CLINICAL NOTES

STRUCTURALIZATION, BORDERLINEOPATHY, AND SCHIZOID PHENOMENA

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Borderline conditions reflect disturbances on the level of personality organization that have common developmental and structural features despite vast differences in clinical symptomatology. Otto Kernberg (1975) argues that many personality disorders, including schizoid, paranoid, narcissistic, and antisocial classifications, generally function at the borderline level, thus accounting for the overlap in personality traits, defensive features, and dysfunctional patterns of behavior among this cluster of disorders. For these reasons, it may prove useful to view borderlineopathy on a continuum of organizational levels of severity, from more benign manifestations to chronic instantiations, each showing functional degrees of variance in symptomatology and etiological influence. The author highlights the nature of attachment-related trauma on psychic structure that manifests on borderline and schizoid levels of organization and functioning. He introduces 2 subclassifications of structuralization by examining case presentations gathered from his clinical phenomenology.

Historically, the psychoanalytic literature has stressed various clinical features over others that distinguish borderline pathology from other personality disorders. Kernberg (1975) emphasized primitive defenses, affective coloration and instability, aggression (primarily rage), self-destructiveness, polysymptomatic neurosis, perverse sexual trends, addictions, and poor impulse control. Masterson (1981) emphasized failure to adequately negotiate the separation–individuation process, split object relations, lack of ego integration of self and object representations, and abandonment depression. Donnelly (1979) emphasized an uncohesive and fragmented sense of self, unintegrated ego nuclei, temporal discontinuity, and lack of an observing self. Adler (1985) emphasized developmental failure in the

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formation of holding introjects, ambivalence toward whole objects, insufficient internal soothing functions, annihilation panic, and a fundamental, painful aloneness or emptiness. Fonagy (2000) emphasized a lack of self-reflectivity or mentalization, hence the inability or incapacity to think about mental states in oneself and in others.

In a previous communication in this journal (Mills, 2004), I elaborated on three subgroups of patients presenting with various deficits in self-states organized at different developmental–structural levels of attachment pathology. In this case presentation on trauma and psychic structure, I wish to further outline two additional forms of structuralization that correspond to borderlineopathy and schizoid states: namely, structural vacuity and structural aggressivity. It is my hope that these views on trauma, internalization, and psychic organization help advance our understanding of attachment-related disorders that lie at the heart of severe character pathology.

Structural Vacuity

Previously, I discussed the nature of structural trauma, fragmentation, and depletion inherent in forms of attachment disorders generally organized at the borderline level. When structural depletion magnifies, it enters into a no-man's-land of emotional detachment, isolation, and dissociative void. I wish to distinguish between the phenomenology of structural depletion and structural emptiness, the latter being a more severe manifestation of characterological depression. Here the psyche is shut off and enveloped in a vacuum of solipsistic withdrawal and isolation, disengagement from the intersubjective world, and unfathomable aloneness. Patients with structural vacuity have an *empty core,* a lacunae in their very being. Patients with this profile may appear to be in a state of derealization, as if they are going through the motions of living and routine banality. Schizoid and schizotypal patients, as well as the dissociative and more classic borderline conditions, compose this subgroup, where depression is taken to the extreme mode of numbing and anesthetized detachment. People become merely things, robots—zombies, dulled to the inner fluctuations of affective life and social participation. These patients seem to be too far gone, unable to feel or reach into the yoke of their existence: They appear to be simply devoid of emotions, which are in actuality sealed off in an airtight container, suffocated, strangulated by death. They have the appearance of the walking dead: They are often so horrifically traumatized by their past that they kill themselves off—their inner experience—and don't grant it a life (let alone a voice) so they do not have to live with the pain and anxiety that threaten to torment their souls.

