Caregiving in Case Management: An Application of Intrapsychic Humanism in the Case Management Setting

by Jeffrey J. Bulanda

Abstract

Case management has become an increasingly popular means of maintaining mentally ill adults in the community. This paper examines the role of the case manager and the importance of a guiding theoretical framework in conducting interventions using the case management model of treatment. The new psychology, intrapsychic humanism, is applied to the case management relationship using a case example from the author's fieldwork experience with a client suffering from mental illness. Intrapsychic humanism is particularly valuable in understanding the client's motives and developing a genuine caregiving relationship between the consumer and case manager.

Introduction

Case management services have increased in recent years with the commencement of a movement toward increasingly less restrictive services for homeless and mentally ill clients (Curtis & Hodge, 1994; Walsh, 2000). In addition, high profile legislature, such as Kendra's Law[1], has brought about a push for increased supervision of persons with mental illness and minimal social support. Indeed, "…case management is recognized as the 'glue' which holds together the continuum of services that are needed by individuals with severe mental disorders and has become a mainstay of state-of-the-art community mental health services" (Williams & Swartz, 1998, p. 299). With the increasing prominence of case management services, it is important to consider the various treatment models that can be useful in building the case manager-client relationship.

One such treatment model, intrapsychic humanism, has been applied to a number of clinical settings, including standard adult and child psychotherapy, residential centers for the mentally ill, and treatment centers for violent youth (Pieper & Pieper, 1992; Pieper & Pieper, 1999; Tyson, 2002; Tyson & Carroll, 2001). However, its applications have not yet been fully explored with regard to case management services provided to clients who are homeless and mentally ill. Thus, this paper will explore differences and similarities between psychotherapy and case management, explain the basic tenets of intrapsychic humanism, and consider applications of this theory to the social worker's role as a case manager.

Differences and Similarities between Psychotherapy and Case Management

Psychotherapy and case management involve different boundaries within the social worker-client relationship and, often times, hold different functions in the client's life. These differences between the psychotherapeutic and case management relationship can be conceptualized by four key themes of the case management relationship, first noted by Curtis and Hodges (1994) and further explicated by Williams and Swartz (1998).

First, case management relationships tend to be multidimensional in nature. The function of the case manager changes with the needs of the client. Duties may include advocacy, education, medication monitoring, crisis prevention, counseling, transportation, assistance with housing, assistance with entitlements, providing companionship, management of the client's finances, job-training, and psychosocial services which include training in social skills and self-maintenance (Johnsen et al., 1999; Curtis & Hodge, 1994). For instance, on a typical home visit, a case manager may help the client clean his or her apartment, assist in filling out paperwork to appeal a decision made by Medicaid, provide them with medication monitoring, deliver the client's weekly grocery check, and engage the client in conversation using supportive, active listening. Thus, it is necessary for a case manager to be flexible in his/her interventions with the client.

While a therapeutic relationship can be multidimensional (i.e. the therapist may make referrals or may advocate for a client), the therapist's functions tend to be more limited and focused than a case man-

[1] Kendra's law, set forth in Section 9.60 of the Mental Hygiene Law passed in New York, provides for assisted outpatient treatment for certain people with mental illness who, in the view of mental health professionals and the court, are unlikely to survive safely in the community without supervision. It was named after Kendra Webdale, a young woman who died in January 1999 after being pushed in front of a New York City subway train by a person who failed to take the medication prescribed for his mental illness.

ager. Throughout the course of their relationship, a therapist's primary function is to talk with the client in working through problems and psychopathologies. A case manager's function changes as frequently as the client's needs change. Case managers may also have more direct opportunities to educate their clients due to the setting. For example, a case manager will be able to teach a client how to cook a meal as they may have access to a kitchen in the client's apartment; a therapist would not have access to this teaching opportunity.

Another key difference between the case management and psychotherapeutic relationship is the amount of power held by the professional. A case manager tends to have more power over a client's life than a psychotherapist, especially over a client's basic needs such as money and housing. For instance, often, a case manager is the payee for his or her client; the case manager may determine how much money a client receives each week from their check. Case managers also hold power in making referrals to housing units and may have power in monitoring the client's medications. Psychotherapists, on the other hand, do not tend to have direct control over the client's basic needs.

