Introduction

The Relational Method for Recovery
There is something about the scent of a freshly lit cigarette. It is simple and sweet. Maybe it has something to do with the initial moment when fire touches tobacco and sets free the secrets of the earth contained within the leaf. There is something about the glow, too, the way it signals the presence of that first breath, which draws the sweetness of tobacco down into the secrets of the soul. Maybe this is why Marilyn is so deliberate about lighting her cigarette. Maybe this is why she stares, as if watching a dream, as she pushes the smoke past her lips in a steady stream toward the sky.

She is twenty-three. Her face is round and heavy and white. She seems older. Marilyn is sitting at a picnic table across from Lisa, a social work researcher, who has been helping Marilyn prepare for a move to a new apartment. They are revising a to-do list; and Marilyn is telling her that she needs to save money. She needs to buy appliances and furnishings. She must arrange for a truck and for people to carry moving boxes. She needs to learn how to use a checkbook. She reminds Lisa that she is working with the social service agency to complete the paperwork to get control of finances. Her mother, now managing her money, wants this to end.
The picnic table where they sit is in a park on a hill overlooking Lake Erie, the shallowest of the Great Lakes. The shoreline, seventy feet below, stretches to the northeast and to the northwest as far as the eye can see, in one big arching smile that curves toward Canada, which no one can see. Out there is nothing but water: It fills the smile with its mood.

It is a perfect summer day. The sky is a deep, comforting blue, spotted with billowy white clouds. It is warm but not hot, and a gentle breeze pushes the water lightly against the large rocks along the shore. From the hilltop where the women sit, there is no sound, just the view of water and sky. It seems just the right setting for their conversation today.

For years Marilyn has dreamed of moving to an apartment of her own. And for the first time it seems close to reality. The social service agency has placed her on a list for the next available unit. It is exciting; and although she feels the prospect of change, she is calm. She changes the topic with the stutter-start of a question she is not quite sure she should ask. With this question, she invites Lisa to a church festival in the neighborhood where she grew up. Her mother, sister, and two nieces will be there. She looks to the lake before saying to Lisa, “It would be a good time for you to meet them.”

In this moment, Lisa cannot decide whether her attendance will fit into the guidelines of the research study. She is supposed to be observing the interactions between Marilyn and the people helping her recover from symptoms of mental illness, including family members, friends, and health and human service workers; a church festival may not qualify as an observable event. Lisa does not want to cross the line that separates the professional from the personal, a line that gets fuzzy with questions like this. Before directing the conversation back to the list of things for the pending move, she tells Marilyn that she will check her schedule.

Marilyn responds with the stutter-start of another question. She is hesitant to ask. Again she is staring out over the lake, at that long thin line of nothingness where the sky and water converge. “What happens to me when the study is over?” she asks. “Do I ever get to see you again?”

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This book is written for everyone like Lisa and Marilyn who wonders about the role of human relationships in mental health recovery. We argue for the importance of relationship by closely examining its process, that is, the back-and-forth exchange of attention and information that occurs between people. We will explain how case managers can use the process of sharing attention and information intentionally to help clients develop or enhance abilities to achieve their greatest potential for living independently in the community with hope, satisfaction, and success.

We focus on case managers and clients with symptoms of severe mental illness because these are the main characters in the story that unfolds on the following pages. The research project that inspired this book and provided the rich data and case studies for the telling of Marilyn’s story is described in appendix 1.2 Lisa is a social work researcher in Cleveland, Ohio, who is a participant–observer case manager. Marilyn, a client in the public mental health system, is navigating relationships with others in the community, including family members, friends, and health and human service providers such as psychiatrists, physicians, nurses, housing specialists, and employment specialists. The story you are about to read unfolds in a linear time sequence. Each chapter and reported event has two parts: a scene titled “Observe,” which describes the interaction between Marilyn and Lisa, and a reflection on the scene, titled “Reflect,” which explores the work of the case manager and how she used the relationship to draw attention to her client’s strengths, namely, her own feelings, thoughts, and actions.

