

Object Relations and Nursing Care of Persons Experiencing Psychosis

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Object-relations theory explains human behavior in terms of a person's inner experiences of others, which are called objects. Internalization of relationships, projective identification, and containment are concepts within object-relations theory that help to explain the confusing and frustrating behavior of acutely psychotic patients. These concepts also provide a framework for understanding the reactions of nurse clinicians to psychotic behaviors. This article explains the basic principles of object-relations theory, illustrates the concepts through a case study, and proposes nursing interventions from an object-relations perspective.

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THE PSYCHOTIC SYMPTOMS of individuals suffering from schizophrenia are often incomprehensible to their caregivers and seem impenetrable except by antipsychotic medications. Although medication attenuates or ameliorates the psychosis, it does not explain it—except as far as one can observe that the symptoms respond to medication and therefore must be biochemical phenomena. However, as certainly as a headache is understood to be caused by stress but relieved by prostaglandin inhibition, the psychotic symptomatology of schizophrenia may be understood both biochemically and in terms of psychosocial stress. The increase in prostaglandins and the stress that causes muscle tension are not two separate causes that act synergistically to produce headache pain. Rather, each in its own right explains a tension headache from a different perspective. Although the evidence for a biological explanation of schizophrenic symptomatology is abundant and indisputable, such an explanation is one of several different and equally valid perspectives. This paper will address another one of these perspectives, object relations, which provides a framework for explaining psychotic symptoms in a way that can be meaningful for inpatient psychiatric nurses delivering care to the person with schizophrenia.

OBJECT RELATIONS

Object-relations theories are those which concern themselves with how individuals develop in

relation to the people around them (Hamilton, 1989). More specifically, object-relations theories account for personality development and psychopathology on the basis of internalization of relationships with others (Summers, 1994). Internalization of relationships describes the phenomenon of individuals having inner experiences of others. Freud (1923) explains that internalization describes the process of taking someone in psychologically, so that when that someone is absent in reality, there remains a presence of that someone that is now part of the self. A person's inner experiences of others affect the way the person thinks, feels, and behaves. A person's inner experiences of others are referred to as objects. Object relations refers to the interactional relationship between a subject and object and concerns the effect of the object on the subject (Walrond-Skinner, 1986). Object-relations theories provide a perspective that elucidates the meaning of psychotic symptomatology.

One essential component of psychiatric nursing interventions is therapeutic use of self. Object-relations theories can enhance the clinician's understanding of this concept and promote skillful

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therapeutic interventions. Clinicians using object-relations theories have an object relational understanding of a symptom's meaning, which ultimately shapes the choice of interventions. Object-relations theories emphasize the role of internalized relationships in both human development and psychological change. Psychological change occurs during the recovery from psychiatric illnesses. The following are central assumptions of object-relations theories:

Internalization of Relationships

The process of object relations—of relating to others—begins in infancy. All infants are born with a capacity to relate to others (Segal, 1964). At this early stage, object relations concerns what is internalized in the infant's relationship with its mother (or mothering figure). An infant does not take in (or internalize) an exact representation of the mother; rather the infant internalizes its experiences with her (Volkan, 1994). At this time, when it is entirely dependent on its mothering figure, the infant does not yet have a concept of its self as a distinct person. Rather, the infant's rudimentary concept of self is tightly enmeshed with that of the mothering figure, its object of dependence (Garfield & Havens, 1991). An infant continually defines and enriches its self as it constantly takes in representations of its experiences with its mother figure (Volkan, 1994). Human infants normally learn from their earliest experiences that the self and the object have both loving and destructive qualities and that the self and the object are related but separate (Mahler, Pine, & Bergman, 1975). Therefore, infants take in painful, rejecting, or frightening experiences, as well as loving and nurturing ones. The infant may cope with its overwhelming bad feelings by projecting its internalized badness into the mother figure, directing its bad feelings outward instead of inward (Tyson & Tyson, 1990). This serves as the basis for projective identification.

Projective Identification

The defense mechanism of projective identification protects an infant from painful realities and represents both the overwhelming nature of the stresses that incite psychosis and the primitive capacity available for coping with these stressors. An infant does not have much capacity to cope with either intense frustration and anxiety or extremely

gratifying feelings. Instead, it attributes its overwhelming experiences to its object, the mothering figure. Projective identification involves attributing an aspect of the self to an object and reidentifying with the element that was projected to have control over it (Klein, 1946). Projective identification helps the projecting individual manage whatever feeling was projected onto the object. In infants and adults, the process allows an individual to get rid of something unbearable from its self-representation and attribute that quality to an object, thereafter reabsorbing (or reintrojecting) it from that object (Volkan, 1994). Projective identification takes place with positive thoughts and feelings as well as negative; for example, an individual does not experience his or her own personal worth but sees these valued qualities in another, and needs to join or identify with that aspect of the other person (Hamilton, 1989).

