RECOVERY TO PRACTICE
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What If A Person Has No Goals?

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What if a person has no goals? This question is raised often by providers who are concerned that the people they work with have given up on whatever hopes, dreams, or aspirations they may have had earlier in life or who, when they have asked the question "What goals do you have?", have been met with an initial blank stare or a shrug. The process of identifying and setting personal goals provides the foundation for recovery-oriented practice, however. The question of whether or not people have such goals, therefore, is an important one to address.

The following are issues to consider in assessing the situation in which a person appears not to have any personal goals:

- Has this person perhaps become demoralized over time due to repetitive experiences of failures and losses that have been due to mental illness, stigma or discrimination, or a combination of both? Has the person lost hope as a result?

  It can be extremely difficult to have a mental illness, and extremely challenging to carry on one's life in the face of it. It also may be hard to keep picking up the pieces time and time again when things fall apart, or to continue to believe that the future might be any better than a bleak or desperate present. The presence of a basic sense of hope is crucial to a person identifying any goals for the future. When hope has been lost, it can and must be restored as an essential basis for the person's active engagement in recovery, and in the central role of identifying and pursuing personally meaningful goals.

  The restoration of hope can come about in a variety of ways, including through the activation of spirituality and faith, experiences of pleasure, and supportive and inspiring social relationships. When a person has lost hope and/or faith, it is crucial that other people continue to carry hope ***for*** *that person until a time that he or she begins once*

again to believe that life can get better. Peer staff, who can provide tangible and credible evidence of the possibility of recovery, can be especially effective in instilling hope through their core function as role models.

- Has this person perhaps become socialized into a mental health system that has not cared about his or her aspirations or interests in the past? Is what you are seeing the result of "learned helplessness" rather than a lack of goals? Or might the person be so impoverished that he or she does not have the means to pursue goals?

  If a person has been receiving services for years that have not been tied to any personal desires or wishes, it might be difficult for him or her to believe that a mental health practitioner all of a sudden wants to know about such things as his or her "goals." The person may first need to come to see that services have changed and that people are now more interested in him or her as a person who is more than his or her diagnosis, problems, symptoms, or deficits. In addition, it is very difficult to pursue many interests without disposable income. The person may be more stymied by a lack of resources than a lack of interest. In this case, the person may need assistance identifying activities and events he or she can participate in without additional resources.

  It is possible that through the combination of socialization and the lack of means to pursue their interests, people may lose any sense of what they might find interesting or enjoyable. In this case, helping the person to get back in touch with what interested him or her, or what he or she enjoyed, prior to becoming ill may be a useful place to begin the process of re-igniting or" jump starting" his or her passion. There also is an array of tools, including interests and strengths assessments, that might help the person to recall those things that he or she had found pleasurable or meaningful in the past. Finally, there can be no substitute for actual life experience in re-igniting, or eliciting for the first time, a person's interest. For some people, simply talking about participating in an activity is just as likely to raise anxiety and introduce doubts as it is to whet his or her appetite for involvement. Especially for people who have become accustomed to viewing life as if from a distance, as something that happens primarily to other people, it may require both encouraging and accompanying the person for him or her to feel comfortable trying new things. In a horseback riding program, for instance, it wasn't until a person was actually helped to climb onto a real horse that he then realized that he was not merely going to discuss horseback riding or watch other people ride horses, as he had become accustomed to doing at the psychosocial club to which he belonged.

- Has this person perhaps become afraid of taking risks, either because he or she might fail or because success or failure might precipitate a relapse or setback?

  For a person to try new things requires him or her to have some sense of confidence in his or her own abilities to succeed. Repetitive failures and losses can drain people of any sense of confidence, making risk taking even more difficult than usual. In the case of a person with a prolonged mental illness, taking risks also poses potential difficulties in addition to not succeeding. Failures can precipitate relapses or setbacks, but also, at times, can successes. For a person who has become resigned to a limited, if comfortable or relatively safe life, trying new activities may also require him or her to face additional

challenges and demands. Such challenges and demands can then increase the person's anxiety or worries about the future. It may be necessary in addressing these kinds of concerns to begin with very concrete, incremental, and everyday goals, such as those described in the story below.

- Could this person have a co-occurring depression?

