Supervising the Countertransference Reactions of Case Managers

Joseph Walsh

ABSTRACT. Most of the literature on countertransference in clinical social work practice is based on assumptions that the relationship between the client and practitioner is structured and formal. These assumptions do not apply in community-based case management practice, where the social worker and client interact in a variety of settings and circumstances. Additionally, the complex problems of clients who have serious mental illnesses may evoke a range of conscious and unconscious reactions from social workers that must be acknowledged for appropriate intervention to occur. In this paper key principles for the supervisor's recognition and management of countertransference are presented and discussed. Case illustrations are included. *[Article copies available for a fee from The Haworth Document Delivery Service: 1-800-HAWORTH. E-mail address: <docdelivery@haworthpress.com> Website: <http://www.HaworthPress.com> © 2002 by The Haworth Press, Inc. All rights reserved.]*

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The complex problems and interpersonal challenges faced by clients with serious mental illnesses tend to evoke a range of conscious and un-

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conscious reactions from their social workers (Brody & Farber, 1996). These countertransference reactions are intensified in community-based case management, where the parties may interact in a variety of settings (such as an agency, the client's home, or a public place) and circumstances (such as an individual counseling session, family meeting, service linkage, or mediation session with an employer) (Deutsch & Munich, 1996). The public dimension of case management further complicates the social worker's relationship with the client, with social and administrative pressures on the worker to achieve certain outcomes that may or may not be consistent with the client's goals (Kanter, 1995). In this paper principles for the clinical supervisor's recognition and management of countertransference reactions are presented and discussed. Helping the social worker to acknowledge and process these feelings can help him or her maintain a focus on client-centered goals, rather than focusing (perhaps unconsciously) on his or her own feelings about and wishes for the client.

COUNTERTRANSFERENCE

The concepts of transference and countertransference emerged within psychodynamic theory during the early 1900s (Gabbard, 1995). The terms carry a negative connotation with some practitioners who believe that psychodynamic ideas are irrelevant to clinical practice in the 21st century. Still, they call attention to subtle aspects of the worker-client relationship and their effects on the intervention process and thus remain critically important. *Transference* was initially defined as a client's projection of feelings, thoughts, and wishes onto the social worker, who comes to represent a person from the client's past, such as a parent, sibling, other relative, or teacher (Jacobs, 1999). The concept has been expanded to refer to *all* client reactions, conscious and unconscious, to a clinical practitioner. These include reactions based on patterns of interaction with similar types of people in the client's past and on here- and-now characteristics of the social worker. Positive transferences are those in which the client is attracted to the practitioner, which can facilitate the clinical engagement process. Negative transferences, characterized by such feelings as anger, distrust, or fear, can impede the client's participation in the intervention.

Countertransference was initially defined as a clinical worker's unconscious reactions to the client's transference (Jacobs, 1999; Kocan, 1988). Contemporary definitions, however, assume that some of the

practitioner's reactions exist independently of the client's feelings. Today the countertransference concept incorporates several meanings, three of which are listed below (Kocan, 1988):

- The conscious and unconscious reactions of a social worker to a client's transference projections (the classical definition)
- The effects of the social worker's conscious and unconscious needs and wishes, based on personal history, on his or her understanding of the client
- The specific and generally conscious attitudes and tendencies that a social worker has about a range of clients (such as being drawn to working with children or having an aversion to older adults)

The focus in this paper is on the second and third definitions, as they are most consistent with contemporary uses of the term (Gabbard, 1995). Positive countertransference reflects a practitioner's attraction to the client, but this can be problematic as well as facilitative of the intervention if the social worker loses the ability to maintain a sense of objectivity about the client's situation. Negative countertransference is almost always a problem for the intervention, as it implies that the social worker is emotionally repelled from the client for some reason and therefore assumes an inappropriate clinical distance.

Transference and countertransference should be taken into account in every clinical encounter. Reflecting on emotional reactions helps the social worker better understand the rationales behind his or her actions, and thus make better clinical decisions. The interpersonal processes inherent in long-term clinical intervention are such that a practitioner should expect to experience mixed emotions with almost any client (Tyrell, Dozier, Teague, & Fallot, 1999). It is one of the supervisor's major responsibilities to help the social worker recognize and process all of these feelings, positive and negative, to enhance the achievement of positive outcomes for the social worker and client.

