20 The Mentally Ill in Your Caseload[1] (1963)

Since the beginning of the century there has been a crescendo of attempts to rescue psychiatry from stagnation. Psychiatrists have had a big task in changing the care and treatment of mentally ill persons from mechanical restraints to a human and humane method. Then came the application of dynamic psychology to psychiatry. It is the *psychology* of mental illness that is of interest to psycho-analysts and to those who work on the basis of dynamic psychology, and this category includes many social workers. My task will be to make this link between mental illness and the stages of individual emotional development and I shall go ahead without being in a position to offer positive proof of the details of my thesis.

First, I must remind you of the psychiatrist's classification of mental disorder. I shall deal summarily with the mental disorders that arise from physical abnormality of the brain, which is the electronic apparatus upon which the mind depends for functioning. The apparatus can be faulty in various ways, hereditarily, congenitally, through infectious disease, because of a tumour, or through degenerative processes such as arteriosclerosis. Also certain general physical disorders affect the electronic apparatus, such as myxoedema, and hormone unbalance associated with the menopause. We must brush aside these considerations, important though they are, in order to get towards the area of mental disorder that is a matter of psychology, of dynamic psychology, of emotional immaturity.

I shall also have to take for granted your knowledge of the effect on mental states of bodily illness, and the threat of bodily illness. It certainly does affect a person's mentality to have cancer or heart disease. Only the psychology of these effects can concern us here now.

A classification starts, then, with these three categories:

(a) Diseases of the brain with consequent mental disorder.

(b) Diseases of the body affecting mental attitudes.

(c) Mental disorders proper, that is, disorders that are not dependent on brain or other physical disease.

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[1] Talk given to the Association of Social Workers, London, and published in *New Thinking for Changing Needs,* by the Association of Social Workers, 1963.

From this we start to divide mental disorder into psychoneurosis and psychosis. You will not jump to the conclusion that psycho-neurotic persons are necessarily less ill than psychotic persons. The word ‘ill’ needs to be examined at this point. Let me use my friend the late John Rickman's definition: ‘Mental illness consists in not being able to find anyone who can stand you.’ In other words, there is a contribution from society into the meaning of the word ‘ill’, and certainly some psycho-neurotic persons are maximally difficult to live with. Yet they are not usually certifiable. This presents a difficulty to which I will refer later.

Health is emotional maturity, emotional maturity of the individual person. Psycho-neurosis relates to the state of the person as a child of toddler age; to the positive or negative family provision; to the way in which the latency period relieved or accentuated the tensions that were operative in the individual; and to the reassembly in the various stages of adolescence of the changes in the instinctual drives, and the new organization of defences against anxiety that came to blue-print in the early childhood of the individual.

Psycho-neurosis is the term used to describe the illness of persons who became ill at the stage of the Oedipus complex, at the stage of the experience of relationships as between three *whole* people. The conflicts arising out of these relationships lead to defensive measures which, if they become organized in a relatively rigid state, qualify for the title psycho-neurosis. These defences have been listed and clearly stated. Obviously the way in which they build up and become fixed depends to some extent, perhaps to a great extent, on the history of the individual prior to his or her arrival at the stage of triangular relationships as between whole persons.

Now psycho-neurosis involves repression, and the repressed unconscious, which is a special aspect of the unconscious. Whereas the unconscious generally is the storehouse of the richest areas of a person's self, the repressed unconscious is the bin in which is held (at great cost in terms of the mental economy) that which is intolerable and beyond the capacity of the individual to accommodate as part of the self and of personal experience. The unconscious proper can be reached in dreams and contributes fundamentally to all the most significant experiences of the human individual; by contrast, the repressed unconscious is not freely available for use, and appears only as a threat or as a source of reaction formation (for example, sentimentality indicating repressed hatred). All this is the stuff of dynamic psychology.

Repression belongs to psycho-neurosis just as splitting of the personality belongs to psychosis.

Psycho-neurotic illness can be severe indeed. Moreover, this type of illness makes the social worker despair, because the repressed unconscious is the province of the psycho-analyst. By contrast, as I shall try to show, the areas of illness named psychosis, or madness, offer more scope for the social worker, and this partly because such disorders offer less scope for the psycho-analyst, unless, indeed, he steps outside his role at appropriate moments and himself becomes a social worker. (This theme will develop gradually as I proceed.)

As I have said, in psycho-neurosis one of the defences has to do with regression. The person who is ill is found to have retreated from genital sexuality and from the triangular relationships as between whole people and to have taken up certain positions that belong to his or her life prior to the stage of the heterosexual and homosexual positions in interpersonal matters. To some extent the fixation points, the points used in these regressive defences, depend on good and bad experiences in the

individual's earlier developmental stages, and of course on the corresponding good and bad environmental factors relative to these stages.