  In the past, serious mental illnesses were thought to be mutually exclusive. For example, it was assumed that a person who had schizophrenia could not also have an affective disorder such as depression. More recent research, however, has shown that it can be very depressing to have a serious mental illness, and that psychotic disorders and depression co-occur very often in the same person. It therefore is important to assess people who have serious mental illnesses for the presence of depression ***in addition to*** *any other illness they may be experiencing. The loss of hope seen in some people who say that they do not have any personal goals may be just as suggestive of depression as of the negative symptoms of schizophrenia. It is important to assess for and to offer effective treatments for depression when it exists.*

- Have you taken the time and made the effort to earn this person's trust so that he or she would feel comfortable enough to share such personal information with you?

  For many people, especially those who have had bad experiences with behavioral health care in the past, trust in health care providers has to be earned. It cannot simply be assumed. It is reasonable, therefore, to wonder whether this person has no goals or, rather, that he or she may not feel comfortable formulating and sharing those goals with a relative stranger. In such situations, it may take an extended period of time to develop a trusting relationship (or therapeutic alliance) that enables the person to feel comfortable doing so. To develop such trust, it may be useful to "start where the person is at" (i.e., not feeling comfortable talking about personal goals) rather than where the provider needs the person to be (i.e., specifying a list of goals for completion of a care plan). As one woman who had been assigned to an assertive community treatment team, and who had refused the staff's initial efforts to engage her in activities, quipped: "There they were, running around making all these plans for me, and they had no idea who I was."

  The rich tradition of psychotherapy offers many useful tools for "joining with" the person under these circumstances. In addition, peer staff may be especially effective in such circumstances, as they have demonstrated an ability to more rapidly engage people into trusting relationships based both on their own history and on the enhanced credibility this history gives them in the eyes of others. In addition to establishing trust, peer staff also can be very effective in offering not only to accompany the person in trying new activities, but also by offering the person a hope-instilling role model that recovery, and a richer life, is indeed possible.

- Is this person experiencing signs or symptoms of a mental illness that might pose barriers to his or her participation in interesting or enjoyable activities?

Some of the more disabling aspects of mental illness are also some of the more invisible aspects, such as neuro-cognitive impairments and communication difficulties. When these aspects of illness interfere with participation in social, recreational, educational, or vocational pursuits, the person may be reluctant to identify any goals for fear of not being able to perform well in such situations. Identifying, assessing, remediating (when possible), and accommodating (when remediation is not possible) the presence of such symptoms, impairments, or fears that pose barriers to relationships and active participation in social activities may be an important first step to facilitating greater involvement. Identifying such barriers also may help practitioners to suggest activities or pursuits that are well-matched to a person's interests while not requiring capacities he or she may not have at the time. Social activities that do not require much verbal interaction, such as gardening, fishing, or attending music or art performances, for example, may be especially appealing to people who worry that they will not be able to carry on conversations for extended periods of time.

The following vignette captures some of these aspects of living with a serious mental illness that might make identifying and pursuing personal goals difficult. We have been impressed with the power that persistence, patience, and gentle encouragement can exert in enabling providers to connect to the person who may have been buried behind or underneath the illness and the secondary effects of institutionalization and/or discrimination.

We were impressed, for example, by a 38 year-old man who had had a psychotic disorder for twenty years and who had lived almost exclusively in his bedroom in his mother's home for the duration of that period. He was occasionally hospitalized when he became incommunicative and stopped eating, but otherwise spent his days almost entirely alone, smoking in his room, except for brief, sporadic encounters with family members. We encountered him during one of his hospital stays, and spent a week trying to talk with him and determine his reasons for not eating and no longer talking with his family. He was reticent to talk with us or any of the other staff, sat silently through group meetings, and ignored his family when they came to visit. He appeared to be making no use of the hospital stay (except for minimal eating and drinking), and both the staff and family felt stuck. He appeared not to want anything, voiced no complaints or dissatisfaction, and refused to participate in care or discharge planning.

