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Intensive care psychiatric nursing – psychoanalytic perspectives[1]

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Based on unobtrusive observations, a parallel is drawn between general and psychiatric intensive care nursing. The correlation between bedside skills and the incidence of physical contact between nurse and patient in each setting is considered. The phenomenon of physical attacks by patients on carers and the process of restraint in the psychiatric intensive care unit (ICU) is then examined. It is suggested that attack by and subsequent restraint of a disturbed patient may be considered in terms of an unconscious re-enactment of an early skin-on-skin object relation. It is argued that the physical holding of a psychotic patient is functional in re-establishing their bodily ego. Some thoughts are offered on how the intensive care of psychotic patients might be carried forward in the future.

Keywords: intensive care, psychoanalytic theory, psychosis

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Nursing the unconscious patient

It is striking that both the psychiatric and general intensive care unit (ICU) milieus are dominated by the unconscious. In the general hospital it is the unconscious patient that is nursed while in the psychiatric ICU it is the unconscious *of* the patient that is focus of care. Such a comparison conflates differing discourses, the somatic and reflexive unconscious of the *brain* on the one hand and, on the other, the unconscious of the *mind* which we occasionally locate when we traverse the path of dreams (cf. Solms 1995); a difference between the neurology of the unconscious and its psychical topography which Freud (1915) described as a rudimentary hiatus. However, the mind and brain dichotomy appear to somewhat converge in the process of nursing ICU patients.

In both the general and psychiatric ICU the patient is in a state of limited body and mind shut down or retreat. In order to maintain survival, scarce resources are redirected from less vital organic and psychical functioning and consciousness is overridden. In the general hospital the brain of the comatosed patient operates at a level of organic reflex while the psychotic mind is arguably driven by the id with depreciated levels of ego intervention. In both cases the patient's admission to hospital is usually directly linked to trauma. Furthermore, both patient groups require the respite of elemental sleep, sedation and comfort – an inward folding of energy, life force and libido which leads to a re-generating primary state. The patient is to all intents and purposes in a regressed state, vulnerable and needy. The required response of the nurse in these acute settings arguably epitomizes the scientific maternal function of nursing.

In a recent paper Henri Rey (1994) recounted his experience of a serious heart operation describing how his post-operative anxiety about his heart beat brought to mind a powerful memory of his mother's heart beat. He drew a parallel between his operative state, his unconsciousness and interuterine sleep. Might the unconscious

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state of the patient in cases of serious illness, where the continuous presence and attention of the nurse is required, be a dynamic re-enactment of the *in utero* state where the infant is inseparable from the mother?

The general and psychiatric ICUs have the highest nurse–patient ratio compared with any other treatment milieu. At the Royal Free General Hospital ICU, 12 nurses care for nine patients on each shift. On the ICU at the Maudsley there are, on average, seven nursing staff for 15 patients although up to 10 staff are needed on occasions. In the general hospital the patient is wired up to various instruments; nursing observations and care necessitate an intensive amount of physical contact; pulses are checked, canulae are monitored, mouths are swabbed and so on. Even though the patient is unconscious the nursing team continue to talk to the patient offering reassurance, informing the patient of procedures that are being carried out. Subtle changes in heart rate, pulse or other vital physiological signs are interpreted as communications, signs of pain for instance, and action is taken accordingly.

On the psychiatric ICU, the patient is also often unable to communicate his needs directly. The task of the nursing team is also to undertake a detailed series of observations, interpret the signs and then respond to the needs of the patient accordingly. The nurses are likewise required to be in close proximity to the patient and the nursing task often requires hands-on bedside skills in order to maintain the life of the patient.

For example a 27-year-old male was admitted to a psychiatric intensive care unit (ICU) after jumping off the roof of an open psychiatric ward. During his admission to the ICU he continued to experience torturous command hallucinations instructing him to kill himself. His suicidality throughout his admission was unremitting. He was nursed under continuous observation which meant that he was always kept within sight of the nursing team and often within arms length. Close physical contact was determined by self-harming acts. On one occasion he attempted to force a metal hair brush down his throat and on another occasion he thrust a dinner knife down his throat. Damage was limited on both occasions by the nurses who were in close attendance.

