The Withdrawn or Recalcitrant Client

34

Richard Lakeman

34.1 Introduction

There are few groups who raise the anxiety of psychiatric/mental health nurses (P/MHNs) more than those who don't improve as expected, those who don't follow recommendations or those who fail to engage with P/MHNs in a cooperative way. Main (1957, p. 129) suggested that the sufferer who frustrates a keen therapist by failing to improve is always in danger of meeting primitive (retaliatory) human behaviour disguised as treatment. He observed that nurses would only give a sedative when they were unable to stand the patient's problems without experiencing anxiety, impatience, guilt, anger or despair, whatever their justification for the treatment. Today the reluctant, recalcitrant or a-motivated service user is at risk of coercion and increasingly desperate and frequently nonevidence-based treatment measures. An armoury of long-acting "depot" medications, other dangerous medications and electroconvulsive therapy (ECT) may be imposed on individuals who fail to improve at the pace expected of them, often perpetuating a cycle of further resistance and reluctance to engage with the mental health-care system. Accordingly, this chapter explores the nature of resistance and offers some interventions and principles of practice that might be helpful whatever the cause.

R. Lakeman
Adjunct Associate Professor, School of Health & Human Science,
Southern Cross University,
Lismore, NSW, Australia

Visiting Senior Lecturer, Faculty of Health,
University of Tasmania, Australia

Adolescent Mental Health Nurse Navigator/Clinical Nurse Consultant
Cairns & Hinterland Health Service District,
Queensland Health, Australia
e-mail: richard.lakeman@scu.edu.au

J.C. Santos, J.R. Cutcliffe (eds.), *European Psychiatric/Mental Health Nursing in the 21st Century*, Principles of Specialty Nursing,
https://doi.org/10.1007/978-3-319-31772-4_34

34.2 Understanding Resistance: Origins, Background and Overview

People who fail to follow health-care advice, who are seen to lack motivation or who actively resist caregivers are often labelled as resistant or reluctant. For the most part, resistance and social withdrawal are best understood as functions of the dynamics between people. People tend to resist what they fear, what they don't want and what is imposed on them. Yalom (1992, p. 220) tentatively proposed:

> perhaps symptoms are messengers of meaning and will vanish only when their message is comprehended.

P/MHNs need to consider what symptoms mean. As a first example, problems with drive and motivation may be part of recognised disorders, but this does not render those symptoms meaningless; often people diagnosed and treated for mental health problems have quite understandable reasons for resisting the well-meaning ministrations of treatment teams. It is worth familiarising oneself with some of the so-called disorders that are thought to impact on motivation and drive.

34.2.1 Neurological and Medical Conditions

Social withdrawal and a-motivation have long been considered part of a range of so-called disorders and syndromes including neurological conditions, the effects of traumatic injury, medical conditions and drug-induced states (see Marin and Wilkosz 2005). In neurology, a-motivation falls on a continuum from *apathy* or indifference at one end, *aboulia* or a lack of will or initiative in the middle and at the extreme pole, *akinetic mutism* (an absence of movement and speech). Treating the primary cause where possible, optimising the person's physical well-being, reducing medications that aggravate a-motivational symptoms, understanding and remediating cognitive deficits and creating an enriched positive environment are important treatment considerations. At the extreme end of the continuum, pharmacological treatments may be introduced as part of treatment, e.g. activating antidepressants, dopamine agonists and stimulants, in addition to specialist neuropsychological treatments (Marin and Wilkosz 2005).

34.2.2 Psychiatric Syndromes

In psychiatry degrees of a-motivation may be part of common syndromes such as (so-called) depression and psychosis and may be exacerbated by common pharmacological treatments (particularly the major tranquilisers). Bleuler who first coined the term schizophrenia suggested that the most prominent symptoms could be categorised as the "4 As", i.e. problems with *associations* between thoughts,

ambivalence, *affect* and *autism*. Although debates continue about what were the more important symptoms of Bleuler's definition and in particular the importance of dissociation and splitting (see Moskowitz and Heim 2011), Bleuler recognised that some people with this complex syndrome of heterogeneous symptoms withdraw from the world and become preoccupied with their inner experience (*autism*). More recently distinctions have been made between (so-called) negative symptoms (an absence or diminishment of functioning), (so-called) positive symptoms (reflecting an excess) and cognitive symptoms (Marneros et al. 2012). Positive symptoms (which include delusions and hallucinations) are generally considered more amenable to treatment, and social withdrawal and cognitive problems are generally considered to be more disabling and resistant to pharmacological treatments. *A-volition* is the term used to describe a general decrease in the motivation to initiate and perform self-directed purposeful activities which is sometimes observed in people who may be diagnosed with schizophrenia.

