

## On “Being” and “Doing”: Supervising Clinical Social Workers in Case-Management Practice

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*As clinical social work has increasingly become synonymous with reflective psychotherapeutic intervention, case-management practice is often perceived as an impediment to the consolidation of a professional identity as a clinical social worker. The clinically oriented case manager is faced with the difficult challenge of addressing the inseparable psychological and environmental needs of clients while meeting the expectations of relevant agencies and institutions. In the supervisory process of case-management practice, clinical social workers have a unique opportunity to consolidate their professional identity as they directly address the dialectic between the individual's maturational processes and the larger facilitating environment. Using illustrations from supervisory relationships, this article discusses the specific challenges of clinical supervision in case-management practice.*

**KEYWORDS** *case management, clinical social work, supervision*

Clinical social workers increasingly find themselves in agency settings whose focus is on case-management interventions. Trained in reflective psychotherapeutic methods, clinical social workers are often uncomfortable with the more active environmental interventions implicit in case-management practice. Although social work espouses a biopsychosocial model, the micro–macro division in practice education often prevents social workers

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from learning integrative practice methods that simultaneously address psychological and environmental domains.

Too often, clinical social workers begin practicing in case-management settings without a conceptual model for integrating these domains in their daily work. When practice settings involve direct case-management interventions, social workers with a “clinical” orientation often intervene with inappropriate psychotherapeutic methods or conclude that their “clinical” background is not relevant for this work. Trained in psychotherapeutic methods that view direct environmental intervention as a violation of boundaries and the “therapeutic frame,” clinical social workers consolidating a professional identity struggle with this “rule book” and bring unique challenges to supervision.

Further, aspiring clinical social workers in case-management practice often experience a profound sense of disillusionment about their social work career. Many have entered the profession to pursue careers as psychotherapists, seeking the rewards of meaningful relationships with clients and intellectual stimulation. Rightly or wrongly, they view case management as offering neither reward while sidetracking their professional development as clinical social workers.

These issues pose special challenges in the supervisory process. In her article on social work supervision, Olive Stevenson (1963) referred to Whitehead’s (1929/1967) classic description of stages in the educational process: romance, precision, and generalization. When clinical social workers begin supervision in psychotherapy practice, they are commonly in Whitehead’s (1929/1967) stage of romance: “The stage of romance is the stage of first apprehension. The subject matter has the vividness of novelty; it holds within itself unexplored connexions with possibilities half disclosed by glimpses and half concealed by the wealth of material” (p. 17).

Sadly, “romance” and “case management” rarely coexist in the psychic space of clinical social workers. Although psychotherapy practice evokes “romantic” excitement, case management is associated with administrative banality. As Stevenson (1963) noted, the beginning social worker is excited because he or she “has chosen a field of work with infinite unexplored possibilities for understanding and helping others” (p. 69). But, in many case-management practice settings, the clinical social worker “leaves the world of romance and meets the hard realities of the situation” (Stevenson, 1963, p. 69).

For example, a case manager supervisee noted, “I don’t want to be a gatekeeper of services like tokens and food vouchers. As a therapist you don’t have to be a gatekeeper.” He later remarked that:

The clients’ expectations . . . and the agency’s . . . can be different from mine. Boundaries are messy. . . and it all happens so fast. The client expects that the case manager will dispense things or provide access to services. A lot of my clients have substance abuse. If I give them tokens

or food vouchers, possibly they would use them for drugs. Sometimes it seems more about the client getting what they want, even when they don't need it. When I ask about it, clients get mad, even fire me . . . and the agency doesn't back me up.

Although the task of the supervisor in psychotherapy supervision involves helping the supervisee “toward the stage of precision, of discipline and of analysis, while leaving unharmed the precious source of his energy” (Stevenson, 1963, p. 69), the initial task in case-management supervision often involves revitalizing this romance with social work practice—to reawaken this “precious” energy.

### CLINICAL SOCIAL WORK SUPERVISION: HISTORICAL PERSPECTIVES

Social work supervision, like the profession itself, dates to the 1800s. As the profession has changed, supervisory practices have changed with it, reflecting the influences and changes in the practice environment of the times. The dialectic between micro- and macroforces, which runs through the history of social work, plays out in the evolution of supervision, as the pendulum has swung between a focus on psychological processes and an emphasis on the environment and social issues.

Seventy-five years ago, Virginia Robinson (1936) articulated this tension as follows:

In the years of prosperity before the depression, material wants were adequately provided for and human need expressed itself in emotional terms. To meet this need psychiatric case work developed, offering intensive treatment for emotional problems, generously supported by communities which recognized little limitation in their capacity to give. With the financial depression, material want became acute and widespread and social case work . . . was forced to shift its service from the emotional to the material level in response both to the pressure of the presented need and of the community's . . . diminishing capacity and readiness to support. During the days of intensive psychiatric services, case work found in psychiatric and psychoanalytic knowledge the greatest contribution . . . today an equal absorption of economic information is essential. (p. xiii)

The field of “case management” developed in the 1970s as social work evolved in a different direction. “Social casework,” historically involving an integrated approach to psychological and environmental needs, was viewed in some quarters as a paternalistic enterprise and essentially disappeared as a content area within social work. On a microlevel, *clinical social work*, often a synonym for psychotherapeutic practice, emerged in professional

organizations, licensing, and academic training. On a macrolevel, social work focused almost solely on community interventions with minimal attention to psychological concerns. Although social work had largely abandoned its integrative “casework” perspective, many populations in mental health, health care, substance abuse, family services, and geriatrics still required interventions with individuals and families that incorporated social work’s historic attention to psychological and environmental concerns. As a result, “case management” was essentially a reincarnation of traditional social casework practice (Kanter, 2010, 2011).

