

# **Who are You? The Use of Self in Clinical Case Management**

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### **Abstract**

The use of self is a prime skill in clinical social work practice. Clinical case management is a part of clinical practice, yet for various reasons it is deemed less clinical by mental health professionals who are less experienced or by MSW graduate students. Drawing from professional literature and my own professional experiences, I will demonstrate how use of self in clinical case management allows me the opportunity to have positive outcomes with clients, despite bureaucratic challenges.

*Keywords:* use of self, self-reflection, home health, interpersonal neurobiology, case management

*It was raining, and raining, and raining. The day was dark, except in sporadic moments of brightness caused by lightning in the sky. I looked out the window and saw the drainage ditch adjacent to the road, full of water. It unnerved me to see the flooding near my compact Ford Focus. The thought of turning back and rescheduling this home health visit crossed my mind. However, my GPS alerted me that I was only two minutes away from the patient's house. I drove up on the patient's street searching for the number two, as it was the physical address of the house. The lightning lit the sky, and I saw the number on a mailbox next to a dilapidated mobile home. I drove into the unpaved muddy driveway and parked. After a heavy sigh, I mentally prepared myself to get soaked. The rain and thunder became stronger and louder as I opened the door. Exiting my car, I was immediately drenched in my dress clothes. Making my way through random junk such as old rusty washers and dryers, I made it to the front door and knocked loudly twice. A tall, bald, bearded, and stocky-build man opened the door and in a deep commanding voice questioned, "Who are you?"*

### **The Initial Visit**

Here I was, a licensed clinical social worker visiting another family with a plethora of psychosocial needs, while being cognizant that resources, interventions, social programs, and social work visits were very limited. I knew of those limitations, because I had worked with hundreds of patients and families in similar contexts for the past 4 years as an independent contractor providing social work services. Georgetown University faculty member Dr. Michael Lipsky included social workers in his reference to street level bureaucrats when he wrote, "Public workers who interact directly with citizens in the course of their jobs, and who have substantial discretion in the execution of their work are called street-level bureaucrats" (2010, p 3). I was about to play the role of that street level bureaucrat with this family. They had not met me, but I was the representation of the social policies that were designed to help them, contingent upon their eligibility for various social programs. I was going to be characterized in either a negative or a positive manner by this family member who asked the key question, "Who are you?"

This question drew out many dynamics for me regarding clinical social work practice. The main dynamic was the effective use of a particular skill and phenomenon known as the use of self. I, the

*\*Privacy Disclaimer: To protect the confidentiality of the client, identifying information has been disguised and certain details have been concealed.*

street level bureaucrat, gave him the obvious answer to his question, "I am a clinical social worker here to help." However, after weeks of reflection on that question, I realized that who I am is the most important element in my clinical case management work, because I only interact with these clients in one or two home visits. The reason for such visit limits come from the home health agencies that prefer to contract with social workers and compensate them per visit, rather than offering full time positions that allow a higher visit frequency. Of course, employing full time workers would require companies to pay for benefits, salaries, and other expenses. Therefore, it is paramount that in my limited time with these clients, I effectively focus on use of self in the most helpful manner despite bureaucratic and clinical challenges. These bureaucratic challenges can be a limitation on visits, resources, and interventions, while clinical challenges can involve the client experiencing distressing psychological symptoms requiring immediate clinical interventions.

In this case study, I will demonstrate the positive effects of incorporating a relational use of self in my case management of a patient and her family who had a list of psychosocial needs. The visit limit was two; comprised of an initial and a follow-up. I focus on a relational use of self, as opposed to a use of self that focuses solely on the individualistic level. For example, the relational use of self is derived from a process of interacting with others and how those interactions affect self while also including personal self-reflection. The individualistic use of self is the traditional focus on personal reflection of one's personal history and beliefs without considering the effect on self from relating with others. In a qualitative study, a group of social workers were interviewed about their experience of use of self, and according to their responses the focus was very individualistic, with minimal attention to how interacting with others affects self (Reupert, 2007). However, Arnd-Caddigan and Pozzuto (2008) argued that the self is more than an individualistic task of self-reflection and described it as, "Self is a function of relationships with others in which the self is continuously created, maintained, and re-created" (p. 235). Reupert did not necessarily adhere to an individualistic focus on use of self, but simply coded themes from her interview transcriptions that revealed such a narrow focus. In fact, Reupert acknowledged, "Participants' views of self as individual, rather than relational and contextual, is concerning" (2007, p. 113). Reason for such concern is justified as the foundation for the social

