Application of Kohut in Public Mental Health: Understanding Fatima

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Kohut's Self Psychology: Contemporary versus Traditional Theory

In 1971, Heinz Kohut published a book titled *The Analysis of Self* that revolutionised psychoanalysis and created a paradigm shift in traditional Freudian concepts (Baker & Baker, 1987; Lee & Miller, 1991). Kohut termed his theory a *deficit model*, and argued that the origins of psychiatric disorders are largely environmental, stemming from disruptions in healthy human development that lead to an ill-developed sense of self through insufficient responsiveness from care-giving environments (Gabbard, 2005; Meares, 1996). This view significantly contrasts with earlier psychoanalytic theorists, including Freud, who believed the aetiology of these disorders to be *intrapsychic conflicts* which were defences against aggressive unconscious and subconscious drives and hostile wishes (Holt, 1989; Meares, 1996), independent of external factors.

Whilst acknowledging that the drives of the *Oedipal Complex* are pertinent to human history and serve as a basic part of human psychology, Kohut did not agree that the drives constitute the meaning of self or that the self is the result of a resolved Oedipal Complex. In opposition, he argued that the expression of such drives in a child indicates a family in crisis (Gabbard, 2005; Strozier, 2009).

Kohut's Self Psychology: Main Concepts

Selfobject

Kohut conceptualised *selfobject*, the importance of the other, as an intrinsic part of the self (Fisch, 2010). The concept of selfobject is a systematic understanding of the critical role of human interaction in the development of self-cohesion (Lee & Miller, 1991). It is derived from children's experience of their caregiver, for a significant period of time, as an extension to their own system of self. Early in life, a mother and her child develop *protoconversation*, which is an interaction of the mother with her child's emotional expression via vocalisation, observation and body movements. The selfobject functions change throughout the child's development and give the child a sense of being connected to another (Fisch 2010; Meares, 1996).

Kohut formulated the concept of a selfobject through his experience with Miss F, a young woman who would become incredibly angry when he remained silent, and condemn him for corrupting her analysis whenever he attempted to interpret her experiences. Kohut initially regarded her protests as resistance to his interpretations, however later realised that Miss F required an environment of responsiveness instead of an interpretative approach. He learned that Miss F experienced him as an extension of herself, over whom she had some degree of control (Fisch 2010; Meares, 1996). She demanded that his responses instantly and totally fulfil the needs she was not able to meet herself. Kohut identified these demands as the result of selfobject needs. Miss F's psychopathology was her complete reliance on the responses of others for her self-esteem (Baker & Baker, 1987; Meares, 1996). The deficiencies in parental empathy resulted in Miss F being overly dependent on people in her surroundings to provide herself with selfobject functions (Baker & Baker, 1987).

Self psychology acknowledges that even though parents are not deliberately unresponsive, children grow up adapting (or maladapting) to their parents' interactional style. Kohut believed that repeated failures by parents to empathise with their children, and their children's responses to them, are at the heart of all psychopathology (Baker & Baker, 1987; Gabbard, 2005).

Kohut believed that human beings never outgrow the need for selfobjects, however throughout people's lives, selfobject needs change. Healthy adult intrapsychic development is where reliable and consistent selfobject needs were met in children's and teenagers' development, so that people become more internally competent and flexible in meeting their remaining selfobject needs, without relying on external sources to fulfil these needs (Baker & Baker, 1987).

Selfobject Transferences

In self psychology, transferences that occur between therapist and patient are viewed as reflecting selfobject needs that are deficient. Kohut identified two transferences initially, *mirroring* and *idealising*, and identified these two poles as the *bipolar* self. He later added *twinship* and *alter ego* as another type of transference, and expanded his conceptualisation of self to the *tripolar* self (Baker & Baker, 1987; Gabbard, 2005).

Mirroring

During sessions with Kohut, Miss F demonstrated a mirroring transference. She would frequently comb her hair whilst looking into the mirror, and would constantly turn to Kohut for his responses to verify her self-worth. Responses that were short of total approval were unbearable and destroyed her self-esteem (Baker & Baker, 1987). Miss F experienced mirroring failures from parents or parental substitutes in her childhood that caused developmental arrest. This predisposed her to psychopathology and deficiencies that persisted into adulthood (Baker & Baker, 1987).

The delighted response of parents to their children creates internal self-respect, as it mirrors back to children a sense of self-value and worth. Conversely, responses of indifference, criticism and hostility produce low self-confidence and inhibit assertiveness in children. Mirroring response should be developmentally fitting and sincere (Baker & Baker, 1987; Lee & Martin, 1991). In a mirroring transference, patients look to therapists for a response of validation (Baker & Baker, 1987).

