

A supportive family and case manager collaborate to help a reclusive, schizophrenic woman to emerge from psychosis and create a fulfilling life.

Terri: Family-Centered Case Management

Joel Kanter

Commentary by Kayla F. Bernheim

This case report describes five and a half years of work with Terri B. (a young, African-American, treatment-resistant, schizophrenic female) and her parents. Throughout most of the time I have known her, Terri has lived in her parental home and the case management was largely a collaborative process between her parents and myself. Although Terri eventually became involved in a variety of other treatments and services, including psychopharmacology, supportive psychotherapy, psychosocial rehabilitation, and residential treatment, the family intervention was essential to engaging her in these other modalities that cumulatively have resulted in a positive outcome.

Both Mr. and Mrs. B. are successful, well-educated professionals; Terri's father has a Ph.D., and her mother has an M.A. Terri's childhood as the oldest of three siblings was unremarkable; she did well in a competitive public school system, was a member of a school athletic team and had a number of girlfriends. However, there is some indication that she tended in high school to associate more with a group of friends than to develop close friendships.

Some identity conflicts became apparent in college, where Terri started at a nearby large public university, transferred after one year to a smaller black college, and transferred again for her last two years to a prestigious private institution near her parents' home. Although both of these transfers were motivated by a desire to find a social milieu where she would feel comfortable, she felt estranged from the social life of all of these schools, even though she always lived in the dormitories and became acquainted with many students.

After graduation, Terri obtained an entry-level professional job in her field of study and lived in her own apartment about ten miles away from her

parents. Over the next several years, she continued to do poorly in her social relationships, changing jobs several times and becoming increasingly reclusive when she was not at work. Finally, she lost her job and it became apparent to Mr. and Mrs. B. that she had become quite paranoid, rarely leaving her apartment or answering the phone. They made an unsuccessful attempt to commit Terri to a hospital before bringing her home to live with them.

Over the next eighteen months, Terri was totally isolated and refused all treatment or social contact. She spent almost all her time staring at TV in her room, coming down to the kitchen briefly to fix herself meals. She exhibited no psychotic ideation but refused to communicate on any level. She engaged in compulsive activities in the bathroom that consumed two rolls of toilet paper daily. Because she was not a danger to herself or others, she was not committable. At this point in time, Mr. and Mrs. B. contacted me to help them engage Terri in treatment and assist her restoring her functioning.

Year One

I hold one two-hour meeting in my office to review history from parents and develop a relationship. A week later, I visit the home to try to speak with Terri. She is lying on her bed staring at TV in a neat, undecorated room. She does not respond to my questions beyond suggesting that I am interfering with her television viewing. She appears affectless and switches channels without any particular interest in what she is watching. I depart after twenty minutes. I return two weeks later for another home visit with the same result. I meet again with her parents in my office and review my observations. I suggest that they monitor any changes closely and stay in contact with me; if there is some deterioration, we may be able to arrange for her hospitalization. Over the next few months, I stay in monthly phone contact with Mrs. B., who reports no change in her daughter's condition.

Five Months. Mrs. B. calls to report that Terri has become extremely agitated; she is running around the house nude, making lewd and threatening remarks. I arrange an emergency home visit within hours. When I arrive, she is upstairs, still nude, and is yelling obscenities. She is clearly upset about my presence ("get that [expletive] out of here"), and I make no attempt to go upstairs. I advise Mr. and Mrs. B. to immediately go to the judge to obtain a detention order. Terri is detained within hours and sent to the state hospital.

On the Tuesday after Labor Day, Mrs. B. calls me to report that the hospital social worker has asked her to pick up Terri today. Because of the Labor Day weekend, the family was not notified of the hearing today, so Terri was released on a technicality after five days in the hospital. She has refused all medication, and she has returned to her previous uncommunicative state. I recommend an emergency family meeting on their return home from the hospital. I advise the parents to state that they will not take Terri home unless she agrees to cooperate with an outpatient psychiatric assessment, attend biweekly

family sessions, and perform some minimal chores. If she refuses to do this, they should put her in a motel while negotiations continue.