work profession is based on the person-in-environment concept, which naturally includes a person's community and relationships (Arnd-Caddigan & Pozzuto 2008; Gibelman 1999; Reupert 2007).

At that mobile home, I was about to enter into the patient's physical environment and social milieu. I answered the unknown man's question. He looked me up and down with a suspicious look and again questioned in a commanding voice, "A social worker? Why are you here? To investigate us? That's why you're here. Is it not?" I needed to engage him and the family quickly. As someone who has done hundreds of these visits, initiating engagement has become a more natural action for me, rather than a forced skill that needed to be checked off a clinical skills list.

I was aware that the first impression was key to cultivating a working alliance and engagement was necessary to help me move the patient along the helping process or case management process, as referred to by healthcare professionals. Hull and Kirst-Ashman (2006) reported:

Engagement is the initial period where you as a practitioner orient yourself to the problem at hand and begin to establish communication and a relationship with others also addressing the problem. Regardless of whether you pursue micro, mezzo, or macro change, you must establish rapport or a harmonious relationship with clients and target systems in order to communicate and get things done. (p. 29)

Both authors revealed that engagement is part of all work whether it is micro, mezzo, or macro. Some social workers believe that engagement is vital in clinical work such as psychotherapy, but not in case management as that involves providing more concrete services, as opposed to psychotherapy interventions. As a professional with a full-time private practice who also happens to do case management contract work, I noticed that there is a need for social workers to bridge the gap between interventions for clinical work and concrete services. Primack and Xenakis (2013) write that many MSW students become disillusioned when their field placements are not the traditional clinical placements that involve facilitating individual and group psychotherapy. They report that MSW students are lacking the skills to think clinically when working in case management settings. When I first started working with case management, I too fell into that

mentality. However, experiences with different patients and families allowed me to use clinical interventions and skills in case management with the primary skill being use of self. Awareness of self kept me calm when this individual was demanding answers from me.

After his second round of questioning I replied, "I'm sorry sir, but I don't know what you mean when you say 'investigate us'."

He quickly replied in a condescending tone, "Don't play dumb with me. You know you APS (Adult Protective Services) workers are all the same. You come into our homes and act like you own the place and that what you say, is what goes. Well I have news for you. My momma is just fine, and we don't need anyone from APS snooping in our business again!"

The challenge to engage this person was evident, since he already assumed I was coming from APS; an agency he viewed as negative and which was already involved with this family. Ernst and Smith (2012) stated: "The majority of states have laws mandating the reporting of elder abuse and neglect and, for the majority of such allegations, staff from APS programs—rather than law enforcement personnel—conduct initial investigations" (p. 23). This had just transpired with this family. They were recently investigated by APS, which meant they would be defensive to anyone requesting entrance into their home. Why were they investigated? I did not know. I took a breath and reminded myself about ways to establish genuine engagement that would establish a collaborative connection between them and I. Empathy came to mind, as I wondered how I would feel if APS had been in my own home.

"Oh, you had APS come to your house recently. That was probably quite an experience for you, wasn't it?" I asked.

"Yeah it was. We didn't have a choice to let them in. They were sent from the state and we had to let them come in and ask us all questions. Lots of questions. They didn't even schedule with us. They just showed up and said that if we did not let them in, then they would call the laws on us," he stated in a calmer voice. "I see. Let me assure you that I do not come from APS. I am a social worker who is here to help your family. I was sent from the home health agency. I am here to see Hope." I replied. "Yeah, my mom is the one who is sick," he said pointing to her.

