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a symbolic tree: loneliness is the root; delusions are the leaves

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For a long time, loneliness has been recognized discussed, and referred to in a voluminous amount of psychiatric literature. Surprisingly enough however, the concept of loneliness as a major contributor to the human condition appears to be underestimated. Only a few discerning writers have realized its importance. Freida Fromm-Reichmann for one, has emphasized loneliness as one of the least understood conceptualized phenomenon.1

Two developments in psychiatric thinking have given impetus to current concepts of loneliness The first was the emphasis on the importance of interpersonal relationships in emotional development. Sullivan, one of the major leaders of this development, was aware of the "exceedingly unpleasant and driving experience" of loneliness He felt that it resulted from the frustration of a "basic need for personal intimacy."2 The second development resulted from the theory that man has a definite need for relatedness. If a particular individual does not have this need met and satisfied, then his loneliness becomes a prominent part of his state of being.

It seems fairly obvious that the unfulfilled need for relationships results in feelings of loneliness. One can gain further insight into and a deeper understanding of this concept through comparing it to the structure of a tree. This tree is used symbolically throughout this paper. Loneliness is the root and can progress to the point where a person's behavior becomes deviant. This progression consists of various components passing up the trunk of the symbolic tree. The absence of relationships is compensated by the manifestations of hallucinations and delusions - the leaves on the symbolic tree.

The fact that loneliness plays an extremely important role in psychopathology suggests the hypothesis that the fulfillment of an intimacy need may constitute a basic factor in psychotherapy not

hitherto recognized.

I will explore in the rest of this paper the concept of loneliness, examine and comprehend the psychological change manifested as the delusional leaves, and then formulate a process of nursing intervention for alleviating this loneliness. The nursing intervention suggested consists in part of a specific case demonstrating the need for intimacy and the resultant psychological disturbance which occurs when intimacy is not obtained.

CONCEPT OF LONELINESS

First, however, a clear, workable definition of loneliness is necessary. In the many writings which I have researched for this paper there is not a clear Definition. In an attempt to come up with such a definition von Witzleben distinguished two types of loneliness. One is caused by the loss of an object (being abandoned, deserted), while the other is inherent, inborn in everyone - the feeling of being alone and helpless in the world.

Loneliness is sometimes used as a synonym of alone. However, many authors who have written about loneliness caution that it not be confused with isolation, solitude, aloneness, separation, and alienation. These writers specifically caution that loneliness be distinguished from aloneness. If a person feels aloneness, he has withdrawn voluntarily. If he feels loneliness, he has withdrawn involuntarily and feels that he has been separated and isolated by forces that lie outside himself. When this loneliness becomes extreme, there is the feeling of no-relationship, the feeling that there is no significant human being in the world with whom one relates at all. While aloneness may be constructive, loneliness is usually destructive. Clark beautifully outlines in explicit detail what she considers to be a suitable definition for this concept of loneliness:

1. Man has a need to transcend his separateness.
2. This need produces tension.
3. Relief of tensions is sought through self-transcendence by:
    - 3.1 Direct means (relationship with others).
    - 3.2 Indirect means (creative expression).
4. If these means are successful, feelings of

loneliness are relieved, at least temporarily.
5. lf these means are unsuccessful, barriers exist (Some of the barriers to self-transcendence are self-alienation, shame and guilt, social ostracis, cultural mobility and exclusion, lack of trust, and pain.)
6. If he is unable to overcome the barriers to self-transcendence, there is an increase in tensions which leads to:
    6.1 An Increase in anxiety.
    6.2 An increase in the degree of loneliness.
7. The persistent unfulfilled need for self-transcendence leads to:
    7.1 Further increase in anxiety
    7.2 A degree of loneliness experiences as psychic pain.
8. Defenses (denial, suppression, repression, alcoholism, somatic complaints, etc.) are used to decrease the anxiety and guard against the pain.
9. Such defenses result in further alienation from the self and others.
10. This alienation leads to an increase in loneliness and anxiety.
11. As the loneliness and anxiety increase, the defenses no longer work.
12. As the defenses crumble, the lonely Individual attempts to escape into a world of unreality (personality disintegration).3

When this definition is applied to the symbolic tree, it is readily seen that as loneliness becomes more intense and progresses up the tree through the branches, leaves appear which represent the extreme escape to unreality, resulting in the manifestation of hallucinations and delusions.

The interpersonal relationship theory and threads of existentialism can also be applied to the symbolic tree, allowing for further exploration and a deeper understanding of the resultant phenomena of hallucinations and delusions.

