

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 resulting from an ever-changing array of reality situations.

Clinical Issues in the Case Management Relationship

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The relationships between mentally ill persons and case managers manifest all of the dynamics encountered in psychotherapy. As clinical case management encompasses a wide range of activities—including sharing a hamburger at a fast-food restaurant, counseling in a clinical setting, and obtaining a detention order for involuntary commitment—the managerial relationship can exhibit an almost overwhelming complexity of interactions. Unconstrained by the parameters of the formal psychotherapeutic situation, 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 caused by a world of reality situations (Kanter, 1985a).

The complex managerial relationship contains both opportunities and hazards. This relationship has a major impact on the mentally ill person's willingness to accept environmental support and psychiatric treatment (Goering and Stylianos, 1988). Over time, the relationship is often internalized and enables clients both to trust others more fully and to function more independently (Harris and Bergman, 1987). Alternatively, difficulties in the managerial relationship can precipitate relapse,

recidivism, and homelessness for clients, and helplessness, anger, and burnout for caregivers.

This chapter, exploring some of the vicissitudes of this relationship, begins with an examination of its real characteristics and moves on to explore its symbolic and transference dimensions. Several common difficulties in the case management relationship are outlined and recommendations proposed for effective intervention.

Although a psychodynamic perspective is used throughout this chapter, such an orientation does not imply agreement with the traditional psychoanalytic viewpoints on the etiology and treatment of severe mental illness. However, psychodynamic theory is the only approach that has systematically attempted to understand the interaction between the psyche and interpersonal relationships. Undoubtedly, human relationships are affected by biological phenomena; yet, psychological phenomena such as trust, dependency, love, and hate are as central to the lives of the biologically disabled as they are to "normal" persons. Similarly, relationships have a major impact on biological treatments; patients are unlikely to comply with medication regimens when they lack faith in physicians and other caregivers.

Characteristics of the Case Management Relationship

Assuming that case management occurs in settings that allow personal involvement, the managerial relationship can be delineated by several characteristics that transcend differences in ideology, professional discipline, and agency setting:

First, clients suffering from ongoing and severe mental illness are often significantly impaired in their capacities to manage their own lives and sustain fulfilling social relationships. The impairments may involve a near total disability in many aspects of daily living or partial handicaps in circumscribed domains such as employment.

Second, case managers must address these deficits by functioning as intermediaries between client and environment. Like parents with their children, case managers assist clients in fulfilling physical and psychic needs while developing their own resources. A relational hierarchy is defined by the case manager's greater expertise in negotiating environmental factors.

Third, while serving as "travel guides" for clients with significant impairments in community functioning, case managers simultaneously function as "travel companions" (Deitchman, 1980) and ease the loneliness of the client (Sheppard, 1963). In so doing, case managers often attempt to obscure the hierarchical dimension in the managerial relationship (Estroff, 1981). As Sheppard (1963) has eloquently illustrated, these obfuscations sometimes enable narcissistically fragile clients to

receive valuable assistance. In other instances, they elicit confusion and resentment about staff motives.

Fourth, in contrast with traditional psychotherapy, case management interventions respond to client need in a variety of settings (home, office, community, and so on) and intervals (daily, weekly, monthly). Duration of contact may range from a brief phone call to several hours spent negotiating the social welfare bureaucracy or moving the client to a new residence.

Fifth, the clients rarely seek out case management services because they tend to have little faith in human relationships and often cannot articulate their needs effectively. Case managers frequently endure lengthy periods of making a larger investment in the managerial relationships than their clients do.

Sixth, 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 psychic and a physical dimension, as case managers provide both emotional and environmental support. Although societal and professional value systems often focus on pathological forms of dependency (Kanter, 1985b), Deitchman (1980) has noted that case managers "must teach clients that there is a form of dependency that is necessary, normal, and constructive" (p. 789). As will be discussed later in this chapter, coping with the dependency inherent in the case management relationship presents a major challenge for both clients and case managers.

Seventh, unlike other mental health interventions based on privacy and confidentiality, the majority of 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 manager's judgment and tact about the handling of these external contacts. Case managers also surrender privacy in their professional activities; in contrast with psychotherapy, their work may be scrutinized by a network of concerned parties.

