taking these challenges into account and working with them, rather than 'fix' or ignore them.

Equally the hope is to find a way to be just as curious about our personal responses to them, rather than to try to eliminate our reactions or respond to them in an automatic or reactive way. Our own thoughts, feelings and urges can provide valuable information about what might be going on for the person, what is working for them and what isn't working so well.

While there are no simples rules to manage the complexities of interpersonal processes, several grounding concepts can be useful guides and provide anchors for ourselves and the work. Four key concepts will be covered here:

- Deep listening
- Boundaries
- Consistency
- Neutrality.

They help us to be alert to the challenges and use what we have to offer in the most effective way. They also help us to focus quickly, by returning to core principles of practice instead of trying to think through an appropriate response for every new situation.

The challenge is to bring an authentic and genuine self to the relationship while remaining consistent, thoughtful and disciplined in maintaining a focus on creating safety and an environment in which change may be possible.

Deep listening

I don't know what it is about listening. I just know when I'm heard, it feels damn good.

Carl Rogers

It's a given that listening is important and yet deep listening is not always easy when we are distracted by our various tasks, the complexities of the work and our own reactions to what is going on in the room.

We can think of listening as occurring on different levels:

- **Hearing**: I am attending to your words.
- **Listening**: I am attending to the meaning of your words.
- **Understanding**: I am making sense of your words by attending to you as a whole person.

Deep listening requires us to be fully present, focussed and curious about everything we are perceiving, including what we see, hear, sense and notice in our own reactions. Easier said than done and yet this is a powerful place to return to whenever we begin to feel stuck or unsure of where the work is going.

Boundaries

We are forming a relationship, and yet the therapeutic relationship is one where we respond consciously rather than react automatically. People can get automatic reactions anywhere. The idea of boundaries asks us to be grounded and aware in our half of the relationship. This awareness helps us to remain anchored in our deeper principles that apply across all our clinical work rather than simply act based on our here and now reactions.

Ideally, the clinician with healthy boundaries maintains a self awareness of how they are being and behaving in their half of the therapeutic relationship throughout the course of treatment and across different clients. Subtle changes in our usual practice may indicate slight slipping of our usual practice, such as how we behave, dress, speak, or react inside or outside of the therapeutic room. For example, we might find ourselves choosing a more conservative or casual outfit on the days we know we will see a particular person. Or we might find ourselves being unusually sarcastic or defensive when talking about the client with other workers.

It may be easy to ignore or rationalise these small changes as insignificant, but they may highlight key issues going on for the client. They can also act as an alarm bell that more serious shifts in

practice could be tempting or possible with this client. At the least, these little slippages are a sign that it will be important to seek some level of supervision to maintain perspective on the work and be mindful of the effect it may be having on us.

While we need to adapt our approach for different points in the work or different clients, our practice is based in how we best enact the same set of guiding principles in each moment. For example, we may start by being very gentle with a client who is very sensitive, then slowly increase the pace and level of challenge in the work as they develop greater resilience. Or we may start by being quite matter of fact and neutral with someone who has a tendency to see expression of emotion as weak, and then gently bring in more warmth as the relationship builds and the mistrust diminishes. The way you start isn't necessarily the way you finish but the common factor is that our fundamental sense of self and principles remain authentic and grounded.

Consistency

The difficulty sometimes is how to be authentic in a consistent way. Authenticity is not about simply being honest or open in the moment, but about being a safe, known quantity over time. The client may not always know what you will say or do, but they need to have a sense of who you are and where they stand with you throughout the process.

While we want to be responsive to the client, we also have to be careful about making exceptions to our usual practice, and if we do we need to have good reasons why. For example it may be tempting to be more casual or disclose more personal information with a client we like and feel comfortable with, while withholding the same behaviours or information from another client who is more difficult to engage or hostile in their manner.

Consistency asks us to question the therapeutic benefit of such exceptions and to hold the idea that they may even be counter productive. For example, the client who is very likeable may have a pattern of wanting to please others at the expense of expressing less comfortable needs or negative feelings. Rather than providing a friendly space for them, we may inadvertently be reinforcing that very behaviour that is causing suffering in their life.

Conversely, the client with more hostile behaviours may have a pattern of testing others' kindness because of a fear it is superficial and they will be rejected when the other person gets to know them. Withholding our usual warmth and care may simply reinforce this world view and we may have lost a valuable opportunity for something different to have been experienced.

Consistency also asks us to consider how it might feel for different clients if they sat down in a room together and discussed how they see us and what it is like to talk with us. While that may be unlikely, it is highly possible that different clients do know each other, particularly in the relatively small world of people who use substances heavily. And they do talk to each other. It would potentially be very disheartening and extremely untherapeutic for one client to realise that they had

not earned the privileges of another client or had not been shown the same degree of care and concern.