Psychosis may be looked at as illness that has more to do with the experiences in the earlier phases than with the tensions at the level of interpersonal relationships which lead to repressive defences. In the extreme case there has been no true Oedipus complex because the individual was so much caught up in an earlier stage of development that true and full-blooded triangular relationships never became a fact.

Of course you will find cases to describe in which there can be demonstrated a mixture of normality in terms of the Oedipus complex and of psychosis in terms of being stuck at a phase of early emotional development. However, these mixed cases need not concern us here, where we are trying to state an extremely complex matter in simple terms.

Psycho-neurosis, then, belongs to the defences organized around the anxieties and conflicts of relatively normal persons, that is persons who at any rate have reached the stage of the Oedipus complex. In a treatment by psycho-analysis the analyst makes it possible for the quantity of repression to lessen, and at the end of the treatment the interpersonal relationships come to fuller expression and experience, and there is a lessening of the pregenital component of sexuality.

All the rest of mental illness (other than psycho-neurosis)

belongs to the build-up of the personality in earliest childhood and in infancy, along with the environmental provision that fails or succeeds in its function of facilitating the maturational processes of the individual. In other words, mental illness that is not psycho-neurosis has importance for the social worker because it concerns not so much the individual's organized defences as the individual's failure to attain the ego-strength or the personality integration that enables defences to form.

I can now return to classification of psychiatric types more happily because I think I may have conveyed to you the idea that madness is your province just as psycho-neurosis is the province of the orthodox Freudian analyst. Moreover madness has a relation to ordinary life. In madness we find instead of repression the processes of personality establishment and self-differentiation in reverse. This is the stuff of madness and it is this which I am principally trying to describe. Failures in the maturational process (itself a matter of heredity) are of course often associated with pathological hereditary factors, but the point is that these failures are very much associated with failures of the facilitating environment. You will see that it is here that the social worker comes in, since the environmental factor has a specific significance in the *aetiology* of madness. The basic assumption here is that the mental health of the individual is held down in the area of infant-care and child-care and both infant- and child-care reappear in the social worker's casework. In the psychotherapy of psycho-neurosis, which is essentially a disorder of inner conflict (that is to say, conflictwithin the intact integrated personalized and object-related self), these phenomena that derive from infant- and child-care turn up in that which is called the transference neurosis.

Let us go back then to my attempt to assemble the illnesses other than psycho-neurosis in the psychiatric classification. It would be simpler from the point of view of my presentation if I could take the two extremes and refer to psycho-neurosis at one extreme and to schizophrenia at the other. I cannot do this, however, because of the affective disorders.
Between psychoneurosisand schizophrenia lies the whole territory covered by the word depression. When I say between I really do mean that in the aetiology of these disorders the points of origin of depression lie between the points of origin of psycho-neurosis and of schizophrenia. I also mean that there is every degree of overlap, that there are no clear-cut distinctions and that in psychiatric illness it is false to label disorders as if they were diseases in the way that is characteristic of classification in physical medicine. (Here of

course I am excluding brain diseases which are really physical diseases with secondary psychological effects.)

The depressions constitute a very wide concept of mental disorder. Developments in psycho-analysis have elucidated much of the psychology of depressive illness and also have related depression to that which is essentially healthy, namely the capacity to mourn and the capacity to feel concerned. The depressions therefore range from near-normal to near-psychotic. At the normal end of the depressions come those depressive illnesses which imply maturityi n the individual and imply a degree of integration of the self. Here, as in psycho-neurosis, the psycho-analyst rather than the social worker is needed, but there is one thing which can be of great importance to the social worker, namely the tendency for depression to lift. Without doing any psychotherapy the social worker can do a great deal on the basis of allowing a depression to take its course. What is needed here is an assessment of the individual as one whose past history gives evidence that the personality integration can stand the strain of the depressive illness in which a certain type of conflict is working through. This conflict in depression roughly-speaking has to do with the individual's personal task of accommodating his or her own aggression and destructive impulses. When someone who is loved dies, the mourning process belongs to the working-through within the individual of the feeling of personal responsibility for the deathbecause of the destructive ideas and impulses that accompany loving. Depression at this end of the scale is formed on this pattern that is more obvious in mourning, the difference being that in depression there is a higher degree of repression and the processestake place at a level which is more unconscious (in the sense of being repressed) than in mourning.