Eighth, although most approaches to case management stress the centrality of client self-determination (Rapp and Chamberlain, 1985), case managers are inevitably subjected to social pressures (conveyed through their agency or other funding source) to place social needs before a client's wishes. These societal interests include a public health (and economic) goal of reducing recidivism and hospital tenure and a social control goal of reducing deviant social behavior. Case management programs are often contacted by politicians complaining about persons alleged to be public nuisances. These conflicting agendas frequently affect the managerial relationship, as staff members are torn between loyalties

to clients and agency mandates. A common example of this phenomenon is when case managers attempt to maintain in the community clients who would prefer to remain hospitalized (Drake and Wallach, 1988).

Transference in the Managerial Relationship

Against this background of the complex managerial relationship, transference reactions—the human tendency to perceive and interpret interpersonal situations as a repetition of prior experience—permeate interactions with mentally ill clients. As Searles (1979, 1982) and Gill (1983) have noted, transference reactions always crystallize around the actual characteristics and behaviors of significant others; they are not merely fantasy creations arising solely from the unconscious. For example, the client might interpret a case manager's compliment as an erotic overture. Although such distortions occur in all human relationships, they pervade the interpersonal relations of persons with psychotic disturbances and severe personality disorders.

Transference reactions, especially those associated with psychotic conditions, are usually not accurate reflections of earlier interpersonal experiences. For example, when a paranoid client repeatedly perceives caregivers as having persecutory motives, such distortions are not necessarily evidence of a history of parental abuse. As Arieti (1974) has elaborated, psychotic patients with distorted perceptions of significant past relationships as well as current ones frequently vilify their parents. However, these memories, like transference reactions, also contain kernels of reality, as all parents behave at times in a punitive, hostile, or inappropriate manner.

The key to understanding and addressing transference reactions involves an appreciation of their reality-based components (Gill, 1983). Although psychotherapists occupy a symbolic parental role, case managers fulfill many real parental functions in that they provide both physical and psychic support. Conflicts often ensue when case manager (parent) and client (child) disagree in their assessment of client capabilities. They may disagree about whether the client is able to manage his or her own apartment or administer his or her own medication. Working with clients who present fluctuating levels of competence, case managers often feel uncertain about the client's level of maturity. Like squabbling parents, caregivers (case managers, psychiatrists, families, residential counselors, and so on) frequently argue among themselves about what can be expected from their clients (Anscombe, 1986).

As transference reactions in case management involve a response to this diverse array of activities and interactions, it is often difficult to determine which experiences precipitated these responses. The following vignette illustrates this difficulty.

Case Vignette: Transference Reactions in a Case Management Relationship

Ms. A., age thirty, diagnosed as having a severe borderline personality disorder, had been hospitalized more than fifteen times in four states. After months of failed attempts to find a place for her in the community, the case manager finally established a relationship with her after her commitment to a local hospital. Working together, Ms. A. and the case manager painstakingly developed a placement in a supportive residential program. In spite of massive support, Ms. A. had to be rehospitalized three days after discharge. On her return to the hospital, Ms. A. adamantly refused to have contact with the case manager. She also refused to discuss her reasons for this dramatic shift in her attitude. This impasse interfered with the formulation of new discharge plans. Several months later, Ms. A. commented to her hospital social worker that she considered her case manager unprofessional because he had accepted phone calls from her at home during her brief community tenure. Before this perception could be explored, the patient signed herself out of the hospital, planning to leave the state.

Apparently, Ms. A.'s fear of becoming romantically or sexually involved with the case manager (especially during community tenure) played a significant role in her wish to sever contact with him. Since her case history revealed a series of relationships with men in which offers of assistance concealed romantic motives, it is easy to understand her tendency to misinterpret the case manager's supportiveness. Had she remained in the hospital, this difficulty could have been addressed. (Although transferring Ms. A. to a female case manager might appear to be a simple solution, her same-sex relationships were complicated by her tendency to view women as sexual rivals.)

As can be noted in this vignette, negative transference reactions often have their origin in positive responses to the dependency and friendship inherent in the managerial relationship. Such clients are embroiled in a need-fear dilemma (Burnham, Gladstone, and Gibson, 1969), where they fantasize that the love and care they crave will be accompanied by disappointment, rejection, domination, and abuse. Understanding these dynamics can help us understand the attention-seeking, help-rejecting behavior that we frequently encounter.

