

Engaging Significant Others: The Tom Sawyer Approach to Case Management

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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 halfheartedness” 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 protectively distance ourselves from a possible

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community resource. Instead, case managers must use their own countertransference experiences to empathize with these concerns (11). Often concerned parties feel defensive about their negative reactions and anticipate 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 critical responses of family members and other concerned parties (12), this criticism 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 “immature” 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 prospect 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 assistance. Often, simply sharing information about the client’s illness and treatment is greatly appreciated; this step can be as simple as explaining a diagnosis or referral procedure, or it can involve a more complex process of psychoeducation and ongoing consultation (13,14). Information about coping with relapses is also valued by most significant others—knowing when and whom to call when problems occur.

I give persons who live or work closely with my clients specific information 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 ongoing consultation to significant others, the first objective should be the collaterals’ safety and well-being. I sometimes cite the first rule in aquatic lifesaving: don’t let the drowning person take you along too. This advice 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 attempting 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 orienting 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. Because 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 consult with them by phone after each client visit. Most of these volunteers remain involved with the same person for at least two years. I offer similar guidance when enthusiastic relatives 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 significant others is addressed, the case manager can help these parties gratify their altruistic needs by providing them with ongoing consultation. Recognizing the immense gratification involved in contributing to the stabilization and rehabilitation of mentally ill clients, case managers can help significant others track the course of the client’s processes of recovery and establish modest and attainable objectives for their own involvement. Although it is important to share the ongoing frustrations and disappointments with the concerned parties in each situation, case managers must also share their joys and satisfactions when, for example, a client remains without hospitalization 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 suggests 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 concerns.

In some situations, these conflicts may be evoked by client behaviors, such as presenting oneself quite differently 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 example, 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 periods of several hours each day. Each sees very different aspects of client functioning.

Clare Winnicott (16,17), a distinguished British social worker who is largely unknown in the United States, suggests that the tensions between caregivers reflect essential identifications that all successful caregivers—case managers, relatives, 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 remain fundamentally unhelped although he may have been adequately housed and fed” (18, p.38).

This insight can greatly assist case managers when negotiating with other caregivers. When conflicts between caregivers occur, case managers can remind themselves that these tensions would not occur if everyone didn’t care, that the passion in these conflicts reflects each caregiver’s critical identification with the mentally ill person. Yet while maintaining this sense of perspective, case managers should not minimize their own concerns as these tensions are “understood and recognized and experienced” (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, includ-

ing 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. ♦

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