Without adequate mirroring, children feel they are inadequate, and they may compensate by trying to be perfect for their parents. This desperate performance and 'showing off' is a manifestation of a grandiose and exhibitionistic self seeking to gain approval and admiration from their parents (Baker & Baker, 1987; Gabbard, 2005).

Idealising

Kohut described idealising as the child's wish to merge with or be close to others who make them feel safe and calm. A simple example of this can be seen in children who fall on their knees and run to their parents for hugs, and the pain disappears. Kohut described this calming and comforting selfobject as the *idealised parental imago* (Baker & Baker, 1987).

In the idealising transference, clients perceive their therapist as a presence to soothe and heal, a source of an all-powerful figure. Children whose parents fail to provide for their need to idealise, or do not provide a commendable model of idealisation, may exhibit this transference in therapy later in adult life (Baker & Baker, 1987; Lee & Martin, 1991).

Alter Ego/Twinship

Alter ego or twinship refers to the need to feel a degree of likeness to others. A small boy may stand beside his father in the morning and mimic his father shaving with an imaginary razor. Alter ego experiences lead to feeling connected and being part of a larger community (Baker & Baker, 1987; Lee & Martin, 1991).

Kohut held that in childhood and teenage years, this closeness with caregivers has a merged quality, and with further development, tolerance and respect for difference emerges. He provided examples of adolescents who tend to dress alike and have similar preferences—so much so that being different is threatening. Whilst adults enjoy having similar interests to each other, they also tend to respect and appreciate differences more (Baker & Baker, 1987; Lee & Martin, 1991).

In therapy, Kohut called for therapists to participate in the revival, repair and growth of self-deficit structures, and recognition of clients' efforts to self-heal via selfobject transferences. This participation requires therapists to be responsive, involved and emotionally available. He believed that the aim of therapy is to provide an environment in which intrapsychic functioning may effectively and belatedly develop (Fisch, 2010). Kohut's contemporary view of analysis contrasted with the traditional emphasis on

analysts' neutrality over the last 75 years of psychoanalytic interpretation, in which analysts' unique personalities are kept out of the therapeutic interaction (Fisch, 2010; Strozier, 2009).

Kohut initially applied this theory in relation to severe narcissistic personality disorder, then later extended self psychology to psychoses, borderline states and neuroses (Baker & Baker 1987: Fisch, 2010;).

Empathy

Kohut described empathy as a reverberation of others within the self in the effort to understand them (Gabbard, 2005; Orange, 2009; Strozier, 2009). He argued that such relatedness in and of itself cures, independently of anything else, during therapeutic work with clients. Kohut also felt that empathy is universal, and that therapists who employ empathy systematically do not only perceive the experience differently but also their experience is therapeutically altered (Strozier, 2009).

Kohut balanced his emphasis on empathy by highlighting the significance of explanation. He promoted the importance for explanation to occur in an empathic therapeutic alliance, as he believed this modifies the quality of interpretation. He also argued for the role of empathy as the sole therapeutic tool, especially at the beginning of therapy before interpretation begins. When therapy is done in this sequence and imbedded in the language of a therapeutic approach, Kohut believed that empathy and interpretation act in synergy, and that timely and accurate interpretation is an empathic act (Lee & Miller, 1991; Strozier, 2009).

Treatment Objective

As well as offering a novel understanding of the aetiology of psychopathology, Kohut's theory also differed significantly in its therapeutic aims. While Freud's therapeutic destination of teleological theory highlighted the aim of analysis as resolving narcissistic strivings, Kohut argued that a form of healthy narcissism naturally continues throughout life (Gabbard, 2005; Strozier, 2009). He asserted that a symbiosis of selfobject relations should continue until the self is able to attune to its own needs independently.

Kohut's Self Psychology and Public Mental Health

In Australia today, biological psychiatry dominates the public mental health setting, whilst psychodynamic psychotherapy is primarily practised in private settings. Limited resources, mainly of time and service funding, have driven the public mental health system to a largely pharmacological domain to serve a revolving door system. I wonder whether the exclusivity of pharmacological solutions in the public system is the very reason the revolving door pattern persists.

Psychodynamic psychotherapy may arguably be seen as incompatible with the acute public setting. For example, the management of acute psychosis at present is not conceptualised as responsive to psychodynamic psychotherapy, especially in the mental

health setting which is characterised by involuntary therapeutic relationships between doctors and patients.

The next section presents a case history in which Kohut's principles were applied in understanding and management of a young woman, alongside medication, and the way these principles facilitated pharmacological therapy with an involuntary client.

Case History: Fatima

Fatima (pseudonym) is a young Muslim female suffering from Schizoaffective Disorder who is a university student. She is of Somalian descent and lives at home with her family.