Patients with such empty structures are plummeted into a black abyss of *nothingness:* They are consumed by lack, absence, and void—a hole in being. Subjective reports of emotional experience are described as if there is something missing, as if feelings and desire have been surgically removed. Psychosocial development appears almost arrested, and they are literally loners and interpersonal hermits. This is not merely existential alienation or isolation but disembodied automatization—living death. Although there are multifarious and qualitative degrees of emptiness and aloneness that plague structural integrity in a variety of clinical syndromes, those with vacuous character structures have entered the realm of horrific excess, swallowed by a dark pit. All need for human connection has been renounced; they literally lack the capacity for attachment.

Warren, a 24-year-old, single White male, was hospitalized for suicidal ideation and chronic depression. He was admitted three times to psychiatric facilities in his late teens and followed by three different psychiatrists who had prescribed a cornucopia of mood

stabilizers, antidepressants, and antipsychotic medication, none of which were effective. He further entered a residential treatment facility for 6 months, receiving both individual and group therapy, but claimed these interventions had no impact either. When I assessed the patient, he had been diagnosed with an anxiety disorder, social phobia, and avoidant personality disorder. It became salient that he had a primary schizoid presentation concomitant with chronic characterological dysthymia.

Warren reported that he never felt happy as a child and in fact confessed that he did not even know the experiential meaning of the word. He could not recall one memory of his parents when he was a child, let alone describe to me what they had looked like. As he told me, "I can remember their bodies, like being in the house or something, but not their faces." The transgenerational transmission of attachment pathology in this family was more than obvious. He reported that his mother was a depressed, aloof, bitter alcoholic, who was sexually, physically, and emotionally abused as a child; his father was a cold, distant, insensitive, and hostile individual with a bad temper who was never home. Warren said that he never felt as though they were truly his parents and wondered if he had been adopted. Apparently his parents had had a very rocky marriage, slept in separate beds for years, and divorced when the patient was 13, after his father discovered that his mother was having an affair.

The patient reported that he always felt odd and excluded, ridiculed and picked on by other children, and that he never formed any friendships or attachments to his peers. He described his childhood as replete with anxiety, instability, rejection, social ostracization, and being physically bullied and beat up. To make matters worse, he had moved approximately every year and a half until his parents' divorced owing to the nature of his father's work, thus creating more difficulties in adjusting to his novel social and school environments. Warren's early attachment deficits predisposed him to develop a very empty core structure: The very fabric of his personality was dearth, dread, and internal aloneness enveloped by a bleak ocean of nothingness. This had left a massive void of agitated depletion, and as a result he struggled with a chronic dysphoria peppered with social rejection and aversion that was exacerbated in various interpersonal contexts. His social phobias and anxieties were particularly related to being judged, disparaged, and shamed by other people, including his parents, who had given up hope that he would "just snap out of it."

Warren developed an avoidant pattern of behavior very early in life in order to remove himself from situations in which he would potentially become subjected to humiliation, abuse, or social denunciation. As a result, he withdrew, shut down, sealed off his emotional life, and retreated into his own stoic universe: The detachment and renunciation of his need and desire to connect with others was a way to protect his inner self from annihilation. He learned that he could trust no one and developed a paranoid wall of impenetrability in allowing others to hurt him, yet at the same time he could not escape their painful intrusions, abnegation, and devaluing insults, which he absorbed like a sponge. Alcohol dependency was a substitute for the anaclitic and relational craving he had to deny within himself to survive such a depriving and hostile reality. But his structural emptiness and depression had left him with the preoccupation of ending his life. He reportedly had no vision of a future, for all hope of a better existence was expunged from his realm of possibility. According to the patient, he had burned all bridges toward getting an appropriate education, was financially impoverished and dependent on welfare, and feared "flipping burgers" or being a laborer living in a "cheap house." The absence of attachment with structural trauma that devolves into unremitting depletion and emp-

tiness is truly a tragic and unbearable subjective reality: "I have no joy in anything, and I feel like I'm just waiting to die."

