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CHAPTER FIVE

The frightened couple*

Stanley Ruszczynski

Working clinically with patients, individuals, couples, and families, who actually act out their difficulties through delinquent, violent, or sexually perverse behaviour, is probably the biggest challenge now facing contemporary psychoanalytic psychotherapy and psychoanalysis. Until recently it was thought that such patients could not benefit from in-depth psychoanalytic work. This view is now changing and increasingly such patients are seen in psychotherapeutic clinics for treatment, and not just for management and supervision.

In the clinical work with such patients it becomes clear that their actions are often driven by anger and hatred. Robert Stoller's description of perversion as "the erotic form of hatred" (1976) could be equally applied to much delinquency and criminality and more obviously to violence. These are all acts of violation and hatred against another.

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However, clinical experience also suggests that this *external* expression of destructiveness and hatred is often a desperate defence against overwhelming *internal* feelings of humiliation, vulnerability, and terror—a fear of becoming overwhelmed by unmanageable anxiety of annihilation. The histories of most of these patients show that they themselves were very often victims and were now in identification with the aggressor as a defence against further feared abuse and violence (Rosenfeld, 1975). In addition, they may also display what Mervyn Glasser refers to as "identification with the neglector" and through projective processes get themselves caught up in situations where they do not gain help, support and care but experience further neglect (Glasser, 1998; Ruszczynski, 2010).

Patients who act out in this way may be thought of as having no internal psychic space within which to manage their anxieties, impulses, and conflicts and, as a result, have to use, through processes of splitting, projection, and projective identification, external space into which they evacuate these unprocessed feelings. The patients find themselves behaving in ways that raise fear, horror, and terror in their external environment, not only in their relationships and in their victims but also in the community in general, including in their clinicians. They do not expect anyone to listen to them or understand them. Their terror about being a victim is unconsciously dealt with by evacuating this and creating a victim in the other person.

Violence is related to destructiveness and aggression, but aggressive feelings themselves do not lead to violence. Aggression is in fact necessarily part of the life-force and, when connected to concern for the other, is the engine behind passion, potency, and authority. In violence, the concern for the other is absent, primarily because there is often a very powerful sense of a desperate need to protect the self (Ruszczynski, 2007).

In this chapter I will discuss how aggression and violence in a couple relationship may be understood as dealing with profound states of fear and anxiety, coupled with disbelief that any help is actually available. The violent couple is always also a very frightened couple and the violence, emotional or physical, is used as a perverse solution to their difficulties in facing their fears and anxieties.

John and Jane are in their thirties and have lived together for three years. They came into treatment because of increasing arguments between them, resulting in physical fights, with Jane usually attacking

John. John usually responded to the violence by trying to ignore it or by briefly leaving the house. When he eventually found himself fighting back—he began to slap Jane—he became very frightened that he might lose control and hurt Jane badly. This brought them into treatment.

In the assessment I learned that the couple's relationship had been unstable from the beginning, with times of sadomasochistic and violent exchanges followed by periods of more reasonable and loving interactions. Sex had always been very poor. Not long before coming into treatment Jane had had a brief sexual affair with John's best friend. Knowledge of this affair, as a result of Jane telling him, contributed to John's beginning to physically attack Jane.

Both came from families that broke up during their childhood. From the age of ten Jane had to look after her ill mother, with her father mostly away from the home because of his work. Jane's mother died when she was thirteen and she and her brother were brought up by her father and an aunt. The two children were subject to very strict rules and expectations. Though the father gave all the appearances of having their interests in his mind, Jane and her brother felt that they had no choice but to do exactly as their father wanted, with no discussion about what they needed or wanted.

John was an only child and at the age of five was sent to boarding school because his parents' work often took them abroad. When he was nine his parents divorced and he spent his summer holidays either with friends or moving between his divorced parents' two homes. He described how both his mother and father seemed to feel threatened by his visits to the other parent, and each anxiously questioned him about the other parent. Both assumed that he preferred to be with the other parent, but never actually asked him. John says that he always felt that his parents related to him on the basis of *their* worries and anxieties rather than being aware of or concerned about his fears or concerns.

John remembers that when he was in his early teens, his father had parties in the house and on two or three occasions a drunken female guest came into his bedroom at night and tried to wake and sexually seduce him. He remembers feeling terrified by this intrusion: the fear "froze" him, he said, and he learned to pretend to be asleep as a way of creating a barrier against the sense of sexual attack.

