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CLINICAL CASE MANAGEMENT

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Over the past 30 years, case management has become a ubiquitous intervention approach throughout the mental health and health care fields. Often poorly defined, case management, perhaps a linguistic repackaging of "social work" or "social casework," encompasses a wide range of environmental interventions with persons in need, including persons suffering from severe mental illness, substance abuse, and chronic medical conditions such as HIV, tuberculosis, and diabetes. In health care, the term *case management* can refer to cost-conscious telephone interventions to monitor medical services or to discharge planning from an inpatient facility. In mental health, *case management* may refer to helping a client obtain disability benefits or apply for housing assistance. Or it may refer to a friendly paraprofessional visitor who assists with homemaking and transportation.

Addressing these disparate needs, an array of case management models have been identified and articulated: brokerage, rehabilitation, strengths based, and clinical. Other adjectives have been frequently used to characterize less specific case

management interventions: "intensive," "assertive," and "standard." Understanding the case management literature often requires readers to carefully examine details of the actual interventions and human resource issues to determine what the term *case management* means in each situation.

♦ Were the interventions short-term or long-term?

♦ Were the relationships between case managers and clients personal or administrative?

♦ Was "case management" the main activity of the worker or one of an array of interventions?

♦ What were the duration and frequency of case management contacts?

♦ Were the scope of case management interventions focused on clients holistically or were they narrowly focused on a single illness or life domain?

♦ How large were case managers' caseloads?

♦ Did case managers address the interplay between psychological and environmental concerns?

♦ What was the professional training and experience of the case managers?

In this chapter, the focus will be on a specific case management model—clinical case management—that addresses the above questions with more clarity than other approaches. In a clinical case management approach, relationships with clients are

valued, interventions are holistically focused, and case managers recognize the interplay between psychological and environmental domains. 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 (Kanter, 1989).

This definition has several distinctive components. First, it identifies clinical case management as a modality of social work and mental health practice, implying that it involves 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, while 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 & Chamberlain, 1985), 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. These involve formal resources, which offer housing, financial support, and medical care, as well as informal resources, such as families, roommates,

neighbors, and churches. From this perspective, a mere referral to a housing program is an inadequate response to a person without a social network or fulfilling daily activities.

In clinical case management, five principles are emphasized:

1. Continuity of care

2. Use of the case management relationship

3. Titrating support and structure in response to client need

4. Flexibility of intervention strategies (i.e., frequency, duration, and location of contact)

5. Facilitating client resourcefulness or strengths

Clinical case management involves an array of intervention strategies. Although the early case management models outlined five core components—assessment, planning, linking, monitoring, and advocacy—an examination of the actual practice of case management identified 13 components that encompass the delicate process of engaging clients in a collaborative relationship, a variety of interventions with both the client and the environment, and the recurring need for crisis intervention in the context of a long-term relationship.

Components of Clinical Case Management

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

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 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 would understand that homelessness often results from multiple factors: untreated mental illness, substance abuse, domestic violence, natural disasters, unemployment, family disintegration, family conflict, poor

social skills, and so on. And even these factors rarely occur in isolation. The survivor of domestic violence may have a severe psychiatric disorder, which makes her susceptible to exploitation. Or a young man ejected from a family home may have severe problems with substance abuse.

Of course, the economic factors that enable residential stability are inevitably affected by these other domains. Employment difficulties are frequently exacerbated by psychiatric disorders, substance abuse, or chronic medical illness. 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 new episodes of 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.

Clinical Case Management: A Historical Perspective

Although environmental interventions have been conducted for many years, the term *case management* did not enter our professional vocabulary until 1976, when it was articulated as a key element of the *Principles for Accreditation of Community Mental*

Health Service Programs, issued by the Joint Commission on Accreditation of Hospitals (JCAH; 1976). This report, authored by Ronald Gerhard and Richard Dorgan, policy analysts for the New York State Department of Mental Hygiene, presented the basic principles of the Balanced Service System model (Gerhard, Dorgan, & Miles, 1981), a comprehensive approach to community mental health programming that provided the conceptual foundation for the National Institute of Mental Health's community support system model (Turner & TenHoor, 1978).

The JCAH's (1976) guidelines defined case management as "activities aimed at linking the service system to a consumer and at coordinating the various system components in order to achieve a successful outcome. The objective of case management is continuity of service" (p. 20). The report went on to enumerate five basic functions of case management: (1) assessment, (2) planning, (3) linking, (4) monitoring, and (5) advocacy.

Reflecting a widespread dissatisfaction with the psychotherapeutic orientation of many community mental health professionals, this concept of case management promoted a service brokerage approach that was conceptually and administratively segregated from other treatment interventions. For example, the JCAH (1976) report states that "case management is essentially a problem-solving function designed to ensure continuity of service and to overcome system rigidity, fragmented service, misutilization of certain facilities, and inaccessibility" (p. 21).

Although acknowledging that "case managers maintain continuous relationships with consumers, assisting, whenever required, in the alleviation of crisis-provoking situations" (p. 21), the thrust of the JCAH (1976) report and the Balanced Service

System model promoted a separation between clinical and environmental interventions. Case management was viewed as an activity that linked clients to an array of services with the following goals: identification, crisis stabilization, growth, sustenance, prevention, and general health. Although the authors of the JCAH report acknowledged that the case manager may be the client's "primary therapist," elsewhere they explicitly advocated segregating case management from clinical services (Platman, Dorgan, & Gerhard, 1982). This conceptual confusion continues through the present day.

Similarly, British social workers had also been conducting such interventions with mentally ill persons for many years (Timms, 1964). Many of these British efforts were inspired by the work of D. W. Winnicott, a pediatrician and psychoanalyst, and his wife Clare, a social worker, both of whom were influential within the British social work profession (Kanter, 2000b, 2004, 2005). D. W. Winnicott, most noted for his concepts of the "transitional object" and the "holding environment," used the term *management* synonymously with *social work* to describe direct interventions with the environment that facilitate the healing and maturation of very troubled individuals, a usage clearly compatible with contemporary case management practice (Kanter, 1990).

While the contemporary usage of the term *case management* emerged from the mental health field, the concept of integrating environmental and psychological interventions when assisting individuals and families with a wide array of difficulties is nearly a century old. In 1922, Mary Richmond defined social casework as "those processes which develop personality through adjustments consciously effected, individual by individual, between men and their social environment" (pp. 98–99). This tradition continued through the 1960s, elaborated by social work leaders such as

Gordon Hamilton (1951), Helen Harris Perlman (1957), and Florence Hollis (1967).

But by 1970, the social work profession had become increasingly bifurcated between the psychological and environmental approaches. Social workers interested in psychological domains identified themselves as "clinical social workers" and increasingly pursued careers as psychotherapists. On the other end of the spectrum, social workers interested in environmental concerns became interested in community organizing. The term *social casework*, reflecting an integrative perspective, became increasingly anachronistic and was largely abandoned by the social work profession. Even the esteemed journal *Social Casework*, founded in 1920 by Mary Richmond, changed its name to *Families in Society*.

Yet the work of "social casework," largely orphaned by the social work profession, had to be rediscovered by others under the rubric of "case management." And the same tensions between the psychological and environmental domains continued in the case management field. Within five years of the publication of the 1976 JCAH report, which introduced the term *case management*, these tensions surfaced in the literature in evocatively titled articles such as "Therapist-Case Managers: More Than Brokers of Services" (Lamb, 1980) and "How Many Case Managers Does It Take to Screw in a Lightbulb? (Deitchman, 1980).