Fusar-Poli et al. (2015) note the importance of distinguishing between symptoms which may be "secondary" to pharmacological treatments and those that appear persistent. Negative symptoms may be secondary to the use of neuroleptic drugs (which traditionally have been very tranquilising and induce states similar to Parkinson's disease). Negative symptoms may also be a response to unstimulating environments (a feature of impoverished community settings as well as traditional total institutions). More recently it has been noted that negative symptoms may not cluster together so neatly and unsurprisingly are inconsistently responsive to pharmacotherapy (Erhart et al. 2006). Regardless of cause however, apathy and a-motivation appear to be the most important predictor of poor functional outcomes in research involving people diagnosed with schizophrenia (Fervaha et al. 2013; Fusar-Poli et al. 2015).

What may be considered a contentious part of one syndrome may sometimes be considered an essential feature of others. *Anhedonia*, for example, is the loss of enjoyment in activities previously found enjoyable. This concept is central to notions of depression, although depression too is an amorphous syndrome with multiple possible causes. People diagnosed with schizophrenia often report anhedonia, but they have been found to enjoy activities "in the moment" as much as people without this diagnosis (Strauss 2013). Where they may differ is in the *anticipation* of pleasurable experiences (if people don't anticipate that an activity is likely to be pleasurable, their motivation to do it is reduced). There is some evidence that negative thoughts about one's ability to successfully perform goal-directed behaviour can prevent behaviour initiation, engagement and anticipatory pleasure (Campellone et al. 2016). Beck et al. (1979) famously observed that depression can be characterised as holding negative beliefs about oneself, the world and the future (known as the cognitive triad of depression). From this model the remedy is to assist the person to adopt more reasonable, realistic thoughts about themselves and the world and reduce ruminations and thinking which are predictive of bad outcomes. Finally fatigue or tiredness, chronic pain and indeed chronic stress can sap people's drive and motivation and can contribute to depression and hopelessness.

34.2.3 Resistance as a Psychological Concept

Resistance connotes a more active stance on the part of people to *not* move forward or do what is needed. In psychoanalytical traditions, resistance was first understood as an effort to repress anxiety-provoking insights and memories and later was ascribed to a reluctance to accept the interpretation of the therapist. In other words resistance is an attempt to control anxiety, and it is more or less functional and necessary for mental health. Resistance can be a function of people's stage of development. For example, it is a natural part of adolescence to resist the direction and control of adults and to identify more strongly with peer groups. This pushing against parental or adult authority assists in the process of identity formation and is arguably essential to enable the young person to leave the comfort of home. Resistance however can be reflected in distorted thinking, a failure to see the best way forwards, an unwillingness to change and sometimes in overt opposition to the P/MHN or the helping process. Generally speaking when engaging with a person in a therapeutic conversation, topics that appear to engender resistance and shifts in affect should be carefully noted and attended to. Sometimes the communication can be quite overt—"Don't go there", the subtext being that this topic is potentially too anxiety-provoking right now. The P/MHNs may use this moment to make an empathic comment, e.g. they can see or sense that this topic causes some discomfort and ask the person whether they would prefer to discuss it at a later time.

The notion of resistance as a feature of the psychology of the individual (whether unconscious or an actively chosen behaviour) can be useful. However, this view can obscure the more commonly encountered reasons for resistance, which are more to do with the *dynamics* or relationships between people. A view which considers interpersonal dynamics invites the nurse to consider how their own behaviour may influence the behaviour of the other(s) (see, e.g. Table 34.1). It can be empowering to "reframe" resistance as a P/MHNs issue: it is widely recognised that one cannot change clients, whereas one *can* change how one interacts with them.

