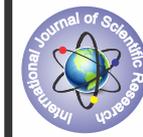


Clinical Application of Self Psychology and Modern Attachment Theory



Psychology

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ABSTRACT

As a mental health clinician, there are many theories that we use every day when assisting patients. The patient selected for this article is a 32 year-old Venezuelan male with a long history of mental health issues. His hostility and history of being uncooperative with treatment make him a difficult case and a difficult patient to understand. Self-psychology and Modern Attachment Theory assist in the treatment of this patient, who has been in and out of mental health facilities, still unable to recover. These theories help explain what has caused our patient to develop in his present state and what we can do to treat patients like this in the future.

As a mental health clinician, I treat patients at an inpatient psychiatric facility located in Detroit, Michigan. This hospital is considered a short-term care facility with an average stay of 10-14 days. One of the more interesting patients I have become acquainted with during my tenure at the hospital is a patient who is a 32 year-old Venezuelan male with a history of mental health issues. Additionally, the patient struggles with substance abuse. He is considered to be a hostile patient and therefore receives treatment in the crisis unit. During a prior hospitalization, the patient refused both his medications and any treatment options. His Urinary Drug Screening (UDS) tested positive for opiates, cannabinoids, amphetamines, and benzodiazepines. Not surprisingly, the patient has had several run-ins with law enforcement. As a result, he is familiar with the judicial process; having previously been arrested for domestic violence, assault, and driving under the influence. For the past year, the patient has been involved in an unstable relationship with a female. On several occasions while highly intoxicated, the patient has become physically aggressive toward his 'girlfriend.'

The patient has a psychiatric history of psychosis and paranoia. His persona alternates cycles where he actively seeks appropriate medications from his outpatient psychiatrist and abruptly changes modes where he becomes non-compliant with his medication. Furthermore, he has a history of recurring auditory and visual hallucinations. The patient's treatment history remains spotty. He will attend outpatient therapy briefly and then miss numerous appointments in between visits. He has also received inpatient psychiatric treatment a total of three times, twice at my facility. His current diagnosis is polysubstance abuse dependence and borderline personality disorder.

During a period of relative calm, the patient confided to me and another therapist that he had experienced a considerable amount of childhood trauma while growing up. He described his mother as a drug peddler who was seldom home to care for his needs. His mother permanently abandoned him at the age of nine. His father was certainly no prize either. According to the patient, his father was "a womanizing drunk." It was better when his father wasn't around because when he was, the patient was a prime target for a beating.

Modern Attachment Theory

During my employment at the psychiatric hospital, I have recognized that these patients are often the product of parents that were absent or mentally and/or physically abusive towards them. Unfortunately, the patient had experienced both mental and physical abuse during his childhood. Often, there is a cycle of abuse that extends for generations. It is very possible that his parents experienced the same types of abusive behavior that they eventually conveyed to him. Love and nurturing are key ingredients and provide the foundation for a child's healthy development. We rely on an empathetic and nurturing environment that will allow our brain and body to begin life in a healthy fashion. However, our mind retains the ability to remain flexible throughout our life, allowing us to adjust, learn, and grow successfully into adults. Our brain is distinguished by our life

experiences and environment (Solomon, 2003). As a therapist, it is critical to observe a person in their biopsychosocial surroundings. Another key factor is the biological component. Affect attunement is crucial for healthy development. The model can best be portrayed by the primary caregiver's resonance within the internal affect state of the infant and child. Normally, the mother is more receptive and alert to the infant's signals. The child's sensitivity is characterized by how quickly her mother responds to the child's needs (Brisch, 2014). In the patient's household, his parents' clearly lacked responsiveness to his needs. He was an impediment to his parent's selfish and abusive behaviors.

The developmental perspective proposes that a central organizing factor in human growth is affect regulation. Affect regulation is a critical component to good mental health. Studies have shown that the concept is actually two-fold. Affect regulation has the ability to either revitalize a person when they are depressed or to calm a person down when they become anxious or agitated and regain homeostasis (Shore, 2012). It is very possible that if the patient had experienced attunement with his mother as an infant, his brain and nervous system would have been constructively set up in such a way that he would have had the ability to control his own affect after a while. Given a reasonably normal upbringing, we all have the capacity to regulate our affect. Some are effective, while others are not.