On the one hand, academics and policy makers envisioned a case management model centered on resource acquisition and brokerage. The case manager would quickly assess what resources a client lacked and would formulate a plan to obtain these. This would involve coordinating referrals to appropriate agencies, obtaining entitlements, and perhaps arranging for appropriate treatment. Reflecting this perspective, one author

defined case management as follows:

> The process of planning for individuals or families who require the
> organization of services to effect desired outcomes by assuring that all
> aspects of that outcome are controlled by reducing harmful effects. . . .
> case management is carried out by case managers, who in turn maintain
> a complete record of interactions by timely notations in the case record.
> (Sullivan, 1981, p. 120)

On the other hand, case managers, supervisors, and program directors acknowledged that the practice of case management was rarely that simple or straightforward. Developing a relationship with clients unfamiliar with respectful collaborative relationships was rarely easy, and clinical instability required varying degrees of support and structure. While the ideal of each client having both a psychotherapist and a case manager seemed appealing, this was difficult to operationalize in actual practice as ongoing psychotherapy was often unavailable. For better or worse, the case manager became a central therapeutic figure in the lives of clients, symbolizing the parental function of supportive care and implementing ego functioning that was frequently impaired by psychiatric disorders.

By the late 1980s, there was a need to delineate a specific model of case management that recognized that both psychological and environmental perspectives were equally important, and a literature emerged that reflected this approach (Harris & Bergman, 1987; Kanter, 1985a, 1987). I first heard the term *clinical case management* used in 1986 by William Knoedler, the medical director of the original PACT (Program

of Assertive Community Treatment) Program in Madison, Wisconsin. This program of "assertive community treatment," pioneered by Stein and Test (1978), has been replicated many times and is a model of assertive outreach to high-risk clients with severe psychiatric disorders. In 1988, Harris and Bachrach edited the first monograph titled "Clinical Case Management," which included an assortment of papers by various authors, including the first article elaborating clinical issues in the case management relationship (Kanter, 1988). Over the next few years, a more substantive literature on clinical case management emerged, including the first paper on clinical case management in a psychiatric journal (Kanter, 1989) and a series of relevant books (Harris & Bergman, 1993; Kanter, 1995; Manoleas, 1996; Surber, 1994; Walsh, 2000; Wong, 2006).

Meanwhile, the clinical case management model was adapted to other populations, including HIV patients (Johnson, n.d.), substance abusers (Siegal, 1998), emergency room recidivists (Okin et al., 2000), and a geriatric clientele (Morrow-Hall, 1992).

Clinical Case Management Research

Various research efforts also addressed clinical case management issues. Hemming and Yellowlees (1997), Australian researchers, explored the issue of construct validity, surveying both clients and case managers about their identification of the 13 case management components outlined in Table 20.1. They found that both groups identified and valued similar activities in the case management process.

More recently, Ziguras and Stuart (2000) published a meta-analysis of mental health case management research. They identified 13 empirical studies that compared

what they characterized as clinical case management with the "usual treatment." They found that "clinical case management is generally effective in improving outcomes from mental health services, as measured by clients' level of social functioning, symptoms, client and family satisfaction, and family burden of care" (p. 1417). In a related meta-analysis, Burns and associates (2007) examined 29 relevant studies and found that "intensive case management" significantly reduced hospital utilization for persons with severe mental illness who were high users of inpatient services.

Similarly, other research has shown that clinical case management reduced emergency room utilization (Okin et al., 2000) and improved outcomes for persons with co-occurring disorders (i.e., substance abuse and psychiatric disorders) (Essock et al., 2006).

Furthermore, empirically validated treatment approaches for borderline personality disorder and schizophrenia have recognized that clinical case management is often a fundamental support for these treatment interventions. In her seminal volume on dialectical behavior therapy (DBT), Linehan (1993) discusses clinical case management as the recommended case management approach to augment DBT interventions. Similarly, Hogarty (2002) discusses clinical case management as an effective support for his "personal therapy" approach to schizophrenia.

Knowledge Base of Clinical Case Management

Responding to the concrete demands of day-to-day practice and the atheoretical ethos in the public mental health and many social services, most literature on case management has avoided discussion of theoretical issues. Perhaps more than any other practice modality in social work, clinical case management requires a comprehensive

biopsychosocial perspective (Engel, 1980) that draws on knowledge from many different fields, including biological psychiatry, medicine, learning theory, psychoanalytic theory (including ego psychology, self psychology, and object relations perspectives), role theory (Estroff, 1981; Kanter, 1985a), social network and support theories (Walsh, 1994, 2000), and general and family systems theory.

While there are certain areas of knowledge that are generic to all clinical case management interventions, practice expertise requires familiarity with information specific to the client population and the community served. Whether clinical case managers are serving persons with severe psychiatric disorders, substance abuse, or medical illness, they should be familiar with each condition's symptoms, course, and treatments.

For example, when treating a male client with a learning disability, a depressive disorder, and poorly controlled diabetes, I had to thoroughly educate myself on diabetes and its management and consider how difficulties in self-management were affected by cognitive and emotional issues (Kanter, 1996a). Because of the cognitive limitations, conventional diabetes education had little impact. And defensive denial often quickly led to diabetic crises. Finally, passive, dependent personality traits were often reinforced by the tendency of nurses to take control of diabetes management rather than promote self-management skills.

Similarly, specific knowledge of environmental resources is essential. Understanding issues regarding Social Security disability programs and other pensions is often critical. When the case manager assists clients in considering a return to work, knowledge of the complex incentives and disincentives regarding employment is

important.

While this sort of information is objectively based, knowledge of other resources requires a more experiential and subjective perspective. For example, treatment resources and social programs (i.e., housing, employment, and social support) often have quite broad admissions criteria. However, understanding the informal criteria can be even more critical.

For instance, with the aforementioned diabetic client, I understood that the mental health residential programs would be uncomfortable becoming involved with diabetic management, while residences that served persons with medical illnesses would have a largely geriatric population, ill suited for a 35-year-old man. Or when seeking housing for a 22-year-old man with schizophrenia, I understood that his occasional marijuana usage would inevitably lead to his expulsion. A durable residential placement required a more tolerant environment while the marijuana use was addressed over several years.

While some case management approaches envision an ideal process where a client freely chooses between an array of resource options and opportunities, more often environmental and social resources are severely circumscribed. I often characterize the case manager's activity as helping find a square hole that can accommodate a square peg. The case manager often can assist both client and social resource in accommodating one another to some degree, but inevitably there are limitations. For example, a mental health housing program was willing to quickly accept a homeless woman with schizophrenia and a forensic history when she agreed to begin injectible long-acting antipsychotic medications (Kanter, 1990). The case manager managed

negotiations with both parties, asking the residential program if initiating injections would encourage them to consider admitting this client and asking the client if she would be willing to try this medication.

The importance of a sound knowledge base around client difficulties and social resources differentiates the clinical case management approach from the "strengths model" of case management (Rapp & Goscha, 2006). In the strengths model, case managers can be trained to work with persons with severe mental disorders in a matter of days with minimal knowledge of psychiatric illness and its treatment. Proponents of the strengths model pose an explicit dichotomy between focusing on client strengths and acknowledging and addressing client deficits (Floersch, 2002). Strengths model case managers are trained to view any focus on deficits as antithetical to case management progress. However, as Floersch's naturalistic study of this approach revealed, strengths case managers are ill equipped to deal with problematic behavior or psychiatric relapse.

Besides factual knowledge about relevant issues such as diagnostic criteria, medications, and eligibility criteria for social programs, clinical case managers use an array of theoretical perspectives to provide guidance in addressing the complex situations and crises faced in everyday practice. The value of a thoughtful eclecticism can be easily illustrated by considering how a clinical case manager addresses a client at risk for homelessness because of a deteriorating living situation. The case manager may consider whether the crisis could be addressed by a referral for a medication consultation (biological psychiatry), teaching social skills (learning theory), helping the client control his or her anger (ego psychology), clarifying the client's distorted

perception of his or her living companion (object relations theory), empathizing with narcissistic rage (self psychology), discussing the role transition involved in moving into a supervised living situation (role theory), or consulting with a landlord or family member (social network and systems theories).

In turn, each of these interventions may also involve multiple theoretical perspectives. For example, in consulting with a family member, a case manager may explain the therapeutic action of psychotropic medications, empathize with the relative's anger, identify ineffectual relational patterns, and teach limit-setting skills.

