CLINICAL NOTES

STRUCTURALIZATION, TRAUMA, AND ATTACHMENT

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Attachment pathology results in deficit unconscious organizational processes within self-structure that predispose patients toward developing character disorders with many overdetermined, polysymptomatic profiles. The nature of developmental trauma on attachment capacities and corresponding emergent structuralization processes is intimately associated with a broad array of clinical presentations that are largely organized on borderline levels of functioning. The author addresses the question of trauma and structuralization and presents various case illustrations gathered from clinical observations. By examining various subgroups of structural pathology, the author hopes to advance knowledge of attachment-related disorders.

When we refer to psychic structure, we do not mean to imply that personality is composed of fixed or static attributes, properties, or foundations that adhere to a substance ontology; rather, structure should be conceived as *unconscious organizational processes* that provide functional semblances of continuity and self-cohesion. Structure is constituted via an agentic system of processes that provide organizational and adaptational functions to psychic experience, which are relatively enduring and invariant. But this does not mean that structure does not change; on the contrary, the self is always in a state of unrest and activity (even if such activity is inhibited, lulled, or pacified). Such structural invariance is always evolving and transforming through a variety of adaptational pressures and contingencies; therefore, psychic structure, like the ontogeny of the self, is a dialectical process of becoming continually plagued by conflict and negativity.

Patients with attachment pathology organized on borderline levels generally present with disorganized, detached, or traumatized profiles, often with fragmented or depleted self-structures marked by extremities in clinical presentation. In my clinical observations, I have identified five subgroups of patients that I frequently encounter presenting with

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Psychoanalytic Psychology, 2004, Vol. 21, No. 1, 154–160
 DOI: 10.1037/0736-9735.21.1.154

varying clinical profiles and self-states, organized at different developmental–structural levels: namely, those with (a) structural trauma, (b) structural fragmentation, (c) structural depletion, (d) structural vacuity, and (e) structural aggressivity (Mills, 2002). These categories are by no means exhaustive or conclusive; I am more concerned here with conceptualizing key organizational valences of psychic structure gathered from my clinical phenomenology. In this clinical communication, I wish to highlight my observations on structural trauma, fragmentation, and depletion.

Structural Trauma

Patients with structural trauma often see themselves as hopelessly damaged, maimed, flawed, and defective. There is a fixation on being abused and spoiled, like a sullied object permanently mangled; therefore, self-representation and personal identity are rendered helplessly molested and repetitiously victimized by an ongoing internalized sense of violation and deformity. This fixation is experientially realized as a gaping wound in their being, a slash in their very existence. Psychic pain remains organized around the trauma, a relentless assault on the integrity of the self. The phenomenology of inner experience centers around being desecrated, torn, and left for dead. Patients with this structural disconfiguration have a *damaged core,* dislocated and polluted. The acute feelings of helplessness, shame, and humiliation heighten the intensity of devaluation and psychic pain. Often patients with structural trauma have severe attachment deficits and dissociative profiles: They are profoundly mistrustful, distant, and aloof. Feelings of detachment and derealization are common defensive organizations that allow the self to survive. Although the traumatized self survives, it is broken, if not destroyed—sodomized then tormented by the sadistic brutality of memory.

Consider the case of Patrick, an 18-year-old White male, who was the victim of years of multiple forms of sexual, physical, and emotional abuse by several perpetrators. Patrick has a dissociative orientation to his very presence: Inwardly preoccupied, almost oblivious to his environment, he never looks anyone directly in the eye. He will frequently bump into objects in his physical surround, such as the door frame coming into my office. He is plagued by various details of his traumas and the affective aftermath of being violated, defiled, and used as an object for others' dirty pleasures. He recalls his perpetrators' mesmeric eyes, the control and possession they had over him, the incessant screaming and helpless passivity he was subjected to during moments of domination and abuse. He was always afraid to go to sleep and would be petrified for days after an abusive episode. With a night-light on next to his bed, he would tie a string around his wrist and some object on the nightstand, hoping it would fall and make a noise to wake him if he turned over in his sleep, or if someone entered the room. Now an insomniac, as a child he would sleep under thick covers in the summer and with no covers in the winter, knowing he would eventually wake from the disparate temperature.

