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Caroline Schnell
The Emergency Department
as a Holding Environment:
Using Object Relations
Theory and Institutional
Transference to Explore
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ABSTRACT

The purpose of this study was to explore if object relations theory and institutional transference can help explain why some people with schizophrenia overuse the emergency department (ED). Since deinstitutionalization, and the implementation of managed care, high utilization of the ED by people with mental illnesses has become an important, and controversial topic within medical and mental health settings. High utilization negatively impacts both ED staff members, and people with schizophrenia.

Specifically, this study examined this phenomenon through the lens of object relations theory, and institutional transference. Object relations theory contributed to an understanding of social relationships in schizophrenia, and how poor object relations impacts the therapeutic alliance. The concept of a holding environment was used to examine the ED as a source of containment for those in crisis. Institutional transference helped to explain why people with schizophrenia may develop transference to the ED instead of transference to an individual therapist. Findings of this research highlight the importance of person-centered care for people with schizophrenia. This thesis calls for a reexamination of our traditional notions of therapy, and connection so that we may better serve those with schizophrenia.

**THE EMERGENCY DEPARTMENT AS A HOLDING ENVIRONMENT: USING
OBJECT RELATIONS THEORY AND INSTITUTIONAL TRANSFERENCE TO
EXPLORE SCHIZOPHRENIA AND EMERGENCY DEPARTMENT OVERUSE**

A project based upon an independent investigation,
submitted in partial fulfillment of the requirements
for the degree of Master of Social Work.

Caroline Schnell

Smith College School for Social Work
Northampton, Massachusetts 01063

2015

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CHAPTER I

Introduction

Overuse of the Emergency Department

Multiple studies have shown that people who overuse the Emergency Department (ED) are more likely to have a diagnosis of schizophrenia than any other mental illness (Chaput & Lebel, 2007). Ledoux and Minner (2006) state that although frequent visitors to the ED represent less than 10% of the patients who present to the ED, they account for approximately 20-30% of the contacts in the ED. As a result, it seems that this concept has received considerable coverage in the discussion of hospital economics and service use. It is difficult to define the term “overuse” as it has been operationalized differently in multiple studies. Ledoux and Minner (2006) have highlighted the difficulty in comparing studies on this phenomenon, because various lengths of time are examined “- ranging from under 1 year, in one of the studies, up to 22 months in another” (p. 116). One might infer that readmission rates suggest that this population experiences many barriers to traditional outpatient treatment methods. This phenomenon warrants further research and examination as it affects both the lives of people living with schizophrenia as well as mental health providers in all settings of social work.

Schizophrenia is a mental illness that impacts a person’s cognitive, emotional, and behavioral functioning (American Psychiatric Association, 2013). Some of the key diagnostic features of schizophrenia include delusions, hallucinations, disorganized speech, disorganized or catatonic behavior, and negative symptoms (APA, 2013). Schizophrenia is often chronic in nature, but the onset often occurs in a person’s early twenties (APA, 2013). Ledoux and Minner (2006) found that people who overuse the ED are more likely to have a diagnosis of schizophrenia than any other mental illness. In addition, this study found that these individuals

are often young, male, persons of color, have few social supports, and are presenting with significant life stress. These findings suggest that there are also significant structural factors that may contribute to the reasons why people with schizophrenia overuse the ED. These individuals have been described as “revolving door patients”, “frequent flyers”, and “frequent repeaters” and unfortunately, the focus of multiple studies has been on the economic burden of their service use patterns. However, Bassuk and Gerson (1980) argue that most “repeaters” have made attempts at therapy and have unsuccessfully tried to become involved in outpatient programs. However, it is hypothesized that they struggle with “ambivalence about involvement in a potentially close relationship” (p.1515) and that the more impersonal environment of the ED provides a comfortable level of containment that cannot be established in closer relationships. Therefore, incorporating a difference perspective about frequent users of the ED is warranted to better understand how to provide a therapeutic alternative.

Current study

In this thesis, I will explore the phenomenon of ED overuse among individuals with schizophrenia. I will describe the current research on ED overuse and investigate two theories that may offer insight into this phenomenon. I will propose a new way of understanding over use of the ED by people with schizophrenia by exploring the therapeutic features of the ED environment and how this particular setting lends itself to act as a type of holding environment for the population of focus. This will contribute to a better understanding of why individuals with schizophrenia may turn to the ED rather than other support mechanisms. In addition, I will introduce a case that is comprised of two cases from Martin (1989) and Gendel and Reiser’s (1981) work. This case study will illustrate the ways in which this phenomenon often occurs. Can object relations theory and institutional transference help to explain why some people with

schizophrenia may frequent the ED? The purpose of this thesis is to provide a theoretical understanding using object relations and institutional transference theory regarding why people with schizophrenia may be more likely to overuse the ED than any other group with mental illness.

Research Gaps

There are many gaps in the literature surrounding overuse of the ED by people with schizophrenia. Many studies focus primarily on the demographic profile of patients who overuse the ED and the economic burdens of this population (Arfken, Zeman, Yeager, Mischel, & Amirsadri, 2002; Ellison, Blum, & Barsky, 1987). This information is pertinent and sheds light on the demographics of people with schizophrenia who might overuse the ED. However, few studies explore what mechanisms contribute to people with schizophrenia overusing the ED instead of other mental health services, in a crisis. The focus on economics could likely be the result of recent changes in healthcare and pressures to reduce rates of readmissions among all populations utilizing the ED (Adams & Neilson, 2012). Additionally, although several studies have described inpatient psychiatric units as holding environments that can protect a person with schizophrenia from perceived internal and external threats (Selzer, 1983), no studies were found that discussed the role of the psychiatric ED as a similar holding environment. For example, Reider (1953) introduced the concept of “institutional transference” and the containment of a psychiatric hospital, arguing that patients often develop a therapeutic relationship to a place or atmosphere, not necessarily a person. Therefore, this study will investigate this concept and how it may contribute to understanding overuse of the ED.

Connection to Social Work

This phenomenon has strong connections to the field of social work. Many articles cite research on ED overuse as relevant given the economic strain on the hospital and the burden placed on hospital staff (Arfken, et al., 2002; Ellison et al., 1987). Yet, as a person-centered profession, it is important to consider this phenomenon as an adaptive behavior. I will use object relations theory and institutional transference to discuss ways in which psychosocial structures contribute to our understanding of this pattern. This sense of safety cannot always be gained from individual contact due to self-object differentiation deficits in schizophrenia (Bell, Lysaker & Milstein, 1992). In a profession that so highly values interpersonal relationships, it is important to know the limits of this and become more creative about ways to help clients with major mental illness find more containment in the environment. A strong therapeutic alliance, combined with insight significantly increases medication adherence amongst people with schizophrenia and this reduces the rates of relapse and hospitalization (Misdrahi, Petit, Blanc, Bayle & Llorca, 2012). However, it is difficult to build therapeutic alliance with a person who has schizophrenia due to poor self-object differentiation (Selzer, 1983). Health providers often view repeat visits to the ED as maladaptive and regressive. However, it is crucial that we examine the therapeutic role of the ED in order to implement better policies and treatment options for individuals who seek containment and therapeutic support outside of the individual therapy relationships. It is also important for social workers to gain a better clinical understanding of schizophrenia and psychotic illnesses and how these factors may impact treatment and ED use.

Overview of Theoretical Frameworks

Two specific theories will be used to examine this phenomenon, object Relations Theory and institutional transference. Object relations theory will be used to examine the social deficits that present challenges to both building a therapeutic alliance and seeking out individual support when in crisis. More specifically, the concept of a holding environment will be examined to explain why people with schizophrenia might feel more contained and grounded in the ED than in an individual meeting with a crisis worker or therapist. This chapter will begin with a discussion of Melanie Klein's work on paranoid-schizoid position and how the anxieties of this infantile stage of life largely characterize relationships in adults with schizophrenia. There is a significant conflict in relationships for people with schizophrenia, "simultaneous longings for, and terror of, fusion; attachments to others are experienced as mergers, and separations feel like death or disintegration of the self or the caregiver" (Berzoff, Flanagan & Hertz, 2011, p. 314). Social deficits have long been observed in people with schizophrenia, and it is important to address how this impacts the development of a therapeutic alliance with a therapist. Bell et al.'s (1992) research indicates that people with schizophrenia have poorer object relations, which often manifests in the mistrust of other people. Of note, the researchers also argue that basic trust of another is a significant part of psychotherapy. This thesis will partially explore the impact of object relations deficits on the development of a therapeutic alliance and how this might contribute to high rates of ED use by people with schizophrenia who might be less likely to seek out crisis support from an individual. In addition, Winnicott's discussions on the concept of a holding environment (1965) will be used to examine the role of the ED as a holding environment. Object relations will be used to focus on the social deficits associated with objects relations that might cause a person with schizophrenia to overuse the ED.

The concept of institutional transference will also be used to help explain why people with schizophrenia might form an attachment to an institution and therefore, overuse the ED. Dr. Norman Reider introduced the concept in 1953 when he observed patients who seemed to form attachments to mental health clinics or inpatient hospitals, rather than to individual therapists. He explained that this phenomenon can occur “with every type of institution which has any characteristic of benevolence” (p.60). This phenomenon was originally described in a clinic setting where clinicians rotated frequently and patients became attached to the agency or hospital itself. This thesis will explore the unique setting of the ED as a “benevolent” institution described in Reider’s work. This concept might help explain why people with schizophrenia may develop a transference to the ED instead of a transference to their individual therapist. This thesis will review some of the different subtypes of institutional transference (Martin, 1989) and the ways in which this concept manifests in multiple clinical settings. The concept of institutional transference will be used to explain why people with schizophrenia might feel more comfortable accessing an institution when in crisis rather than an individual clinician.

Overview of the Next Chapter

The following chapter will discuss this phenomenon and how specific components of the object relations theory and institutional transference might explain why people with schizophrenia are more likely to overuse the ED than people with other mental illnesses. This will be followed by a discussion on the history of phenomenon beginning with the theory of institutional transference that was studied in psychiatric institutions in the 1950’s. This thesis will also briefly address the structural factors that contribute to overuse of the ED by people with schizophrenia, such as changes in the health care system, demographic characteristics, and social policies that impact funding for mental health. The final chapter of this thesis will also synthesize

the theories as they are applied to this phenomenon and will discuss implications for future research.

CHAPTER II

Methodology

Introduction

This chapter will outline the methodological approach used to gather information about why people with schizophrenia overuse the ED. The first section will briefly review object relations theory and institutional transference as the theoretical frameworks that will be used to examine potentially why people with schizophrenia overuse the ED. Further, this section will review the specific concepts of these theories that will be used in this research to shed light on this phenomenon. The following sections will discuss the method of evaluation used to interpret that data using the two theories previously mentioned. Databases and search terms used are provided in Appendix A. The next sections will include an overview of this writer's potential biases and assumptions. The final section of this chapter will give a brief summary of the chapter to follow.

Theoretical Frameworks

Object relations theory is the first part of the theoretical framework that draws from the psychodynamic perspective. Object relations theory posits that infants are “wired for human interaction.” (Mitchell & Black, 1995, p. 113). This theory focuses largely on the early interactions between mother and infant and how this impacts social and romantic relationships in adulthood. Thus, early object relations are often continued throughout adulthood (Mitchell & Black, 1995). These object relations conflicts are often seen in adults with schizophrenia who present with both a social and emotional pathology in relation to close relationships with others (Binder, 2006). In schizophrenia, poor object relations could manifest in the avoidance of close relationships and connection with family, friends, and service providers. Decreased social

functioning is a primary symptom of schizophrenia (APA, 2013) and this has significant implications for the formation of a therapeutic alliance in individual therapy. This thesis will argue that object relations can help to shed light on why social interactions with individuals are threatening and overwhelming for people with schizophrenia. Berzoff (2011) describes the quality of relationships for a person with schizophrenia who has poor self-object relations stating, “The adult relationships of people with schizophrenia may become characterized by simultaneous longings for, and terror of, fusion” (p. 314). This fear of fusion creates a debilitating social barrier that impacts a person’s ability to connect with, and form a sense of trust with an outpatient provider. It seems particularly important to highlight Berzoff’s (2011) point that people with schizophrenia have a desire to connect with others. This is imperative to discuss because it highlights the emotional conflict that accompanies this illness. It is important to address this longing for social connection to both explore the narratives of this illness, and to explain why people with schizophrenia do not simply isolate in a crisis, but do in fact reach out for some type of social contact that is often found in the ED environment.