Ogden's (1979) three-step model best explains the phenomenon of projective identification among psychiatric patients and their caregivers. First, a patient unconsciously projects a self-representation into the caregiver. Second, the caregiver identifies (also unconsciously) with the projected self-representation. Patients' intense affects help bring this about. Third, the caregiver processes this projected material and modifies it before the patient reintrojects it. Ogden's model is useful because it gives nurses a framework for assessing their contributions to nurse-patient interactions in a non-blaming way. One such interaction occurred between Charles, who was diagnosed with psychotic depression, and his nurse. Charles was uncommunicative, hostile, and neglectful of his self-care. Over time, he and his nurse established rapport, and Charles was able to discuss the death of his little sister by accidental poisoning, which he witnessed, and the suicide of his brother with whom he was very close. One day, Charles asked his nurse for a needle and thread so he could mend his trousers. The nurse fully intended to get these items for Charles but, in the rush of a busy day, forgot. The following morning, Charles asked the nurse for the needle and thread. Charles turned his back to the nurse and began speaking loudly over the nurse's voice. "Do not trust Woman, sayeth the Lord. Beware the Woman who will lie to you," he proclaimed. Charles became increasingly agitated, paranoid, and insecure. When the nurse addressed him, he raised his voice, ignored her, and walked

away. A simple mistake such as forgetting a needle and thread can become a threatening, frightening experience for a person who has a fragile self. To Charles, the act of forgetting a simple item seemed to make him forgotten or nonexistent, so he reacted by projecting his feelings of terror into the nurse. By doing so, Charles sought to make the nurse's existence dubious, rather than his own. The nurse was distressed and appalled at Charles' ravings. The inconsistency between the intimacy of Charles' tearful self-disclosure and the hostility of his rejection was disturbing to her. The nurse felt mistrust because the previous rapport between them seemed meaningless to Charles. As the nurse experienced these feelings, Charles identified with them, and his perception that he was forgettable, meaningless, and worthy of mistrust was further justified. However, his perception that someone outside of him judged him to be that way enabled him to retreat and regain whatever he felt that he had lost of himself. Applying the concept of projective identification allows the nurse to perceive such hostile behavior as protective and necessary and to consider interventions that promote more appropriate coping behaviors. The nurse who understands Charles' experience from an object-relations perspective can recognize the dynamics of the situation and avoid taking Charles' ravings personally. The nurse can therapeutically validate Charles' experience and assist Charles in learning to verbalize his feelings rather than projecting them.

Containment

Infants learn frustration tolerance from their experiences of having their distress contained (Bion, 1959). When an infant rids itself of distress, it projects it onto its mother. The mothering figure acts as a container for the frustration and pain that is too much for the infant. She contains the tension and gives it back to the infant in a tolerable form; mothers do this when they hold and rock a crying infant or make soothing noises to it. The mothering figure's ability to do this depends on how well she can absorb the infant's tension and allow the infant to internalize her as an object that can tolerate the original distress. This is how an infant learns to manage its frustration and anxiety, and it depends very much on the mother's ability to accept the infant's projective identifications. If the mother cannot fulfill her function as a container of the infant's distress, then the distressing reality will

cause the infant overwhelming anxiety. When containment does not occur, the infant has so little capacity for frustration that it cannot progress to the level of cognition required for frustration tolerance. Because the infant has not yet developed skills to cope with a bad reality, it is forced to deny it. As with the desperately frustrated infant, the adult with schizophrenia who faces overwhelming distress uses projective identification, which results in a psychotic delusion (Steiner, 1991). Steiner noted that during projective identification, the patient "makes the caregiver feel something which the patient would otherwise have to feel."

In a manner similar to an effective parent figure, the psychiatric nurse can contain the overwhelming emotional upheaval of the person experiencing psychosis. The nurse can draw on his or her own experiences (which were mastered long ago) to respond to the psychosis in an empathic way. It may be difficult to imagine that the nurse and the person who is acutely psychotic have any shared experiences. However, Gabbard (1992), while studying the phenomenon of countertransference with "difficult" psychiatric inpatients, observed that in many ways staff members are more similar to these individuals than different. Countertransference, as Freud (1950) explained, is the patient's influence on the caregiver's unconscious feelings. Recall that persons experiencing psychosis have only their early defenses at their disposal and they are still overwhelmed by the same challenges to the self that we overcame in early life. At one time, clinicians have experienced similar fears, fantasies, and identifications that their patients are experiencing. These feelings provide insight into what the psychotic person is experiencing and are the basis of the nurse's empathic response. This response contains the overwhelming experiences of the acutely psychotic patient.