Neuron stimulation is also an important concept. When sets of neurons are stimulated at the same time in the human brain, they will also be inclined to fire together. As the frequency of these increases, there is the likelihood that they will continue to fire together. This idea is denoted as a neuron network or cell assembly (Cozolino, 2010). What this means to someone like the patient, who has the misfortune of being born into a toxic environment, is the prospect that he could associate abuse with love. So whenever his love neurons fire, the abuse neurons fire concurrently. There is an expectation that abuse and love will accompany each other. When a child is exposed to such a harsh environment, as was the case with my patient, the brain and central nervous system tend to work in an abnormal way that allows the child to adapt to their environment. Other coping mechanisms can also be regarded using this same approach (Applegate, 2005). When the patient's basic needs as a child were ignored, his mind began to reject intimacy. It is likely that avoidant or aggressive attachment was his method of dealing with relationships. As the patient's environment and habits were embedded into his central nervous system, there was an increased manifestation of negative behaviors. It is logical that all behavior can be viewed as a means to affect regulating schemes. As a result of these coping mechanisms, individuals discover how to adjust their affect.

Internal working models of attachment were reviewed by Bowlby (1969). During early childhood, secure and insecure attachments are formed. These attachments are adopted and utilized as a model for all ensuing relationships. It is accepted that the internal working models of attachment become entrenched into the brain as a neural networks. These same attachment examples are then used in the external world as standards for future relationships.

A commonly studied attachment style is a model representing *self* and *other*. This provides a basic description and expectations on how a relationship should function. A key function of attachment theory is the way symbolic models are internalized as a result of the attachment process. Included in the development are positive and negative assessments of one's self and an expectation of what could be determined from other projections about relationship outcomes. Every attachment style results in either positive or negative self-concepts plus expectations from other individuals with whom they share a relationship. Developing a preoccupied attachment creates a strong desire for intimacy with a corresponding response from one's partner. When the appropriate response is not received, individuals tend to blame themselves and can develop a negative self-image. A dismissive attachment style lends itself to a desire for independence and self-sufficiency (Bartholomew, 1991). During inpatient treatment, the patient looks as if he has developed fearful attachment styles, in which he acts out both negative *self* and *other* images. Clients that exhibit symptoms of fearful attachment styles expect the worst possible outcome with their personal relationships. This is exactly why it is so important that they mend their impaired self-image (Dutton, 1998).

The patient's current problems evolved from the deplorable conditions he was exposed to, as well as the omission of love and attention as a young child. His parents were total misfits and were completely unreliable as caregivers. They were not available to fulfill basic needs for their child. The patient did not perceive himself as a loveable person as a result of being left on his own for extended periods of time. The lack of parental love and support coupled with his environment created this negative affect state, also known as self-representation. The patient found it difficult to relate to people as comforting and reliable, which is a condition denoted as the *other* representation. From the time when his brain was developing, his perception of the world as an unsafe place has become programmed into the neural network of his mind. Sadly, like my patient, many children are born into less than optimal conditions. Children begin to learn coping skills through a range of attachment patterns. For better or worse, interpersonal interactions become the lessons that become coded into the brain's neural networks. Strongly attached children become conditioned to presume that others will be available and responsive when they are upset and need comforting. Strongly attached children's emotional states are usually well organized and managed. If the occasional arousal or disorganization does occur, the state is quickly resolved through the comforting actions of an attentive and responsive caregiver. The strongly attached child is not fearful of exploring and progressing beyond the limits of his comfort zone, thus achieving personal growth. When caregivers act as a psychobiological regulator to normalize negative affect states, it results in children that tend to handle and manage stress well (Shore, 2012).

Conversely, children like my patient that are insecurely attached will be hindered in their personal growth. They believe that no one can help them and could remain in their negative affect states forever. Their disorganized arousal states are likely to overwhelm the undeveloped ego and nervous system. The consequence is increased difficulty in coping with stress with the need to self-regulate (Applegate, 2005).

