Understanding how case managers’ use ‘sabotage’ as a frame for clinically difficult situations

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Understanding How Case Managers Use 'Sabotage' as a Frame for Clinically Difficult Situations

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Abstract

Case managers are among the direct service providers responsible for engaging people with severe mental illnesses. Understanding how they interpret and respond to clinically difficult situations can inform ways to intervene and reduce service disengagement. This qualitative study explored clinically difficult situations when case managers invoked the term “sabotage”. Interviews were conducted with 21 case managers and analyzed by co-coders focusing on how case managers used the term sabotage to describe service user behavior. Themes that emerged were attributing sabotage to; fear of success, fear of attaining what you desire, avoidance of responsibility and change, and a lack of structured support. Drawing on the concepts of clinical case management and mental health recovery, we consider implications for the training and supervision of case managers and how services are structured.
Case managers are front line mental health providers who are vested with the task of engaging and maintaining people with severe mental illnesses in services. Yet case management, itself, is often considered to be distinct from a “clinical” service in that its main task is to link service users to services rather than providing the services directly (Corrigan, Mueser, Bond, Drake, & Solomon, 2008). Moreover, case managers frequently work with service users who are ambivalent about services, sporadically access care and drop out of services without any notice. Of those who do seek treatment or are hospitalized, an estimated 24 percent of people do not attend treatment as scheduled and 20 percent drop out of treatment before it is completed (Olfson et al., 2009; Kreyenbuhl, Nossel, & Dixon, 2009). How case managers cope with these challenges has not been widely studied. This qualitative study examines how case managers understand and react to clinically difficult situations paper by exploring how and when they use the term “sabotage” to describe service user behavior. “Sabotage” in this context refers to the concept of self-sabotage in which service users are understood to undermine the progress they have made towards housing and stability. Drawing both on the concepts of clinical case management and mental health recovery, we consider the study’s implications for how agencies train and supervise case managers and how services are structured.

Although the mental health system is seeking to improve services through the implementation of evidence based practices (Drake et al., 2001), the prerequisite to any successful treatment is willing engagement in services on the part of the service user (Tunner & Salzer, 2006). The onus of engagement falls primarily on case managers and other direct service providers, who work on the front line to stabilize people’s lives by meeting basic material needs such as housing and benefits and providing mental health services. Case management emerged as a service modality in the 1980’s as part of the National Institute for Mental Health’s Community Support Program. The service was conceived as a way to prevent service users “falling through
the cracks” by providing a person in the community who could help them negotiate the complexities of the social service system (Rapp & Goscha, 2004). Traditionally, the core functions of case management have been viewed as: assessment, service planning, linking to services, monitoring service provision, and advocacy (Intagliata, 1982; Solomon & Meyerson, 1997). However, the concept of clinical case management has broadened the scope beyond just the coordination of services to include direct service provision activities such as intermittent individual psychotherapy, psychoeducation, and consultation with family members and other caregivers (Kanter, 1989). Surber (1994) describes clinical case management being “as much a way of thinking about care as it is providing specific interventions” (p.3). By focusing more on building capacity among service users, case managers collaborate with service users to develop independent living skills, characterized as “doing with” rather than “doing for” (Floersch, 2002).

However, the relationship between the case manager and the service user undergirds case management activities and is a strong predictor of positive outcomes (Howgego, Yellowlees, Owen, Meldrum, & Dark, 2003). Engaging and maintaining a service user in care depends in part on navigating the power relations inherent within the helping relationship (Walsh, 2000). In this respect, case managers need clinical rather than administrative skills to address the transference and counter-transference that emerges while they work with service users to meet their needs. Social workers, in particular, can bring these clinical skills to case management, both in their role as supervisors and as case managers, themselves. Floersch (2002) describes how social work can provide a theory and language for case managers to frame service user feelings and needs that may not be articulated but influence their behavior. Some states are now requiring master’s level providers to deliver assertive community treatment, an intensive wrap around case management service model and often these providers are social workers. Less
intensive case management services are mainly provided by case managers with bachelor level training or sometimes less, but many will be supervised by social workers and other master’s level trained providers (Corrigan et al., 2008).

