

# A Solution-Focused Approach to Case Management and Recovery With Consumers Who Have a Severe Mental Disability

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## ABSTRACT

Community mental health systems have been increasingly emphasizing providing services and using interventions that support mental health consumers recovering from severe mental disability. It has been noted in the literature that the strengths approach to case management is supportive of mental health consumers experiencing recovery. Although strengths-based case management has been operationalized by six principles and five functions, it has not been very well operationalized at the micro level of direct interactions between case managers and mental health service recipients. This article describes how the perspective of and techniques from solution-focused therapy can be used to further operationalize the strengths perspective for these direct, one-on-one interactions to facilitate mental health consumer recovery.

The community mental health field has been shifting away from viewing severe mental disability as chronic and debilitating (Kruger, 2000). The newer view of severe mental disability that has emerged is reflected in the concept of recovery: individuals living with a severe mental disability can and do improve their functioning and live meaningful and productive lives (Anthony, 1993). This concept of recovery has been a catalyst for community mental health systems of care to rethink what and how services should be provided to persons (consumers) with a severe mental disability (Jacobson & Curtis, 2000). As state mental health systems evaluate and change their current approach to treatment in order to be more supportive of consumer recovery (Jacobson & Curtis, 2000) the practice of case management will need to change

accordingly. Strengths-based case management is one approach that is viewed as being in line with the concepts of mental health recovery (Sullivan & Rapp, 2002). Several studies have found the strengths model of case management to be effective in working with persons living with a severe mental disability (Barry, Zeber, Blow, & Valenstein, 2003; Bjorkman, Hansson, & Sandlund, 2002; Macias, Farley, Jackson, & Kinnery, 1997; Modrcin, Rapp, & Poertner, 1988; Rapp, 1998a, 1998b; Rapp & Chamberlain, 1985; Rapp & Wintersteen, 1989; Stannard, 1999).

Despite its demonstrated effectiveness, Saleebey (1996) found that the strengths model of case management with consumers who have a severe mental disability (hereafter in this article referred to as "consumers") is not being used extensively and appropriately. One possible reason for

Saleebey's finding is that the strengths approach is not adequately operationalized for frontline case managers to consistently use in regular, ongoing, face-to-face interactions with consumers, especially within the mental health system, which emphasizes consumers' deficits and diagnosis. Although the strengths approach to case management is operationalized by the implementation of six principles and five functions (Rapp 1998b), specific techniques the case manager can use when interviewing and interacting with consumers that consistently focus on, reinforce, and amplify consumers' strengths are not very well developed. One clinical approach that can further operationalize the strengths perspective is solution-focused therapy (De Jong & Miller, 1995; Greene, Lee, Trask, & Rheinscheld, 2000). Though solution-focused therapy has been used mostly in brief therapy with consumers who do not have a severe mental disability, there have been some discussions in the literature on using this approach with consumers who do have such a disability (Booker & Blymer, 1994; Hawkes, 2003; Hawkes, Marsh, & Wilgosh, 1998; Rhodes & Jakes, 2002; Rowan & O'Hanlon, 1999; Schott & Conyers, 2003; Vaughn, Young, Webster, & Thomas, 1996). However, solution-focused therapy has not been used consistently in case management with consumers with a severe mental disability. The purpose of this article is to discuss how a solution-focused approach can further operationalize strengths-based case management and enhance the recovery of consumers who have a severe mental disability.

## Case Management in an Age of Recovery

### *Case Management*

According to Rubin (1992) *case management* is "an approach to service delivery that attempts to ensure that clients with complex, multiple problems and disabilities receive all the services they need in a timely and appropriate fashion" (p. 5). The provision of case management services is the "linchpin" of the community mental health system (Rapp, 1998a, p. 368). Case managers provide "individualized advice, counseling, and therapy to consumers in the community" as well as linking them "to needed services and supports in community agencies and informal helping networks" (Rothman, 1992, p. 3). Integral to the success of the case management process is the case manager developing and maintaining a positive collaborative working relationship with mental health consumers (Chinman, Rosenheck, & Lam, 2000; Howegego, Yellowless, Own, Meldrum, & Dark, 2003; Klinkenberg, Calsyn, & Morse, 1998; Rapp, 1998a).

Providing case management services in the community to consumers with a severe mental disability is not new (Marx, Test, & Stein, 1973; Turner & TenHoor, 1978). According to Moxley (2002) early models of case management encouraged consumers with a severe mental disability to "accept the limitations their illness created,

encouraging them to manage their illness and to lower their expectations for future achievement and growth" (p. 481). Initially, the primary focus of case management was on keeping consumers out of the hospital and stabilized in the community (Hyde, 1996) with the emphasis on medication and symptom management (Moxley, 2002). However, this focus began to slowly broaden in response to research which found that many, if not most, consumers with a severe mental disability eventually can and do get better (Harding, Zubin, & Strauss, 1987). These research findings contributed to the belief that consumers with a severe mental disability can experience recovery.

### *Recovery for Persons With a Severe Mental Disability*

Historically, the mental health treatment community viewed someone with a severe mental disability, especially schizophrenia, as having a chronic and debilitating course (Kruger, 2000). Persons living with a severe mental disability were given little, if any, hope for the future by the mental health community (Deegen, 1996). Given such views, it is not difficult to understand the limited focus on keeping mental health consumers out of the hospital and simply maintaining them in the community. Although consumers do experience times when they make little to no progress or temporarily get worse, longitudinal quantitative research has found that many, if not most, eventually can and do get better (Calabrese & Corrigan, 2005; Harding, Zubin, & Strauss, 1987). Consumers with a severe mental disability not only are able to stay out of the hospital but also progressively improve over time in their functioning and ability to maintain themselves in the community while still having symptoms (Anthony, 1993; Anthony, Rogers, & Farkas, 2003; Watkins, 1996; Spaniol et al., 2002; such improvement is called *recovery*).

Further supporting the concept of recovery are consumer stories of personal recovery (Deegen, 1996; Fekete, 2004; Frese, 1993; Henderson, 2004; Leete, 1989; Lovejoy, 1982; Pierce, 2004; Schiff, 2004) and qualitative studies of individuals living with a severe mental disability that examined the concept of mental health recovery in greater detail (Davidson, 2003; Davidson, Sells, Sangster, & O'Connell, 2005; Smith, 2000; Spaniol, Wewiorski, Gagne, & Anthony, 2002; Tooth, Kalyanasundaram, Glover, & Momenzadah, 2003). All of these sources have challenged the notion that a severe mental disability is chronic and debilitating; they tell us that many consumers with a severe mental disability can significantly improve and sometimes recover completely (Anthony, 1993; Spaniol et al., 2002; Watkins, 1996) though for most consumers recovery does not mean cure (Lieberman & Kopelowicz, 2005). As the recovery process unfolds, symptoms do decrease in frequency and duration, allowing the person with a severe mental disability to increase

their functioning for longer periods of time (Ridgeway, 2001; Smith, 2000). Thus, for persons with a severe mental disability,

recovery involves a redefinition of one's illness as only one aspect of a multidimensional sense of self that is capable of identifying, choosing, and pursuing personally meaningful goals and aspirations even when continuing to experience the effects and side effects of mental illness. (Davidson et al., 2005, pp. 149–150)

### **Common Factors in Mental Health Recovery**

Mental health recovery is an individualized process in that it means different things to different people (Loveland, Weaver Randall, & Corrigan, 2005). There are multiple ways of going through recovery and relapse is a natural part of the process for most consumers (Loveland, Weaver Randall, & Corrigan, 2005; Moxley, 1997). Even though recovery is an individualized and nonlinear process, several common factors integral to facilitating recovery for persons with a severe mental disability have been identified from the literature: hope, coping skills, empowerment, and supportive social networks.