One of the most painful inner experiences is the feeling of being thoroughly damaged and sullied. Spontaneously in one session, he associated to a fantasy he used to experience lying awake at night in bed: He imagined himself tied up with rope on the ground while others were defecating on him. Then he realized the connection. His abusers would often remind him, "You're a worthless piece of shit! The only thing you're good for is a toilet." He will often dissociate when describing to me certain details or fragments from his memories, and I have caught my own dissociative countertransference reactions on numerous occasions mirroring his own as a way for me to escape the horror of his pain. What

was perhaps as terrifying as the abuse itself was having no one to hold him or mollify his agitation and fright. Attempting to provide himself with a soothing function in the wake of such unbearable isolation, he would talk to his teddy bear at night, holding and snuggling it, saying reassuringly, "It's alright Teddy, it'll be alright." It is indeed difficult at times to suppress a tear.

Structural Fragmentation

Patients like Patrick suffer the horrible exposure, humiliation, and affective resonance of bearing a damaged psyche, mauled and discarded. With trauma as severe as this, psychic structure is always fighting the experience and tendency toward fragmentation. Patients with structural fragmentation often present in a constant state of agitation, hovering on panic and doom. When the self begins to fracture, it leads into an abyss of annihilatory, disintegrative, and decompensating inner experiences. Structural fragmentation corresponds with looming annihilation anxieties: Anticipation of fragmentation induces annihilation panic, and the self begins to undergo a breaking apart, a splintering of consciousness. Here, patients descend into a spiral regression of persecutory and disembodied torment. Patients with this level of insidious regression plummet into a *psychotic core.* As self-structure attempts to organize itself around pockets or semblances of containment, psychotic anxieties often become too overwhelming. Paranoia—even delusions and hallucinations—is internally constructed and projectively superimposed onto external reality as a crude means of preserving the self and protecting it from total annihilation (see also Lacan, 1993/1955–1956; Pao, 1979). Psychosis thus becomes a means of imposing some control and order on the imminent disintegration of the self. Fragmentation panic occurs when psychic structure is imperiled by experiential dysregulation, a fracturing, cutting up, and dismembering of self-continuity and cohesion. Here the self becomes divided and diffuse. What is most horrific is the anticipatory fear of complete deracination, namely, the *expectation of nonbeing.*

Cliff is a 42-year-old gay man, who is epileptic, with a long history of rapid-cycling bipolar disorder for which he has been hospitalized over a dozen times. He was raised in a strict Anglican, religious home environment, was never shown physical warmth or affection by his parents, and was never told he was loved. He was beaten as a child by his father for the slightest infraction and was battered for years by his first homosexual partner, who reportedly threw him from a two-story balcony, thereby fracturing his hip and pelvis, further triggering the onset of his epilepsy. Cliff remains extremely conflicted by his homosexual identity, which he beliefs is a sin. After the breakup of a four-year relationship, he became hopelessly depressed and suicidal. This was the longest and most significant relationship he had ever known. His partner's abandonment of him was for another lover, which Cliff construed to be a reflection of his inherent worthlessness and lack of lovability, and a punishment from God. He has been characteristically dysphoric, panicky, and intermittently manic, suicidal, and psychotic since he began treatment with me over 4 years ago.

In one moment during the early phases of therapy, I greeted the patient with a perfunctory handshake at my office door. I noticed that he reluctantly accepted my greeting with an ambivalent expression, and an uncomfortable limp extension of what felt like a wet fish followed. His palms were sweaty, which communicated to me that he must have been anxious, but I sensed something else was wrong with the very nature of my gesture. Upon sitting down in our seats, I commented on my observation that it seemed

like he did not want to shake my hand and said I wondered why that was so uncomfortable for him. He told me that he does not like the feel of human skin except during sex, and that even when lovers in the past would try to show him nonsexual, physical affection or warmth, he would "cringe." He further associated to how once his former partner had accidentally brushed his hand up against Cliff's while taking a walk, and this had made his "skin crawl." I acknowledged how my unsolicited social gesture understandably had intrusive significance for him, yet he became apologetic. I suggested there might be more meaning behind his aversion and asked him why he found human touch so repulsive. Upon this question, he began to cry uncontrollably. When he composed himself, he described the emotional pain of not feeling connected to anyone or being truly cared for or loved. When others reach out, he withdraws, because he fears being hurt and would prefer not to feel any closeness at all knowing that it will never last. All he has known is deprivation and abuse: When others show genuine concern, it *cuts.*