Although several writers believe that loneliness is an underlying factor in mental illness, Sullivan is one of the few who has attempted to explore the developmental process of this phenomena. Sullivan believed that the components which culminate in the experience of loneliness begin in infancy and exist in each developmental period. He referred to

these components as being related to the need for tenderness in infants, the need for expressive play in children, the need for compeers in the juvenile area, and the need for a more intimate kind of relationship in preadolescence. He believed that people lack the kinds of experience that they should have in these developmental stages - experiences which tend to minimize loneliness.

Peplau also endorsed these components as the causes of loneliness. The roots of this experience she has described as being "the result of early life experiences in which remoteness, indifference, and emptiness were the principle themes that characterized the child's relationships with others."4

Fromm-Reichmann has referred to "real loneliness" as the state of mind "in which the fact that there were people in one's past life is more or less forgotten and the hope that there may be interpersonal relationships in one's future life is out of the realm of expectation or irnagination."5

Hence, again, if the need for intimacy is not met, the result is degrees of loneliness with the most severe manifestation being hallucinations and delusions often expressed in the form of defense mechanisms, anxiety, and alienation first.

THE DELUSIONAL PHENOMENON

The absence of meaningful relationships which can maximize loneliness**,** appears to cause psychological changes resulting from an effort to compensate. This compensation manifests itself as delusions or hallucinations.

Clark provides a clear, workable outline of the process that results in manifestations of delusions:

1. The need for relationships results in feelings of loneliness.
2. Feelings of loneliness are the motivation factor In the search for relationships.
3. The ability to relate to others is necessary for the relief of loneliness.
4. The quality of relationship is an essential factor in relieving loneliness and in maintaining one's emotional health.
5**.** Feelings of loneliness are experienced in degrees.
6. Fear of loneliness is a motivational factor In defense against this feeling.

7. Absence of meaningful relationships over a prolonged period results in mental illness.
8. As feelings of loneliness increase, behavior becomes more deviant (ex, sexual promiscuity. fantasy and daydreams).
9. Psychological changes take place in the absence of relationships in an effort to compensate for this lack (hallucinations, delusions).
10. Treatment of loneliness consists of a gradual replacement of unreality with reality through meaningful relationships.6

It is well known that different kinds of delusional phenomena exist. In the case study to be presented, the delusional type is that of infidelity.

The nurse's attitude towards those patients who manifest delusions should be one of attempting to understand and recognize their needs for intimacy, as well as one of dealing openly with their needs in the therapeutic setting.

The process of dealing with the needs of the married couple involved in this case was one of providing nursing intervention, or a pruning of the symbolic tree, to meet the intimacy need.

A PROCESS OF THERAPEUTIC NURSING INTERVENTION

There appears to be identifiable steps in the pruning or process of nursing intervention for the delusional experience. The following case study involved a married couple with the wife experiencing the delusions. It became apparent to the nurse-therapist that the significant relationship to be dealt with was the husband-wife relationship. This of course is a type of therapy which differs from individual therapy in which the emphasis of a significant relationship would be the nurse-patient relationship. This particular situation necessitated providing somewhat different techniques in therapy in order that the same goal might be reached. It also required that the nurse-therapist be able to facilitate the kind of relationship which would provide the fulfillment for the need for relatedness.

To reiterate, the purpose or goal of this pruning, or nursing intervention, was to assist this couple in understanding the need for the delusions which the wife was experiencing, teach ways of reducing the

delusions, and understand the relationship of delusions to loneliness. All of these goals were emphasized as means for realizing the overall and long-term goal of providing a meaningful relationship to meet the need for intimacy.

CASE: MR. AND MRS. G.

This couple has been seen in a Marriage and Family Therapy Clinic for a period of twenty-one sessions. The wife had been experiencing delusions.

The therapists involved were a male family therapist and myself. Prior to my becoming involved, another female therapist and the present male therapist had seen this couple a total of ten sessions. The male therapist and I have seen this couple for eleven sessions.

Mrs. G. has received previous psychotherapy which began some 15 years ago. The most recent therapy occurred about two years ago. This is the first time that the husband has also received therapy. During the presentation of this case, it will become apparent that having the husband in therapy was the critical variable that made the significant difference as to whether Mrs. G.'s intimacy need would be met And because this need was met, Mrs. G. no longer had the need to experience delusions.

At the initial stage of the therapy in which I was involved, both Mr. and Mrs. G. were 53 years of age and had been married 31 years. They had three children, two of whom had died from muscular dystrophy. The one living son was 20 years of age.

Mrs. G. spent most of her early childhood in an orphanage and was later placed in several foster homes. She continually felt that she had to "prove" herself and that If she did not "behave correctly" then she would be asked to leave. She finally was adopted by a family, but on condition that she perform properly or she would be left alone. She stated that she had felt rejected all of her life and that as a child she did not have any close relationships with other people. She has had periods of anger, depression, and uncontrolled destructive tendencies, and expressed her feelings of loneliness and her constant fear of being lonely

and being left alone.

