Current Psychiatry

Engage resistant patients in collaborative treatment

First identify and work on what they really want

David Mee-Lee, MD
DML Training and Consulting
Davis, CA

Whenever you feel you are doing more work than the patient and are more invested than he is, something has gone wrong in collaborative care.

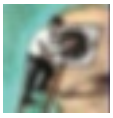
With resistant or hostile patients, fight the urge to move quickly into clinical assessment and to prescribe what you think should be worked on and how. Instead, spend more time—especially when building the treatment alliance in the first 15 minutes (*Box*[1], *page 48*)—exploring their ideas on how, when, and where they feel they can achieve what is most important to them (*Table 1*[2], *page 50*).

Resistant patients may have different agendas, but taking a pragmatic approach can merge their goals with yours.

WHAT DOES THE PATIENT WANT?

When a patient is difficult to engage, begin by listening for the most important concern that brought him to your office.

He may be depressed, anxious, or tired, but exploring why he decided to seek help now ("My



Box

Building the all-important alliance

More than 2,000 research publications in the last 30 years prove the clinical importance of the therapeutic alliance.[1] When working with resistant patients, keep these points in mind:

Develop a strong alliance early in treatment. "Early" is relative to the length of therapy, but evidence suggests sessions 3 to 5 are a critical window.

The patient's experience of being understood, supported, and provided with hope depends on the strength of the alliance early in therapy. His or her interpretation of what you do can be different from what you intend. You may be a great clinician but not necessarily for this particular individual at this time, doing the kind of work you do.

Progressively negotiate the quality of the relationship. The patient's perception of the alliance—not yours—is most influential. Ask specifically if the treatment relationship is working for him or her.

Early in treatment, the alliance itself contributes more to outcomes than do therapeutic techniques and models. First develop a collaborative agreement on the goals and strategies to be used in the therapeutic work.

wife said she would leave me if I didn't get help") reveals what is most important. The "treatment contract," then, is helping this patient save his marriage.

INITIAL ENGAGEMENT

Collaborative treatment begins with a genuinely interested dialogue about what prompted the patient's visit.

Therapist: "Thank you for choosing to work with me. How may I serve you? What is the most important thing you want me to help you with?"

Mr. L: "I didn't choose you; they made me come."

T: "I didn't see anyone drag you in. What would happen if you had not come today?"

Mr. L: "I might lose my job. I came because my boss told me to."

Focus on what the patient wants, not just what others have said he or she needs (treatment for substance abuse, angry outbursts, conflict at work). The patient may want to stay out of jail, keep his job or relationship, regain custody of his or her children, obtain housing, or get people to "leave me alone and quit locking me up against my will." Although the patient's problem may be obvious to us, he needs "discovery" work, not "recovery" work.

Why has the patient come now? What is his highest priority? Can we help him discover the link between his drinking or anger that affects his work performance?

Therapist: "So you want to get the boss off your back. You want people to leave you alone. You feel people treat you unfairly and want them to stop. But why did you come today and not last week or last month?"

Mr. L: "I came now because yesterday my boss said I could lose my job if I didn't get some help."

T: "So what you want most importantly is to keep your job, is that it?"

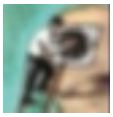
Mr. L: "Well yeah, but I don't have a drinking problem or any problem with my temper. They're just overreacting. It wasn't as bad as they said."

T: "OK, I am willing to work on helping you keep your job if that's what is most important to you. Do you know what you are doing that makes them think you have a drinking or anger problem?

Mr. L: "All I did was come in late a couple of times and got into a little argument with a couple of people."