Bell et al. (1992) research suggests that object relations deficits are observed in all subtypes of schizophrenia indicating that this is a widespread issue that impacts the way in which these individuals can connect with service providers. Thus, general principles of object relations will be used to explain the social deficits that impact a person with schizophrenia’s ability to develop a therapeutic alliance with providers.

The development of a holding environment is the precursor to developing healthy object relations in infancy and adulthood. The primary function of the holding environment is “the reduction to a minimum of impingements to which the infant must react with resultant annihilation of personal being” (Winnicott, 1965, p. 46). The annihilation of personal being will

be an important theme that will be discussed in this thesis as it is related to fears around connecting with others that people with schizophrenia might experience. Object relations theory, and specifically, the concept of a holding environment will help to explain why people with schizophrenia are inclined to seek containment and safety in the ED instead of seeking support from an individual crisis worker or therapist.

Institutional transference is the second part of the theoretical framework that also contributes to the understanding of this phenomenon. Specifically, this concept will help to explain why people with schizophrenia might become more attached to the environment of the ED rather than to a specific provider either in the community or in the ED. Dr. Norman Reider (1953) first introduced the concept of institutional transference based on observations at a teaching clinic for outpatient psychiatry. He described the nature of attachment that chronic psychiatric patients had to both mental health institutions and outpatient mental health agencies where psychiatry residents rotated each month. Dr. Reider describes visits to the clinics as “ritualistic” (p. 60) explaining that patients were often deeply connected to the clinic and even idealized as one would a parental figure. Yet, these patients felt superficially attached to their therapists. He proposes two factors that might contribute to this type of transference to institutions. First, he argues that individuals with chronic mental illnesses depersonalize their attachment to the clinic in order to manage the loss associated with the change in residents. Second, he argues that many of the patients who seem to develop transference to the clinic itself instead of their clinician, often experienced the death of a parent or idealized figure in childhood. This piece of his argument seems to speak to the role of object relations in the attachment to an institution. This first paper laid the groundwork for this theory, which has since been revisited and reexamined. Safirstein (1967) also explored the social deficits that make it difficult for

chronically mentally ill patients to connect with their therapists, but also went more into depth about the nature of a psychiatric hospital and how the environment itself is conducive to developing an institutional transference. Dr. Harold Martin's (1989) work helped to further the evolution of this concept from what seems to be a more humanistic approach. He also addresses the role of the clinician's countertransference and the impact that this has on this population's engagement with outpatient services, as this seems to be an important angle to consider. Investigating the ways in which mentally ill patients attached to the impersonal structure of state hospitals, will contribute to an explanation of the present phenomenon.

Object relations will discuss the social deficits that contribute to this phenomenon. Institutional transference will be used to suggest that the ED is an ideal environment for seeking help when social deficits, such as those found in schizophrenia, are present and create outpatient service barriers.

Method of Evaluation

The method of evaluation for this thesis is a literature review that begins with an evaluation of the data on service use patterns of those with schizophrenia. This phenomenon will be evaluated through data from the literature review presenting the service use patterns of people with schizophrenia who frequent the ED. Specifically, this thesis will compare the rates of ED use and rates of missed appointments with outpatient, individual providers. Service use patterns will highlight the frequency with which people with schizophrenia overuse the ED and miss outpatient appointments. Then, an in depth description of the two theories used to shed new light on ED overuse by people with schizophrenia. Object relations theory and institutional transference will be the two theories used to analyze the data through a psychodynamic lens. These theories will provide a foundation for a new understanding of why people with

schizophrenia may frequent the ED. A case example comprised of two case studies from the work of Martin (1989) and Gendel and Reiser's (1981) work will also be used to illustrate the ways in which the theories explain the phenomenon of ED overuse. EBSCO Information Services was the primary search engine used for this literature review (See Appendix A for a complete list of search terms).

The concept of a holding environment is a specific component of object relations that will also be used to consider the unique quality of the ED, and why it might be preferred to the holding environment that can be found in a therapeutic session. This theory will also contribute to an understanding of social relationships in schizophrenia, and how poor object relations might explain why people with schizophrenia miss outpatient appointments with individual providers. Features of institutional transference will discuss the specific role of the institution as a benevolent parental figure. These two theories will complement one another to explain why people with schizophrenia frequent the ED and seem to develop a transference to it, and are also more likely to miss appointments with outpatient providers (Coodin, Staley, Cortens, Desrochers, & McLandress, 2004). Finally, the case study will illustrate the phenomenon and identify how the theoretical frameworks contribute to an explanation of the case.

Biases and Assumptions

My previous work as a case manager and clinical community support worker have impacted my understanding of this phenomenon and potentially contributes to several biases and assumptions that I have been aware of during this research. Given my connection to this issue and this population, it will be imperative to maintain awareness of how my preconceived notions might impact how I collect and interpret data. Given my interest in this topic, and my

background with this population, I will strive to include all evidenced that both supports and contradicts my argument so that my research is as comprehensive and accurate as possible.

Overview of the Next Chapter

A literature review will be completed to address the area of inquiry and to examine the phenomenon more fully in the next chapter. This will begin with an overview of deinstitutionalization and how this impacted the lives and treatment of people with chronic mental illnesses. A more recent shift to community care has broadened the forms and locations of treatments offered to people with severe mental illness and this will be reviewed in this chapter as well (Carr et al., 2003). This will lead into a discussion and overview of the lack of state hospitals that exist today and how this impacts people living with schizophrenia. The next section will provide an overview of the phenomenon. Specifically, the length of time, scope and population will be considered in order to gain a more thorough understanding of ED overuse by people with schizophrenia. A review of the phenomenon will be followed by a fictitious case study that will illuminate major themes and the role of the theoretical framework in exploring why people with schizophrenia might overused the ED.

CHAPTER III

Overview of Phenomenon

Introduction

This chapter will provide an overview of the current phenomenon of people with schizophrenia overusing the ED. The first section will provide a brief history of the deinstitutionalization movement and how this impacted those with severe mental illnesses in the community. This will be followed by an overview of the phenomenon itself including specifics about the scope of the phenomenon, and the demographic information of the group being examined. The next two sections will provide an overview of service use patterns of people with schizophrenia. These sections will review the literature on this phenomenon and more specifically, the statistical data on use of the ED and adherence to outpatient mental health appointments. The final section will illustrate the negative impacts that overusing the ED has on people with schizophrenia as a call for mental health reform and more comprehensive services.

Deinstitutionalization

In order to better explain why people with schizophrenia might overuse the ED, it is helpful to first examine how the deinstitutionalization of state mental hospitals impacted the lives and access to care for people with major mental illnesses. The Community Mental Health Centers Act (CMHCA) was passed in 1963 as a solution to the isolation of state mental hospitals for people with chronic mental illnesses and to integrate these individuals into the greater community (Kliwer, McNally, Trippany, 2009). It became clear that institutionalization of these individuals perpetuated feelings of hopelessness and fostered little to no expectations for recovery (Kliwer et al., 2009). CMHCA was intended to result in the development of mental health services outside of the hospital in order to promote community integration based on a

recovery model of care. However, the transformation was rapid and mental hospitals shut down before adequate community care was established (Kliwer et al., 2009). For example, in 1967 there were over 400,000 individuals in state mental hospitals. By 1972, 35% of those formerly institutionalized individuals were discharged into the community (Feldman, 2003). CMHCA did not address funding for affordable housing, and this resulted in extensive homelessness among people with mental illnesses who had once been institutionalized (Feldman, 2003). Additionally, the first federally funded community mental health center did not open until 3 years after CMHCA and treatment outside of private practices was limited (Feldman, 2003). Additionally, the broad term ‘community’ conjured up individual, and possibly, idealistic images of what community care would look like in practice (Feldman, 2003). In reality, this image was likely inconsistent with what actually transpired once people were integrated into the community for their care (Feldman, 2003). One envisioned a community mental health center as a place where people could access all services necessary to function in the community (Feldman, 2003). However, the difficulty of coordinating multiple mental health providers and services was grossly underestimated (Feldman, 2003). Although deinstitutionalization promoted greater overall freedom for those with serious mental illnesses, people continued to be isolated in the community upon escaping the isolation of the state mental hospital (Kliwer et al., 2009).

The Function of Asylum

Nearly half a century later, the effects of deinstitutionalization are present and the question of how to best support people with major mental illnesses still looms (Feldman, 2003). Although the conditions of state hospitals were isolative, Kelly and McKenna (2004) suggest that the hospitals offered more than just treatment to these individuals. Specifically, Kelly and McKenna (2004) explored the risks of those discharged into the community after having been

formerly institutionalized in Northern Ireland. Interestingly, they describe some of the protective factors of state hospitals, and specifically, the function of asylum. This new way of considering the role of the state hospital model is largely drawn from the work of several authors on institutionalization during the 1960's and 1970's in the United States.

The medical model terminology has been misleading. When we use the term 'hospital,' we naturally think of treatment. Hospitalization without treatment is an absurdity...If, however we understand the term 'hospitalization' nothing more nor less than asylum (as the mental hospital at one time was called), place of refuge, there is no connotation of medical treatment but rather one of treatment in the broad sense of meaning 'handling of' or 'how we treat one another' (Slovenko & Luby, 1974, p. 224-225).

The use of the word asylum to mean a place of refuge for people with mental illnesses is important to consider in the context of ED overuse. Kelly and McKenna argue that asylums offered safety and containment that does not exist in an outpatient setting. The authors cite their previous work from 1997 that speaks to the need for these protective factors in the current mental health system. "...Even when 'asylum the place' has gone, there will always be those patients who need 'asylum the function'" (p. 239). It would appear that this type of protection is currently missing for many people living with major mental illnesses.

Kelly and McKenna (2004) argue that although people were deinstitutionalized from state hospitals, they remained institutionalized within group homes. In addition, Markowitz (2006) argues that in the United States, people with severe mental illnesses are now being institutionalized in the prison system due to increased homelessness and criminal activity. Markowitz proposes that this is largely connected to a lack of mental health resources as a result of deinstitutionalization. "...in the face of limited treatment options, disturbing behavior that

might have been dealt with medically is now more likely to be treated as criminal behavior” (Markowitz, 2006, p. 49). Recognizing the limited options for treatment of individuals with severe mental illness who struggle to live independently in the community highlights the need for an environment that is both protective and therapeutic. The next section of this chapter will describe those individuals with severe mental illnesses who frequent the ED, and as a result, are stigmatized and labeled as over users.

Overview of the Phenomenon

Scope of ED Overuse.

As previously mentioned, the ED might fill some of the ‘asylum functions’ that institutions once afforded, and this might explain why people with schizophrenia have been increasingly overusing the ED.

As previously mentioned, “overuse” is operationalized in many different ways in multiple studies. Thus, it is important to review how researchers are considering this phenomenon. Ledoux and Miner (2006) define overuse as visiting the ED more than four times in a 16-month index period. In the same study, occasional users of the ED are defined as patients who visit the ED 2-3 during the same index period. Pasic et al. (2005) define overuse in three ways. In their study, patients with at least two standard deviations above the mean number of visits for the general population are considered to be over-users. Additionally, overuse is defined as six or more visits in a single year. Finally, patients with four or more visits in one quarter are considered to be over-users of the ED., Aagaard et al. (2013) consider high use of ED services as ≥ 5 visits to a psychiatric ED, ≥ 3 admissions to a psychiatric hospital, ≥ 60 days of admission per year. Both the breadth of research, and the varied methods of measurement speak to the complexities of studying ED overuse and how it impacts hospitals and individuals.

Demographic Profile.

