COMMUNITY-BASED MANAGEMENT OF PSYCHOTIC CLIENTS: THE CONTRIBUTIONS OF D. W. AND CLARE WINNICOTT

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ABSTRACT: While the term “management” connotes images of impersonal care, D. W. Winnicott repeatedly used this term to describe the responsive environmental holding that is central to all human development. Influenced by observations of how normal mothers and families address the physical and psychic needs of children, he and his wife, Clare, a distinguished British social worker, operationalized this concept in finding and supporting “facilitating environments” with a wide range of disturbed children and adults. Using case material from a contemporary community program for the mentally ill, this paper will review the Winnicotts’ important, but often neglected, perspectives on the environmental management of psychotic adults.

As the burgeoning field of “case management” has focused attention on the environmental needs of psychotic clients, the lack of direct practice models has created a disturbing conceptual vacuum which has been filled by bureaucratic attempts to define this work. Reflecting an all-too-common perspective, one author defined case management as:

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

Reacting to such perspectives, many concerned clinicians have come to view case management as an impersonal service more concerned with

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bureaucratic systemization than providing help to persons in need. While several authors have recognized that addressing the environmental needs of the mentally ill requires a personal relationship and a high level of clinical skill (Lamb, 1980; Kanter, 1985, 1987, 1989; Harris and Bergman, 1987; Harris and Bachrach, 1988), most case management literature reflects an administrative perspective (Sanborn, 1983, Levine and Fleming, 1984; Weil, Karls and associates, 1985).

However, well before the field of “case management” was defined and implemented in the United States, D. W. Winnicott, the British psychoanalyst and pediatrician most noted for his concepts of the “transitional object” and the “holding environment” was stressing the importance of “management” in the treatment of severely disturbed children and adults. As I will outline, he used the term “management” to describe direct interventions with the environment which facilitate the healing and maturation of very troubled individuals, a usage clearly compatible with contemporary case management practice. Drawing from his years of pediatric experience, his usage of “management” reflected the very personal manner by which all “good-enough” parents help their infants and children adapt to the larger environment. In doing so, Winnicott moved beyond the classical Freudian and Kleinian focus on the instinctual components of the parent-child relationship, examining instead the less dramatic regulatory functions of everyday parenting.

In his discussions of management, Winnicott frequently referred to his wife Clare’s writings for further elaboration. A social worker who worked closely with Winnicott during the war, Clare Winnicott was one of the last analysands of Melanie Klein and was awarded the Order of the British Empire for her leadership in the child welfare field (Grosskurth, 1986). Described by a British social work journal as “a well known team in social work and psychotherapy” (C. Winnicott, 1970), the Winnicotts collaborated closely with one another and according to one colleague, E. James Anthony (1989), there is “no way of separating their contributions in (the management) area.”

In this paper, I will outline D. W. Winnicott’s perspectives on “management” with the psychotic client, reviewing both practice and theoretical considerations. As his clinical observations were always integrated with developmental psychology, I will also examine some of his ideas on the role of environment in facilitating personality growth. Finally, after presenting a case vignette and reviewing the writings of both D. W. and Clare Winnicott, I will describe in greater detail how their approach to management can be implemented in clinical practice. As their ideas on management are scattered throughout their papers, I will be quoting their remarks at length to accurately convey the spirit of their thinking. (For purposes of simplicity, I will refer to D. W. Winnicott as Winnicott and refer to Clare Winnicott by her full name.)
Winnicott's Approach to Management

Winnicott's approach to management emerged from his experience as the Consultant Psychiatrist to the program which relocated urban children in England to the countryside during the bombings of World War Two. Working closely with Clare Britton, his future wife, he explored ways of establishing and maintaining environments, both familial and institutional, that facilitated the survival and development of troubled and homeless children (Winnicott and Britton, 1947). This perspective continued throughout his career as he searched for ways to apply psychoanalytic theory to difficult situations where psychoanalysis would involve “wasting our time and someone else’s money” (Winnicott, 1961).

In his classic 1947 paper “Hate in the Countertransference,” Winnicott applied his experiences with normal and disturbed children to both the psychoanalysis and management of adult psychotic patients. Concerned with the abuse of lobotomies and ECT, he examined the hatred that both children and psychotic patients inevitably evoke in their caregivers, including parents, therapists, psychiatrists and nurses. This was perhaps the first of many papers where he integrated observations from psychoanalytic treatment, social casework and his “well-baby” pediatric experience to emphasize the common ingredients of caregiving relationships with children and developmentally arrested adults.