Yet, though many graduate social work internships and employment opportunities for licensed social workers are in agencies with an explicit case-management focus, social work education rarely includes substantive content in case-management practice. Social workers, especially those with clinical inclinations, arrive in agency settings with fragmented educational experiences: interventions with individuals and families are essentially psychotherapeutic and interventions with environmental concerns involve large groups or communities.

The supervision literature in clinical social work has largely mirrored the literature in psychotherapy supervision. Recent articles in the *Clinical Social Work Journal* by Young (2004), Schamess (2006a, 2006b), Bransford (2009), and Miehl (2010) refer to supervision of psychotherapy practice. Similarly, almost all the case vignettes in Munson’s (2002) text on clinical social work supervision involve social workers in psychotherapy practice.

As such, supervision of psychotherapy practice—in contrast to case-management practice—reflects helping the clinical social worker function in a contained social situation with a relatively limited array of practitioner behaviors. Although there are certainly exceptions, the psychotherapist

- practices in a confined office that offers privacy;
- receives clients who initiate interventions and travel to the office;
- is seen by a client who often pays, at least in part, for services;
- meets at regular intervals for predetermined time periods;
- has little or no contact with the social network apart from the individual or family in treatment;
- restricts activity to largely verbal, nonmaterial transactions;
- works with clients who do not depend on the therapist for material support;
- often follows specific treatment protocols.

In contrast, the case manager

- may interact with clients in their home, the community, or an office (frequently these settings are not private);
- often initiates interventions and often travels to meet the client;

- is seen by clients who do not pay for case-management services;
- often meets at changing intervals for variable time periods;
- frequently has direct contact with the individual or family's social network;
- is involved in verbal and material transactions;
- works with clients who are often dependent on the case manager for material support;
- works without a detailed intervention protocol.

The contemporary clinical social work supervision literature, with rare exceptions (Walsh, 2002), simply does not address the complex social field of case-management practice and the wide array of practitioner decisions that are taken for granted in psychotherapy. Nor does it begin to address the many concerns about the provision of an array of material and environmental support.

Although the social work supervision literature addresses many concerns applicable to all practice areas (Kadushin & Harkness, 2002; Munson, 2002), the supervision literature from an earlier era of social casework arguably addresses the complexity of contemporary case-management practice more directly than the contemporary literature (Feldman, 1960; Kanter, 2004; Robinson, 1936; Stevenson, 1963). For example, Feldman (1960) noted that

We began to see that when a client asks for bread he might need the real "daily bread," at other times it might be psychological feeding that he needs, and yet at other times, though he asks for bread, it is not any food he asks for at all, but that we enable him to eat without choking or vomiting. (p. 150)

## CLINICAL CASE MANAGEMENT: DEFINITION AND COMPONENTS

When supervising clinical social workers in case management, our focus will be on a specific case-management model—clinical case management—that addresses the learning needs of supervisees with more clarity than other approaches. In a clinical case-management approach, relationships with clients are valued, and case managers recognize the interplay between psychological and environmental domains (Kanter, 1989, 2010). Clinical case management can be defined as a modality of social work practice that, acknowledging the importance of biological and psychological factors, addresses the overall function and maintenance of the person's physical and social environment toward the goals of facilitating physical survival, health and mental health, personal growth, and community functioning.

This definition has several distinctive components. First, it identifies clinical case management as a modality of social work practice, requiring special training and skills comparable with those required in psychotherapy, psychopharmacology, or psychosocial rehabilitation. Clinical case management is a specialized professional field practiced by social workers and other mental health clinicians; it is not merely an administrative system for coordinating services.

Second, though focusing on the patient's physical and social environment, this definition recognizes the importance of integrating case management into a comprehensive biopsychosocial treatment plan. Although some case-management models advocate segregating case management from other clinical interventions (Rapp & Goscha, 2006), clinical case management can be one of several intervention strategies used by a social worker, or it can be the primary role of the worker, implemented as part of a team of mental health or health care professionals.

Finally, this definition of *case management* focuses on all aspects of the physical and social environment, including formal and informal resources. Although early case-management models outlined five core components (assessment, planning, linking, monitoring, and advocacy), clinical case managers commonly intervene with 13 distinctive activities (see Table 1). These strategies address the delicate process of collaborative engagement with the client, environmental intervention, and the recurring need for crisis intervention in the context of ongoing relationships (Hemming & Yellowlees, 1997; Kanter, 1989).

The scope of clinical case management can be best appreciated through how this approach would be used in assisting a homeless person. In a generic case-management approach, the problem is simple: to help the

**TABLE 1** Components of Clinical Case Management

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Initial Phase
1. Engagement
2. Assessment
3. Planning
Environmental Focus
4. Linking with community resources
5. Consulting with families and caregivers
6. Maintaining and expanding social networks
7. Collaborating with physicians, social agencies, mental health, and health care facilities
8. Advocacy
Client Focus
9. Intermittent individual psychotherapy
10. Teaching independent living skills
11. Psychoeducation about psychiatric and medical disorders
Client-Environmental Focus
12. Crisis intervention
13. Monitoring

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homeless person find housing. The case manager's role might even begin and end with a simple referral to a homeless shelter or to a low-income housing program. Or perhaps, viewing the problem as simply a matter of inadequate resources, the case manager might refer the homeless person to an employment program or to a Social Security office.