Neutrality

Neutrality is a stance of forming a relationship with the client that is genuinely about them and their needs, not our hopes or expectations. It does not mean that we are detached or do not care. Far from it, it is an act of discipline to create an open, curious space in which you can both discover what would be the best use of your time together.

It asks us to be aware of our values, strengths and professional expertise, and have these qualities inform our practice without imposing them on the client. While the theory is good, the practice can be very hard as we have blind spots and areas where our values and expectations are difficult to grasp. Sometimes we discover our assumptions or beliefs by working backwards, trying to make sense of a reaction or urge we had in response to the client. One of the best ways to protect our neutrality is to assume that we are not in fact neutral, and that we need to actively question our perspectives and be alert for our natural biases.

Neutrality means being acutely aware of our agenda or preferred outcome and keeping those hopes on the sidelines rather than be the driving force. Sometimes people choose paths in life that cause us concern, and there may even be times when we need to take action they would prefer that we didn't take such as notifying Child Protection or initiating an involuntary admission to a psychiatric inpatient ward. Our role is to assist people to make truly informed choices, based on acceptance and faith in themselves that they can live with, rather than settling for second best.

Challenges in practice: What might help?

People take different roads seeking fulfilment and happiness. Just because they're not on your road doesn't mean they've gotten lost.

Dalai Lama

The kinds of difficulties clients face in their lives will inevitably enter the therapeutic relationship in some way. These challenges can be seen as a part of the work where it can help to:

- Expect the challenges
- Be curious about them and what they mean for the client
- Be curious about our reaction and what they mean for the work
- Try to work with them rather than against them.

In this section we look at some of the challenges that arise within the therapeutic process. While these experiences are not exclusive to working with co-existing diagnosed mental illness, and it is possible to work with co-existing concerns without encountering these difficulties, they are common enough to be worth looking at them in more depth:

- Complexity
- Avoidance
- Pessimism
- Impulsivity and impaired memory
- Difficulty with trust and intimacy
- Emotional extremes
- Hostility.

The intention here is not to describe how to treat each presenting issue, but more to identify some of the key challenges that arise — how it may influence the AOD work, the relationship being formed and how we may take these concerns into account when treating clients with substance misuse.

We want to be curious about how these relationships form and evolve over time and the way they affect the work. Such attention to process is not simply about managing obstacles or difficulty in the work, but is a rich source of therapeutic information and understanding.

Complexity

Identifying a focal point for the work itself can be difficult. There may be multiple presenting issues with no clear starting point, or a sense of crisis or urgency that invites both client and clinician to try to do a little work on several things for little gain.

The formulation process can be valuable in identifying a deeper level issue that may be underpinning, or at least relevant to a range of the presenting concerns. It can be helpful to actually use the feeling of confusion or competing priorities as a starting point to gain understanding of how it might feel like for the client. Are they feeling confused, frazzled, spread thin in all directions?

If you can identify a common underlying theme, this can be reflected and highlighted across the multiple topics that are raised. For example, rather than simply reflecting on the topic at hand, we may reflect an underlying theme that connects different stresses or challenges:

> *So it's like you were saying before, when you get really stressed, you sometimes make decisions you then regret. And that finding ways to slow yourself down usually leads to choices that work better for you.*

A fundamental question is what would be most helpful in terms of protecting survival before we may be able to enhance life. It can be helpful to think of three broad phases of recovery and ask what stage is the person in and what best suits the phase they are in:

- **Acute**: In this phase, the person may be more focussed on day-to-day coping and survival. Key needs may relate to the basics of life: food, safety, shelter, illness or coping with intense cravings.
- **Consolidation**: In this phase they may be more focussed on creating and protecting stability, reducing the sources of new stress while getting more practiced at the things that feel good. This may not be a time to stray too far out of the comfort zone, but rather look for the little steps that go a long way.
- **Growth**: There may come a time when the carefully managed stability starts to feel restrictive and in this phase the person starts to feel ready to take calculated risks to experience greater quality and richness of life. The focus in this stage may be more on deepening relationships, and pursuing interests, goals and dreams.

It's not uncommon for people to feel more distressed at transition points, and may feel like they are back at 'square one'. However, the increasing discomfort may be a sign that they are ready to move into the next stage and that the strategies they have been using are no longer so suited to them.

For example, the person who has been in the acute phase may have used a lot of short term strategies just to get through each day. As they get ready for the consolidation phase, these strategies seem less effective because the day-to-day coping is much more solid and they are ready to work on the next layer of recovery.

In the same way, someone ready to move into the growth phase might start to feel frustrated with the safe routines of consolidation and may now be ready to introduce healthy risk taking to develop a more satisfying life.