**Hope.** Many consumers reported that the early approaches to case management often resulted in their feeling hopeless; consequently, they recommended that community mental health agencies use approaches that lead to them developing and increasing their sense of hope (Kruger, 2000; Marsh, 2000). The journey of recovery is about moving away from despair and moving toward hope (Ridgeway, 2001). Hope has been conceptualized as goal-related thinking in which a person has a clearly defined goal, perceives one or more clear routes to the goal (pathways), and perceives himself or herself as having the ability to reach that goal (agency) (Snyder, Michael, & Cheavens, 1999; Snyder, Feldman, Taylor, Schroeder, & Adams, 2000; Snyder, Ilardi, Michael, & Cheavens, 2000). Given the frequent severity of symptoms and difficulty functioning for consumers with a severe mental disability, progress can be very slow and frustrating. It is not uncommon for persons living with a severe mental disability to make some progress and then relapse. Consequently, consumers can easily become discouraged and demoralized and give up. In order to experience positive outcomes, consumers need to believe that there is hope for their future and there will be more to their lives than just the severe mental disability (Beck, Brown, Berchick, Stewart, & Steer, 1990; Beck, Brown, & Steer, 1989; Deegen, 1996; Farkas, Gagne, Anthony, & Chamberlin, 2005; Farren, Herth, & Popovich, 1995; Jacobson & Greenley, 2001; Kruger, 2000; Landeen, Pawlick, Woodside, Kirkpatrick, & Byrne, 2000; Marsh, 2000; Mead & Copeland, 2000; Resnick, Fontana, Lehman, & Rosenheck, 2004; Ridgeway, 2001; Russinova, 1999; Torrey, Rapp, Van Tosh, McNabb, & Ralph, 2005).

Hope is developed and maintained within the context of important interpersonal relationships (Snyder, Michael, & Cheavens, 1999; Snyder, Feldman, Taylor, Schroeder, & Adams, 2000; Snyder, Ilardi, Michael, & Cheavens, 2000). For consumers with a severe mental disability to develop and maintain hope, it is essential for their significant others, including case managers, to believe in the consumers' ability to make progress over time (Russinova, 1999). Case managers can find it just as difficult as consumers do to maintain hope in consumers' ability to progress toward recovery. Consumers can find it easier to hold onto hope when they see that their case manager still has hope for them. The case manager can facilitate the development and maintenance of hope by recognizing the consumers' strengths and working collaboratively with consumers in maintaining a future orientation and achieving small goals (Jacobson & Greenley, 2001).

**Coping skills.** Consumers with a severe mental disability have many challenges and stressors with which they have to cope. The development and utilization of coping skills has been discussed as an important way for people to deal with life changes and stress (e.g., Lazarus, 1985, 1993) including those individuals living with a severe mental disability (Farhall & Gehrke, 1997; Wheaton, 1983; Cohen & Berk, 1985). It is considered important for consumers with a severe mental disability to develop coping skills to maintain hope (Roe & Chopra, 2003) and progress in their recovery (Frese, 1993; Leete, 1989; Marsh, 2000; Mead & Copeland, 2000; Spaniol et al., 2002; Tooth et al., 2003). Though the development of coping skills is a highly individualized process (Marsh, 2000; Ridgeway, 2001), Leete (1989) provided guidelines she found helpful in developing and using coping strategies in her process of recovery: (a) recognize when you feel stressed; (b) identify the stressor; (c) remember from past experiences what helped in the same or similar situation, and (d) use that strategy as soon as possible (p. 199). A case manager can be a catalyst for the consumer to maintain hope by collaboratively working with them to recall and use their coping skills during the tough times.

**Empowerment.** Issues of power and empowerment affect all clients to some extent (Parsons, 2002; Rappaport, 1983; Zimmerman, Israel, Schultz, & Checkoway, 1992). Because of their symptoms and diagnosis, consumers with a severe mental disability often feel marginalized in society and social relationships. Consequently, empowerment is an essential factor in the recovery process for consumers with a severe mental disability (Chamberlin, 1997; Deegen, 1996; Jacobson & Greenley, 2001; Mead & Copeland, 2000; Nehls, 2000; Resnick et al., 2004; Ridgeway, 2001; Torrey et al., 2005). According to Gutiérrez (1990), "Empowerment is a process of increasing personal, interpersonal, or political power so that individuals can take action to improve their life situations" (p. 149). Empowerment involves consumer autonomy

(self-determination), courage, and responsibility (Jacobson & Greenley, 2001). Making informed self-determined decisions about how to live one's life, as well as having the power and the options to make those choices, are important aspects of empowerment (Chamberlin, 1997). Empowerment also involves consumers taking responsibility for their choices (Mead & Copeland, 2000; Ridgeway, 2001). Identifying and amplifying consumers' strengths, resources, competencies, and skills are integral to facilitating hope and empowerment because consumers feel more empowered when they feel more hopeful.

**Supportive social networks.** The importance of social support in the lives of persons living with a severe mental disability has long been recognized (e.g., Angell & Test, 2002; Calsyn & Winter, 2002; Cohen & Sokolovsky, 1978; Corrigan & Phelan, 2004; Strauss & Carpenter, 1977). The recovery journey usually requires the help of other individuals (Frese, 1993; Marsh, 2000; Mead & Copeland, 2000; Ridgeway, 2001; Smith, 2000; Spaniol, 2001; Tooth et al., 2003). Consumers in recovery have indicated that it has been very helpful to have people in their lives that "encouraged their recovery but did not force it, who tried to listen and understand when nothing seemed to be making sense" (Anthony, 1993, p. 18). The social support that consumers with a severe mental disability use in their recovery can come from professionals, friends, family, or fellow consumers. Some consumers have placed a premium on peer support (Mead & Copeland, 2000). Support received from a fellow consumer is viewed as providing hope, power, and understanding that is often missing from professionals (Ridgeway, 2001). Although much attention has been given to self-help, professionals still have a role to play in collaborating with consumers to "facilitate a self-directed recovery process" (Ridgeway, 2001, p. 340).

### ***Supporting Consumer Recovery***

Mental health systems committed to fostering consumer recovery should establish services and create environments in which recovery is consistently supported (Anthony, 2000; Jacobson & Curtis, 2000; Farkas et al., 2005). Consumers actively participate in their recovery and consequently recovery involves them increasingly taking more control and responsibility for their lives (Loveland et al., 2005). Mental health recovery is also enhanced when consumers set goals that are meaningful to them and have hope that they can achieve those goals (Torrey et al., 2005). Case managers should encourage consumers to take healthy risks, make changes, and grow (Marsh, 2000; Weingarten, 2005). Many consumers with a severe mental disability have stated that identifying and drawing upon their personal strengths help them successfully deal with difficult situations and facilitate their recovery and growth (Leete, 1989; Moxley, 1997; Weingarten, 2005). Given the importance of consumers using their strengths, it makes sense for case managers to have and use an orientation that

provides specific interventions that helps them to consistently keep the focus on working with these strengths.