Walking in, the horrendous smell was the first thing I noticed. I could not tell if it was coming from the carpet, the furniture, or somewhere else. All I knew was that it did not smell pleasant, and I

wanted to put my arm directly in front of my nose, but I did not want to be rude. From past home health visits, I knew my sense of smell would acclimate to this odor in a few minutes. I walked over to the patient to introduce myself. Sitting on her recliner and with a disoriented look on her face she asked me, "Who are you?"

"I am Louis, the social worker you were expecting," I replied with a smile. "Oh yes, I had forgotten, but then again I forget almost everything. Please, call me Hope," she responded. "Okay Hope. It is a pleasure to meet you. I am here from your home health agency, and hopefully I can address some needs you may have. I will ask you some questions and feel free to jump in when..." Suddenly I heard another demanding voice coming from the hallway, and it was not the man who originally opened the door.

"Who's this guy, and why is he talking to momma?" he asked while staring at me.

Had I asked this man or the first man to change their tone when speaking to me would have been immediately disastrous for the engagement process, which was yet established. Rather, I introduced myself to this six-foot male with a lot of facial hair. He was a little intimidating, especially since he abruptly interrupted me and questioned me in such a deep tone.

This is part of conducting home visits. You are not guaranteed to know beforehand what or who you will encounter in the field. What I do know is that I am a competent professional who uses self as a tool to engage, assess, plan, intervene, and be pragmatic when applying professional knowledge.

After he found out who I was, he became receptive to me. He informed me that he was Bryan, the medical power of attorney (MPOA) for his mother Hope. Bryan guided me to the dining room and began sharing the family's story. Hope slowly walked to the dining room and smiled at me. For some, it may seem like this was just a random frivolous conversation, but I knew that he was inviting me into their world as he disclosed their personal family narrative. I simply displayed active listening, unconditional positive regard, and empathy to help seal a connection with Bryan and Hope. Davies (1994) defines use of self in various concepts, two of which are the social worker's honesty and spontaneity. Both of those concepts are essential in this setting because time is a luxury I did not have. I was honest with them in all my reactions. I needed to be. Meanwhile, the man who greeted me at the door was now sitting on the couch watching television.

Bryan looked at me and said, "Well, I actually asked my mom's doctor if he would send a social worker to our house so we can find out if she is eligible for assistance of any kind. She doesn't get food stamps anymore for some reason. She sometimes needs someone to help her bathe or just be here during the day to cook, clean, or just keep her safe because she falls a lot too."

"Well...what about?" interrupted the brother who was in the living room, but did not finish the question since Bryan automatically interrupted him back, "You shut the hell up, you druggie!" Bryan turned to me and explained that the other man sitting on the couch was the younger brother who stayed at home all day. I was surprised that he was the younger brother, because his demeanor made him look older.

Bryan continued, "He is on disability, on probation, and just waiting to get high again. See, you need to understand that in this home we are pretty fucked up. Oh, I'm sorry for dropping that word on you." He put his hand on my shoulder; hence, another moment conducive to the engagement process. The power of touch. He felt comfortable enough to do that.

"Hey, no problem. I am not offended by the language. Please continue," I replied.

I truly was not offended. I just needed to know how their actual everyday home life was and if there were any significant red flags present. Being there for just 15 minutes, I realized why APS investigated them. It was not because of the poverty, but because of the brother's drug problem and other strong dynamics such as the constant bickering among the family members. I asked Bryan to continue with his story and he eagerly complied.

"Well, I used to live in another state, but moved back to Texas when I found out that momma was having a lot of health issues. I realized that no one was really taking care of her. So I quit my job and came home. After all, I was in the middle of my 3rd divorce and my children were taken care of by their mother. So long story short, I came back, and became my mother's power of attorney, and have now seriously started looking out for her best interest," stated Bryan.

"Ah, I see. I also see that APS was involved with your mom recently. Tell me about that, will you?" I questioned him. By this time, I felt I could use the skill of questioning more. I was there for about 30 minutes, when I subjectively felt genuinely welcomed while listening to their story. Bryan was sharing some personal and specific details that most would not share if they were not

comfortable with the listener. Again, the connection was evolving, which is needed for collaboration purposes between them and I, as they have to be proactive in following-up with agencies after the follow-up visit, when Hope is discharged from social work services.

