An Introduction To Managing Deliberate Self-Harm:
A guide for AOD clinicians

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You must live in the present, launch yourself on every wave, find your eternity in each moment.

Henry David Thoreau
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List of abbreviations

AOD  Alcohol and Other Drug
BPD  Borderline Personality Disorder
DSH  Deliberate Self Harm
MH  Mental Health
TIB  Treatment Interfering Behaviours
Introduction
The aim of this guide is to provide some initial advice and support for alcohol and other drug (AOD) clinicians who are working with clients who engage in deliberate self-harm (DSH). Specifically this guide provides:

- background information about DSH;
- information on how to identify DSH;
- a brief summary of management strategies for DSH;
- a summary of strategies for clinicians to manage their feelings about DSH.

What Is Making Waves?
Making Waves is a program run at Turning Point Alcohol and Drug Centre, Eastern Health, in partnership with Spectrum Personality Disorder Service of Victoria, which provides treatment to clients with substance use issues and Borderline Personality Disorder (BPD). Although this is a specialist service, many clients seeking treatment for AOD issues have difficulties commonly associated with BPD. For example, interpersonal problems, which can make it hard to engage in a collaborative therapeutic relationship, difficulties regulating emotion, DSH and impulsive behaviours. The Making Waves team have collaborated with Turning Point researchers to create a series of resources to assist AOD clinicians in managing some of these issues. These resources are designed to help clinicians manage behaviours that interfere with treatment engagement and retention - Treatment Interfering Behaviours (TIB). They were developed in close consultation with an expert reference group and were piloted by AOD clinicians through a group clinical supervision program.

What are TIB?
Treatment Interfering Behaviours (TIB) is a term used by Linehan(1) in her cognitive behavioural treatment of borderline personality disorder (BPD). In Making Waves, TIB refers to any behaviour that may interfere with a client’s potential to benefit from AOD treatment. TIB are repeated, ongoing or chronic in nature. Some of the most common client TIB include repeated presentations of verbal aggression, nonattendance because of ongoing crises, suicidal threats or DSH. In a recent Making Waves survey, clinicians identified DSH as a particularly challenging behaviour to manage. Clinicians also engage in TIB, for example consistently responding to a client in a judgemental or non-empathic way. For more information on TIB, refer to Recognising and Managing Treatment Interfering Behaviours (TIB): A Guide for Clinicians.
An Introduction to Managing Deliberate Self Harm: A Guide for AOD Clinicians

Section 1: Some Background Information About Deliberate Self-Harm

“A common misconception about DSH is that all self-harming is attention seeking.”

What is DSH?
Deliberate self-harm (DSH) or self-injury, is defined as the “intentional, direct injuring or damage to the body without suicidal intent”.\(^\text{[2, 3]}\)

Some important things to know about DSH are:

- DSH is common among people with BPD;
- The most common form of DSH is skin cutting (making up around 70-80% of those who self-harm);
- The other common forms of DSH include bruising, banging, hitting, burning, scratching, biting, interfering with wound healing and needle sticking;
- The areas of the body that are most likely to be injured during episodes of DSH are the arms, followed by the hands, thighs and stomach;
- DSH is often preceded by a ‘triggering’ event (such as separation, rejection, failure, loss, social isolation or fear);
- DSH often triggers a release of endorphins (which might be why it can become addictive);
- DSH is used as a form of emotional regulation;
- DSH often occurs among people with high levels of impulsivity;
- DSH often occurs among people who have experienced childhood adversity such as sexual or physical abuse, or neglect; and
- DSH lacks suicidal intent.

What is emotion dysregulation?

- People with emotion dysregulation have an extreme range of emotional experiences in addition to problems modulating their emotional responses.
- Emotion dysregulation is common among people who self-harm. They might experience extreme mood swings and be unable to modulate the intensity of their feelings. Possible manifestations of emotional dysregulation include angry outbursts, verbal abuse, destroying or throwing objects, aggression towards self or others, and threats to kill oneself.
- Clients with emotion dysregulation may have high sensitivity to emotional stimuli and take a long time to return to baseline emotional levels.
- High levels of emotion dysregulation can lead to escalating negative mood states and disorganised thinking that can contribute to impulsive behaviour.
- People with emotion dysregulation may have difficulty experiencing empathy and show a limited capacity to interpret the emotions of others. They may also be sensitive to criticism and struggle with feelings of rejection and abandonment.
- Emotion dysregulation can lead to behavioural problems and can interfere with a person’s social interactions and their ability to establish and maintain healthy relationships.\(^\text{[4-6]}\)