PARANOID PHENOMENA AND PSYCHOSIS

Trust versus mistrust is a developmental task that is relevant to object-relations theory as it pertains to the experience of paranoia. The paranoid person, who did not achieve this developmental milestone, cannot trust others, becomes suspicious under ordinary circumstances, and expects to be betrayed. During a nurse-patient interaction, according to this conceptualization, the nurse is the object of mistrust; this, quite naturally, is angering and frustrating to the nurse who cares for these patients and as

a result, finds it difficult to experience empathy for the paranoid person. A different aspect of mistrust, however, concerns the inner experiences of the paranoid person (Garfield & Havens, 1991). The paranoid person experiences mistrust of himself or herself, resulting in internal questions, such as "Who am I?" and "Why would anybody want to be with me?" Responding to the inner experience of the patient enables the clinician to empathize with this type of patient.

Fairbairn (1944) offered another way of conceptualizing the overwhelming anxiety of the earliest time in the infant's life, which he referred to as the schizoid position. During this early part of life, the infant has a vital need to have its love accepted by the object of its love. Conversely, the infant's experience of its love being rejected is quite traumatic. When the infant's experience is that the object has not responded to it, the infant's normal desire to take in the object is intensified. This intensified desire has a desperate, needy quality, which leads to a wish to devour or possess the object. The resultant experience of the infant is that the desire for the object elicits the fear of destroying it. This fear is so overwhelming to the infant because the infant's self is wrapped up in the object's self. Thus, the infant withdraws at this early stage when object contact is vital to its development. To keep its object safe, the infant must withdraw from it.

When we apply this conceptualization to individuals with schizophrenia as we hear them speak of their delusions and observe the outcomes of their interpersonal relations, we can see that they still use these earliest patterns of dealing with objects to which they relate. Donald is a lonely man who remains withdrawn unless the nursing staff seeks him out and engages him. As Donald becomes more interactive, his words and body language show that he is socially awkward, timid, and needy. Donald monopolizes his nurse's attention and becomes clinging, which often results in the nurse extricating herself from the interaction. This is extremely stressful for Donald, who resumes his mistrust of social contacts and often strikes out in his paranoia. In such situations, it is vital to remember that the person with schizophrenia who is becoming symptomatic is responding to his or her experience of an object, not to the object as a separate individual. This is why other patients and staff may interact with that same individual with no

difficulty. The person with schizophrenia may crave attachment with an object and fear that he or she would be engulfed by that object at the same time.

Using a framework of object relations, it becomes easier to understand that it is the internalized representation of the person or event that is disturbing or unsettling to the patient. Insight into the meaning of these behaviors and verbalizations will inform nursing interventions and thus contribute to the patient's mastery of the experience. This process is not the same as challenging a delusion, which involves a dispute about its factual accuracy. Such a confrontational approach attempts to falsify the delusion, which through primitive defense mechanisms such as projective identification, serves as a protective buffer against the external world (Volkan, 1994). A delusion, Freud (1950) wrote, is the schizophrenic's attempt to rebuild his or her internal world so that it becomes tolerable. The object relationship that the person with schizophrenia creates in the delusion is what is necessary to repair the damaged or destroyed part of the self (Steiner, 1991). Conceptualizing psychotic symptoms within an object relations framework shows us the extent of this lack of mature object relatedness. It gives us an appreciation for how overwhelming an interpersonal challenge is for someone who must retreat into psychosis to cope with it. The following case example shows how the conceptualization of a patient's symptoms in an object-relations framework enhances understanding of the patient and thereby prompts a different kind of intervention.

CASE STUDY

Kate S. was a paranoid schizophrenic woman in her mid-40s who was admitted to an inpatient psychiatric unit for an acute psychotic episode and for marked decrease in her self-care. Kate had a history of psychiatric admissions since her early 20s and currently resided in a supervised adult living situation. She presented as a shabbily dressed woman with long, unkempt hair. She was malodorous and missing many of her teeth. Kate was prescribed antipsychotic medication, but she had been off her medication for an unspecified period of time. She often declined to take her medications in the hospital.