Research has consistently shown that people who overuse the ED are also likely to be young men of color with low social functioning, and presenting with early-onset psychosis, or other psychotic illnesses (Pasic, et al., 2005). Klinenberg and Calsyn (1997) found that four distinct factors predicted repeat visits to the ED for both white patients and black patients. Those factors included previous visits to the psychiatric ED, previous psychiatric hospitalizations, current involvement with outpatient services, and not receiving aftercare following their initial ED visit. However, three unique factors predicted repeat ED visits for black patients only: having never been married, a lack of stable housing, and not being admitted at the time of their initial ED visit. Klinenberg and Calsyn (1997) suggest that these factors, which appear to be indicative of poor social connection, might be the result of social isolation related to racial discrimination. Of equal importance, the researchers disclosed that because the site of this research was at a teaching hospital, most of the repeat users were of lower socioeconomic status. Additionally, African Americans of lower socioeconomic status have less access to, or are less likely to utilize financial assistance resources for people with low incomes as compared to lower income white people (Klinenberg & Calsyn, 1997). This disparity could also be the result of institutional racism.

People who overuse the ED are also likely to be young and male. Kessler, et al. (2001) studied individuals with untreated severe mental illness, and sought to understand the factors that contribute to a lack of treatment. Although they controlled for demographics variables such as race, they found no significant correlation between race, and the likelihood that a person will receive treatment, and then drop out of it. However, they did find that younger age generally correlates with higher treatment dropout rates. Specifically, younger participants were likely to

report "...wanting to solve one's own mental health problems on one's own." (p. 997)

Furthermore, younger people were also more likely to deny needing treatment for their mental illness. This seems to suggest that younger individuals are more ambivalent about their condition, particularly if it has recently emerged in the form of a first psychotic episode. This research might imply that younger people have less insight into their condition. It may be the case that younger people do not seek out treatment until they are in crisis and because they are likely to be disconnected from outpatient providers, the ED is the only reasonable option at the time of crisis.

In summary, the previously mentioned research studies suggest that people who overuse the ED are likely to be young men of color with poor social functioning who have been diagnosed with a psychotic disorder and are of a lower socioeconomic status. These findings are critical because they may seem to suggest that institutional racism and a lack of access to resources in addition to having a psychotic disorder contribute to ED overuse.

Diagnostic Profile

This thesis focuses primarily on the diagnosis of schizophrenia or other psychotic disorders and the social functioning implications of this disease as markers for overuse. Current literature overwhelmingly cites schizophrenia or other psychotic illnesses as primary diagnostic predictors of ED overuse. Chaput and Lebel (2007) found that greater numbers of visits to the ED was positively associated with mental illnesses that are more severe and chronic, such as schizophrenia. A Canadian study collected the demographic and diagnostic information on people who made one visit, two visits, three to ten visits, and 11 or more visits in the span of 15 years to the psychiatric ED. This study found that more chronic and severe illnesses were positively correlated with a greater number of visits to the ED (Chaput & Lebel, 2007).

However, Pasic et al. (2005) found that although frequent users of the ED are twice as likely to carry a diagnosis of schizophrenia, it was not found to be an, ‘independent risk factor’ for overuse of the ED (p. 284). This indicates that although certain factors and characteristics can predict ED overuse, this phenomenon is multifaceted and complex.

Other Factors that Contribute to Overuse.

As previously mentioned, there are many psychosocial factors that might predict ED overuse. Arfken, Zeman, Yeager, Mischel, White & Amirsadi (2004) found that people who frequented an urban psychiatric ED were also more likely to have fewer housing and social resources than those who infrequently visited the ED. Additionally, in a study by Clark, Dusome, and Hughes (2007), participants cited several reasons for overusing the ED. For example, having “nowhere else to go” (p. 130) was a common explanation for ED overuse. In this study, 30% of the psychiatric patients in this study arrived at the ED between 3:30PM and 5:30PM. Additionally, 22% arrived between 9:30PM and midnight. One could speculate that this indicates a greater need for care after-hours and on weekends as participants reported feeling that the ED was the only option during these hours of the day when they felt paranoid, scared, or suicidal (Clark, et al., 2007). Those considered to be frequent visitors to the ED in Arfken et al.’s (2004) study were more likely to report that they utilized the psychiatric ED because it is a convenient place to get access to shelter and medication without having to schedule an appointment. Furthermore, independent risk factors for ED overuse in this study included self-reporting a hospitalization within the last 12 months, not being able to provide the name of a family member or supportive person, self-reporting the need for seeking care as running out of medication, and self-reporting being homeless, in an institution, or group home within the last 12 months

(Arfken, et al., 2004). The studies above contribute to a more complete understanding of the factors that contribute to ED use.

Outpatient Non-Adherence

Individuals who frequent the ED appear to have similar demographic, and diagnostic profiles as those who do not adhere to outpatient mental health appointments. Research suggests that for people with schizophrenia, social functioning is one of the most significant predictors of adherence to outpatient mental health appointments (Killaspy, Banerjee, King & Lloyd, 2000). It is crucial to examine the overlap in the demographic and diagnostic profiles of people who overuse the ED and people who miss outpatient appointments. Examining this overlap is important because it may suggest that there is a gap in care for individuals with severe mental illnesses. This overlap seems to suggest that although many individuals might be referred to, or already connected with an outpatient provider, they are unable to access these services and thus, turn to the ED for their care. Additionally, the asylum function that was present in long-term institutions is a component that is clearly missing from outpatient settings and this could contribute to disengagement from services.

This section primarily addresses the adherence patterns of people with schizophrenia or other psychotic illnesses. Kreyenbuhl, Nossel, and Dixon (2009) reviewed the rates and correlates of disengagement from mental health services amongst people with schizophrenia drawing from the National Comorbidity Survey (NCS). The authors found that despite the distressing symptoms of mental illnesses, many people do not seek out treatment. Thus, the researchers make an important distinction between those who do not seek out treatment and those who disengage from it. As previously mentioned, this study also indicates that individuals with certain demographic and psychological presentations such as younger age, race, poor social

functioning, and a diagnosis of schizophrenia or first episode psychosis are likely to disengage from treatment (Kreyenbuhl et al., 2009). Interestingly, the demographic and diagnostic factors that predict ED overuse also seem to predict outpatient disengagement. Killaspy, et al. (2000) examined outpatient adherence and the impacts of missed appointments. They found that follow-up psychiatric patients (not new referrals) are likely to have severe mental illnesses and were more likely to have poor social functioning. Coodin et al. (2004) found that in Canada, a person's level of functioning had a more significant impact on outpatient treatment adherence than any other factor. Specifically, these individuals had low scores on the Life Skills Profile (LSP) Social Contact subscale. Lower scores indicate higher levels of social anxiety and withdrawal, which are common symptoms of schizophrenia. Desai, Lawson, Barner, and Rascati (2013) explored medical costs associated with community-dwelling individuals with schizophrenia. They found that patients with schizophrenia who had a spouse had lower medical and psychiatric costs than un-partnered individuals with schizophrenia. The researchers hypothesized that this indicates greater family support, and that this partially contributes to fewer healthcare costs. Additionally, one could also infer that it is the level of social functioning, presumably required to maintain a partnership, that contributes to lower healthcare costs and lower service need. This study further contributed to the idea that lower social functioning in people with schizophrenia is a major factor that contributes to access to care. The above research suggests that for people with schizophrenia, social functioning heavily predicts overuse of the ED and non-adherence to outpatient appointments (Desai et al., 2013).

Negative Impacts of ED Overuse

Overburdened Emergency Departments.

Overuse of the ED negatively impacts both the hospital and the individual, and this strains the relationship between service providers and individuals who frequent the ED (Clarke et al., 2007). The ED is largely overburdened as a result of deinstitutionalization, ever shortening lengths of stay, and a lack of inpatient hospital beds (Aagaard, et al., 2013). Although there are multiple studies that focused on the experiences of medical staff regarding care in the ED, very few studies examine the perspective of the mental health patient (Clarke et al., 2007). Thus, it feels especially important to consider the experiences of those with mental illnesses in hospital settings as this group is already highly stigmatized.

Pasic, et al. (2005) found that a small number of people represent the majority of contacts in the ED. This small number of frequent users utilizes a disproportionate amount of time and resources, such as staff members, in the ED. Ledoux and Miner (2006) present similar statistics stating that although frequent users represent less than 10% of patients who go to the ED, they account for 20% - 30% of all contacts. Unfortunately, ED staff often lack the training needed to manage a mental health crises, as this setting was designed for medical emergencies, and not psychiatric emergencies (Ledoux and Miner, 2006). One could infer that this lack of training could result in poorer care, and misunderstandings of people with mental illnesses.

Adams and Neilson (2012) argue that the ED is unable to provide effective psychiatric care to patients with mental illnesses and that staff attitudes towards those who overuse the ED hinder successful outcomes and promote continued overuse. Adams and Neilson (2012) explained that the ED is designed to provide an array of non-specialized care, and this does not include managing mental health crises. This seems to create a destructive cycle in which people

overuse the ED, but do not actually receive the treatment that they need. This promotes continued overuse and leads to staff frustration and burnout (Adams & Neilson, 2012). Frustration and negative staff attitudes could result in increasingly poorer care of those with severe mental illnesses who are labeled as “frequent flyers.”

Poor Treatment of Individuals with Mental Illness and the ED.

Without the implication of an appropriate model of care for people with schizophrenia, many hospitals have been forced to “board” psychiatric patients who overuse the ED. Due to ineffective outpatient services, and a lack of inpatient psychiatric beds, individuals with mental illnesses are often “boarded” in the emergency department or on medical floors until an inpatient bed becomes available (American College of Emergency Physicians, 2008). The American College of Emergency Physicians (ACEP) distributed a survey in 2008 to more than 1,400 emergency department directors to gather information about psychiatric boarding. The data yielded shocking results about the rates of psychiatric boarding. The results revealed that 33% of psychiatric patients who have been approved for inpatient admission wait over 8 hours to be transferred. Additionally, in a March 2012, National Association of State Mental Health Program Directors (NASMHPD) also released a report that surveyed more than 6,000 emergency departments nationwide to assess the prevalence of psychiatric boarding. Shockingly, 70% of hospitals reported that they “boarded” psychiatric patients for “hours or days,” and 10% reporting they boarded individuals in psychiatric crisis for several weeks at a time before they either discharged them or were able to locate a hospital bed. Boarding is largely the result of a lack of inpatient psychiatric beds.

The ACEP survey also found that 72% of emergency department directors agreed that psychiatric patients in the ED require more nursing staff than non-psychiatric patients (2008).

This is important to note because staff attitudes towards psychiatric patients could impact their quality of care. Arfken et al. (2002) argue that for ED staff, an increase in workload makes it more difficult to provide the necessary services that patients with mental illnesses need. Furthermore, when staff members are overburdened, and lack the training to work with individuals with severe mental illnesses, staff can become frustrated and hostile towards patients (Arfken, et al., 2002). It is important to consider how providers view individuals who overuse the ED as it impacts quality of care and can unfortunately, can contribute to feelings of stigmatization and shame for those with mental illnesses. Although there are many studies that examine the perspective of the medical patient, there are fewer studies that consider the views of psychiatric patients (Clarke et al., 2007). Clarke et al.'s study examined mental health patients' perspectives of the ED and staff attitudes towards them. Of note, this study examined the perspectives of mental health patients in general, not necessarily patients who were identified as overusers. Among several themes, these patients described feeling that their psychiatric emergencies were not considered a priority in the ED. In addition, a small number of patients indicated that they felt shamed because of their mental illness. Patients also felt that ED staff were often not properly trained to manage mental health crises (Clarke et al., 2007). This information is important because it highlights gaps in care for people with mental illnesses who utilize the ED. Additionally, this research highlights the stigmatization of people with mental illnesses in health care settings, regardless of their service use patterns. Despite the fact that the emergency department has been shown to be an inadequate treatment option for many people with mental illnesses for multiple reasons, many people with psychotic illnesses overuse this treatment setting. People with psychotic illnesses are more likely than those with other mental illnesses to overuse the ED. In addition, this same group of people is more likely to miss

outpatient treatment appointments. Returning to Kelly and McKenna's (2004) concept of 'asylum the function' (239) provides a helpful framework for examining why people with severe mental illnesses, who were once institutionalized, may now be seeking asylum in the ED when in crisis.