It can be helpful to simply sit with the uncertainty and complexity, neither needing to act or give up, with an air of quiet optimism. This can provide useful time to reflect and offer a positive example to the client who is struggling with the complexity themselves.

Formulation may be a valuable process to help explore and consider the range of presenting issues to discover a meaningful and realistic focus.

Some questions worth exploring include:

- What does the client think is the main area of concern? Where are they wanting to start? Are they the same thing?
- Where are they in the treatment trajectory? What would be the most helpful next step or area of focus?
- Are some of the different concerns symptoms of the same thing?
- Is there one thing that would help set them up to manage better with a number of the presenting concerns?
- What next step has the most chance of giving the client an experience of success or feeling effective?
- What would be the next step if they were to start with damage control, taking the edges off the current difficulties rather than committing to completely new behaviours?
- Might having a positive experience of treatment, where they feel heard and respected, be a goal in its own right?

Avoidance

Avoidance is a form of self protection. It is often associated with ambivalence or anxiety about the choices available. It can potentially be a very helpful coping strategy, by protecting ourselves from danger, high levels of distress or unnecessary challenges.

Sometimes it is highly context specific — associated with particular thoughts, feelings or memories. It can also be a more pervasive reflex, a natural reaction to a deeper discomfort that may have been around for a long time.

Anxiety and the tension of unresolved ambivalence can be consuming. The urge is for quick, effective stress relief — short term strategies at the expense of long term gain. While substance use may be that short term strategy, misuse and dependence can also amplify anxiety and heighten the sensitivity to physical or emotional discomfort. Under such circumstances, the tendency to avoid can be reinforced in cycles of repeated tension and relief.

Over-use of avoidance itself can also deepen or prolong anxiety in the long run, by short circuiting the opportunity to develop alternative responses. Over time it can create a restricted world for the person, increasingly reducing sources of pleasure and growth to a repetitive and small comfort zone.

Avoidance may affect all aspects of the treatment process: behaviour change, the therapeutic relationship and treatment. Positive solutions often raise discomfort levels before any of the longer term benefits are experienced.

Avoidance may include behaviours such as not starting or completing goals or steps between sessions that the client had chosen to try, changing topics, lateness, or cancelled appointments. The clinician may feel that progress is being made in session with little being achieved overall. There may be a sense of apprehension or commitment from the client, but either way little change seems to be happening.

While this may be frustrating for the clinician, it can be equally frustrating for the client and may contribute to feeling as if they are not in control or feeling bad about themselves. Plans developed in the session may be abandoned to impulsive, short term symptom relief. Clients may focus the possibility of a bad outcome or not be confident of their ability to cope with distress and difficult emotions.

One of the most useful rules of thumb with avoidance is simply to expect it. It's not an obstacle to the work, it's part of the work and may frequently be part of the presenting difficulties in the first place.

Being curious about the client's perceptions of avoidance can provide a good opportunity to uncover thoughts and attitudes associated with avoidance by exploring times it occurs in session.

Be curious about what the person does seek out as much as what they try to avoid. When might they have successfully stepped out of their comfort zone? For what? How? What helped them to get over the line? What turns apprehension into anticipation? Fear into excitement?

Be curious about the small stuff. Even if they did avoid the bigger step, what parts of the change did they try? How far did they get before the urge to avoid won? What does that suggest would be a reasonable step to try next?

It can help to be mindful of the following:

- The client may be withholding significant details, including risk factors, that may come up well into treatment or may never emerge.
- Avoidance may be associated with guilt (I did something bad) or shame (I am bad)
- Avoidance may itself be hidden — e.g. the sessions sound like they are going well, with a lot of motivation and momentum, but it's only over time that we may see a pattern where little changes.
- Interpersonal difficulties may be more subtle — e.g. if the client typically wishes to avoid conflict or giving difficult feedback.
- Avoidance is highly reinforcing and very well practiced — it may take a lot of time and practice to learn to tolerate the discomfort of feeling vulnerable or making change.
- Safely experiencing and becoming familiar with the feelings being avoided may be helpful — and potentially very confronting at first.
- Use of avoidance strategies may escalate before they decrease as the client contemplates or attempts change.
- One avoidance strategy may be replaced with another before a more sustainable balance can be found.
- Avoidance can be extremely helpful — we're only trying to reduce the over use of avoidance.

Pessimism

Everybody loves something, even if it's only tortillas.

Pema Chödrön

Even where there is a perceived need for change, we know that decision is not enough when making change. We are far more likely to make change when we feel the need to make change

rather than just know it would be a good idea. Change is often hard work and it is the little wins and moments of excitement or satisfaction that keep us going.