Table 34.1 Resistance as a mental health-care professional (MHCP) problem

Resistance occurs when the MHCP
Fails to recognise that all clients are ambivalent about change
Wants more for clients than clients want for themselves
Goals clash with the client's
Is too intent on his/her own agenda
Is going too fast
Does not know what to do
Asks the wrong question or makes a poorly worded or unacceptable statement which to the client is unfathomable and unrealisable
Feels uncomfortable in response to the client's behaviour
Fails to cooperate with the client
Is resisting the client's position

Adapted with permission from Mitchell (2012, p. 8)

34.2.4 Trauma and Learned Helplessness

Childhood abuse, neglect and trauma have been found to play causal roles in depression, anxiety disorders, post-traumatic stress disorder, eating disorders, substance abuse, personality disorders, dissociative disorders and psychosis (Read et al. 2004). The greater the number of adverse childhood experiences a person is exposed to, the more likely they are to engage in risk-taking behaviour, have poor health maintenance behaviours, become ill from a range of often preventable diseases and die prematurely (Felitti et al. 1998). Not surprisingly people exposed to trauma early in their lives, particularly when they do not experience secure, warm and consistent attachment to a caregiver, subsequently have a great deal of difficulty trusting people and sustaining relationships with others (Pearlman and Courtois 2005). The relationships people have with P/MHNs may also be tenuous—why should people trust P/MHNs or other relative strangers when the person's experience of their primary caregivers or others in authority has been a failure to protect, inconsistency and sometimes abuse?

The person's experience of health and welfare systems may also exacerbate a sense of powerlessness and mistrust and a feeling that relationships with helpers are shallow, coercive and uncaring. Watkins (2001, p. 133) suggests that it is not surprising that people with "severe mental health problems" are unwilling to engage with mental health services, given there is sometimes a "legacy of distrust" founded on dealings with statutory agencies, traumatising experiences of past hospitalisations, enforced treatment and experiences of discrimination and racism in their past dealings with health professionals. The experience of having to tell a story multiple times or having to see multiple health professionals before engaging with a primary therapist can be psycho-noxious for someone with attachment trauma. Health professionals need to be alert to the impact of early attachment experiences, trauma and people's experience of engagement with the health-care system and anticipate that many people will not conform to a compliant or acquiescent patient role. Programmes such as 'Safe Wards' aim to reduce the potential for coercionon in hospital through encouraging P/MHNs to engage in respectful interactions and anticipating issues that may cause conflict and responding in a kind and empathic manner (Bowers, et al. 2015).

Health professionals may need to earn the trust of people they work with through demonstrating unconditional positive regard (Rogers 1957) and engaging in a certain kind of respectful, "containing" relationship which individuals may not expect or have experienced before. Indeed, purposefully doing the unexpected is a tool to deal with resistance. As Mitchell (2012, p. 37) notes, "… socially typical responses are, by and large ineffective in creating therapeutic movement. Typical responses beget typical reactions…". Responding to hostility, blaming, anger or expressions of hopelessness (which might ordinarily elicit rejection or defensive behaviour) with compassion, curiosity, empathy and hope may not only help build an alliance, they may also be inherently therapeutic.

Early research examining what happens to both animals and humans when exposed to repeated traumatic events over which they have little control elucidated the concept of "learned helplessness" (Seligman 1973, 1975; Mikulincer 2013).

Over time people in essence give up trying to change their situation or resist what they perceive as being beyond their control. They become apathetic and a-motivated. Resistance can be a highly adaptive response to situations of abuse or injustice, yet people often don't engage in health-affirming behaviour because they don't perceive that it will make a difference. This can in part explain highly institutionalised behaviour. The kind of resistance often seen in response to coercive care might also be considered a natural, if not healthy response.