REFLECTING ON COUNTERTRANSFERENCE PATTERNS

Analyzing the social worker's countertransference patterns with clients who have mental illnesses can be facilitated by a degree of self-disclosure from the clinical supervisor. The purpose of this practice is to establish a tone of acceptance of the social worker's (in the role

of case manager) feelings about clients. For example, I offer the following self-disclosures to my own staff:

- I enjoy witnessing odd behavior in other people. Perhaps I benefit from the vicarious adventure it provides, since my own lifestyle is conventional.
- My family of origin did not share feelings openly. I like clients whom I can see for long periods because I can develop close relationships with them. This can be problematic, however, as it may prompt me to resist a client's desire for a superficial relationship, or to resist ending our work when appropriate.
- I do not need to see rapid progress in a client. I enjoy the relationship by itself and feel rewarded by a client's incremental improvements. But this can also be a problem if I do not maintain reasonable change expectations.
- I enjoy working with clients who are considered by my peers to have a limited capacity for change. I like the challenge of proving them wrong. Of course, sometimes my colleagues have good judgment about the limitations of clients, and my own hopes can be unrealistic.

To model the relevance of self-awareness in practice, the supervisor must be open to describing instances in which his or her patterns have been either helpful or problematic. For example, the supervisor can recount how the last issue listed above enabled him or her to patiently connect with a client who had been found inaccessible by other staff. On the other hand, the same issue may contribute to a failed clinical intervention, characterized by a continual excusing of a client's negative behaviors in an effort to facilitate changes that may not be realistic. The supervisor illustrates in this way that there are no appropriate or inappropriate countertransference reactions, but that they *all* need to be examined for their influence on the clinical intervention process.

Common Transferences

Many common and potentially problematic countertransferences are noted in the literature (Hepworth, Rooney, & Larsen, 1997; Kocan, 1988; Schoenwolf, 1993). The supervisor may provide such a list to case managers as a means of normalizing the issue.

- Having a need for clients to be dependent. In this case the social worker may look to clients for fulfillment of this need.

- Needing to be liked by clients. The social worker may try too hard to please a client, be hurt by a client's criticisms, or have negative reactions to clients who are not emotionally forthcoming.
- Wanting to feel like an expert to an extent that a client's ideas are devalued.
- Needing to control client/practitioner relationships. The social worker may discourage a client's deviations from established relationship patterns.
- Demonstrating too much curiosity about the details of a client's life.
- Tending to be aggressive and thus confrontational with clients, or reacting negatively to clients who are assertive.
- Being uncomfortable with certain types of emotional expression (for example, anger or tenderness) and thus suppressing those feelings in clients.
- Over-identifying with clients whose problems are similar to one's own. The social worker in those situations may be blinded to the part that clients play in sustaining their problems.
- Encouraging clients' blanket condemnations of authority figures. This is particularly common among young professionals who are separating from parent figures.
- Idealizing clients, based on strong positive feelings, and possibly setting unrealistic goals for them.

RELATIONSHIP CHALLENGES WITH CLIENTS IN CASE MANAGEMENT

To understand the development of countertransferences in clinical case management, it is important for the supervisor to consider elements of the case manager's relationship with the client who has serious mental illness. While many of these elements, as summarized by Werbart (1997), might apply to other groups of clients, they tend to be more pervasive with clients who have serious mental illnesses.

The client enters treatment with ambivalence about goals and skepticism of the social worker's potential as a helper. The client has difficulty managing relationships, and has learned from experience that others are likely to reject or devalue him or her. With a tendency to project negative feelings, the client may feel anger toward the worker, and perceive his or her intentions as harmful. The client may be lonely, but feel so anxious about the stress associated with increased social activity

that isolation is in many ways preferable. The client may initially reject help and only in time begin to internalize the case manager's modeling of new behaviors into his or her behavioral repertoire (Harris & Bergman, 1988). The client may eventually come to value the worker's directives as he or she the client fears taking initiatives, but this will likely lead to the client's disappointment when the worker's limitations become evident (Minkoff, 1987).