Overview of the Next Chapter

The following two chapters will summarize object relations theory as well as institutional transference in order to create a framework for better understanding why people with schizophrenia may overuse the ED. The chapter on object relations will include an overview of self-object differentiation and the holding environment. The chapter on institutional transference will provide a brief overview of this theory's historical foundations and its development during the 1950's when institutionalization was the primary form of treatment for people with severe mental illness.

CHAPTER IV

Schizophrenia and Frequent Use of the Emergency Department: Object Relations

Perspective

Introduction

This chapter will review key concepts of object relations theory that are relevant to the understanding of ED overuse by people with schizophrenia and other psychotic illnesses. The chapter will begin with a brief history of object relations theory followed by an overview of Melanie Klein's theories on the paranoid-schizoid position as well as the depressive position. An overview of these positions will create a foundation for later discussion around primitive object relations in adults with schizophrenia. The next section will introduce D.W. Winnicott's concept of the holding environment. The following portion will focus on the experience of fusions and merging for people with schizophrenia. The final section will reintroduce the phenomenon of people with schizophrenia overusing the ED. This chapter will conclude with a brief discussion of the chapter to follow.

Background on Object Relations Theory

Melanie Klein developed the groundwork for object relations theory, which focused less on drives and instincts, and more on the sense of self in relation to others. "...Object relations theory looks more closely at how needs are met or not met in relationships, rather than at the satisfaction or frustration of particular impulses" (Berzoff et al., 2011, p. 120). Klein's ideas differed greatly from those of Freud in a number of ways. Of note, Freud's theories were developed largely with neurotic adult women in mind, believing that psychoanalysis was inapplicable to psychotic patients (Mitchell & Black, 1995). A later portion of this chapter will highlight the work of Arnold H. Modell, who condemned the field of psychoanalysis for largely

disregarding schizophrenia and psychosis as primarily neurobiological conditions that could not be treated with psychoanalysis. In contrast, it was largely young, severely disturbed children and psychotic patients that inspired Klein's theories in the 1920's and 1930's. Therefore, this cluster of theories seems particularly relevant when examining psychosis in adults who overuse the ED. While many theorists at the time were solely dedicated to either the Freud or Kleinian camps of thought, an independent group developed our modern understanding of object relations (Mitchell & Black, 1995). Some of the most prominent theorists of this time included W.R.D. Fairburn, D.W. Winnicott, Michael Balint, John Bowlby and Harry Guntrip (Mitchell & Black, 1995). Each of these theorists expanded on Klein and Freud's work. However, this chapter will primarily highlight the work of Klein, Winnicott, and Modell.

Kleinian Object Relations.

Object relations theory differs from drive theory in a number of important ways. Object relations theory posits that the ego is present from birth, and that the main drive of the individual is the drive for primary relationships, and that this drive is not meant to satisfy impulses of the ego (Alonso, 1984). Kleinian theory became the basis of object relations arguing that infants possessed a type of death instinct that drove their aggression (Mitchell & Black, 1995). Klein begins her theory positing that the infant's first object is the mother's breast (Klein, 1996) She argued that infants developed healthy object relations, and a sense of themselves in relation to others as they moved from the paranoid schizoid position and the depressive position.

During the paranoid-schizoid position, infants are only capable of part-object relation and cannot see objects as capable of holding both good and bad qualities (Klein, 1996) *Paranoid* refers to the baby's fears of annihilation while *schizoid* refers to the baby's need to rigidly separate the good from what is bad (Michell & Black, 1995). The infant's primary defense in this

position is projection. When the infant does not have access to the breast, it projects its own anger and frustration onto the breast so that it may rid itself of bad feelings (Klein, 1996) During this phase of life, at approximately 1-3 months, the infant also sees him or herself as omnipotent, and thus believes that he or she is able to destroy others (Klein, 1996) The infant projects destructive fantasies onto the bad breast and by the very nature of projection, begins to fear its own demise and annihilation. In contrast, when the infant has access to the breast and feels nourished by it, he/she projects love and dependence on the breast and feels that it is good (Klein, 1996). The infant must separate the good breast from the bad breast because if it were to integrate the two, the destructive fantasies towards the bad breast would ultimately destroy the loving, nourishing good breast that the infant depends on for life (Mitchell & Black, 1995). In this way, the infant is able to channel aggression through the relationship with the bad breast while protecting the good breast from its projection (Mitchell & Black, 1995). The annihilation anxiety that occurs during this phase of object relations development seems quite similar to the annihilation anxiety that adults with schizophrenia often experience.

The infant continues his or her development of object relations through his or her primary caretaker, and eventually transitions away from the paranoid-schizoid position into the depressive position (Klein, 1996). When the infant moves into the depressive position, at the age of one, he or she is able to experience whole objects that are integrated and are capable of both good and evil. This position is characterized by a profound sense of loss (Berzoff et al., 2011). The infant experiences depressive anxiety as he or she realizes that the good and bad in a person cannot be split, and as a result, the infant becomes aware that his or her aggression does not discriminate and can destroy both the good and bad parts of the object (Mitchell & Black, 1995). With the recognition of the other as whole, comes the realization that the person who is loving

and nurturing, can also be disappointing and hurtful (Berzoff et al., 2011). The primary defense during this position is projective identification. This defense allows the infant to project unwanted parts of him or herself onto the object (primarily the mother). However, there is a significant relational component to this defense because the infant does not want to lose this part of him or herself entirely. Rather, the infant is attempting to be understood by projecting his or her feeling into the object, and then relating to that object (Berzoff et al., 2011). This relational defense is crucial to the development of object relations as the infant feels both separate and connected to the object. It is through the depressive position that the infant develops a sense of self and others as integrated, complex, and ever changing (Berzoff et al., 2011). Object relations theory is particularly relevant to the study of schizophrenia because it is a disease that is characterized by relational problems with the self and others (Binder, 2006). These relational problems are similar in nature to the problems that an infant experiences, particularly in the paranoid-schizoid position.

Key Features

There are several key features of object relations theory that contribute to an understanding of why people with schizophrenia might overuse the ED. This portion of the chapter will review the nature of social relatedness and object relations in schizophrenia, and how this impacts the clinical relationship. A review of Winnicott's concept of the holding and facilitating environment will provide a foundation for a discussion about the containment of the ED in the final chapter of this thesis. Later, the concept of separation-individuation will be discussed to better understand anxieties around fusion and merging in schizophrenia.

The Holding Environment.

D.W. Winnicott was a British psychoanalyst whose theories landed somewhere between those of Freud and Klein (Mitchell & Black, 1995). Much like Klein, he examined how one's object relations and overall development the nature and quality of human relationships.

Winnicott was particularly interested in the relationship between the mother and infant, and this is reflected in his theory of the holding environment (Mitchell & Black, 1995).

Winnicott introduced the idea of the *holding phase*, and the phases of dependence that the infant masters during this portion of maternal care (Winnicott, 1965). The mother creates a holding environment in which the infant can feel both free to explore the world, and protected from harm. "The holding environment therefore has as its main function the reduction to a minimum of impingements to which the infant must react with resultant annihilation of personal being" (Winnicott, 1965, p. 46). The holding environment is also a concept used in psychotherapy to describe the containment of a therapeutic interaction. This will be discussed in the last chapter of this thesis.

Beginning in pregnancy and into the first few weeks of life, the mother experiences a type of "primary maternal preoccupation" where she and the infant are almost entirely merged and she sees the infant as an extension of herself (Winnicott, 1965). At this point, the infant experiences absolute dependence on the mother. The goal of this phase is to ensure that infant can continue "going-on-being" in its maturational development (Winnicott, 1965, p. 85). In this sense, the infant believes that its needs are magically met as the mother acts as a protective membrane between the infant and the external world (Winnicott, 1965). During the absolutely dependence stage, the infant is unaware of the mother's sacrifices, or even that his desires do not magically appear before him (Winnicott, 1965).

The child enters the relative dependence phase when the mother begins to address her own needs while meeting most of the infant's ego-needs. This phase is characterized by small failures on the mother's part to adapt to her infant's needs. At this time, the infant becomes aware of its dependence on the mother (Winnicott, 1965).

As the mother continues to emerge from her somewhat psychotic maternal preoccupation, and continues to commit small failures to respond to the infant's needs, he or she gradually begins to move towards dependence. At this time, the infant realizes that he can exist for portions of time without his mother's care (Winnicott, 1965). Although the infant remains largely dependent on the mother for survival, he can maintain a sense of trust in his environment through memories of her care and the internalization of her presence. The holding environment is a "physical and psychical space within which the infant is protected without knowing he is protected, so that very obliviousness can set the stage for the next spontaneously arising experience" (Mitchell & Black, 1995, p. 126). The infant feels responded to, and accommodated within this holding environment and this sense of self is internalized throughout his or her childhood development. Conversely, Winnicott (1965) explains that when the holding environment is inadequate, the infant is merely reacting to its environment rather than continuing-on-being, which creates a false-self disorder and a sense of not knowing one's true self. This interrupts the infant's emotional and psychological development and a psychotic anxiety that is annihilative in nature (Winnicott, 1965).

Fusion and Mutual Destruction: Primitive Object Relations in Schizophrenia.

The work of Arnold H. Modell has been extremely helpful in conceptualizing the importance of self-object differentiation in schizophrenia. Of note, he sheds light on the tendency of the psychoanalytic tradition to overlook schizophrenia as an illness that can be explored

through psychoanalysis. Instead, it has often been thought of as deriving from purely a biochemical or neuropsychological source (Modell, 1963). Schizophrenia and psychosis must be examined through both a psychodynamic and biological perspective in order to identify its origins and to improve treatment. Specifically, Modell observes poor object relations in people with schizophrenia through clinical transference (Modell, 1963).

Schizophrenia is marked largely by annihilation anxiety that is similar to that of the children in Klein's paranoid-schizoid position (Berzoff et al., 2011). This terror of annihilation is also similar to the annihilation anxiety previously discussed in Winnicott's theory of the holding environment. Berzoff et al. (2011) articulates how adult relationships evoke this anxiety in adults with schizophrenia.

Adult relations of people with schizophrenia may become characterized by simultaneous longings for, and terror of, fusion; attachments to others are experienced as mergers, and separations feel like death or disintegration of the self or caregiver (Berzoff et al., 2011, p. 314).

This fear of merging with the other is a result of poor ego boundaries. Ideally, these boundaries would have been supported through early object relations development that would have been facilitated through the holding environment (Berzoff et al., 2011). Specifically, the concepts of fusion and mutual destruction, contribute to an understanding of why people with psychosis often avoid intimate personal relationships will be useful when considering the quality of clinical relationships for this population (Berzoff et al., 2011).

This fear of connection could potentially impact the development of a therapeutic alliance in individual psychotherapy as it hinders the ability for people with schizophrenia to remain engaged one-on-one. As previously mentioned, people with schizophrenia have been shown to

have poorer object relations. Modell postulates that poor object relations is directly connected with early relations with the mother. “There is a fusion or a confusion of sense of self with the object; and the object is perceived in accordance with certain infantile phantasies concerning the mother.” (Modell, 1963, p. 336). Modell (1963) continues on to describe this phenomenon of choosing between one’s own safety, and giving part of the self to another. “To give love, is to impoverish oneself – and to love the other person is to drain him.” (p. 338). An earlier paper by Modell (1961) expands on this concept in his discussion of denial and a sense of separateness from the object. This use of denial, often manifested in hallucinations and delusions for people with schizophrenia, results in a significant regression of the ego, and its relation to current and past objects (Modell, 1961). He argues that this regression results in blurred boundaries between the self and objects. Perhaps people with schizophrenia withdraw more from outpatient providers ego regression parallels a diminished capacity for object relations. This diminished capacity for individuation results in annihilation and anxiety and fusion.