The insecure and secure patterns are logical strategies that children use, allowing them to stay attached to the primary caregiver. Encoded within all of these patterns is an approach for affect regulation. An example of this is the avoidant child has learned that his mother will not allow too much interaction. This could cause the child to withdraw emotionally and not expect too much from his mother with the hope that in time, she might express some attention. This is a feasible coherent strategy. The ambivalently attached child quickly recognizes that he must become noisy and commanding for his mother's attention (Cozolino, 2010). This is another example of a coherent coping strategy. The disorganized and disoriented children like my patient never developed a coherent coping strategy for

attachment. This is partly responsible for the difficult position they have found themselves in.

There was a study conducted in 1994 using 120 men who were charged with assaulting their wives. As a condition for a reduced punishment, these men volunteered to participate and receive psychological treatment. This specific cross-section was used in a statistical experiment to determine whether a correlation existed between their abusive behavior and attachment style. The Relationship Style self-report measurement was used to assess participants (Allison, 2007). The inference confirmed abusive behaviors were strongly linked to a fearful attachment style. This study also confirmed the interrelationship of the fearful attachment to elevated levels of anger and chronic anxiety. With respect to physically abused wives, it was interesting to note that many women who have left physically abusive relationships could also be categorized with fearful attachment. 35% of wives whose husbands participated in this study met the criteria. As previously mentioned, the patient has been dealing unsuccessfully with anger issues since he was a child. He has received outpatient treatment several times for his anger and accompanying anxiety (Allison, 2007).

Dr. Donald Dutton (1998) has studied several traits relating to males with abusive personalities. Fearful attachment was the single strongest factor in fixating the anger from the abuser to their love relationships. It is probable that men who demonstrate such a violent response to their partners have a detachment disorder. This is also likely a contributor to the patient's substance abuse.

The patient falls squarely into the category of a violent domestic abuser and from an attachment standpoint; it is a necessity to create a secure environment during therapy. This enables the client to look at past and present attachment relationships and to feel comfortable in the therapeutic bond. Feeling safe is especially important to the patient, since he has likely become very insecure as a result of the pain and disappointments of his personal relationships. The patient likely is already experiencing stress at the prospect of interacting with a therapist who he perceives as having power over him. In addition to providing a safe and comfortable environment for therapy, another valuable element for attachment-oriented psychotherapy is to gently direct the patient to connect with his emotions and with the goal of recognizing the importance of attachment in his life. Essentially, the patient needs to be re-programmed to appreciate that other attachment relationships do not need to involve abusive or controlling behaviors. With his current fearful attachment style, the patient must begin the healing process to alleviate the pain and personal losses associated with his childhood trauma. In this manner, he can learn to reduce his anxiety from attachment without resorting to driving away personal relationships through angry and violent behaviors (Ainsworth, 1978). In our therapeutic setting with my patient, we can concentrate on behaviors as it applies to attachment theory patterns. With detailed analysis of the patient's experiences, the team at the inpatient hospital can increase the patient's awareness of these patterns. We will also focus on a more adaptive response to his attachment anxiety.

There are a wide variety of clients that have been exposed to domestic violence. As a result, therapists are likely to experience many differing insecure attachment styles. The comprehension of the status regarding the client's attachment will assist in formulating a reasonable hypothesis as to how the patient's violence originated. This can allow the client the potential to develop additional adaptive methods to regulate the attachment anxiety. Once a client has committed to long-term therapy, there is a strong likelihood for positive attachment results.

Self-Psychology

Heinz Kohut developed the concept of Self-Psychology theory and clinical application models in Chicago. Dr. Kohut recognized that the

conventional methods of treatment were both ineffective and resisted by the patients. At the time, his patients covered a cross section of disorders including difficulty in sexual and social settings, low self-esteem, a sense of emptiness and loneliness. In developing this new theory, Kohut created his own empathetic perspective to provide a better understanding of what the patient's world was like (Berzoff, 2007). In self-psychology, there are seven fundamental components. They are *self*, *empathy*, *self-objects*, *optimal frustration*, *idealizing*, *alter ego/twinship needs*, and the *tripolar self* (Washburn, 1987). Although Kohut was responsible for large expanse of research and documentation on the psychology of *self*, it was never his intention to define the subject. His reasoning was simply, "we will never understand the essence of the self as differentiated from its manifestations" (Washburn, 1987).