34.3 The Coerced or Involuntary Client

All Western countries have legislation to enable such compulsory assessment and treatment. People who have committed crimes may also be compelled to submit to therapy including those who have committed sexual offences or who have been identified as having problems with illicit drugs or alcohol. Not surprisingly people tend to resist (often quite actively through anger and sometimes violence) the deprivation of their liberty and treatment or care imposed on them. Regardless of their legal status, people may perceive that they have little choice in their treatment or care or about important decisions in their lives. The *perception of coercion* and perception of choice are pivotal to the dynamics that may play out between the individual and MHCPs. Some people who are legally required to engage in treatment may have no perception of coercion at all, and others may welcome help and treatment regardless of perceived legal pressure. Others may not be subject to any legal order but fear that if they don't comply they will be compelled to go to hospital, lose entitlements (e.g. housing or pensions) or lose valued support. People's fears and perceptions around coercion need to be explored.

People may come to accept the need for coercion, particularly when they have been engaged in dangerous behaviour, but they often assert that coercive processes could have been undertaken in a more considerate manner (Sibitz et al. 2011). In many instances MHCPs have little choice but to work with people compelled to be involved with their service, and they may be required to enforce treatment plans in which they have little personal investment and with which they don't agree. This unique dynamic has rarely been explored. A useful strategy to build relationships and to minimise conflict around coercion is for MHCPs to acknowledge this shared position with the client, being honest about what aspects of care or treatment are non-negotiable and being clear about what choices are available. Honesty, transparency and maximising choice are critical ingredients of recovery-orientated practices (Lakeman 2010) as is wholeheartedly embracing and operationalising trauma-informed care (see Chap. 13).

34.4 Motivation and Readiness for Change

People may appear resistant or fail to adhere to treatment plans because they are not ready to change, or more particularly, MHCPs are not in step with their stage of readiness. *Motivational interviewing* (MI) encompasses a range of theories about

change; it articulates ways to identify readiness and practices to assist in shifting people towards making positive changes in their life. It is based on an understanding that people are often *ambivalent* about change and may present with conflicting emotions and thoughts about taking a particular course of action. Ambivalent people met with highly directive or coercive demands for change from health professionals often "dig in" and resist change even further. Consider, for example, smoking cessation—most people are aware of the potential dangers of smoking, yet rarely does a health professional telling them they "should" stop lead to a commitment to changing behaviour. Resistance always arises when there is a mismatch between the MHCP's and the person's aspirations for behavioural change (ABCs)—most commonly when the MHCP's ABCs are high for change in particular area and the person's are low (e.g. the MHCP believes the person should exercise more and eat less junk food, whereas the person does not perceive this as important). The MHCP may ineffectually attempt to manipulate, persuade or cajole the person to change. Conversely the person may have a high ABC on one issue where the MHCP's is low (e.g. the person believes they need a medical intervention to reduce weight, whereas the MHCP believes they should make lifestyle changes). Such a clash of agendas needs to be worked through to prevent an unproductive struggle. The emphasise ought to be on negotiating mutually agreeable goals to progress.

People vary in their *desire* for change, perceived *ability* or confidence to make changes, specific *reasons* for making changes and perceptions of *need* for change (consider the acronym DARN). As illustrated in Table 34.2, the MHCP can ask

Table 34.2 Assessing motivation through listening and asking about change talk

Change talk	Statements about…	Questions to elicit change talk
Desire	Preference for change "I want to…" "I would like to…" "I wish…"	"Why would you want/like/wish/hope….?" How important is this to you?
Ability	Capability "I could…" "I can…" "I might be able to…"	"How would you do it, if you decided to?" "What are you able to do?" "What could you do?
Reasons	Arguments for change: "I would feel better if…" "I would have more… if…"	"What are your three best reasons for …?" "Why would you make this change?" "What would be some benefits of change?"
Need	Feeling obliged to change "I ought to…" "I have to…" "I should…"	"How important is it to you…?" "How much do you need to…?"
Commitment	The likelihood of change "I am going to…" "I will…" "I intend to…"	"What do you think you will do?" "What if anything do you intend to do?"
Taking steps	Action taken "I actually went out and…" "I cut down…"	"What have you done already?" "What would be a first step for you?"