Bryan continued, "I've been back for about two months now and have decided to clean house. What I mean is that I have 2 deadbeat brothers. The one on the couch is one of them, and he has a shit load of drug problems. He's fine now, but probably because you are here and because of the previous APS visits. Then I have another brother who is in and out of jail. He brings his girlfriends home and they stay for days, sometimes weeks. So I came back and told both my brothers that this is momma's home, and that we cannot bring more drama to this house. However, momma doesn't want to kick any of my siblings out, so I have to put up with my two brothers, but not with their girlfriends and drug addict friends. I have been trying to get my own life in order, even though I am the youngest of the three. I worked in construction and everything was fine, but I cheated on my wife, and she threw me out. Now I am here at my momma's home."

After hearing this litany of woes from Bryan, I gathered myself and remained a non-anxious presence. A few years ago, the list of psychosocial challenges this family was experiencing would have overwhelmed me. However, through professional experience and clinical supervision I learned about a powerful tool I can always use; my personal self. Back when I was under supervision, my clinical supervisor had me study the concept of practice in context (PIC), which focused on reading cases and learning about interventions that actually made a difference in practice. Kerson and McCoyd (2013) stated, "We suggest here that case study actually promotes effective, contextualized reflection on practice, the type of reflection that neurobiologists and social scientists now tell us is required for learning deep skill and attuned caregiving" (p. 674). Practice in context helps practitioners learn about any possible scenarios in any setting. The challenge is to effectively utilize interventions that can make a difference in those contexts.

Professional use of self is one concept that significantly appears in PIC research literature. In Kerson and McCoyd's (2013) journal article, they took 31 published case studies using the PIC framework to do a thematic analysis and use of self was one of those themes under reflective practice. In fact, Kerson and McCoyd (2013) also

stated, "A subtext of this is an argument that case studies may provide a unique format for empirically based learning that incorporates context and reflection in contrast to randomized controlled trials that purposely remove context" (p.675). Reflective practice is a theme that is weaved throughout clinical research that can provide practitioners with great insight. Many social work researchers accept the assumption that reflective practice enhances social work practice (2013). The reflective practice naturally coincides with use of self in clinical practice, whether in psychotherapy or case management or other context.

I immediately said to Bryan after he was done venting through his narrative, "It must be very challenging experiencing all of what you just described in addition to being Hope's caregiver." His response was a genuine nod signaling he was listened to without judgment. I was present. He knew it. I knew it. University of California, Los Angeles (UCLA) professor, Dr. Dan Siegel (2010) writes, "In many ways, being present helps all around: We develop focus, resourcefulness, and perspective that support us as individuals and aid in helping others as well" (p. 3). Being present was not only a matter of physicality, but also being present emotionally. As I was relating with Hope and Bryan, I was connecting and seeing how my use of self was affected. I felt compassion and a need to help, while still being realistic of the challenges in getting them the needed help.

I kept engaging Bryan by making eye contact and saying, "I see that the APS case is still active. I imagine that the caseworker will be coming consistently until the investigation is complete. Then they can decide what they want to do, if anything. However, I hear that your momma is on a limited income and is in need of utility assistance and financial assistance for various bills, per the information on this home health referral sheet. She probably can qualify for certain state programs, but they will require some paperwork and documentation. I can help you with this. I also see on here, that your momma suffers from depression, anxiety, moderate dementia, hypertension, clots, and other diagnoses. This means there are many things we should look at together to see if I can refer her to some other agencies for help, but you would need to be involved in some follow-up work required by these agencies. For example, if your momma was interested in psychotherapy, we could arrange for that unless her dementia is so severe that psychotherapy may not be appropriate at this

time. We could also see if she is approved for a provider from the Texas Department of Aging and Disabilities (DADS). If she was approved for a DADS provider then that would help out a lot with the daily care-giving duties, as a DADS provider helps with activities of daily living such as bathing, dressing, meal preparation, housekeeping, et cetera. There are several other things we can look into, since your family lives in an area that has several social agencies."