One of the significant challenges facing someone experiencing depression is that if you are waiting to feel like making change, waiting for it to feel like the right action or timing, you are unlikely to. Where the capacity to experience pleasure or meaning is diminished or seemingly absent, it may be hard for that person to see any hope for themselves or their future.

Whether it is due to symptoms of depression, personality style or other reasons, a pervasive sense of negativity can be extraordinarily hard to work with and we may experience a growing sense of helplessness or frustration. It can feel like every possibility of change turns into a dead end leaving us feeling like there is nowhere to go.

It can be helpful to be curious about the cause of depression — rather than see depression just as a condition in it's own right (which it can be), it can also be helpful to wonder what they are depressed about. For example, the depression may be a reaction to something else more fundamental, where feelings of negativity and hopelessness may be a natural consequence.

Rather than ask "What would it take for this person to feel more positive about change?", it can be more helpful to ask "What would it take for this person to attempt change, despite how they feel?".

There are many things we do in life that are not based on wanting to do them. For example we may not feel like putting the car in reverse to back out of the driveway, we do it because we have to in order to get somewhere else. Likewise, most women not only do not want to go through the process of giving birth, they actively fear or hate the idea of it — but do so because of the far greater value they place on raising a family.

In this sense, it can be helpful to spend some time looking at what matters to the person, what they value, what drives them, and what still registers some level of importance — despite how they feel. Exploring values and meaning will not always be fruitful, but has the potential to find the forces in the person's life that helps them to dig a little deeper to do the thing that is positive but difficult. When we are stuck in the work, it is rarely a waste of time to slow down and get to know the human being in front of us a little better.

Equally it can be useful to be curious about how the current behaviours may be reinforcing or associated with important needs or values. In this there is no sense of judgement, just curiosity about how some habits or ways of living have their own rewards or meaning, even when they are at the expense of other parts of life. Then it may be possible to try to discover ways to meet those needs or be true to those values in more proactive ways that might promote greater quality of life.

Some of the areas to attend to include:

- Identify and monitor the risk of self harm, neglect and suicide.

- Assist the client to find sufficient hope or meaning without reinforcing helplessness if none is easily found.
- Assist clients to find a way to make change despite the fact they do not feel like like making it.
- Attend to the deeper fears of making change, such as the risk of being abandoned if they are seen to no longer need help or to feel overwhelmed by the responsibilities and decisions involved in making change.
- Identify what can be accepted instead of changed, which might relieve some of the burden of what is being seen as needing to be achieved.
- Match our own and the system's response to the client's pace, which may be slow — e.g. we may need to keep time limited resources or services in reserve for when the client is most able to make use of them, rather than use all of the resources and have them run out while the client is still needing support.
- Manage contagious feelings of helplessness.
- Manage frustration with no apparent progress.

Impulsivity and impaired memory

While impulsivity and impaired memory are quite different in many ways, they both pose a similar challenge for the clinician. Regardless of what is discussed and what insights are made during the therapeutic conversation, the person finds it hard to carry those thoughts back into their life and act on them in a planned or purposeful way.

Conversations may feel like sand running through our fingers — no matter what gains are made, they seem to be just as soon lost. Other conversations may feel more like being caught in a windstorm of distraction, fragmented ideas and repetition.

The specific nature of the impulsivity or impaired memory are worth trying to understand, as different sources have different impact and potential to draw on different strengths.

It can be helpful to consider the whether the person's presentation is consistent with a younger developmental age. For example, someone who has been using drugs heavily since early teenage years may be thirty in age, but may present in a way that is more consistent with late adolescence as the drug use may have interrupted or interfered with the developmental process. Adjusting our view of where the client is developmentally may reduce frustration and open up new possibilities in how to work together. For example, we may have more realistic expectation, consider strategies that work well with younger clients or be more patient with the pace of the work.

It may also be helpful to:

- Identify high risk situations for impulsivity and develop strategies to avoid to manage them.
- Discover practical ways to implement concrete and immediate reinforcement for change.
- Use learning principles — many repetitions of consistent consequences and rewards.
- Identify rewards and reinforcers with more immediate 'here and now' impact (e.g. the consequences happen today or this week) rather than abstract or future-oriented motivators (e.g. the consequences are based in thought or happen in one or six months).
- Explore what does help and helping the client to discover their own strengths and strategies.
- Reduce the conversation to key points that can be written down or captured with a meaningful image at the end of the session, using their language and their handwriting.
- Support the therapeutic process with physical reminders, such as notes, a diary or reminder systems.
- Work with carers and other support services to create a more consistent, positive, reinforcing environment around the client.
- Find appropriate ways to transfer insights from the session to the support system so that the environment can help reinforce the memory and intention for the client.
- Work with the people around the client to reduce approaches that might be counter productive to the client's progress.

Difficulty with trust and intimacy

There are too many of us and we are all too far apart.