T: "If we are going to help you keep your job, we could spend our time talking about how unfair your

continued on page 50



continued from page 48

Table 1

How to merge the reluctant patient's goals with clinical needs assessment

	Questions to prioritize patient goals	Questions for clinical needs assessment	Merging patient goals with assessed needs
What?	What does the patient want the most? What undesired consequences will occur if s/he does not get help?	What does the clinical assessment indicate s/he needs? What obstacles/ assets do you need to address to help her/him get what s/he wants?	What treatment contract will drive the treatment plan and organize treatment priorities?
Why?	Why did s/he seek help now? Has s/he realized or been told s/he is at risk to lose freedom, health, a relationship, or a job? How committed to change is s/he?	Why are the assessed obstacles and resources important to include in a treatment plan? What diagnostic, function, or severity problems do assessment data reveal?	Is the treatment plan linked to what s/he wants? Does s/he accept that the treatment priorities will help her/him get what s/he wants?
How?	How will s/he achieve the most important goal? Must you try her/his preferred treatment before s/he accepts methods you prescribe?	How will you develop patient buy-in and get her/him to accept the plan?	Does s/he believe your strategies will help get what s/he wants? Will s/he be actively invested or passively compliant in treatment?
Where?	Where is s/he willing to be treated? Does s/he have strong preferences (such as about group treatment or residential programs)?	Where is the appropriate setting for treatment? What is indicated by the placement criteria?	Refer her/him to the level of care that merges his/her preferences with what is clinically indicated and likely to be effective
When?	When does s/he want to begin treatment? Is s/he feeling pressure to start? How badly does s/he want treatment, or is s/he just complying?	When should treatment begin, based on your assessment? What are realistic expectations and milestones in the process?	How urgent is treatment? What is the process? What is expected from referral?

Source: Adapted from reference 2, Table 3.

boss is and how she's misjudging you. Or we could work to show her that she has you all wrong and that you are a productive worker who does not have a substance or anger problem.

"Let's think together how we could gather the data that would prove you don't have a substance problem. If all that data is squeaky clean, then I can write a very supportive letter to your boss and tell her all is well. If, however, we discover you do have a problem, I can still write a very supportive letter. But we'll have to show her how you are taking care of any problems that interfere with your work performance."

REFRAME THE PRESENTING COMPLAINT

Few patients present fully ready to work on definitive behavioral health recovery. If patients at least attend sessions or talk with you, they must be motivated to do something. Otherwise, they would not show up.

Our task is help patients such as Mr. L get what they want, not what we think they should want. Eventually you will get to explore the patient's substance use, impulse or parenting problems, mental health symptoms, or communication problems, but this discussion will be in the service of allying with his or her goals.

> Eventually you can explore the patient's substance use, impulse problems, or other disorders

Rather than viewing patients as unmotivated or resistant, think of resistance as an interactional process. "If we are going to stop them from locking you up," you might say, "let's talk about what you are doing that makes you look like you are dangerous and out of control. And when you were not locked away, let's think of how you kept 'them' off your back."

Instead of interpreting resistance as pathology, view the behavior as an opportunity to understand and respond to the patient's stage of readiness to change.

STAGES OF CHANGE

By being "difficult," patients are often declaring that they are not invested in what you think the problem is or in working on that problem. Resistance thrives when we and the patient have not allied around a common goal and are at different stages of change. Think of the therapeutic alliance in the context of the widely-used and well-researched Transtheoretical Model's stages of change:[3,4]

Precontemplation. A person at this stage is not considering the possibility of change, although others are aware of a problem. He or she will seldom appear for treatment without coercion. The person could benefit from nonthreatening information to raise awareness of a possible "problem" and possibilities for change.

Contemplation. The person is ambivalent, undecided, vacillating about whether he has a "problem." He wants to change, but this desire exists simultaneously with resistance to change. Motivational strategies can be useful, but aggressive or premature confrontation could provoke strong resistance and defensive behaviors. Many persons at this stage have indefinite plans to take action in the next 6 months or so.

Preparation takes the person from the contemplation stage to specific steps to solve the problem in the action stage. He or she develops increasing confidence in the decision to change and takes the first steps on the road to action. Most people at this stage plan to take action within 1 month and are making final adjustments before beginning to change.