In contrast, the clinical case manager understands that homelessness most often results from the dynamic interplay of multiple factors. Untreated mental illness, substance abuse, severe medical conditions, natural disasters, and family problems can cause or exacerbate the employment difficulties and financial insecurity that leads to a client being without shelter. Even obtaining disability benefits for psychiatric disorders can be impaired by the very disorder that entitles a person to such benefits. Finding and maintaining a stable home involves addressing these relevant factors; otherwise, a simplistic residential "placement" is likely to deteriorate quickly and result in further homelessness. The clinical case manager does not address all these problems single-handedly. Invariably, other resources are involved: concerned relatives and friends, other mental health professionals, health care services, social agencies, community programs, government agencies, and the client himself or herself. The clinical case manager's job is to mobilize these disparate resources, sometimes through a simple referral, sometimes through ongoing consultation and collaboration, and sometimes through direct interventions (Kanter, 1996a, 1996b).

Applying the clinical case-management model in supervision sometimes creates challenges when the supervisee's agency embraces a different case-management model or merely a simplistic environmental reductionism. Sadly, in many quarters today, psychological perspectives, especially psychodynamic perspectives, are ignored or devalued. On one hand, human behavior is often reduced to its neurobiological substrate and, on the other, the focus is solely on environmental provision. Negative transference may be immediately interpreted as medication noncompliance whereas homelessness is viewed as merely a lack of housing, ignoring the complex psychological concerns that keep many homeless persons on the streets for years (Farrell, 2010).

As Floersch (2002) eloquently described, many case managers lack the clinical training that can help them identify and describe the psychic phenomena that they encounter daily. Complex motivational issues are obscured when the agency philosophy centers on such unidimensional themes as "strengths," "empowerment," or "recovery." Although these themes convey admirable values, staff may be discouraged from openly acknowledging and discussing deficits, problems, lack of motivation, and ambivalence; in some settings, even the adjective *clinical* is viewed as a step toward a slippery slope of dehumanization and stigmatization.

In this regard, supervisors must familiarize themselves with the rhetorical climate of their supervisees' workplaces and assist them in using language that promotes collaboration with colleagues and clients. For

example, in some settings, the term *countertransference* may make colleagues uncomfortable, but *frustrations* and *challenges* may be acceptable. Or the term *resistant* may be unpalatable, whereas *hesitant* and *reluctant* are acceptable.

Even the phrase *case management* is now problematic in some programs, and the mantra “I am not a case and I don’t want to be managed” is oft-repeated. Although staff functions may involve the aforementioned case-management principles and components, agency team members may be identified as “recovery specialists” or “rehabilitation counselors.” Often new generations attempt to use linguistic innovation as a stepping stone toward substantive innovation.

Part of the supervisory task involves helping case managers use language appropriate to their practice milieus. In dialogue with medical personnel, one “dialect” is used. Quite different “dialects” are used when interacting with clients, families, and social agencies. In multicultural settings, these linguistic nuances become even more complex. There is a continuing challenge to use language in a manner that promotes effective communication with all parties.

### REVIVING THE “ROMANCE”

When supervision of clinical social workers in case management is initiated, the first task is to stimulate excitement and curiosity in the supervisee. Acknowledging the tedium of bureaucratic mandates and the narcissistic challenge of working with reluctant clients, the supervisor initiates a process where the case manager reflects on the client’s intrapsychic world, the client’s relationships with the case manager and significant others, and the interplay between these inner and outer worlds (Longhofer, Kubek, & Floersch, 2010). Of course, all this transpires as the case manager actively participates in the client’s world, interacting directly with his or her social network and, in many cases, directly involved in the provision of material support. In a given week, the quantity of clinical data is immense, and supervisory attention can be directed in many different ways. But one of the central considerations often concerns what the case manager actively does with or for the client.

For example, the case manager may be asked to drive a client to a physician for evaluation of a physical complaint. Assuming that the case manager has access to a vehicle and is allowed to provide such transportation, an array of questions can quickly unfold:

- Is public transportation an option? Or can family and friends help out?
- Should the case manager assist the client in exploring other options? (i.e., downloading bus schedules and maps or directly asking a family member for assistance)



- Assuming that other resources exist, why is the client asking the case manager for such assistance? Is getting a ride simply easier than using public transportation or is the client hesitant to ask other network members for help?
- How does the case manager subjectively feel about the request? Empathic regarding the client's somatic anxieties or resentful regarding what appears to be dependent exploitation?
- How would providing a ride affect the case-management relationship? Would it stimulate unrealistic expectations that the case manager will always be available? Or might it help build trust in a fearful client? Does the case manager want to discourage or encourage attachment and dependency?
- Is the client really asking for the case manager to be present in the physician's office and assist in the interaction with the medical personnel?

There are often no "right answers" in such situations. The case manager may "do for" the client and simply provide transportation or directly arrange for transportation from other resources. Alternatively, he or she may "do with" the client and participate fully in the whole experience, discussing somatic concerns on the way to the clinic, communicating directly with the medical staff, and processing the whole event on the way home. Or he or she may simply step aside and suggest that the client make his or her own arrangements.