Kurt Vonnegut

Having spent considerable time emphasising the importance of the therapeutic relationship, we need to address the dilemma arising when we work with people who have long standing difficulties forming relationships.

Attachment theory can be helpful in gaining some insight into people's attachment styles. For example, people might be described as having secure, ambivalent or avoidant relationship styles across a range of relationships. It can be interesting to reflect on how these attachment styles may be being expressed within the therapeutic relationship or with their substance use. Sometimes the

person's most secure relationship is with their drug of choice, and giving up or cutting down might feel more like a divorce than a healthy behaviour change.

A cornerstone of therapeutic work is the idea of a trusting relationship. But what if that trust is difficult or even impossible to form in the time we have with the client? As we invite the client to engage and form a relationship with us, we may experience some of the underlying concerns coming into play, such as:

- Interpretation that others' intentions or behaviours are negative or threatening.
- Suspicion that the other person is not genuine, deceptive, has malicious intention or a hidden agenda.
- Fears they will be evaluated as inadequate, unlikeable or hopeless.
- Concerns they will lose control, feel coerced or be powerless.
- Fears of criticism, conflict or rejection.
- Belief they are unworthy or undeserving of another's care or concern.
- Desire to avoid feeling vulnerable, exposed or weak.

It may not always be clear why the relationship feels difficult to form as these concerns may be expressed in a multitude of ways that can leave the clinician unsure where they stand or where to go next. For example:

- Presenting as guarded or difficult to engage.
- Anger, aggression or hostility.
- Overly trying to please, praise or agree with the clinician.
- Engaging superficially, where conversation may feel easy but insubstantial.
- Tendency to blame others.
- Avoidance or shutting down by changing topic, standing up and walking around, reporting mind as 'going blank' or saying "I don't know".
- Avoiding difficult topics or sessions where there may be a perceived risk of conflict or criticism.
- Seemingly inconsistent engagement within or between sessions.
- Presenting as reactive, defensive or volatile.
- Expressing doubt, criticism or lack of confidence in the clinician.

- Asking more than typical personal questions or trying to engage the clinician in a more personal or intimate relationship.

Equally, the clinician may notice their own reactions that suggest they may be experiencing difficulty in engaging the person in a therapeutic relationship, such as feeling:

- Stuck, frustrated, angry or blocked.
- Like they are 'pulling teeth' in attempting to deepen the conversation.
- Flattered, special or unusually effective with this particular client.
- Apprehensive or overly self-conscious about how they express themselves.
- Judged, criticised or rejected.
- Inadequate, confused or belittled.
- Feeling overly protective or judgmental of the client.
- Feeling vulnerable, exposed or violated.

The difficulty with trust and intimacy will be heightened by certain mental health presentations such as paranoia. Clinicians may find themselves not only confronted with profound levels of suspicion and mistrust, but may be incorporated into delusional thinking.

They may find themselves grappling with questions such as "What is abnormal?" when psychotic symptoms blur with personal beliefs or choices that may seem odd or eccentric but are not necessarily signs of mental illness. For example, some less mainstream spiritual beliefs may be unusual or uncommon, while other more common belief systems may be taken to extremes that seem normal within a certain context but may raise questions of psychosis or delusion from a clinical perspective.

Again, every difficulty is an opportunity to gain more insight and understanding into the client's world and experiences. The therapeutic relationship may be able to highlight common patterns in a client's relating style that can be identified and examined with curiosity, rather than be seen as obstacles.

If a client has difficulty with trust it can be helpful to openly state that they do not have to trust us straight away and that it's OK to take their time to get to know us and what we are like. It can be helpful to try to develop a 'working alliance' rather than a therapeutic relationship, where both come together to do some meaningful, practical work together that is not reliant on a feeling of intimacy or trust.

Finding ways to gently and respectfully discuss their experience may be helpful in assisting the person to find a way of expressing their concerns or needs in other relationships — to provide a

model of how difficulty with relationships could be negotiated in a safe and helpful way in other parts of their life.

It is critical that the clinician be on the alert for their own triggers or reactive tendencies in relationships to ensure they maintain a thoughtful approach rather than go into their own automatic reactions.

No matter how experienced the clinician, it is important to seek supervision that assists them to maintain an objectivity while using their personal reactions as potentially helpful information that contributes to deeper understanding of the client and their experience of the world.