Case managers practicing in community based mental health usually spend more time with service users than other providers and therefore, can be the most influential in terms of whether a service user engages and remains in services. Case managers delineate their relationships with service users through service plans, which usually prescribe change in major life domains such as housing, mental health, health and employment. But rarely are case managers given the opportunity or the tools to make service planning a genuinely collaborative process that allow for service users to fully absorb and commit to the change envisioned by these service plans (Tondora, Pocklington, Gorges, Osher, & Davidson, 2005). In addition, there has been little discussion of effective service planning when service users and case managers fundamentally differ on the importance of addressing different service domains (Henwood, Padgett, & Nguyen, 2011). As a result, engagement and retention is rarely straightforward among people with severe mental illnesses, particularly those with co-occurring disorders (Hopper, Jost, Hay, Welber, & Haugland, 1997).

Some service users do not engage with services beyond acute and often involuntary hospitalization, while others engage with outpatient services only then to drop out. When providers make progress with service users through securing benefits, services or housing, sudden disengagement can be particularly vexing and mystifying, as it appears service users are walking away from the very things they want. Particularly, case managers in supportive housing programs, who are under tremendous pressure to move service users out of transitional housing, can experience frustration and disappointment when service users disengage (Stanhope,
Henwood, & Padgett, 2009). It is especially in this context that providers invoke the term “sabotage” to describe service user behavior, by which they mean service users have intentionally undermined their chances of achieving their goals.

Sabotage is one of many behaviors that are perceived to be obstructive to care and often earn service users the label of being “difficult” by providers (Koekkoek, van Meijei, & Hutschemaekers, 2006). Rubin and Panzano (2002) identified a subgroup of people with severe mental illnesses who have the potential to participate in work, education, or vocational training but are fearful of taking risks and may sabotage their own efforts due to having difficulty with success. Some have interpreted the choice to live on the streets rather than participating in a housing program as sabotaging behavior (Koegel, 1992). Sabotage can be characterized as a conscious act, as in a description of case management services in Scotland, where service users were described as sabotaging efforts by providers “in a willful manner” (Mitchell, Robertson, & Weber, 1992). Whereas Farrell (2010) frames the rejection of housing by service users as emanating from an unconscious resistance to changing what has become a deeply familiar life on the streets. Whether framed as unconscious or conscious, when these actions are perceived to be self-sabotage, they are often met with feelings of frustration and anger by providers (Susser, Goldfinger, & White, 1990).

As the mental health system strives to provide recovery oriented services (Department of Health and Human Services, 2003), it is important to consider whether self-sabotage, as a clinical concept, aligns with values central to recovery such as service user self-determination and empowerment. The mental health recovery movement by challenging the notion that severe mental illnesses are chronic and that services should focus primarily on symptoms, represents a major shift from the traditional medical model approach (Davidson, O'Connell, Tondora,
Based on the experiences of service users and research that demonstrates recovery is possible, recovery oriented services are now being implemented throughout the United States (Department of Health and Human Services, 2005). For case managers and all practitioners working with people with severe mental illnesses, recovery means delivering person centered care that acknowledges and embraces the unique path each person takes towards their own recovery (Department of Health and Human Services, 2004). It is within this new landscape of recovery oriented services, therefore, that we must now understand and address the clinically difficult situations that face case managers on a daily basis. This qualitative study examines the contexts in which case managers working with homeless persons with co-occurring disorders invoke the term “sabotage” to describe disengagement and how they understand and respond to these behaviors.

