THE PSYCHOANALYTICAL FOUNDATIONS OF A DIALECTICAL APPROACH TO THE VICTIM/VICTIMIZER RELATIONSHIP

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I saw his round mouth's crimson deepen as it fell,  
Like a Sun, in his last deep hour;  
Watched the magnificent recession of farewell,  
Clouding, half gleam, half glower,  
And a last splendor burn the heavens of his cheek,  
And in his eyes  
The cold stars lighting, very old and bleak,  
In different skies.  
Wilfred Owen, "Fragment: I saw his Round Mouth's Crimson..."  
The Collected Poems of Wilfred Owen  
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Human destructiveness is a problem so pressing that all others pale beside it (Blomfield, 1987; Freud and Einstein, 1933; Twemlow and Sacco, 1995).

Meloy (1992), a sophisticated writer and researcher-clinician, speaks eloquently of our relationship to violence, "This litany of violence can numb the senses and foster a curious yet detached attention to only the statistics. We minimize or deny the affecational paradigms and psychodynamics that existed between the aggressor and the victim. The numbers dampen our wish for insight and our thoughts resist an attempt to comprehend the meaning of such inexplicable, yet troublesome, antisocial behavior" (p.

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xiv). Even children are numbed; recently my wife took our daughter to the movie *Batman Returns*. In this movie a woman is pushed out of a skyscraper and falls to her death. During this sequence, there was a commotion in the movie theater. A boy, approximately 11 or 12 years of age, created a disturbance by jumping up and down on his seat, shouting out “oh great, oh great, oh great! He pushed her out of the window and he didn't even care!”

I propose that today’s psychoanalytic clinician has a much broader theoretical base from which to offer some hope and leadership in this perplexing field than Freud and Einstein (1933) espoused in “Why War?” Our field still falls into the trap of denying the importance of violence, however. Grotstein (1992) pointed to the denial of violence exemplified in the folklore of psychoanalysis and the delayed introduction of the dual-instinct theory. For example, an extraordinary amount of violence occurred in the life of Oedipus Rex, yet it was hardly acknowledged. The focus instead was on sexuality.

We also have a most practical reason for concerning ourselves with violence. A report of the American Psychiatric Association Task Force on Clinician Safety (Dubin, 1993) noted that psychiatrically ill patients tend to be more violent than nondisturbed people, and that approximately 40% of psychiatrists and 50% of psychiatric residents are nonfatally assaulted by someone during their careers.

In this article I will also describe how violence begets intense attachment even between strangers. Violence seems to instantly bond people in a bizarre and perverse pathological intimacy.

Over the many years I have had experience with psychoanalytic psychotherapy and psychoanalysis of people who are both victims and perpetrators of violence. I have trained over 1000 students of martial arts, and have taught participants in numerous seminars on self-defense. Many of these people are motivated for treatment and/or training by their own experiences of victimization. Case vignettes are drawn from patients who are in psychoanalysis, psychoanalytic psychotherapy, or in martial arts/self-defense training. Later articles in this series will address specific technical issues involved in the treatment of victims and perpetrators of violent abuse, the cognitive and perceptual strategies useful in both detecting and handling violent attack in clinical practice, and the special problems posed by chronic victimization and hostage/torture situations.
THE VICTIM/VICTIMIZER RELATIONSHIP

Ogden (1986, 1992), after Hegel, defines a dialectic as "a process in which each of two opposing concepts creates, informs, preserves and negates the other; each standing in a dynamic ever-changing relationship with the other" (1986, p. 208). The important quality of such a dialectic process is that although there is a constant, ever-changing attempt to negate, create, inform, preserve, and integrate, the process is never completed. Each integration creates a new dialectical opposition. In addition, one side of the dialectic has no meaning without the other, that is, in the dialectical relationship, each is essential for the existence of the other. As Marcuse (1960) comments, "Dialectical thought . . . [is] a process in which subject and object are so joined that truth can be determined only within the subject–object totality" (p. viii). I will attempt to show that there is a classic, dialectical relationship between a victim and victimizer, whether or not the two know one another.