Given the ongoing demands of an active caseload, the case-management supervisee will invariably make many such decisions without supervisory assistance. The time constraints of the supervisory hour will only allow for exploration of a small number of such decisions. In an ideal world, clinical "insight" would precede "action," but in everyday social work practice "action" commonly precedes "insight." As Clare Winnicott reflected on her experiences helping troubled children during World War II, she advised the paraprofessional staff she was supervising as follows:

Let's do the best we can in the present situation and then when (the consultant) comes again tell him what we did and see if he's got any comment to make on it and if we can therefore learn something from what we did. (Kanter, 2004, p. 129)

## THE ROLE OF THEORY

The activation of this learning process is the first step in "reviving the romance" with clinical social workers or trainees with clinical social work interests. The next step involves introducing supervisees to clinical theory that links their interest in psychotherapy with their case-management practice. Most supervisees are unaware of the considerable literature

that exists on clinical case management (Harris & Bergman, 1987, 1993; Hemmings & Yellowlees, 1997; Kanter, 1988, 1989, 1990, 1995, 1996a, 1996b, 2000, 2009, 2010, 2011; Longhofer et al., 2010; Storey, 2009; Surber, 1994; Walsh, 2000, 2002). Supervisors can assist by alerting supervisees to these intellectual resources.

Also, the work of Donald and Clare Winnicott offers an accessible bridge between the worlds of psychotherapy and case management (Kanter, 1990, 2000). Integrating Clare's social work perspective with Donald's psychoanalytic insights, they began their collaboration working with evacuated children with special needs during World War II (Kanter, 2000, 2004, 2005, 2009). In this work, they explored the therapeutic impact of various residential environments on the developing child.

Noting the remarkable impact of the "holding environments" that they were supporting, Donald specifically conceptualized the process of "management" as the "provision of that environmental adaptation, in the clinical situation and outside it, which the patient had lacked in his developmental process" (Winnicott, 1975, pp. xxvi–xxvii). He viewed the initial paradigm for "management" emerging from the mother's caretaking of an infant, noting as follows:

It is helpful to postulate the existence for the immature child of two mothers . . . [an] object-mother and [an] environment-mother . . . [These terms] describe the vast difference that there is for the infant between the two aspects of infant-care, the mother as object . . . that may satisfy the infant's urgent needs, and the mother as the person who wards off the unpredictable and who actively provides care in handling and in general management. (Winnicott, 1965, p. 75)

His differentiation of the "environment-mother" or "ego-supportive mother" from the "object-mother" is an important theoretical distinction. Psychoanalytic theory has emphasized the psychosexual dimensions of parenting (i.e., the oral, anal, and genital stages), which reflect the child's passionate experience of the "object mother," and even the oedipal stage, which reflects the "object father." The "environment-mother" can also be differentiated from the "attuned mother" implicit in attachment theory.

What is frequently overlooked are the more banal aspects of parenting reflected in the "environment-mother" concept: bedtimes, selecting appropriate day care and schooling, getting ready for school each morning, engaging the child in household chores, facilitating involvement in hobbies, dispersing spending money, and so on. Much of what is involved here is often referred to as "parental judgment," a complex cognitive process that involves an objective analysis of the child's needs, strengths, and deficits; an empathic understanding of the child's subjective world; and an informed knowledge of community resources.

Donald Winnicott suggested that these parenting functions are internalized by the child in the course of development and become what some call “ego capacities” and what others call “independent living skills.” For example, many adult clients in case management have difficulty with money management, often budgeting limited funds inappropriately without ensuring that basic needs for housing, food, and other essentials are addressed (Brotman & Muller, 1990). These problems often can be traced back to childhood. Some clients may have been continually indulged, given funds for every need or desire whereas others may never have been permitted any financial autonomy. If this tight control is abruptly relaxed in adult life, the lack of internalized money management skills may be catastrophic.

Reflecting on her experiences with social casework and psychotherapy, Clare Winnicott elaborated on the differences between these fields in a 1963 article. Although this passage addresses child welfare practice, its implications for case management should be apparent:

The social worker . . . starts off as a real person concerned with the external events and people in the child's life. In the course of her work with him, she will attempt to bridge the gap between the external world and his feelings about it and in doing so will enter his inner world too.

As a person who can move from one world to another, the social worker can have a special value all her own for the child, and a special kind of relationship to him which is quite different in kind from the value and relationship that a psychotherapist has. [The social worker] can never become entirely the subjective object which the psychotherapist becomes; she is bound to external reality because she is part and parcel of the child's real world, and often is responsible for maintaining that world. The social worker . . . is therefore in a strategic position in their lives because she is in touch with a total situation representing a totality of experience. (Kanter, 2004, p. 171)

Writing years before it became commonplace for social workers to practice psychotherapy, Clare's delineation between “social work” and “psychotherapy” is perhaps excessively dichotomous. Yet she highlights the reality that the community-based interpersonal field occupied by the client and social worker is far more complex than ordinary psychotherapy relationships confined to the consulting room. Further, she described how involvement in our clients' outer worlds leads us into their inner worlds. As case managers become aware of the interplay between the psyche and environment, developing a unitary professional identity as a clinical social worker—rather than disparate identities as case manager and psychotherapist—begins to emerge as an exciting possibility.

Using Winnicott's construct of the “environment-mother,” supervisors can introduce case managers to the fascinating parallels between their

professional practice and developmental processes. For instance, reflecting on the aforementioned question of whether a case manager should transport his or her client to a doctor's appointment, the parallels with similar issues in child rearing become apparent. One supervisor recalled:

I asked Dan to think about his role as parent of two-year-old twin girls. About the basic needs he provided for now and how that would change with chronological age and subsequent developmental stages. How at certain stages Dan would need to provide "stuff" and how at other stages he would need to support them in developing skill in procuring "stuff" for themselves. This immediately resonated with the case-management dilemmas of whether to "do for" or "do with" the client, or whether to insist that he take care of his own needs.