Third, the amount of self-disclosure may also be different in a case management as opposed to a psychotherapeutic relationship. Interactions in a case management relationship tend to be less formal than in a psychotherapeutic relationship due, in large part, to the settings in which the respective interactions take place. Case managers tend to interact with clients in informal settings, i.e. the client's home, the case manager's vehicle, a coffee shop, or a public aid office; psychotherapists almost exclusively interact with clients in a formal office setting. Thus, in informal settings, there are increased opportunities for "small-talk," such as discussing a TV show playing at the client's home, the news, or the weather. In the process, a case manager may disclose what he/she enjoys watching on TV, his/her reactions to the news, as well as his/her outside interests. Despite the increased amount of self-disclosure in the case management relationship, it is expected that professional boundaries are maintained and the relationship is still one-sided - focused on the client.

Fourth, the case management relationship may include after-hours involvement, which is not usually seen in a psychotherapeutic relationship. This may involve conducting a home visit in the evening or on the weekend, taking the client to a meeting, such as Alcoholics Anonymous, at night, or taking a client on a social outing, such as a weekend rally for mental illness advocacy. A therapist, on the other hand, tends to keep more stringent business hours. It is expected that any case management activity occurring after business hours is relevant to the treatment plan of the client.

Despite differences between the two relationships, there are significant similarities between case management and psychotherapy (Carey, 1998). Both are relationship-based and both are one-sided, with the focus on the client and with clear professional boundaries. Further, both are committed to the welfare of the client and have the goal of improving the client's current level of intrapsychic and social functioning. Also, both use a psychosocial assessment in understanding the client's current level of functioning and in determining the best way to utilize the therapeutic or case management relationship. With the assessment, the therapist or the case manager will individualize treatment for the client in meeting their needs. Thus, a relationship-based intervention committed to the client's welfare and using an assessment and individualized treatment is utilized in both case management and psychotherapeutic relationships.

Further, it has been argued that case management relationships have a greater therapeutic component than is generally acknowledged. Williams and Swartz write, "The psychotherapeutic relationship is often a core aspect of case management, although almost paradoxically most case managers do not perform and do not think of themselves exclusively as psychotherapists" (1998, p. 305). Indeed, conversations over coffee or even while the case manager is driving the client to a therapist appointment may be more substantive and meaningful to the client than the actual conversations with the therapist. Since they clearly provide a therapeutic intervention with clients, case managers need to have an understanding of and access to key theoretical perspectives on human behavior and therapeutic intervention. One particularly helpful perspective is intrapsychic humanism.

Case Example

As the concepts of intrapsychic humanism are applied to the case management relationship, a case example will be utilized from the author's field work. The client, Tony, works with a Chicago-based Assertive Community Treatment (ACT) team comprised of eight case managers. All eight workers alternate visiting Tony at home twice a week. Tony also comes to the psychosocial rehabilitation day

program that is offered by the same agency. The author serves as Tony's primary case manager.

Tony[2] is a 52-year-old white male diagnosed with paranoid schizophrenia and has a history of homelessness. Tony's life has been devastated by loss. Tony never met his mother, who departed soon after his birth, and he has never been given an explanation for his mother's departure. While growing up, Tony lived with his father, his grandfather, his aunt, and two cousins. He reports an "average" childhood with an average number of friends and an average performance in school. Tony's first encounter with mental health professionals came when he had been traveling out-of-state and was arrested for public intoxication at age 21. His subsequent stay at a mental hospital lasted several days, at which time his father, grandfather, and uncle picked him up. This incident was never addressed within the family and Tony did not receive follow-up mental health care.

During his early 20s, Tony traveled throughout the United States, primarily by hitchhiking. During his travels he dreamt that his father was in the hospital. Tony immediately returned home to find his father hospitalized and diagnosed with paranoid schizophrenia. Tony moved in with his father and became his father's primary caretaker until his father died when Tony was 25. During this time, he also attended a junior college to obtain his associates degree. Tony states, "I really was trying to make something of my life." While in school, he reports dating many women, resulting in at least two children whom he never met. He regrets not being involved in his children's lives, saying that his actions were "rotten."