Given these histories and the very anxious atmosphere created during the assessment, it became clear that neither John nor Jane had the experience of a parent or of a parental couple who could contain their

fears and anxieties. In fact the opposite was true: *both John and Jane were obliged to be the recipients of their parents' unprocessed anxieties and fears.* This is a highly disturbing reversal of the usual container-contained relationship. Such an experience creates not simply the sense of absence of a good object, and therefore no containment of anxieties, but the presence of a persecutory and intrusive bad object with all the terror that goes with it.

John and Jane could both be described as having primitive anxieties about their psychic existence and hence their defences and object relations remained primarily paranoid-schizoid, with terror about abandonment and intrusiveness central. Frightening anxieties and negative emotions remained unprocessed and were experienced as toxic, humiliating, and persecutory. Jane tended to expel these states externally into John, either through her sadistic attitude towards him or in a physically violent way. Projecting her terror she creates a very frightened and persecuted John. John, in contrast, more often projected these negative emotions into an internal object and tended to be more masochistic and could easily feel demeaned. Both were terrified about their internal states.

As treatment began, it quickly became clear that the couple both feared for their psychic survival and defended against this by living out a sadomasochistic relationship. Jane is very controlling and demanding of John, whilst at the same time being very dismissive of him. She does not allow him to put his point of view in any discussion and insists that he do as she wants. She demands to know everything about his past, especially about his previous girlfriends. She attacks him verbally and, at home, physically, telling him that he is not really a man because if he were he would stand up to her. Her need to expel her own fears into him and there control them became increasingly clear.

In my emotional reaction to Jane I often felt overwhelming anger as she regularly dismissed John, the therapy, and me. She said that the treatment was a waste of time and all men were useless, clearly including me in that view. I found myself feeling anger physically in my body and, when I eventually became aware of it, my countertransference was one of being unsure about my clinical work, of being dismissed and so feeling anxious and humiliated. This could result in an agitated desire to attack the couple or, in despair, to terminate treatment and abandon them.

It was as if any state of anxiety and uncertainty could only be dealt with by an attack or by withdrawal and abandonment, not only in my countertransference but also in the couple's behaviour to each other.

I came to learn that behind Jane's sadistic and violent presentation, there was a terror of separateness which for her unconsciously represented a life-threatening abandonment. John's uncertainty and hesitance about their relationship produced for Jane the presence of a persecutory object that might desert her. Unconsciously, this may be linked to Jane having had the responsibility and anxiety of caring for her ill mother with the constant fear of failing her and of being abandoned as a result of her death.

In a desperate attempt to triumph over this terror of being abandoned, Jane tries to establish an omnipotent and narcissistic phantasy that she and John were the same, and that he wanted what she wanted with no difference between them. She colonised John via intrusive projective identification. When she felt she was failing in this, he was then experienced as a toxic and persecutory presence such that she had to violently attack him to protect herself.

In comparison, John is passive, withdrawn, and sometimes struggling to find his words. In the face of Jane's verbal assault he withdraws into a frozen state. Like Jane, he too is responding in a manner that is driven by a fear for his survival. The story of the approach from the drunken sexual women who, in his terror, John dealt with by pretending to be cocooned in sleep, represents a narcissistic retreat which enables him to fend off the horror of other people's intrusions and demands on his vulnerable self.

John was not consciously aware of how his passivity provokes Jane, brutally feeding all her terrors about being abandoned.

The sadomasochistic atmosphere in the consulting room made my attempts to have a thinking therapeutic mind very difficult. When I did come to try to offer an observation, I was openly dismissed by Jane and received in a passive way by John. Jane described what I said as meaningless or irrelevant, or she attacked me for trying to undermine her. For her, my thoughts and comments were at best empty, but often toxic, making me in her mind sadistic and damaging. John would say that my comments were "quite interesting" but what he actually conveyed was an overwhelming sense of being impenetrable and unmoved. There was no internal model for either of them of a concerned or helpful object.

I often found myself feeling very unsure about my clinical capacity to manage this couple and would sometimes then get caught up in sadistic fantasies, or feel physically disturbed and agitated. This countertransference was an important indicator of how the couple managed their fears and anxieties. An atmosphere had been created whereby I could find myself feeling impotent and hopeless, fearing that my analytic identity was being threatened or even destroyed. I would find myself struggling not to be provoked into being aggressive in my comments, joining them in their sadomasochism. At other times, I wanted to attack them or attack the relationship by terminating the analytic treatment. As for the couple, fear and anxiety felt unmanageable and could only be dealt with by aggression.