Although the pressing demands of this work often minimize opportunities for theoretical reflection, case managers can intervene more effectively in such situations when they can identify the theoretical strands underlying these clinical problems, formulate clinical hypotheses, and test these formulations in the context of an ongoing relationship. Without this comprehensive perspective, case managers are likely to address client difficulties in a stereotypical fashion, attributing most problems to a favored nostrum, such as medication noncompliance, substance abuse, or "manipulation."

All these theories can be applied within the context of a generic stress-vulnerability model of psychopathology (Anderson, Reiss, & Hogarty, 1986) that addresses the environmental factors that trigger relapse; they can also be applied in understanding the impact of case management in facilitating longitudinal processes of recovery and development (Harding, Brooks, Takamaru, Strauss, & Breier, 1987; Hogarty, 2002; Hogarty, Greenwald et al., 1997; Hogarty, Kornblith et al., 1997; Kanter, 1985b; Strauss et al., 1985).

However, as Harris and Bergman (1987) have discussed, object relations theory is uniquely valuable in helping us understand how clients learn to cope more effectively with their environment through internalizing the problem-solving capacities of their case managers. Unlike earlier ego psychology theories, which focus on intrapsychic processes, object relations theories (and its more contemporary "cousin," relational theory) focus on the interplay between the internal and external worlds.

The application of these theories to social work practice was pioneered by D. W. Winnicott and Clare Winnicott, who began their collaboration working with evacuated children with special needs during World War II (Kanter, 1990, 2000a, 2004). In this work, they explored the therapeutic impact of various residential environments on the developing child.

D. W. Winnicott (1953/1975c) 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" (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 . . . 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, 1965c, p. 75)

Winnicott suggests that the "individual introjects the ego-supportive mother" (1958/1965a, p. 32) as "de-adaptation" occurs in graduated doses as a "gradual development . . . of the complex mental mechanisms that make possible, eventually, a move from dependence to independence" (1965b, p. 146).

Winnicott's differentiation of the "environment" or "ego-supportive mother" from the "object mother" is an important theoretical distinction. Psychoanalytic theory has often 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."

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 the environmental resources.

Winnicott suggests 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, budgeting limited funds appropriately to ensure that basic needs for housing, food, and other essentials are appropriately addressed.

In many instances, these problems can be traced back to childhood. One client

may have been continually indulged, given funds for every need or desire; another may have never have been permitted any autonomy around financial matters. If this tight control is abruptly relaxed in adult life, the lack of internalized money management skills may be catastrophic.

When confronted with an adult client with severe money management problems, the clinical case manager supports neither total financial autonomy nor total financial control (Brotman & Muller, 1990). With the developmental objective of promoting skills in this area, the case manager might help establish a plan, with the client's active consent, where important bills are paid directly with a disability check or other funds and small sums are disbursed at predetermined intervals, which the client can spend at will. Over time, this structure, openly discussed with the client, can become internalized, and the case manager's role in this activity can diminish.

The Clinical Case Manager as Transitional Participant

Another dimension of clinical case management is the case manager's role as a "transitional participant." This term comes from the work of Clare Winnicott (Kanter, 2000b, 2004), who extended her husband's concept of the "transitional object" into social work practice. While D. W. Winnicott (1953/1975d) addressed the use of inanimate objects—such as a child's stuffed animal or blanket—to maintain ties between past and present, between fantasy and reality, Clare, explored how social workers and other caregivers play a similar role.

In a jointly authored paper, the Winnicotts described Clare's role as the social worker in a program for evacuated children, who works with the separate threads of the

child's life and gives the child the opportunity of preserving something important to him or her from each stage of his or her experience:

> The function of the psychiatric social worker as far as the children are concerned is to give them a sense of continuity throughout the changes to which they are subjected. She is the only person who knows each child at every stage. It is she who first comes to his rescue in the billet in which he is causing a disturbance. She sees him in his school and billet, and then in the hostel, and possibly in more than one hostel. If there is a change in hostel wardens, it is the psychiatric social worker who gives some feeling of stability during the period of change. It is the psychiatric social worker who re-billets the child if and when the time comes. She is also in contact with the child's home, visiting the parents whenever possible. She is thus able in some degree to gather together the separate threads of the child's life and to give him the opportunity of preserving something important to him from each stage of his experience. (Kanter, 2004, p. 157)

In her later writings, Clare Winnicott elaborated on the difference between psychotherapy and social work. This is a lengthy passage reflecting child welfare practice, but its implications for clinical 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 . . .

Undoubtedly, a very valuable part of our relationship with children lies in their knowledge that we are also in direct touch with their parents and others who are important to them. 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, pp. 171–172)

Besides focusing on how the social worker can be used by children to keep alive positive internal representations of significant others, Clare also described how the worker's ongoing presence in the child's life helps facilitate psychic integration across time and space:

> [We would] go over the same ground again and again. It might begin with "Do you remember the day you brought me here in your car?" And we would retrace our steps, going over the events and explanations once more. This was no mere reminiscing, but a desperate effort to add life up, to overcome fears and anxieties, and to achieve a personal integration. In my experience, feelings about home and other important places cluster round the caseworker, so that when the children see her they are not only reminded of home but can be in touch with that part of themselves which has roots in the past and the [outside] world. (Kanter, 2004, p. 171)

Any parent will immediately recall the "remember when" game that is such a significant component of parent-child interactions. Beyond our universal fascination with photo albums or home videos—especially when shared by significant others—we all take great satisfaction in the mutual recollection of memorable shared experiences; these might include vacations, the death of a first pet, birthday parties, or even a burnt dinner.

Unlike her husband's concept of the transitional object, Clare Winnicott's transitional participant is not a passive recipient of the child's projections; the social

worker actively positions himself or herself in the child's life, making direct contact with an array of significant others and informing all parties of this array of contacts. With the knowledge of this participation, the child is then able to internalize the social worker as an embodiment of this life experience.

This role as a transitional participant is perhaps the defining characteristic of clinical case management practice. Clinical case managers position themselves in the middle of a network of caregivers and concerned parties that may involve dozens of individuals over the years: doctors, nurses, attorneys, home care aides, relatives, acquaintances, pharmacists, social workers, probation officers, rehabilitation workers, and so on.

While our professional literature addresses building therapeutic relationships with our patients, it has largely neglected the professional skills involved in engaging these significant others (Kanter, 1996b). These involve knowledge of the relevant medical, psychiatric, legal, and social welfare systems as well as some facility with the unique language employed in each. As our community has become increasingly internationalized, skills in collaborating with caregivers from other cultures are also important. This involves understanding an array of medical, psychiatric, and legal issues and being able to communicate this knowledge to a wide range of concerned parties without resorting to diagnostic and technical jargon.

The clinical case manager's function as a transitional participant is highlighted when there is a psychic deficit, which Werner Mendel (1976) identified as a "failure of historicity," a characteristic that is common to many clients unable to construct coherent personal narratives. Mendel wrote as follows:

Historicity is that quality in human existence that makes our lived

personal history available to us to draw on for the conduct of our lives.

. . . This lived, available history makes it possible for each of us to risk

new situations, new relationships and new experiences . . . In the

schizophrenic existence, this lived history seems not to be available. . . .

It is as though prior relationships and experiences have gone right

through the person. They have not stuck to his ribs. Each new

relationship has to be entered into anew. Each new activity is taking

place for the first time. Thus the day becomes long and strenuous. The

schizophrenic human being enters into situations and relationships like

a new-born infant, having no experience, no way of predicting, no way

of using shared assumptions with others in the transaction. (pp. 43–44)

To address this deficit, Mendel recommended

arranging concrete experiences with the patient in the therapeutic

transaction that allow him to establish the flow of time from past

through present to future . . . the ongoingness of the relationship, not as

an abstraction, but as a concrete series of events, helps to counteract the

failure of historicity. The patient comes for his therapy appointment. If

he does not appear, the therapist goes out and gets him . . . During the

therapy appointment, the patient is concretely reminded of the prior

appointment and he is told some of the things that were discussed and

planned at that time. He is asked to tell what has happened since his last

appointment and how the plans that were formulated have worked out.