As he graduated from junior college, Tony married his first wife and attempted to start a contracting business, which failed after his first assignment. This marriage was also complicated by his wife's heroine addiction and her interfering parents. This marriage ended three years later when Tony's wife left him. He moved away again at age 30, holding a series of short-term jobs. During this time, Tony met and married his second wife. Also at age 30, Tony was hospitalized for a second time and was in and out of the hospital sporadically during the 10-year marriage. His marriage brought the birth of two daughters. This marriage was stressed because Tony and his family lived with his in-laws, which included a verbally abusive alcoholic father-in-law. The marriage ended when Tony's wife left him; he was 40-years-old.

After his marriage ended, Tony became suicidal and began hearing voices, "cursing heaven, earth, everything." He was placed in a residential living center for six months. For the next ten years, he traveled across the U.S. via hitchhiking. He had very limited contact with his daughters for fear of "being a burden." Tony most recently ended up in Chicago in July 2002 and originally did not plan on staying. He stayed at a shelter until he was arrested in the beginning of August for hugging a woman he did not know. He spent two months in the hospital and was discharged to a transitional living program at the end of September 2002, when ACT services began. Tony currently believes that he will die soon and that he is "damned to hell for not listening to the Lord." At the present time, Tony has no contact with his family.

Intrapsychic Humanism Applications to Case Management

Intrapsychic humanism is based on the premise that all individuals are born with an innate desire to experience pleasure in conflict-free caregiving relationships. However, many people have not experienced such a caregiving relationship and subsequently perceive their abusive or neglectful relationship with their parents as ideal. In idealizing that early relationship, they may have developed motives for painful experiences that have the unconscious meaning of pleasure. Thus, the therapeutic intervention involves the social worker providing the client with a conflict-free relationship with the aim that the client will eventually develop a consciously self-regulated and conflict free inner well-being (Pieper & Pieper, 1992; Pieper & Pieper, 1999; Tyson & Carroll, 2001; Tyson, 2002). The social worker practicing intrapsychic humanism will use an individualized treatment intervention that includes advocacy, concrete service provision, reflective listening, and a focus on the client's strengths in order to develop the capacity for self-caretaking (Tyson & Carroll, 2001).

The caregiving relationship promoted by intrapsychic humanism provides an unconditionally positive relationship, an intervention that has proven to be successful with homeless, mentally ill clients. Brun and Rapp write that "…one of the characteristics of being oppressed is having one's story buried under the forces of ignorance and stereotype" and that research has shown that clients respond positively to being asked about their strengths and being allowed to set the agenda of a discussion (2001, p. 278). Since

[2] All identifying information has be masked to maintain client confidentiality.

homeless mentally ill clients are dehumanized by the greater culture, a genuine caregiving relationship offers an opportunity to address their feelings of worthlessness and hopelessness.

Intrapsychic humanism can be applied to a case management relationship in a number of ways. The ultimate case management goal for many homeless mentally ill clients is to develop a capacity for autonomous self-caretaking needed for independent living and fulfilling lives - the same goal of intrapsychic humanism treatment. In addition, the case management relationship may provide more opportunities for caregiving than the standard psychotherapeutic relationship as the case manager ensures the client meets his/her basic needs and provides direct instruction on independent living skills such as cooking or laundry. It has been found that helping a client do laundry, go grocery shopping, or advocating for them in the community provides a nurturing experience and helps to develop the caregiving relationship between the social worker and client (Tyson & Carroll, 2001). Utilizing intrapsychic humanism, the case manager can gain greater insight into the client's healthy and unhealthy motives. Intrapsychic humanism describes three such motives, each of which leads to a particular kind of experience: motives for constructive pleasure, motives for self-destructive pleasure, and motives for self-destructive unpleasure. These three motives are always present in the client's mind; however, the client's previous relationship experiences determine which motive is the most dominant and pervasive (Tyson, 2002). Thus, self-destructive motives are likely to be manifested during experiences of pain and loss, while constructive motives are stimulated by a caregiving and meaningful relationship. These motives, along with other key concepts of intrapsychic humanism, will be further delineated and examples will be used based on interactions with the primary case example, Tony.