Since her arrival at the hospital, Kate was uncomfortable and defensive about talking about her delusions and adamantly denied having audi-

tory hallucinations. Kate voiced two requests shortly after admission. First, she wanted to go to the cafeteria to get a soda with ice. Second, she wanted to go outside for some fresh air. The staff made fulfillment of these requests and other increases in privileges contingent on Kate's taking her medication and attending to her personal hygiene. This information was presented to Kate in the form of a contract, to which she verbally agreed. However, when staff approached her about taking a shower and washing her hair, Kate's reaction was one of mixed irritation and fear. "You all quit bugging me, okay? I'll take a shower later. Anyway, something's wrong with the water. Like there are chemicals in it or something. Aren't you all afraid to use the water?"

Kate was persistent in her requests for a soda and a trip outside, in response to which the staff reminded Kate of her obligations under the treatment contract. Kate, in turn, became frustrated and mistrustful of the staff. As Kate's agitation mounted, most of the nursing staff agreed that it was appropriate to administer antipsychotic medication.

Kate's nurse went to the patient lounge and found Kate staring out a window and talking in a loud, anxious voice. She motioned to Kate to come away from the window, and she and Kate left the patient lounge. As they walked down the hall, Kate's nurse asked Kate, "What's going on? You seemed really upset in there." Kate shrugged her shoulders and began talking loosely about fumes being in the air, how someone was going to poison her, how fuel and oil were in the hospital food, and how the water was full of chemicals. "I smell something. Like gas or something. Something isn't right. I feel like something is going to happen," she said. "What are you concerned about?" asked her nurse. Kate shrugged her shoulders again. "I don't know," she sighed, as if no one could possibly know. "Something is about to happen. Something is going to happen. I can just feel it."

The nurse momentarily wondered how to reassure somebody who was worried about something that was not going to happen. Among most of the staff, Kate's definitive proclamation of her unshakable irrational fears had a way of causing those who intervened to feel helpless and confused, as well as angry at her "stubbornness." Kate continued talking with conviction about the fumes and how she would be poisoned and contaminated. "You seem really terrified about this," the nurse offered. "Oh,

God, I'm so scared," Kate said. "Tell me about feeling scared," her nurse encouraged. Kate talked at length about how she felt that people were trying to poison her and how she felt as though she could not believe anyone about what was safe for her to eat and drink. Her mood shifted from fearful to intensely sad. Kate talked about how scared she was that she could not take anyone's word for anything and that she knew that everyone talked about her. She cried as she related experiences of feeling left out or an outsider as a young girl. Kate's nurse suggested to her that it might have made her especially sad when she perceived that many people were becoming angry or disgusted with her recently, to which Kate agreed and sighed with relief. Her nurse also explained to Kate that a situation such as the occurrence in the patient lounge was especially stressful to Kate. This stress, the nurse explained, caused her thoughts to run away from her and seem like she had no control over them. Kate was able to attend to this simply worded discussion and stated that she felt calmer afterwards. She agreed to take her antipsychotic medication and shortly thereafter went to sleep.

Case Analysis

Conceptualizing Kate's psychotic symptoms from an object-relations perspective is challenging because the anxieties and frustrations that fuel her psychosis appear remote and foreign to caregivers. Caregivers are generally able to feel empathy for someone who is suffering a loss through a separation or death because they can draw on their own internalizations of similar experiences. However, infantile feelings of being destroyed or engulfed by an object or lacking a distinction between our self and our objects are fears that do not reside in our conscious memory. We have no conscious recollection of these traumas because we repress them; as Freud (1950) said, we dispose of these memories by rejecting them and keeping them out of consciousness, or, in the words of R.D. Laing (1972), we forget them and then forget that we forgot.

Kate's suffering resulted from fear of being destroyed by something, represented by engulfing, omnipresent fumes. This type of fear is not immediately familiar to us. The fear of being engulfed by an object is one that staff members most likely mastered many years ago at the developmentally appropriate time of infancy. The intense experiences of the acutely psychotic patient touch on