**Methods**

**Sample**

The study sample was 21 case managers working in three residential treatment programs serving homeless service users suffering from co-occurring disorders. The programs were the first step in the residential continuum housing model (Leff et al., 2009) providing congregate residential settings and on-site services with an opportunity to graduate to less restrictive environments such as independent apartments. The providers were part of a larger NIMH funded study, which was a longitudinal qualitative study of new service user enrollees of programs serving homeless adults with co-occurring psychiatric and substance use disorders. The purpose of the larger study was to better understand engagement and retention in care from the service user perspective.
The 21 case managers were recruited through their service user’s participation in the study (most case managers had multiple service users participating in the study). The 54 service users were recruited by inviting all new enrollees to these programs to participate in the study during a 1 year recruitment period (individuals without DSM Axis I diagnoses and a history of substance abuse were excluded). One service user declined enrollment due to privacy concerns. All other participants gave informed consent to be interviewed and to have their case manager at the program be interviewed, all of whom consented. The case managers were predominantly female and African American (see table I). The majority had worked at their agency for less than a year and 7 had graduate level training, which included 4 social workers. Case manager participants were paid $30 per interview and all study protocols were approved by the authors’ university institutional review board.

**Data Collection Procedures**

Study protocols included two in-depth interviews with case managers per service user: baseline interviews within a month of their service user’s enrollment in the study and follow-up interviews either six-months later or when their service user left the program, whichever came first. Interviews were conducted by four trained interviewers familiar with the mental health service system usually in a private office at the provider’s agency and lasted approximately 30-45 minutes. Case manager interviews were open ended with questions asking for a description and reflection of their most recent interactions with the service user, their assessment of the service user’s prognosis, and general questions about the program’s effectiveness, including focusing on resistance to services and disengagement.

In total, the 21 providers participated in 92 interviews. There were 5 providers who only gave one interview and 16 providers who gave multiple interviews (the maximum being 14
interviews) due to having more than one service user in the study. Of the 38 service user participants who remained in the study long enough to have baseline and follow-up provider interviews (i.e. 16 service users left the program within a month of enrolling resulting in only a single provider interview), 25 had the same provider for both baseline and follow-up, indicating that staff turnover was an issue for the remaining 13. All interviews were transcribed verbatim and entered into ATLAS/ti software.

Data Analysis

Ninety-two interview transcripts were analyzed to understand the perspective of frontline providers. Both open and template style coding were used. Open coding refers to a technique in which codes are derived inductively from the data (Charmaz, 2006) and a template approach refers to using pre-determined codes in an area of interest and then organizing and coding transcripts based on these codes (Crabtree & Miller, 1999). Initially, the first two authors independently coded 43 transcripts and then compared results in order to reach consensus about the appropriateness of assigning a particular code to a given passage or quote. Ongoing memo-writing was used in the development of findings that allowed for the exploration of ideas and the documentation of analytic decisions (Padgett, 2008). Sabotage emerged as an open code and was then ‘template’ coded for in the remaining 49 transcripts.

Sabotage was coded when case managers used the term to indicate self-sabotage. They either specifically used the word “sabotage” to describe a service user’s actions or spoke about a service user intentionally undermining gains they had made in treatment. One such example was a case manager saying that service users “just throw away all they have gotten”. Having then identified the relevant sections, the context and meaning behind the usage of the concept was analyzed. ATLAS.ti software was used to help separate and sort coded material and several
strategies for rigor were employed: peer-debriefing within the data collection and analytic processes; independent co-coding of transcripts; and the use of memo-writing to aid in the development of ideas as well providing a decisional audit trail (Padgett, 2008).