I met with Fatima when she was expelled from a university tutorial due to "talking too much". She presented with approximately six weeks' history of manic symptoms: namely decreased sleep; elevated and labile mood; pressured speech; increased energy level; and irritability and distractibility. The context of this relapse was multifactorial, as listed below:

– non-compliance with medication;

– second anniversary of her father's death (the month of her relapse);

– stress with university studies;

– pressure from family (particularly her mother).

This admission was Fatima's third hospital admission, having first presented to psychiatric services three years prior.

Past Psychiatric History

Fatima was first brought to hospital by police with a three-day history of insomnia, suicidal ideation and homicidal ideation, evidenced by trying to kill her family. Fatima displayed aggressive behaviours (she swung a vase at a family member) and had to be restrained physically by her family prior to the arrival of the police. During this first admission, Fatima reported that she was "the devil" and claimed that spirits possessed her. Her family described her as "acting weird" around the house and towards them. Fatima also described ideas derived from television and radio and thought broadcasting, along with paranoid and religious delusions. She was preoccupied with thoughts of having "disappointed Allah [God]" and needing to make amends. She was hospitalised because of her ongoing impulse to kill herself and her family.

Three main stressors were identified in her first hospital admission. These were:

– her father's diagnosis with a terminal illness three months earlier and his recent admission to

hospital for complications arising from treatment;
– worsening of bullying at school, which began two years before, at the start of the year;

– fear of failing Year 12 due to late submission of homework and assignments.

Whilst hospitalised, she was treated with antipsychotic medication and was referred to a young people's mental health unit for follow-up. After her hospital discharge, Fatima failed to engage with the mental health unit and became non-adherent to medication.

Six months after her first hospital admission, Fatima relapsed. She was described as aggressive as she had broken several pieces of furniture at home, as well as biting her sister and a police officer while resisting medical attention. Fatima had to be subdued by police with capsicum spray. Her family also reported Fatima had been rambling in mixed English and Arabic with an expansive mood. She was also "digging in the backyard with her teeth, to reach Allah [God]". Paranoid delusions re-emerged, along with decreased sleep and formal thought disorder. The context of her relapse was noted to be non-adherence to medication, stress with studies at university and her father's worsening illness.

In the ward, Fatima was documented to be "highly dangerous", requiring management in the High Dependency Unit with intermittent antipsychotic injections to settle her. She was initially managed by polypharmacy regime and commenced on a different antipsychotic medication. She was discharged with a re-referral to the young people's mental health unit for follow-up.

Family/Substance Use History

Fatima has an extensive family history of psychiatric conditions, as her elder brother and elder sister suffer from Schizophrenia and Bipolar Affective Disorder. She had no record of past substance abuse.

Personal History

Fatima was born in Somalia, the youngest of her siblings. Her mother had an uneventful pregnancy and birth with Fatima, and she achieved normal developmental milestones. Her family fled to Kenya when she was four years old, due to war in Somalia. Fatima grew up in a refugee camp with no proper shelter or food supply, before her family moved into her grandmother's home in Kenya.

As a child, she was very attached to her father, in contrast to significant emotional distance from her mother, who practised physical discipline. Fatima never received formal education in Kenya. She had only learnt the basics of English and Swahili from television programs.

Fatima's mother came to Australia in the late 1990s and sponsored the rest of the family to join her in Australia some years later. She worked in a professional occupation before becoming a refugee, and now works in a non-professional role. Fatima's father worked as a businessman in Somalia, but on coming to Australia similarly had to find work in an unrelated non-professional role.

Fatima came to Australia at age thirteen and attended English language classes for nine months before commencing secondary school. She began to learn to read and write with additional support and classes, as she was diagnosed with dyslexia in the first year of living in Australia.

She described herself as being very socially isolated, and she spent most of her time with her sister, at school and during her free time. She also described having no past intimate relationships. Fatima shared that she was bullied in school, and that the bullying got worse when her elder sister left secondary school. Fatima began donning the hijab (Muslim headscarf) at twelve.

She described her mother as always putting pressure on her to perform academically to become a doctor or a lawyer. Whilst she completed her senior high school examinations with subsequent entry into tertiary education, she had always felt “never good enough” for her mother.

Fatima’s father died in 2009. In the months after her father’s death, she continued with her university studies. Her aim is to work in education to help children with dyslexia. Fatima receives good support from the local Somalian community. She refers to community members as “aunties”, “uncles” and “cousins”. She has had no other social support network since she arrived in Australia.

Fatima shared that she removed the hijab earlier this year, stating, “It is my choice.” She also left the family home a few days before her third admission to move in with a family friend (“auntie”).

