

Connection and Autonomy in the Case Management Relationship¹

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Statement of the Research Problem

Recent reviews of the empirical research on the effectiveness of case management have shown that assertive, community-based interventions are generally more effective than traditional office-based aftercare services at reducing hospital utilization and improving consumer functioning and quality of life (Bond, McGrew, & Fekete, 1995; Mueser, Bond, Drake, & Resnick, 1998).

While the overall effectiveness of case management is generally supported by this literature, there remains rather inconsistent findings and many authors agree that there is a need to improve the conceptualization and design of future studies to better assess effectiveness (Burns & Santos, 1995; Teague, Bond, & Drake, 1998). Nevertheless, more recently the process of case management has become a focus of investigation. One key process variable is the consumer-case manager relationship on which case management hinges. Long recognized as central to the theory and practice of case management, this relationship is assumed to play a pivotal role in case management (Harris & Bergman, 1993). Several authors suggest that this element of case management warrants empirical investigation (Burns & Santos, 1995; Gorey et al., 1998; Mueser et al., 1998; Solomon, 1998). This study is an examination of the consumer-case manager relationship in intensive case management, and aims to explore the impact of the relationship on specific consumer outcomes.

Research Background Questions/Hypotheses

The case manager-consumer relationship has long been recognized as central to the theory and practice of case management with adults with severe mental illness (Harris & Bergman, 1993). However, to date, this relationship has received little research attention. Two recent studies examined the case management relationship; both adapted a measure developed in psychotherapy research, the Working Alliance Inventory (WAI; Horvath & Greenberg, 1989). In a retrospective assessment (two years after the consumers had begun in case management) of the alliance of 143 consumer-case manager dyads, Neale and Rosenheck (1995) found that positive alliances were associated with reduced symptomatology and improved global functioning. Solomon, Draine and Delaney (1995) introduced the WAI to examine the consumer-case manager alliance of 90 dyads at

¹ This research was nested in a larger investigation of the alliance in intensive case management directed by Leslie Alexander, Ph.D., and funded by NIMH (#5RO3MH52734-02).

the 2-year assessment point in a randomized clinical trial. The authors found that a positive alliance accounted for a significant percent of the variance (21-54%) in positive attitudes toward medication compliance, consumer satisfaction with mental health treatment, and consumer-perceived quality of life (Solomon, et al., 1995)

While these studies support the pivotal role of the relationship in facilitating positive consumer outcomes, the fact that the alliance was not assessed until after two years of the consumers' engagement confounds causal interpretation. Nevertheless, the use of the WAI in these studies, and the significant findings of alliance-outcome association, appears to support the compatibility of this construct for the consumer-case manager relationship. However, there remains questions about the conceptual 'fit' of the WAI to assess the relationship in case management of adults with serious mental illness. At the core of the alliance construct are the dimensions of bonding and collaboration (Horvath, 1994). These components are certainly consistent with most case management interventions. On the other hand, it is also conceivable that the consumers served by case management, and the service itself, present unique challenges and demands that may not be fully captured by the WAI. For instance, the concept of collaboration may be problematic for persons with severe mental illness. Ambivalence about personal goals is a prominent feature of schizophrenia (Walsh, 1995), thus making the process of mutual goal setting difficult.

Additionally, the spectrum of case management activities exceeds traditional psychotherapy interventions for which the WAI was developed. Case management typically involves much more frequent consumer-case manager contact than psychotherapy. Case managers become deeply involved in consumers' daily lives and perform a broad array of functions in a variety of settings and situations (Williams & Swartz, 1998). Some of the roles that case managers frequently perform include court-appointed guardian in medical, legal and financial matters, consumer representative/advocate with the consumer's family and/or landlord, and petitioner for involuntary treatment, to name a few. In addition, case managers monitor consumers, negotiate between the consumer and numerous treatment providers, and assist with money management. The intensity, location of contact, and intimate nature of some of these roles and activities introduce dynamics of case manager control that may compromise consumers' sense of autonomy and subsequently negatively affect the consumer-case manager relationship (Drake & Marlowe, 1998). The very nature of assertive outreach in case management "requires the case manager to carefully balance the value of outreach visits with an awareness of and respect for the client's privacy and personal boundaries" (Williams & Swartz, 1998, p. 301).

This study aimed to prospectively examine the effect of connection and autonomy in the case management relationship for adults with serious mental illness in the first nine months of the service on three outcomes: treatment participation, consumer satisfaction with case management, and consumer satisfaction with social life. The choice to focus on consumer satisfaction with case management and consumer satisfaction with social life as relevant outcomes was guided by the previous research on the case management

relationship. In their study, Solomon et al. (1995) found that the alliance predicted subjective outcomes, suggesting that the consumer-case manager relationship "may be particularly useful in improving clients' subjective experiences of community living" (p. 132). In addition, treatment participation, though not necessarily of value in and of itself from the consumers' view, is certainly a necessary condition for treatment success. The study was guided by the following related hypotheses: higher ratings of connection and higher ratings of autonomy by consumers and case managers would correlate with 1) greater consumer participation in treatment, 2) greater consumer satisfaction with case management, and 3) greater consumer-perceived quality of social life. These are based on the assumptions that friendly connection between consumer and case manager would produce positive consumer outcomes, and that given the seemingly intrusive nature of some case management activities, case manager control, or inhibition of consumer autonomy, would have a negative effect on these outcomes.