This patient, like many others patients under intensive observation, would complain about the close attention of the nursing team, a paradoxical situation insofar as his repeated self-harming served to ensure continuation of close attention. It is as if there is a wish to be close to nursing care and a wish to have space simultaneously, a space/no space tension that is suggestive of the claustro-agoraphobia that Rey (1994) locates with the paranoid schizoid level of mental development. Patients behave in the ward milieu in ways that inevitably lead to restraint and then fight against being held. The process of physically holding or restraining the disturbed patient might be said to be a concrete manifestation of the patients need for psychical containment, that is to say, a need to be held in mind. The nursing task of holding a disturbed patient is therefore a complex process beyond the surface of control, although it is rare that the work of restraining a patient is approached with recourse to psychodynamics. For instance the transferential dynamics of the restraint may be overlooked and the patient may be held without in-depth understanding of the meaning of the patient's behaviour.

In recent years there has been an increasing number of nurses who have been trained in what is known as control and restraint (C and R), a technique adopted from the police force. C and R means that fewer staff are required to restrain a patient: the patient can be immobilized safely and quickly, and this is advantageous when it comes to the preservation of the nurse and the patient. However, the shape of the restraint may be undignified to the patient. The control of the patient employs minimum force initially directed at specific pressure points; knees, elbows, wrists and so forth. Where necessary the pressure of the restraint may be increased with ease, arguably to levels of pain, worryingly evoking the convenience of suppression (and a new incarnation of the straight jacket?). However, where treatment emphasizes control of the patient, the psychodynamics of the exchange between nurse and patient may be nullified and the patient's need for care, rather than control, may be subverted. Stirling & Mchugh (1997) have recently argued in favour of 'natural holding therapy' as an alternative to the increasingly popular C and R trend in nursing, a shift towards reconsidering a more humane model of restraint.

A preliminary schema for psychosensual maturation

For a psychoanalytic perspective on the intimate physical exchange between nurse and patient we might begin with Esther Bick's (1968) theory about the role of skin in the development of the infant's world. In her short but seminal paper Bick develops Freud's (1923) original idea that the ego is first and foremost a bodily ego. Freud posited that the surface of the body was not only an entity in itself but is experienced as a projection of psychical matter. Bick (1968) conceptualized this early development as the formation of a 'psychic skin', describing how the formative personality in the infant has no binding force of its own in the beginning. In the first place

the skin functions as an early physical boundary which acts as a template for holding the psyche together, a tactile sensuality which equates with the foundation of mental process.

The maturation of the psychic skin in the formation of psychological development can be further formulated following Rey's (1988, 1994) investigations into intrauterine life which he posits as the neuronal substrate of experience and the basis of nuclear memory, which shapes how we relate to the world around us in later life. During the early months of growth the foetus explores different domains of the inside of mother, from as low the groin to as high as the rib cage. Freedom of movement becomes less and less during the pregnancy until the final few weeks when the space is quite congested. The external world and its discomforts increasingly impinges on the sleepy world of the *in utero* baby which culminates with the head becoming locked into the pelvic canal.

Birth may be the protomentality of being unheld but it may also be a relieving re-capitulation of the previous experience of freedom of movement from the earlier *in utero* experience, when the space was much greater. The conflicting wish to be simultaneously both inside and outside is perhaps the basis of the claustro-agoraphobic state that Rey (1994) describes. The liberation of being outside for the newborn infant converges with the desire for the tight holding reminiscent of the *in utero* oneness with its mother. Midwives teach new mothers to wrap the new born tightly in a blanket. The distressed new born is comforted by this swaddling experience and crying subsides.