### ***The Strengths Perspective in Case Management***

At least four models of community mental health case management have been developed and are currently being used: the strengths perspective, Assertive Community Treatment (ACT), the rehabilitation model, and the expanded broker model (Solomon, 1992). Of these four approaches, ACT and the strengths perspective of case management have received the most attention in the professional literature and were found to be effective models of case management (Rapp, 1998a). In his comparison of ACT and the strengths perspective of case management, Rapp (1998a) argued that both approaches are more similar than they are different in terms of their components. For example, both approaches articulate an in vivo approach to services provision, 24 hours a day, 7 days a week, and the direct provision of most services consumers need on a day-to-day basis. Where the respective components of these two models differ, the differences are only a matter of degree (Rapp, 1998a). While both models endorse the use of consumer strengths and assets in the treatment process (Stein & Test, 1980; Rapp, 1998b), the strengths perspective, unlike ACT, views identifying and using consumer strengths as the cornerstone of the treatment process. Because focusing on consumer strengths represents a way to support consumers' movement toward recovery, the strengths perspective of case management is, as Degeen (2003) and others have suggested (Sullivan & Rapp, 2002), more of a recovery-focused model of case management than the other models.

The strengths perspective has been operationalized by six principles that encourage case managers to view consumers of professional services as having the resources, skills, and competencies necessary for successfully coping and making positive changes (Rapp, 1998b; Saleebey, 2002). Each consumer is unique and can be a powerful agent in creating and sustaining positive changes by using their strengths. However, consumers of mental health services often are not using, are underusing, or are not aware that they are using their personal strengths and resources (Saleebey, 1992). Case managers working from a strengths perspective facilitate consumers tapping into these resources in order to achieve their goals (Saleebey, 2002; Rapp, 2002). Strength-based practice helps consumers experience themselves as empowered agents of change (Rapp, 1998b; Rapp 2002) rather than passive recipients of mental health services.

Proponents of the strengths perspective have discussed how focusing on consumer strengths can be incorporated into the treatment process [see Rapp (1998b) for a discussion of the five functions of case management]. In particular, focusing on consumer strengths in the assessment and treatment planning stages of the case management

process can be particularly potent in helping consumers recognize and utilize their personal strengths. In developing a strengths assessment, case managers work collaboratively with consumers (Cowger & Snively, 2002) in obtaining information about six interrelated life domains. For each of these domains, the case manager asks (a) what the consumer's present situation is in the given domain; (b) what goals, if any, the consumer wants to achieve; and (c) what the consumer has achieved in these areas in the past (Kisthardt, 1992, p. 69). The case manager and consumer then use the information obtained from the strengths assessment to collaboratively develop short-term and long-term goals. In addition, the strengths assessment can help consumers notice and amplify their personal strengths (Rapp, 1998b). The case manager and consumer can update the strengths assessment and personal plan at any time as they identify new strengths and/or goals (Rapp, 1998b).

The strengths perspective emphasizes the importance of dialogical and collaborative interaction between the case manager and the consumer (Rapp, 1998b; Saleebey, 2002). However, Saleebey (2002) only briefly discusses five different types of questions a case manager can use in such interactions: (a) survival questions, (b) support questions, (c) exception questions, (d) possibility questions, and (e) esteem questions (p. 89). Rapp (1998b) also provides eight general guidelines for interviewing for strengths such as "use open-ended questions" and "help clients see the well part of themselves" (pp. 90–91). These strengths-based questions provide only a general foundation for operationalizing case manager–consumer communication; more specificity is needed for guiding the case manager in consistently keeping the focus on identifying, amplifying, and reinforcing consumer strengths. One approach that provides interviewing tools and techniques that the case manager can consistently use in further operationalizing the strengths model is solution-focused therapy (De Jong & Miller, 1995; Greene et al., 2000).

## The Solution-Focused Approach

In solution-focused therapy, the focus of intervention is on identifying and amplifying consumer strengths, competencies, and resources in achieving goals and positive change rather than trying to rectify the consumer's deficits (de Shazer, 1985; de Shazer, Berg, Lipchik, Nunnally, Molnar, Gingerich, & Weiner-Davis, 1986). The solution-focused approach has several assumptions and guidelines that help clinicians to consistently operationalize it in practice (O'Hanlon & Weiner-Davis, 2003; Walter & Peller, 1992).

### *Assumptions and Guidelines*

**All people have strengths, resources, and competencies.** All people, regardless of their level of functioning, have strengths, resources, and competencies that they can consistently use in solving problems and achieving desired

goals (Walter & Pellar, 1992). It is true that consumers with a severe mental disability often have many problems and symptoms and it may be very difficult for the case manager to refrain from trying to fix clients' deficits and problems for them. However, by consistently maintaining and operating from this assumption, it is easier for case managers to patiently and persistently work collaboratively with consumers in maintaining a focus on their strengths and solutions.

**Change is happening all the time.** Change is inevitable and continuous (Breulin, 1989). Problems fluctuate over time and do not remain constant in severity; there are times when the consumer does not have the problem or the problem is less frequent or intense than at other times (Berg & Miller, 1992b). Solution-focused therapy assumes that when the problem is less of a problem, consumers are somehow actively contributing to this improvement by using their personal strengths and competencies and/or those within their environment. The task of a case manager using a solution-focused approach is to work with consumers to identify what they are already doing that contributes to the improvement of the problem. The solution-focused case manager's focus is on (a) identifying what is happening when things are going well or better, and then (b) supporting the consumer in doing more of what works.

**Engage in solution talk rather than problem talk.** Discussing with another person their specific thoughts, feelings, or behaviors tends to amplify and reinforce them. If case managers and consumers primarily discuss the consumer's problems, symptoms, personal deficits, dysfunctional family history, and so on, then the consumer's sense of being deficient, defective, incompetent, and powerless can be reinforced (Greene, Lee, & Hoffpauir, 2005). Therefore, to reinforce and co-construct with consumers a greater sense of strength, competency, hope, and empowerment, it is important for the case manager to consistently keep discussions focused on the consumer's strengths, competencies, resources, successes, and so on. A solution-focused dialogue consistently emphasizes strengths/solution/change talk over deficit/dysfunction/problem talk (Berg & De Jong, 1996; Walter & Peller, 1992). Gingerich, de Shazer, and Weiner-Davis (1988) found that when clinicians intentionally engage in change talk, consumers are more than four times likely to discuss change in their next speaking turn.

**Consumers are the experts.** Solution talk invites consumers to be the experts on their lives and their situations. Therefore, case managers should take an egalitarian, nonexpert, nonauthoritarian, nonhierarchical approach in their work with consumers. Consumers are much more likely to collaborate and cooperate when case managers take such an approach. In this approach, case managers essentially consult with consumers to discover from them their strengths, competencies, and resources within

themselves, and also their environment and their culture (Lee, 2003). Viewing consumers as having such expertise means case managers need to listen and pay very close attention to what consumers say. Being in a conversation with consumers this way can communicate to them that the case manager is truly interested in and curious about the consumer as a person; this can further enhance the quality of the case manager–consumer relationship and consumer cooperation and collaboration.

**Emphasize the present and future.** In their initial meetings with case managers, consumers usually tell their “story” which contains their problems, concerns, and history. Having such a discussion can be helpful for the case manager in building a positive relationship with the consumer. However, once the consumer’s primary problem is defined, a case manager using a solution-focused approach should focus more on the present in order to answer the question “what can be done about the problem?” rather than “what caused the problem?” A *present focus* is also necessary for identifying and amplifying the client’s existing strengths in facilitating positive change. A *future focus* involves collaboratively working with the consumer in defining and working toward consumer-defined outcome goals.