From the psycho-analyst's point of view the psychotherapy of depression of this kind is not unlike that of psycho-neurosisexcept that in the transference the most powerful dynamic is in the two-body relationship based on that which was originally infant and mother. The important part of the analyst's therapeutic in the treatment of depression is his survival over a period in which destructive ideas dominate the scene, and here again the social worker who sees a depressed person through a depression is doing therapy simply by continuing to exist in person and by survival.

Allied to depressive illness of this reactive kind is that which is associated with menopausal and other types of contraction of opportunity for construction and creative contribution.

At the other extreme of this grouping of the depressions is

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psychotic depression in which there are associated features which link illness with schizophrenia. There may be some degree of depersonalization or of unreality feelings. Depression here is also associated with loss but the loss is of a more obscure kind than is the case with reactive depression and derives from an earlier date in the development of the individual. For example, the loss might be that of certain aspects of the mouth which disappear from the infant's point of view along with the mother and the breast when there is a separation at a date earlier than that at which the infant had reached a stage of emotional development which would provide the infant with the equipment for dealing with loss. The same loss of the mother a few months later would be a loss of object without this added element of a loss of part of the subject.

It is necessary therefore to categorize two forms of depression: *reactive depression* and *schizoid depression.* In extreme cases of the latter the clinical picture resembles that of schizophrenia, and in fact there can be no clear line of demarcation between any form of mental illness and the other forms. And in an individual's illness any kind of mixture and alternation must be expected. And alternations occur in one individual between a psycho-neurotic manifestation and a more psychotic illness (e.g. obsessional neurosis breaking down into a phase of agitated depression, and recovering to obsessional neurosis, etc.). For mental illnesses are not diseases like phthisis, or rheumatic fever, or scurvy. They are patterns of compromise between success and failure in the state of the individual's emotional development. Thus health is emotional maturity, maturity at age; and mental ill-health always has behind it a hold-up of emotional development. The tendency towards maturation persists, and it is this that provides the drivetowards cure, and towards self-cure if no help is available. It is this that is at the back of the *process* that can be relied on to appear if there can be provided a facilitating environment, nicely adjusted to the immediate needs of the person's maturational stage. It is here that the social worker becomes involved in a constructive way, and in fact the social worker has power that is not available to the psycho-analyst in so far as the latter is confining his work to interpreting the nascent conscious elements in the transference neurosis, appropriate in the treatment of psycho-neurosis.

Let me emphasize the point that mental illnesses are not diseases; they are compromises between the individual's immaturity and the actual social reactions, both helpful and avenging. In this way the clinical picture of a mentally-ill person varies

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according to the environmental attitude, even when the illness in the patient remains fundamentally unaltered; for example, a thirteen-year-old girl was dying at home, through refusing food, but normal and even happy in an alternative environment.

At the end of the scale beyond schizoid depression is schizophrenia proper. Here the accent is on certain failures of personalityconstruction. These will be listed, but first it must be made clear that clinically there may be a normally functioning area of the personality even in a severe schizoid case, so that the unwary may be deceived. This complication will be dealt with below under the term false self.

To understand schizophrenia-type illness it is necessary to examine the maturational processes as they carry the infant and the small child along in the early stages of emotional development. In this early time, when so much development is starting and nothing is being completed, the two trends are described by the words *maturation* and *dependence.* The environment is essential and gradually becomes less essential, so that one could speak of double dependence, changing into simple dependence.

The environment does not make the infant grow, nor does it determine the direction of growth. The environment, when good enough, facilitates the maturational process. For this to happen the environmental provision in an extremely subtle manner adapts itself to the changing needs arising out of the fact of maturation. Such subtle adaptation to changing need can only be given by a person, and one who has for the time being no other preoccupation, and who is ‘identified with the infant’ so that the infant's needs are sensed and met, as by a natural process.

In a facilitating environment the infant person is engaged in making various grades, three of which can be described as:

Integration

Personalization

Object-relating

Integration rapidly becomes complex, and soon includes the concept of time. The reverse process is that of disintegration, and this is a word used to describe a type of mental illness: disintegration of the personality. In lesser degree the reverse of integrationis splitting, and it is this feature, splitting, that characterizes schizophrenia, hence its name.

Personalization is a word that can be used to describe the achievement of a close relationship between the psyche and the body. Freud said that the ego is essentially built up on a basis of

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body-functioning; the ego is essentially a body-ego (that is to say, not a matter of the intellect). In the present context we are looking at the achievement in each individual person of the linkage of psyche and soma. Psycho-somatic disease is sometimes little more than a stressing of this psycho-somatic link in face of a danger of a breaking of the link; this breaking of the link results in various clinical states which receive the name ‘depersonalization’. Here again, the reverse of the development that we see in the dependent infant is a state that we recognize as a mental illness, namely depersonalization, or psycho-somatic disorder hiding this.