**Results**

Case managers invoked the word sabotage to describe service user behaviors when they demonstrated resistance or complete rejection of services. Although sometimes this was in the context of treatment, often it referred to service users’ rejection of housing. Despite acknowledging a service user’s concerns about having to share an apartment with someone she did not know, one case manager stated, “she came into my office and gave me 65 excuses for why she wasn’t going to take an apartment”. Often regardless of the reason, repeated refusal of housing was perceived as signs of sabotage, “they refuse it, refuse it, refuse it, and they sabotage themselves.” In other cases, it was a pattern of rule breaking that would lead to expulsion from the program that was seen as a deliberate effort to fail in the program. One case manager describes this pattern, “He didn’t feel as though he had a curfew… he felt like he didn’t have to listen to what staff had to say… so we saw those signs of sabotaging and that’s what he did basically.” In most cases, sabotage was seen as intentionally destructive, but sometimes it was communicated in more benign terms by case managers as just being an inability to follow through. This often occurred at critical junctures, such as when there was the prospect of a housing placement, with one case manager noting, “quite often when they are this close, they’ll drop the ball.”

**Fear Steps In**

Case managers often attributed sabotaging behavior to fear, as one case manager expressed it, “fear steps in sometimes”. They described the fear of what it means to be
successful in the housing placement process, “usually, it’s the fear of actually now taking responsibility and getting the things that you’ve been talking about you wanting to get for a long time”. Related to the fear of responsibility was a fear of failure, which case managers also viewed as resulting in service users being unable to follow through, “we have people who constantly, not only this program but other programs they’ve been in … and other help they’ve got, just when they got to the time to do what they needed to do they sabotaged it.” After witnessing a service user ‘sabotage’ a potential placement by returning to the shelter instead of accepting a housing placement, one case manager describes,

we’re working on him now by basically building his confidence again. He’s ready to live on his own. He’s been there, and he knows what he has to do. It’s just that sometimes they get very afraid when they’re not around staff that they’re used to being around.

Remarking on this observed phenomenon, one case manager opines,

I think the only difference [between service users and case managers] is instead of relapsing or sabotaging the things that we need to do, we just buckle down and take it on and try to handle it the best we can in a responsible manner.

But there was also a realization that beyond having to take responsibility, the very experience of success in reaching your goals was intimidating for people whose have experienced cumulative adversity and stigma. One case manager described this phenomena, “Lack of commitment to self and not used to the feelings of success and don’t feel worthy of succeeding so they sabotage themselves”.

**Wanting Too Much Too Fast**

Case managers also used the term sabotage to suggest that the service user was simply not ready for housing, “I don’t think [service user name] is ready for housing. He may surprise
me but I think they’ll get him into housing, maybe he’ll stay for 3 months and then he’ll sabotage”. Another case manager expressed it in terms of moving too fast through the housing process, “Another thing that could sabotage her, which sabotages a lot of service users, is wanting too much too fast. They tend to overwhelm themselves.” In this example, the case manager is referring to a disconnect between the service user’s desire for housing and material stability and her lack of housing readiness. ‘Housing readiness’ was understood in terms of having a significant amount of time being sober and in treatment. Based on this understanding, case managers believed that service users were setting themselves up for failure by agreeing to housing before they were ‘ready’, “so although they want their own place, or they have their own room, and they are more independent, it can be too much freedom.”

Differing from the views of his peers, one case manager, rather than seeing refusal of housing as sabotage, instead understood refusal as a way to preempt sabotage before it could happen, “And I kind of leaned towards the refusal…. He was gonna have more freedom and less structure and he wasn’t ready for it. So it was a good thing he didn’t go cause he would have sabotaged over there”. Still others occasionally acknowledged that what could be construed as sabotage, in fact, had its roots in the system’s failure to meet service users’ housing needs in a timely manner,

After 6 months, they could be on the waitlist for housing, so they go over the 6 months. They may have to apply again because they weren’t accepted. That’s the hardest part… the housing. Some get so frustrated waiting they throw away all they have gotten.

One case manager articulated this concern directly, saying “… like they failed when they really hadn’t. It’s really the system that failed them more than anything.”
Diminished Expectations

When case managers characterized service user behavior as sabotaging, this was often accompanied by frustration and a feeling that their hard work had been wasted. One case manager said, “The most frustrating part is people who self-sabotage right before they get housed.” Most case managers expressed that navigating the housing placement system was difficult, which is why ‘sabotaging’ a placement was viewed as frustrating. As one case manager said,

We had a client here who was bugging me for months and months to get her housing, and I worked my butt off to get her housing. We got her into a scatter-site housing program located on [the upper east side of Manhattan]. She would share an apartment, have her own room, common living room, common kitchen and bathroom, for 600 bucks a month fully furnished.