In our meeting, they implement this plan. Terri becomes irate and insists on returning home without conditions. The parents hold their ground, and I pick up the phone several times to call the motel. Finally, after ninety minutes, Terri agrees to comply with her parents' conditions, and the family returns home.

Four days later, another family session is held. I take a social history from Terri in her parents' presence. Although her affect is flat and she exhibits little insight, she does cooperate to the extent of giving me basic information about her educational and employment history. She offers little, however, about the development of her illness and denies any difficulties. I refer her to a female psychiatrist for an extended evaluation.

Over the next six months, Terri and her parents continue to attend biweekly family sessions on a regular basis. Terri has little to contribute and I spend much of the meetings chatting casually with her parents. Terri denies that she has any difficulties and defends her current functioning as a chosen lifestyle. We do discuss several issues including her progress in the extended psychiatric evaluation. The psychiatrist is trying to develop a therapeutic alliance, and the evaluation is extended over several months. The psychiatrist refers Terri to her internist and a neurologist for further evaluation, but their findings are largely negative. The psychiatrist is not able to achieve any consensus with Terri about her difficulties and concludes her meetings in several months. As Terri was unwilling to take any medications, even iron pills for anemia, psychotropic medications could not be considered.

In our family meetings, we also discuss her excessive use of toilet paper but are unable to achieve a consensus. At the end of each session, I meet privately with Mr. and Mrs. B. for about ten minutes; Terri does not seem to mind this and seems relieved to be able to leave the office. In these parental contacts, they agree to begin to give Terri a \$10/week allowance; predictably, she initially rejects this money but eventually begins to squirrel it away and then spends it. She had not been in a commercial establishment in two years.

In our third family meeting (held around noon), I terminate the session early and ask the family to come with me to an Italian deli around the corner, where I buy Terri a slice of their unique homemade pizza. She seems pleased by this, and at the next session, we go on a similar expedition to a nearby Jamaican lunch spot. In a phone call to Mrs. B. between meetings, I recommend that the parents stop for lunch at a restaurant after our next session. Terri accompanies them for a seated meal without comment. The biweekly meetings become an occasion for family outings, and Terri begins to use her funds to shop. They also see several movies and go bowling.

Ten Months. Terri is taking some walks during the week in her neighborhood to a nearby convenience store. However, her demeanor in our sessions remains unchanged and she still spends most of her time alone in her

room. For several weeks, she becomes interested in crocheting, but soon becomes frustrated with this.

Year Two

Terri asks her mother to buy paint to redecorate her room. She completes the project with minimal help. She also asks her parents to take her for a day trip to a regional amusement park. Surprised by this request, they agree and have a pleasant trip. In our continuing biweekly sessions, an invitation to a June wedding of Terri's high school friend is discussed. Although she refused to make a decision until the last minute, Terri accompanies her parents on a 200-mile trip to her friend's wedding, but stays in the motel during the ceremony and reception. She does go on with them to spend several days at the beach and participates in recreational activities.

Sixteen Months. In a family meeting, Terri expresses an interest in employment for the first time. She says she would like to work as a salesperson in the women's clothing department of an upscale store. Though rational, her speech sounds somewhat pressured. Later that evening, Mrs. B. calls me to report that Terri has decompensated. Mr. B. obtains another detention petition, and Terri is rehospitalized at the state hospital.

Three weeks after admission, Mrs. B. reports that the hospital plans to discharge Terri the next day because she refuses to take medication. A family meeting is scheduled before discharge. Consulting with Mrs. B. and the hospital social worker, I recommend that her parents tell Terri that she cannot return home unless she takes medication. (This will also stop the discharge plans as the hospital is reluctant to discharge patients without a home.) Without any fanfare, Terri immediately agrees to begin medications in the family session, and she is retained at the hospital.

I work with the hospital staff by telephone to reformulate discharge plans. Terri takes a hospital bus to begin to attend a psychosocial day program one day a week, and I meet her there for her application interview for this program. I advocate with their intake coordinator to ignore her poor functioning in recent months and place her in the more vocational units of their program. I also arrange for her to begin outpatient treatment with a second female psychiatrist, involving medications and biweekly supportive psychotherapy sessions.