In his introduction to a collection of Winnicott's papers, M. Masud Khan (Winnicott, 1975) outlined Winnicott's perspective on “management.” Stating that Winnicott viewed regressed patients as “inevitably” requiring management, Khan outlined three basic types of management in Winnicott's thinking and practice:

1. The quality of the analytic setting: its quiet and freedom from impingement on the patient;
2. The provision by the analyst of what is required by the patient: be it absence from intrusion by interpretation, and/or a sensitive body-presence in this person, and/or letting the patient move around and just be and do what he needs to;
3. The management that can only be provided by the social and familial environment: here the range is from hospitalization to care by family and friends.

Khan goes on to note that Winnicott viewed management as:

neither indulging the patients' whims and wishes nor avoiding meeting the demand for help by reassurance. Management, in fact, is the provision of that environmental adaptation, in the clinical situation and outside it, which the patient had lacked in his developmental process . . . It is only when management has been effective that interpretative work can have clinical value (p. xxvi-xxvii).
As Khan’s remarks are directed toward his fellow psychoanalysts, they place equal stress on management inside and outside of psychoanalytic treatment. Unquestionably, Winnicott was very concerned with both the psychic and physical dimensions of the symbolic environment he created in his consulting room. As Margaret Little (1985) noted, he saw to it she was “warm and comfortable” and regularly ended their sessions with coffee and biscuits.

However, when Winnicott discussed management in his writings, he almost invariably was referring to environmental interventions outside of the office. For example, in 1953, Winnicott wrote several scathing letters in response to a meeting which discussed a paper Herbert Rosenfeld (1952) had written on the psychoanalytic treatment of a schizophrenic man. Winnicott wrote Rosenfeld that another analyst told him that:

the whole work of the management (of this case) was a very specialized business and that as far as could be seen the bit of work you did by analysis made no appreciable difference . . . (p. 44)

In response to this discussion, Winnicott also wrote Hanna Segal on the same day to argue with her assertion that the management needs of disturbed patients are recognized by all psychoanalysts:

you mentioned the fact that no-one would analyze somebody who had not had food for five days. Presumably they would give food. You went on to imply that there is no essential difference between the management needs of a psychotic and a neurotic patient. If you really mean this, heaven help your psychotic patients, and until you recover from this point of view I am afraid you will not make a very interesting contribution to the theory of psychosis.

If you really believe . . . that the psychotic patient is in an infantile state . . . then what you are really saying is that there is no essential difference between the management needs of an infant and those of a grownup. Yet . . . I am sure that you would admit that whereas a mature person can take part in his own management, a child can only take part to some extent and an infant . . . is absolutely dependent on an environment which can either chose to adapt (or fail to adapt) to the infant's needs . . . As management problems are essentially different according to the level of development . . . then (they) must be different in the analysis of psychotics and neurotics. As you know, I am one of those . . . who say that in the analysis of psychotics we must actually study what we do when we take part, as we always must do, in management (Rodman, 1987, p. 47)

A year later, Winnicott wrote Sir David Henderson, a Scottish psychiatrist about the treatment of “borderline cases,” commenting that “it is merely a matter of time before psycho-analysis as a whole concerns itself with the whole aspect of the management problem . . . without
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abandoning the main principles of psycho-analytic technique” (Rodman, 1987, p. 69).

Although Margaret Little (1985) writes that Winnicott's concerns about the confidentiality of his adult patients inhibited him from presenting case reports of adult patients, he published two case studies which illustrate how he used management as a primary treatment technique with severely disturbed children. In one paper, titled “A Case Managed at Home”, Winnicott (1955) reported on his work with a six year-old psychotic girl. After carefully assessing the child and family, he empowered the mother to turn the home into what he termed a “mental hospital” and help nurse the child back to health over a 15 month period. Winnicott assisted the family in this task by asking the local school and clinic to leave the family alone. He also had “very brief” weekly contacts with mother and child where he consulted with mother on the home situation and “gave the child the opportunity to be negativistic” (p. 124). However, Winnicott was quite clear that it was the “management rather than direct psychotherapy which (returned) the child to normal. (While) some direct work was done with the child in the weekly visits . . . (these) brief contacts (were) not the main part . . . of the treatment, but (were) in fact a useful addition” (p. 119).

In a second case he entitled “Peter”, Winnicott (1971) was consulted by the parents of a troubled 13 year old boy who had engaged in a series of bizarre thefts and destructive acts at a boarding school. Again, after evaluating the boy and his parents, he recommends that the child return home to be nursed back to health by his parents. After an initial series of office consultations, Winnicott supported the parents' efforts at managing their son at home with a series of phone calls and letters. He paid close attention to the process of choosing a new school which could which would facilitate the progress that Peter had made at home. In this case, three individual contacts with the people had no psychotherapeutic impact; they only provided Winnicott with information which could guide his managerial interventions.