The first few months are a dawning of psychosensuality dominated by the demand for homeostasis. The external skin, once warmly engulfed *in utero*, now has range of curious new experiences and textures such as coldness or overheating. Bion (1962) has described how 'the emotional experience of the digestive system' (p. 62) is a helpful metaphor for understanding how bodily states unfold new layers of mentation. For instance, the newly functioning alimentary canal with its peristalsis, wind, indigestion and the bodily discharge of faeces brings new repertoires of mental states. According to Klein (1946) the first few months generate oppositional states which are the infant's prototypes for aggressive relations; the splitting of love and hate, annihilatory anxieties, the expulsion of what is perceived to be bad inside, and so on. However, to my mind, these states coalesce with less oppositional sensations such as unpleasure; discomfort and irritability vs. the equilibrium of pleasure and comfort (the pleasure/unpleasure dichotomy that Freud identified). Klein's notion of a polemic between good and bad experiences may rather reduce the complexity of more blurred mental states in the early months. For instance feeling sated and sleepy vs. feeling hungry, crotchety, fractious and dyspeptic may evoke more curious and less extreme states of mind rather than annihilatory anxiety and aggression.

Bick (1968) has described how the mother stabilizes the infant during the early months by providing a constant holding object, for example the nipple, the familiarity of smell, the sound of her voice and so on. This constancy enables the formation of a solid primary psychic skin which is integrated gradually through introjection. Bick also describes how the impeded development of a healthy psychic skin, a failure of maternal empathy, leads to a baby who is rigid, with jaws clenched, biting and acting violently towards their primary objects and carers. A second false skin is developed which defends the fragile ego.

Skin-on-skin and physical restraint

Bick's description of a disturbance in the formation of psychic skin is apposite when it comes to thinking about the restraint process with psychotic patients insofar as the patient may also exhibit rigidity, biting and attacking behaviour towards their primary carers. The ego boundary of the patient is blurred. The experience of restraining a patient is confusing; for a while it is not always possible to know where the patient begins and the staff members end as the patient thrashes around, with limbs flailing.

I was working on a psychiatric ICU on the day of the royal wedding of Andrew and Sarah. I was talking with a female colleague about the events of the wedding. We were standing behind a patient who was seated watching the television. Suddenly, the patient reeled up and began attacking me. We fell to the floor, almost inseparable. I pushed the patient off only for him to return with his attack. He continued to punch as I attempted to restrain him. It seemed as if he was attempting to meld into me as he pummelled my abdomen and my face with his fists. He was eventually restrained by several members of the team but not before he caused me bruising and slight concussion.

I believe I became embroiled in this patient's mind and body space disturbance insofar as I was behind him and out of sight and perhaps indistinguishable from the voices inside his head. Rosenfeld's (1971) paper on projective identification in psychosis is helpful in unravelling the attack. In his paper Rosenfeld began with a critique of Margaret Mahler's (1952) paper about symbiosis in infantile psychosis where the infant appears to

desire fusion with the maternal object. Rosenfeld was happy with Mahler's ideas only in part and argued that the process of fusion was rather driven by envy mediated by projective identification where forceful entry into the object was the aim in order that the object might be dominated and controlled. He concluded that the fusion process was more parasitic than symbiotic.

It was not made clear in Rosenfeld's schema as to whether or not he saw the attempt at parasitic fusion as pathological or normal. However, Jackson (1992) sees the psychotic wish for fusion as pathological, where the dread of separation leads to an attempt at invasion or colonization of the maternal space. Knowles (personal communication) points out that the parasitic dynamic between mother and infant must begin with the perception of the mother – that the parasitic exchange can only occur when the mother is an unwilling host.

In the vignette above, the patient's attack appears to have been an attempt at parasitic invasion of my body space (insofar as I was an unwilling host), suggesting that there was a disturbance in his own mind–body spatial relations. The process of fusion that Rosenfeld (1971) describes appears to be enacted during the restraint process where the skin-on-skin contact between the patient and the nursing team mean that the boundary between patient and other is blurred. The patient for a while may not be experienced as a whole as several nurses restrain a limb each and one nurse is assigned to the head of the patient to prevent biting or head banging. The person at the head is usually the nurse who is delegated the task of talking to the patient. The patient may be lost in a miasma of rage but talking through the restraint, firmly and calmly, is required reality orientation.