After Terri's discharge, we resume our biweekly family meetings. Terri attends the day program regularly but expresses little interest in other members or the activities. However, neuroleptic medication seems to have a significant impact on the quantity and quality of her communications, and her parents report more spontaneous conversations.

Eighteen Months. Terri continues to attend the day program regularly for several months. She gets a paid position ringing bells for the Salvation Army but quits this after several days; subsequently, her attendance at the day program declines. She claims that the program is not interesting to her, but she is not interested in any other activity. Within a month, she stops attending the program and makes sporadic attempts to look for work.

About a month after leaving the day program, Terri obtains a part-time position doing clerical work for a businesswoman in her home. While it sounded ideal in terms of reasonable hours and a personal work environment, Terri is uncertain she is doing good work and quits after several weeks. Soon after, she discontinues her medications, claiming that she does not think they are helping her. However, she continues to meet with her psychiatrist. Recognizing Terri's impressive willfulness, the psychiatrist, her parents, and I decide not to try to persuade her to resume her medications. To do so would likely provoke a battle of wills and would be unlikely to achieve the desired outcome.

Within a month, Terri reports feeling "depressed"; her psychiatrist and I are uncertain what she means by this, but she agrees to a trial of antidepressant medications. Several weeks later, she agrees to resume her neuroleptic medication. She works a few days for a temporary agency but does not like this. I discover that she began receiving Social Security Disability (SSDI) benefits several months earlier as a result of an application made at the state hospital.

Year Three

After expressing little interest in structured activities for several months in the biweekly family sessions, Terri obtains a volunteer clerical position at an agency for mentally retarded persons. Within a month, her hours increase from twelve to twenty-five weekly and she is given increasing responsibility as the staff are impressed with her skills and reliability. She is offered a paid position with the agency, but she expresses considerable anxiety about this change. Although it does not appear to involve any change in her hours or duties, she is troubled by the symbolic change.

Soon after, her psychiatrist takes a five-week vacation to get married. Although Terri had never expressed any special attachment or affection for her, she abruptly terminates her volunteer job and medication soon after her psychiatrist's departure. I advise her parents to avoid overreacting when Terri says she never wants to work or take medication again.

Thirty Months. Terri resumes her medication several weeks after her psychiatrist returns. A month later, she expresses an interest in the family meetings to move from her parents' home to a supervised apartment program. When I inform her that all of these programs will require that she be involved in a structured day activity, she initiates an investigation (with my urging) into all of the local alternatives. After contacting several programs, she decides to enroll in a hospital-based day treatment program with an intensive psychotherapeutic focus. While initially noncommunicative in the group therapy sessions, she seems interested in the problems of other members. I consult with the day program staff to discuss how they can facilitate Terri's progress.

Over the next few months, Terri continues in the day program and openly expresses her satisfaction with it; however, she denies that she has any special interest in any particular staff members or patients. In family meetings, she expresses concern about activities after she leaves the day program. She enrolls

in an evening and weekend socialization program at another agency. In recounting the activities they offer, she reports that she does not think she is ready yet to take their class on dating etiquette. She also enrolls in a volleyball clinic and aerobic dancing classes at a nearby recreation center. She smilingly reports her enjoyment of these activities. The quality of the family meetings has greatly changed as Terri often brings an agenda of matters that she wants to discuss.

Thirty-Four Months. After discussing her interest in a job in the data entry field for several months, she obtains a temporary job for six weeks in this field through her own efforts and leaves the day treatment program. She successfully completes their weeklong training program in three days and reports finding this work satisfying. She continues to attend the socialization program and other recreation activities. Her parents report that acquaintances from these activities have begun to telephone Terri. She purchases a pedigreed puppy and becomes quite involved in its care.

Year Four

While continuing to work at seasonal employment in data entry (eight weeks on, five weeks off), Terri discontinues her other recreational activities. She abruptly loses interest in her puppy and gives this expensive animal to a local animal shelter. She offers no explanation for this impulsive action.