Mrs. G.'s delusions appear to be pathological jealousy, during which she has unconscious extramarital sexual impulses either heterosexual or homosexual, which are then projected onto her husband and appear clinically as delusions of infidelity. It is important to note that the reason for these impulses or desires was again the need to fulfill the need for intimacy. This intimacy need was not simply a sexual one but rather a need for an emotional closeness with another person.

Mr. G. was a passive-aggressive individual who had extreme difficulty in expressing his feelings. He stated that he was always taught as a child to control his feelings and thus appeared very bland, rigid, and stone-faced as an adult. He withdrew and became detached when Mrs. G. was feeling upset. He stated that he didn't know how to respond or to what when Mrs. G. became upset. It Is very ironic that while Mrs. G. felt left out of Mr. G.'s life and his interests, he lived vicariously through Mrs. G.'s many accomplishments. He also had many feelings of unworthiness and inadequacy and had also experienced loneliness but did not know how to establish close relationships. The degree of Mr. G.'s loneliness was not as extreme as his wife's.

Thus, although Mrs. G. came to the Clinic as the identified patient, it was evident that the problem was a relationship in which neither husband nor wife was having his or her intimacy needs met. As a result both were experiencing feelings of loneliness and unworthiness. Mrs. G.'s loneliness manifested in more deviant behavior than Mr. G.'s but both individuals played a significant role in the alienation that each felt.

STEP ONE - ESTABLISHING A THERAPEUTIC NURSE-PATIENT RELATIONSHIP

One of the most essential needs in this relationship was to establish trust since the major concern was loneliness. A good trust relationship already existed with the male therapist and Mr. and Mrs. G. when I entered the therapeutic sessions as a co-therapist. However, it became necessary for me to establish a close relationship with the married couple.

That a lack of trust existed, became evident in my second session with Mr. and Mrs. G. Mr. G. would not look me in the eye when he spoke to me. I then realized that I must intervene and comment on my observation to Mr. G. and describe the feeling I was experiencing as a result of his avoiding looking at me. This allowed Mr. G. to know that I was interested in him as a person and wanted more meaningful contact with him. After my intervention, we both gave each other direct eye contact when responding to each other. Hence as a result of that intervention, a sense of trust developed.

STEP TWO - THE THERAPIST'S ACCEPTANCE OF HER OWN FEELINGS OF LONELINESS

My acceptance of my own feelings of loneliness was an extremely important phase of the intervention process. I had previously learned the importance of this step when a patient inquired if I was ever lonely because I was away from home. At that time, I was somewhat defensive at the suggestion that I might also be experiencing such feelings. It helped me realize that at times the pain of loneliness is simply too painful for people to express and therefore we build defenses to guard against this disclosure. However, the lesson I learned suggested that if therapists deny their own feelings of loneliness, then they may be unable to accept the patient's expression of these feelings or may ignore any nonverbal behavior indicating loneliness.

My acceptance of my own feelings of loneliness was hence not a problem with the married couple in question because of my previous experience.

STEP THREE - THE THERAPIST'S ACCEPTANCE OF HER OWN HUMANNESS

An acceptance of one's own humanity overlaps with the previous step but is more general. In this step it was necessary for me to be willing to accept my own humanness. It was necessary for me to have experienced, recognized, and have an awareness of the feelings of fear, happiness, pain, loneliness, anger and other significant emotions. To the degree that I was able to do this, the climate of the therapy sessions was an open, trusting one which allowed the patients to reveal their real feelings.

STEP FOUR – ENCOURAGEMNT OF
DESCRIPTION OF DELUSIONS

By encouraging descriptions of the delusions, the male therapist and I were able to gain this couple's perception of the experience:

Mr. G.: When she becomes upset, she always accuses me that I have an interest in other women,
- but she knows that isn't true.

Mrs. G.: But when he'll just leave me at night alone,
- what am I to think?

Nurse-Therapist: What are you feeling at the time when you leave home Mr. G.?

Mr. G.: Well, - I've just had it. She follows me from room to room screaming and yelling. I just can't take it anymore – so I leave.

Mrs. G.: When I become that upset, it's because I haven't been able to get a response out of you, and so I have to go to the point of screaming.

Mrs. G.'s delusions always seem to follow incidents in which she could not make meaningful contact with her husband. As a result, she projected her desperate need for relatedness into a delusion – her husband's infidelity.

