The Injustice Collector in SUD Treatment

Deep Dive Modules · Clinical Strength

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Part 1 · Overview

The Injustice Collector in SUD Treatment

A Clinical Intensive for SUD Counselors & Treatment Staff

Recognizing · Navigating · Intervening — The Recovery Files

Recognize

Early pattern ID

Navigate

Clinical response

Intervene

Therapeutic tools

FOR CLINICAL STAFF

This intensive is designed for SUD counselors, clinicians, case managers, supervisors, and treatment staff — not for direct patient use.

Clinical Reading Sections

Clinician Self-Assessment

Clinical Tools & Worksheets

Tool 1: Intake Screening — Recognizing Injustice Collector Presentations

Tool 7: Treatment Team Splitting — Recognition & Response Guide

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Part 2 · Recognizing the Injustice Collector in Your Caseload

Recognizing the Injustice Collector in Your Caseload

Every experienced SUD clinician has worked with them — the patient who arrives in treatment carrying not just a substance use disorder but an archive. A carefully cataloged, frequently cited, emotionally charged archive of wrongs, betrayals, unfair treatments, and deliberate disrespects stretching back years, sometimes decades. The patient who, before the first session is over, has conveyed that their employer is against them, their family doesn't understand them, the legal system failed them, and the previous treatment program — which clearly didn't work — was run by people who didn't know what they were doing.

The injustice collector in your caseload presents a distinctive clinical profile that, if not recognized early and navigated skillfully, will undermine treatment outcomes for them and create significant stress for your entire treatment team.

Clinically, injustice collecting is characterized by several core features. At the cognitive level, these patients demonstrate a consistent attribution bias — attributing negative outcomes to others' malicious intentions rather than to circumstances, misunderstandings, or their own behavior. They exhibit confirmation bias, selectively attending to information that confirms their worldview of being uniquely and persistently mistreated while discounting evidence to the contrary. Ambiguous situations are reliably interpreted through the most threatening possible lens. A clinician's honest challenge becomes "proof" they don't care. A treatment policy is evidence the program is punitive. A peer's success in group is experienced as personal diminishment.

At the emotional level, these patients experience a chronic low-grade hyperactivation that manifests as irritability, suspicion, defensive posturing, and hair-trigger reactivity to perceived disrespect. This is not malingering or manipulation — it is a nervous system trained by real experiences of being genuinely wronged to remain perpetually vigilant. The tragedy is that the vigilance that once protected them now distorts their perception of environments that are actually safe.

Behaviorally, you will observe the injustice collector: frequently citing past wrongs in current discussions, making global negative attributions ("clinicians never listen," "treatment programs are all the same"), testing staff for signs of bias or disrespect, bringing perceived grievances from other treatment settings into yours, responding to constructive feedback as personal attacks, and — critically — having a history of premature treatment terminations that they attribute entirely to the failures of previous programs.

What distinguishes clinical injustice collecting from healthy advocacy or appropriate protest of real wrongs? Three markers are most useful: first, the pattern is consistent across diverse relationships and settings — it is not context-specific; second, the emotional response is disproportionate to the triggering event — a minor oversight produces a major rupture; and third, the pattern is ego-syntonic — the patient experiences their grievance collecting as accurate

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perception of reality rather than as a pattern that might be examined.

Why does this pattern intersect so powerfully with substance use disorder? Because resentment is one of the most reliable relapse triggers in the clinical literature, and because the same survival adaptations that produce injustice collecting — emotional hypervigilance, difficulty trusting, externalizing blame, resistance to vulnerability — are the precise adaptations that make the honest internal work of recovery so difficult. The patient who is perpetually focused on what others have done to them cannot simultaneously do the searching, fearless self-examination that recovery requires.

Recognizing this patient profile is not an invitation to pathologize patients who express legitimate grievances. It is the foundation of an appropriately tailored clinical response — one that honors the real pain underneath the pattern while refusing to collude with the pattern itself.

Clinical Reflection Questions

1. Who in your current caseload demonstrates some or all of the features described here? How early in the treatment relationship did you recognize the pattern?

2. What is the most reliable early indicator in your clinical experience that a patient is an injustice collector rather than someone with a specific, bounded grievance that needs addressing?

3. How do you currently document injustice-collecting presentations in your clinical notes? Is your language clinically precise and ethically grounded, or does it inadvertently pathologize?