**Only small change is all that is necessary for larger change to occur.** Case managers working with consumers with severe mental disability can easily get overwhelmed with the multitude of problems and symptoms consumers often have. At times like this it can be helpful for the case manager to keep in mind a basic tenet of solution-focused therapy: small change is all that is necessary to elicit larger change (O’Hanlon & Weiner-Davis, 2003; Walter & Peller, 1992). This proposition is influenced by systems theory which holds that only a small but important change in one part of a system will lead to change in other parts of the system. Focusing only on one small change at a time also helps both the consumer and case manager to avoid getting overwhelmed and discouraged; small change can lead to another small change and the consumer can begin to feel more confident and hopeful, which in turn can lead to a positive, self-fulfilling prophecy.

### **Using Solution-Focused Interventions in Case Management**

**Defining problems and goals.** Solution-focused therapy places much more emphasis on defining and setting goals than problems. However, the case manager should spend sufficient time asking about and listening to the consumer’s *problem-saturated story* and not move too quickly to discussing goals. By listening to the consumer’s story, the case manager is able to express empathy and acceptance, and the consumer experiences the case manager as being truly interested in and curious about them as a person and not just as handling another case.

The goal-setting process involves asking consumers to describe a desired future without the presenting problem or at least acceptable improvement in it. In this process, case managers also ask consumers to identify small steps (subgoals) they can achieve in working toward the larger outcome goal. Consumers should define and set their own goals; doing so facilitates consumer empowerment (Carling, 1995) and recovery (Mead & Copeland, 2000). Such goals should be well-formed in that they should be

- stated in the positive rather than the negative; as the presence of something rather than the absence: “What will you be doing instead of spending all your time by yourself?”
- stated in a process form: “How will you be doing this?”
- defined as concretely and specifically as possible: “What, specifically, will you be doing when you are spending time with other people?” “Who, specifically, will you be talking to when you start spending more time outside your room?”
- within the control of the consumer: “What will you be doing when this happens?” (Walter & Peller, 1992, pp. 53–60)

*The miracle question and dream question.* Several questioning strategies can be used to help consumers develop well-formed goals; one of these is the “miracle question” (De Jong & Miller, 1995):

Suppose that after our meeting today you go home and go to bed. While you are sleeping a miracle happens and your problem is suddenly solved, like magic. The problem is gone. Because you were sleeping, you don’t know that a miracle happened, but when you wake up tomorrow morning, you will be different. How will you know a miracle has happened? When you first wake up and when you are first starting your day what will be the first small sign that tells you that a miracle has happened during the night and the problem is resolved? (Berg & Miller, 1992, p. 359)

Some consumers do not respond well to the miracle question; when this happens, a case manager can then use a variation on the miracle question called the *dream question* (see Greene, Lee, Mentzer, Pinnell, & Niles, 1998; Greene et al., 2000; Lee, Greene, Mentzer, Pinnell, & Niles, 2001). Both questions can engage a consumer’s imagination and curiosity in new and creative ways. Using these questions can be a catalyst for a consumer to set outcome goals by describing their future without the problem or with improvement in the problem. The case manager should follow up these questions with open-ended questions that

invite the consumer to describe concretely and specifically what will be different after the “miracle” or “dream.”

*Outcome questions.* At times, some consumers are not very responsive to the miracle question or dream question. When this occurs, the case manager can ask the consumer other questions to facilitate defining intermediate and longer-term goals. Two examples follow:

- “The next time you and I meet together, what will I notice about you that will tell me that you are feeling less anxious; that you have moved from a 3 to a 4 on the 1-to-10 scale, where 1 is the most anxious you have ever been in your life and 10 is no anxiety at all?”
- “Let’s say that 6 weeks from now you and I are having coffee together at McDonald’s and at that time you have made the changes you want to make. What will I notice that is different about you that will tell me you have made these changes? What will you be telling me about yourself that will indicate you have made these changes?”

Goals represent the foundation of the development and direction of hope (Snyder, 2000). The goal setting endeavor also involves setting tasks to reach the goal(s) (Rapp, 1998b). Tasks can be conceptualized as pathways toward goals. The development of pathways toward goals has also been considered a necessary aspect of hope (Snyder, 2000). Setting goals in the context of case management can facilitate consumers developing a sense of hope, and using a solution-focused approach has been identified as one way of doing so (Michael, Taylor, & Cheavens, 2000).

*Identifying and amplifying solution patterns. Exceptions.* Consumers have periods when their presenting problem is not present or at least less frequent or intense; however, consumers are often unaware of these exception times. The solution-focused practitioner, therefore, focuses on asking consumers *exception-finding questions* to facilitate identifying, recognizing, and amplifying the strengths consumers use at these times. Two examples follow:

- For a consumer who frequently forgets to take medication: “When are there times that you do remember to take your medication? How are you able to get yourself to remember?”
- For a consumer who is bothered by auditory hallucinations: “When are there times that the voices do not bother you? What’s different about those times?”

Exception questions can help consumers view themselves as positive and powerful, which can then be helpful to their recovery. In pondering what has been different, the consumer in the second example above may state that she

or he was able to get out of their apartment and be around other people more often. Thus, being around other people may then become a coping skill for the consumer to use when the voices are more problematic or as a preventive technique for keeping the voices at bay. Exception questions can also encourage agentic thinking, which fosters a sense of hope and empowerment. When exception questions are asked in relation to a particular goal, they can point to previously unconsidered pathways toward reaching a particular goal, which in turn can further facilitate the consumer’s hope (Snyder, 2000).

*Past successes.* Sometimes consumers may be unable to identify current or very recent exceptions to their presenting problem. One alternative then is to ask consumers about exception times in the past, even if those times were years ago, when they were able to more successfully handle the same type or similar situation. Once the consumer identifies a past success, then the case manager can ask follow-up questions to identify what, specifically, the consumer did in the past at those exception times. The case manager can then ask the consumer additional follow-up questions to facilitate considering how to use those past successful skills to deal with their present problematic situation. As previously noted, Leete (1989) found that using past experiences contributed to her recovery.

*Current successes.* Sometimes the consumer’s presenting problem will involve some issues of impulsive, compulsive and/or other behaviors that may seem completely out of the consumer’s control. A solution-focused approach assumes that there have been times when the consumer has been successful in exercising some self-control. Examples follow:

- For a consumer who has problems with anger: “When are there times that you feel like going off on someone but you are able to stop yourself? How are you able to do that at those times?”
- For a consumer who is trying to quit smoking: “When are there times you want to smoke another cigarette immediately but you decide to wait awhile before you do so? What’s different at those times when you resist the temptation?” “How are you able to resist such strong urges to have another cigarette?”

After the consumer identifies current successes, then the case manager can follow up with questions for the consumer to elaborate further on how they are able to successfully control themselves at those times.

*Coping questions.* At times, the case manager will find that consumers are not able to identify any exceptions, current successes, or past successes. From the consumer’s perspective, nothing is going right and nothing positive ever happens, especially in regard to the presenting problem. While such consumers may genuinely feel discouraged, defeated, and hopeless, they continue to keep going; they

have not given up completely. Often consumers do not notice the coping skills they are using at those times. At times like this, case managers can ask consumers questions that invite them to identify the specific ways they are able to cope with such overwhelming situations and keep going (Greene et al., 2000). The case manager should first agree with consumers as to how badly things are going and then ask how they are able to cope with this very difficult situation. Using coping questions can further reinforce and sometimes amplify the consumer's coping skills. In addition, coping questions can promote agentic thinking, pathway thinking, and empowerment.