A common misconception about DSH is that all self-harming is attention seeking.
Some reasons why some people self-harm:

- To alleviate negative emotions or emotional distress
- As a distraction from unpleasant or intrusive thoughts
- To substitute emotional pain with physical pain
- To induce an ‘auto-hypnotic’ or dissociative state
- To feel ‘something’
- So their emotional pain is taken seriously by others
- As a call for help
- As a form of escape
- To communicate intense emotional pain
- To communicate intense ambivalence about life
- To punish oneself or another
- To express hatred towards oneself or another
- To express anger towards oneself or another
- To bond with friends who self-injure
- To generate excitement or exhilaration
- To feel independent and in control
- To resist the urge to commit suicide
What is Dissociation?
- Dissociation can be thought of as a state of ‘tuning out’, ‘switching off’ or “detaching” and it is common among people who self-harm.
- A common way of describing dissociation is feeling temporarily separated from your own emotions, body or surroundings.
- Research findings have established links between DSH and other BPD traits including suicidality and dissociation.\(^7\)
- It is important to note that people often perform self-harming rituals in private and attempt to hide their scars from others. DSH can provide immediate relief from emotional distress, but is then followed by feelings of shame and remorse.
- Clients might attempt to keep their DSH hidden from their clinician in order to avoid it being a focus of treatment.\(^8\)\(^-\)\(^10\)
- Alternatively, clients may want to regularly show the effects of their DSH.

A common misconception about DSH as a cry for help – most self-harm occurs in private.

What is the Relationship Between Deliberate Self-harm and Suicide?
- There is some evidence of a significant and persistent risk of suicide following an occasion of self-harm.\(^10\) However, it is important that the motivations and treatment of DSH are distinct from the motivations for and treatment of suicidal behaviour.
- It is important to note that 50% of people who self-harm report having attempted suicide at least once. Thus engaging in DSH doubles the risk of actual suicide.\(^11\)\(^,\)\(^12\)

What Role Does Substance Use Play in Episodes of Deliberate Self-harm?
- Alcohol and other substance use plays an important role in DSH.
- In one study of this relationship, around half of those who attended an emergency department following DSH had consumed alcohol immediately preceding or as part of the self-harm episode.\(^13\)
- Intoxication can be used before or during an episode of DSH to reduce inhibition or increase dissociation. It has also been suggested that self-harm through intentional wounding may be substituted with self-harm via excessive alcohol or other drug use.\(^14\)
- In Victoria, studies have rated the co-occurrence of BPD and AOD as ranging from 11% to over 80%.\(^2\)
- It is recommended that joint assessment and treatment begin as early as possible between AOD and MH services. The treatment requires a strong therapeutic alliance and should be long term (for example, more than 3 months).\(^2\)
Section 2:
Assessment of Deliberate Self-harm

- It is important that a risk assessment is conducted with AOD clients at the first point of contact, and this should always include an assessment of risk of self-harm (including DSH) and suicide.
- Once a risk of DSH is identified, the assessment should include whether the client has an immediate plan to self-harm, and the means to do so. A valid risk assessment is very difficult to conduct when DSH is evident without knowing the client’s prior history. Clients who engage in DSH may not be a reliable source of information about their own DSH outside a therapeutic relationship, so developing an optimistic and trusting relationship is paramount.
- It is important to continually review your risk assessment, due to the considerable suicide risk associated with DSH and concurrent AOD use.
- Risk assessments may be more valid if you have an ongoing collaborative therapeutic relationship with your client.
- Clinical judgement in a risk assessment needs to take into account whether particular incidents of risk are over and above the usual chronic presentation of the client’s DSH pattern.
- Time should be devoted in treatment to exploring the reasons behind DSH because this will likely guide the direction of treatment. For example, focusing on emotion regulation skills may be the most appropriate treatment when DSH is motivated by negative emotions. Alternatively, when DSH is a function of interpersonal influence, treatment directed at fostering interpersonal skills might be more appropriate. These strategies are discussed in more detail in Section 3.
- Acts of DSH are usually preceded by a triggering event. Therefore, it is important to apply good cognitive and behavioural assessment procedures to understand the triggers of a self-harm episode for the client.
- DSH is likely to be a way of relieving distress, or coping with something distressing. Although it may seem ‘dysfunctional’ it is important to understand that the DSH serves a purpose.
- In this way, DSH can be understood in the same way we conceptualise substance abuse. Use your existing skills in AOD assessment and apply many of the same principles to understanding triggers, modulating, and maintaining factors.