Then he is told of the next appointment. (p. 46)

Mendel is addressing the same issues as Clare Winnicott; whether a child in need or an adult with schizophrenia, a sense of personal integration—of people, places, and events—develops as the flow of time is experienced through the actual involvement of a "transitional participant" in the flow of life. This integration occurs first in the mind of the clinical case manager, whose capacity for historicity is unimpaired; certainly, a process of internalization plays a major role in this process.

Practice Issues in Clinical Case Management

As indicated in Table 20.1, clinical case management has at least 13 distinct components. These include the engagement, assessment, and planning of the initial phase as well as interventions focused on the environment, interventions focused on the client, and interventions that encompass both client and environment. Some have suggested that case management interventions must focus on the environment and be administratively separated from more psychological interventions (Johnson & Rubin, 1983).

While this may be an attractive ideal, such a separation is rarely workable on an ongoing basis. Although the aforementioned components may be implemented by various members of a treatment team, including case managers, nurses, psychiatrists, and staff from rehabilitation and residential programs, the clinical case manager is ultimately responsible for the provision of these services, gathering together, as Clare

Winnicott noted, the "separate threads" of the client's life. For example, staff from a residential program may be responsible for teaching independent living skills when clients reside in their program; however, when clients leave the program, the case manager again assumes this responsibility.

The clinical case manager recognizes that even environmental interventions require psychological sensitivity. Clients may be afraid to enter a new residential or vocational program. Merely referring them with the program may result in failure unless there is ample preparation and an ongoing dialogue is maintained about these new experiences. In some situations, this dialogue can help clients overcome their fears and successfully adapt to new experiences; in others, these discussions can help clients and case managers learn from unsuitable placements without exacerbating feelings of failure.

The very process of linking clients with resources has important psychological implications. Clinical case managers may choose whether to have clients contact resources on their own, to only make an initial phone contact, or to accompany clients through some or all phases of an application processes. Each of these strategies conveys a different message to clients and presents them with different levels of challenge. In some instances, minimal intervention may convey the strongest message of support. In others, the case manager's activities may provide clients with "a model for operating in the world as a capable individual, secure in the ability to influence external events" (Harris & Bergman, 1987, p. 298).

Finally, clinical case managers play a central role in facilitating communication between all caregivers, relatives, and members of the treatment team. Although these

collateral consultations are essential components of effective case management, social workers and other professionals receive little training in conducting these interventions (Kanter, 1996b).

As Perlman (1979) has eloquently outlined, case managers must listen as attentively to the concerns of these significant others as they do to their clients:

> Take care not to lose sight of the signs of (the collateral's) dubiousness or halfheartedness. They need to be acknowledged openly and understandingly received. Perhaps his participation can be tentative, a tryout. He must not feel, when you have gone, that he has been had, because his cooperation then is likely to be short-lived. If he is openly resistive, we need to take care to act in full awareness that being our client's advocate does not mean we are thereby the other's adversary. Rather, our task is to try to draw him into a shared, partway advocate position. (p. 194)

This empathic, even seductive, approach to client advocacy is often far more effective than approaches that rely on assertive persuasion, negotiation, and bureaucratic and legal "clout."

However, the successful implementation of this approach also requires that clinical case managers have a clear understanding of the client's strengths and deficits, including any psychiatric or medical disorders, as well as knowledge of available resources. In many instances, this requires an ongoing learning process as the case manager may need to learn more about a psychiatric illness, a medical condition,

community resources, or cultural issues that are relevant to a specific client. This may involve consulting the professional literature or asking informed sources for further information.

Titrating Support and Structure

While some approaches to case management have emphasized the importance of assertive outreach with reluctant and resource-poor clients (Stein & Test, 1978), clinical case managers must vary the intensity and nature of their involvement to reflect their clients' individualized and ever-changing needs, personalities, and psychiatric disorders. Like psychiatrists who adjust medication dosages to reflect the client's fluctuating competence in coping with an ever-changing world, case managers collaborate with clients and social networks in titrating the levels of environmental support and structure needed to facilitate recovery and community functioning and avoid deleterious effects.

Recognizing their clients' changing needs, clinical case managers often begin interventions with high levels of support, including assistance with housing, transportation, and entitlements, especially following a psychiatric hospitalization or other crisis. As clients stabilize and crises are resolved, support can be reduced, and clients should be expected to manage more of their own affairs (Bjorkman & Hannson, 2000). In other situations, especially when clients are wary of any sort of social support or interpersonal contact, case management interventions may begin with less intensive contacts as trust and rapport are developed. Similarly, case managers vary their activities in response to the availability of other community resources (Fiorentine & Grusky, 1990).

The expertise of case managers in titrating their support in response to both the changing needs of clients and the available community resources has important economic implications; effective timing of interventions can enable case managers to greatly maximize their efficiency and serve larger caseloads. Too often, case managers spend many hours in futile pursuit of reluctant clients and then withdraw when crises ensue, sometimes requiring hospitalization, that offer opportunities for learning and growth (Kanter, 1991).

These issues are especially relevant when considering the assertive community treatment (ACT) model of intervention with persons with severe psychiatric disorders (Dixon, 2000; Stein & Test, 1978). In this model, caseloads are low (8–10:1), service intensity is high, duration of services is unlimited, and there are often specific guidelines for frequency of staff contact. These resource-rich case management programs have demonstrated great effectiveness and cost savings with clients who are frequent hospital recidivists. However, there is increasing evidence that the benefits of ACT relative to less intensive approaches diminish when clients are not high users of hospital treatment or when clients stabilize over time (Burns et al., 2007; McRae, Higgins, Sherman, & Lycan, 1990; Ziguras & Stuart, 2000).

In fact, McRae and associates (1990) demonstrated in a naturalistic study that it was possible to quadruple the caseloads of ACT case managers without deleterious effects after several years of stabilization. This suggests that over the long term, continuity of case management relationships may be more important than the level of intensity.

Understanding the Case Management Relationship

The case management relationship, with clients, families, and other caregivers, is the cornerstone of clinical case management. The case management relationship manifests all the interpersonal dynamics encountered in psychotherapy. As case management encompasses a wide range of activities—including sharing a hamburger at a fast-food restaurant, counseling in a clinic office, obtaining a commitment order, and driving a client to a doctor's appointment—the case management relationship can exhibit an almost overwhelming complexity of interactions. Unconstrained by the parameters of conventional psychotherapy, case managers strive to establish collaborative relationships that address both the psychic and the environmental needs of clients; yet they encounter a variety of transference and countertransference reactions evoked by a wide range of reality situations (Angell & Mahoney, 2007; Kanter, 1988).

This relationship contains both opportunities and hazards. A supportive collaboration can help clients accept social support and psychiatric treatment. Over time, the relationship is often internalized, enabling clients both to accept needed support and to function more independently (Harris & Bergman, 1987). And, as discussed previously, the case manager's role as "transitional participant" can help clients construct an ongoing personal narrative that can become a cornerstone for recovery and personal integration.

Alternatively, difficulties in the case management relationship can precipitate client relapse, recidivism, and even homelessness or case manager helplessness, anger, and burnout.

Although most case managers attempt to interact with clients and their social

networks on a conscious and concrete level, transference and countertransference reactions abound. These reactions crystallize around the complex reality of the case management relationship, including the following seven factors:

1. When clients require case management, they have at least a partial impairment, either temporary or ongoing, in their capacity to fulfill their environmental needs. These needs involve both concrete and social dimensions: for housing, employment, or entitlements on the one hand and for friendship and personal support on the other. This impairment is not directly related to the extent of psychopathology; even some persons suffering from schizophrenia are able to manage their lives with minimal assistance.