This scenario continued until a family meeting was facilitated with the presumptive agenda of discharge planning. After a couple of weeks there appeared to be no reason to keep this man in the hospital any longer, but his family was concerned that he was only minimally better than when admitted and did not want to take him back only for him to resume his earlier behavior. The family reassured him that they wanted to take him back home, but expressed their concerns that he no longer ate meals and no longer even spoke to them, worrying that he was "wasting away" before their eyes. When we first asked the young man if he was aware of these changes in his behavior, and, if so, if he had any ideas about what might have happened, he did not respond. We then asked the young man if he felt ready to return home under these circumstances, to which he again did not respond. After a brief, awkward, silence, we then asked him if he felt that perhaps this was all that life had to offer him. Was he resigned to

spending the rest of his life alone in his bedroom? At this point, tears started to well up in his eyes and began to slide down his cheeks. After another brief silence, he said simply "No." After waiting for a further response which did not come, we then responded: "I'm glad. That would have been really awful. What else would you like to do?" At which point he begrudgingly explained that he had felt that his family had "given up" on him. His perception was that they had gradually invited him to fewer and fewer activities and events, had gradually sought him out less frequently, and had begun to leave him out, and leave him behind, as they went on with their own lives. His further withdrawal and refusal to eat was both a test of their abandonment (would they simply let him die, like the bug in Kafka's *Metamorphosis?*) and a sign that their giving up on him had led him to give up on himself. He was hurt and angry that, despite his many refusals, they had not continued to pursue him.

Rather than responding to what the family might have viewed as obstinence, the man's mother was overwhelmed by his expression of affect (something she said she had not seen for twenty years) and readily understood his concerns about her preoccupation with other family matters, the decreased availability of his siblings (who now had families of their own), and how these changes in the family had affected him. We suggested that the family's insistence on bringing him to the hospital, and their continued concern with his "wasting away," was "proof" that they would not simply allow him to die alone, and suggested that perhaps they could discuss some of the ways in which he might like to be included in family activities and events. This one meeting did not, of course, bring about a significant shift in his pattern of withdrawal and isolation, or in the difficulties the family would face in trying to include him more in family life, but it did serve to establish an important lesson for the involved parties. As much difficulty as this man had in participating in family relationships, activities, and events, it was not to his benefit for the family to passively accept his withdrawal, or to contribute to his further marginalization. An important challenge for this person and his mother, and the mental health providers working with them, became how they could build bridges for him back into that world. In this case, person-centered care planning began with the goal of increasing the person's contact with family members, with one measurable objective being that he and his mother would have several meals together each week (instead of him taking all of his meals alone in his bedroom). A seemingly small step, perhaps, but the beginning of his recovery journey nonetheless.

As this story suggests, many attempts can be made to encourage and support people in identifying personal goals. These include restoring or building hope; developing a therapeutic alliance; adopting a person-centered and strength-based approach; appreciating the value, dignity, and potential fears involved in taking risks; treating underlying depression; addressing skill or neuro-cognitive impairments; and expanding access to opportunities for a person to explore his or her interests and to participate in meaningful and/or pleasurable activities. A final consideration is that most people do not live their lives in terms of "goals" at all, and that discussion of such goals may at first strike some people as a foreign or artificial exercise. In this case, in addition to the strategies recommended above, it may be useful for the provider to assist the person in the process of identifying interests, desires, or aspirations, and then breaking these down into incremental steps that can be formulated as short-term "goals." This is a process for which the discipline of psychiatric rehabilitation has developed valuable tools.

WEBINAR

Mental Health for Military Families: The Path to Resilience and Recovery

Tuesday, August 3, 2010, 3:00 p.m.–4:30 p.m., Eastern Time (ET)

To Register:

http://promoteacceptance.samhsa.gov/teleconferences/default.aspx

SAMHSA ADS Center invites you to a free training teleconference entitled "Mental Health for Military Families: The Path to Resilience and Recovery." This training teleconference will help current and past recipients of mental health services, U.S. service members and their families, U.S. Department of Veterans Affairs health providers, veteran advocacy organizations, family and peer support personnel within the U.S. Department of Defense and branches of the military (including the reserves), and the general public.

CALL FOR PERSONAL STORIES

Deadline: Ongoing

The Recovery to Practice (RTP) Resource Center's database continues to grow. We particularly invite you to submit personal stories that describe recovery experiences. To submit resources, please contact Stephanie Bernstein, M.S.W., at 1-877-584-8535 or email RecoveryToPractice@dsgonline.com.

We welcome your views, comments, suggestions and inquiries.

For more information on this topic or any other recovery topics, please contact the *Recovery to Practice* Resource Center at

1-877-584-8535 or email RecoveryToPractice@dsgonline.com

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