This helped me to understand the structure of the couple's unconscious marital fit and object relationship: overwhelmed by unprocessed internal fears and anxieties the couple are both preoccupied with a terrorising internal persecutor, which, in both of them, is sometimes projected outwards, leading to a sense of murderousness, or identified with internally, leading to a self-destructive passivity.

Jane projects her vulnerability and fear into John and through projective processes has to keep him frightened and controlled so that she does not have to face that terrifying vulnerability in herself. John projects his aggressive and therefore more potent self into Jane. He, too, via projective processes, has to go on seeing her in that way, otherwise he would have to become more aware of his own feared aggression and destructiveness. It was when John started to respond violently to Jane's violence that they became concerned about the danger in their relationship and came into treatment.

You will recall from their histories that both of the couple had no containing parental objects but also each had to deal with the terror of the intrusion of a demanding and persecutory object. This vicious and ceaseless movement between colonising closeness and abandoning separateness is a central experience for many patients who act out perversely or violently. Mervyn Glasser has described this in his discussion of the "core complex" (1964), and Henri Rey in his discussion of the "claustro–agoraphobic" dilemma (1994).

One of the difficulties of working with this couple was that if I showed any interest or curiosity about them they both experienced this as highly intrusive and violating. To defend against this they would often verbally dominate the therapy hour, colonising the therapeutic process, but in so doing I would be rendered impotent and in effect,

specifically in my curiosity and thinking, I would be destroyed. Jane used to accuse me of having a perverse interest in the way they related, and used to ask why I could not simply let them be the way they were. In the transference, I was, at best, dismissed as useless but more often seen as a dangerous figure whose curiosity and desire to understand was experienced as hostile and aggressive and hence had to be made silent or destroyed.

In working clinically with this couple and other violent patients, couples, and individuals, I have come to find it essential to have in mind the idea of the patients' anxiety and terror of violation as a central element in the meaning of the sadomasochistic behaviour and violence. The perpetrator's sense of being humiliated, diminished, and violated, physically or emotionally, is at the core of that state of mind, which protects itself by activating the psychically or physically violent behaviour towards the victim. The victim then becomes the terrified, hurt, and frightened person, freeing the abuser from experiencing these terrors. In a sadomasochistic or violent couple this psychic constellation is likely to be shared.

Mervin Glasser, in his writing on aggression and violence (1964, 1998), makes an important distinction between what he calls "self-preservative violence" and "sadistic violence". In *self-preservative violence* the overriding aim is to eliminate anxiety, fear, and a sense of threat by attacking and destroying its source. In *sadistic violence* the aim is to gain control and vengefully gain pleasure and relief from dominating and inflicting pain on the threatening object. Sadism suggests *some* capacity to imagine the emotional reaction of the other person and also, through the sadomasochistic interaction, some investment in sustaining the relationship. This differs significantly from self-preservative violence where the fate of the object is irrelevant, as the overriding aim is to simply annihilate the perceived threat to the self.

This difference in the nature of the relationship to the object is important. The capacity to imagine or have some awareness of the other is in contrast to the much more primitive and narcissistic personality for whom difference and boundaries between selves are absent. Sadistic violence, by definition, involves some awareness of the separate other, and self-preservative violence is characteristic of much more primitive and narcissistic states of mind.

In reality, of course, as we can see with John and Jane, these different states of mind are never that distinct, and are certainly not fixed structures. There is always movement between the anxieties, defences,

and types of interaction belonging to these two types of object relations. Attempts to manage unbearable fear and anxiety are at the heart of both, with domination and control being essential features in both. Sadistic violence, based on sadomasochistic object relations, may break down into the more dangerous self-preservative violence if the object continues to feel persecutory and psychically toxic. Narcissistic and borderline patients rapidly *oscillate* between these states and *this oscillation itself* comes to add a further disturbing dimension to the persecution and threat. The act of violence might sometimes be enacted in the attempt to stop this highly disturbing oscillation.

Glasser's concept of the "core complex" (1964), similar to what Henri Rey describes as the "agoraphobic–claustrophobic dilemma" (1994), as mentioned above, refers to the inevitable human dilemma between the deep-seated longing for intimacy and closeness, and the need for autonomy and separateness. The closeness may come to feel claustrophobic or like merger, and the separateness may come to feel agoraphobic or like abandonment. This struggle between individuality and partnership is, of course, central to the constant and inevitable tension in any and every couple relationship, between legitimate and necessary separateness and appropriate and desired intimacy.