This dialectical structure has been implied within the object relational framework of psychoanalysis since the time of Freud, but has recently been given central emphasis by Ogden (1994). Following Freud's emphasis that consciousness and unconsciousness must be conceived of as coexisting qualities of what is psychological, Ogden proposes that the convergence of the subjectivities of the analyst and analysand form a dialectic he calls "the analytic third" within which the work of analysis proceeds. How can this construction explain the victim/victimizer relationship? Dialectical struggles around activity and passivity can be seen to form a contextual background to all relationships, including the analytic relationship, and become more like conflicts as aggression is added to the equation. For example, the language of drive defense theory (e.g., defense, resistance, etc.) implies a struggle, which in a satisfactory treatment is therapeutic. It is this dialectical struggle that some, particularly Ogden (1994), see as the essential crucible of psychoanalytic treatment. We know that as aggression becomes more central in the analytic interaction, victim/victimizer transference/countertransference paradigms become more prominent. I postulate that similar dialectical mechanisms are operative in all victim/victimizer dyads.

Borrowing from the language of chemistry, victim and victimizer can be represented as a mass law equation and thus operate in
such a way that if one changes, the other will change; each can preserve or create the other; and each can negate the other from second to second during acts of physical and psychological violence. A unique and new psychopathology is created within this equation with a balance as fragile as that implied by a similar representation by Bion (1970) in his conceptualization of the ever-changing, omnipresent relationship between the paranoid schizoid and depressive positions, a relationship he once conceptualized as a dialectic between chaos and order. Preventable damage in the relationship between victim and victimizer depends a great deal on how this interpersonal relationship is transacted.

I hypothesize that the psychoanalytically informed victim has a considerable advantage if he/she can reestablish boundaries to terminate the spiraling dialectic that is initiated by the destructive intent of the attacker. This equation is also influenced by many additional factors that allow the victim to push that equation to the right, that is, the victim needs to reverse the regressive spiral of giving up and becoming more of a victimizer. A case vignette from psychoanalytic psychotherapy will illustrate.

A 65-year-old woman was in her basement gathering firewood to take upstairs when the boyfriend of a relative came up behind her and attempted to rape her. She was overcome with what I have called “cold rage,” an intense form of outrage that gave her the “strength of 10 men” akin to the not infrequent occurrence of similar strength in, for example, a housewife who lifts a car off of her husband who is accidentally trapped beneath. She grabbed his lip in a painful pinch and stepped him back upstairs and then threw him outside with appropriate, shouted verbal expletives. He ran off in a panic!

What seems to occur is a form of perverse or “negative intimacy” not unlike a lovesick relationship. Lovesickness as I have described elsewhere (Twemlow and Gabbard, 1989) involves several discrete phenomenological states:

**Emotional Dependence:** Each person feels linked to the other by forces beyond his or her individual control. Terror and sadistic control rather than the ecstasy of lovesickness are the dominant affects. The total helpless fear of victims of severe violent attack is well known. Less well recognized is the process in which perpetrators of violence report grandiose, sadistic, control fantasies as the victims become more clearly submissive.

For example, a 30-year-old male rapist, during psychiatric eval-
uation, reported an overwhelming feeling of power and strength as his victim was crying and pleading for mercy and relief from pain. He reported this affect as though it "took him by surprise."

**Intrusive Thinking:** Thoughts of the other constantly preoccupy the mind, often with significant denial of reality. Victims often grossly misperceive the physical and psychological characteristics of their attackers in ways that make legal testimony difficult, in much the same way as partners in lovesickness misperceive each others' beauty and intelligence. A woman in psychoanalysis reported a sexually harassing employer as always present in her thoughts, so that people with similar dress, vehicles, and even cologne and cigarette brand would elicit an immediate and troubling flashback.

**Altered States of Consciousness and Physical Sensations:** Physiological symptoms of fear, with feelings of weakness, sweating, and palpitations, usually occur. Dreamlike states of consciousness close to sleep are commonalities of the autonomic disruption.

**A Sense of Incompleteness:** The passivity of the victim and the activity of the attacker naturally complement each other in a bizarre fashion. In a sense, this state is a pathological whole. Victims of domestic violence often appear to mourn the loss of the victimizing other. Once, while on ward rounds, I entered a hospital room in which two women were arguing bitterly about whose husband was the most skilled at inflicting injury. One patient triumphantly shouted that her husband practiced karate. Both had suffered serious and repeated injuries from their spouses over the years.

**Social Proscription:** Social proscription often intensifies the excitement of relationship, although once the victimization has commenced, the situation is not pleasurable. The extraordinary and unnecessary risks taken by victims of violence sometimes appear to court danger, and danger-seeking is a commonly recognized personality trait (Tellegen and Atkinson, 1974).