The first motive that the theory of intrapsychic humanism identifies is the motive for constructive pleasure. This motive operates when an individual takes part in self-caretaking behaviors and is necessary for therapeutic intervention to occur (Tyson, 2002). Generally, this motive is minimized for the homeless, mentally ill client who has probably experienced significant trauma; hence, this is the core motive that the case manager is trying to develop. Several examples of motives for self-caretaking that Tony has shown include complying with rules at his transitional living program and the case management team, going to the doctor and following the doctor's recommendations, asking the case manager for help to develop a low-salt diet, allowing case managers to take him out for coffee or lunch, and openly sharing his fears of going to hell and his regrets from the past.

The next motive to consider is the motive for self-destructive pleasure. This motive causes the client to seek experiences others would consider unpleasurable, but that to the client represent conscious pleasure (Tyson, 2002; Tyson & Carroll, 2001). An example of a self-destructive motive from Tony's past includes his alcohol abuse; fortunately, his self-caretaking motives overrode his motives for self-destructive pleasure as he has been sober for a number of years. Motives for self-destructive pleasure in the form of trying to obtain the case manager's approval can often interfere with the caregiving relationship (Tyson, 2002). For instance, consider the two examples of dialogue between Tony and his case manager.

#1

Case manager: *I have been looking forward to going out to lunch for your birthday all week!*

Tony: *Why? I don't have anything. Well, if you want, I have two pairs of shoes. You can have my other pair of shoes.*

#2

Tony: *People do not think about the lives they lead until it's too late. It's too late for me. God gave me the tools and I cursed the Holy Spirit. If I could do it all over again, I would read the bible, go to church and hand out pamphlets about the Lord to everyone on the streets. Are you listening to me? You still have hope. Are you going to read the Bible tonight? It's too late for me, but I want you to learn from my mistakes.*

Case manager: *Tony, I really appreciate you sharing your feelings with me. I think you gave both you and I a lot to think about.*

In both of these cases, Tony is trying to take care of the case manager by offering compensation for spending time with him and then by worrying about his case manager's faith. Both may seem pleasurable to Tony, but both obstruct the sharing of underlying pain and endanger the one-sided therapeutic relationship. Instead of utilizing the relationship to reflect on his own inner pain, Tony is switching the attention to the caseworker and concerns about the worker's

well-being.

Another destructive motive is the motive for self-destructive unpleasure. This involves self-sabotaging experiences that clients recognize as unpleasurable but do not realize they are self-caused or that they can be stopped (Tyson, 2002; Tyson & Carroll, 2001). Such motives lead to experiences of self-harm, e.g., cutting, nightmares, delusions, or hallucinations. At age 40, Tony experienced auditory hallucinations in the form of "cursing the Holy Spirit," which led to his current delusions that the devil is in him and he is going to spend a "billion, trillion years in a fiery hell." Tony does not believe that his destiny can ever be changed. He also does not concede the possibility that the hallucinations could have been self-caused as a means of reacting to his divorce and subsequent homelessness, which occurred right before the voices started. Thus, the treatment goals include developing his self-caretaking motives, which will allow him to control his destiny and then prevail over these self-destructive motives.

Another helpful concept to the case manager is the aversive reaction to pleasure. Individuals who have become accustomed to experiences of unhappiness may become uncomfortable in response to feelings of happiness. An aversive reaction occurs when a client sabotages feelings of happiness. The most powerful aversive reactions occur when a client experiences conscious caregetting pleasure, because this experience causes a loss to the unconscious motives for unpleasure. The client may create unpleasure or sabotage the caregetting situation in order to satisfy learned needs of unhappiness (Pieper & Pieper, 1999).

Consider the following example with Tony.

Case manager: *Well, we had a long and frustrating day at the social security office. Are you ready to relax and just enjoy a nice lunch?*

Tony: *Yeah. Finally, no social security. No talking about feelings or assessment. We can relax.*

Case manager: *Yeah, well, what would you like for lunch?*

Tony: *Thank you for getting me lunch. I really appreciate it.*

Case manager: *No problem. I enjoy listening to you talk about your experiences and working through some of that.*

Tony: *What's your IQ?*

Case manager: *I actually don't know. That's an interesting question to ask.*

Tony: *You seem smart. I probably have an IQ of 3 or 4. I can't do anything.*

In this case, Tony was experiencing pleasure as his case manager took care of him by helping him at the social security office, taking him to lunch, and then complimenting him. Tony had an aversive reaction to this pleasure by making a self-deprecating statement, which made him unhappy. His unconscious motives for unpleasure brought Tony back to his learned state of unhappiness.