The aforementioned resources all required action on the part of the family, as some do not accept third party referrals. This indicates that the family would have to be diligent in following-up with some of these resources after they are discharged from social work services due to the visit limits. By establishing engagement, I was able to have a strong connection that would make collaboration between them and I easier and effective. The horrendous smell inside the house and being drenched from the rain did not impede me from being present in the moment with this family.

Professional discretion was at play during this visit. I have freedom to use my network connections and professional knowledge to help meet some of Hope's family needs within the time constraints. The autonomy I have begins with even my own work schedule. I decided when it was appropriate to schedule them. There was not a supervisor telling me what to do or how to do it. I did not have a checklist from the home health company to complete, but I assessed the situation and identified needs that were not mentioned on the referral sheet. My professional discretion was used automatically. Lipsky (2010) wrote, "Street-level bureaucrats, by definition, have an autonomous core. In a limited sense, they are the authors of the policies that are finally delivered" (p. 212). For example, Hope's psychosocial needs were addressed, directly and indirectly, through different social and health policies, but are ultimately connected to those policies through my case management. My professional skills unfolded as I used self to connect with the entire client system while simultaneously becoming reflective on how I was feeling during this interaction.

Social policies are intended to address a need or service and it may be too late when it trickles down to the recipients, as they get lost in the bureaucracy that is inherent in systems. Lipsky argued that discretionary actions by professionals can at times lead to limited and effective service for the client. For example, he writes,

Street-level bureaucrats work with a relatively high degree of uncertainty because of the complexity of the subject matter (people) and the frequency or rapidity with which decisions have to be made. Not only is reliable information costly and difficult to obtain but for street-level bureaucrats high case loads, episodic encounters, and the constant press of decisions force them to act without even being able to consider whether an investment in searching for more information would be profitable. (2010, p. 29)

I can see those dynamics at work in the delivery of home health services, but I contend that a practitioner who uses self effectively will establish engagement to the point that the patient and entire client system will in fact collaborate with the practitioner by making sure there are follow-up phone calls, completed and mailed applications, and other tasks needed to secure services. It may not happen for all clients who simply get a practitioner who only assesses without properly engaging and then makes fast, uninformed decisions like Lipsky suggested.

Therefore, I made sure to cultivate my working alliance with this family as I provided active listening while they shared their narrative, followed by some of my suggestions. Immediately after sharing my tentative plan, there was a strong, "BOOM!" The power went out. I could not believe the power had gone out on this family with so much need. It almost seemed rehearsed. The mobile home went dark even though the blinds were open. Hope, was startled and began to cry. I reassured her that everything was okay. Suddenly someone arrived and pushed the door wide open. I only saw a silhouette outlined by the lightning, but I definitely heard him yell, "Damn, it just won't stop raining! It reminds me of Hurricane Ike. This better not be another storm where we get more damage on this home."

Bryan replied loudly, "Shut up. Come in and close the door!"

"You shut the hell up, and don't tell me to shut up! I am older than you and can kick your ass!" replied this person as water dripped from his clothes.

"I give up, I give up, I give up. I just can't win with Tony, my other brother. He's probably drunk and it's only around 5:00pm," exclaimed Bryan in frustration while raising his arms signaling capitulation.

"Tony, this is the social worker that came to help out momma and you're coming in making the family look bad...again!" added Bryan.

"I don't give a damn about this guy being here. I'm going to my room. Everyone leave me alone!" cried Tony as he slammed the door to his room.

"Well, I see your other brother is not in good spirits right now," I said. Hope reached for my hand and said, "I don't like it when they argue like that." Bryan immediately answered, "Well momma, that's the way it is in this house. Sorry if it upsets you, but you know my brothers!"