To avoid provoking unmanageable responses to these emerging positive feelings, case managers may have to suppress their friendly inclinations by initially approaching the client with more professional interest than warmth. Fromm-Reichmann (1959) warned therapists against openly acknowledging positive transference before the client indicates that he or she is ready to discuss it and suggested that therapists "may easily freeze to death what has just begun to grow and so destroy any

further possibility of therapy" (p. 125). This advice is equally appropriate for the managerial relationship.

Case managers also commonly encounter transference reactions around issues of control. Attempts to provide clients with some stability and structure are often perceived as attempts to control them. For example, Ms. A. responded angrily when staff members attempted to address her history of medication noncompliance by treating her with injectible medications. She responded to this attempt to promote stability by discussing delusions about gangsters who had kidnapped her and injected into her arm a substance that caused her to lose her mind.

In other situations, these reactions crystallize around involuntary commitment proceedings, money management, or expectations to participate in day activities. Regardless of the case manager's therapeutic motives or even the client's own expressed wishes, the case manager may be viewed as a controlling tyrant who aggrandizes his or her ego at the expense of the client. Logically confronting these perceptions usually has little positive impact and often exacerbates tensions, as clients experience case managers as questioning their judgment or sanity.

Again, acknowledging the kernels of reality in these reactions is an important first step in effective intervention. Although case managers consciously attempt to avoid the rigid hierarchies common to hospital milieus, casual dress and the use of first names (Estroff, 1981) do not eliminate the elements of authority implicit in case management (Will, 1968; Mendel, 1970; Diamond and Wikler, 1985). Besides participating in the expanding use of outpatient commitment (Applebaum, 1986), case managers often act as petitioners for inpatient commitment, as formal or informal financial guardians, and as dispensers of medication. All of these activities, for better or worse, involve authoritative components that cannot be eliminated by professing allegiance to an ideal of client self-determination.

Countertransference in the Managerial Relationship

Although burnout is frequently discussed in case management literature, countertransference reactions are rarely acknowledged. Burnout is often conceptualized as a staff member's response to an unsupportive work environment and inadequate resources (Mendel, 1979); countertransference, however, involves a reaction to the interpersonal relationship between staff members and clients. The psychoanalytic literature on countertransference with schizophrenic patients arises from work in private psychiatric hospitals, where external pressures were minimal, and it gives us a unique opportunity to understand staff reactions to these patients apart from the external stresses of community settings (Searles, 1979).

Thus, on the one hand, case managers often encounter a lack of appro-

priate residential care, which leaves them feeling helpless, guilty, and angry, and on the other hand, they commonly encounter clients who are hostile, rejecting, uncommunicative, and unappreciative, which also causes them to feel helpless, guilty, and angry. There may be biological and psychological explanations for these characteristics; nonetheless, no matter how hard case managers try to understand and accept their clients, they still have undesired emotional reactions. This phenomenon was illustrated in Winnicott's (1975) seminal 1947 paper, "Hate in the Countertransference," in which he enumerated the many reasons why "normal" mothers hate the helpless infants they also love so much. More than anyone else, Harold Searles (1979) has explored the vicissitudes of countertransference reactions with severely impaired, schizophrenic patients. Although his findings were derived from intensive psychotherapeutic relationships within a hospital setting, his observations have equal relevance for case managers and other caregivers (I have substituted the term *caregivers* for *therapists*):

1. Caregivers should recognize that the gratifications of chronic psychosis are quite sobering, "not only the myriad regressive gratifications of a positive sort . . . but also those which derive from the [patient's] large-scale obliviousness of and apartness from such mundane daily-life sources of frustration, despair, and grief as are involved in the maintenance of a marital relationship, the rearing of children, the paying of taxes, the living in the clear knowledge of the inevitability of one's own death" (Searles, 1979, p. 590). There is a "basic philosophical question of whether sanity or psychosis is the more desirable mode of existence" (p. 590). Unrealistic rescue fantasies may arise when caregivers defend against their envy of the aforementioned gratifications and simply assume that patients view recovery as advantageous.