The degree to which the victim fuses or merges with the attacker, presumably in an attempt to masochistically identify with the aggressor, is sometimes extreme and is actually part of societal ritual. One female victim of rape spoke of being "spot welded on to his (the rapist's) mind."* She was obsessed in a negatively lovesick way, and felt lost without him. After the rape, she changed

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*Case material provided by George Hough, Ph.D.
her brand of cigarettes to that of the attacker. Campbell (1988) describes ritual torture in ancient Native American rituals in which the captured warrior, before being slowly skinned alive, is showered with food, gifts, and affection and then aids the torturer with suggestions and expressions of love and affection. Qualities in the victim that promote the success of the victimizer are documented in the literature: external locus of control (Myers et al., 1984); past history of sexual and/or physical abuse (Carmen et al., 1984; van der Kolk, 1989); traditional views of authority and of gender identity (Weis and Borges, 1973); unemployment and a history of alcohol or drug abuse (Myers et al., 1984); recent disruptive home situations; and submissiveness (Richards et al., 1991). Characterizations of the victimizer include: presence of psychosis (Brizer and Crowner, 1989; Holcomb and Adams, 1985); narcissistic personality pathology (Schulte et al., 1994); history of drug and alcohol abuse (Brizer and Crowner, 1989; Felson and Steadman, 1983); and unemployment and poverty (Sigelman et al., 1984).

The environment and the availability of help, for example, the presence of others, helps prevent the deep regression that often occurs. Light rather than dark conditions prompt less regression. Quite commonly, attacks are made on individuals while they are asleep or under the influence of drugs or alcohol when ego boundaries are shifting and where the contents of dream-life can interpenetrate reality and encumber the individual with problems in quickly judging and responding to reality.

For example, in a forensic psychiatric evaluation, a case of perverse sexual assault and burglary involved the giving of a forceful enema to an unsuspecting sleeping victim as part of a psychotic “hot burglary” break in. A victim in an altered state of consciousness is often unable to comprehend what has happened till some time later, being “stuck” in dream-like states of pain, shock, and sometimes, sexual arousal.

In any case, victims often describe their state of consciousness as “dreamlike” whether or not the attacks have occurred in states of sleep, when drugged, or under the influence of alcohol. In these violent cases, the attack itself seems to precipitate a rapid regression to ego states reminiscent of the infant’s lack of boundaries and helplessness without the comforting and soothing breast-container functions that often appear to be split off from the oceanic blissful experience. Smith (1977) conceptualized this split-off function as an unanalyzable “golden fantasy.” Those without
access to the soothing, infinitely tolerant and loving “golden fantasy” will fare poorly in violent attack. Spitz (1956) observed that mother/child bonding diminished in the 1940s as more mothers worked outside the home. He predicted that as the trend continued we would live in an increasingly violent society. He said, “Infants without love will end as adults full of hate.”

Federn (1952) described the ego as a continuous experience of the psyche. He postulated an inner and outer ego boundary demarcating the border between the conscious and unconscious (inner) and between the internal and external world (outer). Both of these boundaries are breached in the regression that occurs during victimization. The conscious mind becomes flooded with fantasies: ideational, affective, and physiological (inner-ego boundary), as well as distortions, errors, and fantasies about sensory input (outer-ego boundary). The basic senses are no longer reliable indicators of the predictable external world, and the orienting spatial and temporal frame of reference for the outside world is temporarily lost. The rapidity of regression appears clinically related to a history of prior experience with victimization, and is sometimes dramatically obvious.

A psychoanalytic patient who was a victim of perversive sexual abuse as a child was prone to an automatic reaction of falling to her knees with pleading and crying whenever spoken to sharply by older men. (She was victimized by her stepfather.) Initially she had no conscious control over this response, but would wait for the sword to fall, with her head hanging submissively and tearfully “as still as a stone,” she would say.