The case manager may also experience particular reactions to the client. A certain amount of "magical omnipotence," the social worker's conviction that he or she will help the client improve dramatically despite the existence of severe disabilities, is helpful for preserving a positive attitude when working with persons who have serious mental illness (Savage, 1987). Still, when not monitored this can be problematic, resulting in exaggerated reports of client progress and an accumulation of unconscious anger. Most countertransference problems when working with clients who have serious mental illness, however, are related to an absence of *identification*, or the inability to perceive the client as having qualities in common with oneself. If the case manager cannot identify with the client, he or she cannot understand the client, and will subsequently feel anxious and detached. Normal feelings of guilt may arise, although they may be denied. On the other hand, if the social worker does identify and empathize with the client, he or she will experience the client's distress. The case manager may defuse these feelings through excessive tenderness, or defend against feelings of helplessness by trying to facilitate unrealistic changes (Kanter, 1988).

Many case managers maintain an interpersonal distance from their clients. This may be an appropriate stance for establishing therapeutic boundaries, but might also represent negative countertransference reactions. The case manager may react negatively to the client's appearance, passivity, lack of motivation, noncompliance, manipulative behaviors toward others, poor hygiene, and other behaviors which are contrary to the worker's values (Novalis, Rojcewicz, & Peele, 1993). The case manager may experience anger toward clients who appear to be dependent, entitled, or self-destructive (Mehlman & Glickauf-Hughes, 1994). The case manager may also be uncomfortable with the need to be more active than is typical with other types of clients, or with the strength of the client's dependence (Kanter, 1995). The worker may defend against frustration with slow client change by projecting ambivalence onto the client or blaming service inadequacy for the client's problems. Positive worker reactions that must be monitored include over-devotion to, and over-involvement with, the client. With these feelings the case man-

ager may have difficulty recognizing the client's right to self-determination or letting go as the client detaches from the relationship.

The earlier list included *general interpersonal patterns* that case managers bring to their work with clients. What follows are signs of common countertransference reactions to the *specific behaviors* of clients, with examples (Hepworth, Rooney, & Larsen, 1997; Kanter, 1996; Schoenwolf, 1993):

- Dreading or eagerly anticipating seeing a client. The case manager with a need to be controlling of others may dread an upcoming visit from a client who is protective of her autonomy in decision-making, because he anticipates a power struggle.
- Responding with differential promptness to clients' phone messages or failed appointments. The case manager who enjoys feeling needed may call back a cooperative client immediately, but wait several days or even weeks to get in touch with a client perceived as resistant.
- Thinking excessively about a client during and after agency hours. This may indicate too much interest in that client. There are many possible reasons for such a preoccupation, one of which might be sexual attraction.
- Having trouble understanding a client's conflicts. A case manager who drinks alcohol may have trouble seeing that a client's alcohol abuse is problematic, particularly if the worker is in denial about his own level of use.
- Feeling bored with a client. This may reflect a need to see change occur at a faster pace than a client with schizophrenia can reasonably sustain.
- Feeling angry with a client for nonspecific reasons. As one example, a young case manager may project onto a client his own need to break away from his family of origin. If the client does not do so, the case manager may feel anger but be unaware of its source.
- Being unduly impressed with a client. Many people with serious mental illnesses have strengths and talents about which the case manager may be envious. The worker who is a frustrated musician may be extremely impressed with the musical accomplishments of a client. This might result in an idealization that impedes the case manager's ability to help the client achieve more basic goals.
- Feeling defensive or hurt by a client's criticisms may be related to a social worker's general need to be liked or needed by clients.
- Doing tasks for clients that they are capable of doing for themselves. Social workers, particularly in case management programs

that do not clarify staff/client boundaries, may be inclined to assist favored clients with activities of daily living. A case manager may enable dependent behavior by assuming responsibility to locate housing for a client who is capable of doing so without assistance.
- Feeling uncomfortable about discussing certain topics with a client. A case manager who is uncomfortable discussing sex may steer a client away from topics such as sex education and safe sex.