Both states therefore might raise fear and anxiety about separateness and loss, either the loss of the self or the loss of the desired and/or required other. The capacity to achieve and tolerate this anxiety suggests a move towards the depressive position, which is only really possible if there has been a reasonable resolution in infancy of the anxieties of the oedipal situation. In a couple relationship, this means coming to tolerate the anxieties provoked by both dependence and independence, and to manage the anxieties of sometimes being included and sometimes excluded.

In a relatively mature relationship, with depressive position functioning being more predominant, this oscillation will be contained and tolerated. If this depressive capacity has not been achieved, as with John and Jane, the conflicts are experienced at the border of the more primitive, persecutory, and threatening anxieties. In a psychic structure that is more paranoid-schizoid, or if there is a regression to that state, the sense of difference is experienced not as separateness, with the ensuing sense of mourning and loss, but more as an intrusion by a terrifying persecutor. The experience is not primarily one of *loss* but of the *presence* of something persecutory, humiliating, and

unbearable. It is this persecutory invasion that has to be dealt with by its annihilation.

If there is some fragile capacity to imagine the feelings of the other, a more sadistic reaction might emerge with domination, control, and possibly revenge, actively or passively, becoming primary. In this situation, however, the ongoing presence of the other is essential and so defensively the aggression is sexualised as a way, in phantasy, of binding the object into the relationship, albeit a sadomasochistic relationship. As already suggested, it is likely that there will be an oscillation between these two states of mind and ways of object relating, as became a familiar part of my experience with John and Jane.

Is it possible to understand why some patients actually act out their violent feelings as a means of dealing with their deep anxieties and fears? Various authors have suggested that enactments of aggression, violence, and murderousness are induced by the psychic toxicity resulting from certain impulses, anxieties, and conflicts being unprocessed as a result of a failure or lack of containment, or because of a lack of a capacity for mentalisation (Fonagy & Target, 1995). Without the experience of containment, no development of a *psychological self* can take place, of a self that can process and think about experiences and psychic states. Such development requires the primary experience and perception of oneself, with all one's fears, anxieties, and conflicts, being present in *the mind of someone who is able to feel these feelings and try to think about them*. Without this, what results is "mindlessness", an empty, inanimate, and even malignant sense of the self rooted, not in the mind, but in the body. The inability to reflect on and integrate mental experiences results in only the body and bodily experiences being available to be used to provide a sense of relief, release, or consolidation. If this threatening object is projected into another, as with Jane, it may result in a sadistic, violent, or murderous attack on the body of the victim. If identified with, as with John, it results in a masochistic or suicidal attack on the physical self.

With violent and perverse patients, there has very often been not just a lack of parental containment but of violent or perverse parents with a predatory aspect to their relationships, emotional, physical, and sexual. Such patients often display a desperate urge to evacuate their psychic states into the mind and body of the other so as to expel their own toxic states. This might lead to sadomasochistic interactions, and it might also be more destructive, violent, and murderous.

In thinking about failure in containment or the lack of a capacity for mentalisation we should keep in mind the nature of the death instinct, which, at its strongest, attacks and distorts the capacities for perception and judgement, both in the potentially available containing object and in the self. Clinically, the concept should be thought of as a destructive *psychological* force. Michael Feldman says that what is deadly about the death instinct is the way in which meaning, and specifically difference, is attacked (2000). Bion describes this process very powerfully, saying that it is characterised by experiences being denuded of their meaning and value (1959). As a result of these attacks, ordinary developmental processes, which would eventually result in the development of a thinking psychological self that is able to manage and contain most fear and anxiety, are retarded or undermined. This understanding seems clinically helpful when thinking about perverse attacks on the emotional facts of vulnerability, neediness, dependence, separateness, and loss. All these experiences need to become tolerable in the mind, so as to allow for the capacity to develop relatively mature couple relationships.

Working with such patients has to take their violence and destructiveness seriously. However, this can probably be done more easily if *in addition* such patients are also understood as attempting to manage anxiety and fear which feel unbearable and which have to be evacuated externally and so creating a victim in the other, thereby to ensure that they themselves do not again become victims. I hope that the phase of work with John and Jane described above illustrates that struggle.

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