4. What populations in your caseload most commonly present with injustice-collecting features? Are there specific cultural, professional, or trauma-related factors that you have observed contributing to this presentation?

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5. How does recognizing this pattern in a patient change your treatment planning and your initial clinical stance?

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Part 3 · Clinical Navigation: Evidence-Based Approaches

Clinical Navigation: Evidence-Based Approaches

Working therapeutically with the injustice-collecting patient in SUD treatment requires a precisely calibrated approach — one that is simultaneously empathic and honest, warm and boundaried, validating and challenging. The most common clinical errors in each direction — over-validation and premature confrontation — both produce the same outcome: treatment rupture, premature termination, and a new item added to the patient's grievance archive.

The first clinical principle is validation before exploration. The patient who enters treatment carrying genuine wounds from real injustices — which virtually all injustice collectors do — cannot hear a clinical challenge to their interpretive pattern until they have experienced genuine acknowledgment of the real pain underneath it. This is not about colluding with the narrative. It is about meeting the person where they actually are before attempting to move them. "It sounds like you've experienced real disrespect and real betrayal in your life — that's important and we need to understand it" creates the alliance foundation from which later, more challenging work becomes possible. Skipping this step to get to the "confrontation of the pattern" produces defensiveness, rupture, and resistance.

Motivational Interviewing provides the methodological framework most suited to this population. The injustice collector is, almost by definition, ambivalent about the aspects of their worldview that maintain their resentments — some part of them is exhausted by the weight of the backpack even as another part is committed to carrying it. MI's core principles — rolling with resistance rather than confronting it, exploring ambivalence rather than resolving it externally, evoking the patient's own discrepancy between their values and their patterns — are precisely calibrated to this clinical challenge.

Socratic questioning is the most powerful specific technique for disrupting injustice-collecting cognitions without triggering defensiveness. The direct confrontation "I think you're misinterpreting that situation" will reliably be added to the grievance list. The Socratic alternative — "Help me understand: what evidence do you have that he intended that as a disrespect? Could there be any other explanation?" — creates the space for the patient to examine their own interpretation from the inside, which is the only place where genuine cognitive change occurs.

Connecting resentments to substance use is a critical clinical intervention that these patients often initially resist. The connection must be made explicitly and repeatedly, because the patient's externalization of blame extends to their substance use — it's everyone else's fault, so why would releasing resentments help? Effective framing: "Your resentments are costing YOU your sobriety. Not the people you resent — they're not drinking every night. You are. The resentment is poisoning YOUR recovery, not theirs." Twelve-step literature supports this framing, and for patients working a program, this connection can be made through the lens of Step 4 and 5 work.

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The use of the therapeutic relationship as a corrective experience is perhaps the most powerful intervention available. Many injustice collectors have never experienced a relationship in which they were heard honestly, challenged respectfully, held accountable without being shamed, and valued consistently regardless of how difficult their behavior became. When a clinician can provide exactly this experience — maintaining empathy and warmth while declining to collude, maintaining honest feedback while sustaining the relationship through ruptures — the therapeutic relationship itself becomes a model for what trust looks like.

Timing and pacing are critical. The premature introduction of perspective-taking exercises, self-accountability work, or direct challenges to the resentment narrative — before sufficient alliance is established — will reliably rupture treatment. A useful clinical heuristic: spend the first several sessions primarily validating, exploring, and building alliance. Introduce gentle Socratic challenges only when the patient has experienced you as genuinely on their side. Move to direct naming of the pattern only when the alliance is robust enough to survive the patient's initial reaction — which will be resistance, and which is itself therapeutic data.

Finally, group therapy presents both the greatest challenge and the greatest opportunity with this population. The injustice collector in a group will reliably receive feedback from peers that they resist when it comes from staff — peers who say "I recognize that pattern because I do it too" carry a credibility that clinicians cannot. Structuring group interaction to create these peer-to-peer moments of recognition, while managing the group dynamic carefully to prevent the injustice-collecting patient from dominating group with their grievance narrative, is a sophisticated clinical skill that rewards deliberate development.

Clinical Reflection Questions

1. What is your current default clinical approach when a patient presents a strong resentment narrative? How closely does it match the evidence-based framework described here?