Source: Adapted from Rollnick et al. (2008)

questions and listen for talk about change. Note that individuals will vary in the intensity of their desire, their confidence, how pressing their reasons and how compelling their perceived need for change. They may, for example, desire something greatly but have a low confidence in their capability to achieve it. Their ambivalence may be expressed in statements such as "I really want to give up smoking [desire], but I really don't think I can [ability]". Additionally, expressions of commitment to change suggest a greater *likelihood* of actually making change, and taking actual steps towards change may suggest that a person is *ready* to make change.

34.5 Responding to Resistance and Recalcitrant Behaviour

Just as numerous theoretical lenses can be employed for *understanding* resistant or difficult behaviour, so too many different approaches may considered in determining *how best to respond*. Mental health nurses who work with people with complex needs ought to develop and maintain a "toolbox"/set of useful psychotherapeutic skills. Education and supervised practice in solution-focused and strengths-based therapies (see, e.g. Ungar 2015), positive psychology and motivational interviewing (see, e.g. Rollnick et al. 2008; DiClemente and Prochaska 1998) will be particularly useful. The following are a precis of some general principles to consider when working with resistant clients.

34.5.1 Build an Alliance

The capacity to work productively with someone using any set of skills depends a great deal on the quality of the relationship that is formed between P/MHNs and person. Rogers (1957) famously observed that the necessary and sufficient conditions for personality growth of clients in therapy were congruence on the part of the therapist, communication to the client of the therapist's empathic understanding and unconditional positive regard. As has been noted, prior adverse experience (of the patient, the P/MHN or both), conflicting goals and resistant behaviour sometimes make it difficult to establish or sustain an ideal relationship. Trotter (2015) suggests that when working with involuntary clients (of all kinds), what has been emphatically demonstrated to work are role clarification, reinforcing and modelling prosocial values, collaborative problem solving, cognitive behavioural strategies and providing a service in an integrated way. Developing the relationship through appropriate use of empathy, humour, the communication of optimism, judicious use of self-disclosure, working with family and peers and employing principles of case management have all been found to be somewhat helpful. Clarifying with the person what the P/MHN's role is from the outset and revisiting that periodically are helpful in building a working alliance. This is particularly true when the P/MHN may have multiple roles in relation to the person. The P/MHN needs to be clear with what services or tasks they may be mandated to provide and which are negotiable.

Modelling unconditional positive regard and maintaining a friendly, concerned and professional countenance may be taken as a given. As important is modelling how to contain anxiety and strong emotions and to deal with inevitable ruptures that may occur in the relationship. Sometimes service users may express overt hostility or anger towards the P/MHN and be unable to regulate their emotions or arouse fear and anxiety in caregivers. The P/MHN needs to learn to contain these strong emotions in a similar way to that of a good-enough parent who calmly soothes an infant experiencing distress. This skill of emotional containment has recently been conceptualised as pivotal in the care and treatment of people with personality disorders (Goodwin 2005). It is now widely recognised that interpersonal environments characterised by high expressed emotion (i.e. over involvement, critical comments and hostility) contribute to a worsening of problematic behaviours in a wide range of mental health presentations (van Audenhove and Van Humbeeck 2003). P/MHNs need to learn to moderate and contain their own responses to distress and distressing behaviour (reduce expressed emotion) and model how to solve problems.

34.5.2 Be Motivational

Motivational interviewing involves some core skills that might be considered universally good practice in the helping field, e.g. resisting the righting reflex, understanding the person's motivation, listening and empowering (Rollnick et al. 2008). MI involves reaching agreement on a focus and setting an agenda and emphasises the "spirit" of the approach. Conversations exploring and building motivation to change progress through exchanging information, asking useful questions, listening reflectively and sometimes using structured approaches (e.g. eliciting the pros and cons about a particular behaviour). Summarising progress, returning to agenda setting and considering the next step are part of the iterative process.

People rarely benefit from being told that something is wrong with them, nor do they respond well to being told what to do. A first principle in motivational interviewing is "resisting the righting reflex", that is, to avoid correcting another's course, giving unsolicited advice or overusing direction. People have a natural tendency to resist persuasion (no matter how well motivated). If the P/MHNs or others argue for change (e.g. "You ought to do…"), then the person is likely to argue against change. Whilst there may be an occasional need to confront, inform or announce a different viewpoint, these strategies ought to be used the least and undertaken with great care and often with permission.

