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ATTACHMENT DEFICITS, PERSONALITY STRUCTURE, AND PTSD

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The question surrounding etiological factors informing the emergence of posttraumatic stress disorder (PTSD) due to preexisting personality deficits is explored in relation to recent advances in understanding the indissolubility between attachment pathology and developmental trauma. Universal generalizations regarding the causal relation between structural self-deficits and the emergence of PTSD remain suspended. The nature of traumatic representation continues to be a contested area of empirical and theoretical debate, the consequences of which may inevitably inform clinical technique.

Keywords: PTSD, attachment, trauma, personality structure, neurosis

In a recent article, Paul Verhaeghe and Stijn Vanheule (2005) provide an invaluable contribution to our understanding of posttraumatic stress disorder (PTSD) and neurotic psychological structure that deserves our serious attention. By incorporating Freudian, Lacanian, and attachment perspectives, the authors provide a cogent series of arguments delineating two major theses: (a) The development of PTSD in adults is necessarily predicated on the preexistence of an actual neurosis that predisposes them to experience this type of disorder along with accompanying symptomatic, somatic, and anxiety-related sequelea; and (b) this neurotic structure is constituted in the early child–parent dyad as a failure of the Other to appropriately provide mirroring functions necessary for arousal and affect regulation that informs the symbolic formation of self-identity. Verhaeghe and Vanheule conclude that

> PTSD occurs in those victims who, prior to the traumatic incident, *already had an actual-neurotic structure*. It is precisely because of this structure that they are unable to process the trauma in a psychical, representational way, and as a consequence, develop PSTD. (p. 499)

I wish to revisit this conclusion via critical inquiry on the nature of trauma, personality formation, and attachment, and I raise clinical questions that challenge the universality of the authors' generalization.

The value of the authors' insights are theoretically sophisticated and clinically veri-

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fiable on many accounts when applied to traumatized patients who present with chronic and complex PTSD and are readily confirmed in my clinical work with such populations. What Verhaeghe and Vanheule refer to as actual neurosis I have referred to as structural deficits in personality organization due to attachment pathology constituted as a disorder of the self and maintained on unconscious representational levels (see Mills, 2005). From my account, what predisposes patients to experience future PTSD profiles, as well as most major mental disorders including borderline organizations, anxiety and panic disorders, phobias and agoraphobia, affective and somatoform disorders, and the like, must be predicated on earlier deficits in personality structure due to developmental traumas that threaten the child's sense of safety and take place within the attachment system. Such traumas predispose the child to develop differential organizations and trajectories of psychic structuralization that instantiate themselves as traumatic, fragmentary, depleted, vacuous, and aggressive valences. These structures are in fact process systems largely organized on unconscious levels of representation and meaning dominated by fantasy and defensive formations that comprise self-structure. From my perspective, future pathology is always conditioned on structuralization deficits due to attachment disturbances early in life, which color self and object representation, affect regulation, identity formation, and psychosocial functioning. Here structural deficits are constituted through various forms of developmental trauma and hence, both logically and maturationally, necessarily predate and predispose the child to future vulnerabilities, which may explain in part the onset of severe pathology including PTSD.

Verhaeghe and Vanheule's conclusion that "there is no direct connection between trauma and the development of PTSD" (p. 494) must be reconsidered in light of copious clinical evidence that explains psychic organization and self-development based on encounters with early developmental trauma. Developmental traumas may be discrete, cumulative, and overdetermined with qualitative variations in the intensity, duration, and felt or perceived severity depending upon the subjective mediating factors that constitute the phenomenology of lived experience. Furthermore, these traumas are subjected to unconscious defensive organizations and fantasy formations that attempt to alter, symbolize, or represent the trauma. This of course impacts on internalized self and object representations and the formation of self-identity, which thereby affect both intrapsychic self-regulatory functions as well as intersubjective relations. Developmental traumas are mediated by the agentic unconscious ego and subjected to internal intervening relations despite the fact that such intrapsychic processes stand in relation to others. Because developmental traumas are often secretive and cryptic, thus relegated to the privitization of subjectively internalized pain, psychic vulnerabilities and related structural deficits evolve as lacunae in self and object representations inherent in the ontogeny of self-structure. These internalized traumatic events, contents, and their derivatives largely consist of *toxic* and *parasitic introjects* that assail psychic structure and thereby predispose the patient to future vulnerabilities.

We need to make a distinction between actual neurosis as a precursor to trauma versus deficit personality structure as caused by developmental trauma due to attachment disturbance. This is a vital distinction Verhaeghe and Vanheule do not make. Furthermore, the problem they introduce by making such a universal categorical statement that all PSTD profiles are the result of neurotic structure, which in all fairness they may simply relegate to a hypothesis, is that it must withstand the test of particularity that could betray such blanket generalizations. This is why I prefer to refer to deficit personality structures rather than actual neurosis, which are internally organized (albeit compromised) process systems that can potentially explain, at least in theory, divergent symptomatic profiles that span

across a wide range of pathologies without making the specific commitment that there is "no direct connection" between trauma and PTSD. In fact, my clinical practice tells me exactly the opposite: In all cases of chronic and complex PTSD I have treated, I cannot recall one patient who did not have preexisting developmental traumas and structural deficits that exacerbated their current traumas and subsequently incapacitated their ability to cope with and ameliorate their symptomatology. In other words, the precipitant trauma that triggers PTSD is actually due to the intrapsychic retrievability of previous trauma that the patient had hitherto sequestered, dissociated, repressed, compartmentalized, or defensively kept in abeyance. In effect, the present trauma opens a porthole to the past traumatic events and/or their affective and somatic reverberations that were in an unconscious state of unrestful or disquieted slumber. In that instant, the present becomes merged with the past in temporal diffusion and PTSD subsequently becomes the symptomatic outcome.