2. Clinical case managers address these impairments by functioning as intermediaries between clients and their environments. They assist clients in fulfilling concrete and psychic needs while facilitating the development of their clients' capacities to fulfill their own needs. For better or worse, a relational hierarchy is defined by the case manager's greater expertise in obtaining environmental resources.

3. While serving as "travel guides" for clients with impairments in community functioning, case managers simultaneously function as "travel companions," offering empathic support and understanding. In so doing, case managers often attempt to obscure the hierarchical dimension in the case management relationship (Estroff, 1981), ameliorating the narcissistic injury implicit in the acceptance of the client role.

4. Having little faith in human relationships in general and professional relationships in specific, many clients are reluctant participants in the case management process. Often, case managers have more investment in the relationship than their clients. In some

situations, clients may be indifferent to contact with their case managers; in others, clients may desire a personal, even erotic, involvement with their case managers while avoiding a working collaboration. These divergent agendas are a major source of tension in the case management relationship.

5. When successfully engaged in a case management relationship, clients will inevitably be dependent, to a greater or lesser extent, on their case managers. This dependency has both a psychological and a physical dimension, as case managers provide both emotional and environmental support. Although societal and professional value systems focus on pathological forms of dependency, case managers "must teach clients that there is a form of dependency that is necessary, normal, and constructive" (Deitchman, 1980, p. 789).

6. Unlike other mental health interventions based on privacy and confidentiality, most case management relationships have a significant public dimension, as case managers interact directly with clients' families, social networks, and formal caregivers. Such environmental interventions require quite different understandings about confidentiality; in many cases, clients come to trust their case managers' judgment and tact about how these external contacts are handled. Case managers also surrender privacy in their professional activities; in contrast with psychotherapy, their work is often scrutinized by a network of concerned parties.

7. Finally, while client self-determination is a cornerstone of mental health practice, case managers are inevitably subjected to social pressure, conveyed through their agency or other funding sources, to place social needs before client wishes. These

societal interests include an economic goal of reducing recidivism and hospital tenure and a social control goal of reducing deviant social behavior. These conflicting agendas frequently affect the managerial relationship as staff are torn between loyalties to clients and agency mandates.

Transference Reactions in Case Management

Against this background of complex reality, transference reactions—the human tendency to perceive and interpret interpersonal situations as a repetition of prior experience—permeate the case management relationship. These transference reactions always crystallize around the actual characteristics and behaviors of significant others; they are not merely fantasy creations arising from the unconscious. While psychotherapists occupy a symbolic parental role, case managers activate transference reactions when they actually fulfill parental functions, providing both physical and psychic support.

Negative transference reactions often ensue as a defensive reaction to the dependency and friendship inherent in the case management relationship. Clients may become embroiled in a "need-fear dilemma," where they fantasize that the love and care they crave will be accompanied by disappointment, rejection, domination, and abuse (Burnham, Gladstone, & Gibson, 1969). To avoid provoking such responses to the emerging positive feelings, case managers may consider suppressing their friendly inclinations, approaching their clients with more interest than warmth.

Although not unrelated to dependency issues, case managers commonly encounter transference reactions around issues of control (Angell, Mahoney, & Martinez, 2006). Attempts to provide clients with stability and structure are often

perceived as attempts to control them. Such responses are commonly evoked by involuntary commitment proceedings, medication issues (Angell et al., 2006), money management (Brotman & Muller, 1990), or expectations to participate in daily activities. Regardless of their therapeutic motives or even the client's expressed wishes, case managers may be viewed as controlling tyrants who aggrandize their egos at their clients' expense.

Countertransference Reactions in Case Management

While burnout and compassion fatigue are frequently discussed in the case management literature, countertransference reactions are rarely acknowledged (Kanter, 2007). While burnout is often conceptualized as a staff response to unsupportive work environments and inadequate resources, countertransference involves reactions to the interpersonal relationship between staff and clients.

In case management practice, countertransference problems occur when case managers struggle with their helplessness, anxiety, and anger. While these emotions can be overwhelming to professionals working in inpatient settings or private practice with middle-class clients with less challenging disorders, they are even more problematic in case management practice. Besides coping with the objective challenges of severe mental illness, homelessness, substance abuse, or chronic disease, case managers also struggle with the confounding variables of poverty, racism, conflicting legal and administrative mandates, bureaucratic inertia, limited access to social resources, inadequate professional support, large caseloads, voluminous paperwork, and low salaries.

Thus, it is hardly surprising that case managers are often overwhelmed by their

countertransference responses to clients who may be attention seeking, help rejecting, or even suicidal. Unprepared to treat such difficult situations, case managers may simultaneously feel pressured to keep the client alive, avoid rehospitalization, gratify narcissistic needs, and document ongoing progress in meeting service plan goals.

Often lacking the experience or training to establish realistic expectations for their own performance, clinical case managers cope with their anxiety and helplessness through a variety of strategies, including the following:

1. Undertaking quixotic efforts to resolve characterological deficits and childhood trauma

2. Withholding attention from "unmotivated" clients

3. Neglecting clients unable to access a given resource (e.g., "There's nothing I can do unless he or she is admitted to a residential drug treatment program")

4. Establishing written treatment contracts likely to fail

5. Substituting compliance with bureaucratic mandates for creative clinical interventions

6. Leaving case management for another line of work

Sadly, none of these coping strategies is likely to facilitate client recovery or the case manager's professional development.

How, then, can case managers cope more adaptively with their feelings of

helplessness, anxiety, and despair? First, they can come to accept these emotions as an implicit part of the challenge of the work itself; much as a stage actor accepts "stage fright" as part of the challenge of live performance. Familiarity with the professional literature on countertransference can reassure the neophyte case manager that even highly skilled, experienced professionals struggle with these emotions (Kanter, 2007; Searles, 1979).

D. W. Winnicott's classic paper "Hate in the Countertransference" (1947/1975a) specifically addresses the emotions evoked in the management of psychotic patients, reminding professionals that intense hostility is commonplace even when "normal" mothers care for their beloved infants. He emphasizes that these responses only become problematic when they are repressed and thus are not subject to conscious control.

To become aware of and understand these responses, case managers need an agency and supervisory climate that is accepting of their personal responses, enabling them to share feelings of affection and disgust, satisfaction, and disappointment. Case managers should be able to complain freely about case assignments or discuss sexually charged situations. They should also be able to reject cases that elicit particularly uncomfortable reactions, such as clients who too closely resemble a relative or who make persistent sexual advances.

Second, they can acquaint themselves with the emerging scientific data on the longitudinal course of severe mental illnesses (Harding et al., 1987) or the issues involved in any given client population. This research suggests that these disorders are treatable; however, it also indicates that recovery may take many years and is rarely a linear, predictable process (Björkman & Hansson, 2007; Hogarty, 2002; Hogarty,

Greenwald et al., 1997; Hogarty, Kornblith et al., 1997). When case managers are familiar with this research, they can view their efforts as analogous to running a marathon in which they struggle—with their clients—to learn, through trial and error, better ways of preventing relapse, ameliorating despair, and enhancing community functioning.

Finally, they can learn to avoid case management "technologies" that seductively promise simple and painless methods for achieving successful outcomes. Even for skilled, experienced practitioners, clinical case management is stressful and challenging work, requiring patience, resiliency, creativity, and courage.

The following case will offer an illustration of this process.

[BEGIN CASE STUDY]

Case Illustration

Craig was a 22-year-old single male who became homeless in a large city far away from his family of origin. An intelligent man who had dropped out of several colleges, he had lived at home for several years working at a challenging job. During this period, Craig's social and recreational life was minimal, and though his parents encouraged him to seek psychiatric treatment, he did not follow through with either medications or psychotherapy.

Various grandiose fantasies of professional success had caused Craig to move to a new city that he viewed as more glamorous than his hometown. His move was precipitous, and for several months his parents had no knowledge of his whereabouts. Without any substantial resources, he was homeless, and his

inappropriate behavior soon led to his arrest on a minor charge. The police recognized a psychiatric disorder, and he was psychiatrically evaluated before going to court. His mother learned of this court proceeding and flew in to attend his trial. He was released for "time served" and rushed out of the courtroom without speaking to his mother.