Yet the patient paradoxically and repetitiously creates the very thing he does not want: He unconsciously picks bad objects that exploit and abandon him, thus reinforcing that he is not deserving of love or interpersonal happiness. Cliff wants emotional warmth and acceptance so badly that he defiles himself, grovels to other's expectations, and allows people to use and take advantage of his money and good will. During manic episodes, he is easily manipulated and buys his so-called friends lavish gifts he cannot afford. When he was arrested for writing fraudulent checks, he experienced even more acute structural fragmentation and became psychotic. Over the years, he has slowly been able to internalize a positive introject of me as a calming, soothing presence. He often tells me during moments when he feels upset, paranoid, or on the verge of suicide that thinking of me or imagining being in my office helps him calm down. He tells me he often calls my office after hours to listen to my voice on the answering machine, which evokes and sustains, even if temporarily, a holding, soothing imago.

Cliff feels he deserves to die for his forbidden desire and sinful lifestyle, and thus he unconsciously orchestrates his own self-destruction. Patients like Cliff seem to be always living on the precipice of annihilatory anxiety, what I would refer to as *psychic purgatory.* Fragmentation threats summon paranoiac and psychotic anxieties, further triggering annihilation panic, primitive splitting, and a fracturing of the psyche. As a result, the self becomes dislocated and persecuted by the fear of deracination. When schizoid mechanisms fail, the self is imperiled by the return of projected persecutory fantasies, oppressive guilt, self-flagellation, and death wishes.

When crippling anxiety, panic, and psychosis are not present, the traumatized self tends to find another avenue in order to survive. Here enters the realm of detachment, impoverishment, and depression.

Structural Depletion

So far, I have presented extreme cases emphasizing the effects of trauma on character structure; however, there are more benign, less insidious forms of developmental trauma informing attachment vulnerabilities and dysfunctional adaptation patterns that organize around more depleted aspects and qualities in self-structure. Patients with structural depletion fall on a continuum ranging from more agitated, restless, and dysphoric tendencies—those harnessed from more fragmentary propensities—to those who are more structurally depressed and internally empty. Let us look at structural depletion proper.

Depleted psychic structure is vapid, deflated, and lacks vitality. Patients have a very blunted inner life and restricted range of emotional expression. They often complain of not

feeling connected to their inner affective states, which seem to be segregated, detached, and compartmentalized. There is a very weak and torpid sensation of absence and melancholia. Clinical depression is a very common dimension of their life histories and can organize around loss, complicated mourning, abandonment, rejection from dependency figures, emotional estrangement, and alienation, to numbing and anaclitic depressive manifestations. Patients with structural depletion have a *depressive core,* a characterological dysthymia. Those with dysphoric or hypomanic proclivities may slip into restlessness, agitation, or fragmentation accompanied by regression and depressed mood. They often absorb a pervasive oppression and meaningless to their existence; lack interest or enthusiasm in life activities; are physically lethargic, languid, and apathetic; are somatically focused; and can retreat into substances, addictions, or food for numbing purposes.

Consider the case of Winny, a 39-year-old, divorced White female, who sought out long-term psychoanalytic treatment because psychopharmacological intervention proved to be of little help. She had been on four different types of antidepressants, including SSRIs, for the past 8 years with no substantial change in her depressed orientation. She had deliberately sought out many thrill-seeking behaviors and activities, such as bungee jumping and obtaining her pilot's license, hoping to engender vitality and liveliness in her sense of self, but to no avail.

Winny complained of feeling like a whipped dog with a broken spirit, unable to shake herself loose from the melancholic grip of indifference and lethargy that drained her very sense of feeling alive. During our initial consultation I asked what she believed to be the ultimate cause of her malaise, and she replied that she didn't have a clue. It soon became apparent that Winny had suffered in silence from many developmental traumas that had left a wake of characterological depression. She had endured an early childhood of constant parental negativity, emotional invalidation, and a plethora of devaluing remarks about her selfhood and capabilities, which she internalized and adopted as her inner self-representational world. She left home at 15, had a child out of wedlock when she was 17, had abused drugs and alcohol, and was on her third marriage at the time of our treatment. Her son's father had died in a fire before he was born, literally "burned to a crisp." She began a life of promiscuity and substance abuse and severely neglected her son's needs, later leaving oppressive guilt and self-reproach. Her first husband was an unavailable alcoholic, whereas her second husband was emotionally devaluing and verbally aggressive. She described her current husband as "nice but aloof." She had an entrenched repetition of picking cold, volatile, and humiliating men like her father, who was verbally abusive, dismissive, and shameful and showed no warmth or love, as well as her mother, who was emotionally unavailable and delivered beatings with a belt strap when Winny challenged her authority. The patient reports scant memories of her early childhood, and those she has are tainted with negativity and parental neglect.