Action. The person takes specific actions intended to bring about change. This busiest stage of change is characterized by overt modification of behavior and surroundings and requires the greatest time and energy. Support and encouragement

continued on page 55

continued from page 51

are crucial to prevent drop-out and regression in readiness to change.

Maintenance. Goals at this stage are to sustain the changes accomplished by previous action and to prevent relapse. Maintaining new behaviors requires different skills than were needed to initiate change. Gains are consolidated. "Maintenance" is not a static stage; it can last 6 months or up to a lifetime. The patient learns new coping and problem-solving strategies, replaces problem behaviors with a healthier life style, and works through emotional triggers of relapse.

Relapse/recycling can happen but is not inevitable. When setbacks occur, help the patient avoid becoming stuck, discouraged, or demoralized, and help him learn from relapse before committing to a new action cycle. Conduct a comprehensive, multidimensional assessment to explore all reasons for relapse.

Termination is the ultimate goal: to exit the cycle of change without fear of relapse. Certain problems may be terminated or merely kept in remission through maintenance strategies.

MATCH STRATEGIES WITH STAGES

Discovery planning. Engaging patients in collaborative care starts with honoring their stages of change and working with them and their families on different tasks for each stage of change.[4-6] A patient such as Mr. L, for example—who is at an early stage of change and thinks he has an "unfair boss problem" (not an alcohol problem) or a "nagging wife problem" (not an anger or domestic violence problem)—needs a discovery, drop-out prevention plan.

The cause of the patient's work or relationship problem may be obvious to you, but a patient in early stages of change resists that information and, if pressed, gets frustrated and leaves treatment. A "discovery" treatment plan embraces the patient's views and could be

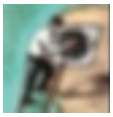


Table 2

Transtheoretical model's 9 processes of change: What happens at each step

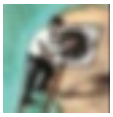
Process of change	The person. . .
Conscious-raising	**becomes aware** of a problem from education, advice, self-awareness, or feedback from others
Social liberation	**begins to think** about change because external forces raise awareness (a ban on smoking in restaurants, for example, can heighten awareness that one has a smoking problem)
Emotional arousal	**becomes more convinced** of the need to change when faced with a strong and sudden emotional experience related to the problem (such as death of a loved one)
Self-reevaluation	**examines his or her values** to see whether or not the behavior conflicts with what is important to him or her
Commitment	**accepts responsibility** for changing and affirms to self and others the decision to change
Reward	**uses self-praise, positive feedback** from others, improved well-being or financial security, "natural highs," and other reinforcing benefits to consolidate change
Countering	**substitutes other responses** to counter unhealthy choices and behavior (such as relaxation techniques to combat angry outbursts or urges to resume smoking)
Environmental control	**changes surrounding** people, places, or things to reduce the risk of continuing or resuming the problem behavior
Helping relationships	**seeks assistance** from trusted friends, professionals, spiritual advisors, or significant others to initiate and sustain the change process

Source: Adapted and reprinted with permission from reference 4.

focused, for example, on gathering data that would prove to the employer that there is not an alcohol problem.

If random breath alcohol testing, feedback from family, and review of past job losses all prove negative for alcohol problems, the patient would have data to support his or her view that he does not have an alcohol problem. If, however, this exploration reveals an alcohol problem, the patient "discovers" he has more of a problem than he thought. For this plan, the challenge is to keep Mr. L engaged long enough to discover the connection between his alcohol problems and his employment or marital problems.