Structural Aggressivity

Trauma can lead to many different orientations and degrees of psychic organization and functional adaptation, from more agitated, fragmentary, and hyperaroused structural processes to more depressive and vacuous instantiations. The degree to which the psyche is oriented toward a primary structuralization over another is largely based on the unique subjectivity of each individual and the contingencies he or she faces. Psychic structure is the succession of organizational processes influenced by unconscious teleology and is largely the constitution of defense. Defense becomes organized into functional patterns of behavior and adaptability and is never ontologically separated from one's social and interpersonal world, hence one's object relations. But what happens when the psychic register identifies with the violence that is imposed on it by trauma—so much so that it becomes violence? Here enters another subgroup of attachment-disordered patients— namely, those with structural aggressivity.

Patients with aggressive organizations are saturated with negativity, hate, rage, and destruction. Their psychic structure is suffused with chaos, invasion, animosity, and militancy that are internally absorbed (via introjection, identification, and internalization) and externally split-off, projected, and violently channeled. Developmental trauma is perceived and felt as a pernicious assault on the structural integrity of the self, which is combated with the same fierceness and level of barbarity. Defensive manifestations are mobilized around survival, and the most primitive impulses are summoned and sustained in order to fend off the perceived onslaught on the self. Unlike the destructive principle that is turned onto the self in fragmentary and depleted structures, we may conjecture that psychic energy is activated and cathected from the death drive, deflected from inversion, and primarily redirected toward the object world. Perhaps informed by evolutionary currents as well to fight and aggress, there is a primal identification with those who inflict trauma as a primitive reaction and bid for intrapsychic survival. Unfortunately this soils character structure with an unremitting, sadistic, and violent negativity. The Other becomes the generalized enemy, not to be trusted or loved but rather distanced from, if not destroyed. But the aggressed and aggressive self wages an inner war that cannot be won, for brutality is ultimately enacted through tormenting internalized representations and self-destruction. Attachments to others are violent, unpredictable, cruel, and manipulative, as often seen in the paradigmatic antisocial and borderline syndromes. Psychic reality is embroiled in havoc and ruin, always tarrying with the negative.

Patients with this psychic structure have an *aggressive core* marked by conflict, conflagration, and inner implosion. The world becomes a nemesis that is ruthless, persecutory, and dangerous, and this becomes the prototype for human relatedness. Human tenderness and vulnerability are disavowed if not aborted altogether out of fear of exploitation, sabotage, and death of the self. The self hostilely defines itself in relation to opposition, which the self must negate. As a result, the Other becomes an antagonistic and malignant imposition that must be opposed, contained, controlled, and dominated. Patients with this personality structure are tormented with negativity: They can find no refuge or peace from the condemning, malicious, and haunting introjects, memories, and developmental traumas that have formed the sediment of their inner representational worlds and self-identity.

Like many clinical populations that shield the pain of developmental trauma, overwhelming feelings of helplessness, exposure, humiliation, vulnerability, weakness, and cowardliness rupture psychic equilibrium and militate ego capabilities to cope with intersubjective strain. Shame or any condition that evokes feelings of inferiority, inadequacy, and the like trigger hate and narcissistic rage because of the intolerability of injury to the self. When this occurs or is solicited, objects uniformly become sullied, bad, and combative, to the point that splitting is employed in the service of a rigid, simple economy of negation and difference. The blaze within is fueled and increasingly stoked. At the extreme, those who are cast as the enemy literally become things that oppose and transgress on the structural integrity of the self. Primitive survival mechanisms convert them into predators that must be predated on before the self is surprised, ambushed, and devoured. Confrontation is psychically realized as a battle to the death where only the patient's subjectivity shall be affirmed. In more sadistic instances, the other shall be made to crawl and show humiliating deference to the illusory superiority of the patient, who is now the one to shame, dominate, and vanquish. The Other is turned into an object that has no feelings, needs, desires, or rights of its own for the simple reason that, whether in reality or fantasy, it *can kill* the self. The psyche follows a primitive economy of rigid identification with itself and its own subjectivity, whereby opposition is radically split off, violently cleaved, and condemned. Here, we are reminded of Bion (1959/1988a, 1962, 1962/1988b): There is an omnipotent evacuation of self-negativity (as bad self-representation) and a violent attack on linking the Other to qualities of mutually shared human experience. The aggressive self cannot recognize the authentic subjectivity of the other because attachments to others are drenched with pain. Because the self feels it has been harmed, it does not see or recognize the harm it does to others; when it does, its actions become quickly justified as deserved punishment.