Clients should be asked to explore the times when they have used other coping skills instead of DSH. If there is evidence of previous coping skills that have been effective, it is important to reinforce and build these strengths.
Chronic Suicidality

- While clients with BPD are often chronically suicidal, under-response to risk of suicide is important to address because DSH poses a significant risk of successful suicide, especially when there is a co-occurring AOD. Finding a balancing can be difficult, but cannot be done in isolation from your ongoing therapeutic relationship with the client.[16]

- Suicidal behaviours in BPD can take three forms: chronic suicidality, acute suicidality and acute-on-chronic suicidality, the first being the most common.[10]

- Clinical judgement therefore needs to take into account whether the current suicidal presentation represents a risk over and above the usual chronic presentation of the client. The affect associated with the presentation may be of greater intensity; usual social supports may have been withdrawn or alcohol and substance use may have escalated.[16]

- The management of chronic suicidality in clients with BPD and AOD represents a significant risk of burnout and ‘empathy fatigue’ in treating clinicians, therefore collegial support, case review and secondary consultation are essential in supporting practitioners to remain involved in treatment over the long-term management. Being mindful that under response to suicidal presentations may occur when desensitised to suicide, is another guard against invalid assessment of risk.[1]

Although organising an admission to a Psychiatric Inpatient Unit is outside the remit of AOD treatment, it is important to consider the following principles when working in collaboration with a client’s mental health team, if an inpatient admission is warranted:

- Brief, limited hospital admissions may be appropriate to contain crises when they are clearly unable to be dealt with in the community, but longer inpatient stays are counterproductive for many clients.

- Inpatient admissions should be facilitated by a MH treatment team, treating psychiatrist or medical practitioner.

- If consent to communicate with the client’s MH treatment team has been acquired, a referral letter or communication outlining current AOD issues can be important in the management of withdrawal symptoms while an inpatient.

- If you need to facilitate an admission, follow your service’s existing policy on referral to psychiatric crisis services such as the CATT or psychiatric triage. On discharge, continue with your standard treatment plan such as weekly appointments. Avoid excessive contacts post admission. Understand that planning for discharge, follow up and aftercare are critical.

- Be alert to the transition from acute to chronic suicidality

- Don’t forget that a client’s sense of rejection is correlated with increased risk of suicide i.e. BPD clients may have a heightened sensitivity to perceived abandonment or rejection.
Section 3:
Management of DSH

The First Step

Develop a treatment agreement
- Developing a treatment agreement that includes safety is a good principle for treating DSH and should be commenced during assessment and early engagement. It involves asking clients to reduce the levels of harm they inflict on themselves and asking them to commit to treatment with the use of a written agreement.
- A treatment agreement, can be updated and changed as treatment progresses. Its purpose is to ensure there is agreement between you and the client about the boundaries in the therapeutic relationship, which can be a challenge for clients with BPD. The agreement should be an outcome of initial discussions about the goals of treatment (i.e., reduced self-harm, reduction of drug and alcohol use), and the expected roles of the client and the clinician in achieving these goals. The tasks of the client should be determined, which might include things like commitment of attendance, timeliness of attendance, commitment to stay for the whole session. The clinician’s role might include things such as providing understanding, consistency and empathetic feedback.
- The treatment agreement might be so specific as to delineate the policy in regards to email and telephone contact, but also how and when the treatment can be terminated, or how to proceed if/when the client doesn’t follow up for treatment.[17-19]
- A treatment agreement might cover whether the person wants family members involved in their treatment.
- A clear plan for the handling of crises or emergencies should be included in the treatment agreement. Details of emergency and CATT contacts should be given to the client.
- e.g. “If we can agree on a plan of how we will respond to an episode of DSH early on in treatment, we can avoid misunderstandings in the future and work together to keep you safe so you get the most from treatment.”
- You should be mindful of establishing agreements to which clients are unable to adhere and setting the client up for treatment failure.
- Bear in mind that most people will have experienced rejection, shame, abuse, trauma and encountered stigma often associated with DSH or BPD.
- In regards to the risk assessment, if the means are present, the clinician should encourage the client to dispose of them, and make a contract with the client stating that they will not act on their urge to self-harm.[20]
- Ask directly if the person wants family members involved in treatment and crisis management plans, when establishing a treatment agreement.
Practice elements in the management of DSH