Present Research

Morris D. Bell has contributed significantly to a contemporary understanding of object relations deficits in schizophrenia. He describes his understanding of object relations in schizophrenia as distinctly different from a psychoanalytic understanding of object relations that focus more on maternal failures in early development (Bell, 2001). Rather, his understanding of object relations deficits in schizophrenia is seen through a neurodevelopmental model of schizophrenia. He poses the question, “Which came first: poor object relations or schizophrenia?” (Bell, 2001, p. 290). He argues that this question cannot be explained exclusively through a psychoanalytic or neurodevelopmental model. He argues that current research generally suggests that early cognitive deficits often manifest as schizophrenia later in

life. Additionally, these cognitive impairments might affect attachment and the ability to relate to an object.

Poorly developed object relations may make a person more vulnerable to confused and stressful interpersonal experiences and less able to benefit from the support of family or friends. As confusion and isolation increases, so does the likelihood of over psychosis (Bell, 2001, p. 291).

Though Bell (2001) understands schizophrenia as having a neurodevelopmental origin, the importance of object relations deficits in schizophrenia is still relevant when considering this phenomenon from a psychoanalytic approach.

Bell et al. (1992) research examined the nature of object relations in schizophrenia as they are expressed through the Bell Object Relations Inventory (BORI), a series of questions that tests object relations strength on a number of subscales. Specifically, the Alienation subscale showed that people with predominantly negative symptoms of schizophrenia were more likely to have poorer object relations than those with positive symptoms (Bell et al., 1992). Thus, people with paranoid schizophrenia were more likely to be alienated from others and hold the belief that others cannot be trusted and that closer relations cannot be gratifying. The authors note that this deficit in object relations has significant implications for the development of a dyadic therapeutic alliance, which is founded on a sense of trust (Bell et al., 1992). These authors argue that in order to enter a psychotherapeutic relationship, one must have hope that the relationship can be gratifying and safe. Thus, clinicians might need to spend more time building rapport and strengthening object relations for clients with schizophrenia.

Harrop and Trower (2001) make an interesting observation about how the onset of schizophrenia, during late adolescence and early adulthood, occurs during a time of great conflict

within families around separation and individuation. This conflict seems similar to the conflict that mother and their infants experience during the prime years of object relations development. It is important to acknowledge that this study is somewhat culturally bound as it is based on studies primarily in Western countries. Harrop and Trower (2011) consider the unique onset of schizophrenia and psychosis to reflect a maturational disorder that emerges when young people attempt to individuate from their parents. This relates directly to object relations development. Harrop and Trower (2001) explain that those who develop schizophrenia often did not develop the ego strength needed to fully separate from their parents without significant disruption and conflict both internally and externally. The authors propose that ideally during this time in one's life, they are better able to make a declarative statement about their sense of self that is separate from their parents. "I am of you, but I am not the same as you." (Harrop & Trower, 2001, p. 243). This current theoretical piece reinforces Klein and Winnicott's more traditional perspectives and sheds light on how the conflicts of early infancy are often parallel to those that occur in young adults with schizophrenia.

Key Points of the Phenomenon

Deinstitutionalization and the subsequent lack of community resources for people with severe mental illnesses, has left people with schizophrenia isolated and without outpatient care. Examining this phenomenon through the lens of object relations offers a psychodynamic understanding of the quality of relationships for many people with schizophrenia. Psychodynamic object relations theorists such as Melanie Klein, D.W. Winnicott, and Arnold Modell posited that early relations with primary caretakers shaped one's sense of self as separate from others. Thus, early disturbances in attachment resulted in a confusion between the self and other. This confusion and disconnection from reality manifests in a fear of connection and

intimacy in adulthood. The concept of the holding environment is also a critical component of object relations that contributes to an understanding of the asylum and containment that the ED might offer people with schizophrenia who are less likely to access support from an individual when in crisis. Contemporary studies have identified a deficit in object relations that contributes to social withdrawal, which could possibly increase psychotic symptoms (Bell, 2001). Many of these studies utilize a neurodevelopmental model to explore object relations, but still posit that social functioning significantly impacts one's ability to connect with, and utilize support from family, friends and providers. Early object relations in schizophrenia impacts the ability for people to access community care and also results in a lack of social support and a sense of ego strength. As a result, people with schizophrenia are more likely to seek out the ED for holding and treatment rather than an individual clinician due to fears of fusion and merger.

Overview of the Next Chapter

The next chapter of this thesis will expand on the idea of institutional transference. This will include a brief history of the theory and the impacts of mental health policy and the civil rights movement. This history will include a description of the theory as it is applied to asylums that were commonplace prior to deinstitutionalization. A brief overview of theorists who contributed to this concept will be included. It is also necessary to address the controversial nature of this theory as it has been called into question as of late. Additionally, this next chapter will include a discussion around the reintroduction of this theory to community mental health training clinics.

CHAPTER V

Overuse of the Emergency Department in Schizophrenia: Institutional Transference Perspective

Introduction

This chapter will focus on the key concepts of this thesis' second major theory: institutional transference. This chapter will begin with a brief history of institutional transference including the major theorists who contributed to this theory and the population that inspired this framework. This history will also include a brief discussion of trends that occurred overtime to include newer target populations in more modern settings. The next portion of this chapter will include a description of the key features of this theory. This section will be followed by a summary of the key features and an outline of the final chapter of this thesis.

History

To begin with, a discussion of Freud's conceptualization of transference is offered. It is also important to begin this chapter by defining 'transference' and 'institution' separately before exploring institutional transference as a theoretical concept in itself. Freud (1912) discusses the dynamics of transference explaining that individuals carry with them images of parental or omnipotent figures, which will be roused in therapy through interaction with the therapist. Freud argues that the patient will insert the clinician into one or more of several images of omnipotent parental figures and that these dynamics will reveal themselves in the therapy session itself. An understanding of this transference creates a foundation upon which to discuss institutional transference. Wilmer (1962) defines transference as "...repressed unconscious feelings which were originally experienced toward omnipotent parental figures" (p. 173). Additionally, he defines institution as "...an enduring social organization transcending the individuals who work

as its members.” (Wilmer, 1962, p. 176). As previously mentioned, schizophrenia has been historically overlooked by the psychoanalytic community (Modell, 1963). Safirstein (1973) argues that the concept of institutional transference is a departure from Freud’s original understanding of transference and in many ways, reintroduces the importance of transference when working with people who have schizophrenia.

Freud’s definition of transference...is being somewhat enlarged to include groups of people, animals, plants and inanimate objects...For the time being I prefer to call it a ‘phenomenon’ which can be observed in many diagnostic categories and also in people at large without diagnosis and which has descriptive and dynamic properties and, furthermore, can be included in the basic psychoanalytic system of transference (Safirstein, 1973).

Dr. Norman Reider (1953) first introduced the idea of institutional transference in his now infamous paper entitled *A Type of Transference to Institutions*. Dr. Reider used institutional transference to describe patients who received their psychiatric care at training clinics where psychiatry residents were on rotation. He spoke of patients who seemed to develop a personal connection to the clinic itself, but not to their individual clinician. He argued that patients who presented with institutional transference typically carried a diagnosis of schizophrenia suggesting that the inability to form meaningful relationships with other people was at the heart of institutional transference (Reider, 1953).

Dr. Harry A. Wilmer was the next major contributor to this theory. He chronicled the presence of institutional transference throughout time and noted that the earliest institutional transference could be seen in religious communities (Wilmer, 1961). Specifically, he likened religious institutions to medical centers. He explains that historically, those who fell ill would

make pilgrimage to a religious institution for healing in the same way that patients travel to specific medical centers for their care. “The cures reported are manifestly related to the transference to the institution which drew the sick on their pilgrimages of hope” (Wilmer, 1961, p. 174). The medical center, like many other institutions transcends the individual members of the staff. For example, although patients might work with multiple physicians, and cannot guarantee that their care will be under a specific person, they have faith and hope in the healing powers of the institution separate from those of the individual practitioners. The medical center itself is symbol of power and it is to this that patients form their transference (Wilmer, 1961). The specific features of this symbol will be discussed later in the chapter.

Dr. Samuel L. Safirstein (1967) used institutional transference to describe the relationship between individuals with severe and persistent mental illness and the inpatient psychiatric unit at Mount Sinai Hospital in New York City. Diagnostically, he described these patients as having schizophrenia. He described the fear of both being dependent on others and fearing them that is the primary conflict for these individuals (1967). He explains that primary attachments at the hospital were not to individual people. Rather these individuals formed attachments to the institution that could be both idealized, and kept at a safe distance that did not feel threatening. Four years later he spoke about his observations of people without psychiatric diagnoses developing an institutional transference (Safirstein, 1970). Like previous theorists, he proposed that poor object relations and the lack of a sense of self were at the core of institutional transference. Safirstein (1970) also pointed out that many individuals function best when under the security of an institution. He cites military personnel, corporate executives for major companies, and government employees to name a few examples of individuals who feel more comfortable working and operating largely within a greater institution.

Critiques

Dr. Harold P. Martin (1989) challenged the traditional concept of institutional transference deeming it as pathologizing and diagnostically narrow because it primarily applied to those individuals with schizophrenia. Additionally, he argued that transference to an individual and transference to an institution are not mutually exclusive, and that patients exhibit four distinct types of institutional transference. Type 1 constitutes two subtypes: those who cannot form transferences to anyone, and those who cannot develop transferences to their therapist, but do not struggle to create this type of connection with others. Type 2 describes individuals who are able to develop a transference to both an institution and a therapist thus illustrating that transferences to people and institutions are not mutually exclusive. Type 3 describes individuals who indiscriminately develop transferences to people within specific institutions because they have previously developed an institutional transference to the institution itself. Type 4 describes a type of adaptive transference in which the patient forms an adaption to an institution because they are unable to adapt to a person. Martin argued that this often occurs in teaching hospitals where providers rotate frequently. Though patients have the capacity to form a traditional transference to a clinician, they do not in this case due to the reality of frequent changes in providers. Martin (1989) also introduced the idea that individuals could be attached to the institution of medicine, religion, or law, thus proving that a physical building is not a particular qualification of institutional transference.

Other contemporary theorists, such as de Booset (1984) have also argued that institutional transference is overgeneralized. Specifically, she argues that it advocates for a detached approach to working with chronic psychiatric patients and that this results in disengagement from this group of people. Gendel and Reiser (1981) support de Booset's position

arguing that therapeutic progress cannot unfold if a therapist sees his or her patient as static stating, “A long history of treatment need not automatically consign a patient to interminable treatment.” (p. 511). This acceptance of a detached therapy style can be seen in Safirstein’s (1967) work when he states, “Most of the therapy is done by residents in their first and second year of training. This necessitates relatively frequent changes of therapists. It has been observed that these patients do not mind it” (Safirstein, 1967, p. 560). While this might be partially true, it may have also contributed to negative stereotypes and almost excused clinical withdrawing from this group. Dr. Harvey D. Lomas also contributed in a meaningful way to the reexamination of this concept from the perspective of the psychoanalyst boldly stating, “...while there is no question of good intentions, it is literally “hell” to differentiate transference from reality” (Lomas, 1979, p. 550). After De Booset’s article, it was nearly two decades before Bridget B. Matarazzo reintroduced this concept to the academic community in a 2012 publication. Dr. Matarazzo applied the concept of institutional transference with individuals with borderline personality disorder. She observed an, ‘adaptive institutional transference’ in individuals who received treatment at a training clinic, and struggled with fears of abandonment.

Key Features of Institutional Transference

Leading theorists on institutional transference have identified several central characteristics of this phenomenon. Though one might traditionally consider transference to a human or living object, it seems crucial to highlight that based on the previously mentioned theorists transference can exist between a person and an inanimate object. This would imply that inanimate objects can also come to represent many of the features of idealized figures from one’s personal history. Miller (1983) addresses the three constructions of transference as presented by Freud between the years of 1895 and 1915. “That the transference reenacts the past using present

objects for the projection of these antique contents is the foundation of the clinical construction of transference” (Miller, 1983, p. 155). Transference to an inanimate object might seem very dissimilar to a traditional transference involving two humans. However, it seems that the institution itself, which transcends all of its individual members (Miller, 1983), can become a meaningful transference object for a person who diagnostically struggles to trust the external world and those who live in it.

