Engaging Significant Others: The Tom Sawyer Approach to Case Management

Joel Kanter, M.S.W., L.C.S.W.

In recent years, case management approaches with severely mentally ill clients have focused on assertive, in vivo interventions by case managers with small caseloads (1,2). Although these interventions are demonstrably effective (2), economic pressures have led many programs to increase caseloads and decrease intensity of case management services. In this column, I will discuss ways in which social workers and other case managers can address these challenges by more effectively engaging significant others—relatives, neighbors, volunteers, and other agencies—in a coordinated caregiving effort.

The clinical challenges of engaging significant others have been largely neglected in the case management and social work literature. The concept of linking clients to community resources has been a central component of "case management" since this term came into usage two decades ago (3), but little attention has been given to the practice skills involved in this work. Some authors have recommended empowering case managers with administrative and financial clout to facilitate this engagement through the purchase of services (4), but this approach has rarely been implemented or empirically studied.

Without such coercive or financial power, case managers, often with marginal professional status, must mobilize a repertoire of interpersonal skills to persuade, cajole, or negotiate with others to provide support to their mentally ill clients—to somehow, like Tom Sawyer, encourage others to pick up a paintbrush and join in the case management efforts.

When the task of engaging significant others is considered by case managers, many complain that it is another burden and seem unaware that such collaborative efforts can have a rapid return on the time and energy invested. For example, Altman (5) has demonstrated that when hospital and community staff meet with clients and families in a single predischarge meeting, recidivism over the next 12 months is dramatically reduced.

A much larger body of empirical evidence has clearly demonstrated how engaging families in the treatment process can significantly improve outcome (6). However, many case managers are unaware that research has demonstrated that perhaps half of all mentally ill persons in community settings have "competent others" who provide de facto case management services (7), too often, case managers either duplicate or compete with the efforts of these indigenous caregivers.

Although social workers with mentally ill clients were actively creating innovative methods for engaging significant others and community resources more than 40 years ago (3), including developing perhaps the first family psychoeducation program (8), contemporary case management practice has largely evolved without the benefit of this practice wisdom. In outlining ways social workers and other case managers can more effectively engage their clients' significant others, I will—to paraphrase the title of Perlman's more recent book (9)—"look back to see ahead" and will discuss the ideas of Helen Harris Perlman and Clare Winnicott, two of the most distinguished social workers of the past 60 years.

Acknowledging ambivalence

In a chapter on "Relating to Significant Others," in an earlier book, Perlman (10) recommends that social workers begin this process of engagement by openly acknowledging the "dubiousness or halffaredness" of participants in our clients' networks. Too often, we ignore this hesitation or ambivalence, formulate a plan with relatives, acquaintances, or staff from other agencies, and then watch this plan disintegrate over the next few weeks or months.

In some instances, concerned caregivers, perhaps uncomfortable with their own feelings of irritation or perhaps wishing to please the case manager, deny or conceal any ambivalence about becoming involved. In these situations, the case manager might ask, "How do you manage to be so patient," or "How do you avoid losing your cool?" Such inquiries often facilitate a more candid discussion of the difficulties of supporting a person with a major psychiatric disorder.

Alternatively, if the significant other's hesitation is too fraught with anger or distress, we may protective distance ourselves from a possible

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Mr. Kanter is senior case manager at the Mount Vernon Center for Community Mental Health in Fairfax County, Virginia, and is in private practice. His address is 207 Leighton Avenue, Silver Spring, Maryland 20901; e-mail, kovp97@prodigy.com. Janice Berry Edwards, D.S.W., is editor of this column.
community resource. Instead, case managers must use their own counte
rupttransference experiences to empathize with these concerns (11). Of	ten concerned parties feel defensive about their negative reactions and an	icipate criticism from the case manager. When they feel their concerns are
heard and appreciated, they relax, and positive responses emerge.

Although the “expressed emotion” construct has pathologized the criti
cal responses of family members and other concerned parties (12), this criti
icism can also be a very useful source of information about difficulties in the
client’s interpersonal functioning. As Perlman (10) notes, the social worker
should press for specifics: how has the relative been “crazy since the day
he was born,” or in what ways has the group home resident been “imma
ture” or “irresponsible”?  

Identifying motivating gratifications
Perlman then recommends that social workers consider what “payoff” will
motivate significant others. She notes we are all motivated “by some pro
spect of reward” and that unless the social worker can “proffer some small
crumbs of gratification, there is little hope that the other will be much
moved” (10, p. 195).

This reward may be as subtle as an empathic hearing of the concerned
party’s grievances or as concrete as helping a family obtain financial assis
tance. Often, simply sharing information about the client’s illness and treat
ment is greatly appreciated; this step can be as simple as explaining a diagno
sis or referral procedure, or it can involve a more complex process of psy
choeducation and ongoing cons
ultation (13,14). Information about
coping with relapses is also valued by
most significant others—knowing
when and whom to call when prob-
lems occur.

I give persons who live or work
closely with my clients specific informa
tion on how to contact me and
strongly encourage them to call me at
the first signs of difficulty. This is not
merely selfless dedication; helping a
family member obtain a prescription
refill is much easier than arranging for hospital admission.

When case managers provide ongo
ing consultation to significant others,
the first objective should be the col
lateral’s safety and well-being. I
sometimes cite the first rule in aquat
ic lifesaving: don’t let the drowning
person take you along too. This ad
vice is not merely for the benefit of
the collaterals. Too often, persons
with mental illness are abandoned by
relatives, friends, and agencies who
have exhausted themselves attempt-
ing to “rescue” the client.