The story is told in a third-person narrative voice that acts as a movie camera in each scene. Sometimes it hovers close to the client. Sometimes it hovers close to the case manager. Sometimes it drifts up and out of the scene in a panorama to report on larger issues. In moments like these, we draw on what we know about the social, historical, and intellectual context of what the narrator reports. In many scenes, the narrative voice hovers close to the case manager because she is the one who conducted the research and observed, not only Marilyn but also herself. This is why the book is written for case managers. However, it is not written exclusively for them but for everyone with whom they interact in everyday relationships, including consumers, family members of consumers, and other service providers.3 In short, this is a book about being and having a case manager.4
This book describes a practical method for engaging in supportive recovery relationships. Because the method uses ordinary everyday language, everybody involved in mental health care, including service providers, clients, and family members and close friends, can share it. It is important to emphasize that we are not proposing here a new service model for mental health treatment. This is not meant to be a substitute for the many, varied, and important case management models: recovery, assertive community treatment, or strengths. Rather, we offer a method of relating that is down-to-earth and intentionally collaborative. The method functions like a common user interface for and a complement to existing models. This is why the ordinary everyday language in this book is built on clinical theories that have been developed from close observations of human relationships, including therapeutic relationships, but it keeps most of that language in the background.

Do not let the words clinical theories and therapeutic relationships intimidate you. We use them here simply to distinguish between relationships that are arranged to help people understand and navigate their intrapersonal (internal) and interpersonal worlds and those that are not. For example, relationships between psychotherapists and their clients are therapeutic. However, relationships between employers and employees are not, nor are those between teachers and students and between parents and children. Relationships between case managers and clients are often not as clearly delineated. Sometimes the relationships are therapeutic. Sometimes they are not. It depends on the philosophy and mission of the organization that employs and trains managers and provides mental health services. However, as you will discover from the story that unfolds in the following chapters, it is helpful for case management relationships to lean toward the therapeutic, especially because those relationships are intended to help people live with and recover from disruptive and debilitating symptoms of mental illness. Of course, the case manager cannot substitute for the psychotherapist or psychiatrist. And although it is not the role of the case manager to provide therapy, case managers trained to use a more clinical approach and the method proposed here will not only complement the work of psychiatry and psychotherapy. It will also prepare managers for ways of relating with others in the community: family members, psychiatrists and nurses, and co-workers. And perhaps most
important, understanding how to relate, using this method, can enhance all models of case management, in many settings and with many populations.

Before we outline the relationship method and language explored in this book, we first need to clarify a few ideas about mental illness, mental health, and recovery. One of the simplest and most effective ways to understand human experience is to think about the relationship between our internal (intrapsychic) and external worlds (interpersonal or intersubjective). Throughout life—from birth to old age—each of us uses internal resources (feelings and thoughts) to acquire external resources, such as food, clothing, housing, medicine, education, employment, income, and supportive relationships and services. In short, we strive to meet our needs and desires. The internal and external worlds constantly interact, each influencing the other (figure I.1).

Self and Society

Like the world around us (our social surround or environment), our internal world is in a constant state of flux. It is always changing. Sometimes we feel vibrant and alive. Sometimes we feel quiet and still. At times, the shifts are manageable: We find a way to manage the tension between the two to achieve our goals with success and satisfaction. In other words, we maintain our mental health. However, sometimes the shifts are difficult to manage. We experience unbearable, disruptive, or debilitating feelings and thoughts, which inhibit our abilities to take care of ourselves, to interact with others, and to feel satisfied. In other words, we experience mental illness.

Mental health and mental illness are complex topics, and there are limitations to these simple definitions. However, we want to inspire you to think about both in the context of ordinary everyday life. Mental health and mental illness—like physical
health and illness—are a part of our collective human experience. The potential for both coexists in each of us continuously. Mental illness is not something that happens only to “others,” like Marilyn. We must be cautious, always, not to treat those with symptoms as “others,” so different from us that we lose contact. And if we lose contact, we’re likely to treat “others” as cases, as objects to be managed.