After about six months of increased withdrawal, Terri's name comes to the top of a residential program waiting list. This application had been made two years ago and had largely been forgotten. Although she is getting along well with her parents, she is enthusiastic about having the opportunity to move into her own apartment. She continues to work seasonally in data entry but has few other activities.

After several months of interviews and trial visits, Terri moves into a supervised apartment program. She is very pleased about this move but seems more excited about the concept of "independence" than the reality. She continues to work in data entry.

Year Five

About four months after her move, Terri announces her intention to quit her job in several days. Her residential program counselor joins our family meeting where this issue is discussed. We calmly point out that she will still have to have a day program to continue to reside in her apartment. She says she does not want to do anything and suggests she may just move to a homeless shelter to avoid returning to her parents.

In a phone conversation with her residential counselor, a summer intern, I learn that she had just completed an ambitious service plan with Terri. She accepts my suggestion that she scale this back. In another phone conversation with her mother, we decide that her mother will invite her to a movie and

avoid discussion of her job. Three days later, Terri returns to work. We also learn that because she has been “gainfully employed” for nine months, her SSDI benefits are being cut off.

Sixty-Four Months. Terri calls me to request special assistance to help her obtain entry to a local day program during her layoff period at her seasonal job. As she rarely contacts me outside our monthly family meetings, this is an unusual occurrence. I arrange an individual meeting to complete a lengthy application form.

Soon after, a new residential counselor calls me to report that Terri is isolating herself in the apartment. In our family meeting, Terri indicates that she has refused a special assignment at her job and is beginning a day program within several days. She says she would prefer to do nothing every day, but contacted this day program because daily activity is part of the treatment contract of her residential program. Several weeks after her admission, I attend a treatment planning meeting at the day program. Within a week, Terri quits the day program, saying she is bored. A week later, she returns to her data entry job.

Sixty-Eight Months. Terri continues to do well at her job and her residential placement. She is socializing more with other program members and has confided in her residential counselor that she would eventually like a boyfriend. She invites a roommate to her parents’ home during the Christmas holidays.

Seventy Months. Terri is told that her residential counselor is transferring to another unit in her agency. Within a week, Terri decides to leave the program and return home. She also quits her job and again announces she is not interested in employment.

Before convening an emergency family meeting, I confer with Terri’s residential counselor and psychiatrist. Given her past history, we try to respond calmly to this latest crisis. In the family meeting, I state that I think she was upset about the fifth change of residential counselor in the past year. She denies this and says she has no interest in people or work. Her family is also upset because her grandfather’s health is deteriorating, and he may have to come live with them. Within two weeks, she says she is bored and joins a health spa. She faithfully works out four or five times a week.

Informing Terri of my plan—which she says she does not care about—I write a letter to the director of the residential program, protesting the repeated change in workers. The assistant director of the agency responds, apologizes for all the changes, and agrees to convene a family meeting to address these concerns. He also proposes a way that Terri can continue her relationship with her residential counselor.

Year Six

A week later, the residential program convenes a family meeting, and Terri agrees to continue working with her residential counselor although she still

wants to live with her parents. She says she does not want to live with other mentally ill persons but will consider a supported living arrangement. In our family meeting, she says she would like another job, and we discuss several possibilities. Within four days, she obtains a part-time job selling women's clothes in a department store. She reports that she greatly enjoys this job.

Seventy-Six Months. We are meeting every four to six weeks because of Terri's shifting work schedule. Terri reports that she began working full time in the department store after a month and was permanently assigned to the lingerie department. While she would previously focus in a perfectionistic manner on her vocational shortcomings, she now openly takes pride in her accomplishments and expresses pleasure with her job.

Living at home with her parents in a mutually rewarding relationship, she envisions herself obtaining her own apartment at some point in the future. She meets monthly with her psychiatrist and continues on a low dose of a conventional neuroleptic medication. She also meets weekly with the residential counselor to discuss her daily activities and to participate in some recreational activities. More than at any time since I have known her, she exhibits a radiant smile, a lively wit, and an interest in the world around her.