2. Think of a patient whose injustice-collecting pattern you challenged too early, before sufficient alliance was established. What was the outcome? What would you do differently?

3. Think of a patient whose injustice-collecting pattern you failed to challenge because you were colluding — or because the alliance felt too fragile. What was the outcome of that avoidance?

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4. How do you currently use Socratic questioning in sessions with grievance-presenting patients? What are the two or three most effective questions in your clinical repertoire for this work?

5. How do you use the therapeutic relationship itself as a corrective experience with this population? What specific in-session behaviors on your part most consistently model a new relational experience for them?

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Part 4 · Countertransference: The Clinician's Own Injustice Story

Countertransference: The Clinician's Own Injustice Story

Of all the clinical populations that activate countertransference, few do so as reliably and intensely as the injustice collector. This is not simply because they are difficult to work with — though they are. It is because they are extremely skilled, often unconsciously, at activating the very reactions that confirm their worldview. And because clinicians, being human, carry their own relationships with injustice, resentment, and fairness that this work brings directly to the surface.

The two most common countertransference responses are poles of the same spectrum. At one end is collusion — the clinician who resonates with the patient's narrative, who finds themselves agreeing that yes, the patient has been treated unfairly, that their anger is fully justified, that the people they resent really are villains. This clinician mirrors the patient's worldview, validates the grievances without examining them, and inadvertently reinforces the pattern by providing an authoritative ally in the case for the prosecution. Collusion feels like empathy but functions as abandonment — the patient loses the one person who might have helped them see differently.

At the other end is reactive confrontation — the clinician who finds the patient's grievance narrative exhausting, irritating, or contemptible, and who responds with escalating challenge, dismissiveness, thin patience, or subtle condescension. This clinician may sincerely believe they are being direct and honest, but what the patient receives is confirmation of their worldview: another person in a position of authority who doesn't really listen, doesn't really respect them, and whose guidance is therefore unreliable. The patient adds the clinician to the archive and leaves treatment, or stays and disengages.

What activates each of these responses? Collusion tends to be activated by patients whose grievances resonate with the clinician's own unprocessed experiences of injustice — the clinician who was bullied by authority figures finds themselves over-identifying with the patient's narrative about their oppressive employer; the clinician who has felt disrespected by the treatment system finds themselves cosigning the patient's critique of every previous program. Reactive confrontation tends to be activated by the clinician's own perfectionism or rule-following — the patient's pattern of externalizing blame violates the clinician's value of personal accountability, producing an overcorrection. Or it is activated by fatigue — the grievance-collecting patient is exhausting to work with, and the exhausted clinician's empathy supply depletes faster than usual.

A third countertransference pattern is particularly insidious: the clinician who takes the patient's complaints about them personally. When the injustice-collecting patient begins to add the clinician's interventions to their grievance list — "you never really understood me," "that last thing you said was disrespectful," "other clinicians don't challenge me like this" — the undertrained or undersupported clinician is at risk of either caving to the complaint (abandoning a correct clinical stance to preserve the alliance) or becoming defensive and retaliatory (responding to the challenge to their professional identity with escalating confrontation). Neither serves the patient's treatment. Both serve the clinician's own emotional needs.

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The practice of countertransference management with this population is not optional — it is a clinical necessity. Supervision, peer consultation, and honest self-reflection are not self-care luxuries. They are the mechanisms by which the clinician maintains the calibrated neutrality that the work requires. Specific practices worth developing: a regular self-assessment of your emotional response to individual patients (noticing irritation, over-investment, rescue fantasies, or contempt as data requiring examination); a consultation relationship with a colleague you can be honest with about your reactions; a clear personal awareness of your own injustice-collecting tendencies and their triggers; and a supervision relationship that creates space to process the work rather than simply report on it.

The clinician who has done honest personal work on their own relationship with resentment, fairness, and grievance — through their own therapy, recovery, or deep supervisory work — brings a qualitatively different quality of presence to this clinical challenge. Not because their resentments are gone, but because they know their resentments, they have examined their origins, and they can prevent them from running the treatment session without their knowledge.

Clinical Reflection Questions

1. Which of the two primary countertransference responses — collusion or reactive confrontation — is your more common default when working with injustice-collecting patients? What specific patient presentations trigger each for you?

2. Name a patient whose grievance narrative resonated with your own experience of injustice. How did that resonance affect your clinical work with them? Were you aware of it at the time?