**Symptoms**

The technical or clinical term for mental illness is *mental disorder*. All disorders have symptoms, which are internal experiences (feelings, thoughts, self-perceptions) and external expressions (behaviors or actions). There are many symptoms—too numerous to list here.

In an attempt to understand symptoms and their impact, the American Psychiatric Association publishes the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*, which most mental health and human service providers use to assess clients, diagnose mental disorders, and plan their work with clients (table I.1).

<table>
<thead>
<tr>
<th>Examples of Symptoms</th>
<th>Type of Mental Disorder</th>
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<tbody>
<tr>
<td>Depressed mood</td>
<td>Depressive mood disorders</td>
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<tr>
<td>Loss of interest in life</td>
<td></td>
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<tr>
<td>Changes in sleep</td>
<td></td>
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<td>Changes in appetite</td>
<td></td>
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<tr>
<td>Feelings of worthlessness</td>
<td></td>
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<tr>
<td>Suicidal thoughts</td>
<td></td>
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<tr>
<td>Panic attacks</td>
<td>Anxiety disorders</td>
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<tr>
<td>Phobias (unreasonable fears)</td>
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<tr>
<td>Chronic worrying</td>
<td></td>
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<tr>
<td>Obsessions (intrusive thoughts)</td>
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</tbody>
</table>
The severity of symptoms occurs along a continuum from mild to severe. Mild symptoms do not always disrupt or debilitate. With mild symptoms, we do not lose our ability to take care of ourselves, to maintain relationships with others, and to achieve personal goals with success and satisfaction. Severe symptoms almost always do.

The relationship method described in this book can be used with anybody who experiences symptoms at any point on the continuum. However, it is particularly relevant for those with severe symptoms, because we are more likely to experience negative life outcomes, including the following:

- Broken relationships with family members, friends, and co-workers
- Underemployment and unemployment
- Poverty
- Arrest, incarceration, and re-incarceration (recidivism)
- Homelessness
- Inadequate health care
- Poor nutrition
- Hospitalization and emergency room visits
- Complications resulting from chronic illnesses such as diabetes and cancer
- Witnessing and being victims of violence, including physical assault, sexual assault, and death
- Suicide

| Compulsions (rituals that must be performed to decrease obsessions) | Hallucinations (hearing voices or seeing things that others do not) |
| Disorganized speech | Schizophrenia and psychotic disorders |
| Disorganized behavior | |
| Delusions (fixed false beliefs) | |

**Continuum of Symptom Severity**
In this book, we will assume that symptoms are always meaningful. What does this suggest? Keep four things in mind as you think about symptoms. First, although we may have and occasionally use a checklist meant to be applied to all people, symptoms always mean something different; in short, our symptoms are unique, individual, specific, and particular. For example, you may get a headache because your sinuses swell easily when you are exposed to allergens. Someone else will get a headache when they are under stress. When they are not under stress, the headache goes away. Both share the same symptom, a headache, but the symptom means something very different for each. And they may even relieve the symptom by taking the same drug, aspirin. Second, because symptoms are always meaningful, the meanings will change through time, even during the course of the day: We may be incredibly stressed when we’re with strangers at work but quite comfortable with family and friends. Third, it is best to discover how a person experiences symptoms over time. Sometimes our symptoms have been with us for a lifetime. Sometimes they are brought on by an identifiable event or exposure (e.g., dust or pollen, stress, or traumatic events). Sometimes symptoms worsen incrementally; they appear slowly over time. At other times, symptoms appear suddenly and surprisingly. Fourth, we are often not aware of our symptoms. Some can live quite happily with their symptoms. Perhaps there are times we'd rather not trade our symptoms; for example, some people would rather be sad than angry. In short, using the relational method of case management, we take symptoms seriously. It is our job to know and be familiar with symptoms so that we can offer a relationship to someone appropriately.