It can be helpful to:

- Gently assess their expectations, concerns and hopes for how you might work together.
- Be clear about what you can offer, how long you can work with them and the limits of the work — don't set up unrealistic expectations that you cannot live up to.
- Go at the clients pace.
- Work with how far they can engage rather than focus on the ways they can't as yet engage.
- Check in regularly regarding how comfortable the client is with the pace and intensity of the work.
- Enquire about the ways the client prefers to seek support if they have a prior history of seeking professional help. What works for them? What doesn't work?
- Be curious about our own reactions and where they might be coming from.
- Preempt likely difficulties, and normalise that it is common for people to want to miss sessions or feel angry during the work, and that it can be very helpful to talk about these experiences rather than avoid them.
- Be accepting and positive when discussing concerns about the relationship between you — it's more important that the sessions are experienced as helpful rather than achieve a particular level of intimacy or trust.
- Be wary of using too many 'I' statements, as it can communicate that you have particular needs or expectations of them, rather than keep the focus on their needs.
- Be careful about using praise, as this subtly reinforces the clinician's role as having the power to approve or disapprove — e.g. we might say "You must be proud of yourself" rather than "I'm proud of you", or "That strategy worked for you" rather than "Well done".

Emotional extremes

Some clients will present with particular emotions that feel unusually compelling, overwhelming or pervasive. For example, the person who feels irritable or angry much of the time, the person who feels fear or panic readily, or feels stuck in helplessness, pessimism or shame.

Some people don't have a problem with a particular emotion (e.g. anxiety or anger) as much as with the whole emotional experience. Emotions seem strong, reactive, overwhelming and dominate the client's personal world. Or fluctuate between overwhelming feelings and dissociation, where they feel detached or absent from their experience.

Whether one agrees with the diagnosis of Borderline Personality Disorder (BPD) or not, people who meet the criteria for the condition are usually highly distressed and experience repeated patterns of pain and misunderstanding within most human encounters. The concept of 'personality disorder' is used here to include people who have profound difficulties in their relationships and broader lives that can be traced back in part to pervasive disruptions with their sense of self and their capacity to relate to others. These patterns play out in most if not all relationships.

People who meet criteria for BPD may experience their sense of self as fragmented, incomplete, or profoundly empty — not just in a sense of something is missing in their lives, but something may feel like it is missing within them or how they are 'put together'. People with BPD may feel like they are constantly 'creating' themselves with each person they are with, seeking feedback on who they are from an external source. While experience of childhood abuse or trauma is extremely common, experience of emotional neglect may be even more common. Either way, they may find it hard to 'read' their emotions with confidence, and feel somewhat insubstantial or sensitive to what is happening around them.

Relationships often are fraught with tension, fear of rejection and seemingly chaotic or unpredictable behaviour. The experience of someone with BPD is often that no matter who they meet or how long it takes, other people will eventually reject them for thinking wrong, feeling wrong or going about meeting their needs in the wrong way.

Whether the emotional extremes are related to BPD or other concerns, some of the ways they may present in session include:

- High levels of intense feelings of sadness, loneliness, anger or anxiety.
- Difficulty regulating and tolerating emotions.
- Difficulty maintaining calm, 'rational' discussion as the emotion escalates.
- Emotional lability — seeming to flip between one emotion and another.
- Emotional reactivity — emotions escalate rapidly and sometimes unexpectedly.

- Impulsivity in session or between — it may feel like little is being ‘achieved’ in the longer run.
- Clinging and pushing away.
- Dissociating or shutting down when emotions escalate.
- Requiring crisis intervention.

While each of the presenting emotions may benefit from specific interventions, some general principles may help to ground the work:

- Remain calm, unreactive, accepting and gently soothing.
- Learn to identify the difference between healthy emotional arousal, which is common when discussing sensitive material, and emotional escalation, which may simply leave the client more distressed.
- Develop skills in de-escalating strong emotions, such as respectfully naming the emotion, inviting the person to attend to sensations in the here and now (e.g. the temperature of their feet or colours in the room), deep breathing, or engaging the person in non-challenging conversation that engages their cognition (e.g. asking for facts, talking about neutral topics).
- Seek supervision to maintain an objective, grounded approach.
- Identify and validate the emotions.
- Don't offer advice or problem solve too early in process.
- Be curious what it feels like for the other person and their understanding of what is going on.
- You may need to repeatedly name, validate and de-escalate emotions to a level where they are tolerable throughout the course of the work. This is not necessarily an interruption in the work, it may be a profoundly valuable process by which the client becomes better at identifying, validating and managing their own emotional experience for themselves.
- The aim is not to make the feeling go away, but to help bring it back to a level where it is manageable and possible to still make considered decisions the person can feel good about afterwards.
- Be highly attentive to what the person is able to tolerate. For example, someone who frequently dissociates, may need to build up their capacity to experience their emotions very slowly and gently. Someone who experiences hyperarousal (such as in PTSD) may not be able to tolerate traditional relaxation strategies as they may leave them feeling more vulnerable by letting their guard down.

- If the treatment is short term, it is important to moderate the degree of attachment formed in relationship, because the withdrawal of the relationship may be damaging or overly distressing if a strong connection has been developed.