Discussion

Terri's treatment and recovery process illustrates the role of the case manager in collaborating with a supportive family. While case management is most often associated with mentally ill clients with nonexistent, severely damaged, or malevolent social networks, the majority of these individuals do have families who are willing to provide substantial levels of support yet need consultation and support themselves (Bernheim and Lehman, 1985; Kanter, 1985a). In many situations, like the B. family, relatives are actually the primary "case managers" and prefer to share this responsibility with a professional case manager rather than discontinue their caregiving abruptly.

However, as a professional, I was able to perform certain case management activities that would have been difficult for Mr. and Mrs. B. to perform, most notably in forming linkages to psychiatrists, day and residential programs, and hospitals. As a professional, I was able to establish more direct and candid communication with these caregivers than most families would find possible, and importantly, I was able to offer many of them consultation that enabled all parties to sustain a coherent long-term treatment approach.

Similarly, as Terri recovered, she increasingly became her own case manager, exploring day program options, finding her own jobs, and joining a health club with little external assistance. Titrating the levels of support, I offered less and less assistance as the recovery process evolved, only becoming more active when crises ensued (Kanter, 1985b, 1987, 1989).

From the beginning, I saw my primary role as a consultant to Mr. and Mrs. B. and rarely attempted to intervene on an individual basis with Terri. During these six years, I only had three contacts with Terri without her parents

present: one session she requested to get my help with applying to a day treatment program; one visit to see her apartment in the residential program; and one treatment planning conference at a day program. Yet, she would tell staff from other programs that I was her therapist, implying that I have a psychic significance for her that she has never expressed to me directly.

My relationship with Terri and her family was almost always casual and nonintensive, with neither strong transference nor countertransference. Of course, Terri devalued any contact with me for several years, but this response was characteristic of her schizoid devaluation of any human connection. While she was angry at me during several early crises, this anger was quickly repressed and was never discussed. I sometimes commented that Terri seemed unhappy with a particular action or suggestion of mine, but she repeatedly denied that she had any anger toward me, and I generally avoided challenging this defense (Meyer, 1988).

My main interpretative interactions with Terri were in gently, but repeatedly, commenting that her schizoid defenses—her lack of interest in people or activity—were an effective way of protecting herself against further disappointments. She often would dismiss these comments, and again, I would not confront her defenses. However, I would return again and again to this theme. After her recovery was well underway, I went somewhat further on this theme when, during a relapse, she again insisted that she had no interest in social relationships. I told Terri directly that she was “once a loving and lovable little girl” who sought contact with others. When she denied this, I turned to Mrs. B. who vividly reminisced about Terri’s childhood desires for social relatedness. Similarly, my recent intervention with her residential program around the repeated changes of staff was an attempt to acknowledge the hurt these transitions had done to the shy child who was beginning to reemerge.

The development of my rapport with Mr. and Mrs. B. also deserves some attention. This case was treated in my private practice, and my work was paid for by the family. In contrast to the initial contact of an assigned case in a clinic setting, a respected professional had referred them to me, and they read my booklet for relatives soon after we met (Kanter, 1984a). Thus, we were able to begin working together with a level of confidence that might have taken months to develop in a clinic setting. However, the content and intensity of my interventions were not different from my usual practice in a busy agency—about twelve to thirty hours a year.

From the beginning, our meetings have always begun with ten to thirty minutes of quasi-social conversation, discussing movies, books, television shows, current events, family gatherings, and similar interests. Sometimes, these topics involved African-American personalities or interests.

On a surface level, these conversations could be viewed as technique for joining with the family. However, from the beginning, they reflected a more ambitious therapeutic effort to address Terri’s schizoid defense, a condition more commonly referred to as negative symptoms or a deficit syndrome. Drawing on my earlier work in day treatment (Kanter, 1984b), these casual

conversations were an attempt to operationalize Winnicott's (1971) concepts about the therapeutic impact of play. From the first meetings in my office, I was trying to facilitate the development of a mutually pleasurable relationship between Terri and her parents. To accomplish this, I did not want to encourage the anguished dialogues characteristic of traditional family therapy or the didactic atmosphere implicit in more contemporary psychoeducational approaches. Thus, I invited the family out for a slice of pizza and later encouraged Mr. and Mrs. B. to fulfill Terri's request to visit an amusement park. The success of these outings soon inspired other activities that were initiated outside of our family meetings.