Idealization.

Idealization is a central component of institutional transference as it is central to the traditional understanding of transference itself. By the very principles and mechanics of transference, institutions often become symbols of parental figures for chronic psychiatric patients (Wilmer, 1962). Safirstein explains that as a result, the institution idealized and “endowed with the benevolent characteristics of parental figures” (Safirstein, 1973). The role of benevolence is monumental when considering overuse of the emergency department and this will be discussed in the final chapter.

Interestingly, Matarazzo (2012) notes that Reider (1953), Safirstein (1973), and Byrne and Valdiserri (1982) all highlight the importance of idealization as a primary defense for individuals who deeply fear abandonment. It is through the idealization of the institution that one is able to navigate interactions with the individual providers that make up the institution itself (Matarazzo, 2012). The role of idealization eases the transitions between providers at a training clinic Matarazzo (2012) for people with schizophrenia. He explained that the idealization eased the transition between new providers in a training clinic because the patient essentially associated the newest trainee with the benevolence of the institution, regardless of their experience or style of therapy. It is this belief in the benevolent power of the institution that

allows patients to continue presenting at such clinics or institutions despite not having a particular connection to a therapist or provider (Matarazzo, 2012).

Lack of Object Constancy.

The previous chapter of this thesis provides a more thorough overview of object constancy as it is identified in object relations theory. “Those who use institutional transference in their object relations are usually people who lack the feeling of autonomy and are unable to relate to others via individual transference” (Safirstein, 1973, p. 154). As previously discussed in the prior chapter, individuals presenting with poor object relations can often experience closeness as extremely threatening (Berzoff et al., 2011). Safirstein (1973) argues that these individuals suffer from an ego defect that was not lost, but merely never developed through interpersonal relationships with caretakers as a child. This seems to be a poor prognosis for the development of object relations, as Safirstein (1973) points out that in fact nothing was lost, it was undeveloped, and therefore, there is nothing to regain. One might infer that institutional transference is in fact the most advanced level of object relatedness that some patients are able to master. Safirstein (1973) also points out that a family is in itself, an institution comprised of separate individuals. Patients with this type of family system might also have a tendency to develop an institutional transference over an individual transference.

Impersonalization.

Impersonalization is an especially relevant feature of institutional transference when considering individuals with schizophrenia (Safirstein, 1973). Several authors have described the anonymity of the staff members who exist within these institutions as an example of the impersonalization that is observed in institutional transference (Safirstein, 1967; Wilmer, 1962). “The institution exists as an enduring social organization transcending the individuals who work

as its members.” (Wilmer, 1962, p. 176). Wilmer goes on to provide a case study of a patient who, despite routinely seeing the same physician for many years, cited The Center as his savior, rather than citing the work and talent of the physician. Safirstein (1973) seems to suggest that modern day ‘grounds’ might be represented by the waiting room or office where the treatment takes place.

Compliance.

Safirstein (1973) and other theorists argue that compliance is an essential feature of institutional transference. Safirstein (1973) argues that this compliance is deeply rooted in wanting to be seen positively by the benevolent power, which is the institution. He states that these individuals are exceedingly dependent on their attachment to the institution and thus, they seek to protect this alliance with the institution through compliance and passivity. This sense of compliancy also speaks to the rigidity and ritualism that will be discussed shortly. Safirstein (1973) explains that the attachment to the institution lacks any type of spontaneity that would typically be seen in a dyadic relationship between two individuals. Reider (1953) brings to light the importance of service fees into a discussion about compliance. Training clinics often provide free or low cost services to those with chronic mental illnesses. It is crucial to consider how a lack of payment for service might contribute to the image of a benevolent parent figure who cares for one unconditionally without payment expectations. This system could contribute to a patient feeling like he or she does not have the voice to question or critique the institution or service because it is free. The role of payment will be further discussed in the final chapter of this thesis.

Ritualism.

Reider (1953) noted the ritualistic nature of institutional transference. He described patients who would present to the clinic, even when their individual therapist was out of the office or on vacation. This example of ritualism seems to reveal both the power of the attachment to the institution as well as the reassurance of routine for individuals who might otherwise live relatively chaotic and disorganized lives. This example also speaks to the sustainability of institutional transference for those who struggle to form attachment to others, or those who fear abandonment. Gendel and Reiser (1981) also note that these individuals are often concerned with keeping their object of attachment the same. Thus, these individuals might benefit from a transference that is reliable and predictable (Gendel & Reiser, 1981). Institutional transference lends itself to ritualistic tendencies, as the object of attachment remains largely the same throughout a person's involvement with the center or clinic.

Summary of Key Features of Institutional Transference

Reider (1953) first introduced the concept of institutional transference to describe psychotic patients who formed impersonal attachments to a training clinic, rather than to an individual clinician. Reider (1953) largely described as aloof and disconnected from other people. He argued that they sought to avoid friendship and closeness for fear of destruction (Reider, 1953). Although this theory progressed and was eventually applicable to those with other mental health diagnoses, or no mental health diagnoses at all, it was still criticized for being largely narrow and pathologizing (Martin, 1989). The features of individual transference seem to be quite similar to those of institutional transference with idealization and poor object constancy as central themes. More recently, this theory broadened to include institutional transference to both inpatient and outpatient clinics (Matarazzo, 2012). However, there are no

articles that describe an institutional transference to the emergency department. As previously mentioned, the ED has in many ways served as a source of routine psychiatric care for people with severe and persistent mental illnesses, who may or may not be attending their outpatient appointments (Klinenberg & Calsyn, 1997). Thus, the concept of institutional transference appears to be a helpful framework for understanding why people with schizophrenia may be more likely to overuse the ED, but disengage from services with an individual provider in the community.

Overview of the Final Chapter

The final chapter of this thesis will be a synthesis of both theoretical perspectives. This will begin with a brief overview of the key points of each theoretical perspective. A case study will also be used to illustrate the phenomenon of people with schizophrenia overusing the emergency department. This case study is a compilation of two case studies presented in Martin (1989) and Gendel and Reiser's (1981) work. This case study will be followed by a discussion about the weaknesses and strengths of the methodology and the findings of this thesis. The chapter will conclude with a focus on the implications of this phenomenon and discuss ways in which social workers can use these theoretical perspectives to conceptualize the phenomenon of people with schizophrenia overusing the ED.

CHAPTER VI

Discussion and Recommendations

Overview of Chapters III-V

The purpose of this thesis is to explore how object relations theory and institutional transference contribute to an understanding of why people with schizophrenia may be more likely than those with any other mental illness to overuse the ED. Chapter III introduced the phenomenon of ED overuse by people with schizophrenia, and also focused on the lack of engagement with outpatient providers that is observed in this same population. ED overuse is relevant because it has negative impacts on both patients and ED staff. The ED is unable to provide effective psychiatric care to patients with mental illnesses and negative staff attitudes towards those who overuse the ED hinder successful outcomes and further stigmatize those with mental illness (Adams & Neilson, 2012). Chapter III also examined the outpatient service patterns of this same group. Although scholars have identified many factors that impact ED overuse such as age, race, socioeconomic status, and diagnosis, some authors have noted that social functioning is the single more significant predictor of outpatient non-adherence (Desai et al., 2013). One could potentially infer that poor social functioning in schizophrenia, which might be an expression of weak object relations, contributes significantly to both ED overuse and outpatient non-adherence.

Chapter IV provided an overview of key components of object relations theory with a focus on the role of the holding environment, and the development of a sense of self. Winnicott (1965) described the main function of the holding environment as a protective barrier against impingements on development of the self. When the infant feels protected and safe, spontaneity can be enjoyed and explored without the threat of annihilation (Winnicott, 1965). It is thought

that the infant internalizes this sense of safety and containment, creating a foundation upon which the infant develops a cohesive sense of self. Berzoff (2011) expanded on this lack of a cohesive self, describing some of the relational qualities that can be observed in schizophrenia as a result of a poor sense of self. Specifically, she highlights the psychic conflict of wanting to be close to others, and simultaneously fearing an ultimate merger and annihilation. Modell's (1960) words on the quality of relationships in schizophrenia illuminate this conflict. "To give love, is to impoverish oneself – and to love the other person is to drain him" (p. 338). Poor object relations and a lack of a cohesive sense of self result in the fear of close relationships. Relational conflicts and anxieties might have significant implications for the efficacy of individual psychotherapy for those with schizophrenia.

Chapter V examined how institutional transference might also contribute to a clearer understanding of why people with schizophrenia may develop an attachment to an institution such as a hospital, or clinic, rather than to an individual outpatient provider. Norman Reider (1953) coined the term institutional transference to describe patients who formed attachments to psychiatric training clinics where residents rotated frequently. Though this term evolved over time to include a diversity of presentations, the key features of institutional transference have remained largely consistent throughout time. These features as mentioned in the previous chapter include, idealization, lack of object constancy, impersonalization, compliance, and ritualism (Safirstein, 1973). Although there is no current literature that examines institutional transference in the context of the ED, this chapter will use the theoretical perspectives of both object relations theory and institutional transference to offer a potential explanation regarding why some people with schizophrenia may overuse the ED.

Case Illustration: Mr. A

In order to better understand how to support the population that has been the focus of this thesis, it is essential to include a more comprehensive example of people living with schizophrenia who frequently come into contact with the ED and to honor the lived experiences of schizophrenia. We must recognize that these individuals often have few options for accessible outpatient care besides the ED due to a lack of services. Furthermore, discussing this phenomenon only through empirical data seems reductive and far from person-centered. The following case study is intended to illuminate some of the key principles of object relations and institutional transference that contribute to ED overuse by people with schizophrenia. The following fictitious case example is comprised of excerpts from the two case studies included in Martin (1989) and Gendel and Reiser's (1981) work. This writer has also elaborated on these excerpts to provide a more complete picture of this person.

Mr. A was a 45-year-old unmarried man of eastern European heritage. He was living with his mother, as he had for most of his life. His father, a skilled laborer, had been physically and emotionally distant during Mr. A's childhood, and Mr. A described his mother as demanding, authoritarian, and hypochondriacal. At age 18, during his ninth month in the Army, he decompensated after an encounter that involved both heterosexual and homosexual experiences. At that time he reportedly was withdrawn, autistic, and paranoid and experience auditory hallucinations. Mr. A was discharged from the service with the diagnosis of paranoid schizophrenia (Gendel & Reiser, 1981, p. 509).

Mr. A's mother passed away in his late thirties. He states that she was his only contact for many years. Thus, her death left him more isolated and lonely. At this point, he moved into an affordable housing unit. Although he maintained his apartment, he seemed to decompensate

quickly, requiring an inpatient hospitalization. After several hospitalizations, he was referred to a community mental health center for case management with the hope that he would become connected with outpatient providers and would remain out of the hospital. Mr. A met with his case manager biweekly at his apartment, which was often quite messy. He had a cat that he seemed to take good care of, despite the state of the apartment. Meetings with his case manager were always brief, typically lasting between 10-15 minutes. He was withdrawn, disconnected, and guarded, though he was always appreciative of her time. Mr. A's case manager was able to schedule him to meet with both a therapist and a psychiatrist through the agency. With the support of his case manager, he attended the initial appointments with these providers, but often cancelled follow-up appointments explaining that he was not feeling well, and had to reschedule. Mr. A took his medications inconsistently and there were many factors that contributed to his non-adherence. He was on numerous medications, and often struggled to put them properly in his pill-caddy accordingly. Often times, he would simply fall asleep early, and forget to take his evening medications. In addition, his pills needed to be refilled at different times of the month. This posed a barrier because he struggled to be out in public for more than a few hours a day, and would often try to refill certain prescriptions too early or late. He was often left confused and frustrated by the process, and reportedly would "give up." Of importance, he also noted that the negative side effects of his antipsychotics such as significant weight gain (approximately 100 pounds at one point in his twenties), dry mouth, muscle spasms, headaches, and slowness as barriers to taking medications. Although it was never explicit, he alluded to some shame around taking medications, citing various Netflix documentaries about Americans overmedicating themselves and the corruption within the pharmaceutical companies.