Methodology

This study used an exploratory, single-group repeated measures design. Case management units were approached and explained the purpose and procedures of the study. When a consumer was newly enrolled in case management, a study interviewer would meet with the dyad, explain the study and obtain signed consent forms from each party. Separate interviews of consumers and case managers occurred within six weeks of a consumer's admission to case management. The relationship and outcome measures were assessed at three subsequent time-points: three months, six months and nine months.

Measures

Consumers and case managers at each interview point beginning at 3 months completed the self-rating Short Form of the *Structural Analysis of Social Behavior* (SASB; Benjamin, 1988). The SASB is a circumplex model and measure of interpersonal interactions that captures two fundamental factors of relationship: connection and autonomy. In the model, connection and autonomy comprise two intersecting axes with positive and negative poles, which represent the extremes of the dimensions. For instance, in the connection dimension, the poles are "friendly" (positive) and "hostile" (negative). In the autonomy dimension, the poles are "emancipate" (positive) and "control" (negative). The axes form quadrants, designating points along the circumference of the circle that signify unique "blends" of connection and autonomy, combining in various degrees to form intermediate clusters.

The SASB Short Form consists of 16 items on each surface for a total of 32 items. The items are worded to represent specific topographical positions on the dimensions of connection and autonomy. First, clients were asked to rate their case managers actions towards them (Focus on Other), and then their actions towards their case managers (Focus on Self). Case managers were asked to do the same in relation to their client.

Items are rated on an 11-point scale ranging from 0 (never) to 100 (always). These extreme end points are the scale's only descriptive anchors. In this way, >50 is

thought to represent the midpoints between the two extremes, or the boundary between “false” and “true” (Estroff, Zimmer, Lachiotte, & Benoit, 1994).

Benjamin (1988) recommends asking subjects to rate the relationship “at best” and “at worst” to account for the dynamic nature of relationships. However, given the length of the overall interview it was decided to administer the questionnaire only once at each of the assessment points. To account for relational variance, interviewers were instructed to inform participants that they should respond about the “overall context” of the relationship, taking into account both good days and bad days. For instance, one item reads, “He/she lets me speak freely, and warmly tries to understand me even if we disagree.” If a respondent replied, “Well, sure, most of the time, but sometimes she seems to get mad if I don’t go along with her,” then the respondent was instructed to take this into account in choosing a rating. Conceptually, this comprises an averaging effect for both “good” and “bad” states of the relationship. Others have used the same procedure in assessing the therapeutic relationship with the SASB.

SASB data are analyzed with a SASB software program which generates connection and autonomy scores from the raw data for clinical and research interpretation (Benjamin, 1988). Each item of the Short Form questionnaire represents a cluster point on the circumplex (Benjamin, 1988), and the scores are generated by weighting the items according to their spatial relationship to the intersecting axes (Pincus, Newes, Dickinson, & Ruiz, 1998). The resulting scores represent dimensional ratings of relational quality in terms of connection and autonomy. Higher CONNECTION scores indicate “friendly” connection; lower CONNECTION scores indicate “Hostile” connection. Higher AUTONOMY scores indicate “Emancipate” or “Separate”, and lower AUTONOMY indicates “Control,” or “Submit”.

The psychometric properties of the SASB have been validated by a number of methods; test-retest reliability is comparable to other standard self-report measures in common clinical use (Pincus, et al., 1998).

Case managers completed the *Treatment Participation Index* (McGurrin & Worley, 1989) rating the level of their consumer’s participation on a 7-point scale (1 = full participation to 7 = non-participation).

Consumers completed the *Satisfaction with Case Management Services Scale* (Hoult, Reynolds, Charbonneau-Powis, Weekes, & Briggs, 1983), a 12-item scale. Each item describes a service typically provided in case management. Consumers rated the helpfulness of each service on a 4-point Likert scale (1 = very helpful to 4 = not helpful).

The *Satisfaction with Social Life* measure is a subscale of Lehman’s (1988) Quality of Life Interview (QOLI), designed for use with persons with chronic mental illness. (The full QOLI was administered as part of the larger investigation in which this study is nested). The *Satisfaction with Social Life* subscale is a subjective assessment

consisting of 6 items. Consumers rated on a scale of 1 to 7 (1 = terrible to 7 = delighted) their feelings about their social life.