- Individual psychosocial treatment is the recommended treatment approaches for DSH. A range of psychosocial treatments have shown good results for treating DSH, particularly interventions that focus on psychosocial treatments have shown good results for treating DSH, particularly interventions that focus on psychosocial treatments have shown good results for treating DSH, particularly interventions that focus on psychoeducation, effective coping, distress tolerance, mindfulness, behavioural interventions and cognitive strategies.\textsuperscript{(10, 11, 16, 23, 24)}

- A focus of treatment should be the ways in which DSH and substance use interact and are mutually reinforcing.\textsuperscript{(14)}

- It is likely that treatment of DSH will need longer-term interventions (e.g. longer than 3 months). Therapeutic alliance will need to be built over time to address issues of DSH, with a constant focus on issues of risk, impulsivity and relapse prevention.\textsuperscript{(14, 20)}

- Developing an optimistic and trusting relationship is a key element of all individual psychosocial treatments when working with people with BPD.

- Explore treatment options in an atmosphere of hope and optimism, explaining that recovery is possible and attainable.

- Build a trusting relationship, work in an open, engaging and non-judgemental manner, and be consistent and reliable.

Strategies to manage DSH\textsuperscript{(16)}.

Maintaining a collaborative therapeutic relationship and psychoeducation are essential strategies. Both helps you and the client build a shared understanding of the triggers and consequences of DSH. (For more information on the therapeutic relationship and the aetiology of BPD, see the Making Waves guide for managing TIB).

NORMALISE the way the client is feeling, then VALIDATE the emotional experience.

REFRAME the client’s urge to engage in self-harm as a way of dealing with strong emotion or to gain a sense of safety.

Engage in PROBLEM SOLVING to identify alternative ways of managing the distressing emotions typically leading to DSH. Collaborate with the client to brainstorm and evaluate solutions in terms of the short and long-term consequences. Ask the client to reflect on solutions successfully used in the past and identify possible barriers that could interfere. Help the client to identify a solution that does not involve self-harm.

Alternative solutions could include: SELF-SOOOTHING TECHNIQUES, such as taking a warm bath, having a warm drink, practicing breathing techniques, progressive muscle relaxation, or exercise; pleasant activities; distraction techniques; anger management techniques; and GROUNDING TECHNIQUES involving the client describing what they see, hear, feel, and smell around them. Clients should be encouraged to express their experiences which may help them to develop a sense of safety, ownership, and control over their own body.
Understand the **TRIGGERS AND CONSEQUENCES** of DSH. It is important to discuss any self-harm incidents after they occur, asking the client to describe step-by-step the events leading to self-harm. Examining the external and internal events, such as thoughts and feelings; consequences, such as a sense of release, followed by shame; patterns in behaviour; and typical responses to stressful situations can increase the client’s insight into the motivations behind DSH. Once the client is able to identify high-risk situations for self-harm, they can be avoided or managed effectively. Assist the client in developing a plan of how to manage high-risk situations without relying on the usual response of self-harming. Examining the consequences of DSH, such as increased self hatred, shame, and negative responses from family and friends can assist the client in understanding the impact of their self-harm.

**REINFORCE** the effective management of distress. Successful attempts by the client to manage intense emotions or stressful experiences without engaging in self-harm should be highlighted. The client should be encouraged to provide self-reinforcement when he or she successfully resists the impulse to self-harm. For example, he or she could reflect on the progress made or acknowledge success with a self-reward.

Build a trusting relationship, work in an open, engaging and non-judgemental manner, and be consistent and reliable.
Four Helpful Clinical Tools for Addressing Deliberate Self-harm

**Tool 1: Coping with distress by distraction**

Teaching clients skills to help them tolerate distressing situations can be a useful initial step when managing DSH. Learning to cope with distress by developing or strengthening distraction skills are an achievable initial step for the management of DSH and can help clients increase self-efficacy in managing trigger situations; however, over time, through the practice of mindfulness and other cognitive or behavioural strategies, distraction can be replaced by more adaptive coping skills.[25] Helpful cognitive distraction techniques might include counting the number of breaths or attending to a neutral physical sensation, such as the rise and fall of the chest during breathing or feeling the soles of the feet on the ground while walking. Alternatively, distraction through engaging in pleasant activities, such as a bath, a walk in the sunshine, talking to a friend or helpline can be useful.