Kohut's belief was that social disorganization resulted when parents were incapable or unwilling to be *empathetic* with their children. The concept is certainly relevant in our patient's case with his loss of *other* and the other's *self-object*. This has left the patient depressed, sluggish and uninterested in life in general. Following Kohut's model, the therapist should employ an empathetic approach to fully understand and connect to the distress the patient endured as a child. The use of empathy will aid in developing a bond with the patient. The ensuing relationship will use empathy to help create a strong relationship and assist in formulating a cooperative plan for modifying the early self-pathology. This approach permitted me to better understand the patient's underlying issues (Washburn, 1987).

Self-object can be described as an object being used for the service of objects or the self that could occur as part of the self. It also provides a purpose for the self. The concept is comprised objects, activities and people used to create the complete self. The idea is central to normal functioning (Brisch, 2014). As an overview of my patient's self-psychology, the initial focus was on his self-object connections. Specifically, we were interested to determine his habits, his work interests and the type of woman he likes.

If a self-object is unavailable, that is acknowledged as *optimal frustration*. Kohut's views that optimal frustration is also associated with the relationship between an individual and his mother. When the patient's mother failed to placate his childhood needs, the resulting disappointment necessitated other methods for moderation. Ultimately, this included self-medication.

Kohut proposed that *idealizing* preceded narcissism (Washburn, 1987). His view was that the need to be close to others had a soothing effect. For example, when a child falls and scrapes his knee, it is very likely he will run to a parent. The calming effect will come not only from any immediate first aid, but also the comforting manner the parent will handle the issue. This might entail kissing the 'boo boo' and making a fuss over him, but in the matter of a few minutes, everything is all better. Idealization is an evolving process. It begins with the child wanting to meld with the ideal parent image. As the child matures they will want to be close to the power source and finally it is sufficient to know that the parent (or feelings of parental comfort) are available when needed. Just being there for young children is the key to good parenting. Without consistency from the idealizing individual, the child might not be able to experience growth and independence as they mature.

Twinship or *alter ego* is another self-object requisite. As children, most boys emulate simple tasks with our fathers just to feel connected. Many of us had toy razors and we would lather up and pretend to shave alongside our dad. Through imitation, we develop a feeling of similarity that helps us to connect with others. With the process of normal growth and maturity, we learn that it is alright to be different. A trusting and loving relationship with our parents is essential for obtaining independence (Berzoff, 2011). My patient's parents were not responsive in demonstrating any closeness with their child. This led to his highly defensive demeanor ensuring the likelihood of following in his father's alcohol and drug fueled abusive

patterns of behavior.

Kohut references our internal needs as poles. Three poles make up the self. Self objects serve to satisfy certain needs. The first function is that of mirroring, also referred to as the *grandiose exhibitionistic pole*. A mother's seemingly minor behaviors are perceived by the infant child. When she fusses and makes over him, those actions are interpreted and understood that he is loved. The *idealizing pole* is the second function. Here a child can merge with a trusted individual to serve as a role model. The child can feel vulnerable during this phase and wants reassurance that he has someone to depend upon. The *twinship pole* is the final phase. Here, there is the need to feel valued and useful to others. It is an emulation to feel like an individual who is admired (Washburn, 1987).

We all share similar desires to develop intimate relationships, strong friendships and provide great value to others throughout our lives. However, these goals can only be attained when our interactions with others demonstrate empathy, understanding and acceptance. These traits are invaluable in Social Work when relating to dysfunctional clients such as my patient. A respectful, restrained approach should be utilized with an empathetic ear to gain their side of the story. We are all human and without genuine empathy and support, the development of an effective treatment program is very unlikely.

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