P/MHNs will be well acquainted with communicating empathically (e.g. "You feel… [identifying the correct emotion and intensity]… when or because… [identifying accurately the trigger]") (Egan 2013) or using selective reflection to enable deeper exploration about a topic of interest. A motivational form of reflection involves selectively reflecting the change talk (illustrated in Table 34.3) and/or the person's ambivalence. The goal (and natural tendency of the person) is for them to then argue *for* change or a different behaviour. Being motivational also means

Table 34.3 Twenty skills for ecological practice

Navigation skills
1. Make resources available—help the person identify internal and external resources
2. Make resources accessible—discuss how the person can access resources
3. Explore barriers to change—discuss the barriers to change and what resources are most likely to address which barriers
4. Build bridges to new services and supports—discuss supports that are available and build bridges to make new resources available and accessible
5. Ask what is meaningful—explore which resources are the most meaningful given the person's culture and context
6. Keep solutions as complex as the problems they solve—explore solutions that are as complex (multi-systemic) as the problems they address
7. Find allies—explore possible allies who can help the client access resources and put new ways of coping into practice
8. Ask whether coping strategies are adaptive or maladaptive—explore the solutions that the person is using to cope in challenging contexts and the consequences of the choices the person is making
9. Explore the person's level of motivation—discuss with the person their level of motivation to implement preferred solutions
10. Advocate—advocate with, or on the behalf of, the person, or show the person how to advocate independently to make resources more available and accessible
Negotiation skills
11. Thoughts and feelings—explore the person's thoughts and feelings about what brought the client into contact with the helping system
12. Context—explore the context in which problems occur and the conditions that sustain them
13. Responsibility—discuss who has responsibility to change patterns of coping that are causing problems for the person and/or for others in the person's life
14. Voice—help the person's voice be heard when they name the people and resources necessary to make life better
15. New names—when appropriate offer new names and descriptions for problems and explore the new meanings for the person
16. Fit—enable the person to choose one or more descriptions of the problem that fit with how they see the world
17. Resources—work together to find the internal and external resources to help the person put new solutions into practice
18. Possibilities—enable the person to experience possibilities for change that are more numerous than expected
19. Performance—identify times when the person is performing new ways of coping and discuss who will notice the changes
20. Perception—help the person find ways to communicate to others that they have changed or are doing better than expected

Adapted with permission from Ungar (2015)

understanding what motivates and drives specific individuals, their values and aspirations and whether they are motivated primarily by intrinsic or extrinsic rewards. Where people may appear high on desire but low on other aspects of motivation, then the MHCP may need to negotiate the provision of incentives. A long-standing and robust principle of behavioural psychology is that behaviour that is followed by positive consequences is likely to be repeated. Providing incentives or rewards for

meeting specific behavioural goals (e.g. verified abstinence) has a strong evidence base in drug use (Carroll and Onken 2005), and increasingly direct incentives are proving to be useful to secure adherence to many health treatments of importance to public health. However, few things motivate individuals more than the praise, attention and approval of peers and trusted people. Therefore, praise people often and acknowledge their struggles and achievements.

34.5.3 Be Ecological/Solution Focused

A tradition and tendency of health and welfare services has been the focus on the identification of problems. Service users frequently develop or have reinforced a perception that they are at fault and need fixing. Often however, the person's problematic behaviour is a response to contexts beyond their control. As Ungar (2015, p. 66) notes "Individuals are not to blame for the strategies they use to cope in contexts that deny them choices". An ecological approach to problems emphasises the development and mobilisation of skills in navigation and negotiation (see Table 34.3) to identify and evaluate internal and external resources available to them and help people influence which resources they receive, by whom, how, when and where. Emphasising the idea of *resourcing* the person to deal with the world rather than fixing them goes a long way to avoiding conflict and positions the P/MHNs as an ally in coping. Giving people something they want or need is a shortcut to building a relationship. Indeed, whether or not people perceive they got something of value from their first encounter with a P/MHN may well influence the trajectory of the relationship from that time forward.