Over the next several months, a young professional couple, Mr. and Mrs. A, met Craig wandering around their neighborhood. Young and relatively unscathed by homeless life, he seemed different from other homeless persons. The As took a personal interest in him, offering him the opportunity to earn some money doing odd jobs around their home and yard. Craig performed well in these tasks, and the couple offered him a place to stay while he did more work for them and earned enough to find his own place.

Mrs. A understood that Craig had some sort of psychiatric illness but was unable to learn much about his background, family, or current situation because he was very guarded in his communications. While the living arrangement worked out adequately for a month, Mr. and Mrs. A became dissatisfied because Craig essentially stopped doing any work around the house and showed no interest in obtaining competitive employment. Nor would he seek treatment or other housing. Over time, he became more hostile, paranoid, and entitled.

Eventually, Mrs. A learned about the whereabouts of Craig's family and contacted them without his knowledge. They were relieved to learn about his whereabouts and to learn that he was safe for the time being. However, over the next month, Craig's behavior became intolerable for the As and, because he would

not collaborate with any mental health program or social service agency, they regretfully came to the conclusion that he would have to leave.

At this point, Craig's mother contacted me for assistance. She desperately wanted to help her son and did not want him becoming homeless again. Meanwhile, the As wanted Craig out of their home in the next few days. I spoke at length on the phone with Craig's parents and with Mrs. A, learning as much as I could about Craig's history and current functioning.

Given the impending crisis, there were several problematic options. One possibility involved the As simply going forward with their plan to insist that Craig leave their home. There was some chance that he would stay in the As' neighborhood and that he could be engaged in some sort of helping process through persistent outreach efforts. But it also seemed likely that even if he stayed in the As' neighborhood, Craig would be difficult to locate and that outreach efforts would be highly time-consuming and likely to fail.

Another possibility involved me going to the As' home to meet Craig before he left and offering assistance at that time. But it seemed most likely that he would reject this assistance as he had rejected all prior efforts at professional intervention.

After extensive discussion, Craig's parents, Mrs. A, and I decided to pursue a third alternative. Craig's parents would fly in over a weekend, and we would have a collective meeting at the As' home. We debated whether to inform Craig of this meeting in advance, but it seemed inevitable that he would leave the As to avoid such an encounter and the visit would be futile. So we planned to go to the As' home at a time when Craig could be expected to be there.

About an hour before this meeting, I met with Craig's parents at a nearby coffee shop. They seemed, as in our phone calls, genuinely concerned with their son's welfare. I prepared them for the meeting at the As'. I thought it was quite likely that Craig would become quite distraught at this unexpected gathering and certainly paranoid fantasies would be activated. I encouraged them to simply express their concern about Craig and follow my lead. But we soon received a call from Mrs. A that Craig had not returned home at his usual time. I waited another half hour, and we planned a meeting at the As' home early the next morning, when we knew Craig would be there.

The next morning, Craig's parents and I arrived at the As' home and were greeted at the door by Mrs. A. We were escorted into Craig's room, and he awoke with a start, seeing his parents for the first time in months. I introduced myself and explained that we were concerned about his impending homelessness and wanted to assist him. Craig did not respond verbally. He hopped out of bed, got dressed quickly, grabbed a small backpack, and dashed out the door, walking at full speed down the street. Craig's father, and I followed.

I walked alongside Craig, and Craig's father followed about 100 feet behind. I explained that I was a social worker who was intervening in a difficult situation and empathized with his shock at seeing his parents. Craig never responded verbally and continued walking at a very fast pace. Sometimes he would glance at me, and occasionally he would offer some sort of mischievous gesture. He seemed aware that his father was tailing behind but never made direct eye contact with him.

After about 15 minutes, it seemed clear to me that Craig was not taking any

evasive action to "escape" from us and seemed to be enjoying challenging our stamina. He led us across the city for over an hour, and we eventually entered a shopping mall that had a movie theater. As it was Sunday morning, a community church was holding services in one of the theaters. The church featured a young, blue-jeaned minister and a rock band. Most of the participants were casually dressed young adults. It seemed apparent that Craig was familiar with this church and had this destination in mind when he left the As' home.

Craig took a seat at one end of a crowded row, and Craig's father, and I remained in the back until the service ended an hour later. In the interim, I called Craig's mother and Mrs. A on a cell phone and asked them to join us at this mall. When Craig emerged from the service, he walked more slowly back out to the mall's food court and remained stationary several feet away from his father and me for several minutes. Then, he took off again in another direction leading out of the mall.

As we went up an escalator, his mother appeared on the next floor. Suddenly, Craig stopped and silently embraced her. He then signaled for all of us to follow him. As I had spent more than three hours that morning attempting to make contact with Craig, I used that opportunity to excuse myself. Later that day, I learned that he had lunch at a restaurant with his parents and Mrs. A. He spoke minimally, and his parents, as we had planned, made no overt attempt to bring him home or help him get treatment. Before returning home later that day, their objective was simple: to merely express, "We care about you and we are here for you when you are ready."

The next day, Mrs. A told Craig that he could not live in their home unless he

was working with me, and we had a three-way meeting to develop a new plan. Craig agreed to a meeting with me at a bookstore. To my surprise, he seemed willing to converse with me. He told me about a talk he had just heard at the bookstore and took me inside to show me the speaker's book. He also thanked me for telling him about a special exhibit at an art museum we had passed on our "walk" a few days earlier. (I had been trying to make conversation during that walk and spoke about various buildings and sights that we had passed by.) He said that he had gone to the exhibit earlier that day and had enjoyed it.

I suggested that I drive him back to the As and we discuss his continued residence there with Mrs. A. He refused to ride with me and suggested that I take the bus with him. I told him that I was unable to do this as I did not have time to take a bus to and from the As and then return to my office in my car.

I told him that Mrs. A would not take him back that night unless there was a three-way meeting between us. Craig said that he didn't know why our conversation outside the bookstore wouldn't be sufficient. I told him that Mrs. A had concerns about him that she wanted to discuss. Ultimately, Craig headed back toward Mrs. A's neighborhood carrying a sleeping bag in an egg crate. He wanted to pick up a jacket at Mrs. A's but seemed resigned to sleeping outside.

The next three weeks were stressful on all involved. Craig remained largely on the streets; fortunately, the weather was mild. One night, he was found sleeping on the porch of a nearby suburban house where a high school acquaintance resided with four young professional girlfriends. Needless to say, all were concerned about the uninvited appearance of this homeless man. The acquaintance later called

Craig's mother and offered to help, but Craig did not return to her home.

Talking to Mrs. A, I learned that there was evidence that Craig lurked around their home at night. I suggested that she leave out a package with food on the porch with a friendly note. The package was gone the next morning, and we began to use this as a method to communicate with Craig. I left some notes offering to assist with housing and other needs, and I encouraged his mother to send a parcel with some shoes and clothing that he valued. These too were removed overnight.

After several weeks, Craig knocked on Mrs. A's door around 10 p.m. and asked if he could come in and shower. She agreed and gave him a meal. Craig puttered around the As' home until 2 a.m. before departing. Finally, he agreed to a three-way meeting with Mrs. A and myself. This was held at the As' home, but Craig was evasive and uncooperative, and we were unable to arrive at any consensus.

About a week later, one month after the initial visit, Craig returned to the As' home, frankly acknowledged his difficulties, and asked Mrs. A for help. This was in sharp contrast to earlier dialogues where he had approached her with a sense of haughty entitlement, as if he were doing her a favor by gracing her home with his presence. He expressed an interest in working with me, and Mrs. A called me immediately to set up another three-way meeting.

When the meeting was held the next day at the As' home, it was apparent that there was a dramatic change in Craig's mental state. He was communicative, personable, and collaborative. Mrs. A decided to allow Craig to return while he worked on getting a job and alternative housing. Also, Craig expressed an interest in communicating with his parents and was pleased that I was in touch with them.