I found it helpful during the restraint to encourage the team to talk to each other about their experience of the patient's body parts, for instance was the patients left arm feeling more relaxed, had the left leg stopped kicking? In this way body parts could be released gradually; a process of peeling off or weaning. Following the restraint I observed that if all of the restraint team left the patient at once there was a higher likelihood of another incident occurring, whereas if one or two members of staff stayed with the patient for a while then there was less chance of a further incident. Quite simply the patient did not want to be left alone.

At this point I would like to suggest a preliminary psychodynamic formulation: *that the patient engulfed by the physicality of the restraint process may experience a new synthesis of safety and containment if the restraint is delivered with care and insight on the part of the nursing team*. In the same way that the swaddling process with the infant soon after birth has a calmative effect, the holding of the psychotic patient brings about a containing transformation. A clue to the effectiveness of the swaddling of the infant lies in what Rey (1994) has described as the 'marsupial space', a transitional space where the move from inside to outside is mediated by an experience of being held. The holding of the psychotic patient may have its corollary in a similar shift from the damaged inner world to reparative external relations.

Charlie was a very disturbed 19-year-old suffering from schizophrenia who was treated for several weeks in a psychiatric ICU. His self-care was very poor and excrement would often be visible on his clothes. He was barely communicative and he would lie on his back for hours staring at the back of his hand as he held it above his head. He was lonely and isolated and I would wonder if the absence of real voices was somehow eased by the hallucination of dialogue in his head. His formative reality was dislocated, dominated by a mother who herself suffered from schizophrenia. Charlie knew little of what it was liked to be loved and held. His contact with staff and patients was branded by a series of assaults which served to pervert his need for physical contact and holding. In spite of Charlie's aggression, a female colleague said she had nonetheless 'had a soft spot' for him. One day I recall an incident as she came out of the kitchen with two jugs of orange juice, one in either hand. Charlie walked up to her and without warning punched his hand between the jugs and into her face.

Charlie had a need for close sensual contact. He needed to be held but the nurses also needed to hold him at a distance. In quizzically gazing at his hand perhaps Charlie was exploring where he began and others ended. With the attack on my colleague he was perhaps reaching out to her, but all he discovered was an empty space that was familiar to him. His actions suggested that physical contact, perhaps with a good maternal breast, was a mystery to him. I wonder how long he must have waited to be picked up, to be loved and cuddled, and how long must he have been left in his own faeces and urine.

The future of ICU psychiatry

Nurses might understandably wish to keep the patient at a distance, at arms length so to speak, as self-protection against the invasive attack of the disturbed patient. It is usually very difficult for nurses to step back and think about their work. Cognitive, behavioural and biological approaches which have been the predominant therapeutic modalities that have underpinned nursing for the last 20 years or so would appear to be defensive attempts at

keeping the patient at a distance. Yet a patient's psychopathology may burrow into the body and (unconscious) mind of the nurse, leaving both physical and psychical bruising. The latter is far more difficult to account for and systems of support and supervision need to take these psychodynamics into account (Winship 1995). Likewise the more mechanized approaches to treatment of acute episodes where the emphasis is on control and restraint may deprive the patient of an opportunity of being held (in mind) where the meaning of their disuturbance may be understood.

If dangerously ill psychotic patients are to receive quality in-depth nursing care there is a need to develop a specific programme of preparation for ICU psychiatric nurses. Nurses working in the general ICU already attend a specific English National Board programme of training which prepares them for working with the unconscious of the physically ill patient. As well as research that examines the precipitant environmental factors when patients have required restraint or other observable patterns of behaviour that might inform us of how to prevent and manage acutely ill patients, there needs to be recourse to the psychodyanmics of the *process* of nursing and therein the unconscious processes. Encouragingly, there does appear to be some emerging pockets of interest in developing psychoanalytic approaches in ICUs (cf. O'Connor 1998). It would be timely for there to be equivalent psychiatric courses that provide comparable in-depth preparation for nurses in which the psychiatric unconscious is treated with as much importance as the unconsciousness of the patient in the general ICU.

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