Less severe forms of aggressivity come out in competition, intellectual argumentation, interpersonal command, and exhibitionistic power—to pleasure in inflicting pain onto others through oral means, such as verbal remarks, sardonic deprecation, and manipulative threats. For example, Steve, a 36-year-old successful entrepreneur, saw me for "anger management." He worked 14-hr days in a highly stressful and competitive job, rarely seeing his wife or children. When he was home on the weekends, he would displace his frustration on his family by initiating arguments that would escalate into yelling rampages during which he would kick and bang objects. He reported feeling tense and angry throughout most of the day for years; he was constantly grinding his teeth and clenching his fists in his office, swearing at the slightest irritant and growing so exasperated at the littlest things that he would become enraged and explosive. For example, he got his coat stuck on the door handle, and instead of removing it gently, he ripped it off. Items in the garage would be arbitrarily smashed, and the family dog was the object of routine beatings when it disobeyed. People were always a source of opposition or in his way. Road rage was a daily occurrence. His dentist told him that if he did not stop grinding his teeth, he would require serious surgery. After many verbally hostile and profane exchanges with his wife, she threatened to leave him if he did not get help.

Upon my initial consultation, I asked him how long he had felt angry. "My whole life," he replied. Steve revealed that he was systematically picked on, bullied, chased home from school, and beaten up on almost a daily basis from the time he entered kindergarten until eighth grade. His parents were concerned but passive: They were not very helpful in protecting him, nor were school authorities. He would suffer horrible humiliations in front of his peers and classmates, and his beatings were pervaded with shame and degradation. For instance, gangs of kids would swarm over him on the playground or on his way home,

corner him at school, and incessantly tease, ridicule, and badger him. He lived in constant fear and panic. In many ways Steve stood out as the class "geek." He was a tall and lanky kid with glasses, nicely dressed, and from a rich family; yet he was quiet, shy, and withdrawn. He had a heart murmur from infancy onward, which interfered with his respiration, and as a result, he could not participate in sports or gym. The other children, mainly boys but girls as well, would verbally degrade him through name calling and would often surprise him in the hall, knock books out of his hand, steal his belongings out of his locker, throw gum in his hair during class, and, when he was older, hit him on the head with their class rings. He would often be made to fight younger kids and was warned that if he won, the older bullies would beat him more severely. He was made to beg for mercy—only to be hit and laughed at after doing so, thus sacrificing his self-respect and dignity.

When the patient was 8, two older boys pummeled him in an alley and made him get on his knees to perform fellatio. When he refused, he trembled in tears as they urinated all over his face, hair, and body. Then they beat and kicked him and smashed his bike. The unimaginable shame and defloration coarsened his psyche with hate and murderous rage, which he had to indignantly swallow his whole life. During our initial meeting, he told me that he had not thought of or told anyone of his childhood pain and rage for over 20 years: The shame and vulnerability from his confession was so unbearable that he had an abreaction. It was reportedly the first time he had cried about it since the incident. Throughout therapy, Steve began to trace back elements of his own misogynist feelings to his mother, who used to call him a "wimp" and a "sissy" for not fighting back, as well as toward girls at school, who would instigate other boys to pick on him. He came to realize that his hostile feelings toward his wife were partly due to this early affective coloration, and his generalized rage toward the world was the result of unprocessed trauma, thus besieging his psychic cohesion.