Margaret Little's (1985) report of her own treatment provides one of the only case reports of how Winnicott managed a psychotic illness in an adult patient. During her psychotic regressions, he took an active role in arranging for hospitalizations, negotiating the ground rules for her treatment with the attending psychiatrist and checking with her frequently to assess her subjective experience of the hospital. In one instance, he even arranged for her to take her on a vacation.

Little describes Winnicott's “‘holding’, of which management was always a part” as reflecting his assumption of:

full responsibility, supplying whatever ego strength a patient could not find in himself and withdrawing it gradually as the patient could take over on his own. In other words, providing the ‘facilitating envi-
environment', where it was safe to be. Only rarely did 'holding' mean literally restraining or controlling. He was compassionate, but consistently firm, sometimes to the point of ruthlessness where he felt it necessary for the safety of his patient. Short of bodily intervention he could 'forbid' action (p.21).

Little continues by observing that:

sometimes the holding had to be delegated, handing over a dependent patient temporarily to someone else so that he could get a rest or a holiday, but always keeping in close touch. . . when he feared I might kill myself while he was away, he arranged for hospitalization . . . At one time I was liable to rush out of his room in a fury and drive away dangerously. He took charge of my car keys until the end of the session, and then allowed me to lie quietly alone . . . til I could be safe (p. 22).

Both Winnicott's and Little's reports clearly illustrate that he viewed direct intervention in the patients' environment as an essential component of effective treatment. In a classic paper on therapeutic regression with psychotic patients, he explicitly commented that the "accent is more surely on management . . . sometimes ordinary analytic work has to be in abeyance over long periods (with) management being the whole thing" (1954, p. 279).

Management: a Theoretical Perspective

Winnicott's approach to management was firmly grounded in his developmental theories of how social environments facilitate personality development. His pediatric experience with thousands of normal mothers and infants gave him a unique perspective on the essential everyday interactions between the "ordinary devoted" or "good-enough" mother and her child. In exploring these commonplace phenomena, Winnicott moved beyond the instinctual relationships so central to classical and Kleinian psychoanalysis and instead focused on the parental provision of ego support. He commented that:

a source of misunderstanding here is the idea that the term 'adaptation to need' in treatment of schizoid patients and in infant care means meeting (or frustrating) id-drives. There are more important things going on, and these are of the nature of giving ego support to ego processes (1963c, p. 241).

Along these lines, Winnicott (1963a) believed that:

it is helpful to postulate the existence for the immature child of two mothers . . . (an) 'object-mother' and (an) 'environment-mother'. (These terms) describe the vast difference . . . for the infant between
the two aspects of infant-care, the mother as object . . . that may satisfy the infant's urgent needs, and the mother as the person who wards off the unpredictable and who actively provides care in handling and in general management (p. 75).

Winnicott (1961) viewed infant nurture as "an everwidening interpretation of the word holding," a term including "all physical management . . . done in adaptation to an infant's needs" (p. 237). By this he meant much more than breast feeding, including regulation of temperature, stimulation, frustration and activity.

Foreshadowing Kohut's work (1971), Winnicott suggests that the "individual introjects the ego-supportive mother" (1958, p. 32) as "de-adaptation" occurs in "graduated doses" as "part of the gradual change toward independence" (1963c, p. 239). Later, the family unit as a whole continues this process, providing both "opportunities for regression to dependence of a high order" (1961, p. 237) as well as a "graduated failure of adaptation that is an essential part of the healthy environment" (1965a). This titration of environmental support in response to the child's needs is the core of the process of management.

**Etiological Considerations**

Given his interest in the environmental influences on development, it is unsurprising that Winnicott generally viewed psychotic disorders as largely caused by environmental forces. In a typical comment, he stated that psychosis is "etiologically linked with environmental failure, failure to facilitate the maturational processes at the stage of (infantile) dependence" (1963b, p. 226). However, rather than focusing on the pathogenic factors in the parent-child relationship, Winnicott more typically focused on its positive characteristics. For example, he wrote Herbert Rosenfeld that:

> if it is possible for an analyst or . . . a mental hospital to cure a schizophrenic patient it must certainly be possible for a mother to do so . . . (with her) infant . . . (The) logical conclusion is that the mother often prevents schizophrenia by ordinary good management (Rodman, 1987, p. 45).