Being solution focused is in part a way of being as well as encompassing a set of techniques. An elegant and respectful way to demonstrate being solution focused is to judiciously attempt to reframe deficit and negative talk, statements about what people don't want into a desire for a solution, a more positive frame or a statement about what people want:

e.g. "I really hate that doctor… he never listens to me" [person]
"You would feel warmer towards your doctor if you had more opportunities to be heard" (P/MHN)
e.g. "I find it so hard to get out of bed right now" [person]
"You would like to have more energy in the mornings" (P/MHN)

The classic solution-focused question which can elicit aspirations for positive goal setting is the "miracle question". Have the person imagine or anticipate at some point in time in the future (the next day when they wake up or in a year's time) that their problems are resolved (and they don't need to know how it happened). Ask them to describe how it would be and what they would be doing. A variation of this approach (anticipatory open dialogue) can also be used with families or others in the network (Seikkula et al. 2006)—what they imagine things might be like and how they might help people get there.

34.5.4 Clarify and Set Meaningful Goals

People don't tend to resist what they really want. Often people may want something from the relationship but not always what is being offered. Early in the relationship, it is important to negotiate meaningful goals. Goal setting will proceed from an evolving understanding of the person, their context and the resources available to them. Where the individual's goals appear to be discordant with the health-care team, it is necessary to find some common ground. The aforementioned miracle question can be helpful to identify areas to aspire to. It is important to explore the person's motivation to attain a particular goal. Goal setting involves a commitment of one or more people to do something. As well as being specific, meaningful, action-orientated, realistic and with a clear time frame ("SMART"), the P/MHN may need to assist the person to determine who needs to do what and to identify motivational rewards or contingencies if the steps are not intrinsically motivating in themselves.

34.5.5 Engage Allies

An ecological approach acknowledges that people are part of a social system that is an integral part of a person's life and is a necessary resource for a person's well-being. P/MHNs are part of that system and whilst a fundamental goal is to be an ally to the person, the P/MHN also needs to mobilise other social resources. The P/MHN ought to negotiate who needs to be involved and what roles they need to assume. Consider, for example, someone who needs to lose weight. Some people may need information (and referral to a dietitian), some may need a coach (a referral to an exercise physiologist) or a companion to attend an exercise class with, whilst others might need a family intervention. All forms of family therapy and solution-focused therapy acknowledge that the solutions to problems or the resources to solve them are largely within the social group.

A sense that a team is working together to find solutions is a powerfully and reassuring idea. It is perhaps one of the critical ingredients of programmes such as assertive community treatment (the most evidenced-based programme for people with complex mental health needs) and is fundamental to innovative new programmes such as open dialogue (Lakeman 2014). Readers will note Ungar's (2015) list of negotiation skills (Table 34.3) ending with having the person's voice heard and their improvement witnessed by others. This involvement, witnessing and engagement with others are a powerful motivator of positive behaviour, and connectedness with others is perhaps the lynchpin of mental health. People need the opportunity to share their successes, help others and be needed by a social group. Engaging peer support and encouraging people to be peer supporters are a sound motivational strategy.

Lastly, P/MHNs need to remain engaged with allies themselves. When enmeshed in clinical roles, it is sometimes hard to see the forest (dynamics) for the trees (behaviours). Clinical supervision or at least open dialogue with others who are able

to identify the dynamics involved in interactions, able to model the kind of containing presence that MHCPs need to model and able to enrich the P/MHN's toolbox of solution-focused strategies is essential to developing effective practice with the recalcitrant or highly resistant client.

References

Beck AT, Rush AJ, Shaw BF, Emery G (1979) Cognitive therapy of depression. Guilford, New York

Bowers L, James K, Quirk A, Simpson A, Stewart D, Hodsoll J (2015) Reducing conflict and containment rates on acute psychiatric wards: the safewards cluster randomised controlled trial. Int J Nurs Stud 52(9):1412–1422

Campellone TR, Sanchez AH, Kring AM (2016) Defeatist performance beliefs, negative symptoms, and functional outcome in schizophrenia: a meta-analytic review. Schizophr Bull 42(6):1343–1352

Carroll, K. M., & Onken, L. S. (2005). Behavioral therapies for drug abuse. American Journal of Psychiatry, 162(8), 1452–1460.