*Scaling questions.* Frequently, consumers' problems and symptoms may seem so large and overwhelming that they do not know where to begin in working toward change. Scaling questions can provide a way for the case manager and consumer to break down the problems and symptoms into more manageable parts. With scaling questions, case managers ask consumers to rate on a scale of 1–10 where they currently are on any aspect of their lives, for example, their problem and goal, feelings, thoughts, behaviors, attitudes, motivation, and so on. Usually, 1 or 0 represents the worst the situation can be, and 10 represents the best the situation can be. Examples follow:

- “Last week you ranked the anxiety you have at a 3 and you said you eventually want to get to at least a 7 on the 1–10 scale. So where are you today on the 1–10 scale, with 1 being as anxious as a person could possibly be and 10 being completely relaxed and having no anxiety at all?”
- “On a scale of 1–10, with 1 being that the voices are bothering you all the time and 10 being the voices never bother you, where are you on the 1–10 scale today?”

Case managers can ask consumers to rank the same feeling, behavior, or attitude on the scale every time they meet. Using scaling questions at every meeting provides a sense of focus and consistency in the clinical work and serves as something consumers can learn to anticipate at every meeting and use on their own between meetings. When used frequently, the scaling question can provide specific information that can be plotted on a chart as a visual aid for both case manager and consumer to see how they are progressing.

The scaling question can also be used in identifying and amplifying consumer strengths. For example, if a consumer reports that today she is at a 4 on the scale, whereas last week she was at a 3, then the case manager can ask her how she was able to get herself to go from 3 to 4. The case manager can also use the scaling question to get the consumer to be on the lookout for more strengths in the near future by asking the consumer what he or she will need to do to go from a 4 to 4.5 or 5. If a consumer reports that he or she has not made any

progress—that they are still at a 3—then the case manager can ask the consumer, “How have you been able to keep your situation from getting any worse?” As consumers move up the scale from lower numbers toward higher numbers, they can begin to recognize themselves as agents of change and feel an increased sense of empowerment. As a result, consumers' agentic thinking can increase, as can their level of hope. In addition, many consumers often start using scaling questions on their own and with their significant others; this can become another coping skill for consumers to use in their recovery process.

With the scaling question there is the possibility that consumers might report having made progress when they actually had not in order to please their case manager (social desirability). However, we want to emphasize that the primary use of the scaling question is to identify and amplify consumers' strengths and competencies; monitoring progress is a secondary use of this question. If a consumer reports doing better than last week when they really are not, then a case manager uses the reported improvement on the scale as an opportunity to discuss with the consumer what she or he has done to contribute to that improvement; this discussion then is focused on the consumer's behavior. If the consumer reported having done something different in the direction of positive change, the case manager then asks the consumer what she or he specifically did and how they were able to get themselves to do it. If the consumer responds that they actually did not make any changes then the case manager can ask the consumer hypothetical questions, such as, “Well, OK, let's say you actually did make that change. What would you have done to get that to happen?” Such a discussion of the specifics can further reinforce and co-construct positive change whether or not the consumer actually did what they said they did. For the most part, social desirability is not an issue in solution-focused therapy because the use of the questions and interviewing tools unique to this approach can contribute to the creation of a positive self-fulfilling prophecy and consumer change (Weiner-Davis, 1993; Snyder, 1984).

*Relationship questions.* Having a supportive social network is important to a consumer's recovery. However, the social support networks of persons living with a severe mental disability are often small (Cresswell, Kuiper, & Power, 1992) with close members of the consumer's support network, such as caretakers (Webb et al., 1998), sometimes feeling overwhelmed as they also learn to cope with their friend's or loved one's symptoms. One goal of case management is to help consumers strengthen their natural social support network (Rapp, 1998b). Case managers can use relationship questions to facilitate consumers expanding their connections with other people and their larger social context. At a minimum, these questions ask consumers to consider the point of view of other people.

These questions can broaden the consumer's view of their situation by adding new perspectives and ways of thinking.

Relationship questions serve as an adjunct to each of the already mentioned questioning strategies. These questions ask consumers to consider the point of view of others in relation to any of the questioning strategies. Some example questions follow:

- As a follow-up to a miracle question: "What would be the first thing that your landlord will notice different about you after this miracle has happened?"
- As a follow up to an exception question: "What would your mother see different about you when the voices are not so active?" "How will your brother know when you are feeling more comfortable being with other people?" "What will he see different about you that will tell him you are ready to be more socially involved with others?"

The information and framework presented in this article should provide the foundation for the development of a treatment manual and/or guidelines to be used in researching the effectiveness of this model.

Using relationship questions with consumers can open up new possibilities for them in their relationships with other people. Consumers may need a lot of time to strengthen or expand a supportive social network, but the case manager patiently and persistently using relationship questions can facilitate this process.

## Discussion and Conclusion

The accumulation of research shows that persons with a severe mental disability are capable of successfully engaging in the process of recovering from their disability. No longer are consumers of mental health services viewed as passive recipients of services who are incapable of growth and change (Anthony, Cohen, Farkas, & Cohen, 1988). Traditionally, the primary job of the case manager has been to help keep consumers out of institutions and maintain them in the community. However, with the advent of mental health recovery, the focus of case management is shifting. To support consumer recovery, mental health systems and providers are asking case managers to practice in a way that focuses on increasing consumer personal growth, development, hopefulness, empowerment, and skills for coping and recovering rather than for maintenance (Torrey & Wyzik, 2000). Case managers focusing on, identifying, and amplifying consumer strengths has been

viewed as very helpful in facilitating mental health recovery (Sullivan & Rapp, 2002). The strengths perspective has been operationalized according to six practice principles and five case management functions (Rapp, 1998b) that provide a general structure to the case management process. However, specific techniques and tools for consistently operationalizing this perspective on an interactional, conversational level is still underdeveloped. Case managers may find it very difficult to consistently maintain a focus on consumers' strengths when these consumers have many complex and long-standing problems and the mental

health practice environment in which they work places great emphasis on consumers' deficits and diagnosis. It is very likely that having a more specific and coherent approach to operationalizing the strengths perspective at this level will help to counter these negative influences.

The position taken in this article is that case managers can use the interviewing and intervention tools of solution-focused therapy to further opera-

tionalize strengths-based case management (De Jong & Miller, 1995; Greene et al., 2000). Solution-focused therapy provides conversational tools and techniques that case managers can use in patiently, consistently, coherently, and respectfully working with consumers who struggle every day with the complex challenges presented by having a severe mental disability. Case managers can consistently use solution-focused interviewing techniques to help consumers notice and use their personal strengths toward solving problems and achieving goals and, thus, increase their level of functioning. In addition, the use of these interviewing techniques should be a catalyst for increasing consumers' experience of the core common factors in recovery: hope, empowerment, coping skills, and supportive social networks.

To be effective this solution-focused approach to case management must be competently implemented; if case managers use the solution-focused interviewing tools in an inauthentic, formulaic manner, this approach could interfere with the development and maintenance of a positive, collaborative working relationship with consumers. The interviewing tools of solution-focused therapy are simple, but not simple to use effectively. Learning how to consistently use these interviewing tools in a genuine conversational style takes training, supervision, and experience. However, once case managers develop competence in

solution-focused interviewing skills, they can consistently use and integrate them not only with the strengths model of case management but also with other existing case management models to enhance the recovery process of persons with a severe mental disability.