As Mr. A. aged, his paranoia and anxiety worsened. He was constantly anxious about neighbors breaking into his home and reported that people were talking about him on the street. When in crisis, he would often walk to the ED in his neighborhood. He presented without specific complaints, but felt that he was unsafe to return home. Because he was not suicidal or homicidal, he was never admitted to a psychiatric unit, and often times had to wait for several hours to be seen. He was always offered a sandwich, and a ginger ale, and some time to calm himself down. Hospital staff would check in with him briefly, suspecting that his fears were delusional. They would check his vitals, and check in with him a few times before discharging him home.

The social worker at the ED always left a voicemail for Mr. A's case manager when he was discharged. The case manager encouraged Mr. A. to utilize the agency's 24-hour on-call crisis service so that he could speak with someone over the phone should he feel scared in the evenings. He tried this for some time, but eventually began returning to the ED. Though the hospital staff found him to be pleasant and friendly, they often became frustrated when the waiting room was full, and he seemed to have no acute needs. The team prioritized more acute patients, and Mr. A. would often wait in the waiting room for several hours.

He came often to the hospital lobby and sat for hours, talking to no one. While there, he experienced a tranquility that felt like being part of a family whose members all have separate lives, but who really care about him (Martin, 1989, p. 59).

The wait did not necessarily upset him, and on many occasions he would walk home several hours later, after checking in with a nurse. Of note, he never requested to meet with a particular healthcare provider upon entering the ED, which was just as well because shift changes occurred multiple times each day and night. Mr. A.'s conversations always seemed

superficial, offering very little information about his personal history or life. However, because Mr. A. frequented the ED so often, and felt so familiar to staff members, it was understood that the psychiatry residents who conducted initial assessments, simply copy and pasted the psychosocial from his previous admission into the current note. A newer resident, who seemed to take a particular interest in Mr. A. was perplexed when Mr. A. did not seem to form an attachment to him despite doing several of his admissions in the past few weeks.

...The resident felt confused and overwhelmed; the patient seemed to be more a part of the training program than the resident himself. Mr. A knew the clinic director, joked with all the secretaries, had called the emergency room each night for years, and knew the names of the entire residency classes. Reading through Mr. A's chart the resident found the names of former residents, teachers, and administrators. The resident felt more like part of a tradition than a therapist, for Mr. A was truly the sword in the stone, a kind of monument to the clinic and a challenge to any who would try their mettle with him...The history taking was not done without apprehension, for the resident feared that Mr. A might react poorly to it. Specifically, he feared that it might disrupt Mr. A's fantasy that the clinic "knew all" and cause him to decompensate (Gendel & Reiser, 1981, p. 509).

Analysis of Mr. A.'s Story

Object Relations Perspective.

Chapter V introduced object relations to better understand the quality of relationships for people with schizophrenia. Mr. A.'s case illustration provides an example of how poor object relations in schizophrenia can impact connections with outpatient providers.

Mr. A.'s relationships with his mother, case manager, and the ED staff all illustrate the longing for, and fear of human connection that is consistent with schizophrenia (Berzoff, 2011).

One could speculate that Mr. A.'s mother was unable to provide an early holding environment that would promote strong ego boundaries, given his description of her as "...demanding, authoritarian, and hypochondriacal" (Gendel & Reiser, 1981, p. 509). As a result, he presents with a longing to be around others, but fears connection to them. Of interest, Mr. A.'s first breakdown occurred after both homosexual and heterosexual encounters while in the military. Raja and Anzoni (2002) argue that sexual activity might reflect a person's ability to manage complex social interactions. One could argue that sexual intercourse might represent not only an emotional merger, but also a physical merger with another that felt intolerable and annihilative to Mr. A.

It also seems that less intimate social mergers caused Mr. A. great stress. For example, the relationship between Mr. A. and his mother seems to reflect a merger in which Mr. A.'s dependence on her represented a type of merger in which he could not decipher between himself and her. In contrast, Mr. A. demonstrates a fear of deep connection with his case manager resulting in brief interactions, and often missed appointments with her, his therapist, and with the psychiatrist on the team. It is clear that Mr. A. struggles to manage the complexities of social relationships. Because of his poor ego boundaries, he is either completely fused with the other (his mother) or detached (case manager, therapist, psychiatrist) and there seems to be little ability to negotiate the grey areas of relationships and interactions.

Object relations deficits also help to explain why Mr. A. seeks refuge in the ED, rather than using the on-call system or making more time to meet with his case manager each week. Mr. A., like many individuals with schizophrenia, experience delusions reflective of annihilation anxiety. This can be seen in his delusion that people are trying to break into his apartment and that people are laughing at him when he goes into the community.

One can see that introducing the conflict that arises with social negotiations might actually make Mr. A.'s anxiety worse given his annihilation anxiety that is organized within paranoid-schizoid position (Klein, 1986). According to Kleinian theory, Mr. A's parents were probably unable to contain the libidinal urges and aggressive phantasies that all infants experience as they move from part-object relations (paranoid-schizoid position) to whole-object relations (the depressive position). "With ongoing containment and processing, persecutory fantasies regarding annihilation and object destruction begin to coexist with fantasies of reparation, forgiveness, negotiation, difference, and tolerance" (Waska, 2002, p. 51). When Mr. A. panics during the nighttime, he seems to gain a type of systemic reassurance from the ED. This reassurance cannot be gained from individual connection with another person, whether by phone or in person. Additionally, Mr. A. continues to be mistrustful of relationships, and considers them to be unpredictable, and therefore, threatening. This annihilation anxiety that is consistent with part-object relations as an adult, might explain why people with schizophrenia might retreat from direct social interaction in favor of the more impersonal setting of the ED when in crisis. The ED affords Mr. A. a physical and emotional holding that others might find in an individual counseling session.

Institutional Transference Perspective.

Institutional transference allows us to explore Mr. A.'s ED overuse in the context of managed care through a more comprehensive, less pathologizing, psychodynamic lens. Although institutional transference was initially conceptualized as existing only in a hospital setting, Safirstein (1970) notes that institutional transference can be observed in many settings such as the military and in large corporations suggesting that each person settles in the setting that best meets their needs. Mr. A.'s enrollment in the military could suggest an underlying preference for

transference to an institution rather than a person, or a smaller group. It appears that after his breakdown, Mr. A. was connected primarily with a parental figure (mother) until her passing. Though it seems that their relationship was quite strained, her death was a significant loss. This loss also calls into question the importance of the parental relationship for someone with Mr. A.'s presentation. Since deinstitutionalization, caregiving of people like Mr. A. have fallen upon the family, and primarily the mother (Goldman, 1982). However, it seems that when Mr. A. lost his mother, he developed a transference to the ED as a replacement parental figure.

The notion of the ED as a benevolent parental figure is crucial in understanding the role of institutional transference and how it directly relates to the environment that is specific to the ED, and distinctly different from other parts of a hospital. The emergency department is self-containing, and mostly separate from the rest of the medical service. It is open 24-hours a day, seven days a week to provide care to individuals regardless of their insurance or ability to pay. Mr. A. is able to idealize the ED as he might a parental figure because of its accessibility and unconditional acceptance (Wilmer, 1962). Additionally, when Mr. A. is given a soda and sandwich, this is further contributing to the ED as a benevolent, parental provider. Mr. A.'s sense of the ED as a benevolent parental figure that is all knowing contributes to his institutional transference, and sense of containment in that setting as well.

It is also due to the idealization of the ED itself that Mr. A. is able to trust the residents that are so frequently rotating. He inherently trusts them not because of their personal or professional merits, but because of their association to the institution. Mr. A. also exhibits impersonalized interactions with the ED staff, and is largely able to do so because of the constant shift changes, and resident rotations. He is familiar enough with the staff that he feels they "know him," but is distant enough to feel safe and separate. Martin's (1989) excerpt seems

especially powerful when considering the sense of safety that is found in impersonalization.

“While there, he experienced a tranquility that felt like being part of a family whose members all have separate lives, but who really care about him (p. 59). Mr. A. also exhibits a ritualism consistent with features of institutional transference. The ritualism likely stems from both fear of losing his connection with the ED, and the need for routine given his fragmented internal and external realities.

Synthesis of Object Relations Theory and Institutional Transference

A synthesis of both object relations theory and institutional transference highlights the lack of a core sense of self that is at the center of ED overuse, and outpatient non-adherence. This lack of a core sense of self is a common thread beginning in infancy, and continuing throughout adulthood that results in internal conflict about managing the complexities of human relationships. One could argue that poor object relations is a precursor for institutional transference. This might largely be due to the fact that clients who have poor object relations struggle to connect with individual clinicians in the early stages of therapy. In contrast, those with stronger object relations might be more likely to develop a transference to their individual therapist, rather than to the institution under which they are receiving therapy. The synthesis of these two theories also suggests that for people with schizophrenia who have poor object relations, developing an institutional transference offers the containment and safety that an individual therapeutic relationship cannot always provide. Bringing awareness to the concept of institutional transference might give clinicians a better understanding of how people with poor object relations develop relationships with others. This knowledge might be especially important for new clinicians who might become more easily discouraged at their inability to connect quickly, and in a traditional way, with clients who present with a strong institutional

transference. It is at this point that the question of pathology arises, and the original critique of institutional transference resurfaces. How do clinicians engage with individuals who do not connect in a traditional way? Are clinicians overly invested in maintaining the dyadic therapeutic relationship? Are clinicians imposing this treatment onto a group that is not asking for this type of care, or are we being complacent to the theory that people with schizophrenia cannot benefit from therapy? Because of the emphasis on connection in the therapeutic relationship, it is crucial to reexamine our definitions of connection and broaden our ideas about what constitutes as connection so that we may support all forms of connection, not only those that feel traditionally rewarding or familiar.

The synthesis of these theories also makes a case for the consideration of schizophrenia through a psychodynamic lens. The introduction of antipsychotic medications and advances in neuroscience has contributed to a more biological understanding of schizophrenia (Modell, 1963). However, it is important for clinicians to recognize our own biases about schizophrenia, and how we may have contributed to the notion that these individuals cannot benefit from psychotherapy as well. The consideration of ED overuse through object relations, and institutional transference reminds us that overusing the ED is an adaptive behavior, and not one that is necessarily indicative of characterological pathology. Chapter III introduced the phenomenon of ED overuse by people with schizophrenia and highlighted many of the negative impacts that ED overuse has on staff members, but especially on the individuals who are overusing it. Institutional transference should not be viewed as negative or less functional than transference to an individual person. As previously mentioned, institutional transference can be seen in a multitude of settings, and is not necessarily pathological. Safirstein (1970) mentions the military, and large corporations as sites of institutional transference. Other examples of

institutional transference include college campuses, clubhouses, and childhood homes. Although the people associated with these settings is important, there seems to be a particular fondness for the place, and a sense of safety, and belonging that is internalized (Safirstein, 1970).

Unfortunately, it seems that ED overuse eventually becomes detrimental to the emotional wellness of people with schizophrenia because it increases stigma and results in a lack of appropriate care. Thus, it is imperative that clinicians take a lead role in finding alternative treatment options that nurture institutional transference, and offer those with schizophrenia a sense of containment, and holding.

Strengths and Weaknesses

Examining ED overuse by people with schizophrenia through a theoretical lens is a significant strength of this research as much of the previous research on this topic has drawn primarily from empirical data. Though there is a breadth of research on the negative impacts of ED overuse on the hospital, its employees, and individual patients (Adams & Neilson, 2012), this research seems to lack a biopsychosocial understanding of the issue. Utilizing both a biopsychosocial perspective and empirical data supports a more comprehensive understanding of this phenomenon, and is less stigmatizing.