Although this sort of activity or dialogue can occur in individual psychotherapy (Frederickson, 1991), it can be difficult for the therapist to sustain a playful attitude without reinforcement from the client. However, in a family, group, or milieu setting, case managers can find other partners who are capable of engaging in playful activity or interaction. Clients can observe this interaction for months and eventually begin to participate without the caregivers succumbing to boredom or despair. When clients do begin to participate, they begin to enjoy themselves again in the company of others, a profound healing experience. Of course, in this situation, the bulk of this work occurs at home between our meetings.

Finally, Terri's recovery from schizophrenia, though not yet complete raises questions about our treatment goals and expectations with similar clients. Her relatively successful premorbid history would suggest a higher likelihood of a good outcome (Fenton and McGlashan, 1987), but her persistent deficit syndrome would suggest the likelihood of a poorer outcome. However, in spite of the severity of her illness, early intervention, involving at different points in time medication, case management, family consultation, hospitalization, day treatment, and residential support, was able to mobilize family resources and eventually Terri's own considerable abilities. In doing so, Terri has made major strides toward developing a real life in the community, not merely a marginal existence with troubling residual symptoms and make-work activities.

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Commentary

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This case begins in a way that is familiar to those of us who have ever worked in a community mental health center: parents call us, frantic about their young adult child whose behavior has become increasingly reclusive, bizarre, and frightening. They receive with disbelief and dismay our “sorry, there’s nothing we can do because your daughter (or son) doesn’t want help and isn’t a danger to self or others.” How can it be that someone so obviously ill can not be helped? Terri B. and her family did get help—meaningful help—and the story of how that happened contains several useful lessons for clinicians working with persons with chronic mental illness.

Trust has to be earned through stability, reliability, and availability. Clinicians often label patients’ or families’ unwillingness to do what we suggest as “resistance” or “sabotage” or lack of motivation. Often, however, we have failed to demonstrate sufficient interest, competence, or caring to justify their trusting us.

In the public mental health system, it is quite rare for a patient or family to have the luxury of working with the same clinician for over five years. This case illustrates how valuable such a long-term relationship can be to a person with a long-term illness.

Kanter’s steadfastness, manifested in his availability at times of crisis, his willingness to go to the home, and his consistent meetings with the family during good times and bad, allowed him to function effectively as family consultant and ombudsman. For example, his suggestion that the B’s refuse to take Terri home from the hospital unless she agreed to certain conditions would be extremely difficult for most families to carry out. However, after five months of relationship-building, along with Kanter’s presence during the meetings, they were able to implement this successfully. His willingness to collaborate with and coordinate a myriad of other caregivers represents clinical case management at its best, further enhancing his relationship with both patient and family.

If you can’t do what you want, do what you can. Initially, Kanter tried to establish a relationship with Terri so that he could get her into treatment. No doubt he would have liked to see her hospitalized, or at least medicated. Neither was possible, but unlike most clinicians, he did not stop there. Instead, he continued to stay in contact with the B’s, earning their trust and enabling him to mobilize them effectively when a crisis occurred.

When Terri proved unwilling to discuss illness-related issues in family meetings, Kanter was willing to spend six months mostly “chatting casually” with her parents. Most of us (and most insurance companies) would hardly regard this as “therapy,” but I suspect it was invaluable in helping to contain the family’s anxiety and in helping the parents develop realistic expectations. It may also have functioned, as Kanter suggests, to address Terri’s deficit syn-

drome through modeling. It certainly set the kind of nonthreatening, “low EE” (Vaughn and others, 1984) tone that facilitates reconstitution from acute psychosis. With the family’s support, facilitated by Kanter, Terri was able to stay out of the hospital for a full year until, under the self-imposed pressure of thinking about going to work, she relapsed. It is interesting to speculate whether this outcome would have been different had the family had to cope with their child’s symptomatology, as so many still do, with little professional guidance and support. The research literature (Anderson, Reiss, and Hogarty, 1986; Falloon and others, 1981) suggests it would have.