The empirical literature largely confirms that victims of PTSD have functional deficits in the mnemonic representation of traumatic events, which cannot be remembered in associative, declarative, or narrative forms; hence the inability to symbolize the trauma lies at the core of sustaining its pernicious effects on psychic functioning. Although I do not dispute this general consensus, we must nevertheless revisit the question of the representability of trauma in the psyche. Verhaeghe and Vanheule accept the view from neuroscience that trauma is not stored in declarative or narrative memory but rather is remembered in implicit procedural memory, and hence trauma cannot be properly represented in associative or symbolic narrative forms. Although this may be true for many trauma victims, I have encountered patients who have had no trouble remembering what happened to them and can indeed describe such events in clear and articulate ways with appropriate metaphorical and symbolic articulation in their verbal narrative declarations. Here the problem was not so much the question of representation, but what kind of representations were simultaneously operative, as well as how they were mediated by the subjective mind.

Consider the case of Mr. P., a successful educated business man, who at the age of 65 began to develop severe suicidal depression in response to his inability to manage his overwhelming traumatic symptoms that he harbored his whole life. From the ages of 6 to 11, he was subjected to horrific physical violence, repeated sexual abuse, and perverse cruelty at the hands of his stepfather, and before that, from the ages of 2 to 4, he was physically abused by his biological father. He furthermore witnessed his mother on several occasions being beaten and left unconscious and bloodied by both of her husbands as he watched in terror while trembling in extreme fear and helplessness. The actual memories of these events were burned into his consciousness and had tormented him his entire life, thus leaving a massive structural depletion despite his financial and occupational success and happy marriage. He characterized himself as chronically joyless and self-loathing, which eventually led to five suicide attempts in response to unremitting nightmares of his assaults and flashbacks that took on psychotic properties in the form of hallucinatory persecutory images that visited him during the day. These visitations were clearly projected unconscious representations of his perpetrators, but his cognitive appraisal and associational narration of them as such did not diminish their internalized presence. They had acquired an ego dystonic organization despite his subjective realization that they were only represented images and memories of his past. He furthermore was able to write about his trauma in several journals, in poems and short "fiction" stories, and his trauma was apparently sublimated, so he thought, through artistic endeavors and physical sports (i.e., such as painting and the martial arts). His ability to symbolize, articulate, and represent his trauma in verbal discourse, however, was less fluent and much more difficult for him to

share because he bore the shame and crucible of his internally damaged core. His reluctance to speak out loud about the details of his sexual abuse was a primary obstacle to his recovery. This was complicated by the fact that he had privately internalized his pain his whole life, never speaking about it to anyone including his wife and children; like so many trauma victims, he was scared to death to speak about it because as a child he was threatened with being killed by his perpetrator. A main point I wish to make here is that higher modes of mnemonic representation were achieved, although therapeutic transformation was stymied due to the inability of Mr. P. to verbalize and work through the details of what he had actually survived. He had a subsequent suicide attempt once he had an emotional session in which he felt he had not survived, thus triggering the onset of more hallucinations.

Verhaeghe and Vanheule maintain that trauma is not psychically mediated but rather, if I understand them correctly, it is somatically channelled, contained, and/or converted. In fact, they believe that "traumatic experience is not inscribed within the psychic apparatus and therefore cannot be associatively elaborated" (p. 497). For my patient, trauma was inscribed on the psychic register and subjected to various fantasy systems that fuelled his anxiety, depressive, suicidal, and psychotic symptoms emanating from his traumatic self-structure, which led to reality distortions based upon the indistinguishability of the present from the past. Hence the therapeutic obstacle was in the nature of representability that could not properly diffuse the anxiety attached to the memory. There was a fusion of the past memory with the immediational present experienced as an intensification and reexperience of the traumas rather than simply a rememberence of them devoid of the affective hyperarousal attached to the horrific contents; thereby clear temporal division between the present and the past was lacking. It is important to make a distinction between the defensive or dissociative processes that protect the psyche from complete fragmentation or annihilation due to the invasiveness of trauma versus the notion that it is "not inscribed" within the psyche. Because the psyche is embodied, I do not make the ontological distinction between psyche and soma. The body-psyche or embodied-subject must be understood as a complex totality and not as a dualistic entity. It is for these reasons that, in my opinion, we should conceive of representation and the question of representability from within a monistic ontology that allows for different modifications of psychic activity.