older, similar fears of the staff members. This insight about caregivers' experiences when interacting with psychotic patients sheds some light on the relationship between staff members and Kate. Kate's beliefs had a "stubborn" quality, which makes them seem volitional. Assuming that they are volitional only positions Kate at one end of a power struggle with the staff at the other. Kate's delusions served to rid herself of some abhorrent quality. She used the metaphors of fumes and chemical poisoning and projected these onto the psychiatric hospital and its staff. She became increasingly anxious and fixated on her delusion as she became more frustrated and ostracized around the issue of bathing. Despite initial confusion and reluctance, the nurse contained Kate's fears. In the process of containment, the nurse did not dispute the delusional material but explored the intense accompanying affects. The nurse accepted the mistrust and fear that Kate was experiencing and identified with it. Kate began to feel safe in the presence of the nurse. When the nurse sensed this, she "returned" these affects to Kate in the form of verbal statements that validated Kate's feelings. Kate was then able to make an association to some other painful feelings, those of feeling completely excluded and lonely, that were similar to her recent experiences on the unit. Kate may have achieved some active mastery over this overwhelming interpersonal situation, as Gabbard (1992) explains. Kate re-created old feelings of loneliness and exclusion in a new stressful situation on the unit. Both in her present situation and in her recollections, she felt disgusting and unacceptable, but her noncompliance with staff and patient requests afforded her an illusion of mastery and control over the situation.

In this example, Kate experienced relief from her psychotic symptoms and participated in a successful, self-disclosing personal interaction. The nurse was able to assign meaning to Kate's bizarre behaviors: what Kate's delusional fears represented and why these fears were so overwhelming. This added to the staff's knowledge about Kate for future interventions. Kate's condition requires adherence to an antipsychotic medication regimen. Using an object-relations framework to guide this intervention helped Kate realize the necessity of medication, which obviated the need for delusion-reinforcing threats or restraints to administer the medication. This interaction was one in which Kate evoked an experience in the nurse to communicate

something that she could not verbalize about herself (Summers, 1994).

OBJECT RELATIONS AND PSYCHIATRIC NURSING

Advanced practice psychiatric nurses are in an excellent position to incorporate an object-relations perspective into their practice. On an inpatient psychiatric unit, there are a variety of opportunities to incorporate this perspective into nursing assessment and intervention. Object-relations theories can enhance the quality of supervision that advanced practice psychiatric nurses provide to their staff members. Object relations-informed supervision will facilitate the development of the capacity for insight among psychiatric nursing staff, which will improve immediate patient outcomes as well as enhance long-term professional growth. Object-relations theories widen the field from which the psychiatric nurse develops psychiatric formulations, thus enhancing the nurse's ability to prevent and solve problems and to contribute to meaningful and enduring patient outcomes. The presence of a nurse with an object-relations perspective on the treatment team adds depth to the existing difference in perspective among team members. Because object-relations theories explain behavior in terms of inner experiences and in terms of relationships with others, it provides a means of assessing the root causes of symptoms and relevance of interventions. However, object-relations theories are not in competition with other theories that explain psychotic symptomatology, such as the vulnerability-stress model or the biological model. The psychiatric nurse can use object relations to increase understanding a patient's condition while implementing other interventions during treatment, as in the above case study.

In a time of great emphasis on the biological basis of psychiatric illnesses and treatments, object relations gives psychiatric nursing a perspective that is in keeping with its role in the treatment of the mentally ill. Lego (1992) explains how the psychiatric nurse in this unique role facilitates patient outcomes that attain overall hospitalization goals. Psychiatric nurses offer the patient a relationship that can change the patient's interpersonal situation, thereby changing the intrapsychic situation, which changes the chemistry of the brain. An expertise in object relations grants the psychiatric

nurse role an appropriate and invaluable knowledge for improving patient outcomes.

One potential impediment, however, to the acceptance of object-relations theories among psychiatric hospital staffs, and by extension, among psychiatric nurses, is the difficulty in confronting countertransference issues (Gabbard, 1992). Part of a nurse's response to psychotic patients stems from the nurse's identification with a projected part of the patient's self. Another part of the response stems from the nurse's own particular anxieties about or aversions to certain kinds of issues. Understandably, this is difficult; it challenges the means by which one protects the self against something objectionable. It is beneficial to process the distress with another clinician. The process of talking about intensely stressful interactions with a knowledgeable other allows thoughts and feelings to emerge that would otherwise remain unexplored and confound future interactions with patients. This supervision process increases caregivers' insight into patients' behavior and their own reactions.

Object relations is an intrapsychic and interpersonal framework that focuses on emotional interactions (Hamilton, 1989). This framework will inform and enhance the relationship between the nurse clinician and the psychotic patient. Nursing practice that is informed by object relations also requires a knowledge of cognitive, biological, and social theories. Object relations assists the practitioner to construct a psychiatric formulation about the patient. This knowledge informs treatment, the goal of which is to restore and maintain the patient's functioning and well-being. Attending to the object relationships of psychotic patients will demystify the experience for both clinician and patient, thus enriching psychiatric nursing interventions and facilitating enduring therapeutic outcomes.

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