Kohut’s Self Psychology: Understanding Fatima

Fatima’s relationship with her mother has always been based on mismatched expectations. It has been tainted since her childhood by her mother’s physical methods of discipline and expectations that Fatima will achieve a career of no less a standing than a doctor or lawyer. Her mother’s insatiable need for Fatima to over-perform caused her to feel “never good enough”. This illustrates a maternal lack of mirroring since childhood, which persisted into adulthood, causing Fatima to react in the way Kohut hypothesised, that is, in a *grandiose* and *exhibitionistic* way. Fatima’s pursuits in life demonstrate her attempts to obtain her mother’s approval and affirmation. Despite having only received formal education at age thirteen following migration to Australia, and suffering from dyslexia, she persevered with academic study into tertiary education. Fatima’s engagement in culturally inappropriate behaviours, such as removal of the hijab and leaving the family home before marriage, could also be understood as maladaptive grandiose and exhibitionistic behaviours in response to the persistent lack of mirroring by her mother.

In her father, Fatima found emotional stability and approval. Her father provided the mirroring response and acted as an idealised parental imago—a former successful businessman who gave up his career for a better future for his children and a parent who approved of her efforts and subsequent achievements. Although growing up in a harsh

environment, living as a refugee, she did not experience emotional breakdowns. It was only when her father was diagnosed with a terminal condition and began suffering from its complications that Fatima began to display cracks in the cohesiveness of her *sense of self*. Fatima's delusions mainly manifested as feeling she had "disappointed Allah [God]" and needed to make amends at the threat of losing her father. This proved to be the perpetual theme of her subsequent yearly relapses, worsened only by her father's death as she had lost and could not find a substitute for idealisation and mirroring.

Fatima's wish to serve children with dyslexia indicates her acknowledgement of the importance of mirroring in children's development, perhaps representing an unconscious longing for similar encouragement and approval in her own life. It probably also indirectly provides her with an objective sense of self-worth, in providing an idealised figure for these children.

Fatima seeks a stable nourishing environment for herself, identifying primarily with her sister and the Somalian community in twinship. This helps her feel connected to others for support and as validation of her existence.

Kohut's Self Psychology: Engaging Fatima

Understanding the mirroring and twinship transferences that Fatima displayed allowed me to identify and target my empathic approach in caring for her.

Extrapolating on the concept of protoconversation, I began to gradually engage Fatima when she was acutely psychotic. Albeit not prolonged (often during consultant psychiatrist review or registrar review), as Fatima was not able to engage in any meaningful conversation due to her mental state, I ensured that my therapeutic exchanges included providing the selfobject function through vocalisation, therapeutic silence and open body language.

As Fatima improved in her mental state with residual affective and psychotic symptoms, I continued to engage her verbally with mirroring and twinning. I realised that the demands of my job on the ward allowed me limited time, but I was cognisant of ensuring the quality of our exchange was nourishing for Fatima, gradually restoring her sense of self. During one of her craft sessions, she made a bracelet and presented it to me, a further indication of her twinship transference. In response to this, I mirrored as much of the 'gleam in the mother's eyes' as I could muster.

Fatima continued to resist the depot medication (delivered by injection) prescribed for her. The highlights of her life and academic achievements, as well as her potential to achieve more success, were mirrored on many occasions in a bid to persuade her to continue the depot medication that she subsequently reluctantly accepted.

In a meeting with Fatima, I was required to give testimony to the Mental Health Review Board regarding discharging her as an involuntary patient on a Community Treatment Order. Instead of identifying me as an antagonistic figure akin to her mother, Fatima, who has been known to be aggressive and rebellious, was calm and receptive of my views.

In the long term, I feel that, despite Fatima's chronic fragmented sense of self and continued resistance to pharmacological treatment, I was able to provide a source of idealisation and remedy her self-deficiency with mirroring and twinship through a long-term therapeutic relationship. Through building trust, the deficit in her self-cohesion could be addressed in the hope that upon termination of therapy, Fatima would be more self-cohesive and able to identify selfobject figures within her social network and, better still, internally. This cohesion of self could play an important role in relapse prevention.

From an interpretive angle, self psychology could also tackle Fatima's underlying anger and rage that have surfaced in her relapses, to achieve long-term resolution of these painful affects.

Conclusion

Despite my limited time and capacity as her treating doctor, and being untrained in self psychology, Fatima and I created a therapeutic relationship which contributed positively to her recovery, even after she was discharged from hospital. Empathic twinning and mirroring responses experienced by Fatima also assisted in gradually reaching the pharmacological goals with the depot medication, which would otherwise only be achievable through treatment orders under the *Mental Health Act*.

I believe the brief relatedness that I shared with Fatima through empathy catalysed our therapeutic goals, even in a therapeutic relationship that was forced and compromised by the involuntary treatment order, as with most patients encountered in the public setting.

While delivery of psychodynamic psychotherapy may not be possible in its traditional means (that is, via a private consultation room with a couch), its concepts continue to be relevant in acute psychiatry and can be adapted to clinical consultations. It is hoped that this will serve to promote holistic recovery in our client populations.

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