INTRODUCTION: THE RELATIONAL METHOD FOR RECOVERY

1. This study was approved by the Case Western Reserve Institutional Research Board. To ensure confidentiality, the names of places and all participants have been changed. The data were collected by Jerry Floersch with support from the Ohio Department of Mental Health. Jeffrey Longhofer and Lisa Oswald participated in the data collection, and Jeffrey Longhofer analyzed the data in cooperation with Jerry Floersch. See appendix 1 for a detailed discussion of the research methods.

2. You will find at the end of this chapter a long note about how this book might be used in graduate courses on qualitative research methods and in discussions of the uses of ethnography and grounded theory in the study of practice. Also, you will find a list of suggested readings to help you deepen your understanding.

3. Therapists, clinicians, psychiatric nurses, and psychiatrists will find this account of and method for case management useful in working with both case managers and clients. For example, the relationship method described in this and subsequent chapters could easily become the basis for developing and deepening the supervisory relationship and for organizing a consultation practice. It could also be useful as a planning tool. For example, one might learn that many practitioners are predisposed to work in the mode of “doing for,” whereas others are disposed to promoting independence prematurely. “Doing for” may also become an unnecessarily expensive and wasteful use of human
capital. See appendix 2 for a schematic (figure A.2, “Relational Case Management Daily Intervention Note”) useful in personal and agency planning.


5. We want at this early point to caution the reader about the language used to describe those who practice mental health in communities, “case managers,” and the practice they engage in, “case management.” We are keenly aware that these terms are loaded with meaning and potential misunderstanding. First, if there are “case managers” there must also be the “case managed.” This suggests that we “manage” “cases.” People are not cases. And this language is and should be troubling to us. It comes, ultimately, from the practice of law. This is not about political correctness. This is about how we think about and treat one another. We have adopted this language in the book because for now it is commonly accepted. However, as you will see in the pages that follow, we never take our terms and concepts for granted. They should always be debated, challenged, and when possible transformed. We are always and necessarily in relationship with one another, not as objects to be managed but as people in continually changing relationships. Indeed, this book is about the nature and quality of those relationships.

6. For an excellent summary and discussion of the relational paradigm in psychodynamic social work, see Borden (2000).

7. In this book we sometimes use the term *client* and at other times we use the term *consumer* to describe those with mental health symptoms who seek services. You will find that these terms have undergone change. For example, in the mental hospital, clients or consumers of mental health services are generally called patients. When our large publicly funded and managed mental hospitals were closed beginning in the 1960s, we were faced with the need to care for those with symptoms in the community. We also needed an entirely new language or conceptual vocabulary. So we turned to the language of business (consumers) and law (clients) to borrow what seemed a more familiar, everyday, and appropriate terminology. All of us are consumers, most of the time, of something. Thus, we become consumers of mental health services. Many of us at sometime will become a client in the legal system. And those who manage our services eventually became known as case managers. Clients and consumers, then, became a function of managers. Managers were charged with, among many other things, the management of symptoms in the community. Still today, in hospitals,
one does not often hear the terms *consumer* or *client*. Only upon discharge do people shed their identity as patients to become once again consumers or clients of the mental health system, subject to case management. See Floersch (2002) for a history and discussion of these issues and debates. Much is at stake with this change in language. It’s not just a subtle shift in meaning. It has much to do with the nature of power in relationships. And although we’ll never find a perfect language for those who receive our mental health services, we should forever strive to remain sensitive to how our “clients,” “consumers,” or “patients” want to be addressed and, more importantly, understood.

8. It is important to know the distinction between positive and negative symptoms. Psychosis, for example, manifests in many ways and differently affects thoughts, feelings, and behaviors. Thus symptoms of psychosis are often separated into positive and negative categories. They are positive when thoughts, feelings, and behavior are added onto how a person usually thinks and feels (e.g., delusions, hallucinations, and tangential or incoherent speech). They are negative when something is taken away (e.g., motivation, range and intensity of emotional expression, fluency and productivity of thought and speech, or goal-directed behavior).

9. Peter Fonagy, Mary Target, and Linda Mayes have conducted research and written widely on this subject. See “Suggested Readings” for recent work on this subject. See Allen et al. (2008) for a very nice application of these ideas. They also discuss how mentalization relates to ideas in cognitive psychology and the more recent literature (cited throughout this book) on mindfulness.

10. See appendix 2, figure A.2, “Relational Case Management Daily Intervention Note,” for a discussion of how to use the matrix in your daily work with a client.

11. It is a good idea to be familiar with the codes of ethics and standards of practice in your profession or organization. See the end-of-chapter resources and discussion topics for an exercise on this and related topics.

12. See Arnd-Caddigan and Pozzuto (2008) for a very important discussion of a relational approach to the use of the self.