Winny described a chronic pattern of self-blame and fixation on being inferior, as though she were lacking something, and that she always felt wrong in comparison with others' beliefs or actions. In fact, she believed that everyone else was "normal" but her. She was so confused about her own inner intentions, beliefs, and autonomy that she would habitually question her judgment and reality testing during interpersonal situations. Furthermore, she was disheartened by the fact that she could not "correctly" identify her inner emotional states at all, which made her feel even more inadequate. She would typically blame herself for creating conflict in interpersonal encounters even when there was reasonable evidence to the contrary, or she would fantasize that people would inevitably see her deficits and reject her attempts at friendship. In the end, she would still feel "bad"

about whatever course of action she took and believed she was ultimately to blame for all disappointments she incurred.

Throughout our treatment, the patient began to realize that she had incorporated many negative introjects and endured many developmental traumas that had formed the sediment of her depleted psychic structure. Her parents' deprivation and critical judgment of her became the foundation of her impoverished representational world, and their lack of physical affection and warmth left an anaclitic neediness, which she compensatorily acted out through her promiscuity and substance use. During the course of some deeply painful emotional work, the patient reported a screen memory of being abandoned in her crib and utterly left alone, helpless and terrified. This association was followed by a memory of being told by her mother, "I wish I never had you." Upon this disclosure, she remembered asking her parents during early adolescence, "Why don't you love me?" Winny felt that she was not worthy of love, and this explained why she was never given hugs or told she was valued.

In piecing together her past, a past she had buried and yet converted into structural despair and anguish, Winny realized how her very being was methodically beaten down into a state of passivity and defilement that she identified with and made her own. "I didn't live, I just existed," she confessed. The patient could not have genuine feelings, for they were stifled, invalidated, and disallowed—especially her anger, which in a more classical, dynamic sense was turned inwardly and redirected onto her self. She had turned herself into a Winnicottian false self in order to survive her oppressive and belittling environment.

The screen memory of being abandoned in her crib bothered her enough to ask her mother about the incident. Her mother reportedly told her that she was always an angry child, feelings the patient could not recapture or identify at the time, and that often she was so angry that her mother would have to place her in her crib and shut the door because she was screaming uncontrollably. This discussion evoked a certain psychic shift in the patient's repressed hostilities, which she later more appropriately directed outward, toward others, rather than harboring contempt for herself. Getting in touch with disavowed and segregated aggression allowed her to mobilize certain defenses and creative energies she had not enjoyed before. Until then, her original traumas were inverted, sequestered, and not permitted channelization through external expression. Yet they were granted a secret life of lulled, self-contained attacks on her structural integrity. When the potentiality of her lulled aggression was realized, awakened, and allowed a voice, I encouraged its expression.

Over the course of therapy, Winny gradually became more assertive, self-assured, and capable of discerning her own authentic emotional states. When she realized that she had repetitiously allowed others to devalue and use her unjustly as an unconscious attempt to win over her parents' recognition and love, she was able to disengage from her maladaptive pattern of manufacturing unavailable and exploitive relationships and began to more accurately perceive her interpersonal environment and set appropriate boundaries and limitations when conflict arose. This shift allowed a vitalization of her psyche that combated her depressive core: The genuine engagement of her inner experiences further served as a catalyst for enacting more spontaneous and creative self-expressions of her individuality and autonomy.

Throughout this project we have seen how attachment disruptions and developmental trauma insidiously affect structuralization, functional adjustment, and the phenomenology of lived conscious experience of self and others. Further clinical investigations into attachment-related processes, internalization, self- and object representation, and real or

perceived trauma may provide us with a propitious new theory of psychic structure, self-regulation, and attachment pathology.

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