Another concept that will aid in understanding how to understand and respond to clients is the reaction to loss. The case manager will need to understand the nature of the loss (i.e. loss in the caregiving relationship if therapist is on vacation, a death in the family, loss in housing, etc.) and what this loss means to the client and his/her likely response to the loss (Tyson, 2002; Tyson & Carroll 2001). Tony's reaction to losing his family after the divorce included a suicide attempt and auditory hallucinations. In addition, Tony, at times, shows reactions to prospective loss when his case management sessions are ending:

Case manager: *Good Morning, Tony! How are you?*

Tony: *I'm fine.*

Case manager: *Good to hear. Now, Tony, I'm not going to be able to stay as long as I usually do today. We only have 10 minutes. I'm sorry, but my day is crazy today.*

Tony: *OK. <Lays on bed and closes his eyes>*

Case manager: *Gee, I would like to use our short time together to talk about your week.*

Tony: *I'm fine. <Still has eyes closed>*

Case manager: *Maybe you are tired and want to take a nap?*

Tony: *Yeah. I will see you next week.*

Case manager: *Ok. I know it may have been disappointing not to get our full session today. I was disappointed too. But, next week, we will have an hour. OK?*

Generally, Tony sits up during home visits and it could be argued that he was disappointed that the home visit was going to only last 10 minutes, so his reaction to the loss of his full session was to avoid the session altogether.

A way for the case manager to assess the level of the client's engagement in the caregiving relationship is by looking for process meanings in the context of each session. Process meanings provide the case manager with insight into how the client conceptualizes the caregiving relationship, which indicates the level of closeness or distance between the client and case manager (Pieper & Pieper, 1999). Process meanings take the form of observed behaviors or dialogue in the context of the therapeutic relationship. As the following extracts from meetings with Tony highlight, Tony's process meanings changed significantly over six sessions:

Second interview with Tony:

Case manager: *Before we start the rest of the [psychosocial intake] assessment, I was just wondering something. I know you have been in several hospitals and have probably seen many different counselors and doctors. How do you feel about the questions?*

Tony: *It gets old. So many people. Doctors, interns, case workers, interns, doctors, more interns. It gets old. I'm sorry. I can't answer any more questions. I just can't!*

Case manager: *Why don't you take a drink of water? Just take your time, ok? There's no hurry.*

Tony: *Ok, I'm sorry. Go on.*

Sixth interview with Tony-at the end after two hours together where Tony talked almost nonstop:

Case manager: *<Dropping Tony off at his home> You know what? Here we are at your place. So, I must get going. You did a real nice job of sharing your feelings and experiences.*

Tony: *Thank you. You know I haven't talked about this stuff with anyone in a long time.*

Case manager: *How are you feeling? I know we talked about a lot of intense stuff. Will you be alright the rest of the day?*

Tony: *Yeah, I feel better.*

Case manager: *Good. Well, is it alright if I come to visit you next week and we can talk some more about these things?*

Tony: *Yeah. I appreciate it.*

The process meaning changed from initial resistance to the caregiving relationship due to numerous other ineffective service providers in Tony's past, to an appreciation and utilization of the caregiving relationship that included Tony acknowledging feelings of pleasure from the relationship. It is important to pay attention to the client's process meaning as the caregiving relationship is the primary instrument of change.

Indeed, on many levels, intrapsychic humanism can be applied to the case management relationship as a means of gaining a greater understanding of the client's motives. These concepts develop a framework through which the caregiving relationship can be understood and enhanced. It is also important to recognize the limitations of the case management relationship and how intrapsychic humanism could be applied in response to the limitations.