Recovery

The concept of recovery is somewhat new in mental health services. However, many people (advocates, policymakers, researchers, service providers, family caregivers, and people with mental illness) have come to agree that recovery is a personal journey toward independence with many paths that may last a lifetime. Moreover, it does not proceed in a straight line toward a single destination. It occurs in forward and backward loops and cycles; and therefore every person has a different experience of recovery. For example, there is no one optimum level of independence.
In its guidebook *Emerging Best Practices in Mental Health Recovery*, the Ohio Department of Mental Health defines recovery as “a personal process of overcoming the negative impact of a psychiatric disability despite its continued presence” (Townsend et al., 2000:7). Clinical psychologist Patricia Deegan adds that recovery is not just about finding a new way of surviving in the external world but also about finding a new way of understanding the internal world:

Disabled persons are not passive recipients of rehabilitation services. Rather, they experience themselves as recovering a *new sense of self* and purpose within and beyond the limits of the disability. . . . Recovery refers to the lived or real life experience of persons as they accept and overcome the challenge of the disability. (Deegan, 1988:11–12)

In other words, recovery is a process of understanding and managing symptoms in the context of everyday life and taking care of the self by engaging in daily activities, such as finding employment, seeking and maintaining friendships, using money, and finding safe and affordable places to live.

**Human Relationships**

The activities of daily life require each of us to continuously engage in relationships with others. And our success in navigating the external world of goods, services, and support depends on the nature and quality of our relationships. Likewise, our success in navigating the internal world of feelings and thoughts depends on relationships. In other words, it is in our relationships that we maintain and recover mental health (Stanhope and Solomon, 2008).

In the most supportive service environments, the human relationship is the primary tool of mental health intervention and treatment. Of course, it is enhanced by other tools, such as psychotropic medications, which are especially helpful in minimizing the negative effects of symptoms. To be effective, case management relationships must be specific and intentional about the work they do. Simply getting together for a cup of coffee, a cigarette, or small talk about recovery goals and medication regimens will not make symptoms more manageable; this may help fulfill a basic human need for social interaction, but it will not help those with difficult symptoms work toward
recovery. In addition, the relationship cannot be one-sided. The person giving help must not take control. He or she must not simply assert authority and power over the client, even with the best intentions (Berlin, 2005; Borden, 2000; Reid, 2002).

The Mind

As described earlier, there are three basic domains of our mental lives: feelings, thoughts, and actions (behaviors). All three are in constant interaction (figure I.2). In addition, these domains influence and are influenced by our social environments: family culture, ethnicity, neighborhoods, work, school, gender, and much more. In the dynamic interaction between us and others, the human mind emerges and continuously develops throughout life (Allen and Fonagy, 2006; Bateman and Fonagy 2006; Damasio, 1994; Fonagy, 2002; Kandel, 2005; Siegel, 1999). Alone our brains and bodies do not produce a mind. The mind results from complex and dynamic interactions between the person and his or her environment—the exchange of attention and information about feelings, thoughts, and actions.

THE WORKING TRIANGLE

Figure I.2
Self-Reflection

Some part of the mind reacts automatically to its environment, without reflection. As a result, we often do not know or understand why we feel, think, or act as we do. Another part of the mind observes, evaluates, and responds, after reflection. Some have called this the observing self. Others have called it the observing ego. Still others have described this as the mindful self. Self-reflection is sort of like slowing your internal video, watching it proceed frame by frame, pausing it from time to time, and peeling away layers of thought, feeling, and behavior—from the present and past—to understand how they help or hinder.

Self-reflection is not easy. Nor does it emerge spontaneously. Rather, it develops over time in relationship with others as we notice them noticing us—what we feel and think, what we say and how we say it, and what we do and how we do it. Self-reflection is continuously refined throughout our lives. For example, in childhood we learn to count by having someone watch us, encourage us, and point out paths toward success. In adolescence, we learn additional math with the same technique, especially with peers and teachers. And throughout adulthood, if we remain open to feedback from others (e.g., supervisors, instructors, and consultants), we refine our skills for more sophisticated purposes. A similar process occurs not just with thinking but also with feelings and actions. For instance, young children learn to understand their emotions with adults who observe changes in facial expressions, tone of voice, and behavior and to name the feelings that inspire those changes. Similarly, in adolescence, and if we stay open to this process throughout adulthood, we learn from others (e.g., from our supervisors, case managers, teachers, and psychotherapists) how our feelings, thoughts, and actions interact and facilitate or inhibit success and satisfaction.