If flexible roles and boundaries make you nervous, think about working with a different population. Consider the long list of Kanter’s unorthodoxies: his initial meeting is two hours in length, he makes three home visits, he takes the family out during a “therapy” session and buys the patient pizza, he attends meetings at other agencies and invites other involved professionals to his family meetings, he gives very specific, directive advice, he helps the patient fill out a form and accompanies her to an interview, he writes an indignant letter to a residential program director, he talks to the parents about the patient behind her back. He appears to neither know, nor care, whose therapist he is—or indeed, whether he is a family therapist, case manager, or family consultant. There are certainly pitfalls possible in this sort of seat-of-the-pants, pragmatic approach, and I am tempted to warn (as they do in the commercials), “Don’t try this at home!”

How did Terri feel about Kanter’s strong alliance with her parents and how did it affect her ability to relate to the treatment system? How did Terri’s psychiatrist feel about Kanter’s intervening with the residential counselor to scale back the service plan? How did he decide that he, rather than Terri or her parents, should complain about the frequent change of residential counselors? How would Kanter respond to a genuine conflict of interest between Terri and her parents? These are the kinds of questions that Kanter was probably considering as he went along. Most case managers lack Kanter’s years of experience, so strong supervision and collegial support should be provided to help clinicians think through the loyalty, ethical, and practical issues that are bound to arise.

Timing is everything. Even, uninterrupted progress is rare in the life of the young adult with schizophrenia. Terri B. had numerous setbacks during the five years covered by this case report. These tended to occur whenever she experienced the expectation, external or internal, of a higher level of functioning. Kanter showed unusual patience and persistence, keeping his focus on the long haul rather than on day-to-day perturbations in Terri’s clinical condition or level of motivation. He modeled for the family (and treatment team) an emotionally measured response, not overreacting to the patient’s inevitable resistances and fears, nor succumbing to hopelessness about her chances for substantial recovery. Choosing when to intervene with the treatment system is particularly delicate— inappropriately timed interventions can engender resistance while holding back risks allowing an unnecessary exacerbation of symptoms to occur. Kanter’s case report does not give us a direct window into

how he chose when to intervene, but the two examples of intervention he provides are instructive. In one, he acted to reduce the functional expectations for Terri. In another, he acted to preserve what had become a strong therapeutic alliance Terri had developed with a residential counselor. Indeed, modulating the levels of stress and expectation and fostering positive interpersonal connections are important goals in working with this population.

Take a holistic approach. "Treat the whole person." "Use a biopsychosocial model." These maxims are difficult to put into practice in an often fragmented mental health system. Level of psychiatric symptoms, work readiness, social supports, and personal motivations may be very weakly correlated, but each is relevant to the patient's capacity for rehabilitation. Kanter always kept sight of the "whole elephant," coordinating psychiatric, residential, vocational, and counseling services as well as trying to understand Terri's needs within her cultural, familial, and stage-of-life frames.

His knowledge of and interaction with the family was, I believe, critical to his success. The family is the repository of a great deal of useful information, not only about the development of the illness and current level of functioning, but about the patient as a person. Family members also constitute the inner hub of the patient's support network. While it is true that some chronically mentally ill individuals are abandoned by or lose contact with their families, many more maintain ties with parents and siblings. Indeed, many relatives function as integral parts of the caregiving network. As such, family members should be regarded and treated as valuable members of the treatment team (Bernheim and Lehman, 1985).

This case illustrates how family-based clinical case management, when carried out by a seasoned, flexible, attentive, and assertive clinician over an extended period of time, can contribute to the reintegration into life of a severely impaired person. In addition to the lessons it teaches, the case raises the fundamental question: What is success? After five years, Terri is again living at home. Has she failed at the fundamental task of living independently? I prefer to see her as having succeeded, at least for now, at living interdependently and in a mutually satisfying way with loved ones. She has a life that provides her with some rewards and is not an undue burden on others. To me, this is success aplenty.

Commentary References

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