An additional strength of exploring this phenomenon through a theoretical perspective is that it further integrates issues impacting those with schizophrenia into the psychoanalytic community. This is significant because the psychoanalytic community has historically condemned schizophrenia as a disease that is primarily biological, and cannot be treated through individual psychotherapy, but rather exclusively through psychiatric medications (Modell, 1986). It is crucial to articulate the interpersonal complexities of people with schizophrenia through object relations, and institutional transference in order to demystify and humanize this illness.

This theoretical research also reintroduces a controversial theory (institutional transference) so that it may be applied to the modern dilemma of managed care and shrinking social services in the community for those with severe mental illnesses.

One of the limits of this thesis is that it does not include personal narratives of those living with schizophrenia. So although the theoretical perspectives offer a dynamic framework for exploring the quality of relationships for those with schizophrenia, this thesis did not include personal narratives of people who overuse the ED.

Additionally, this research was conducted within the time constraints of a Master's thesis. As a result, there was not ample time to expand on certain aspects of this phenomenon and to provide a more in-depth discussion of the theories proposed.

Recommendations

Exploring Countertransference with Psychotic Clients in Individual Therapy.

It is essential to examine the ways in which the limited capacity for object relations in schizophrenia often inhibits the therapeutic alliance, and can cause disengagement from psychotherapy. Yet, the dynamic quality of psychotherapy cannot be forgotten and it is equally important to explore the role that clinicians often play in disengaging from psychotherapy with psychotic clients. Horowitz (2002) argues that because psychotic illnesses have responded so quickly, and somewhat well to anti-psychotic medication, the focus on therapy with people who have schizophrenia has started to fade. She also notes that although a multitude of academic articles has been written about psychotherapy and schizophrenia, far fewer focus on countertransference, and schizophrenia. Might this gap in research reflect a bias that clinicians hold about the prospects of connecting with, or being moved by, a psychotic patient? "The greatest obstacle to therapeutic listening with schizophrenic patients is counter-transference"

(Wasylenki, 1992, p. 125). Horowitz calls on clinicians to explore their countertransference to psychotic clients as a way to truly connect with them. Of course, the challenges of connecting with psychotic patients have been widely noted, in part, because the disorganization and terror that clinicians might experience in their countertransference to these clients might feel intolerable. Clinicians often struggle with feelings of hopelessness and despair due to the chronicity of schizophrenia and the slow rate of progress. Of great importance, he notes, is that inexperienced clinicians are most susceptible to feelings of inadequacy and failure when working with these clients. Green, Albanese, Shapiro and Aarons (2014) explored staff burnout in the community mental health setting and found that age was positively correlated with personal accomplishment. Thus, older providers reported higher levels of job satisfaction. Though it was difficult to find statistics on this concept, one could argue that many mental health social workers find themselves working in a community mental health setting early in their career. It is crucial that supervisors facilitate conversations about countertransference with their supervisees who are working with those experiencing psychotic symptoms.

Social Work Education.

Schizophrenia is perhaps the most debilitating, and highly stigmatized mental illness and social workers provide the majority of treatment to these individuals (SAMHSA, 2001). Thus, it is important for clinicians to recognize our own biases and presuppositions about this group. Eack, Newhill, and Watson (2012) examined how the attitudes of Masters of Social Work (MSW) students changed towards people with schizophrenia after taking a course on severe mental illness, and coming in direct contact (within their field placement) with someone who has schizophrenia. Interestingly, increased knowledge about this group alone did not improve general attitudes about this group. Rather, it was the combination of increased education, and

contact with someone who has schizophrenia that significantly changed students' attitudes. This is crucial and reveals a major gap in social work education. The study cites individuals with same-sex orientations, individuals from racial and ethnic minority groups, and people with psychiatric disabilities as some of the most "socially stigmatized" groups with whom social workers come into contact (p. 425). This study considered "contact" in broad terms. Thus, it did not examine the impact of working clinically, or even therapeutically with individuals who have schizophrenia. It was difficult to find information about the percentage of MSW courses that focus on schizophrenia and related illness. Yet, because social workers provide the majority of care to those with severe mental illnesses (SAMHSA, 2001), MSW programs must make a stronger commitment to expanding coursework that focuses on the specialized training needed to work effectively with this population. In an effort to reduce stigma amongst among clinicians, increased coursework and contact through fieldwork might also dispel the myth that people with schizophrenia cannot benefit from therapy. Perhaps it is this gap in social work coursework, and field education that contribute to this myth. Social work students might not feel equipped to engage in psychotherapy with people who have schizophrenia because they lack a deep understanding of this illness, and the current treatment methods available. Both clinicians and people with schizophrenia require a sense of empowerment in order to successfully engage in psychotherapy.

Alternatives to the Emergency Department.

The Living Room is located in Skokie, IL, a suburb of Chicago, Illinois. It is conveniently located on the public bus line and is attached to a well-known community mental health center (Heyland, Emery, & Shattell, 2013). It is described as a community care respite program that is an alternative to the ED for people in crisis and is based on the Recovery Model. *The Living*

Room was developed to provide care to individuals who experience mental health crises, but have few options besides the ED and have had negative experiences seeking crisis support within the hospital setting. *The Living Room* staffs one psychiatric nurse, one social worker, and three peer support workers. There are six beds available in *The Living Room* and this is to ensure that there are no waiting lines or a delay in access to care. Those who utilize *The Living Room* are deemed guests and are welcome to leave at any point, given that they are assessed and considered to be safe to return home (Heyland, et al., 2013). After an initial meeting with a social worker and the psychiatric nurse, guests are paired with a peer support counselor and discuss the details of the crisis and coping skills that might be helpful. *The Living Room* itself seems to emulate a holding environment:

The environment of the actual space is warm and welcoming with carpeted floors, paintings (art) on the walls, comfortable furniture, and soft lighting. The environment was designed so that guests are likely to feel safe and not overwhelmed by excessive stimuli (e.g., television, radio, or excessive number of people (Heyland, Emery, & Shattell, 2013, p. 3).

Aside from social support, there are separate rooms that provide a more private experience for those needing less social interaction, but find comfort in knowing that staff and peer workers are available. This sensitivity to the need for a more impersonalized, less intrusive experience is important for those with poor object relations. In its first year, *The Living Room* hosted 87 individual guests with a total of 228 visits. This diverted 213 visits to the ED resulting in a 93% diversion rate (Heyland, et al., 2013). These diversions alone decreased healthcare costs in Illinois by \$550,000 since most of the individuals overusing the ED were on Medicaid, or are uninsured (Heyland, et al., 2013). Thus, *The Living Room* not only seems to provide appropriate

care to these individuals, but is also a less expensive alternative to the ED, despite the fact that this service is free of charge. The location of *The Living Room* within a community mental health center is crucial because it illustrates ways in which social workers can support institutional transference to a community mental health center to establish an alternative the ED that has some connection with the previously established center. Shattell et al. (2014) examined the experiences of the guests who utilize *The Living Room*. The guests described *The Living Room* as a “ ‘safe harbor’ or ‘oasis’ ” (Shattell, et al., 2014, p. 7). Without a “safe harbor” like *The Living Room*, people with schizophrenia who are scared and in crisis have turned to the ED for safety. *The Living Room* is an excellent example of a dignified, and supportive treatment alternative to the ED that can support institutional transference to hospitals or community mental health centers in order to provide the best care for people who frequent the ED.

Treatment Implications

Several significant research implications were identified during this theoretical exploration. First, these findings call for more targeted outreach to vulnerable populations who might be more likely to feel they cannot access outpatient services. As previously mentioned, young men of color with schizophrenia are more likely to overuse the ED than young white men with schizophrenia (Pasic, et al., 2005). This indicates that individuals from racial and ethnic minority groups likely face additional barriers to accessing both mental health and primary medical care that white people with schizophrenia do not. Thus, further research is needed to better understand the role of structural barriers impacting ED overuse by people with schizophrenia. Second, it is especially important to consider the lived experiences of those with mental illnesses in both community mental health settings and in hospital settings to better understand the role of stigma when accessing care. Focusing on the personal narratives of those

with schizophrenia who frequent the ED will also be a crucial component to future research. Of course, it is important to consider the confounding factors that contribute to the gaps in this type of research mainly ethical considerations of participation in research for individuals who have experienced psychosis. For example, future researchers could explore ethically sound methods for interviewing those who have overused the ED in the past while psychotic, but who later, at the time of study, are stable (and have been for a certain amount of time) and are able to reflect on their ED use in the past. This would shed light on the lived experiences of people with schizophrenia who overuse the ED and give voice to a group whose opinions have been excluded from research.

Conclusion

People with schizophrenia or other psychotic illnesses are more likely to overuse the ED than any other population of people with mental illness (Chaput & Lebel, 2007). In addition, these individuals are likely to be young men of color with poor social functioning (Pasic, et al., 2005). Of importance, many of the demographic, and diagnostic factors that predict ED overuse also seem to predict outpatient disengagement. Thus, for people with schizophrenia, social functioning heavily predicts overuse of the ED as well as non-adherence to outpatient appointments (Desai et al., 2013). ED overuse might indicate that some people with schizophrenia are not receiving the appropriate outpatient care that they need. ED overuse has negative implications not only for the individuals seeking mental health treatment, but also for the ED staff providing care. This is largely because the ED is unable to provide effective psychiatric care to patients with mental illnesses (Ledoux and Miner, 2006). This fosters negative staff attitudes towards those who overuse the ED, and this hinders successful outcomes and promotes continued overuse (Adams and Neilson, 2012). It is useful to apply object relations

and institutional transference to explain why people with schizophrenia might overuse the ED and miss outpatient appointments. Poor object relations in schizophrenia often manifests in both a longing to be with others, and a fear of intimate connection largely caused by annihilation anxiety (Berzoff et al., 2011). This might help to explain the research, which suggests that people with schizophrenia do not adhere to their outpatient appointments. Additionally, object relations helps us to consider the ED as a type of holding environment for individuals who find individual interactions threatening (Winnicott, 1965). Institutional transference (Reider, 1953) also offers an explanation as to why some people with schizophrenia might be more inclined to develop a transference to the ED, rather than to an individual clinician. It is important to consider how ED overuse might be a symptom of poor treatment options for people with schizophrenia. These theories offer a new way of understanding ED overuse and treatment non-adherence that is non-pathologizing and calls for greater examination of countertransference when working with psychotic clients.

People with schizophrenia deserve treatment that is comprehensive and current. The harsh climate of managed care often disregards the needs of the most vulnerable populations, and can stifle therapeutic creativity, and curiosity. Horowitz (2002) eloquently describes the danger of rigidity in defining connection and relationship stating, “In our passion for certitude and rigor, in our quest for unambiguous answers to questions of limitless complexity, we lose our appreciation for the mysterious and ultimately ineffable realities of relationship.” (p. 242) Clinicians can bring about change in the way that we connect with our clients who are living with schizophrenia. It is imperative that we embrace the diversity of connection that we encounter in our clients and challenge our traditional notions of a therapeutic alliance. It is my hope that this thesis contributes to a greater understanding of ED overuse by some people with

schizophrenia so that we may better understand how to support this population in a more meaningful and therapeutic way.

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Appendix A

EbscoHost Key Search Terms

ACT + Team	On-Call
Adherence	Ontological security
Admission	Outpatient
Appointment	Over-Use
Asylum + Function	Patterns + Use
Connection	Psychodynamic
Countertransference	Psychosis
Crisis	Psychotic
Crisis Services	Readmission
ED	Recidivism
Economic + Burden	Relationship
Emergency + Department	Safety
Emergency + Room	Schizophrenia
Emergency + Service	Seeking
Environment	Shelter
ER	Therapy + Relationship
Fear	Therapeutic Alliance
Frequent-Flyer	Transference
Frequent	Winnicott
Freud	Working Alliance
Fusion	
Help-Seeking	
High-Utilizer	
Holding + Environment	
Hospital	
Hospitalization	
Idealization	
Individual + Therapy	
Intimacy	
Institution	
Institutional + Transference	
Klein	
Living Room	
Mental	
Mental illness	
Merger	
Missed	
Non-urgent	
Object + Relations	