**Tool 2: Mindfulness**

Mindfulness is a core component of cognitive behavioural treatments for BPD such as Dialectical Behaviour Therapy (DBT) and Acceptance and Commitment Therapy (ACT). Mindfulness involves observing one’s own thoughts, emotions and actions without attempting to control or change them. Mindfulness is an important component of treatment of DSH because it involves learning to accept what has happened in the past and being able to continually reflect on experiences with awareness about the events and emotions that created these experiences. Mindfulness has been described in many ways, however, at its core is a number of constructs, which can be explained to clients in the following way:

>"Mindfulness can best be explained as a way of controlling your attention, usually by holding it in one place. It means letting go of your thoughts and bringing your attention back to the “here and now” whenever you’re distracted. It is about learning to be more present with your experience. It means attending to events, feelings and sensations without trying to change them. By being mindful we are aware of all that is going on, letting things happen, but not getting lost in the experience. In summary, mindfulness is learning how to pay attention, on purpose to each moment of your life without judgment. By becoming aware of how quickly your mind shifts and wanders, you can also see how this wandering mind allows negative thoughts and feelings to feed low mood and stress. The aim of mindful exercises is to increase awareness so that we can respond to situations with choice rather than react automatically. We do that by practicing to become more aware of where our attention is, and deliberately changing the focus of our attention, over and over again.”

### Mindfulness

- Helps tolerate distress
- Promotes the acceptance of reality
- Promotes acceptance
- Promotes emotion regulation
- Reduces impulsivity
- Reduces dissociation
An example of a Mindfulness script to use with clients:

**MINDFULNESS OF BREATHING**

1. Begin by sitting in a comfortable spot, either in a chair or on a soft surface on the floor. If using a chair, sit away from the back of the chair so that your spine supports itself. Keep your back straight, and get in a comfortable position with your feet flat on the floor and your legs uncrossed. Let your eyes close gently.

2. Become aware of any feelings in your body, noticing the feelings in your feet where they touch the floor, and noticing how it feels to sit in the chair. Spend some time scanning through your body for any other feelings. [PAUSE] If there’s any tension or uncomfortable feelings, just gently notice this.

3. Focus your awareness on the rise and fall of your stomach as you breathe. Notice the feelings that occur as your stomach goes in and out with each breath.

4. Become aware of feelings of slight stretching as the stomach goes in and out with each breath. Notice the slight pause in between each breath.

5. Don’t try to control or change your breathing in any way. Simply allow the breath to come and go naturally. Try to apply this attitude to the rest of your experience - simply just let things be as they are. Don’t try to change anything.

6. Your attention will probably drift away from focussing on the breath. You might be aware of thoughts, things that you have to do. This is normal – minds usually wander. When you become aware that your attention is no longer on your breathing, just notice what you’ve been thinking about, without judging yourself or criticising. Gently bring your attention back to your breath, and keep noticing the feelings in your stomach.

7. When you notice that your mind has wandered again, gently guide your attention back to your breathing, noticing the changing feelings you have with each breath.

8. Try to be kind to yourself as you pay attention to your breathing - try not to criticise or judge yourself when your mind wanders. These are useful opportunities to bring patience and gentleness to your experience.

9. Continue noticing your breathing, remembering that the purpose is to just be aware of your experience in each moment. The breath is an anchor to help you connect with what’s happening right now, each time you get caught up in thoughts. Continue noticing each breath for a little while longer (1 minute).

Adapted from: Segal, Z.V., Williams, J.M.G., & Teasdale, J.D. (2002).\(^{[30]}\)
Every wave, regardless of how high and forceful it crests, must eventually collapse within itself.

Stefan Zweig ~ Austrian Novelist (1881-1942)
### Table 1 – Strategies to assist in the management of crises in clients with DSH and AOD