3. How does your treatment team use supervision or consultation to process countertransference reactions to difficult patients? Is there room to be more honest about your reactions than current structures allow?

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4. What is your own relationship with resentment and grievance — not in your patients but in yourself? How might your personal patterns in this area affect your clinical work with injustice collectors?

5. Describe the most challenging moment of countertransference you have experienced with a grievance-presenting patient. What happened? What did you do? What would you do differently?

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Part 5 · Treatment Team Dynamics & Systemic Navigation

Treatment Team Dynamics & Systemic Navigation

The injustice collector does not confine their impact to the individual therapeutic relationship. They operate with equal — and often greater — effect within the larger treatment system. Understanding how injustice-collecting patients create treatment team splitting, how they navigate staff hierarchies in search of allies, and how their grievance dynamics can activate organizational resentments that were already simmering, is essential for any clinician who works in a treatment setting rather than in isolated private practice.

Treatment team splitting is the most predictable systemic effect of the injustice collector in residential or intensive outpatient settings. The patient who collects injustices does not experience staff as a unified team — they experience each staff member individually, testing for sympathetic response and sorting them into allies and enemies based on the results. The technician who expressed sympathy about the food quality becomes "the one person in this place who actually gets me." The counselor who maintained their clinical boundary becomes "the one who has it out for me." The clinical director who enforced a program consequence becomes "the one who runs this place like a prison."

These characterizations are then circulated to other patients, to family members, and to sympathetic staff, creating a system-level grievance narrative that can divide treatment teams, undermine program culture, and derail the treatment of other patients who absorb the narrative.

The clinical leadership response to splitting requires both individual case management and systemic attention. At the individual level: consistent, coordinated team response to the patient that does not give the splitting dynamic the differentiated staff responses it requires. This means regular team communication about the specific patient, explicit awareness of splitting dynamics, and conscious coordination of how different team members handle the patient's grievances about each other. "I know you've had concerns about how [colleague] handled that situation. That's something to discuss directly with [colleague] or in your session. What I want to focus on with you today is..."

At the systemic level: case consultation that names the splitting dynamic explicitly and invites all team members to examine their own reactions, including any organizational resentments that the patient may be accurately intuiting and exploiting. The injustice-collecting patient is often, paradoxically, a skilled reader of organizational dysfunction. They are drawn to pre-existing fissures in treatment teams — tensions between counselors and technicians, between clinical and administrative staff, between the director's stated values and the program's actual practices — because these fissures provide real material for their grievance collecting.

When a patient's complaints about program inconsistency are actually accurate, the clinical response must be able to distinguish between the legitimate systemic critique and the grievance-collecting amplification of it. This requires honest organizational self-examination rather than reflexive dismissal of patient feedback as "addict behavior."

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Managing family and external systems is another dimension of this work. The injustice collector often has a family system that has been organized around their grievance narrative for years — family members who have been cast as villains, others who have been recruited as allies, and family dynamics shaped by decades of accumulated resentments. Family sessions with this population require specific preparation: explicit awareness of the patient's likely use of the family session to obtain additional validation of grievances; clear clinical direction of the session toward communication patterns and recovery support rather than grievance adjudication; and careful attention to how family members' own resentments of the patient may interact with the patient's resentments of them.

Finally, the clinician's role in documenting injustice-collecting presentations in a way that serves treatment without stigmatizing the patient requires careful attention to clinical language. The goal is documentation that accurately describes observable behavior and its treatment implications without labeling the patient in ways that create bias in subsequent providers or that pathologize a pattern that has clear adaptive origins. Behavioral descriptions of specific observable patterns — rather than diagnostic labeling or characterological summary — serve both the patient's dignity and the treatment system's need for accurate information.

Clinical Reflection Questions

1. Describe a time when an injustice-collecting patient created treatment team splitting in your setting. How did the team respond? What worked? What made it worse?

2. What systems does your treatment team currently have for identifying and addressing splitting dynamics? Are they adequate? What would improve them?

3. Has an injustice-collecting patient ever accurately identified a real organizational problem or staff inconsistency while amplifying it with their grievance-collecting pattern? How did you and your team navigate that complexity?

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4. How do you currently document injustice-collecting presentations in your clinical notes? Review recent documentation and assess whether your language is behavioral and clinically precise, or whether it inadvertently pathologizes or creates bias.