There is a cross-cultural parallel for this unusual instant submission in the Malay condition, “Latah” (Kenny, 1983; Murphy, 1983; Simons, 1983). Reported in a number of cultures, this bizarre response is characteristically a sudden fright in response to an unexpected attack. The subject becomes physically uncoordinated, falls down trembling and is immediately obedient to commands, sometimes shouting affect-laden words. For example, Kenny (1983) considers this response to be the adult equivalent of the infantile Moro reflex and thus to be instinctual. Others, for example, Simons (1983), strongly disagree, considering “Latah” to be a dissociative state such as hysteria, and to be noninstinctual and conflict based. Another vignette illustrates a “Latah-like” response.
A middle-aged professional man and student of karate, when fighting, was observed by his instructors to sometimes fall suddenly to the ground in an apparent faint, lying until told to rise. He himself noted that this only occurred when fighting skilled and frightening instructors who were superior in rank. He was perplexed by his own exaggerated response even to minor blows. This man was a victim of child sexual abuse by a male school teacher and by his mother, a grossly obese and very powerful woman, whom he described as a “mud wrestler.”

An object-relations conceptualization of this sudden regression might involve a tipping of the balance to the paranoid/schizoid position (Bion, 1970; Ogden, 1986) with a return to the self-as-object posture, that is, self-awareness is diminished and the world is experienced as containing only omnipotent, powerful, persecuting bad objects, capable of annihilating the victim (Eigen, 1985); a sense of catastrophe is experienced as a nameless dread. More particularly, resistance is difficult and all hope is lost in those with a paucity of good internal objects, such as in child-abuse victims.

THE INTERNALIZATION OF COMPLEX PSYCHOPHYSIOLOGICAL STATES

The concept of “traumatic bonding” is a term used to describe the relationship between victim and victimizer (van der Kolk, 1989). It is not a new concept when one recollects that remembering is the hallmark of the traumatic bond, which often evokes strong physiological accompaniments and associated memories and fantasies, as in psychedelic drug-induced flash backs (Twemlow and Bowen, 1979). We know that early affective, physiological, and ideational complexes may be internalized as a unit or engram that may later form a template for adult responses.

This traumatic introject is, in my opinion, a unified complex of part object and part self representations linked by an affect, similar to what is called a Split Object Relations Unit (ORU) by Masterson (1976). As van der Kolk (1989) indicated, trauma can be repeated on behavioral, emotional, physiologic, and neuroendocrinologic levels. Since the early studies of Janet (1907) and Freud (1896) utilizing hypnotic abreaction and recollection, a great deal of work has been done on dissociative state-dependent learning. The transition from unconsciousness to awareness is often sudden if conditions in the external world are similar to those prevailing
at the time of the original storage of the memories. Affects or any cognitive perceptual set can trigger this “remembering”: however, affects are clinically more powerful triggers. Two examples dramatically illustrate this phenomenon.

This young patient's husband was a social worker. He battered her on a daily basis and sexually abused their 10-year-old daughter. The battery was always performed in a ritualistic way: he would force her to drink quantities of alcohol until she was partially drunk; then he would threaten her with a knife, seize her by the throat, slam her against a wall lifting her off her feet, and scream in her ears (loudly enough to rupture her eardrums). In psychotherapy, this woman realized that 12 years of compliance with this extraordinary battery was partially explained by the fact that, as a child, she had been beaten and sexually abused by being dragged from her bed by her stepfather and abused while sleepy. The alcohol created a state that triggered a helpless, dependent posture; the child reappearing in an otherwise quite sophisticated woman.

A nurse in psychoanalysis, who was sexually and physically traumatized as a child and who had also experienced Vietnam-era trauma, became very astute at recognizing the early physiological signs of imminent psychophysiological regression. Knowing that these early signs heralded a deep and fantastic regression with reliving of traumas from the battlefield and childhood, she developed a means of sublimating the rageful affect in very intensive, vigorous housework. She would stimulate her "golden fantasy" by looking at pictures of her husband and children while she worked, to create a net of safety, while feeling deep and conscious feelings of guilt with suicidal ideation during the regression.

Abused children are likely to blame themselves when, as adults, they are attacked. There is a return of the fear of turning on the caregiver who, paradoxically, not only abuses but also often provides the net of safety. This complex double-bind often produces difficult-to-understand, apparently unconscious masochistic responses on the part of the victim. Rosen (1993) noted that in such circumstances a bad-enough object is sometimes better than none at all, and is frequently accompanied by a parallel wish/hope to transform the bad object into a good one. Bowlby (1984) and others have described the critical importance of the attachment response in preventing regression. Both social support, the metaphor for mother's love, and the presence of benign parental transference to current spouses and others, are often critical in preventing severe reactivation of traumatic split object relations units.
One such adult woman in psychoanalysis was perversely and grossly abused as a child. When she saw a small child with a man in a car, she would immediately cringe and drive off at a furious pace locking herself into her car, screaming “Mother, Mother” at the top of her voice. In this instance, although her mother participated by denial in the perverse, caustic, blood-letting and other daily tortures when she was a child, she was certainly better than no support at all. The sound of the word “Mother” was often sufficient to trigger a repression of this traumatic abusing object relations unit.