Bryan turned toward me and the power was back on. There was a sense of relief on their faces, as well as for me who was a little rattled by Tony. It was vital that I be attuned to how I was feeling so that it would not interfere with how I related to them. Hope continued holding my hand while at the table. I knew that appropriate touch, empathy, and listening could integrate and help sustain the working alliance. Every moment I can display such integration is key for effective case management with this family. Dr. Dan Siegel, (2012) asserted,

Integrative communication involves the sharing of energy and information in which each individual's internal world is respected and allowed to be differentiated and then compassionate connection is cultivated. Integrative communication promotes the development of healthy relationships as it honors differentiation and linkage. (p. 18-1)

Here, Hope is allowed the opportunity to connect with me. I am aware of this moment that allows Hope and Bryan to differentiate and willingly link with me in a professional helping relationship. This has to happen now because their needs are pressing, and one should not wait until new macro policies are implemented. The professional use of self helps any practitioner who is currently working in such challenging case management scenarios.

Bryan looked directly into my eyes and continued sharing, "You need to understand that this family can't talk to one another without arguing. This is what we do. This is how we do it. It gets worse when random people come and knock on our door in the middle of the night, and I turn them away; druggies coming for some action. Then my brothers accuse me of kicking out their friends. Then we get into an argument in the middle of the night, and momma wakes up all upset. Sometimes I just want momma to live with my nephew and his girlfriend. They live in that RV

outside. However, there's no room there, and they have 3 children in that one-bedroom RV. So, that is not going to work. Plus I think my nephew is using drugs too. I just haven't caught him...yet! Also, Child Protective Services of Texas (CPS) is already doing an investigation on them, but we don't know the reason."

I sighed and silently pondered about the numerous psychosocial needs of this family. This elderly woman lives with these sons, and it is not the most conducive environment for physical and psychological wellness. Bryan looked at his mother, sighed, and then said, "Louis, please see if we can get her a provider and anything else that may help her. I know she needs help. As you can see, we can't give it to her. I will do everything I can to make sure applications are turned in or anything else you might need." He almost started crying. I on the other hand was elated to hear words of commitment coming from him. I now knew Bryan would collaborate with me. It is significant in case management when a person who is part of the client system is ready to be involved in his own family case.

"Good," I replied and validated him. "I am glad to know that you are interested in your mother's well-being. We need to see how long some of these waiting lists are and put her on some of them. Also, I need to verify some of her financial records to see if there are other programs she may qualify for. I have to warn you though that these agencies may take a while to get back to you. It is imperative that you call them back after they call you and leave you a message, or they will close your case." Bryan nodded his head at me displaying agreement and comprehension. For me, this brought a great deal of satisfaction. I saw the collaborate connection established. Visit limits create the challenge in these cases, but use of self helps the practitioner overcome some of those challenges.

I looked at Bryan and asked him if he had other questions. He did not. I reminded him that I would do a follow-up visit in about a week or two. He acquiesced and said, "Good, and thanks for coming today in the middle of this storm and flooding." I remembered how I did not want to come for that very reason, but his honest gratitude helped solidify my constant awareness of self. When the visit started, I was not looking forward to the visit, but through my interactions with this family that began to change. Nevertheless, I knew that Bryan would now collaborate with me, and that he would be assertive and diligent in keeping up with phone calls from the agencies. That commitment

to collaboration would have never existed had the connection not happened through the engagement process and my use of self. I politely excused myself from the home. Bryan walked over with me to the porch, and I ran to my car in the pouring rain.

I shivered a bit inside my car. My clothes were wet again. I could not see through the windshield as I sat there in my parked car. I began a private reverie thinking about all the psychosocial needs and how two visits were not enough to address all needs. However, I was encouraged by knowing this family was willing to collaborate and that I would soon find out to what extent.

### **The Follow-up Visit**

Two weeks passed, and I was on my way to the follow-up visit. I drove up on a sunny day and Bryan was on the porch. He immediately addressed me, "Welcome Louis. There is so much that has happened in that last two weeks. I did follow-up with some calls. I have to tell you this though. One of my brothers, Tony, is back in jail. I am debating on whether or not I will press charges against him. He actually took a swing at me a week ago while he was drunk. He had a lot of druggie friends over, and I kicked them all out. Then he went straight at me, and we had a short fight, but I managed to call the laws on him and they arrested him. Plus he had violated some probation terms, so they kept him even longer. I love my brother, but he deserves what happened to him."