5. What organizational resentments or systemic tensions in your treatment setting might be making your program more vulnerable to patient splitting? This is an honest and important question for clinical leadership.

Part 6 · Clinical Competency Self-Assessment

Clinical Competency Self-Assessment

Rate each statement: 1 (Not confident/skilled) to 5 (Very confident/skilled)

I can reliably identify injustice-collecting patterns in patients early in treatment, before they escalate

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Not at all · Very much

I can distinguish between a patient who is genuinely processing a real injustice and one engaged in chronic grievance collection

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Not at all · Very much

I recognize when a patient's resentment narrative is functioning as a relapse risk factor requiring direct clinical attention

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Not at all · Very much

I am aware of the cognitive distortions (attribution bias, confirmation bias, magnification) that drive injustice collecting

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Not at all · Very much

I can identify how a patient's grievance-collecting history is connected to their substance use patterns

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Not at all · Very much

I recognize how injustice collecting manifests differently across populations (first responders, trauma survivors, personality disordered patients)

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Not at all · Very much

I identify when a patient's therapeutic resistance is specifically resentment-driven versus other forms of ambivalence

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Not at all · Very much

I can recognize injustice-collecting dynamics that develop toward me (the clinician) during treatment

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Not at all · Very much

I can engage a patient's resentment narrative without colluding with it or inadvertently reinforcing it

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

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Not at all · Very much

I use motivational interviewing techniques effectively when a patient is defending their grievance collection

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Not at all · Very much

I can help patients develop perspective-taking without triggering defensiveness or rupturing the therapeutic alliance

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Not at all · Very much

I am skilled at using Socratic questioning to help patients examine their interpretive patterns

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Not at all · Very much

I effectively use empathy for the original wound while not validating the ongoing pattern

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Not at all · Very much

I can connect a patient's resentments directly to their substance use in ways they can hear and accept

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Not at all · Very much

I am comfortable making direct clinical observations about a patient's injustice-collecting pattern when clinically indicated

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Not at all · Very much

I effectively facilitate group discussions where injustice collecting is present without the session becoming unproductive

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Not at all · Very much

I am aware of my personal emotional reactions when working with patients who present strong grievance narratives

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Not at all · Very much

I can maintain therapeutic neutrality when a patient's resentment narrative feels valid, invalid, or irritating to me personally

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Not at all · Very much

I recognize when I am being pulled to collude with a patient's injustice narrative (agreeing too readily with their grievances)

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Not at all · Very much

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I recognize when I am being pulled to confront too aggressively (becoming defensive or dismissive of the patient's real pain)

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Not at all · Very much

I use supervision, peer consultation, or personal reflection to process my reactions to difficult grievance presentations

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Not at all · Very much

I can maintain compassion for a patient whose injustice-collecting behavior is making treatment difficult

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Not at all · Very much

I do not become personally reactive when a patient adds me, my feedback, or my clinical decisions to their grievance list

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Not at all · Very much

My own unresolved resentments or injustice-collecting tendencies do not routinely interfere with my work with this population

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Not at all · Very much

I can build and maintain a working therapeutic alliance with patients who are suspicious, defensive, and grievance-oriented

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Not at all · Very much

I effectively manage alliance ruptures when patients add my interventions to their list of perceived injustices

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Not at all · Very much

I understand how to use validation of the real wound as an entry point to exploring the ongoing pattern

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Not at all · Very much

I pace my interventions appropriately — not moving to confrontation before a sufficient alliance is established

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Not at all · Very much

I can be honest with a patient about their pattern without triggering a therapeutic rupture

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Not at all · Very much

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I adapt my communication style to meet injustice-collecting patients where they are rather than where I want them to be

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Not at all · Very much

I effectively use the therapeutic relationship itself as a corrective emotional experience for these patients

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Not at all · Very much

I know when a patient's injustice collecting has exceeded the scope of individual SUD treatment and requires referral or additional clinical support

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Not at all · Very much

I effectively communicate about patients with injustice-collecting patterns to my treatment team without creating splitting or bias

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Not at all · Very much

I recognize and address treatment team splitting when an injustice-collecting patient has divided staff into "allies" and "enemies"

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Not at all · Very much

I maintain professional boundaries when a patient attempts to use me as a validator of their grievances against other staff