In an unpublished manuscript, Winnicott elaborates on this theme, noting that the:

> average family is all the time preventing and clearing up the disturbances in this and that child, usually without professional help. It is a mistake for a psychotherapist to usurp the total family functioning except where this functioning is doomed to failure because of some inherent defect (1965a, p. 143).
This emphasis on the therapeutic capacity of ordinary “good-enough” families was operationalized in the case reports mentioned earlier. Both reports describe how Winnicott empowered parents to assume the primary role in treating severely disturbed children. Also, neither report contains any suggestion that deficient parenting was responsible for the child’s illness. This emphasis on the positive elements in family life extends to Winnicott’s empathic appreciation for the inevitable psychopathology in the normal parenting experience, including the postnatal near-psychotic maternal preoccupation (Winnicott, 1956) and the hatred and rage evoked by children of all ages (Winnicott, 1947).

Reconciling this appreciation and respect for ordinary family life with his belief in an environmental etiology was not always an easy matter. In 1964, Winnicott published a letter in the London Observer which stated that a lack of maternal devotion predisposed the infant to become autistic. This letter elicited a barrage of criticism, as both parents of autistic children and leaders of The Society for Autistic Children (of which Winnicott was a board member) and The Association of Parents and Friends of Autistic Children publicly argued that he had blamed parents for their children’s tragic conditions while ignoring biological factors.

Winnicott was genuinely stung by this criticism and attempted to repair the damage by writing the parents, the organizations and the newspaper to clarify his viewpoint and assuage the feelings of those he had offended. Acknowledging that “autism has a complex aetiology”, he nonetheless wondered how he could express his deep conviction that the “infant is fortunate if, at the very beginning, he or she can have ‘all of mother’” without inadvertently evoking guilt in some parents (Winnicott, 1964b).

Over the next two years, he reworked his thinking about the etiology of severe mental disorders in a series of unpublished manuscripts. In one paper, he attempted to demonstrate his appreciation of biological factors by describing the case of a boy whose behavior problems were caused by a brain cyst and alleviated by its removal (Winnicott, 1965c). Later in the same paper, he acknowledged that there are “powerful inherited factors in some cases of schizophrenia,” although he argued that environmental considerations were also important. In a lecture given that year, he also remarked that biological research on schizophrenia deserves “full support” (Winnicott, 1965b).

In an unpublished paper the following year entitled “Social Aspects of Autism”, Winnicott (1966) discussed the impact of etiological theories on parents of autistic children. Acknowledging the many mistakes professionals have made in differentiating the biological and psychological factors in this complex disorder, he discussed the varieties of guilt experienced by the parents of abnormal children. Aware that environmental
theories evoke guilt in parents, he nonetheless associated these theories with a therapeutic optimism absent among many biological psychiatrists of his era.

CASE VIGNETTE

To illustrate Winnicott's approach to the management of a psychotic client, I will present a vignette of two and a half years work with a severely impaired homeless woman:

Sharon, a 35 year old widowed mother with a diagnosis of paranoid schizophrenia, has been a patient at the mental health clinic for the past two and a half years. Because she is reluctant to talk about her past and has no family nearby or social network, we still do not have a good history of her illness and life. We do know that she came to the United States with her husband and child ten years ago. Her husband died suddenly at age 30 two years later, leaving her in custody of a 6 year old son. Although Sharon had a well-paying position in a technical field, her incipient psychosis rendered her unable to care for this child. Ultimately, he was legally removed from her custody and sent to live with paternal grandparents in another city. After creating a public disturbance, Sharon was hospitalized three years ago at a state hospital. She was discharged to our clinic's shelter outreach program which, at that time, served homeless persons who were housed by the Department of Social Services in inexpensive motels. The outreach worker helped connect her with our medication clinic and case management unit. She also linked her with a community agency that helped her obtain a job in a restaurant kitchen.

Stabilized, though still very guarded and schizoid, she met with me in my office on a weekly basis for about two months. Although she consented to take 200 m.g. of Thorazine daily, she did not openly acknowledge any difficulties beyond her wish to reestablish contact with her son. At her request, I contacted the grandparents who indicated that they did not want Sharon having any direct contact with her son, now 13. As they had no objection to correspondence, I helped Sharon draft a letter to him. Soon after, she received a devastating reply in which her son indicated that she had ruined his life and that he wanted nothing to do with her. Sharon reacted to this letter by expressing pride in its compositional skill, acknowledging no shame, grief or anger. Soon after, she discontinued our meetings. As she was steadily employed and had moved into a rooming house, I did not see how I could persuade her to continue our meetings, especially as she reacted with irritation to any expressions of interest or support.