I connected with Bryan again by making sure he felt listened to. The smell was there again. We walked inside and sat in the dining room waiting for Hope to come out of her bedroom. She walked slowly toward me and sat next to me. She smiled, but I could tell that she did not remember who I was. Bryan reminded her that I was the social worker who was helping her with the current needs. Again she smiled and stared at me with that same disoriented look. However, I knew that if I listened to her comments, and really engaged her, she would freely participate in the conversation.

"Well Bryan, I found out who her DADS case worker is. Here is the name of the caseworker and the direct line to her office. If you have not heard from her yet, then you can call directly now. They won't speak to me, because I am a third party, yet I am the one who made the referral. I know that sounds odd, but that's part of the bureaucracy," I explained to Bryan who was nodding his head signaling understanding. I then continued talking,



“Also, she is now on the waiting list for Meals on Wheels. I found out she can get transportation benefits from her insurance, since she is on the advantage plan also known as Medicare Part C.”

That last piece of news seemed to bring some limited relief for Bryan. I then asked, “so what has APS said to you now? Are they still investigating?” Bryan looked at me and stated, “Well, they said that nothing will happen, since she is not being abused or in danger. Especially because she also says she loves her sons and told that worker that she would not survive in a nursing home.”

I imagined how deep her love for her sons was, despite the tumultuous environment they created in her own home. They fought verbally and physically. I met Hope where she was at in life; a woman with dementia and other physical and psychological disorders, yet with the capacity to love her sons unconditionally. I knew that I was working with empathy again. I was aware of self again and the feelings of angst. The self-awareness process repeats itself each time I spend time with clients.

After that short thought-sequence, I asked Bryan if they had thought about long range planning. I knew that this subject matter was difficult to discuss, because long range planning includes discussing options such as placement in a skilled-nursing facility. I directed this at Bryan, “Let me just throw this out there. Have you ever thought about nursing homes?”

He quickly replied, “Absolutely not! I promised my momma I would never put her in one of those places.”

I saw Hope getting upset at the mention of the nursing home, so I reminded her that it was just an option for long range planning. I quickly said, “Remember, I just want you to know that there are many options when it comes to long range planning, and there is nothing wrong with having a plan, just in case care-giving cannot continue in the home.”

That explanation made Hope sigh with relief. To me, it just validated the connection previously established and the collaboration with this family. I could now bring up more subject matters knowing that they were receptive to me, as a collaborator in their clinical case management care. Now that Bryan collaborated with me as evidenced by his own follow-up phone calls, I mentioned some resources specifically geared for family therapy, placement, and other long range planning information. Collaborating with the patient and a leader in the family can open more

doors for providing interventions for the entire client system (Kirst-Ashman & Hull, 2006).

Hope was getting sleepy and excused herself to go to bed. I then questioned Bryan about the incident with his brother. Bryan eagerly explained, “We fight. We punch each other. It’s not something new. I am glad he is in jail. Plus, I think he might be stealing money from our mother. We have been like this forever. Some cops in this area know who we are. They know me by name and know my brothers by name. I guess it’s good, because they also know my mother and check up on us, which means checking up on my mother specifically. This is how people live in this neighborhood Louis. It’s not like your suburb life.”

“What do you mean, my suburb life?” I quickly replied while aware of my feelings and not being defensive, but questioning to find out what he really meant by that statement. “You know. Everything is perfect in your world.” Bryan responded. “No, I actually don’t know. What are you getting at, because my world is far from perfect,” I asked, although internally, I knew he wanted to share his views through his own personal lens. “Whatever, as if you knew what this kind of living feels like,” said Bryan with a look of skepticism.