In my clinical work with traumatized patients, I have made theoretical distinctions between (a) somatic schemata, which are embodied-sentient representational organizations; (b) affective schemata, which correspond to feelings and emotions; and (c) conceptual schemata, which describe higher mediated forms of symbolic, narrative, and associational processes of meaning derived from conscious and self-conscious life (Mills, 2005). Here mind must mediate trauma that is inscribed on the psychical apparatus by virtue of the unconscious agentic ego that directs defensive pathways toward finding suitable or adaptive internal constellations that contain, protect, and insulate the self from annihilation. My argument is that trauma is mediated and represented in mind, but such processes are redistributed through somatic, affective, and conceptual forms of internal unconscious order. Of course somatic and affective schemata are more primitive, unsymbolized, prereflective, and unformulated, whereas conceptual schemata are higher order semiotic and rational mediations that have undergone inner transformations in content and form. This is why conceptual, narrative, and associational processing of traumatic details in the service of forming synthetic integrations and semiotic connections allow for more embodied forms of traumatic representations to sublate themselves in psychic structure and expression. When this occurs therapeutically, the patient can often make a transition

from experiencing the somatic, physical, and emotional upheaval inherent to more constricted forms of traumatic representation to finding new transformational achievements and psychic spacings that allow for higher order meaning constructions and containment via narration within the security, frame, and holding functions the analytic environment affords.

There is no question that the importance of otherness becomes a mediating factor in the development of psychic structure, but the details are moot and in need of precise explanation, a topic I cannot adequately address in this context. Because attachment is a central ontological process in personality development responsible for engendering certain forms of representation and symbolic functions, what Verhaeghe and Vanheule attribute to the Lacanian Other, I wish to clarify that from my view this process is mediated by the agency of the mother and not simply the generic attribution of language that Lacan situates in the realm of the Symbolic. I prefer to describe this function as situated in the M/other, which is the presentation of the original love object qua primary attachment figure who simultaneously communicates as an embodied linguistic subject. Language is a discernable part of the mother, but only after being differentiated out of the original unity of the infant–mother dyad (also see Loewald, 1978) once self and object representations take on modified aspects of representability. It is really the discourse of the M/other that mainly informs unconscious structure and its corresponding representations, but this is still not a sufficient condition to account for psychic structure in its totality, a discussion that is best left for another venue.

Verhaeghe and Vanheule situate the locus of the "actual-neurotic structure" in the failure of the Other to appropriately mirror the infant's affective-mental states, which allows for arousal levels, affect regulation, self-identity, and a reflective or mentalizing function—hence a theory of mind—to develop (see p. 500). Although I agree that these are important aspects of the ontogenesis of the self, this assessment appears to me to be too insular and singular of an interpretation. Furthermore, it implies a causal determinism that occurs as a one-way relation directed from the Other, which is attributed to both the interpersonal actions of the object in the infant–maternal milieu as well as the symbolic function of language superimposed by our cultural ontology. Once again I do not dispute the significance of these factors, but we need to account for psychic agency and how the incipient ego mediates such intersubjective social events. To explain the mediatory aspects of mind that take seriously the need to safeguard the concept of freedom as well as describe how synthetic operations are intrapsychically constituted, there must be some accountability for the two-way relation that transpires between the internality of the ego and the externality of the object world.

Elsewhere (Mills, 2002a, 2002b) I have shown how the epigenesis of the unconscious ego comes into being through trauma as a rupture from its primitive corporeal sentience, to the life of feeling, culminating in the ego of consciousness and self-conscious reflectivity. Psychic structure is forged through conflict and negation as an architectonic developmental accomplishment. Mind is predicated on chaos, destruction, and death that become the positive significance of the negative that impels and fortifies psychic structure. Freud's views on the economics of the pulsions or *Treibe*, Lacan's emphasis on the Symbolic, and contemporary attachment theory all potentially share common affinities.

Earlier I warned about the inherent riskiness of universalist claims of generalizability. Although I greatly admire Verhaeghe and Vanheule's contributions to this important subject matter, the question of whether actual neurotic structure, or, from my account, structural deficits in personality organization, must necessarily exist before the patient later experiences actual trauma must be suspended. It is tempting to conclude that PTSD

patients must have deficit psychic structures that predispose them to symptomatic chronicity, however, this would mean that in all cases of PTSD there would be no single person who had a relatively healthy or cohesive self-structure prior to experiencing the onset of trauma. Perhaps a case can be made that for patients who had a relatively simple to moderate form of PTSD the aforementioned thesis does not apply; however, like Verhaeghe and Vanheule, I am not prepared at this time to offer any substantial clinical evidence to support this claim. This does not mean that such clinical phenomena do indeed exist. Although I have offered a conceptual argument that the psyche is originally constituted through trauma and hence the future experience of traumatizing events in certain people with deficit self-structures would necessarily evoke earlier unsymbolized and complicated overexpressions of unresolved trauma, I can envision the possibility that even the healthiest people could develop PTSD regardless of their preexisting psychic structure. I would be grateful to the authors if they could attend to my concerns and shed more light on this important topic.

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