2. Clients may derive passive aggressive, sadistic gratifications in response to the dedicated efforts of their caregivers. In other words, some clients may enjoy watching a caregiver helplessly struggle to assist them, much as school children enjoy passively tormenting a frustrated teacher by "forgetting" what has been taught.

3. Caregivers may project unconscious omnipotent longings onto their clients, whom they then view as having limitless potential. In so doing, these hopeful caregivers give clients the power to disappoint them.

4. Caregivers often repress their own ambivalence about involvement with their clients and project these doubts back onto clients.

5. Overly helpful caregivers are often defending against unconscious feelings of envy and anger toward clients, who are also unable to deal with these emotions.

6. Caregivers should not attempt to constantly maintain a stance of benevolent neutrality with schizophrenic clients. Efforts to be "neutral" may elicit provocative behaviors that test the caregiver's personal commitment.

7. Limit setting is an essential part of treatment; caregivers must acknowledge their own limitations and abandon omnipotent fantasies of benevolently enduring all client behavior. Clients may respond to limits by calling caregivers insensitive, obsessive, or even cruel. Such responses may evoke guilt and shame and induce caregivers to abandon their limits.

While recognizing that each of these observations does not apply to all relationships with mentally ill persons, Searles's provocative ideas are likely to unsettle case managers and other caregivers who view their clients as innocent victims of biological deficits and an uncaring society. These case managers may argue that their clients sincerely want to recover and do not intend to upset their caregivers.

Searles acknowledges this perspective but notes that unconscious motives (in conflict with conscious intentions) are more difficult to address than conscious motives. If we accept the universality of core human conflicts (independence versus dependence, intimacy versus isolation, activity versus passivity), we observe that mentally ill persons find it more difficult than others to remain aware of these conflicts while struggling with their ambivalence (Schulz, 1984).

The assessment of motivation and volition is intertwined with any discussion of countertransference reactions. Staff conflicts over whether clients "can't" or whether they simply "won't" often reflect differences in countertransference reactions (Anscombe, 1986). Frequently, one caregiver responds sympathetically and maternally to a client viewed as inept and helpless, while another responds angrily to the same client, who is viewed as greedy and manipulative. Often, each of these reactions may be understandable reactions to aspects of the client's personality elicited by different relationships and situations.

Consultation is often required to assist case managers to integrate these perceptions and tolerate the intense ambivalence found in successful parental relationships (Climo, 1983). Although the negative impact of a lack of compassion or sympathy is self-evident, the harmful effects of repressed anger and envy are more insidious. When case managers express an attitude of unconditional acceptance and understanding, they unwittingly dehumanize their clients by implying that they have no capacity for self-control (Kanter, 1984). In repressing their own negative affects, these staff members may reflect their clients' fears that such emotions cannot be appropriately modulated and expressed. Furthermore, they may unconsciously act out these feelings by distancing themselves from their clients, a response that may precipitate self-destructive behaviors in suicidal persons (Maltzberger and Buie, 1974). More often, though, such defensive reactions cause case managers to abandon clinical practice with this population, a significant factor in the high rates of staff turnover in community programs (Mendel, 1979).

Countertransference Reactions to Client Dependency

Many case managers find it more difficult to cope with their clients' intense dependent yearnings than with their aggressive and manipulative behaviors. Although aggressive behaviors evoke unambivalent angry responses, client dependency evokes a complex mixture of compassion, guilt, and anger. In coping with client dependency, case managers are affected by both external and internal conflicts. Case managers are expected to gratify their clients' needs while pressuring them to become more independent. Similarly, they are affected by their own unresolved conflicts around their own dependency needs. Many case managers are young adults struggling with their own emancipation from their mothers and fathers; to facilitate this process, they may repress their own dependent yearnings. Finally, all case managers are subject to cultural values that now find dependent wishes more shameful than sexual wishes.

Addressing client dependency wishes is a complex undertaking even when it is unaffected by personal conflicts. For example, let us consider a client's request for transportation to a dental appointment. The case manager may evaluate this request from several perspectives. First, is the office nearby or accessible by public transportation? Is the client familiar with public transportation? Does the client have other acquaintances who could provide a ride? In other words, does the request reflect an actual physical need or does it also reflect psychic needs? If the former is the main consideration, the case manager may arrange for a ride or help the client more carefully explore options. However, if the request reflects psychic concerns, different questions must be asked. Does the request reflect an emerging trust in the case manager and suggest a need for support during an anxiety-provoking experience? Alternatively, does it reflect a depleting symbiotic attachment in which the case manager feels deluged by the client's constant demands? In the first case, the case manager may provide transportation personally, even when other resources are available. In the latter, the client should be firmly encouraged to explore alternative resources.