Contemplating such questions, it is not difficult to see the similarities between how a parent responds emotionally to a child's needs and how a case manager responds to the needs of clients. In a professional context, we frequently acknowledge work satisfactions and "compassion fatigue" (Kanter, 2007) and in personal caretaking relationships—with children and elderly parents—we also acknowledge rewards and exhaustion. There are children and clients who "push our buttons," evoking feelings of anger, guilt, helplessness, and despair. This certainly occurs in psychotherapy as well as case management, but the tangible physical and temporal demands in case management are much closer to what we experience in our personal lives.

Furthermore, though the psychotherapy literature has numerous discussions of countertransference responses, these responses are ubiquitous in case management (Kanter, 1988, 2007; Walsh, 2002, 2011). Case managers inevitably experience feelings of anger, guilt, despair, and helplessness. As Clare Winnicott observed:

We have to tolerate sometimes feeling awful or confused or ignorant and at other times feeling good or clever or lucky. If we cannot tolerate the whole range of feelings which we are capable, we can easily become rigid and seek to make everyone else, including our clients, fit in with our pattern and our time. . . . Perhaps the most difficult thing in social work is fitting in with someone else's processes and therefore with his or her time, because processes cannot be hurried. . . . In social work "time not our time rings the bell" and we find that we have to be prepared to wait and perhaps carry the case through long periods of doubt and uncertainty in which we do not know yet what the outcome will be. (Kanter, 2004, p. 234)

In contrast with psychotherapy, these responses are affected by the social milieu of case-management practice as well as by the case

manager–client dyad. For example, there may be external pressures to produce a given outcome which the client is not able or willing to achieve.

In one situation, the case manager was pressured by his agency to help a client move out of a homeless shelter in which she had lived comfortably in for years. When funders insisted on a short-term crisis model, her reluctance to leave the shelter became an issue on all levels of the program's administration. The case manager found himself sandwiched between the administrative mandates and the client's wishes.

For case managers interested in clinical practice, supervisory assistance in acknowledging and containing countertransference responses not only enhances their effectiveness, but also helps them appreciate that their case-management practice is facilitating, rather than forestalling, their development as clinical social workers.

### DEVELOPING CASE-MANAGEMENT PRACTICE SKILLS

As noted earlier, the clinical social work supervision literature has focused on the skills involved in the practice of psychotherapy (Munson, 2002; Schamess, 2006a, 2006b). These include developing a therapeutic alliance, diagnostic assessment, empathic listening, understanding defenses, and recognizing and containing transference and countertransference. All of these skills are useful in case management. However, case managers also need to learn how to assess the material and environmental needs of clients, familiarize themselves with community resources, develop consultative and advocacy skills in relationships with significant others and network members, and understand the interplay between the individual and the social and physical environment.

In addition, as case managers cannot simply apply the conventional psychotherapy parameters vis-à-vis duration, frequency and location of contacts, these issues need to be explored on an individual basis in light of client need, agency function, and caseload demands. Further, the content of each contact with clients varies greatly. Although we assume that psychotherapy contacts will focus on a verbal interchange, case managers may conduct such verbal interchanges, provide a material service, intervene directly with community resources, or accompany clients as they interact with their network or social environment. Such choices of case-management activities affect the client–case manager relationship in unpredictable ways.

This complexity may seem overwhelming to the supervisee and poses unique challenges for supervision. With a neophyte case manager, the supervisor may have to take a more active didactic role, guiding the supervisee as he or she “learns the territory.” This may involve learning about the issues and problems that impair their clients' functioning. In mental health

settings, this may involve learning about psychiatric diagnosis, psychopathology, medications, and other treatments. In health care, this may also include learning about the relevant health conditions such as HIV/AIDS, diabetes, cancer or Alzheimer's disease. In addictions, case managers need to learn about substance abuse and treatment options.

From an environmental perspective, this involves learning about such governmental resources as Social Security pensions, Medicare, Medicaid, food stamps, subsidized housing, and vocational rehabilitation. With such resources, case managers need to understand the formal and informal dimensions of such program.

For example, helping a homeless person, the case manager may know that the client is qualified to obtain a Section 8 certificate, but that there is a 5-year waiting list for such assistance. Or, when helping someone apply for Medical Assistance or Social Security, the case manager should understand how long the client might have to wait in the local office to see an eligibility worker. If the wait is long and the client's tolerance for frustration is limited, this information can affect the case manager's decision about whether to accompany the client. The supervisor's knowledge about how the "real world works" can be invaluable to the supervisee.

Similarly, there are other challenges in consulting with informal resources such as families, roommates, landlords, employers, and staff from other agencies (Kanter, 1985a, 1996b). One of the central tasks in case management involves organizing the energies of the social network in a collaborative helping endeavor. Often, network members are "burnt out" or ambivalent toward the client and case managers must address the affective issues that impair collaboration and support. These issues are an important component of the supervisory agenda.

## BEING AND DOING IN CASE MANAGEMENT

The unique supervisory challenge in case management involves helping the case manager consider when and how to actively intervene in a client's life and when to quietly listen and reflect. Fifty years ago, Feldman (1960) noted that

Our method of helping people in the past was to respond directly to the request of the client. A man asked for a ton of coal and he was granted a ton of coal. He asked for bread and bread was given to him. Soon it became apparent that the granting of the request did not solve the client's problem. We decided we must investigate the need. Sophonisba Breckenridge used to put the need for investigation briefly by telling her students, "Never give relief today if you can postpone the giving for tomorrow." . . . Social workers began to fear, and rightly so, that

their help might have a destructive aspect by making people dependent. (p. 150)

More recently, Longhofer et al. (2010) recommended that case managers

Listen. Remain attentive to what you, along with your client are feeling, thinking or doing. Second, avoid becoming active; if you feel the impulse to act, not only are you likely to step out of the present, you are also taking control. (p. 25)

Such views reflect the psychotherapeutic perspective within social work practice. However, a contrasting case-management approach is known as intensive or assertive case management; this perspective is implicit in the oft-replicated assertive community treatment (ACT) model (Stein & Test, 1978). In this model, an assertive, action-oriented approach to case management is advocated. In many programs, case managers are required to do home visits (Strickler, 2011) and meet with clients at least twice each week. Sometimes, ACT clients are required to designate the agency as the representative payee for their disability benefits, and the case manager is directly involved in budgeting the client's funds. Various authors have even questioned whether this assertive approach infringes on the rights of patients for self-determination (Gomory, 2002; Williamson, 2002).