Hostility

I don't like that man. I must get to know him better.

Abraham Lincoln

There are few presentations like hostility that can bypass a considered clinical response and elicit a raw, personal reaction from us. Whether we have our own histories of violence or not, the feeling of being under threat pulls at our basic urge for self preservation. Risk and safety issues must take precedence, and yet examining the nature of hostility can be as fruitful as any other presenting challenge.

Hostility may be overt, expressed through insults, arguments, threats and a menacing manner. It may be more covert, harder to put a finger on, and yet a feeling of unease becomes hard to shake off.

Aggression must be managed to ensure risk is minimised and a respectful safe environment is maintained for both clinicians and clients of the service. By itself aggression doesn't tell us much about the underlying concerns - the person who feels vulnerable and uses hostility as self protection may initially present very similarly to the person who the person who is callous and enjoys putting others on the defensive.

Hostility may reflect a range of underlying concerns, including:

- A belief that others do not accept them.
- A belief others want to limit their freedom.
- A belief that others are dangerous and that they must get the upper hand first.
- An attempt to demonstrate power and intimidation.
- Testing the therapist to see if they are strong enough to be trustworthy and offer help.
- Testing the therapist for weak points or opportunities for manipulation.
- Defensive mechanism — a way of warning others 'don't get too close'.
- A way of communicating their own feelings of frustration, fear or vulnerability.
- Pleasure in making others uncomfortable or scared.

Given the elevation of possible risk, hostile presentations should always be discussed in supervision to ensure an appropriate balance of safety and therapeutic measures can be put into place. It can be helpful to:

- Pay attention to your gut reactions.
- Be mindful and curious about our own reaction, rather than see it as an obstacle ('I shouldn't feel angry toward my clients so I need to get rid of this feeling' or 'Clients shouldn't treat me like this, I need to get rid of this client').
- Reflect on our own life experiences, our associations with hostility and aggression and how we typically respond.
- Be alert to our own personal reactions coming into the work — it's likely to happen, we just want to know where they are coming from.
- Be alert to acting 'out of character' and any temptation to rationalise or justify these shifts in practice as not being important.
- Try to refrain from responding with extremes — e.g. responding with hostility, becoming inflexible, withdrawing or avoiding.
- Try to remain calm, consistent and respectful.
- Separating the behaviour (which may be difficult or confronting, and may need to be managed) from the person (who has equal worth).
- Try to maintain a non-judgemental stance (they are who they are, they do what they do) even if consequences must be initiated or imposed.
- Return to, and vigilantly maintain, gold standard best practice with a clear sense of boundaries, role and ethics.

Attending to the bigger picture: How do we protect the work?

I may not have gone where I intended to go, but I think I have ended up where I needed to be.

Douglas Adams

Therapeutic work involves us in a very real way. We are constantly forming relationships with people experiencing hurt and distress. We can't look after others without looking after ourselves:

- We are half of the relationship
- We need supervision and the space for reflection and feedback
- We need to know when we are being affected by the work.
- We need to have good self care.

Good practice relies on good relationships. It is hard to know how best to support another person without genuine engagement or understanding. And yet to form therapeutic relationships is to involve us, the worker, in a very real way.

As highlighted in the section on assessment, our reactions to the client and what happens in our work together can be very helpful — far from irrelevant or something to be 'managed', our thoughts, feelings and urges can be a source of valuable insight into what is going on for the client and how they or others may be feeling.

Even with a skilful self awareness, the constant sensing and perceiving can come at a cost. We may not always be aware of every bias or automatic reaction. Because we are there, in the relationship, we need to have solid, sustained strategies to maintain perspective, see the work with fresh eyes and question our assumptions. This is where supervision and self care come in.

Supervision

Supervision is an essential ingredient in doing clinical work, especially where we are dealing with complexity, therapeutic process and our own responses to the work. Ideally regular, constructive and positive supervision is provided within the organisational setting. Where this is not available, it is still important that clinicians seek input and feedback from experienced colleagues in the form of private or peer supervision.

This work involves us, our senses, our feelings, our insights and our ability to connect with others — in other words, we are a vehicle for the work and as such need to regularly check in with someone impartial who can help us stand outside ourselves to evaluate our practice, reactions and the broader impact that comes from working with human pain and trauma.

Hawkins and Shohet (2012) offer their Seven Eyed Model, which provides a systematic approach to the supervision process and what aspects of the work are evaluated:

1. Focus on the client and what and how they present
2. Exploration of the strategies and interventions used by the supervisee
3. Exploration of the relationship between the client and the supervisee
4. Focus on the supervisee
5. Focus on the supervisory relationship: evaluate the quality and patterns emerging in the supervisory relationship
6. The supervisor focusing on their own process
7. Focus on the wider contexts in which the work happens.