The same will be found if we examine object-relating, and the instinctual life. The infant becomes able to relate to an objectand to join up the idea of the object with a perception of the whole person of the mother. This capacity to relate to an objectdevelops only as a result of a maternal adaptation that is good enough; the theory of this is complex and I have tried to describe its complexity elsewhere (**Winnicott, 1951**). This capacity cannot develop by maturational process alone; the good-

enough adaptationof the mother is essential, and this must last over a long enough period, and a capacity for relating to objects can be lost, in part or wholly. At first the relationship is to a subjective object, and it is a long journey from here to the development and establishment of a capacity to relate to an object that is objectively perceived and that is allowed a separate existence, an existence outside the omnipotent control of the individual.

Success in this field of development is closely linked with the person's capacity to feel real; this, however, has to be brought into line with the idea of feeling real in the world and feeling that the world is real. It has to be acknowledged that the normal person cannot achieve a feeling of reality in the world comparable with the schizophrenic's feeling of reality in the absolutely private world of the schizophrenic's relation to subjective objects. For normal persons the only approach that can be made to this quality of feeling is in the cultural field. The opposite to the maturational trend towards object-relating is de-realization and loss of contact with (shared) reality, and here again are words that describe mental illness.

Added to all this there is a whole category of illness, paranoia and the persecutory elements that may complicate depression, and which, when contained within the personality, bring about the state of hypochondria. It is not possible to include a description of this here, because paranoia is not an illness in itself, but it is a complication of either depression or schizophrenia. In

the last analysis the origin of the persecutory elements that complicate depressive illness takes the patient and the analyst to oral sadism that has not been accepted by the individual, along with its results in the patient's imaginative concept of the psychosomatic self. But there can be a deeper origin to paranoia, which may be associated with integration and the establishment of a unit self: I AM.

Here could be brought in the concept of the true and the false self. It is essential to include this concept in the attempt to understand the deceptive clinical picture presented in most cases of schizophrenic-type illness. What is presented is a false self, adapted to the expectations of various layers of the individual's environment. In effect the compliant or false self is a pathological version of that which is called in health the polite, socially adapted aspect of the healthy personality. (I have described elsewhere (**Winnicott, 1952**) the point of origin of the false self, in relation to a not-quite-good-enough adaptation in the process in the infant of relating to objects.

In the pathological form of this the individual eventually destroys the false self, and attempts to reassert a true self, although this may not be compatible with living in the world, or with life. A mental breakdown is often a ‘healthy’ sign in that it implies a capacity of the individual to use an environment that has become available in order to re-establish an existence on a basis that feels real. Naturally such a device does not by any means always succeed, and it is very puzzling to society to see a compliant and perhaps valuable false self destroy good prospects by a renunciation of every obvious advantage simply for the hidden advantage of gaining a feeling of reality.

One other type of illness, psychopathy, must be described. In order to do this it is necessary to get on to another track and to look at the emotional growth of the individual in terms of dependence.

It will be observed that there is no place, in my way of stating these matters, for a mental illness that is not related to a developmental immaturity, perhaps with distortions due to the attempt of the individual to use the environment for the purpose of self-cure.

In terms of dependence it can be stated that there are for comparison two extremes and an area in between. At one extreme, *where dependence is adequately met,* the child achieves interpersonal relationships as between whole people, and is healthy or mature enough to suffer from, and to deal with, the conflicts that are personal and that belong to the individual's own psychic reality,

or that are in the person's own inner world. Illness here is called psycho-neurosis and is measured by the degree of rigidity of the personal defences organized to deal with anxiety in the personal dream.

At the other extreme is mental illness of mental hospital type, psychosis, that is aetiologically linked with environmental failure, failure to facilitate the maturational processes, at the stage of double dependence. The term double dependence implies that the essential provision was completely outside the perception and comprehension of the infant at the time. Failure here is called *privation.*

In between is failure on top of success, failure of the environment that was perceived by the child as such at the time that the failure occurred. For such a child there was good-enough environmental provision, and then this stopped. The going-on-living that belonged to taking for granted a good-enough environment became replaced by a reaction to environmental failure, and this reaction broke up the sense of going-on-living. The name given to this state of affairs is *deprivation.*

This is the point of origin of the antisocial tendency, and here begins that which takes hold of the child whenever he or she feels hopeful, and compels activity that is antisocial until someone acknowledges and attempts to correct the failure of the environment. A failure really did happen in the child's history and there really was a significant maladjustment to the child's essential needs. Ironically, the child who is compelled to state and restate this claim on society is called maladjusted.