This dynamic and complex process (bringing the outside world inside as we notice others who notice our feelings, thoughts, and actions) has been called mentalizing (Allen et al., 2008). There is much more to be said about this very important concept, but a discussion of it here would detract from the central purpose of this book (see “Suggested Readings” at the end of this chapter if you want to explore these ideas further). We use this idea to give emphasis to the simultaneous action between two or more people in reflective case management: noticing, evaluating, and exchanging...
attention and information about feelings, thoughts, and actions. Self-reflection thus is always an interpersonal activity. So it is that reflective case management is also an interpersonal process.

**Reflective Case Management**

Throughout life, symptoms of mental illness influence the process of self-reflection, often inhibiting it. However, the consistent presence of another person who is committed to helping us notice when and how we shift away from then back toward an awareness of our feelings, thoughts, and actions—and those of others—can help us develop or recover our self-reflective skills. This can be accomplished in part because the symptoms of mental illness are included in the process. In other words, the person who supports us during recovery notices our symptoms and talks about them in a way that promotes, with empathic understanding, our awareness of and mastery of them.

Case managers are in a perfect position to help those of us with problematic symptoms enhance our self-reflective capacities because they spend so much time in the community helping us from day to day. It is the most logical and practical context in which to begin this work. This book is an exploration of how to do this work. Here is a brief overview of the method.

**Honesty and Openness**

Case managers can encourage and support trust in relationships with clients by being scrupulously truthful and by maintaining professional boundaries. One way to accomplish both is to continuously discuss and clarify the purpose of your relationship. In the engagement stage (discussed in greater detail in chapter 1) of case management, some clients might not be ready. They might need time to decide whether the relationship with you will be safe—that you will address their needs and not shame or take advantage of them. However, once you establish trust and help them identify their goals—that is, their needs, hopes, and dreams for daily living—you might say something like this to explain your work together:

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You have told me that your goal is to find a quiet and safe place to live. My job is to help you through the process of achieving that goal for yourself. It is also my job to help you through the process of maintaining that goal. Sometimes you will need me to do things for you. Sometimes you will need me to do things with you. Sometimes you will just need me to stand by and be there for support. And, finally, sometimes you will do things for yourself. It is important for us to talk about your experiences. This is the purpose of our relationship: We help each other understand when and why you need me to do for you or do with you, and we help each other understand when and why you need me to stand by for support and when you need to do things for yourself. Our job is to keep talking about this.

Of course, it is important to let the conversation occur naturally, in your own words, and to stay open to your client’s response. It is also important not to overwhelm your client with too much information or too many questions, especially in the early stages of your relationship. However, it is important that you discuss, openly, all the terms of the relationship. Here are other thoughts that might be conveyed. Remember, you will need to find your own words to express these ideas, and they should come when the time is right:

A big part of my job is to help you notice that your feelings, your thoughts, and your actions influence each other. They can help you achieve and maintain your goals. They can also disrupt you and prevent you from achieving what you want. So we have to keep talking about your feelings, your thoughts, and your actions, especially when we are working together. You are going to feel things and think things and do things when I am working with you, and it is important for us to talk about this. The more we do this in our work together, the more you will learn to do this for yourself, especially when you are with other people. We will work together to help you use feelings, thoughts, and actions to achieve goals. Sometimes you might not know what you are feeling, thinking, or doing. Or perhaps you won't have words for them. So when this happens, I might have to do for you: I might observe what I think you are feeling, thinking, and doing. And I might be wrong. The only way we will know is if we keep talking and reflecting together. If you think I am wrong, you have to tell me, and we will explore it together. When we
explore together, I will be doing *with you*. Eventually you will do *for yourself*. This is how we are going to work together. Sometimes I will do for you, sometimes I will do with you; sometimes I will stand by for support; sometimes I will let go and you will do for yourself.