Attending to the above issues in supervision is critical because many authors who have written about clinical practice *and* case management argue that the development of a positive relationship is a prerequisite to the social worker's ability to realistically assess a client's growth potential (e.g., Floersch, 2002; Walsh, 2000). Sometimes called a "working alliance," this relationship is characterized by the social worker's understanding of the client's strengths and limitations, and the worker's awareness of his or her feelings about the client (Horvath & Greenberg, 1994). Further, the nature of the relationship, and the social worker's countertransference, may change over time.

MANAGING COUNTERTRANSFERENCE

The basic principle for the supervisor's constructive processing of countertransference reactions is to *routinely* discuss them with the case manager. The case manager should receive regular clinical supervision toward that end, either individually or in a team setting. The social worker's confidential relationships with professional peers can also be helpful. Described below are specific recommendations for clinical supervisors (Gabbard, 1995: Hepworth, Rooney, & Larsen, 2002; Kocan, 1988; Minkoff, 1987; Nehls, 2000; Savage, 1987). The first four of these apply to all types of clients, but the other five are more specific to working with clients who have mental illness.

- Be proactive in identifying and evaluating countertransference concerns of case managers. Prepare them to expect a range of emotional reactions to their clients, and help them differentiate normal reactions from feelings that may be exaggerated.
- Pursue discussions of feelings about clients with guided exploration rather than cross-examination (Gutheil & Gabbard, 1998). The former practice encourages discussion, while the latter practice puts the worker on the defensive.

- Help the case manager be aware of his or her own emotional and physical needs, and to be wary of obtaining too much personal gratification from a client.
- Selectively use self-disclosure with the case manager to process countertransference feelings in a therapeutic manner. It is important for the worker to learn that negative feelings are universal and can be contained.

The next five guidelines have particular relevance with clients who have serious mental illness:

- Promote clarity in staff roles. Community-based case management is stressful in part because boundaries are often blurred. With role clarity, case managers have an easier time determining what behaviors are or are not appropriate in their work with clients.
- Help the case manager set clear boundaries with clients at the beginning of those relationships about what his or her roles and activities *will* and *will not* include. Consistency of expectations is an excellent way to track unusual behaviors or feelings that arise in either person.
- Help the case manager clarify boundaries with the client over time, as they will change. As examples, the case manager and client may decide that home visits, not made previously, are now indicated, or that they will address a broader or narrower scope of the client's issues than was done initially.
- Focus with case managers on clients who have a tendency to be manipulative as a means of establishing influence. In case management the social worker has an active role, attending to some tasks on behalf of clients. Determining what clients should be expected to do for themselves can be difficult, and if the case manager feels manipulated, he or she may develop negative feelings about a client.
- Help the worker understand the client's cultural and community standards of behavior, so as to appropriately assess behavior in those contexts (Herlihy & Corey, 1997). This relates to the public dimension of case management. Case managers spend much time within the geographic and social milieus of clients. These may be quite different from surroundings with which the social worker is familiar and give rise to certain reactions.

Three supervisory themes emerge from the above list. Most prominently, case managers should receive regular *clinical* (as well as administrative/linkage/referral) supervision, because the range of countertransference issues they experience is no less broad than that of any other clinical practitioner. This range may be broader, in fact, because their reactions can relate to client behaviors *and* environmental challenges such as frustrations with linkage efforts and the quality of interactions with other resource providers. Normalizing responses and accentuating areas of effectiveness can do much to counteract the worker's frustrations. The supervisor's inquiries about how assessments were done, plans developed, and interventions implemented should include reference to how the social worker's feelings are influencing the process.

A second theme is that the interdisciplinary nature of case management can create boundary confusion about professional roles and responsibilities and, in so doing, affect countertransference. The supervisor's ability to help the case manager clarify these boundaries over time (as they may change) will help him or her to maintain a focus on client interactions and be less emotionally reactive, as tends to occur in an atmosphere of ambiguity. The supervisor should routinely inquire about the case manager's quality of interactions with other providers, not only to evaluate them but also to determine if they are affecting the clinical relationship. That is, the social worker may project negative feelings onto the client in these circumstances (Goldstein, 1995).