STEP FIVE – INTERPRETATION OF DATA

There is an important difference in interpreting the data in couple's therapy as compared to that in individual therapy. In the case of Mr. and Mrs. G., the difference was that the therapist attempted to have this couple aid in interpreting the data. In individual therapy, most of this responsibility rests with the therapist. The reason for the therapists using this technique was that both the husband and wife needed to learn to be aware of the messages that they were sending verbally and nonverbally and also to be aware of how those messages might be interpreted. Once this was recognized, the couple learned explicit messages without fear of misinterpretation.

Nurse-Therapist: Mr. G., you have your arms folded very tightly about your body. I'm wondering

what meaning that has to you?

Mr. G.: Well, I guess I it means that I just want to clam up.

Nurse-Therapist: Is that the message you want us to have?

Mr. G.: No, but I find it hard to say my feelings. (Mrs. G.) can express her feelings so easily.

Male Therapist: What message does crossing your arms and being quiet give your wife?

Mr. G.: I guess it says you do your thing and I'll do mine.

Nurse-Therapist: Do you want Mrs. G. to have that message?

Mr. G.: No – I don't.

Mrs. G.: I feel like I'd like to get involved with you, to have you share with me.

This interaction allowed the couple to see that because of the messages they were giving, neither was able to have his or her own needs met.

STEP SIX – EXPLORATION OF REASON FOR THE NEED FOR DELUSIONS

The following excerpt from a session with Mr. and Mrs. G. reveals delusions and why Mrs. G. behaved in a dysfunctional manner.

Nurse-Therapist: What do you do Mrs. G when your husband folds his arms and you receive that message?

Mrs. G.: I tell him, "Please don't draw away from me. Please don't fold your arms." – because then I feel panicky and start to throw things.

At this point, Mrs. G.'s behavior became even more dysfunctional and she began to accuse her husband of infidelity.

Another excerpt illustrates the effect on Mrs. G. when

her feeling of unrelatedness was active. Mr. G. had been expressing his hurt, began to show his emotion by crying, and stated he felt like a “boob.” Both therapists reassured him that this was an honest, genuine acceptable display of emotion:

> Male-therapist: what happens to you when you see (Mr. G.) this way?
>
> Mrs. G.: Well, it makes me feel bad for him, but I’m glad that you’ve brought this up. It’s something I’ve wanted for a long time…so many times. He’s quiet, pulling away from me, I’m left alone…feel like I’m going to be left to tread water. I want him to be able to share these things with me.

STEP SEVEN - TEACHING WAYS OF REDUCING OR CONTROLLING THE DELUSIONS

In order to reduce or control the delusions of Mrs. G. the two therapists assisted the couple in developing more effective ways of communicating their feelings to one another. They did this with the idea that such communication would help decrease the loneliness that each felt and help them fulfill their need for intimacy and relatedness.

Nurse-Therapist: I would like you both to share with each other how you feel about what's just happened. You've just had a meaningful experience with one another and I feel it is important that you now share your feelings about it.

{Their chairs were turned so that they were directly facing one another. The therapists became active observers.)

Mrs. G.: Tell me what happened when I hurt you. (Her voice indicated compassion).

Mr. G.: Well, I feel that you knew as much about it as I did.

Mrs. G.: I knew, but I could misinterpret

Male Therapist: Tell (Mrs. G.) what you're feeling

right now.

Mrs. G.: I am – Well, I don't want it to be always so one-sided, that it's me asking for help. I wish you would share your interest with me.

Nurse-Therapist: What do you hear your wife saying to you?

Mr. G.: I hear her saying she's interested in me, but I don't know what would be of interest to you that I do. (He turned his attention back to his wife.)

Nurse-therapist: What about your work? Have you shared that with (Mrs. G.)?

Mr. G.: No, not really. I didn't think it would be that interesting.

Nurse-Therapist: Would you like to hear about his work, (Mrs. G.)?

Mrs. G.: Yes, I would.

The couple then accepted this assignment: Mr. G. would begin to share the events of his day at work with Mrs. G. each day for the next week. They would then report back to their therapists. The report the following week indicated that both had found this a rewarding sharing time and wanted to continue it.

SUMMARY

This particular case involving the suggested nursing intervention was very successful and rewarding. It is very important, however, that therapists realize that these seven steps were acceptable in this particular case, but steps four-to-seven may be modified with each couple. However, the first three steps are more than likely essential to any effective intervention dealing with loneliness. Also, the excerpts from this case happen to illustrate the highlights that were related to loneliness. The therapists recognized that there were other issues and concerns that also needed to be dealt with and which were, but the need for intimacy seemed to have top priority.

Loneliness rooted in the symbolic tree cannot be dealt with by plucking the leaves; it must be dug out by the roots. Psychotherapy needs nursing psychotherapists who will contribute to this digging.

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