<table>
<thead>
<tr>
<th>STRATEGIES</th>
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<tr>
<td>Conduct thorough risk assessment, using known factors relating to risk for the client, with particular attention to intoxication</td>
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<tr>
<td>Use clinical judgement in the context of past suicidal presentations</td>
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<tr>
<td>Explore the problem in the immediate time frame by identifying key events which led to the emotional state and sense of crisis</td>
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<tr>
<td>Formulate and summarise the problem</td>
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<tr>
<td>Help client commit to a crisis management plan</td>
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<tr>
<td>Focus on problem solving</td>
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<tr>
<td>Attend to the emotion rather than the content</td>
</tr>
<tr>
<td>Provide education, give advice and make suggestions</td>
</tr>
<tr>
<td>Identify factors interfering with a productive plan of action (e.g. anticipate substance misuse)</td>
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<tr>
<td>Reinforce adaptive responses to crisis</td>
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<tr>
<td>Predict positive future response to crisis management plan</td>
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<tr>
<td>Reinforce harm reduction for substance use</td>
</tr>
<tr>
<td>Remove or instruct client to remove lethal items identified in suicide plan</td>
</tr>
<tr>
<td>Emphatically instruct client not to commit suicide</td>
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<tr>
<td>Maintain a position that suicide is not a good solution</td>
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<tr>
<td>Generate hopeful statements and solutions</td>
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<tr>
<td>Validate treatment progress</td>
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<tr>
<td>Keep in contact when suicidal risk is imminent</td>
</tr>
<tr>
<td>Anticipate recurrence of crisis response</td>
</tr>
<tr>
<td><strong>Short term future planning is important e.g. focus on engaging client next day/week with a phone call</strong></td>
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<tr>
<th>WIDER SERVICE STRATEGIES</th>
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<tr>
<td>Referral to psychiatric triage and area mental health crisis and assessment team</td>
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<tr>
<td>Notify all treatment providers</td>
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<tr>
<td>Notify family members when warranted</td>
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<tr>
<td>Engage other service providers and family members (where appropriate) in risk management plan</td>
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Section 4: Managing Yourself when working with DSH

Be aware of your own feelings as a clinician when working with clients who engage in DSH. A recent study[27] found that clinicians experience a range of difficult feelings when working with clients with DSH, including anger, anxiety, sadness, feeling overwhelmed, irritation, compassion, helplessness and incompetence. If unmanaged, these difficult feelings contribute to clinician TIB and may make it very difficult to empathise with a client. Managing these feelings to guard against clinician TIB is imperative through collegial support, clinical supervision and secondary consultation.

In order to work effectively with DSH, it is essential to empathise with the client, regardless of the TIB that the client may exhibit. A clear understanding of the aetiology of BPD and DSH can assist in maintaining empathy in the therapeutic relationship (see the Making Waves guide to managing TIB for more information on aetiology). Beatson[27] suggests that strong emotions are apparent for all clinicians when treating people who self-harm, also called countertransference. 'Countertransference is defined as all of the emotional reactions stirred up in the clinician towards a particular patient'.[27, p 196] For more information on countertransference, see Recognising and managing Treatment Interfering Behaviours(TIB): A Guide for Clinicians.

The management of DSH in clients with DSH and AOD use represents a significant risk of burnout and ‘empathy fatigue’ in treating practitioners. Services require good clinical governance models, to support clinicians managing presentations of TIB and ongoing DSH. Additionally, collegial support, case review, clinical supervision and secondary consultation are essential in supporting practitioners to maintain an optimistic and trusting therapeutic relationship, over long-term treatment.

Other tips to manage the therapeutic relationship

The difficulty in developing a working therapeutic alliance with clients who engage in DSH is an ongoing challenge. Like all good therapeutic relationships, it is important that the relationship is characterised by warmth, empathy and support.[29] Research has shown that not only is a therapeutic alliance important but the earlier this relationship is established the better.

The treatment context for DSH and AOD must be long term and if possible based on a single therapeutic relationship (with the backup provided by designated team members), to address both disorders at once. When this is not possible, and mental health care and AOD treatment are split between services and practitioners, then regular and open communication is required. Regardless of the treatment model or paradigm you are working from developing an effective therapeutic relationship is of utmost importance when working with clients who engage in DSH.[29]
• Always assess DSH and suicidality at initial presentation and throughout treatment.
• Use standard service protocols for risk management and referral to psychiatric services when significant risk is identified.
• Set goals for treatment with AOD, mental health and wellbeing targets
• Allow for longer term engagement and treatment episodes with clients.
• Always follow up assertively – it is up to the service to follow up not the client.
• Consistently work on client motivation
• Become familiar with intervention manuals and attend training for evidence based interventions that have been shown to have positive outcomes with DSH, such as ACT and DBT.
• Look for hooks to increase motivation
• Take a long term view in your relationship with client with BPD
• Manage your anxiety through good clinical supervision, secondary consultation with senior clinicians, and by involving your team in your management and treatment planning as much as possible. Their involvement will assist you to identify any blind spots or countertransference.
Further Readings


References