Of course, in this age of evidence-based practice, the solution-focused approach to case management practice proposed in this article should be evaluated for its effectiveness. One of the key aspects of evidence-based practice is the use of treatment manuals and guidelines. The information and framework presented in this article should provide the foundation for the development of a treatment manual and/or guidelines to be used in researching the effectiveness of this model. As in previous research on recovery of consumers with a severe mental disability, improvement in functioning should be measured in evaluating the effectiveness of the model presented here. However, measures of the core common factors of recovery presented in this article should also be used in evaluating the effectiveness of not only the solution-focused approach to case management presented in this article, but also in evaluating any other approach to treatment that aims to support consumers with a severe mental disability along the path toward recovery. Such an evaluation is the next step in further developing and refining this solution-focused approach to case management and recovery.

## References

- Angell, B., & Test, A. (2002). The relationship of clinical factors and environmental opportunities to social functioning in young adults with schizophrenia. *Schizophrenia Bulletin*, 28, 259–271.
- Anthony, W. A. (1993). Recovery from mental illness: The guiding vision of the mental health service system in the 1990s. *Psychosocial Rehabilitation Journal*, 16, 11–23.
- Anthony, W. A. (2000). Recovery-oriented service systems: Setting some system level standards. *Psychiatric Rehabilitation Journal*, 24, 159–168.
- Anthony, W. A., Cohen, M., Farkas, M., & Cohen, B. F. (1988). The chronically mentally ill and case management: More than a response to a dysfunctional system. *Community Mental Health Journal*, 24, 219–228.
- Anthony, W., Rogers, E. S., & Farkas, M. (2003). Research on evidence-based practices: Future directions in an era of recovery. *Community Mental Health Journal*, 39, 101–114.
- Barry, K. T., Zeber, J. E., Blow, F. C., & Valenstein, M. (2003). Effect of strengths model versus assertive community treatment model on participant outcomes and utilization: Two-year follow-up. *Psychiatric Rehabilitation Journal*, 26, 268–277.
- Beck, A. T., Brown, G., & Steer, R. A. (1989). Prediction of eventual suicide in psychiatric inpatients by clinical rating of hopelessness. *Journal of Consulting and Clinical Psychology*, 57, 309–310.
- Beck, A. T., Brown, G., Berchick, R. J., Stewart, B. L., & Steer, R. A. (1990). Relationship between hopelessness and ultimate suicide: A replication with psychiatric outpatients. *American Journal of Psychiatry*, 147, 190–195.
- Berg, I. K., & Miller, S. D. (1992). Working with Asian American clients: One person at a time. *Families in Society*, 73, 356–363.
- Berg, I. K., & De Jong, P. (1996). Solution-building conversations: Co-constructing a sense of competence with clients. *Families in Society*, 77, 376–391.
- Bjorkman, T., Hansson, L., & Sandlund, M. (2002). Outcome of case management based on the strengths model compared to standard care: A randomized controlled trial. *Social Psychiatry and Psychiatric Epidemiology*, 37, 147–152.
- Booker, J., & Blymer, D. (1994). Solution-oriented brief residential treatment with “chronic mental patients.” *Journal of Systemic Therapies*, 13, 53–69.
- Bruenlin, D. C. (1989). Clinical implications of oscillation theory: Family development and the process of change. In C. N. Ramsey, Jr. (Ed.), *Family systems in medicine* (pp. 135–149). New York: Guilford.
- Calabrese, J., & Corrigan, P. (2005). Beyond dementia praecox: Findings from long-term follow-up studies of schizophrenia. In R. O. Ralph & P. W. Corrigan (Eds.), *Recovery in mental illness: Broadening our understanding of wellness* (pp. 63–84). Washington, DC: American Psychological Association.
- Calsyn, R. J., & Winter, J. P. (2002). Social support, psychiatric symptoms, and housing: A causal analysis. *Journal of Community Psychology*, 30, 247–259.
- Carling, P. J. (1995). *Returning to community: Building support systems for people with psychiatric disabilities*. New York: Guilford.
- Chamberlin, J. (1997). A working definition of empowerment. *Psychiatric Rehabilitation Journal*, 20, 43–46.
- Chinman, M. J., Rosenheck, R., & Lam, J. A. (2000). The case management relationship and outcomes of homeless persons with serious mental illness. *Psychiatric Services*, 51, 1142–1147.
- Cohen, C. I., & Berk, A. (1985). Personal coping styles of schizophrenic outpatients. *Hospital & Community Psychiatry*, 36, 407–410.
- Cohen, C. I., & Sokolovsky, J. (1978). Schizophrenia and social networks: Ex-patients in the inner city. *Schizophrenia Bulletin*, 4, 546–560.
- Corrigan, P. W., & Phelan, S. M. (2004). Social support and recovery in people with serious mental illness. *Community Mental Health Journal*, 40, 513–523.
- Cowger, C., & Snively, C. (2002). Assessing client strengths. In A. R. Roberts & G. J. Greene (Eds.), *Social workers' desk reference* (pp. 221–225). New York: Oxford University Press.
- Cresswell, C. M., Kuiper, L., & Power, M. J. (1992). Social Networks and support in long-term psychiatric patients. *Psychological Medicine*, 22, 1019–1026.
- Davidson, L. (2003). *Living outside mental illness: Qualitative studies of recovery in schizophrenia*. New York: New York University Press.
- Davidson, L., Sells, D., Sangster, S., & O'Connell, M. (2005). Qualitative studies of recovery: What can we learn from the person? In R. O. Ralph & P. W. Corrigan (Eds.), *Recovery in mental illness: Broadening our understanding of wellness* (pp. 147–170). Washington, DC: American Psychological Association.
- Deegen, G. (2003). Discovering recovery. *Psychiatric Rehabilitation Journal*, 26 (4), 368–376.
- Deegen, P. (1996). Recovery is a journey of the heart. *Psychiatric Rehabilitation Journal*, 19, 91–97.
- De Jong, P., & Miller, S. D. (1995). How to interview for client strengths. *Social Work*, 40, 729–736.
- de Shazer, S. (1985). *Key to solutions in brief therapy*. New York: Norton.
- de Shazer, S., Berg, I. K., Lipchik, E., Nunnally, E., Molnar, A., Gingerich, W., & Weiner-Davis, M. (1986). Brief therapy: Focused solution development. *Family Process*, 25, 207–221.
- Farhall, J., & Gehrke, M. (1997). Coping with hallucinations: Exploring stress and coping framework. *British Journal of Clinical Psychology*, 36, 259–261.
- Farkas, M., Gagne, C., Anthony, W., & Chamberlin, J. (2005). Implementing recovery oriented evidence based programs: Identifying the critical dimensions. *Community Mental Health Journal*, 41, 141–158.
- Farran, C. J., Herth, K. A., & Popovich, J. M. (1995). Longitudinal analysis of hope in community-based older adults. *Archives of Psychiatric Nursing*, 3, 272–276.
- Fekete, D. J. (2004). How I quit being a “mental patient” and became a whole person with a neuro-chemical imbalance: Conceptual and functional recovery from a psychotic episode. *Psychiatric Rehabilitation Journal*, 28, 189–194.