This antisocial tendency is naturally very common in its minor manifestations, since to some extent parents must fail to meet even essential needs often; but these minor failures of adjustment are corrected by the parents with the child living a home life in the family. The more serious examples of letting a child down (failure of ego-support), however, give the child an antisocial tendency and lead to character disorder and to delinquency. When the defences have become hardened and disillusionment is complete the child who has been affected in this way is destined to be a psychopath, specializing in violence or theft or in both together; and the skill that goes into the antisocial act provides secondary gains, with the result that the child loses the drive to

become normal. But in many cases, had treatment been given at an early stage, before secondary gains had complicated matters, it would have been possible to find in the manifestations of the child's antisocial tendency an S.O.S. to society to acknowledge its debt and to re-establish for the child an environment in which

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impulsive action was once more safe and acceptable, as it had been before the environmental maladjustment.

The field of psychiatry having been covered in this psychological way, in terms of the emotional development of the individual, it is possible for me to pass over to a description of mental illness in terms of response to help. We need to acknowledge that there are cases that are outside remedy. We may die straining to give help where help cannot be given. Apart from this, I do know that psychiatrists and psycho-analysts constantly hand over cases to the care of the psychiatric social worker for no better reason than that they can do nothing themselves. I do this. What sense does it make?

Well, in my view, there are reasons why you might accept the position as it is. First I would call attention to **Clare Winnicott's (1962)** statement of agency function. For instance, the fact that you represent the Mental Health Act, or the Home Office, or society's genuine concern in regard to its deprived children, really does put you in a position that is unique in each case. This gives you special scope, especially in respect of the mentally ill who are not psycho-neurotic and in respect of the early cases displaying an antisocial tendency.

Your function can logically be reviewed in terms of infant-care, that is in terms of the facilitating environment, the facilitationof maturational processes. Integration is vitally important in this connexion, and your work is quite largely counteracting disintegrating forces in individuals and in families and in localized social groups.

I think of each social worker as a therapist, but not as the kind of therapist who makes the correct and well-timed interpretationthat elucidates the transference neurosis. Do this if you like, but your 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 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. Special care becomes irksome once the need for it has passed.

For instance, think of casework as providing a human basket. Clients put all their eggs into one basket which is you (and your agency). They take a risk, and first they must test you to see if you may be able to prove sensitive and reliable or whether you have it in you to repeat the traumatic experiences of their past. In a sense you are a frying-pan, with the frying process played backwards, so that you really do unscramble the scrambled eggs.

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Infant-care can almost be described in terms of holding, holding that starts off immensely simple and that steadily becomes extremely complex, yet remains, just the same, a holding. In other words, social work is based on the environmental provision that facilitates the individual's maturational process. It is simple and at the same time it is as complex as this environmental provision rapidly becomes in infant- and child-care. It is even more complex because it continues the provision to cover family care and the care of the small social unit. Always it has as its aim not a directing of the individual's life or development, but an enabling of the tendencies that are at work within the individual, leading to a natural evolution based on growth. It is emotional growth that has been delayed and perhaps distorted, and under proper conditions the forces that would have led to growth now lead to a disentanglement of the knot.

One of the difficulties you encounter may be singled out for special consideration. I refer to the clients who become clinically ill *because they find in you and your care the environment which is reliable,* and which, for them, practically invites a mental breakdown. In the area of delinquency (antisocial tendency related to deprivation) this means that when the client gains confidence in you there comes stealing, or destruction that uses your capacity to act strongly, backed by your agency. In the area of madness, what happens is that your client uses your special provision in order to become disintegrated or uncontrolled or dependent in the way that belongs to the period of infancy (regression to dependence). The client goes mad.

This has the germ of healing in it. It is a process of self-cure that needs your help; and in some cases it works. It is relaxation that is not possible except in the setting you have shown you can provide, in a limited professional area. All the same, you may find this difficult to distinguish from the willy-nilly breakdowns of those who cannot wait for good conditions but who simply fail to maintain the integration and emotional growth which they have attained or have seemed to have attained. Usually it is not impossible to make the distinction.

You will see why it is that I spoke first of psycho-neurosis and the repressed unconscious. On the whole repression is not relieved by environmental provision, however skilled and constant. Here the psycho-analyst is needed.

However, the more psychotic or insane disorders are formed in relation to failures in environmental provision, and they can be treated, sometimes successfully, by new environmental provision and this may be your psychiatric social work, casework. What

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you find yourself providing in your work can be described in the following ways:

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 problem.

You accept being in the position of a subjective object in the client's life, while at the same time you keep both your feet on your 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 the 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 limited 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.