When the service user turned down this placement, the case manager turned his attention more towards other service users, telling the service user “I can’t force you into this housing program, but I’m taking you off my priority list as far as getting you housing. I’m gonna focus my energy on people who are ready.” Another case manager described needing to adjust to the fact that service users would sabotage, “that would upset me because I couldn’t understand what happened. So I did have an unrealistic expectation when I first got here. Now I don’t.” Some focused more on needing to explain the consequences for actions they perceived to be sabotaging, “what we told her is that ‘you are taking a risk’ cause we might not be able to house you back right away.” But a few case managers were able to put a positive frame on sabotaging behavior, either because they agreed with the decision, or because they saw it as a learning
experience, “But I think now…he’s gone through that experience, and I think it’s had its pluses and minuses for him.”

**Discussion**

Case managers, similar to other providers within mental health, employ the concept of “sabotage” to explain instances when service users refuse or drop out of services when they are on the brink of success. At times, case managers used the term in a more psychodynamic sense to refer to service users’ inability to tolerate getting what they desire or a fear that they will fail to hold onto “success”. At other times, case managers appeared to be referring to more straightforward fears service users may be experiencing due to change or taking on new responsibilities. Therefore, in some instances, case managers framed ambivalence about housing transitions in more therapeutic terms. However, case managers also understood the rejection of housing to be a sign that service users were not ready for more independent housing and needed a more structured environment. They often responded to what they perceived as “sabotage” with frustration, a lowering of expectations, judgment and sometimes, a lessening of effort for the service user, all of which undermines service quality.

The demanding nature of front line service provision should be taken into account when we consider how case managers understand and respond to clinically difficult situations where service users reject services. Case managers experience high levels of burnout and turnover due to the exacting nature of the work (Boyer & Bond, 1999). In housing programs, case managers are faced with the difficult task of moving the service user through the housing continuum as expeditiously as possible. This pressure combined with larger case loads often precludes case managers from paying enough attention to the mental health needs of their clients (Henwood,
Stanhope, & Padgett, 2010). Ironically, it is these psychological barriers that can result in the undoing all of the hard logistical work done by case managers.

Clearly this study underscores the clinical nature of case management. More clinical supervision and direct training would help case managers have a more sophisticated and nuanced lens with which to understand service users. They would acquire a language and skills to address these very common human fears that manifest when people are faced with transition during the initial service planning process (Drake & Marlowe, 1998). Case managers, because they are front line providers working in the community, are in a unique position to provide a “holding environment” for service users as they struggle with inner conflicts resulting from environmental changes (Kanter, 1990). Supervision, which is usually delivered by social workers and other master’s level providers, is one way that case managers can receive guidance about how to recognize, understand and address fears about transition and strengthen their therapeutic alliance with service users.

In addition to intensifying therapeutic interventions at critical times for service users, there are also ways to make environmental changes that can reduce the likelihood of service user disengagement from services. The way housing is allocated in traditional housing models contributes to the pressures service users experience as they are constantly faced with changing their living environments in a system that “graduates” service users to increasingly independent housing. Firstly, the lack of affordable housing means that service users often have to wait for long periods, which can become intolerable for them. Then, although these moves are intended to be positive, they can provoke anxiety as it means leaving a familiar environment, mastering another setting and working with new staff. The alternative is the more recovery oriented supported housing model which provides independent housing for service users and instead,
adjusts the level of support services according to the service user’s needs (Ridgeway & Zipple, 1990). However, even when transitions to new living environments are minimized, service users can still experience difficulties and risk disengagement from services. More flexible models, such as Housing First, which offer services based on service user choice, greatly reduce the pressure service users feel to “succeed” and ensure that the service users make transitions only when they decide it is right for them (Tsemberis, Gulcur, & Nakae, 2004).