To effectively supervise case managers, supervisors must be fully acquainted with the agency mission and ideology and be able to support the supervisee's practice within the agency's parameters and mores. Although the supervisor may help the case manager to "think outside the box," he or she must be able to help the case manager practice within this same "box." The "box" includes agency mission, caseload size and expectations for productivity expectations.

The problem of caseload management is one of the major challenges that differentiates supervision of case management from supervision of psychotherapy. The psychotherapy caseload can be neatly slotted into a calendar. However, case managers are faced with the problem of triage: "If I spend more time with one client, I will have less time for others." If a client is in crisis and the case manager needs to spend much of a day evaluating the need for hospitalization and accompanying the client to an emergency room, other activities are put on hold. Or if one client needs daily contact, other clients may only be seen every two to four weeks. Similar issues are involved in home visits; case-management travel time means less time for face to face interaction.

Noting this dilemma in public sector practice, Donald Winnicott (1986) asked the question:

What is our aim? Do we wish to do as much as possible or as little? In psychoanalysis we ask ourselves: how much can we do? At the other

extreme, in my hospital clinic, our motto is: how little need we do? This makes us always aware of the economic aspect of the case; also it makes us look for the central illness in the family, or for the social illness, so that we may avoid wasting our time and someone else's money. (p. 102)

Although clinical supervision focuses intensely on a small number of cases, case-management supervision should periodically attend to caseload management issues, intermittently reviewing clients receiving intensive services as well as those who are "stable" or seen less frequently. Although psychotherapy supervision usually addresses treatment with a fixed frequency, often once weekly, case-management supervision should continually ask the questions: "Can the time spent with this client be reduced? Can we meet less frequently or for shorter periods?"

Conversely, there are other situations where time or frequency should be increased, at least for brief periods. For example, visiting patients in the hospital or jail, though time consuming in the short run, can prove highly beneficial in the long term. The visits often demonstrate the case manager's commitment, offer an opportunity to review clinical issues that precipitated the crisis, and enhance discharge-related communications with facility staff.

Similarly, supervisory discussion of the location of case-management interactions can be very helpful. In one situation, a male case manager was meeting a female client with schizophrenia in the small apartment she shared with her parents. To give the case manager and client privacy, the parents went into the bedroom when the case manager visited. On the third visit, the client appeared wearing revealing clothes and considerable makeup. Her stares also made the case manager uncomfortable, and he discussed the situation with his supervisor. She simply advised the case manager to inform the client and her parents that future contacts would have to take place in the agency office. This change transpired without incident.

In a related situation, a young female case manager was visiting the home of a single male client with schizophrenia. Again, privacy concerns were an issue. Because the client's mother always occupied the living room, the case manager met with him in his small bedroom. When the client told his psychotherapist about how he found the case manager attractive, the therapist called the case manager's supervisor and expressed concerns about the excessive stimulation of the client's sexual fantasies. The supervisor discussed the situation with the case manager and a plan was made to instead accompany the client while walking the family dog.

Similar supervisory discussions about the location of case-management contacts can occur for a variety of reasons. With clients with violence potential or actively psychotic, it can be safer and more effective to meet in a public place like a city park, a coffee shop, or fast food restaurant. The case manager and the client may feel more comfortable knowing that they



can quickly leave should tensions arise. Also, the presence of others often minimizes regressive thought processes.

Alternatively, other case-management clients prefer the privacy of the consulting room. One case-management client recently wrote an article decrying his state mental health system's funding mandate that only reimbursed agencies when case-management contacts occurred in the home or community (Strickler, 2011). This client felt that being seen at home or in public settings with his case manager stigmatized him and sometimes served to "foster resentment and thwart the healing process" (Strickler, 2011, p. 1216).

Finally, there are the multiple questions about when to materially support the client—to "do for" or "do with"—or to simply "stand by" and observe while the client addresses his or her own needs. These questions are highlighted in the lengthy evocative case report in Longhofer et al.'s book *On Being and Having a Case Manager* (2010). In their narrative, Lisa, the case manager, is repeatedly faced with a choice of maintaining a reflective, empathic stance or becoming involved as an active participant in her client Marilyn's life activities. This case material offers an excellent learning opportunity for case managers to explore the tension between action and reflection.

For example, Lisa accompanies Marilyn to the community college for an interview with the disabilities services counselor. While Lisa sits by silently, the college counselor recommends that Marilyn first take the required math, English, and lab science classes before she pursues her field of interest. Returning home from the college, Lisa observes that Marilyn was displeased with the interview. She speculates that Marilyn "might feel overwhelmed if she takes both math and English in her first semester" and might require supportive services to manage her homework (pp. 47–48).

As the narrative proceeds, Lisa returns with Marilyn to the community college several times as she deals with the bureaucracy and paperwork involved in registration and financial aid. However, she eventually enrolls in an English and physical education class. Within a month, she is falling behind in English and finds the physical education class too strenuous. The case report implies that Lisa quietly observed what was transpiring.