The third supervisory theme relates to processing the impact of the client's community culture on the case manager. The community-based case manager will be participating in the client's social milieu, and when different from the case manager's familiar lifestyle, it will evoke more reactions than would occur if meeting in an agency office. The supervisor should routinely ask the case manager to describe the client's physical environments, the client's housing, where the client spends his or her time day to day, and the social worker's attitudes about these characteristics. These conversations will lead the case manager to reflect on the relationship in a fuller sense.

CASE ILLUSTRATIONS

The following two examples demonstrate how the above themes can be implemented. The nature of the interventions described below was strongly influenced by the worker's countertransference reactions. In

the first case the social worker's reactions contributed to a negative outcome, but in the second case the outcome was positive.

Nate

Jean worked with Nate for two years. He was 25 when they met and had paranoid schizophrenia. He was a loner, minimizing the stimulation that prompted his auditory hallucinations. Nate never seemed to like Jean, who seemed to be a primary outlet for his frustrations. Nate had a passive-aggressive personality style, outwardly cooperative with goals and objectives but then sabotaging them. He often missed appointments and failed to make promised calls. He often degraded Jean and said that she had an easy life.

While Jean tried not to be defensive, she became angry with Nate at times. She was well known by her colleagues to be especially comfortable with persons who had serious mental illnesses. Her clients sensed her empathy and usually responded by confiding in her. Nate's contrary attitude confused and frustrated her. Despite this, Jean and Nate worked together to stabilize his mood, minimize his symptoms, improve his social life, and get him into a vocational training program. They reached a point where Nate was ready to transfer to a case management team. He would have access to vocational and housing specialists, and begin a job in computer programming.

Nate saw his transfer from Jean as a sign of progress and shared no regrets about it. Jean was relieved too, as she had always felt uneasy about their relationship. Thus it was a surprise to her that, within one month of the transfer, Nate despaired about the stress of a new job and attempted suicide. He survived the overdose, but complained to his new case manager that he felt very alone. Nate did not feel close to his new staff and felt that Jean had abandoned him.

Presenting this case to her supervisor for the first time, Jean became aware that she had decided too quickly to transfer Nate. The supervisor suggested that a major source of Jean's satisfaction from working with clients was their positive regard for her, which was fine, but in this instance her anger at Nate's negativism contributed to her decision to transfer him. The supervisor helped Jean reflect on how her desire to be appreciated by clients could be an impediment to her practice at times. Nate's behavior after the transfer was an indication that he was more attached to Jean than she had thought. The supervisor suggested that Nate's manner with Jean might be an indication of his own transference pattern, that it might mirror his relationships with all significant people

in his life. Perhaps Nate was threatened by intimacy and used anger to maintain interpersonal distance. Thus, Nate's hostility was evidence of Jean's success at drawing him into a relationship. Contrary to Jean's assumptions, Nate's growth experiences may have been due to the stability and support he received from their relationship. Jean's own detachment contributed to her overlooking Nate's anxieties about the changes in his staff and intervention activities.

Jean was able to accept this input from her supervisor because it was processed in the context of his also recognizing the positive aspects of her work with him. Her countertransference issues would have been important for Jean to comprehend earlier because of her need to delicately titrate interventions with Nate. She needed to determine at what times Nate was ready for another step in his rehabilitation, when he needed to be restrained from moving too quickly, when he needed to be pushed, and when services should be withheld to encourage him to take initiatives. Bringing this case to her clinical supervisor earlier could have helped Jean to reflect on the extent to which her need to feel appreciated contributed to her detachment from Nate, and also the nature of Nate's transference. Jean's sensitivity to this issue may have helped Nate reconcile his own dilemma and helped her more carefully address his needs.

Robyn

Robyn was a 28-year-old single female with schizophrenia who lived with her younger sister. She was marginally functional, having been hospitalized with psychotic symptoms three times in the past two years. Were it not for her father's material and emotional support, she might have spent even more time in psychiatric hospitals. Robyn did not bathe, wash her clothes, or eat properly. She rarely initiated conversation, seeming lost in her thoughts. She sometimes said, in tears, "Life is too hard for me." At home Robyn did little but watch television. She went out every few days to shop or take walks.