I discussed these changes with Craig's parents, who were delighted about the change in events. I asked for their cooperation in several ways: to send some clothes, to fund an inexpensive prepaid cell phone so we could all be in contact with Craig, and to send him weekly gift cards from a nearby grocery.

Also, I asked his parents to pay for an optical exam and an inexpensive pair of eyeglasses. This was an important issue as Craig was severely nearsighted and had been for months without glasses. Previously, he had refused eye care, preferring to see the world as a blur. Now, he was amenable to getting eyewear, a sign that he had a strong desire to "return to reality." I made a plan to meet Craig the next day and take him to an optician for an exam and a purchase of eyewear.

Craig was waiting for me at the appointed location, and we went to the optician. He cooperated, seemed pleased with the exam, and sought my advice in selecting glasses. I gave him the prepaid cell phone, and he seemed pleased with this possession. I programmed my number in the phone so he could reach me. Then, we had a brief lunch and scheduled an appointment for the next day at my office.

Craig arrived for his appointment in a timely manner, and we discussed various options for getting employment. He had changed into neat casual dress clothes, which his parents had sent and looked presentable for job hunting.

For the next several weeks, we met twice weekly in my office. While Craig initially seemed to be enthusiastic about looking for work, it became apparent that he was doing more thinking about applying for jobs than actually applying. While he had had previous success in his hometown in food service jobs, he was not interested in these positions but rather preferred a well-paying position as an

administrative assistant. He seemed unable to understand that he would likely not be competitive for these positions because of his erratic work record and recent criminal record.

Meanwhile, it became apparent to Mrs. A that Craig was not complying with her expectation that he look for work on a daily basis. He had become increasingly rude and entitled in her home. In one of our sessions, he told me that he would not accept any job that paid less than $100,000.

Clearly, Craig's mental state was deteriorating. While medication might have helped, it was apparent that he would not see a psychiatrist or take medications. Craig no longer acknowledged his difficulties but rather blamed a community that would not recognize his superior talents. Finally, Mrs. A, quite reluctantly, told Craig that he had to leave her home as he had not been willing to cooperate with the plan that they had made. Craig ignored her request, pursuing his activities in her home as if she was not there. Finally, she told Craig that she would call the police if he would not leave. He ignored her, and Mrs. A did call the police. They came an hour later and asked Craig to leave the premises. He quietly gathered his possessions and left. Mrs. A felt extremely guilty about taking this stance.

Nearly eight weeks after his parents' visit, Craig was back out on the streets, to the dismay of all involved. He also had ended his contact with me and was not answering his cell phone. Again, we arranged for small parcels and notes to be left on Mrs. A's porch. These included more gift cards for the grocery from his parents; it was important for Craig to understand that his parents cared about his material welfare.

For much of the next week, Mrs. A, his parents, and I heard nothing from Craig, and anxiety mounted about his whereabouts. Then, he returned one morning to the As' home and had a reflective conversation with Mrs. A about his prospects. He acknowledged his difficulties in finding work and wondered if his prospects would be better in his hometown, where he had an established employment record. Mrs. A encouraged him to consider this course of action and invited Craig to return for dinner the next evening.

Later that day, Craig called his mother and expressed his wish to return home in an extended phone call. His mother was pleased about this initiative but was anxious about the actual possibility of his return after a year's absence. She contacted me for advice, and I suggested that she and her husband discuss what they would require from Craig if he did return. This involved working with a mental health professional and seeking a job where he had realistic employment prospects.

Over the next several days, there was a flurry of contacts, both by phone and by e-mail, between all involved: Craig, Mrs. A, Craig's parents, and myself. Craig and his mother had another lengthy phone call where they discussed the details of a possible return to the family. His mother told Craig that it was important that he respect the needs of others in the home, keeping regular hours, joining the family for dinner, and performing household chores. (All these areas had been problematic before Craig left his hometown.)

She also told him that it was important that he meet with Dr. Z, the psychiatrist whom Craig had seen before leaving. Dr. Z was an experienced psychotherapist who used medications sparingly and understood the challenges of forming an

alliance with patients such as Craig. This led to an extended conversation on whether psychotherapy would be helpful. Craig feared an excessive focus on the past. His mother said that unless one understood the past, one was doomed to repeat it. Craig agreed with this and thought it would be helpful if his mother came to some sessions to understand his history.

Craig's mother contacted Dr. Z and asked if he would be willing to treat Craig if he returned. Dr. Z said Craig would have to understand that he would likely prescribe medications and suggested raising this issue before his return.

To further evaluate Craig's readiness to return to his family, his mother recommended that he contact me for an appointment. Craig called me, and we met a day or two later. His appearance and demeanor were much improved, and he seemed comfortable collaborating with his parents' expectations.

Craig also had various contacts with Mrs. A during this period, and these contacts were pleasant and respectful. We also arranged for his parents to pay for him to live in a youth hostel instead of a homeless shelter. Craig seemed appreciative of these improved accommodations and family support.

I discussed with Craig's parents the possibility of their flying to our city to further evaluate his return, but this seemed impractical. With a holiday approaching in a few days, we collectively agreed to facilitate Craig's speedy return, and an airplane ticket was purchased. A plan was made for Craig to visit me at my office for a termination session before heading off to the airport.

Craig appeared on time at my office, backpack in tow. We chatted about his experience and plans for returning home. His schizoid demeanor had disappeared.

He seemed to enjoy our conversation while expressing excitement about leaving. I printed out a boarding pass and called for an airport shuttle to pick him up at my office.

Later that day, I received an e-mail from Craig's mother discussing his first day at home. Some relatives were leaving their city just after Craig arrived at the airport and greeted him at the gate. Then, he enjoyed a family dinner with his parents and siblings and conversed for hours. He began playing his beloved piano and then enjoyed guitar duets with his father.

Over the next year, Craig's recovery continued in his hometown. He quickly obtained employment—two part-time jobs in retail and food service, was awarded "employee of the month," and became a shift supervisor in one position. Working nearly 50 hours weekly, much of his earnings went to pay off the substantial debts he had incurred some years previously when living in another locale. Family life was calm, and social life was minimal. Craig saw Dr. Z for a few sessions but did not continue. He still considered Mrs. A a confidante and e-mailed and called her occasionally. He wanted to return to college as a full-time student, but because of his previous academic difficulties, his parents insisted on only funding a single class initially. Craig would not accept this compromise and saved his earnings for a full-time enrollment.

It is apparent that there are residual difficulties, but both Craig and his supportive family are working on these. Everyone agrees that returning home was the right decision.

[END STUDY]

Discussion

Although my intervention with Craig was uncharacteristically short-term, lasting barely two months, it illustrates many of the components of clinical case management, most notably the balance between engaging the client in a working alliance and ongoing consultation with the social network. My initial extensive contacts with Mrs. A and his parents were critical, enabling me to construct a portrait of Craig in my own mind that allowed me to create a workable plan for intervention. It seemed quite evident that Craig was suffering from some sort of psychotic state with both paranoid and schizoid features. Similarly, narcissistic issues, including a sense of entitlement, alienated Mrs. A, the life-saving social support who had generously volunteered her involvement with Craig. These issues made any sort of collaboration in a helping relationship problematic.

At the same time, I quickly appreciated that Mrs. A and Craig's parents were empathic and caring supports. If we were to prevent Craig becoming homeless in a large, chaotic city, we needed to act quickly; there was no time for an extended period of outreach engagement. Thus, his parents' visit was a way to buy another week of the As' support. Although Craig was sorely trying the As' patience, they were amenable to allowing him to stay until his parents arrived.

How did I come up with the plan for the parents' impromptu visit? This involves a process of what Fonagy and associates (2002) described as *mentalization*, a form of imaginative mental activity that allows us to perceive and interpret the behavior of others in terms of intentional mental states. This capacity clearly evolves in one's professional development as one gains experience with a wide range of clinical

situations.