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Not at all · Very much

I am skilled at facilitating team case consultation on difficult grievance-presenting patients without pathologizing the patient

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Not at all · Very much

I recognize when a patient's injustice collecting is activating grievance dynamics within the treatment team itself

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Not at all · Very much

I provide clinical leadership in establishing consistent team responses to patients who present injustice-collecting patterns

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Not at all · Very much

I model appropriate clinical responses to grievance presentations for less experienced staff and interns

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Not at all · Very much

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I advocate for patients with injustice-collecting patterns within my organization, balancing empathy with honest clinical assessment

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Not at all · Very much

1. Which competency domain scored lowest? What specific knowledge gaps, skill gaps, or experiential gaps explain this score?

Your clinical reflection...

2. Which domain scored highest — and what has contributed to that strength? How can you build on it?

Your clinical reflection...

3. Which individual items across all domains did you rate as 1 or 2? These represent your most urgent professional development priorities.

Your clinical reflection...

4. What surprises you most about your own profile? Did the assessment reveal a blind spot or confirm what you already suspected?

Your clinical reflection...

5. Based on this assessment, write a brief professional development plan: what are your top three goals for developing greater competency with injustice-collecting patients, and what specific steps will you take to address each?

Your clinical reflection...

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Scoring guide

Reset all progress? This cannot be undone.

Your Clinical Competency Profile

Higher scores reflect greater self-reported competency in each domain. Look for your lowest-scoring domains — these represent your most important professional development priorities for working with this population. Use this profile to guide your supervision conversations and professional development planning.

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Part 7 · Tool 1: Intake Screening — Recognizing Injustice Collector Presentations

Intake Screening Tool

Use this tool during intake assessments to identify early indicators of injustice-collecting patterns.

Document observable indicators, screening questions used, and initial treatment planning considerations...

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Part 8 · Tool 2: Behavioral Pattern Documentation Guide

Behavioral Pattern Documentation Guide

Practice documenting injustice-collecting patterns using behavioral, non-stigmatizing language.

Draft sample documentation that captures the pattern without pathologizing the patient...

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Part 9 · Tool 3: Motivational Interviewing Dialogue Scripts

MI Dialogue Scripts

Practice MI-informed language for engaging resentment narratives without collusion.

Write dialogue examples in your authentic voice for opening resentment conversations, connecting to substance use, exploring ambivalence...

Part 10 · Tool 4: Socratic Questioning Bank for Resentment Work

Socratic Questioning Bank

Build your repertoire of Socratic questions that invite examination without defensiveness.

List your top 10 Socratic questions for examining evidence, exploring patterns, cost-benefit analysis, and opening forgiveness...

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Part 11 · Tool 5: Alliance Building & Rupture Repair Strategies

Alliance Building & Rupture Repair

Develop strategies for building alliances and repairing ruptures with this challenging population.

Document your approach to early alliance building, deepening challenge, and rupture repair protocols...

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Part 12 · Tool 6: Countertransference Reflection & Self-Check

Countertransference Reflection

Examine your emotional reactions and develop management strategies.

Identify your countertransference patterns (collusion, reactive confrontation, personal resonance) and management plan...

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Part 13 · Tool 7: Treatment Team Splitting — Recognition & Response Guide

Treatment Team Splitting Guide

Develop protocols for recognizing and addressing splitting dynamics in your treatment team.

Draft your team's anti-splitting protocol: communication structures, case consultation practices, response coordination...

Part 14 · Tool 8: Group Facilitation Strategies

Group Facilitation Strategies

Practice managing injustice-collecting dynamics in group therapy settings.

Document facilitation approaches for managing dominance, peer targeting, recruiting, staff complaints, and using peer feedback...

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Part 15 · Tool 9: Resentment-Relapse Risk Assessment & Planning

Resentment-Relapse Risk Assessment

Assess resentment as a primary relapse risk factor with ongoing monitoring protocols.

Document active resentment load, substance use connection, recovery engagement quality, and safety planning...

Part 16 · Tool 10: Supervisor & Team Consultation Framework

Supervisor & Team Consultation Framework

Develop effective use of supervision for this high-intensity population.

Plan supervision agenda items: case presentation, countertransference disclosure, team dynamics, stuck cases, ethical clarity...

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