Of course, in clinical practice, physical and psychic factors interact in complex patterns that cannot be isolated from the subjective responses of case managers. As the developing child learns to accept scheduled feedings to accommodate parental needs, mentally ill clients often learn new skills to lighten their caregivers' burdens. In most managerial relationships, support is titrated in response to client needs (Kanter, 1987) and, over time, it is reduced considerably (Harding and others, 1987).

Often, countertransference responses can provide case managers with guidelines for titrating support. Maternal feelings can help caregivers patiently tolerate prolonged periods of unresponsiveness, and irritable or angry reactions can provide an impetus for needed limit setting. How-

ever, maternal responses may involve a defense against angry feelings elicited by exploitation, whereas angry feelings may help case managers avoid more personal involvements. Again, supervision and consultation are needed to help case managers understand and make use of these reactions.

A common difficulty arises when case managers overidentify with their clients, who are unable to tolerate their dependent wishes. Hurrying toward an illusory goal of independence, such clients often engage inexperienced staff members in establishing ambitious plans. Progress may ensue rapidly for several months, and the case manager may become intoxicated with a sense of therapeutic potency. However, this pseudocolaboration frequently blinds the case manager to the client's unconscious dependent yearnings, which resurface when "independence" seems imminent. The dynamic significance of the subsequent relapse may be totally ignored, and the case manager may repeat the pattern.

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

Externalization of Conflict

When case managers experience clients as "resistant," intrapsychic conflicts have often become externalized in the case management relationship. For example, one client indicated an unambivalent wish for employment but rejected every suggestion that might help him work toward that goal. Alternatively, another client left the hospital appreciative of the positive impact of neuroleptic medication. Several months later, she adamantly expressed an intention to discontinue this treatment. In both of these examples, client ambivalence about employment and medication compliance, respectively, became externalized in the relationship with the case manager. Instead of reflecting on their internal dialogues, clients often become vehement exponents for one side of these psychic conflicts while the other side is articulated by an unwitting caregiver.

In some instances, these conflicts can involve a number of caregivers who reflect different sides of a client's ambivalence. In one case, a case manager argued with the day-program staff about whether a client was capable of competitive employment. Sharing their respective interactions, they learned that the client spent many of his contacts with the case

manager reflecting on his prior employment history, although he never discussed this topic in the day program. His internal conflict around employment was then enacted in the relationship between caregivers, rather than between staff and client.

Conclusion

Regardless of the case manager's attempts to establish collaborative, egalitarian relationships with mentally ill clients, transference and countertransference responses to case management's inherently parental functions complicate interactions between case managers and clients. Case managers are needed because they have the hindsight, foresight, and judgment to assist psychiatrically impaired persons in coping effectively with a complex environment. When these clients are effectively managing their own lives after extended periods of intervention (Harding, Zubin, and Strauss, 1987), the case management relationship is terminated, and both parties can then determine whether any sort of ongoing friendship is appropriate. By maintaining a conscious awareness of the hierarchical dimension of the managerial relationship, case managers can more honestly interact with clients and negotiate respectfully about the provision of both physical and psychic support.

Finally, as clients discover that their case managers are neither omnipotent tyrants nor fountains of unlimited support and unconditional acceptance, a process of internalization occurs wherein the ego functions performed by case managers are incorporated into the clients' psychic and behavioral repertoires (Harris and Bergman, 1987). As may be observed with children, these identificatory processes facilitate the development of self-regulatory capacities and interpersonal skills at a much faster pace than pedagogical approaches that attempt to teach living skills in isolation (Tolpin, 1971). Children rarely learn judgment in social situations from didactic interventions; most often, they carefully observe parental figures and peers, imitate their behaviors, and selectively internalize their wisdom. By more carefully examining how caregiving relationships promote the capacity of children to interact successfully with their environments, we can maximize the effectiveness of our case management relationships with mentally ill adults.

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