Three weeks later, Marilyn asks Lisa for help with "intimidating" letters from the college apparently seeking Marilyn's tuition payments and warning her that they will withhold her grades if she does not remit what she owes. At this point, she is missing classes and is late on paying her college bills. Later, Lisa learns that Marilyn dropped out of the community college but now has debts that exacerbate her financial situation.

Different supervisors would approach their supervision of Lisa in different ways as she observes her client making problematic decisions. Certainly, the supervisor can explore Lisa's views of Marilyn's plans and elicit her views on the appropriate case-management intervention. However,

if Lisa anticipates Marilyn's failure, but is reluctant to interfere with her "self-determination," does the supervisor help Lisa contain her anxiety as she "stands by" or forcefully suggest that she assertively intervene before Marilyn enrolls in classes and assumes new loans? Or might the supervisor explicitly suggest a third alternative, advising Lisa to systematically introduce Marilyn to an educational planning process that will maximize the probability of success and minimize the costs of failure?

Often, active supervisory intervention is required when the supervisee finds himself or herself torn between a psychotherapeutic ideal of nonintervention and a wish to prevent impending failure. Given that there may be only a single supervisory session before Marilyn enrolls in college, the supervisor has a brief window to influence Lisa's case-management intervention. As Schamess (2006a, 2006b) would suggest, the choice of supervisory response impacts the supervisory relationship as well as Marilyn's life. Although "mistakes" in psychotherapy can often be "worked through," "mistakes" in case management frequently have more tangible consequences—consequences that obviously affect the client but also affect the case manager and the supervisor.

Providing a conceptual rationale for case-management intervention, Harris and Bergman (1987) suggested that case managers often provide important support to clients with significant ego deficits in the areas of planning and affect and impulse regulation. The case manager can overtly describe the processes involved in charting a given course of action; and, over time, these ego capacities may become internalized by the client. In practice, this might involve something like Lisa saying to Marilyn: "Let's think over this idea you have. What are the upsides and downsides of taking a challenging course load? Perhaps let's start with an 'easy' class and see how that goes." Activating a process of mentalization, the supervisor can invite the supervisee to imagine how Marilyn might respond to such comments—"You don't think I can succeed" or "You always interfere with my choices"—and can explore the dialogues that might transpire.

When there is adequate time for reflection and exploration, the case manager might use techniques from motivational interviewing (Miller & Rollnick, 1991) to help clients explore their ambivalence regarding a given course of action. But when time pressures limit such opportunities, case managers often need supervisory assistance in the best ways to offer direct advice and how to respond to the transference implications of such interventions.

Similarly, case managers intermittently find themselves in actively authoritative positions vis-à-vis their clients. If the agency serves as a representative payee for government disability pensions (SSI or SSDI), they may be directly involved in budgeting and distributing their clients' funds. Or they may find themselves initiating a petition for psychiatric commitment if a client becomes suicidal or violent.

In the aforementioned case of Marilyn, she asked Lisa to physically help her move to a new residence. When Lisa arrived at her residence, Marilyn had not packed and the apartment was a mess. Although Lisa could have just driven off, she began doing all the packing and moving herself while Marilyn sat by passively. Longhofer et al. (2010) describe the scene as follows:

Lisa conveys her displeasure with silence. Fifteen minutes pass before Marilyn asks “Am I being helpful?”  
Lisa makes eye contact and says, “No, not especially, but I’m guessing that maybe you are feeling really overwhelmed or something like that, and that is making it very hard for you to help with the move.”  
She says “I guess.”

Obviously, Lisa was uncomfortable assuming any sort of authoritative position, such as directly asking Marilyn to help her: “C’mon gal, I need you to help me get your stuff packed up and out to the car.” Lisa’s nondirective empathic response reflects the conventional perspective in clinical social work and an attempt to avoid an enactment of parental authority.

In clinical supervision of case management, such “nondoing” can be explored as a form of “doing”; perhaps Lisa and Marilyn were unwittingly enacting Marilyn’s relationship with a masochistic and infantilizing mother. And if Lisa had told Marilyn to “get up and help me,” she may well have become involved in a different sort of transference enactment with an authoritarian parent. Alternatively, Lisa’s straightforward request for help may have been experienced by Marilyn as a new experience, one that required neither submission nor oppositional defiance.

The central lesson here for the supervisee in case management is that the case manager is inevitably a participant in the client’s life, even if only a transitional participant (Kanter, 2000, 2009, 2010). The case manager is not just a participant in the intersubjective dyad of the psychotherapy relationship; the case manager, as Clare Winnicott implied, “is bound to external reality because she is part and parcel of the (client’s) real world, and often is responsible for maintaining that world” (Kanter, 2004, p. 171). Helping case-management supervisees understand the unique opportunities and challenges of this role is perhaps the central task of clinical supervision.

## COPING WITH CRISES

Inevitably, case managers have to struggle with their clients’ life crises on a continuing basis. Although these crises often involve relapse of psychiatric disorders, they also include medical illness, loss of housing, arrest and incarceration, addictions relapse, family conflict, and financial emergencies.

And often crises emerge from multiple sources; a relapse into mania leads to overspending that leads to eviction. Such crises, frequently involving psychological and environmental domains, evoke powerful responses in the social worker who also is responding to pressures to be the “fixer” from the client, the agency, and the community. These responses include compassion, guilt, helplessness, empathy, anger, and the wish to “rescue.”