The channelization of negativity outward is an abortive attempt to protect the self from annihilation, and in this regard, it is generally a more adaptive defense than succumbing to the downward plunge of fragmentation anxiety or depletion; but this style is ultimately just as pathological. There is a continual immersion in the trauma that is continuously retraumatizing—to the point that psychic structure becomes trauma—both violently inflicted and assimilated. The self cannot rid itself of such atrocious violence because its essence is violence as such—Being *qua* Negation! The psyche cannot rest and is flooded with revenge, which ultimately comes back to taunt and haunt structural integrity.

Gregg, a 27-year-old father of an infant daughter, was separated from his common-law wife when he sought treatment for his uncontrollable bursts of anger. He had hit his wife in the face on one occasion while allegedly experiencing an enraged blackout, thus having no conscious recollection of the event. He was not under the influence of alcohol or drugs at the time. On another occasion he grabbed her arm and dragged her to the refrigerator door when she complained that there was not enough food in the house. He nearly dislocated her shoulder. Their relationship was replete with volatility, verbal abuse, and screaming matches, followed by mutual distancing and passive aggressiveness. The patient later learned his wife was having an affair, and he sought to avenge his wounded ego by falsely reporting her to the authorities for child abuse in order to seek custody of his daughter.

The patient had rarely been physically disciplined as a child, but when he was, the discipline was experienced as harsh and unjust. He was routinely subjected to cruel verbal debasement by a cold, detached, and embittered father; his mother never stood up for him or protected him from his father's vicious acts of shameful humiliation. When Gregg was

4 years old, he threw a ball into the lake. His incensed father made him strip down to his underwear and fetch the ball in front of his sisters and some neighbors who were visiting their cottage. He was a chubby boy, and he remembered how they had all laughed at him after someone said he looked like a "beached whale." When he was 8, he had difficulty learning to read, and so his father would make him read aloud in the car during trips. For every word he failed to pronounce correctly, he received a smack on the hand with a stick. One such trip was reportedly two hours of sheer hell. While playing football in the yard, his father once threw the ball in his face as a lesson to keep his hands up. In addition, his father would frequently disparage the patient at the dinner table until he was brought to tears.

The patient's psyche was consumed with hate, rage, and negativity. As an adolescent, he would deliberately seek out conflict and initiate fights as a means of discharging his tension. Alcohol and substance use was a frequent means to self-medicate, and his relationships with others were based on personal gain, exploitation, possession, and pleasure. He had suffered from migraine headaches since latency age and developed blackouts during times of intense emotional upheaval, beginning in early adulthood. He would realize later that he had often trashed his room during such episodes. In describing his relationship with his wife, it was suspected that she, too, had a personality disorder. She would devalue his occupation as a skilled laborer, shame him about his sexual performance, goad him into arguments, and humiliate him publicly in front of his friends. When she finally confessed to seeing another man on the side, he told me, "I almost put her fuckin' head through drywall."

We have seen how developmental trauma—both horrendous and moderate—erodes healthy attachment capacities and predisposes psychic structure toward borderline and schizoid levels of organization. It should be noted that anyone with these clinical profiles can potentially exhibit structural shifts in self-states: They can be contiguous with one another, such as with dysphoria and paranoia, and show overlap in inner organizational processes, content, and form. In other words, each of these clinical subcategories may possess shared qualities and experiential functions, thus producing hybrid manifestations in clinical phenomenology. Neither conclusive nor exhaustive, the subclassifications of structuralization I have highlighted in this clinical case presentation and elsewhere (see Mills, 2002) are merely appearances or forms of attachment-related developmental trauma. Because psychic structure may mutate and transmogrify, it can exhibit combinations of these complex and overdetermined states, modify and adapt to various contingencies, or regress to earlier developmental constellations and primitive aspects of being and experiencing. It is mainly for conceptual and descriptive purposes that I propose these distinctions, for ultimately, psychic structure is ontologically undifferentiated.

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