13. Some have argued that we should actively engage clients with our accumulated knowledge and awareness of who we are (i.e., our personality, personal beliefs) and with what we know from our professional training. See Edwards and Bess (1998) for helpful suggestions about the professional use of self. They talk specifically about inventory of self, development of self-knowledge, and acceptance of risks.
1. CULINARY ARTS

2. See especially chapter 3 of Germer et al. (2005) for a discussion of mindful attention.
3. At the end of this chapter, you will find an exercise related to this topic.
4. Again, at the end of this chapter, you will find a useful exercise on this topic.
5. Case manager safety has become an important issue in our current mental health system. A 2002 survey, among 800 social workers, found that 19 percent had been victims of violence, and 63 percent had been threatened. In a 2006 national study of the licensed social work labor force, 44 percent of 5,000 respondents reported facing safety problems. It is our responsibility to know when we are in danger and to be prepared and to always seek supervision when we are in doubt. See your agency protocol for safety management. Know the protocol. Follow it. Also, see the safety guidelines of the Boston National Association of Social Workers at http://www.socialworkers.org/profession/centennial/violence.htm.
7. We all do reality testing, moment to moment, in two ways. We test to know what is inside us and what is outside us. We test also to know the difference between what is inside and what is outside. Why is this important?
8. To learn more about empowerment, consider adding to your reading list Robert Adams, Social Work and Empowerment (2003). In this book, Adams offers a succinct discussion of empowerment along with an overview of theories, models, and methods related to empowerment. He covers self-empowerment and empowering work with individuals, groups, communities, and organizations, including examples of work with children, families, and adults. Also, Peterson and colleagues have written important essays, empirical and conceptual, on community empowerment: what it means, how it is to be studied, and a method for producing empowerment (Peterson and Hughey, 2004; Peterson and Zimmerman, 2004).
10. For an excellent discussion on knowing and not knowing, see Fulton (2005).
11. See Faust (2008), an especially important article on the role of the social worker as advocate.

12. Anthropologists Douglas Hollan and C. Jason Throop argue, convincingly, that we can easily and mistakenly assume that empathy is always and everywhere a desired goal (Hollan, 2008; Hollan and Throop, 2008).

2. AN APARTMENT OF HER OWN

1. Turnover is very costly, not only to our clients but also to the mental health system; see Gitter (2005).

2. See “Topics for Discussion” at the end of this chapter for an exercise on the treatment alliance.

3. DISAPPEARANCE

1. Jay Neugeboren has written a wonderful book, Imagining Robert (2003), about his brother’s long struggle with schizophrenia. If you work with people with severe mental illness, please add this book to your reading list, along with Elyn Saks’s The Center Cannot Hold: My Journey Through Madness (2008). Neugeboren (2008:49) writes, “We all need and cherish the feeling of safety that comes from knowing someone who knows us and cares about us. For most mental patients, however, such a relationship is the rarest of commodities. Even when community centers, mental hospitals, and residences try their best, they are usually compromised by inadequate budgets in which pills—the ultimate downsizing of care—become the primary, and often the sole, form of treatment. Consider: in one six-month period, my brother had seven different social workers assigned to him.”

2. Agencies can develop management strategies to reduce costs and improve efficiency by helping managers and supervisors use the relational method—doing for, doing with, standing by, and letting go—to allocate effort across these areas in the case management of money. For example, if you find that some managers have allocated too much effort to doing for in money management, you may want to pay closer attention to their working relationship. You might find that the manager has too many clients in his
or her caseload for whom doing for is necessary. There may need to be a reallocation of effort so the manager is working with fewer clients in this category. Or you might find that the manager also struggles with money management, so it is very difficult to do with. You might also find that some managers should be doing for in the management of money when they are letting go. This, too, would suggest a need to look again at the management relationship so that manager and agency effort can be more efficiently and meaningfully reallocated.

4. REALIZING THE PROMISE OF CASE MANAGEMENT

1. Social scientists across the disciplines were involved in the early critique of state mental hospitals. For example, Thomas Szasz (1961), a psychiatrist argued that mental illness was a myth, invented or socially constructed by psychiatry. See Cresswell (2008) for a recent review and discussion of the debate initiated by Szasz. In a very controversial study (something that could never be done today, ironically, because it would not pass most institutional review boards), sociologist David Rosenhan (1973) placed healthy “pseudopatients,” in twelve mental hospitals; they simulated auditory hallucinations to gain admission. The psychiatric staff was then asked to detect the patients feigning mental illness. In one hospital they failed to detect a single pseudopatient. In another they falsely identified large numbers of legitimate patients. The study is still widely cited in the criticism of psychiatric treatment and diagnosis.

2. Sociologist Erving Goffman (1961) studied what he called “total institutions.” In one of his well-known books he describes the mental hospital in these terms: Daily life in all its aspects is under total institutional control; people must submit to and are dependent on the authorities of the organization.

3. In 1967, Frederick Wiseman produced and directed a documentary film, *Titicut Follies*, about the Massachusetts Correctional Institution at Bridgewater, a prison hospital for the criminally insane. The film, banned by the Massachusetts Supreme Court, looked into the most private lives and horrors of a prison for the insane.

4. Indeed, many adopted a “deficit model” as a kind of unreflective mantra. With this dismissive talk, one could imagine, among other things, that the self is taken care of once material needs have been met.
5. See Joseph Walsh (2000) and Joel Kanter (1987) for their work on clinical case management.


APPENDIX 1: RESEARCH METHODS

1. The research methods used in this study have been further developed and are the subject of a forthcoming book for Oxford University Press by Jeffrey Longhofer, Jerry Floersch, and Janet Hoy, *Qualitative Research for Practice*. 