As a reflective case manager, you talk with your clients about their feelings, thoughts, and actions in the context of your relationship. And you are constantly talking to yourself and with your supervisors in a similar way.

**The Relationship Matrix**

The relationship matrix combines all the elements of the reflective relationship discussed earlier (table I.2). The matrix may be used to track and thereby focus your relationship with clients for most activities of daily living. With this approach you can more clearly see the ongoing and changing nature of your relationship.\(^{10}\)

<table>
<thead>
<tr>
<th>Reflective Relationship</th>
<th>Three Primary Domains</th>
</tr>
</thead>
<tbody>
<tr>
<td>Person Who Supports Recovery</td>
<td>Person Who Engages in Recovery</td>
</tr>
<tr>
<td>• Do for you</td>
<td>• Do for me</td>
</tr>
<tr>
<td>• Do with you</td>
<td>• Do with me</td>
</tr>
<tr>
<td>• Stand by for support</td>
<td>• Support me</td>
</tr>
<tr>
<td>• Let go or do for oneself</td>
<td>• Do for myself</td>
</tr>
</tbody>
</table>
In this book, the words *independence* and *living independently* have very specific meanings. First, there is no such thing as a self-made man or woman; no person stands alone in the world. Second, because human beings are in constant relationship, we are influenced by and reliant on others; in short, we are always in and products of relationships. Third, *independence* for us refers to specific kinds of relationships and ways of relating, ones in which both (or all) people strive for independence in seeking needs and wants, setting goals, and asserting ourselves in interactions and negotiations with others to obtain, to achieve, and to live with success and satisfaction.

Here is another point of clarification. Although independence may often be the goal in helping relationships, it is not always attainable or sustainable. Marilyn’s story in the chapters that follow represents a noticeable pattern in human experience that is reflected in the relationship matrix. Although each of us may strive for independence, there is for everyone an ebb and flow between independence (i.e., doing for oneself), interdependence (i.e., doing with and standing by to support), and dependence (i.e., doing for). Anyone who has ever experienced disruptive or debilitating episodes of physical illness, mental illness, or even economic hardship knows that the fluctuations between dependence, interdependence, and independence occur every day and are often quite troubling. If we pay close enough attention, we will discover that we often cycle, recursively (back and forth), through doing for, doing with, standing by for support, and doing for oneself many times, even during the course of a day. In figure 1.3, you get a visual sense of how your relationship to others may change, even rapidly, throughout life. In sum, the goal of recovery relationships should be to help each client maintain a level of feeling, thinking, and acting necessary to achieve his or her greatest potential for recovery and independent living. And the potential for independence is different for everyone. Some will need more support than others. Some will never seek independence. Others will face daily, moment-to-moment barriers to independent living. And it is especially important to recognize that mental health professionals and interventions may not be needed as one reaches for recovery. As we will show in this book, they may even interfere. Some have argued, as we
will show in this book, that our clients often use self-help models or deploy personal support systems. Sells et al. (2004:96) argue that when services are used, we should endeavor not to intervene and minimize symptoms; instead, our purpose is to act as “a facilitator of self-definition.”

THE RELATIONAL CYCLE

![Diagram of the Relational Cycle](Figure I.3)

**Professional Use of Self**

In your work as a case manager, you may be required to observe and conform to the codes of ethics set forth by your profession (e.g., social work, counseling, psychology, family and marriage counseling), your organization, or the laws of the state in which you practice. Ethics are codes of conduct that describe acceptable standards for your behavior. However, to be most effective in supporting consumers in recovery, managers must also reflect on their own feelings, thoughts, and actions in the context of their relationships with others. We call this the professional use of self. Managers may develop and enhance this capacity in their relationship with their supervisors. For example, as you work with clients to make sense of their internal experiences and behavior, your supervisor may help you make sense of your experience with your clients. This, in turn, deepens the supervisory relationship and the professional use
of self. Reflecting in this way helps you become more aware of how your feelings, thoughts, and actions support or inhibit clients on their recovery journeys.13