About 5 months after my last session with her, I heard from a worker at another community agency that Sharon had relapsed, becoming paranoid and delusional. She lost her job and room, and soon moved into a local shelter. Our clinic's shelter outreach workers reported that they had been unable to persuade her to accept treatment. I visited Sharon in the shelter for about six weeks. These visits appeared to have little positive value and sometimes seemed to increase Sharon's agitation. Initially, she acknowledged a need for housing assistance, but refused to accept the medication that was a prerequisite for admission to the appropriate programs. Later, she denied any problem with housing, claiming that she owned a home which had been illegally confiscated by her
native country's secret police. She also accused me of being an agent of this police force. Alternatively withdrawn and argumentative, she did not exhibit behavior which would have permitted an involuntary commitment. Finally, after spending four months in a shelter with a 60 day limit, the shelter staff expelled her.

Within 24 hours, she was arrested for disorderly conduct and imprisoned. The jail psychologist contacted me for information, reporting that Sharon refused to answer any questions or cooperate with treatment. After a month in jail, Sharon's attorney successfully petitioned for transfer to a psychiatric hospital for a competency evaluation. Soon after Sharon's admission, I bumped into her while visiting another patient at the hospital. She barely acknowledged my presence and indicated that she had no wish to speak with me. Three more visits produced a similar result. Finally, on a fifth visit, I found her crocheting in the day room and she greeted me politely as if nothing had happened. I continued to meet with her on a weekly basis and we discussed options for discharge.

I also spoke intermittently with her hospital social worker. She surprised me one Friday afternoon by informing me that Sharon was being returned to jail the following Monday to stand trial on Tuesday. As the patient was a forensic case, the social worker had no formal responsibility for discharge planning and had no idea what would happen to Sharon. Unable to attend the trial, I frantically arranged for a social services worker stationed near the courthouse to assist with emergency housing after her expected release from custody. Although Sharon's attorney had assured me that he would assist her after her release, Sharon called me from outside the jail, frightened and homeless. I found a jail psychologist to transport her to the social services department. When I didn't hear from Sharon that evening, I became concerned and contacted the social services worker early the next day. I learned that they were not able to locate any local shelter beds and had sent her downtown to a large, chaotic shelter with instructions to return to their suburban office the following morning. I worried that she would not return and that I would not be able to locate her in a thousand bed shelter. After losing my temper with several social services workers for abandoning this patient, a social services supervisor called me a week after her release to inform me that Sharon had been in one of our county shelters for the past four days.

I visited Sharon at the shelter and found her more responsive and communicative than she had been in the hospital. She had continued taking her medication and had even worked several days for a temporary agency. I recommended a transfer to a small shelter near our clinic, a move which would facilitate planning for a longterm placement. Sharon agreed to this move. Over the next 6 weeks, I helped Sharon obtain temporary financial relief and a placement in a supervised apartment program. With the help of a job counselor from another community agency, she secured a fulltime restaurant job. Of course, none of these developments would have been possible without Sharon's clinical improvement and energetic collaboration. For example, when the coordinator of the apartment program told her that injectible medication would help maintain her community tenure, Sharon promptly initiated negotiations with her psychiatrist to administer IM Prolixin.

As Sharon remained very isolated four months after discharge, I found a volunteer from her native country who could meet with her socially on a bi-weekly basis. As she had not spoken her native language for almost eight years, she anticipated her initial contact with this volunteer with uncharacteristic excitement. Introducing them in a neighborhood restaurant, I had to keep excusing
myself to use the bathroom or make phone calls so they would not feel compelled to converse in English.

Around this time, Sharon kept expressing an interest in returning to the technical work she had abandoned seven years earlier. As her thinking was still quite concrete and her social skills were limited, I feared she might fail if she returned to this work. Furthermore, computers had revolutionized the practice of her specialty in the intervening years, a fact she was reluctant to acknowledge. I arranged for an instructor at a local college to review her work history and credentials and counsel her on the best way to update her skills. However, before she could enroll in a college course, she obtained an entry level technical position with the help of the state employment commission. Laid off two months later, I was uncertain whether she had been able to handle this cognitively demanding work. However, within two weeks she secured a higher paying position in her field through a private employment agency, evidencing her developing social skills.

Over two years after her hospital discharge, Sharon continues to build a life for herself in the community. She receives Prolixin injections (1 cc.) on a monthly basis, participates in a weekly apartment meeting and a weekly individual session. In our individual meetings, we discuss recent events in her work and social life, her ambivalence about her medication, and future plans for housing after she leaves the residential program. Gradually, she has begun to talk about events from her past, a process I foster by bringing her clippings about news from her native land.

Besides her external accomplishments of stable housing and employment, she now interacts with a gleam in her eye and sense of humor, both missing during her earlier period of stabilization. Although initially schizoid and isolated, she now enjoys the companionship of others, especially the aforementioned volunteer, a 22 year old roommate and an older gentlemen she has recently begun dating.