I strongly encourage all caregivers,
regardless of motivation or affection,
to pace themselves for the marathon
of the recovery process in severe
mental illness. For example, in orient
ing volunteers to serve as case aides
with my clients, I carefully review
their time constraints, exploring both
for the intensity and for the duration
of their possible involvement. Be
cause I prefer involvements that last
years rather than months, I usually
recommend that volunteers begin
their contacts on a biweekly basis,
and for the first several months I con
sult with them by phone after each
client visit. Most of these volunteers
remain involved with the same per
son for at least two years. I offer sim
ilar guidance when enthusiastic rela
tives offer to help troubled family
members, attempting to disrupt or
prevent a caregiver cycle of intense
involvement, disappointment, and
abandonment.

Once the safety and security of sig
ificant others is addressed, the case
manager can help these parties gratify
their altruistic needs by providing them
with ongoing consultation. Rec
ognizing the immense gratification in
volved in contributing to the stabili
zation and rehabilitation of mentally ill
clients, case managers can help signifi
cant others track the course of the
client’s processes of recovery and es
tablish modest and attainable objec
tives for their own involvement. Al
though it is important to share the on
going frustrations and disappointments
with the concerned parties in each sit
uation, case managers must also share
their joys and satisfactions when, for
example, a client remains without hos
pitalization for more than a year, reads
her first novel in a decade, or simply
retells a humorous story.

Tensions between caregivers
In case management with mentally ill
persons, tensions between caregivers
inevitably arise. One party suggests
the client “can’t”; another suggests he
or she “won’t” (15). One party sug
gests the client’s alcohol consumption
is occasional; another sees a pattern of
alcohol abuse. One party thinks the
client is ready for an unsupervised
apartment; another has major con
cerns.

In some situations, these conflicts
may be evoked by client behaviors,
such as presenting oneself quite dif
ferently to different significant others
(11). In others, a client may be testing
the collaborative motivations of his or
her caregiving network. Finally,
these conflicts often occur because
caregivers have different patterns of
involvement with clients. For ex
ample, a case manager may have brief
weekly or biweekly contacts with a
client over a period of several years
while a group home staff member
may interact with the client for peri
ods of several hours each day. Each
sees very different aspects of client
functioning.

Clare Winnicott (16,17), a distin
guished British social worker who is
largely unknown in the United States,
suggests that the tensions be
 tween caregivers reflect essential
identifications that all successful
caregivers—case managers, rela
tives, milieu staff, and so on—have
with the persons in their care. She
notes that “if there is no tension,
there has been no real identification,
no real giving, and [the client] will re
main fundamentally unhelped al
though he may have been adequately
housed and fed” (18, p. 38).

This insight can greatly assist case
managers when negotiating with oth
er caregivers. When conflicts be
 tween caregivers occur, case man
agers can remind themselves that
these tensions would not occur if
everyone didn’t care, that the passion
in these conflicts reflects each care
giver’s critical identification with the
mentally ill person. Yet while main
taining this sense of perspective, case
managers should not minimize their
own concerns as these tensions are
“understood and recognized and ex
perienced” (18, p. 37).
Psychotherapeutic implications
Winnicott observes that beyond the apparent impact of offering clients a greater quantity and quality of social support, the relationship between the social worker and significant others has a psychotherapeutic impact on many clients. Recalling her experiences in child welfare, she notes that "a very valuable part of our relationship with children lies in their knowledge that we are also in direct touch with their parents and others who are important to them. For a time, perhaps, our relationship is the only integrating factor in their world, and we take on a significance which is beyond what we do or say. We make links between places and events and bridge gaps between people which they are unable to bridge for themselves. As we talk about real people and real happenings, feelings about them soon become evident and before we know where we are, we have entered the inner world of the individual" (18, pp.45-46).

Unlike the psychotherapist, the case manager has an actual familiarity with the client's significant others. When I am introduced to my clients' friends in the parking lot of their day program or when I tell clients "Yesterday your mom called me," I am able to help them integrate disparate experiences and improve their interpersonal functioning. With clients who have difficulty sustaining accurate object representations—a critical element in social interaction—the case manager's involvements with significant others offer a unique psychotherapeutic opportunity.

Conclusions
Engaging significant others in the case management process has a positive impact on clients, the concerned parties, and the case managers themselves. If effectively sustained, this engagement can provide clients with increased social support, significant others with reduced tension and an increased sense of satisfaction, and the case managers with a reduction of their professional burden.

Although seemingly straightforward, the process of engaging significant others requires considerable professional skill and wisdom, including knowledge of mental illness, community resources, and interpersonal dynamics (19,20)—social work knowledge exemplified by the work of Perlman and Winnicott.

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Conclusions
Full risk-bearing capitation increasingly has become a mainstay of managed behavioral health care systems. Its main advantage is that it shifts the risk of providing mental health services to the provider and thus creates incentive for the provider to reduce costs. These features make capitation funding attractive to policy makers in the public sector who are faced with escalating costs and increasing demand for services. Although capitation fits well with government entitlement programs and commercial managed care organizations, it is much less appropriate for governmental grant-in-aid programs.

Until grant dollars for mental health and substance abuse treatment services are folded into some kind of entitlement system, the promise of capitation will remain unfulfilled. In other words, until units of government entitle the citizenry to mental health services, based on a set of eligibility requirements, capitation will remain possible only in the public and private insurance systems.

References