One way to increase self-reflection is to use the relationship matrix after visits with clients and supervisors. It will help you evaluate progress toward doing for oneself in the primary domains—feeling, thinking, and acting—while engaging in the activities of daily living. It will also help you evaluate whether you encourage or discourage progress by doing too much for. The research produced for this book suggests that managers often get stuck in doing-for modes of relating. Indeed, this may be one of the factors contributing most to burnout and thus staff turnover. We’ll have more to say about this in the pages that follow. Whereas some with severe and persistent symptoms may need other people to do for them with great frequency, others like Marilyn may not; they may need more doing with and standing by to encourage them to internalize confidence in their own abilities. One solution for decreasing burnout and staff turnover might be found by carefully monitoring and reducing the number of doing-for activities.

By using the matrix to track interactions with clients, you will be collecting data for agency planning and supervision. For instance, you might find that you are, in fact, engaging in too much doing-for activity because of your own anxiety and fear of failure, or you might be engaging in doing-for activity because your clients need it. Knowing these differences is crucial to your own professional development, success, and satisfaction. And in supervision you will learn to balance caseloads by assigning a mix of clients, not just those who need doing-for activity.

**Personal Narratives: The Importance of Stories**

Recovery is a personal journey in which each person defines a new sense of self and purpose within and beyond the limits of his or her symptoms. It is a process of personal change that involves a transformation of self-perception. It is a process of creating a new story about the self that acknowledges limitations (or deficits) but focuses primarily on personal strengths and positive attributes. Yet creating this new narrative of the self can be quite challenging, especially in the present state of mental health service systems.
Unfortunately, for those of us who turn to systems of care for help, our personal stories do not begin with our strengths and positive attributes; instead, they begin with our deficits. After all, we seek or are referred to treatment because of a particular problem or set of problems. In addition, after an initial assessment, our mental health provider will probably assign one or more diagnoses from the DSM. Therefore, our story in treatment typically begins with the official language of deficit and pathology. Although the DSM is valuable for helping service providers make sense of symptoms and in planning interventions, it also conveys a negative message to us and to all those within view or earshot of our diagnosis. In short, it produces stigma (Corrigan, 2007). A narrative of a client that begins with a diagnosis reads like this: “You have a disorder. You have problems. You are ill.” The client’s internalized version of this story might go something like this: “I have a disorder. I have problems. I am different from other people. I am ill.”

Here is another way to look at this situation. By maintaining an emphasis on diagnosis and assigning a DSM identity, the mental health system is doing for us in the domains of feeling and thinking. It makes us dependent on their interpretations—their story—of us as flawed human beings (Stanhope and Solomon, 2008). Unfortunately, it is not easy to avoid a diagnostic identity and diagnostic narrative because the diagnosis is often required by public and private insurance organizations, and both consumers and mental health providers depend on this financial support.

Although the diagnostic narrative is unavoidable, the reflective case manager refrains from doing for in this way. The reflective case manager does not impose a diagnostic disorder story. Rather, we help clients construct their own stories about strengths and positive attributes within and beyond the limits of their symptoms through the process of self-reflection, using the relationship method and language outlined in the matrix in table I.2. In other words, the reflective case manager helps clients notice strengths and accomplishments by calling those strengths and accomplishments to attention.

As human beings, all of us are storytellers; it is in our nature. Through the art of storytelling, we learn to understand ourselves, the world around us, and our relationships to others. Storytelling is one of the primary technologies available to us. It is there. It is free. And you don’t need a prescription.
How to Read This Book

The story that unfolds in the next three chapters may appear, at first glance, to be one story: Marilyn’s struggle for recovery and independence. Yet we invite you to consider that several narratives are at work simultaneously. There is Marilyn’s story, of course, as observed and told by Lisa. Then there are glimpses of Marilyn’s story as observed and told by family members, friends, and other service providers such as the housing specialist, work supervisor, nurse, psychiatrist, and physician. Then there is the narrator’s story of Marilyn as the hypothetical client, Lisa as the de facto case manager, and you as the hypothetical case manager. You may be wondering why we have included you in the narrative. We will explain in a moment.