continued on page 58



continued from page 56

Table 3

Strategies and interventions to motivate patients at each stage of change

Stage of change	Most useful processes of change (see *Table 2*)	Goal of treatment	Strategies and interventions
Precontemplation	Consciousness-raising Social liberation	To raise doubt	• Establish a relationship and identify treatment contract • Develop discrepancy between patient's goals and behavior • Use leverage to create incentives to change
Contemplation	Consciousness-raising Social liberation Emotional arousal Self-reevaluation	To tip the balance	• Allow and explore ambivalence • Decisional balance (pros and cons, costs and benefits) • Elicit self-motivational statements
Preparation	Social liberation Emotional arousal Self-reevaluation Commitment	To determine best course	• Clarify and reinforce patient's goals and strategies • Identify obstacles to follow through • Declare plans to change to others
Action	Social liberation Commitment Reward Countering Environment control Helping relationships	To take steps to change	• Strategize on how to reach patient's goals, and start behaviors and changes in thinking • Identify what is working and do more of that (solution-focused) • Establish support network and coping skills
Maintenance	Commitment Countering Environment control Helping relationships	To prevent relapse	• Strengthen and support lifestyle changes • Celebrate successes and rewards of change • Identify relapse triggers and develop plan to avoid or deal with relapse
Relapse/recycling	Depends on stage to which patient returned	To renew processes of change	• Reinforce patient's honesty to admit relapse and his/her return for help • Identify to which stage patient returned • Examine where patient got "off track" and what needs to change to resume recovery

continued on page 61

continued from page 58

Recovery planning. On the other hand, a person at the action stage who wants to avoid becoming depressed again or wishes to live a life of sobriety collaborates on a recovery, relapse prevention plan. This patient is committed to developing the knowledge and skills to prevent relapse and open to whatever will promote health and well-being.

The Transtheoretical Model's 9 processes of change[3,4] inform which interventions might be most effective at various stages of change (*Table 2, page 56*). For example, a patient might be proud of the fact that "I can hold my liquor and drink everyone under the table." Consciousness-raising—such as by explaining that his high alcohol tolerance is a danger signal, not a beneficial ability—can enhance his change process. Even if he is not ready to commit to definitive change, at least exploring whether he has a problem may move him from precontemplation to a contemplation stage of change. Table 3 (*page 58*) shows how other processes of change can help motivate patients in later stages of change.[4,5]

Bottom Line

To engage resistant patients, develop an alliance around what they want, not what you think they need. Reframe resistance by understanding the stage of change and tasks that match that stage. Trust that you will get to address other mental health problems while helping the patient discover the need to change.

Related resources

- Scott D. Miller, PhD. Institute for the Study of Therapeutic Change, Chicago, IL. (773) 404-5130; www.talkingcure.com.
- Miller WR, Rollnick S, Moyers TB. *Motivational interviewing: professional training videotape series.* Albuquerque, NM: University of New Mexico, 1998. Six videotapes (about $130 total); (505) 768-0279 or 0100.
- Miller WR, consensus panel chair. *Treatment improvement protocol. Enhancing motivation for change in substance abuse treatment*. Rockville, MD; Center for Substance Abuse Treatment, 1999. DHHS Publication 99-3354. Available from the National Clearinghouse for Alcohol/Drug Information, Rockville, MD; (800) 729-6686.

ACKNOWLEDGMENT

Dr. Mee-Lee is a board-certified psychiatrist and is certified by examination of the American Society of Addiction Medicine (ASAM). He is based in Davis, CA, and is involved in full-time training and consulting. For information, visit www.DMLMD.com.

References

1. Horvath AO, Bedi RP. The alliance. In: Norcross JC, ed. *Psychotherapy relationships that work: therapist contributions and responsiveness to patients.* New York: Oxford University Press; 2002.
2. Mee-Lee D. Treatment planning for dual disorders. *Psychiatr Rehabil Skills* 2001;5(1):52-79.
3. Prochaska JO, DiClemente CC, Norcross JC. In search of how people change: applications to addictive behaviors. *Am Psychol* 1992;47:1102-14.
4. Prochaska JO, Norcross JC, DiClemente CC. *Changing for good.* New York: Avon Books; 1994:54.
5. DiClemente CC. Conceptual models and applied research: the ongoing contribution of the transtheoretical model. *J Addict Nurs* 2005;16:5-12.
6. Miller WR, Rollnick S. *Motivational interviewing: preparing people to change addictive behavior.* New York: Guilford Press; 1991:18.