Discussion

Although many of my interactions with Sharon involved psychotherapeutic techniques, the core of my work was management of her needs for environmental support in the areas of housing, work and her social network. Although I had some intermittent contact with her for a year before her hospitalization, I was not able to establish a psychotherapeutic or managerial relationship during her residence in three different settings which offered inadequate support: the motel shelter program, her rooming house, and the first large shelter. I did learn, however, that she responded poorly to both isolation and overstimulating chaos.

When I visited her in the hospital, I observed that Sharon was able to benefit from the combination of medication and a non-intrusive inpatient setting. During this hospitalization, observing that I continued to demonstrate interest while experiencing repeated rebuffs, she began to allow me to attend to her needs for support. Unfortunately, the forensic nature of her hospitalization made smooth discharge planning difficult
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and my attempts to securely house her after her release from jail were temporarily unsuccessful.

Like a parent of a lost child, I had to charge around the network of services for the homeless trying to find her. When I did, she allowed me to try again, moving her to a smaller, more familial shelter and then again to our clinic’s supervised apartment program, settings that facilitated “regression to dependence.” At each placement, I spent much time consulting with the residential staff to help them respond appropriately to Sharon’s needs.

Vocationally, in spite of the severity of Sharon’s illness, I supported her interest in working, resisting the advice of other caregivers to help her apply for Social Security. Knowing she could work successfully while quite disturbed, I also knew that her schizoid and paranoid characteristics would make it difficult for her to find work on her own. Fortunately, a job counselor was able to quickly place her in a job with a minimum of red tape. I also used a volunteer to help her negotiate the immigration bureaucracy to replace her lost “green card.” Later, as Sharon’s paranoia diminished and her interpersonal skills improved, she began to manage most of her vocational concerns.

Finally, in the social sphere, my recruitment of the volunteer who spoke her native language seemed to facilitate a rapid relaxation of her paranoid and schizoid defenses. This volunteer, a reserved older professional woman, offered Sharon an opportunity for a maternal interaction that was rewarding without activating her paranoid defenses.

Overall, I can count contacts over the past three and a half years with more than twenty caregivers involved with Sharon’s case, including our clinic’s psychiatrists and nurses, outreach workers, residential staff, volunteers and social workers. As almost all responded supportively, I experience a sense of gratitude for their assistance analogous to a parent’s gratitude to his or her child’s teachers, babysitters and activity leaders. Somehow, Sharon’s sense of my reliable holding is inextricably interwoven with the quality of these other caregivers. The developing trust from our direct interactions would have easily eroded if I had failed her in these managerial interventions.

Practice Considerations in Management

Reviewing this case, Winnicott’s concept of the ego-supportive mother helps us understand a process of personality growth involving neither interpretation, unmanageable regression, catharsis, or exploration of the patient’s childhood. In this approach to management, clinicians, families and other caregivers provide specialized environments where the “highly complex internal factors” in troubled individuals and their social milieu could “rearrange themselves . . . over a period of
Winnicott primarily saw this work as the function of social workers, noting that “psychiatrists and psychoanalysts constantly hand over (psychotic patients) to the care of the psychiatric social worker (because) they can do nothing themselves” (1963b, p. 227). In such cases, he viewed the psychoanalyst as relatively impotent “unless . . . he steps outside his role at appropriate moments and himself becomes a social worker” (p. 219). He suggested that analysts might learn from social work that “interpretation is not the most important part of the work” with these difficult patients (Rodman, 1987, p. 142).

Winnicott (1961) viewed this work as the “professionalized aspect of the normal (holding) function of parents and (communities), a ‘holding’ of persons and situations, while growth tendencies are given a chance” (p. 237). He viewed “each social worker as a therapist, but not as the kind of therapist who makes . . . well-timed (transference) interpretations” (1963b, p. 227). He argued that they could do this if they liked, but that their:

more important function is therapy of the kind that is always being carried on by parents in correction of relative failures in environmental provision.” “What,” he asked, “do such parents do? They exaggerate some parental function and keep it up for a length of time, in fact until the child has used it up and is ready to be released from special care (1963b, p. 227).