- Frese, F. J. (1993). Twelve aspects of coping for persons with serious and persistent mental illness. *Innovations and Research*, 2, 39–46.
- Greene, G. J., Lee, M. Y., & Hoffpauir, S. (2005). The languages of empowerment and strengths in clinical social work: A constructivist perspective. *Families in Society*, 86, 267–277.
- Greene, G. J., Lee, M. Y., Mentzer, R., Pinnell, S., & Niles, D. (1998). Miracles, dreams, and empowerment: A brief therapy practice note. *Families in Society*, 79, 395–399.
- Greene, G. J., Lee, M. Y., Trask, R., & Rheinscheld, J. (2000). How to work with clients' strengths in crisis intervention: A solution-focused approach. In A. R. Roberts (Ed.), *Crisis intervention handbook: Assessment, treatment, and research* (pp. 31–55). New York: Oxford University Press.
- Gingerich, W. J., de Shazer, S., & Weiner-Davis, M. (1988). Constructing change: A research view of interviewing. In E. Lipchik (Ed.), *Interviewing* (pp. 21–33). Rockville, MD: Aspen.
- Gutiérrez, L. M. (1990). Working with women of color: An empowerment perspective. *Social Work*, 35, 149–154.
- Harding, C., Zubin, J., & Strauss, J. (1987). Chronicity in schizophrenia: Fact, partial fact, or artifact? *Hospital and Community Psychiatry*, 38, 477–486.
- Hawkes, D. (2003). A solution-focused approach to 'psychosis.' In B. O'Connell & S. Palmer (Eds.), *Handbook of solution-focused therapy* (pp. 146–155). London: Sage.
- Hawkes, D., Marsh, T. I., & Wilgosh, R. (1998). *Solution focused therapy: A handbook for health care professionals*. Oxford, England: Butterworth/Heinemann.
- Henderson, H. (2004). From depths of despair to heights of recovery. *Psychiatric Rehabilitation Journal*, 28, 83–87.
- Howegeo, I. M., Yellowles, P., Own, C., Meldrum, L., & Dark, F. (2003). The therapeutic alliance: The key to effective patient outcome? A descriptive review of the evidence in community mental health case management. *Australian and New Zealand Journal of Psychiatry*, 37, 169–183.
- Hyde, P. S. (1996). Creating incentives for the delivery of services. In M. F. Shore (Ed.), *Managed care, the private sector, and Medicaid mental health and substance abuse services* (pp. 25–34). San Francisco: Jossey-Bass.
- Jacobson, N., & Curtis, L. (2000). Recovery as policy in mental health services: Strategies emerging from the states. *Psychiatric Rehabilitation Journal*, 23, 333–341.
- Jacobson, M., & Greenley, D. (2001). What is recovery: A conceptual model and explanation. *Psychiatric Services*, 52, 482–485.
- Kisthardt, W. E. (1992). A strengths model of case management: The principles and functions of a helping partnership with persons with persistent mental illness. In D. Saleebey (Ed.), *The strengths perspective in social work practice* (pp. 59–83). New York: Longman.
- Klinkenberg, W. D., Calsyn, R. J., & Morse, G. A. (1998). The helping alliance in case management for homeless persons with severe mental illness. *Community Mental Health Journal*, 34, 569–578.
- Kruger, A. (2000). Schizophrenia: Recovery and hope. *Psychiatric Rehabilitation Journal*, 24, 29–37.
- Landein, J., Pawlick, J., Woodside, H., Kirkpatrick, H., & Byrne, C. (2000). Hope, quality of life, and symptom severity in individuals with schizophrenia. *Psychiatric Rehabilitation Journal*, 23, 364–369.
- Lazarus, R. S. (1985). The psychology of stress and coping. *Issues in Mental Health Nursing*, 7, 399–418.
- Lazarus, R. S. (1993). Coping theory and research: Past, present, and future. *Psychosomatic Medicine*, 55, 234–247.
- Lee, M. Y. (2003). A solution-focused approach to cross-cultural clinical social work practice. *Families in Society*, 84, 385–395.
- Lee, M. Y., Greene, G. J., Mentzer, R. A., Pinnell, S., & Niles, D. (2001). Solution-focused brief therapy and the treatment of depression: A pilot study. *Journal of Brief Therapy*, 1, 33–49.
- Leete, E. (1989). How I perceive and manage my illness. *Schizophrenia Bulletin*, 15, 197–200.
- Liberman, R. P., & Kopelowicz, A. (2005). Recovery from schizophrenia: A criterion-based definition. In R. O. Ralph & P. W. Corrigan (Eds.), *Recovery in mental illness: Broadening our understanding of wellness* (pp. 101–129). Washington, DC: American Psychological Association.
- Lovejoy, M. (1982). Expectations and the recovery process. *Schizophrenia Bulletin*, 9, 604–609.
- Loveland, D., Weaver Randall, K., & Corrigan, P. W. (2005). Research methods for exploring and assessing recovery. In R. O. Ralph & P. W. Corrigan (Eds.), *Recovery in mental illness: Broadening our understanding of wellness* (pp. 19–59). Washington, DC: American Psychological Association.
- Macías, C., Farley, O. W., Jackson, R., & Kinney, R. (1997). Case management in the context of capitation financing: An evaluation of the strengths model. *Administration and Policy in Mental Health*, 24, 535–543.
- Marsh, D. T. (2000). Personal accounts of consumer/survivors: Insights and implications. *Journal of Clinical Psychology*, 56, 1447–1457.
- Marx, A. J., Test, M. A., & Stein, L. I. (1973). Extrahospital management of severe mental illness. *Archives of General Psychiatry*, 12, 505–511.
- Mead, S., & Copeland, M. C. (2000). What recovery means to us: Consumers' perspectives. *Community Mental Health Journal*, 36, 315–328.
- Micheal, S. T., Taylor, J. D., & Cheavens, J. (2000). Hope theory as applied to brief treatments: Problem-solving and solution-focused therapies. In C. R. Snyder (Ed.), *Handbook of hope: Theory, measures, & applications* (pp. 151–166). San Diego: Academic.
- Modrcin, M., Rapp, C. A., & Poertner, J. (1988). The evaluation of case management services with the chronically mentally ill. *Journal of Evaluation and Program Planning*, 11, 307–314.
- Moxley, D. P. (1997). *Case management by design: Reflections on principles and practices*. Chicago: Nelson-Hall.
- Moxley, D. P. (2002). Case management and psychosocial rehabilitation with SMD clients. In A. R. Roberts & G. J. Greene (Eds.), *Social workers' desk reference* (pp. 481–485). New York: Oxford University Press.
- Nehls, N. (2000). Recovering: A process of empowerment. *Advances in Nursing Science*, 22, 62–70.
- O'Hanlon, B., & Weiner-Davis, M. (2003). *In search of solutions: A new direction in psychotherapy* (Rev. ed.). New York: W. W. Norton.
- Parsons, R. J. (2002). Guidelines for empowerment-based social work practice. In A. R. Roberts & G. J. Greene (Eds.), *Social workers' desk reference* (pp. 396–401). New York: Oxford University Press.
- Pierce, R. D. (2004). A narrative of hope. *Psychiatric Rehabilitation Journal*, 27, 403–409.
- Rapp, C. A. (1998a). The active ingredients of effective case management: A research synthesis. *Community Mental Health Journal*, 34, 363–380.
- Rapp, C. A. (1998b). *The strengths model: Case management with people suffering from severe and persistent mental illness*. New York: Oxford University Press.
- Rapp, C. (2002). A strengths approach to case management with clients with severe mental disabilities. In A. R. Roberts & G. J. Greene (Eds.), *Social workers' desk reference* (pp. 486–491). New York: Oxford University Press.
- Rapp, C. A., & Chamberlain, R. (1985). Case management services to the chronically mentally ill. *Social Work*, 30, 417–422.
- Rapp, C., & Wintersteen, R. (1989). The strengths model of case management: Results from twelve demonstrations. *Psychosocial Rehabilitation Journal*, 13, 23–32.
- Rappaport, J. (1983). Studies in empowerment: Introduction to the issue. *Prevention in Human Services*, 3, 1–7.
- Resnick, S. G., Fontana, A., Lehman, A. F., & Rosenheck, R. A. (2004). An empirical conceptualization of the recovery orientation. *Schizophrenia Research*, 75, 119–128.
- Rhodes, J., & Jakes, S. (2002). Using solution-focused therapy during a psychotic crisis: A case study. *Clinical Psychology and Psychotherapy*, 9, 139–148.
- Ridgeway, P. (2001). Restorying psychiatric disability: Learning from first person narratives. *Psychiatric Rehabilitation Journal*, 24, 335–343.
- Roe, D., & Chopra, M. (2003). Beyond coping with mental illness: Toward personal growth. *American Journal of Orthopsychiatry*, 73, 334–344.