John was assigned to provide Robyn with case management services. Most of John's colleagues thought Robyn was limited in her potential for growth, but he liked her immensely, much more so than the other helpers who came to know her. He was fascinated by the extent of her reality detachment and was encouraged by her tolerance of his company. John admitted liking people who were "strange" because he led such a conventional life himself. Because of his own interpersonal insecurities, John also felt good when he perceived that clients needed his

help. John presented Robyn with a modest intervention plan that she accepted. They met every two weeks at her condominium and either took a walk or went to lunch. John did not attempt to persuade her to accept medication or attend rehabilitation programs, although he hoped that she eventually would. John thought that she needed a relationship of acceptance above all else.

A positive relationship developed between them, evidenced not by her direct acknowledgement but by her ongoing willingness to meet with John. Still, for almost three months they had little verbal interaction. John initiated conversations, avoiding topics that she might perceive as threatening, but Robyn's responses were limited to a few sentences. Robyn still did not bathe or wash her clothes. She claimed to be eating well, but looked pale and thin. John assumed that her sister and father were attending to her material needs (she did not give him permission to talk with them). Eventually, Robyn began to talk vaguely about her anxieties. Over time John learned that she was terrified of death, abandonment by her family, physical injury, and the possibility of living in a hospital for the rest of her life. She was overwhelmed with anxiety in social situations and thus resented professionals who were eager for her to make changes in her routines. Robyn wanted to feel calmer, be rid of suicidal thoughts, and have several friends. She did not want a job or to be linked with social activities.

John and his supervisor discussed the fact that Robyn needed to experience a safe therapeutic climate before risking changes. John needed to accept her world rather than expect her to invest energy in his. Like many persons with schizophrenia, Robyn employed schizoid defenses, minimizing stimulation by avoidance, limited interpersonal contacts, and a structured routine. Had John initially pushed harder for Robyn to enter into formal programs, he may have lost her trust. While John felt good about his work with Robyn, his supervisor suggested after six months that John should encourage the client to take more responsibility for her self-care. The supervisor recognized that John was reluctant to do this, fearing that Robyn might react negatively to directives and stop working with him. His supervisor realized that John needed to find and maintain a delicate balance of supportive and more directive behaviors, and that part of John's reluctance was due to his countertransference rather than Robyn's clinical factors. John's total acceptance of Robyn had been a great strength of his work for those first three months, but now it was preventing him from helping the client move forward.

John was able to reflect on his supervisor's observations and to present his client with more concrete goal-focused plans. After six months, the

extent of Robyn's changes included her bathing weekly, occasionally washing her clothes, accepting medications from the agency psychiatrist (which had modest benefits), and allowing John to talk with her father. She still did not enter into formal rehabilitation activities. She worked toward her goal of making friends by practicing scripted conversations with store clerks, whom she viewed as non-threatening. While these may appear to be small gains, they were remarkable in the context of her functional limitations. She was not rehospitalized. Robyn was able to accept John's directives because of the strength of their relationship.

SUMMARY

Countertransference refers broadly to the effects of the social worker's conscious and unconscious needs, wishes, and attitudes on his or her understanding of clients. In case management practice, where long-term relationships with clients who have serious mental illnesses and multiple problems are common, countertransference should be consistently monitored through clinical supervision. This is because the quality of client/social worker relationships is significant to the process of effective intervention. Supervisors can monitor and process a case manager's countertransference by providing regular group or individual supervision, creating a safe environment for personal disclosure, normalizing the phenomenon, and proactively alerting social workers to common countertransference and relationship challenges with clients who have mental illness. The supervisor should inquire or comment about countertransference issues regularly, monitor how the interdisciplinary and public dimensions of case management affect the social worker's feelings about clients, and help the case manager develop a broad respect for clients' cultural and lifestyle differences. Two case illustrations demonstrated that countertransference can work in a negative or positive manner for a case manager and client. In the second vignette, when countertransference issues were discussed early, the social worker was able to make adjustments in the intervention that were beneficial to the client.

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