I looked straight into his eyes and used appropriate self-disclosure, as this could have been a rupture in the working alliance, which could have affected their case management. This skill is not part of a checklist that the home health agency expects I demonstrate, but as Lipsky (2010) stated about discretion, I use that professional discretion every time I work with patients in a limited amount of time. I shared with Bryan that my life today was a lot better, at least, economically then it was when I was growing up. However, I also shared with him that I lived in some rough inner-city areas of Houston when I was a child. Bryan was surprised. I knew it was appropriate to share pertinent details of my story with him in this critical moment of case management. Self-disclosure is a major part of the use of self skill. Some clinicians are apprehensive about using self-disclosure for various reasons, but I contend that it is mainly because this skill is not taught appropriately in MSW programs and clinical supervision. Knight (2012) wrote, “It is argued that self-disclosure reflects a lack of self-awareness on the part of the clinician and is a manifestation of countertransference” (p. 297). When a clinician is truly present, there is an opportunity to display genuineness to the client, but self-awareness must be in full force.

I saw Bryan lean a little closer to me as if he wanted to hear every single detail when I stated, "Look, I've been poor. I lived in a mobile home with a bunch of family members. I saw my parents work countless hours to provide what little they could provide so that my siblings and I could have a better life. I know what it's like to live on welfare. I know what it's like when strong family dynamics exist. My story may not be identical to yours, but it also involved suffering and hurt."

I could see in Bryan's eyes that this was resonating in him. He got a little emotional and revealed, "Sometimes it's so hard to live like this. I try to help my momma, but it's hard to live in this area with all this shit going on."

I knew I established strong and stable rapport with the patient and with Bryan. Knight (2012) stated, "Self-involving disclosure also is assumed to be empowering to clients and to foster a sense of solidarity with the therapist" (p. 299). Bryan and I had such solidarity in the two visits thus far. As a clinician, case management skills have to be up to par so that such solidarity exists between clients and professional. However, I also realized that this was the follow-up visit and Hope would be discharged. The encouraging factor was that the son was now pro-active in long range planning. The meant his involvement would continue after I was out of the picture if he is to truly help his mother. As the helping professional, I have to make sure that there was a true connection and not just compliance by the patient or family, like Muran and Safran (2006) stated, "The therapist may fail to recognize that what looks like an alliance may in fact, be a subtle form of compliance on the patient's part, motivated by various unconscious factors" (p. 287). In this case, I already had definitive actions by the son that he had followed up as I had instructed him during the initial visit, but not because of compliance. Bryan shared that he whole-heartedly wanted to help his mother. The problem was that his back was against the wall with so many macro level policies that did not address the micro level needs.

Gammonley and Mason (2012) reported, "There is a marker of sorts, in the modern era in home care and that is the passage of the Balanced Budget Act of 1997 (BBA), which dramatically changed the relationship between public policy and HHC needs" (p. 127). As home health care in the US becomes more prevalent with seniors who wish to remain in their homes, as opposed to a skilled-nursing facility, the emphasis on social work services may increase; thus allowing social work to play a leadership role in an

interdisciplinary field. In a society where this becomes a reality, families such as Hope's will receive better treatment through more interaction and interventions by the social worker. The connection and collaboration that is focused on with limited visit frequencies helps the client system move along the helping process even though there are time constraints. Macro policy change takes time, yet the clients need the help today. Therefore, mental health professionals that are equipped with the proper clinical tools will be able to truly help clients such as Hope. All psychosocial needs may not be met, but the needs that are met can change the patient's life in a dramatic positive manner. Each case management case allows the clinician a glimpse into the patient needs and although the clinician's experience is subjective, so is the patient's. The patient is able to describe how she is experiencing her needs and the clinician can use that to better understand the patient's world and current perception. It is two different minds connecting with one another. Two minds needing one another to help develop the mind past neural firing and into interpersonal experiences (Siegel, 2012).

My work with this family was rewarding. Visit limits cannot be the excuse for being phlegmatic about interventions. Although this was not in the scope of this case study, the macro aspect of healthcare policies and the effects it has on case management can be explored further. Clinical case management is enhanced by mental health professionals who effectively utilize the use of self skill. This tool is everywhere social workers go. It is a part of them. It is who they are.

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