Winnicott then offered a listing of the essential tasks for caregivers involved in the management of psychotic clients:

- You apply yourself to the case.
- You get to know what it feels like to be your client.
- You become reliable for the limited field of your professional responsibility.
- You behave yourself professionally.
- You concern yourself with your client’s problems.
- You accept being in the position of a subjective object in the client’s life, while at the same time you keep both feet on the ground.
- You accept love, and even the in-love state, without flinching and without acting-out your response.
- You accept hate and meet it with strength rather than with revenge.
- You tolerate your client’s illogicality, unreliability, suspicion, muddle, fecklessness, meanness, etc. etc., and recognize all these unpleasantnesses as symptoms of distress. (In private life these same things would make you keep at a distance.)
- You are not frightened, nor do you become overcome with guilt-feelings when your client goes mad, disintegrates, runs out in the street in a nightdress, attempts suicide and perhaps succeeds. If murder
threatens you call in the police to help not only yourself but also your client. In all these emergencies you recognize the client's call for help, or a cry of despair because of loss of hope of help.
In all these respects you are, in your... professional area, a person deeply involved in feeling, yet at the same time detached in that you know that you have no responsibility for the fact of your client's illness, and you know the limits of your powers to alter a crisis situation. If you can hold the situation together, the possibility is that the crisis will resolve itself, and then it will be because of you that a result is achieved (p. 229).

While these comments eloquently outlined the personal dimension of management, Winnicott frequently referred his readers to his wife Clare's writings for further elaboration. Although her papers address management problems in social casework with children, it can be adapted to the difficulties of adult psychotic clients. To elaborate D. W. Winnicott's perspective on management, I will briefly summarize Clare Winnicott's discussion of three topics: 1) the integrative function of the managerial relationship; 2) authority issues in the managerial relationship; and 3) the relationship between the case manager and residential caregivers.

**Integrative Functions of the Managerial Relationship**

Although Clare Winnicott (1954) saw the social worker's "first responsibility" as determining where the client will "sleep tonight," she viewed the his or her ongoing participation in the reality of the client's life as having profound intrapsychic significance. While the psychotherapist is largely a subjective figure, the social worker "starts off as a real person concerned with external events and people in the (client's) life" who "attempts to bridge the gap between the external world and his feelings about it" (C. Winnicott, 1963, p. 45). Bound to external reality by his or her actual involvement in the client's world, the social worker cannot serve as a relatively opaque receptor of transference fantasies.

However, this unique relationship offers alternative therapeutic possibilities. As the social worker may be the only person familiar with the family and other caregivers, he or she can "make links between places and events and bridge gaps between people which they are unable to bridge for themselves" (p. 45). Having lived through significant life events with the client, including transitions between family and residential programs, he or she can explore the feelings about these events at an appropriate moment. Clare Winnicott (1961b) described how children in her care would:
go over the same ground again and again. It might begin with: ‘Do you remember the day you brought me here in your car?’ And we would retrace our steps, going over the events and the explanations once more. This was no mere reminiscing, but a desperate effort to add life up, to overcome fears and anxieties, and to achieve a personal integration. In my experience, feelings about home and other important places cluster round the caseworker, so that when the children see her they are not only reminded of home but can be in touch with that part of themselves which has roots in the past and the (outside) world . . . (p. 34).

Case managers have similar experiences with mentally ill adult clients, helping them connect their internal experiences with such significant events as a family dispute, a psychiatric hospitalization or a period of homelessness (Harris and Bergman, 1987).

Clare Winnicott (1954) viewed the casework relationship as a reliable environment “within which people can find themselves or that bit of themselves which they are uncertain about” (p. 13). Foreshadowing Ogden’s (1982) discussion of projective identification and Searles’ (1986) recent work on borderlines, she described how social workers “can ‘hold’ the idea of (the client) in our relationship so that when he sees us he can find that bit of himself which he has given us” (p. 13). She goes on to describe how social workers also:

- hold the difficult situation . . . by tolerating it until (the client) either finds a way through it or tolerates it himself. If we can hold the painful experience, recognizing its importance and not turning aside from it as the client re-lives it with us in talking about it, we help him to have the courage to feel its full impact; only as he can do that will his own natural healing processes be liberated (p. 13).

**Authority Issues in the Managerial Relationship**

Clare Winnicott (1961a) forthrightly addressed the tension between the therapeutic and social functions of the managerial relationship. Recognizing that child welfare agencies assume parental responsibility for their clients, she viewed the social worker as “the overall caring parent behind the parents and (other caregivers), supporting their relationship and preserving continuity and reliability” (p. 66). Acknowledging that “it is difficult . . . to know when the rights of the (client) to exercise self-determination must be overridden,” she observed that such actions can often make the relationship more real and lead to “more productive work” (p. 67). While she was referring to decisions concerning parental custody and placement, similar decisions are made by case managers in initiating commitment petitions or referrals to community residential programs.
These authoritative actions are not without transference implications. Clare Winnicott (1954) noted that the social worker is:

not just the accepting understanding person ... which she wants to be . . . . . she is also a powerful person who can be a threat or a saviour . . . Unless (the social worker) fully recognizes the implications of this fact . . . (and) brings into the open the possibility that she may be felt as a threat or a saviour, she will find her relationship confused and will find her relationship difficult to handle (p. 10).