First, we call to your attention the multilayered narrative reality of this book to point out that this is how narrative occurs in daily life, out there in the community. There is never just one story about you and the people you know. Think about your own family and your own circle of friends. Each person in your social network has a different perspective—a different take on the details. Each perspective contributes a piece to the puzzle. And each narrative perspective says as much about the storyteller as it does about the main character. Therefore, in the story that unfolds in the next three chapters we include you, the reader, because we are inviting you to begin the process of reflection that is necessary to become a reflective case manager, a reflective supervisor, and a reflective supporter of recovery.

It is our intention with this book not to present an authoritative view on the value of self-reflection and reflective case management. Rather, we want to inspire you to use this book to create your own narrative about self-reflection, about reflective case management, and about the value of reflective relationships in the context of everyday life. If you are a seasoned case manager or a case manager in training, we invite you to use this book not only to reflect on Marilyn’s story. We hope that you will also reflect on your stories and those of your clients. Use this book with your clinical supervisor at your service organization, with professors and instructors at the college or university you attend, and with the trainers and consultants from technical-assistance organizations that are providing you with continuing education. Collaboration with others is the key to lifelong learning and discovery. Try applying this method to the
model of management used at your agency. It is an opportunity to notice the beauty in the complexity of feelings, thoughts, and actions as they emerge in the context of human relationships.

You will notice that throughout this text we observe the powerful effect of shame in the case management relationship. We’ve done this because we found substantial evidence in the ethnographic data collected for this book. And it is our hope that you will gain from our understanding of how shame is an ever-present dynamic in the daily lives of those we work with.

Finally, there are two ways to read this book. If you are interested in the historical and cultural background of case management, you might consider starting with chapter 4. If not, we advise that you read the chapters in order.

On Being and Having a Case Manager Online

Please see our Web site (http://relationalcasemanager.com) for podcasts and additional resources on topics covered in this chapter:

SUGGESTED READING


Topics for Discussion

1. For one week, keep a personal journal. Each day observe how, what, when, where, and who you depend on to do for you (e.g., partners, parents, teachers, supervisors, peers); also observe when you do for others. Describe these in detail, each day, and note how they differ. Also, observe when you are doing with someone and when someone is
doing with you. Note in your journal the differences between the doing-for and doing-with activity. Finally, observe the things you do on your own. How do they differ from activities that you do for others or have done for you? Note your feelings as you think about each of these activities.

2. You will find on the World Wide Web numerous examples of codes of ethics for case managers. For example, the state of New Mexico has a very strong code of ethics for case management. Find several, read them, and then consider the following. Joe is a case manager at the Hope Mental Health, Inc. After work he meets a client at a local coffee shop and shares with him the details of a recent struggle and conflict with his supervisor at the agency. Is this a possible ethical conflict? If so, why? See these sites for codes of ethics:

http://www.yournacm.com/guidelines.html

3. This book can be used to complement comprehensive texts in qualitative research methods. It is an in-depth example of an ethnographic project from beginning to end, from question formulation to the writing phase. Students will see how qualitative and ethnographic data are collected in a natural setting and how grounded theory techniques are used for coding. If you use this book in teaching research methods, we suggest that you begin with appendix 1. Then read chapter 4. The remaining chapters should be read in order. Students will see how problems are identified and how data are collected. They will see how an analytic strategy is developed and how research is written up for a broad audience. First, we identify the research question in everyday provider–client interactions and show how relationships were used to facilitate recovery from severe mental illness. Second, we show how ethnography and participation–observation are used for data collection. Third, we show how grounded theory coding techniques are used for comparison of everyday problem-solving activities. Fourth, we compare the relational activities of all observed instances and identify the constructs: doing for, doing with, letting go, and doing for oneself.