Limitations of the Case Management Relationship

The first limitation is the limited resources available to many case managers. A case manager may have a caseload of 15-50 clients, and effectiveness of the case manager decreases when caseloads exceed twenty clients (Walsh, 2000). With such high caseloads and unending paperwork, case managers simply do not have the time to fully develop the caregiving relationship. With the current emphasis on medicating psychoses (Walsh, 2000), the case manager may be content with watching the client take their medicine. As a result, home visits often become ten-minute drop-in visits limited to superficial conversation about the weather. Clients do not have the opportunity to increase their self-caretaking motives. Some case managers may be content with maintaining the client's existence instead of enhancing it.

Another limitation is the structure of the case management team. Intrapsychic humanism is ideally implemented using a primary relationship model as opposed to a team model, which generally results in superficial relationships between clients and staff

(Tyson & Carroll, 2001). However, in a misguided understanding of efficiency, many ACT case management teams take on a team approach whereby any one of six or seven team members may visit a client on any given day. Thus, a client does not consistently see one case manager and this hinders the development of a stable caregiving relationship. The client's experience with the case management relationship will likely be unpredictable and chaotic using the team approach, which actually reinforces the client's unconscious views that relationships should be unpredictable and chaotic.

Intrapsychic humanism can be used to minimize the burnout, or compassion fatigue, of social workers caused by high caseloads (Pieper & Pieper, 1999). Pieper & Pieper argue that compassion fatigue occurs when a social worker does not truly understand a client's motives. However, intrapsychic humanism helps the social worker understand and reframe the client's motives and thus be more apt to stay motivated in working with the client. The adoption of intrapsychic humanism would also help social workers better understand the hazards of a team-based approach in providing services and how such an approach may actually lead to greater levels of compassion fatigue because of the minimal improvements observed in the relationship between client and worker.

As discussed earlier, case managers tend to have greater power over the client than a therapist would. For instance, a case manager may control how much money the client receives. So, if a client is a substance abuser, the case manager may limit the client to receiving three dollars a day so the client does not use all of their check on drugs. In the ideal situation, the person providing the caregiving relationship for the client should not be responsible for losses relating to issues such as money and removal from housing. Rather, the case manager should be available to support the client during times of such loss. Unfortunately, the case manager tends to be in charge of these losses which again limits his or her ability to develop a conflict-free caregiving relationship.

However, the social worker can use intrapsychic humanism to help the client mourn such losses. No therapeutic intervention is completely free of conflict; scheduling conflicts and expectation of payment are two sources of conflict in a typical therapeutic relationship. Thus, the goal of all therapeutic relationships is not necessarily to create a conflict-free worker-client relationship but rather to create a conflict-free inner well-being for the client. Intrapsychic humanism allows the worker to be attuned to the client's inner motives and needs and, thus, will likely increase the effectiveness of the intervention.

Conclusion

Case managers have a huge impact on the lives of their clients and, unfortunately, their therapeutic impact is minimized by high case loads and an emphasis on doing tasks for clients instead of talking with them. Thus, case managers would clearly benefit from training in intrapsychic humanism and would likely gain an increased awareness of the importance of the caregiving relationship with their clients. Further understanding of this theory would likely give case managers "peace of mind" when working with homeless, mentally ill clients who are known to be paranoid about and mistrustful of service providers (Walsh, 2000). Case managers would be able to understand their clients' motives in resisting help or in self-sabotaging relationships, and the worker could intervene with their clients using this perspective.

Additionally, intrapsychic humanism can be utilized in response to the losses that occur in the case management relationship, such as worker time restraints, requirements to confront clients, and power differentials - all of which will likely lead to some conflict and instability in the case manager-client relationship. Intrapsychic humanism emphasizes that the caregiving, trusting relationship with the client is the cornerstone of any intervention. Using this relationship, case managers will be able to increase their clients' constructive motives, limit their own compassion fatigue, and overcome the limitations inherent in the case management relationship.

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Jeffrey J. Bulanda completed his first year in the MSW program. His field placement was in a day program at Chicago Health Outreach providing case management services to the mentally ill. He has since become employed by Chicago Health Outreach as a mental health worker in a residential treatment center for mentally ill adults. His second year field placement will be with the Chicago Public Schools working with elementary school children. This paper received a School of Social Work Distinguished Writing Award 2003.