Given the tendency of psychotic patients to create grotesque transference fantasies from kernels of reality (Searles, 1979; Kanter, 1988), social workers have to be constantly attentive to such phenomena.

**Collaborating with Other Caregivers**

Whenever disturbed persons require residential care, be it in a hospital, halfway house, supervised apartment or foster home, caregivers will disagree in their appraisal of the client's needs or behavior. Often these differences crystallize around the intensity of contact. For example, staff nurses in hospitals frequently disagree with attending psychiatrists while halfway house counselors often disagree with case managers and therapists.

While there is a common belief that these differences can be resolved with adequate discussion, Clare Winnicott (1961b) argued that these tensions are inherent in the work of management and should be "understood and recognized and experienced" (p. 37). Besides the usual jealousies and rivalries, she attributed these tensions to the inherent difference between residential staff and case managers in the nature of their involvement and identification with their clients. In comparison with caregivers who have only intermittent contact, residential staff develop a more subjective identification with their clients.

Both make themselves available for identification to clients who internalize them in different ways. The client thus "represents ... something of themselves to each worker and each feels possessive about him." Clare Winnicott argued that these competing identifications are:

the fundamental source of tension, although it may be disguised in discussion about . . . hours of work, pay or status or demands of the job. But contained in the tension and possessiveness is the most valuable bit of each worker, the bit that enables each to do his or her job well. If there is no tension there has been no real identification, no real giving, and (the client) will remain fundamentally unhelped although he may have been adequately housed and fed (p. 38).
The Therapeutic Action of Management

Keeping these ideas in mind, I would like to return again to the case of Sharon presented earlier. Although I view empathy as an important element of our relationship, a transcript of our interactions would contain little evidence of any concerted attempt to understand her. For the most part, we chat about her current activities without any psychic exploration. Sharon’s experience of my empathic appreciation comes more from my management activities than from my verbal statements. This empathic appreciation extends far beyond my respect for her defences; it also encompasses an appreciation of her changing needs and capacities as she interacts with a complex environment. If I had offered too much (applying for disability benefits or referring her to a halfway house with 24 hour supervision) or too little (expecting her to negotiate the immigration bureaucracy by herself), the empathic failure would have been at least as damaging as any comment. Of course, my managerial interventions have decreased as Sharon’s capacities have developed, perhaps partially through identification with the managerial functions I have performed (Harris and Bergman, 1987).

The importance of the child’s internalization of such management functions has been largely neglected in developmental theory. How parents assess a two year old’s readiness to give up the bottle, a five year old’s readiness for kindergarten, a six year old’s readiness for piano lessons, or a twelve year old’s readiness to ride the subway conveys as much or more to the child than empathic comments or expressions of affection.

As Sharon’s management needs diminish, the importance of the integrative function of the managerial relationship that Clare Winnicott (1961b) described becomes increasingly apparent. Sharon’s isolation led to an almost total fragmentation of her life experience prior to our initial contact. She had no one who knew her in her country of origin, in her initially successful years in this country, and in her years of psychosis and homelessness. Having lived with her through periods of schizoid rigidity, psychotic disintegration, and recovery, I can refer back to these periods and facilitate the ongoing process of psychic integration. The volunteer from her country also helped Sharon rediscover disassociated “good” self-object representations which greatly enliven her current interactions.

Although the extent of Sharon’s recovery is striking, this vignette vividly illustrates the therapeutic impact of the approach to management that Winnicott advocated, an approach which integrates clinical sensitivity with environmental intervention. Like several other case reports (Sheppard, 1963; Khan, 1982; Kanter, 1984), it suggests that substantial personality growth is possible for severely disturbed persons outside of psychoanalysis or intensive psychotherapy.
Although Sharon’s progress in the past eighteen months overshadows the earlier period, the despair and helplessness she evoked in our first year cannot be overlooked. Repeatedly, Sharon refused to acknowledge my existence as a professional or as a human being: a condition I was willing to endure but not accept. Reflecting on those trying months, Winnicott’s (1970) comments from a lecture to social workers given just three months before his death seem most apt:

Your job is to survive. In this setting the word survive means not only that you live through it and that you manage not to get damaged, but also that you are not provoked into vindictiveness. If you survive, then and then only you may find yourself used in a quite natural way by the (client) who is becoming a person and who is newly able to make a gesture of a rather simplified loving nature . . . (Management) can be a very deliberate act of therapy done by professionals in a professional setting. It may be a kind of loving but often it has to be a kind of hating, and the key word is not treatment or cure but rather it is survival (p. 227-228).

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