The history I had gleaned from his parents and Mrs. A informed me that Craig had powerful attachment needs, which he struggled with internally. At times, he had sought the support and protection of the As and his parents, and at others, he had pushed them away and created a pseudo-independent existence where he coped marginally. I thought it worth the gamble to have his parents appear in person to remind Craig that their love and support truly existed. And combining this with my initial appearance in his life, Craig might see me as an extension of this caring family.

When discussing this plan with Craig's parents, I was explicit that I did not know if this plan would be successful; nor did I have any clear idea about how events would unfold. But given that the As were at the end of their rope and Craig faced a return to the streets, I saw little downside to trying something that might seem "out of the box."

As the visit approached and as his parents arrived in town, I continuously addressed the anxieties of all involved, sharing my own worries about what might transpire. I prepared everyone to expect Craig to be shocked when we greeted him at home and advised all to give Craig "space." When he quickly bolted out the door, none of us were surprised. Following him across the city in this torrid "walk," I carefully monitored Craig's nonverbal communications, which clearly signaled that he did not wish to escape his father and me. I was also impressed with his father's empathic sensitivity in following us at a modest distance. He was clearly in Craig's field of vision but also allowed Craig and me to share some personal space. As the morning transpired, Craig increasingly signaled a desire to connect with us, and I felt comfortable having

his mother and Mrs. A join us at the mall. When he embraced his mother, I knew that this intervention might bear fruit.

Also, I had prepared his parents to simply share their love and concern for him, not to threaten his fragile sense of autonomy by recommending a return home or any other course of action. This template continued through the weeks ahead. I worked with his parents to carefully titrate their gestures of support, a grocery gift card and some clothes initially and, later, eyeglasses, a prepaid cell phone, and so on.

In guiding these gestures, I used a metaphor from feeding programs that help persons suffering from starvation; in such situations, one understands that the digestive system cannot tolerate large quantities of food and that overfeeding can lead to distress and even death. We began with "small meals" and gradually increased the quantity of support. Even so, there were times when Craig's schizoid defenses could not tolerate this support and he withdrew from contact.

Winnicott's (1954/1975b) concept of "regression to dependence" is very relevant here. To move ahead in their development, many case management clients, particularly those with paranoid and schizoid characteristics, first need to begin to come to terms with their own dependency needs and allow others to care for them. This process often runs counter to the ethos in many mental health and social service programs that promote "independence" as a valued goal. But "independence" is invariably an illusory state for the human species; we all are interdependent in various respects, and "dependency" predominates at various points in the lifecycle: childhood, illness, old age, and even a college student's return on vacation. At the same time, it is important that these needs are expressed in an appropriate way that does not alienate

social supports.

Conclusion

This case report offers an illustration of the distinctive practice model of clinical case management. Conventional office-based psychotherapy clearly could never have helped Craig at this stage in his life. Nor could a brokerage model of case management have assisted him in this crisis. Actually, Craig had some interaction with case managers at a program for the homeless. This intervention was able to help Craig obtain some minimal resources, such as bus tokens, which made his homeless state more tolerable, but was unable, lacking any relational matrix, to address the basic facts of his homelessness and psychiatric illness.

The strengths model of case management may have ultimately been helpful, working as part of a homeless outreach team, and in many respects, this is how Mrs. A functioned in the first weeks of her contacts with Craig, when she invited him into her home. She astutely recognized the strengths underlying his eccentric presentation and attempted to support these while housing him. But she, like the strengths case managers that Floersch (2002) observed, was unable to muster a useful conceptual framework to address Craig's problematic behavior in her home. Nor could she appreciate Craig's intense intrapsychic conflict regarding his dependency needs, which, quite possibly, was activated by the very support she was providing.

Finally, the strengths case management approach does not encompass the clinical skills involved in what Winnicott (1971) called *therapeutic consultations* with the network of caregivers. Both he and his wife, Clare, saw this consultative work with

the persons directly involved on a daily basis as a cornerstone of effective social work practice (Kanter, 1990, 2000b, 2004, 2005). Applying the clinical understanding of experienced psychotherapists, these consultative interventions require the same skills used in clinical supervision: containing countertransference responses, conceptualizing clinical hypotheses, and exploring possible intervention strategies (Kanter, 1996a).

Undoubtedly, effective clinical case management requires a professional level of competence (Kanter, 1987). Some case managers without a professional background can obtain this in on-the-job experience, ongoing study, and clinical supervision. However, for most, professional training is of considerable benefit, offering an initial introduction to psychiatric diagnosis, psychodynamic issues, interviewing skills, and the "person-in-environment" paradigm. Even so, achieving competence as a clinical case manager often involves at least three years of postgraduate supervised work experience.

Sadly, the belief that case management is a paraprofessional activity has led to poor salaries and, in turn, high turnover. Many new social workers begin this work enthusiastically, but many agencies do not fund career tracks, which would encourage case managers to remain in their positions long enough to attain substantive competence.

Often, a false sense of economy is involved here. Consider, for example, the cost of my involvement with Craig and his network. Although relatively intense for several months, about 40 hours spread over nine weeks, the costs were considerably less than long-term homeless services, incarceration, hospitalization, or even a year's prescription of a single psychiatric medication. Even within a managed care context, clinical case management can lead to major cost savings in medical and psychiatric care

(Kanter, 1996b; Okin et al., 2000).

And since clinical case management titrates intervention levels according to need, it provides a conceptual model for increasing support in crises and minimizing involvement during phases when engagement is problematic or when crises have stabilized. Similarly, clinical case management, embracing a network consultation approach, economizes by empowering the family and social network to function more effectively (Kanter, 1995). In Craig's situation, more than two thirds of my time was spent in consulting with his parents and Mrs. A. The follow-up in this case suggested that his parents learned skills during this intervention that proved extremely useful to them in subsequent months, helping them support Craig's functioning with minimal professional intervention.

Furthermore, while clinical case management merely stabilizes some situations by providing appropriate environmental support, this approach can have a definitive therapeutic impact, contributing to recovery from psychiatric disorder and facilitating personal maturation.

As Bachrach (1992) has suggested, a false dichotomy has developed between the professional knowledge and skills implicit in clinical case management and the personal qualities of enthusiasm, commitment, warmth, and respect emphasized in other case management approaches. Effective clinical case managers do not wear "white coats" or engage in psychiatric reductionism. They acknowledge both strengths and deficits in both the client and the network and use their clinical skills to mobilize these same strengths to address an array of difficulties.

Finally, acknowledging the importance of theory, rather than just simplistic

techniques, clinical case management provides a framework for addressing complex problems and unpredictable events. As Clare Winnicott sagely observed of social workers,

> [They] have to be able to tolerate sometimes feeling awful and or confused or ignorant and at other times feeling good or clever or lucky . . . in almost every case there is a difficult middle period to be gone through while things are sorting themselves out and we cannot see the end, or even if anything is happening at all. . . . Something goes on is us all the time and the experiences with clients are being unconsciously assimilated, and every now and then we become aware that this is happening. . . .
>
> As we make the effort to consciously assimilate our experiences . . . there comes a point at which we can very usefully turn to the theory of dynamic psychology which can throw further light on our work. . . . The theory can not only enable us to understand ourselves and our clients better, but, most important of all, it can provide a frame of reference which gives us a feeling of confidence . . . [that] we need not be entirely at sea when we face the unknown. Moreover, theory can save us time by helping us to see more quickly what is significant. . . . .theory . . . does not have to be complete or final, and it does not necessarily have to be right, but does have to *exist* and to be there as a starting point, or as something to catch hold of so that we can meet what comes without panic. (Kanter, 2004, 233–234)

Arguably, clinical case management is the most challenging approach in clinical social work practice. It not only requires all the knowledge and skills of the psychotherapist but also requires us to apply these in the dynamic social environment without the comforting certainties of our enclosed consulting rooms and the 50-minute hour. But over time, the clinical case manager participates in unfolding dramas that are both personally and professional rewarding.

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