The *Brief Psychiatric Rating Scale* (Rhoades & Overall, 1988) was used as a measure of control because of the negative effect that symptoms may have on the relationship and outcomes. The BPRS is a 24-item semi-structured interview instrument, each item representing a specific symptom that is rated on a 7-point scale (1 = none observed to 7 = extremely severe). Study interviewers were trained in the use of the BPRS for research purposes to ensure inter-rater reliability.

Statistical Methodology.

Multivariate regression analyses were used to evaluate the effects of connection and autonomy on the outcomes in a two-step process. First, 3-month CONNECTION and AUTONOMY scores were entered as independent variables to evaluate their effect on 9-month outcomes. Secondly, 6-month scores were entered to assess the impact on 9-month outcomes. Each outcome was tested in four separate regression models (consumer and case manager ratings X two surfaces) for each time point that contained the following variables: CONNECTION, AUTONOMY, BPRS score, and outcome.

Summary of Results

Descriptive analyses.

The consumer sample consisted of 30 males and 25 females. The majority was Caucasian (85.5%) and ranged in age from 19 to 60 years old ($M = 38.7$, $SD = 10.41$). Most were single [either never married (60%) or separated or divorced (38.2%)]. The sample was evenly divided by diagnosis (28 schizophrenia, 27 schizoaffective disorder). The average number of years ill was approximately 15, and the average length of time in the mental health system was 11 years.

The case manager sample consisted of 23 males and 20 females. Nearly all were Caucasian (95.3%) and they ranged in age from 23 to 63 years old ($M = 32.7$; $SD = 10.17$). While nearly half of the case managers were relatively new to their position (46.5% < one year), 35% had more than five years experience in the mental health field.

Statistical Analyses of the Effects of Connection and Autonomy.

Only two models testing the effects of 3-month connection and autonomy scores on 9-month outcomes were significant. When case managers focused on the consumer's behavior, positive connection had a positive effect on treatment participation ($B = .436$, $p = .010$). When case managers focused on themselves, connection also had a positive effect on treatment participation ($B = .499$, $p = .032$). Ratings of autonomy were not significant on either surface. These models accounted for 14.9 – 21.1% of the variance.

The remaining discussion of the effects of 6-month SASB ratings on 9-month outcomes is organized by outcome.

Treatment Participation. When consumers focused on case managers, positive connection alone predicted higher treatment participation ($B=.270, p=.039$). When case managers focused on consumers, positive connection ($B=.415, p=.006$) and higher autonomy ($B=.456, p=.081$) predicted greater participation. When case managers focused on themselves, only connection was significantly associated with treatment participation ($B=.521, p=.009$). These models accounted for 11–16% of the variance in treatment participation.

Satisfaction with Case Management. When consumers focused on case managers, positive connection ($B=.157, p=.005$) and autonomy ($B=.144, p=.033$) were associated with greater satisfaction with case management. When consumers focused on themselves, positive connection alone ($B=.218, p<.001$) correlated with greater satisfaction. When case managers focused on their own behavior, positive connection had a positive effect on satisfaction ($B=.215, p=.010$). These models accounted for 20.8–33.3% of the variance in satisfaction with case management.

Satisfaction with Social Life. Six-month consumer ratings showed that positive connection was associated with greater satisfaction with social life at 9 months on both surfaces (Focus on Other, $B=.284, p=.032$; Focus on Self, $B=.296, p=.044$). Ratings of autonomy were not significant. Only one model of case manager ratings was significant. When focused on their own behavior, autonomy had a significant negative effect on consumer satisfaction with social life ($B=-.502, p=.076$). These models accounted for 10–13% of the variance in this outcome.

Utility for Social Work Practice

Although the study limitations need to be considered (sample size, abbreviated assessment period, subjective measures), this exploratory study has important implications for practice. First, the three-month relationship measure predicted very little in regards to outcomes. This suggests that relationship formation with persons with severe mental illness may require a longer period of time. This has been suggested in the literature (see for example, Frank & Gunderson, 1990). Secondly, the findings support the importance of a positive connection between consumers and case managers. In fact, while symptoms of schizophrenia create serious challenges to the development of reciprocal relationships (Corrigan, Davies-Farmer, & Stolley, 1990), the consumers' own connecting behaviors may have a positive role in improving consumer outcomes. Finally, for the most part the results indicate that consumers and case managers value autonomy in the relationship, and that granting and taking autonomy may improve treatment participation and satisfaction with case management. However, the one study outcome that captured an important area of the consumers' lives *outside* of case management (satisfaction with social life) had a negative correlation with autonomy. This suggests that to produce any significant improvement in consumer quality of life may require case managers to act with *less* autonomy. While granting consumers autonomy is important, influencing some areas of consumers' lives might be best facilitated by being more directive, even risking "intrusion," within the context of an affectively positive connection.

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