- Rothman, J. (1992). *Guidelines for case management: Putting research to professional use*. Itasca, IL: F. E. Peacock.
- Rowan, T., & O'Hanlon, B. (1999). *Solution-oriented therapy for chronic and severe mental illness*. New York: John Wiley & Sons.
- Rubin, A. (1992). Case management. In S. M. Rose (Ed.), *Case management & social work practice* (pp. 5–20). New York: Longman.
- Rusinova, Z. (1999). Providers' hope-inspiring competence as a factor optimizing psychiatric rehabilitation outcome. *Journal of Rehabilitation, 65*, 50–57.
- Saleebey, D. (1996). The strengths perspective in social work practice: Extensions and cautions. *Social Work, 41*, 296–305.
- Saleebey, D. (2002). The strengths approach to practice. In D. Saleebey (Ed.), *The strengths perspective in social work practice* (3rd ed.; pp. 80–94). Boston: Allyn & Bacon.
- Schiff, A. C. (2004). Recovery and mental illness: Analysis and personal reflections. *Psychiatric Rehabilitation Journal, 27*, 212–218.
- Schott, S. A., & Conyers, L. M. (2003). A solution-focused approach to psychiatric rehabilitation. *Psychiatric Rehabilitation Journal, 27*, 43–50.
- Smith, M. K. (2000). Recovery from a severe psychiatric disability: Findings from a qualitative study. *Psychiatric Rehabilitation Journal, 24*, 149–158.
- Snyder, C. R., Michael, S. T., & Cheavens, J. S. (1999). Hope as a psychotherapeutic foundation of common factors, placebos, and expectancies. In M. A. Hubble, B. L. Duncan, & S. D. Miller (Eds.), *The heart & soul of change: What works in therapy* (pp. 179–200). Washington, D. C.: American Psychological Association.
- Snyder, C. R., Feldman, D. B., Taylor, J. D., Schroeder, L. L., & Adams, V. H. (2000). The roles of hopeful thinking in preventing problems and enhancing strengths. *Applied & Preventive Psychology, 9*, 249–270.
- Snyder, C. R., Ilardi, S., Michael, S. T., & Cheavens, J. (2000). Hope theory: Updating a common process for psychological change. In C. R. Snyder & R. E. Ingram (Eds.), *Handbook of psychological change: Psychotherapy processes & practices for the 21st century* (pp. 128–153). New York: John Wiley & Sons.
- Snyder, M. (1984). When belief creates reality. *Advances in Experimental Social Psychology, 18*, 247–300.
- Solomon, P. (1992). The efficacy of case management services for severely mentally disabled clients. *Community Mental Health Journal, 28*, 163–180.
- Spaniol, L., Wewiorski N. J., Gagne, C., & Anthony, W. A. (2002). The process of recovery from schizophrenia. *International Review of Psychiatry, 14*, 327–336.
- Stannard, R. P. (1999). The effects of training in a strengths model of case management on client outcomes in a community mental health center. *Community Mental Health Journal, 35*, 169–179.
- Stein, L. I., & Test, M. A. (1980). Alternative to mental hospital treatment: I. Conceptual model, treatment program, and clinical evaluation. *Archives of General Psychiatry, 37*, 392–397.
- Strauss, J. S., & Carpenter, W. T. (1977). Prediction of outcome in schizophrenia. III. Five-year outcome and its predictors. *Archives of General Psychiatry, 34*, 159–163.
- Sullivan, W. P., & Rapp, C. (2002) Social workers as case managers. In K. J. Bentley (Ed.), *Social work practice in mental health: Contemporary roles, tasks, and techniques* (pp. 180–210). Pacific Grove, CA: Brooks/Cole.
- Tooth, B., Kalyanasundaram, V., Glover, H., & Momenzadah, S. (2003). Factors consumers identify as important to recovery from schizophrenia. *Australasian Psychiatry, 11*(Suppl. 1), S70–S77.
- Torrey, W. C., & Wyzik, P. (2000) The recovery vision as a service improvement guide for community mental health center providers. *Community Mental Health Journal, 36*, 209–216.
- Torrey, W. C., Rapp, C. A., Van Tosh, L., McNabb, C. R. A., & Ralph, R. O. (2005). Recovery principles and evidence-based practice: Essential ingredients of service improvement. *Community Mental Health Journal, 41*, 91–100.
- Turner, J., & TenHoor, W. (1978). The NIMH community support program: Pilot approach to a needed social reform. *Schizophrenia Bulletin, 4*, 319–348.
- Vaughn, K., Young, B. C., Webster, D. C., & Thomas, M. R. (1996). Solution-focused work in the hospital: A continuum-of-care model for inpatient psychiatric treatment. In S. D. Miller, M. A. Hubble, & B. L. Duncan (Eds.), *Handbook of solution-focused brief therapy* (pp. 99–127). San Francisco: Jossey-Bass.
- Walter, J. L., & Pellar, J. E. (1992). *Becoming solution-focused in brief therapy*. New York: Brunner/Mazel.
- Watkins, J. (1996). *Living with schizophrenia: A holistic approach to understanding, preventing and recovering from "negative" symptoms*. Melbourne, Australia: Hill of Content.
- Webb, C., Pfeiffer, M., Mueser, K. T., Gladis, M., Mensch, E., DeGirolamo, J., & Levinson, D. F. (1998). Burden and well-being of caregivers for the severely mentally ill: The role of coping style and social support. *Schizophrenia Research, 34*, 169–180.
- Weiner-Davis, M. (1993). Pro-constructed realities. In S. Gilligan, & R. Price (Eds.), *Therapeutic conversations* (pp. 149–157). New York: W. W. Norton.
- Weingarten, R. (2005). Calculated risk-taking and other processes for my psychiatric recovery. *Psychiatric Rehabilitation Journal, 29*, 77–80.
- Wheaton, R. B. (1983). Stress, personal coping resources, and psychiatric symptoms: An investigation of interactive models. *Journal of Health & Social Behavior, 24*, 208–229.
- Zimmerman, M. A., Israel, B. A., Schulz, A., & Checkoway, B. (1992). Further explorations in empowerment theory: An empirical analysis of psychological empowerment. *American Journal of Community Psychology, 20*, 707–727.

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