The study was limited by the fact that a few case managers were overrepresented in the sample because they were interviewed about multiple clients who were involved in clinically difficult situations. However, these case managers also had clients with whom they had positive alliances and other case managers had clinically difficult situations, indicating the phenomena was found throughout the case manager sample and not just with particular case managers. Narrowing the data to use of the word sabotage or explicitly describing a situation involving sabotage was necessary for consistency of the analysis across cases, but may have led to the exclusion of some pertinent data. Finally, discussing clinically difficult situations retrospectively may have led to social desirability in the responses of some case managers.

Understanding why case managers invoke the term sabotage can provide insight into how to train case managers to intervene more effectively and reduce service user disengagement. However, the term “sabotage” clearly carries judgment, suggesting an unjustified or irrational undermining of services on the part of the service user. On closer analysis, what actually happens is far more nuanced and often implicates the providers and the housing system in the causes of service user resistance to services. This finding also has implications for broader mental health services, beyond case management, as its usage is common in an array of settings, including inpatient and outpatient services. While the term “sabotage” may, at times, be applied
correctly to a fear of success on the part of the service user, at other times, it may simply deflect the reality that the action is the result of dissatisfaction with services. In this case, what is characterized as sabotage is, in fact, a rational response to inadequate services. The term clearly indicts the service user not the system and the almost short hand use of this term in clinical documentation or communications can provoke a negative response among providers who continue to work with these service users. As the mental health system strives to become more recovery oriented, such characterizations of service user actions are clearly antithetical to providing person centered services and engendering a sense of hope and possibility for service users despite the difficulties they face. This highlights one of the greatest challenges for the mental health system posed by the recovery movement: how to maintain a positive frame and honor service user choice when service users show ambivalence about the services they are providing.
ACKNOWLEDGEMENTS

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REFERENCES


Rockville, MD: Substance Abuse and Mental Health Services Administration.


Table I. Demographic Characteristics of Case Manager Sample

<table>
<thead>
<tr>
<th>Category</th>
<th>Case managers n=21</th>
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<tr>
<td>Gender</td>
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<tr>
<td>Male</td>
<td>7 (33%)</td>
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<tr>
<td>Female</td>
<td>14 (67%)</td>
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<tr>
<td>Race/Ethnicity</td>
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<tr>
<td>White</td>
<td>6 (29%)</td>
</tr>
<tr>
<td>African American</td>
<td>9 (43%)</td>
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<tr>
<td>Latina/o</td>
<td>6 (29%)</td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
</tr>
<tr>
<td>Length of employment</td>
<td></td>
</tr>
<tr>
<td>&lt; 1 year</td>
<td>9 (43%)</td>
</tr>
<tr>
<td>1-3 years</td>
<td>7 (33%)</td>
</tr>
<tr>
<td>&gt; 3 years</td>
<td>5 (24%)</td>
</tr>
<tr>
<td>Highest educational degree</td>
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</tr>
<tr>
<td>Graduate</td>
<td>7 (33%)</td>
</tr>
<tr>
<td>Bachelor</td>
<td>9 (43%)</td>
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<tr>
<td>Associate</td>
<td>5 (24%)</td>
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<tr>
<td>High School</td>
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<td>Previous work experience with similar consumer population?</td>
<td></td>
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<tr>
<td>Yes</td>
<td>16 (76%)</td>
</tr>
<tr>
<td>No</td>
<td>5 (24%)</td>
</tr>
</tbody>
</table>
Biography

Victoria Stanhope is an Assistant Professor and Deborah Padgett is a Professor at the New York University Silver School of Social Work. Emmy Tiderington is a doctoral student and Benjamin Henwood is a Post-Doctoral Fellow at the New York University Silver School of Social Work.