DiClemente CC, Prochaska JO (1998) Toward a comprehensive, transtheoretical model of change: stages of change and addictive behaviors. Plenum, New York

Egan G (2013) The skilled helper: a problem-management and opportunity-development approach to helping. Belmont, Cengage Learning

Erhart SM, Marder SR, Carpenter WT (2006) Treatment of schizophrenia negative symptoms: future prospects. Schizophr Bull 32(2):234–237

Felitti VJ, Anda RF, Nordenberg D, Williamson DF, Spitz AM, Edwards V, Marks JS (1998) Relationship of childhood abuse and household dysfunction too many of the leading causes of death in adults: the adverse childhood experiences (ACE) study. Am J Prev Med 14(4):245–258

Fervaha G, Foussias G, Agid O, Remington G (2013) A-motivation and functional outcomes in early schizophrenia. Psychiatry Res 210(2):665–668

Fusar-Poli P, Papanastasiou E, Stahl D, Rocchetti M, Carpenter W, Shergill S, McGuire P (2015) Treatments of negative symptoms in schizophrenia: meta-analysis of 168 randomized placebo-controlled trials. Schizophr Bull 41(4):892–899

Goodwin JM (2005) Redefining borderline syndromes as posttraumatic and rediscovering emotional containment as a first stage in treatment. J Interpers Violence 20(1):20–25

Lakeman R (2010) Mental health recovery competencies for mental health workers: a Delphi study. J Ment Health 19(1):62–74

Lakeman R (2014) The finnish open dialogue approach to crisis intervention in psychosis: a review. Psychother Austr 20(3):26–33

Main TF (1957) The ailment. Br J Med Psychol 30(3):129–145

Marin RS, Wilkosz PA (2005) Disorders of diminished motivation. J Head Trauma Rehabil 20(4):377–388

Marneros A, Andreasen NC, Tsuang MT (eds) (2012) Negative versus positive schizophrenia. Springer Science & Business Media, Berlin

Mikulincer M (2013) Human learned helplessness: a coping perspective. Springer Science & Business Media, New York

Mitchell CW (2012) Effective techniques for dealing with highly resistant clients, 2nd edn. Clifton W. Mitchell, Tennessee

Moskowitz A, Heim G (2011) Eugen Bleuler's dementia praecox or the group of schizophrenias (1911): a centenary appreciation and reconsideration. Schizophr Bull 37(3):471–479

Pearlman LA, Courtois CA (2005) Clinical applications of the attachment framework: relational treatment of complex trauma. J Trauma Stress 18(5):449–459

Read J, Mosher LR, Bentall RP (2004) Models of madness: Psychological, social and biological approaches to schizophrenia. Psychology Press, London
Rogers CR (1957) The necessary and sufficient conditions of therapeutic personality change. J Consult Psychol 21(2):95
Rollnick S, Miller WR, Butler CC (2008) Motivational interviewing in health care: helping patients change behaviour. Guilford, New York
Seikkula J, Arnkil TE, Hoffman L (2006) Dialogical meetings in social networks. Karnac Books, London
Seligman MEP (1973) Fall into helplessness. Psychol Today 7(1):43–48
Seligman MEP (1975) Helplessness. Freeman, San Francisco
Sibitz I, Scheutz A, Lakeman R, Schrank B, Schaffer M, Amering M (2011) Impact of coercive measures on life stories: qualitative study. Br J Psychiatry 199(3):239–244
Strauss GP (2013) The emotion paradox of anhedonia in schizophrenia: or is it? Schizophr Bull 39(2):247–250
Trotter C (2015) Working with involuntary clients, 3rd edn. Allen & Unwin, Sydney
Ungar M (2015) Working with children and youth with complex needs: 20 skills to build resilience. Routledge, New York
van Audenhove C, Van Humbeeck G (2003) Expressed emotion in professional relationships. Curr Opin Psychiatry 16(4):431–435
Watkins P (2001) Mental health nursing: the art of compassionate care. Butterworth-Heinemann Medical, Oxford
Yalom ID (1992) When nietzsche wept: a novel of obsession. Harper Collins, New York