While the model was developed for supervisors, the first five levels provide a useful framework for clinicians to examine our own practice. The first level invites us to describe the client without interpretation, speculation or judgment. In the second level we review treatment options, selection and implementation. In the third level we evaluate the qualities of the therapeutic relationship, the patterns emerging and implications for treatment. The fourth level asks us to honestly reflect on the reactions and responses coming up in ourselves: our biases, judgements, feelings and personal concerns. Level five invites us to look at the patterns and processes occurring in the supervisory relationship, their impact and whether they reflect the work going on with the client in anyway. For example, we might find ourselves being more defiant when describing an antisocial client, or the supervisor may become unusually directive when we are discussing a client with a passive or dependent presentation.

Supervision offers the chance to see the work with fresh eyes, find possibilities we may have missed in session and prepare for challenges that may lie ahead. No one is too experienced or

qualified to not be able to find something useful in well-suited supervision. However, our needs may change as we progress through our career as helpers, needing perhaps more instructional input in the early stages and a more reflective sounding board as we gain more experience.

It is advisable and protective to have a good contracting process in place at the start of supervision that is regularly reviewed and adjusted as needed. Hawkins and Shohet (2012) highlight useful areas to consider in the contracting process include:

- **Focus**: What will be the purpose of your sessions together? How will you know the sessions had made a difference to your practice?
- **Practicalities**: How often will you meet? Where? How long?
- **Boundaries**: What are the limits of what can be discussed?
- **Confidentiality**: What are the limits of confidentiality? What notes will be taken and how will they be stored? How will concerns about practice be addressed?
- **Session format**: How will the sessions be conducted? How many clients will be discussed, what aspects of the work will be addressed and how will the supervisory process occur?
- **Working alliance**: What are your expectations of each other? What is your best learning style and what is the supervisor's preferred mode of supervision? What kind of relationship do you want to form?
- **Pace and level of challenge**: How fast a pace is good for you and how hard do you want to be pushed or challenged? How will you let each other know that the pace or level of challenge is of concern?
- **Broader context**: What external factors may affect the supervision?

Self care

Self care is as essential a component of being a helping professional as continuing to develop therapeutic skills, maintaining knowledge of relevant laws and ensuring adequate documentation of the work.

Just as a physiotherapist needs to manage the wear and tear on their body from providing physical interventions during their work, we need to monitor and manage the impact on our emotions, sense of the world and relationships with others.

And this applies to new and experienced clinicians alike. It's the nature of the work, not an indication of level of skill.

Getting ‘good’ at something in this work might mean it becomes harder to do something else in our personal lives. For example, the better we get at conscious responding, the harder it might become to be spontaneous outside of work. The more familiar the extreme worlds in which many of our clients function become, the more our sense of ‘normal’ might be skewed rather than simply broadened.

Be aware of the way in which the work subtly changes us. Pay attention to small changes in your behaviour or attitudes that don’t seem quite ‘typical’. Be curious about the nature of the change. The work can shape us in two very common directions:

- Compassion fatigue: becoming more hard-hearted, less trusting or more critical.
- Vicarious trauma: becoming more sensitive, over-committing, over-stretching and burning out.

It can be helpful to look for antidotes for those changes and seek the opposite to regain a sense of balance. For example, if we notice we are starting to feel numb, we might seek experiences that specifically engage one or more of their five senses. If we are struggling with people’s capacity for violence and to hurt each other, we might seek out examples of human generosity and love.

You matter. You are the vehicle through which the work happens. Being affected by the work is the default setting. Self care is an occupational requirement. Stepping up the self care may be an occupational response in times of greater need.

This is difficult work. We may be feeling our way for much of the time. Our guiding principles offer an anchor, our formulation offers a chance to see the situation afresh and our supervisors may help shine a light into the areas we haven’t seen as yet.

In some ways, the art of navigating such troubled interpersonal terrain is not so much a case of continually acquiring more tools to have at hand, although this is most definitely a field that requires lifelong learning.

More fundamental is our ability to consistently and consciously use the things that work to the highest level of our ability. And that takes time, practice and discipline. Listen deeply. Develop and share your understanding. Be aware what is going on for you in your half of the relationship. Form a partnership of equals to discover together how you could best spend your time together. And then work out together how best to do it.

In walking, just walk.
In sitting, just sit.
Above all, don't wobble.

Yun-Men

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Appendix 1: The six Ps

Four Ps	Predisposing	Precipitating	Perpetuating	Protective
Biological				
Psychological				
Familial				
Social				

Personal	Impression	Feeling	Urge	Possible relevance
As a person				
As a client				
Our work together				

Patterns	Approaches	Avoids
In general		
Substance use		
With me		

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