The role of the supervisor is first to provide a “container,” a “holding environment” for the case manager where these responses can be acknowledged and, at least to some degree, processed while a course of action is considered. The case manager cannot simply assume a passive reflective stance and empathically listen. Part of the case manager’s role involves environmental provision and this cannot be abdicated. So, as the affective response to the crisis is addressed, the supervisor must help the case manager examine the options for psychological and environmental intervention. These options must be evaluated in light of the client’s needs, the agency’s role expectations, the impact on the overall caseload, and the case manager’s personal capacities, stamina, and limitations.

Almost always, case managers require supervisory support to navigate between these powerful internal and external forces, avoiding the *Scylla* of compassion fatigue and the *Charybdis* of bureaucratic detachment. As a marathon runner needs help in pacing himself or herself, the supervisor becomes a sort of external “pacesetter,” helping the case manager understand what can realistically be accomplished given the limitations of time, energy, and resources. Over time, the case manager may internalize these supervisory expectations and become able to “pace” oneself appropriately.

There is little longitudinal research on case management that offers guidance on the expectable rate of change with various client populations. In his 3-year study of “personal therapy” of schizophrenia, a treatment model that explicitly included a clinical case-management component, Hogarty (2002) reported almost no symptomatic or functional change in the first year of intervention, very modest change in the second year, and quite dramatic improvement in the third year (Hogarty, Greenwald, et al., 1997a; Hogarty, Kornblith, et al., 1997b). Sharing these research findings with supervisees can help them understand that developing an effective case-management relationship often takes many months and does not proceed according to the conventions of a 90-day service plan (Kanter, 1985b).

Given these findings, supervisors often need to help case managers contain their need to “rescue” the client and desire for rapid change. As Clare Winnicott suggested,

The social worker has to be able to contain in herself and her relationship to the client both the good and the bad in a situation and in an individual. If she cannot bear the conflict herself and seeks to end it by rescuing the client from what she considers to be the bad influences in his life, she is only doing half her job, and, moreover, she is denying to the client

the possibility of discovering the strength which comes through finding his own personal solution to his problem. . . . There are situations from which the social worker . . . may have to rescue a client because all other methods have failed. . . . But that is quite different from being motivated to rescue . . . the social worker is aware that the problem is not solved by the act of rescue. It is transferred from one place to another, and it has to go on being solved in the new setting. (Kanter, 2004, p. 215)

That said, it is often tempting for case managers to withdraw from situations when useful assistance is possible. A common example of this is when a client is hospitalized after relapse from a psychiatric disorder. Although even a single visit to the client in the hospital can be of great value, many case managers are tempted to discontinue services until the client is discharged.

Supervisors can help case managers exploit the implicit opportunities in crises for change and growth. The case-management relationship can be reexamined. Collaboration with significant others can be initiated or revitalized. Addictions issues can be addressed. New residential arrangements can be made. Medications can be adjusted and medical interventions initiated. In sum, crises are always an opportunity to develop new case-management and treatment objectives and interventions.

At the same time, supervisors must be attentive to case manager anxiety and safety. Case managers sometimes work with unstable clients in unsafe communities. In his excellent article "Too Little Fear Can Kill You: Staying Alive as a Social Worker," Smith (2006), a British social worker, reviewed various tragic situations involving social workers and presents research on social workers' experiences of fear and threat. Protecting the safety of case-management supervisees should be a high priority for all supervisors. Supervisees should feel comfortable sharing their anxieties and concerns in supervision, especially when there are actual experiences that elicit "fear." Often, case managers feel ashamed to acknowledge such feelings to colleagues and are encouraged to wade feet first into problematic situations. When these concerns are openly discussed, supervisors can help case managers develop "survival skills" that will minimize risk and, as a result, enable case managers to interact with clients with less defensive, and often unconscious, anxiety. Such "skills" may involve such simple strategies as having a second colleague participate on a home visit or meeting a client in a public space with ample egress.

## CONCLUSION

Ultimately, in facilitating the case manager's professional growth, the clinical supervisor also plays a role in the case manager's personal development. As Schamess (2006a) noted, "supervisees' ego structures and their internal

self and object representation change” in response to their supervisory experiences (p. 444). However, the material “social care” dimension in case management extends such experiences beyond what is commonly encountered in psychotherapy practice.

On a daily basis, case managers encounter issues of caregiving, need, and dependency that are part of our lives from birth through old age. A commonplace example of this can involve the question of whether to transport a client to an appointment. Whereas a parent responds positively or negatively to a small child’s plea to “carry me” out of physical necessity, empathic attunement, or irritable exhaustion, similar dynamics are reflected in the case manager’s response to “can you give me a ride?” Beyond the “rational” response to such requests, the case manager may respond as an empathic parent, an overstressed parent, a young adult struggling with his or her dependent strivings, an envious sibling, or even as the adult child of a “needy” elderly parent. For clinical social work supervisees interested in the resonances between their personal and professional lives, case-management practice offers unique opportunities for personal growth.

Similarly, case managers also serve a unique function as a “transitional participant” in their clients’ lives (Kanter, 2000, 2009, 2010). As Clare Winnicott noted,

Of a time, perhaps, our relationship is the only integrating factor in their world, and we take on a significance which is beyond what we do or say. We make links between places and events and bridge gaps between people which they are unable to bridge for themselves. As we talk about real people and real happenings, feelings about them soon become evident and before we know where we are we have entered the inner world of the individual, and so we bridge another gap, that between fact and fantasy. (Kanter, 2004, p. 171)

By attending to the unique opportunities for learning and growth at the juncture of the psyche and the environment, the case-management supervisor can help the clinical social worker experience their practice experience as more than just a way station en route to a graduate degree or social work licensure, but as an opportunity for intellectual, professional and personal development.

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