Victims, when chronically abused and when fatigued, will often seek increased contact with their attackers and with others in an attempt to placate and prevent such regression. These behaviors are illustrated by the cruelty of certain Jewish inmates of death camps who would identify with their Nazi torturers, and become informants on their own people (van der Kolk, 1989). Spouses and girlfriends of serial murderers cling most intensely to these men despite knowledge of the imminent danger to themselves (Meloy, 1992). Abused children cling to the abusing parents often in direct proportion to the perversity and extremity of the abuse. In chronic spouse abuse, the spouse frequently organizes his/her total life around the battering spouse and spends most of his/her life trying to placate the batterer. When the danger is over, there is often a response of overwhelming relief on the part of the victim, and the victimizer is treated with a bizarre form of love. This pattern is seen time and time again in chronic spouse battering and hostage situations.

A colleague of mine was regularly tortured in prisoner-of-war (POW) camps during World War II. On one occasion, after a daily torture session, he was suddenly overwhelmed by feelings of love and compassion for the torturer. When he expressed these feelings to the torturer, it produced a look of fear in the man. The perplexed torturer then stopped and never again touched him. An unusual sublimation of this horrible experience was seen when he later became a fakir and a pundit in the field of physiological self-control, particularly the control of pain and bleeding. This man has gone on to help many people by teaching control of pain and bleeding and other psychological survival skills.

What about the many who have not had such horrifying experiences of physical and/or sexual abuse? In one sense, we have all had such an experience; at least, according to the theories of Otto
Rank (1929). Rank’s ideas, initially embraced by Freud, fell into disrepute partly because of their oversimplified reduction of all psychopathology to birth trauma. Winnicott (1975, 1988) wrote two thought-provoking papers on birth trauma. He proposes that a paranoid disposition might be explainable by the setting up of a pattern for persecution. He says “in a percentage of paranoid cases, there is this additional fact that birth was traumatic and placed a pattern on the infant of expected interference with basic being” (1975, pp. 190, 191). Grof and Halifax (1978) say that in their lysergic acid diethylamide (LSD)-treated patients: “In the birth experience there is a unique emphasis on the role of the victim and the fact that the situation is inescapable and eternal. There appears no way out, either in space or time” (p. 49). Thus the victim/victimizer object relational unit may be deeply embedded in all of us in one way or the other, whether it is the Rankian birth trauma, or for that matter, the terrifying common root of all anxiety as speculated by Sullivan (1965) who related the root of anxiety to choking on amniotic fluid. In Beyond the Pleasure Principle, Freud (1920) observed a passive reaction to trauma in the cases that he studied, although he did not fully explain the relationship of activity to mastery. In these writings he clarified the concept of anxiety versus fright: “anxiety is a particular state of expecting danger or preparing for it even though that danger may be unknown, and fright is the state a person gets into when he has run into danger without being prepared for it” (p. 12). This view of fright employs the idea of hypercathexis. Freud explained the passivity in traumatic situations as a “lack of hypercathexis of systems that would be the first to receive the traumatic stimulus” (p. 31). Mastery to him was the “binding” of that stimulus (p. 31). Thus for Freud, in traumatic neuroses “an ‘anti-cathexis’ on a grand scale is set up, for whose benefit all other psychic systems are impoverished, so that the remaining psychical functions are extensively paralyzed or reduced” (p. 30). The pleasure principle is thus put out of action resulting in what Freud called “a comprehensive enfeeblement and disturbance of the mental capacities” (p. 12). The repetition of traumatic dreams was seen by Freud to be an attempt to hypercathect the relevant systems whose emission was the cause of the traumatic neuroses. It was not until his writings on Inhibitions, Symptoms and Anxieties (1926) that a fuller explanation was available. With the concept of signal anxiety, he showed that the subject’s ego has developed the capacity to utilize the states of tension as signals of danger. This must, of course,
mean that he has acquired the ability to attribute meaning to these states of tension where such ability was absent in the past. Thus, *passivity is equated with unpreparedness and activity with mastery.* Stern (1988) has an interesting theory that gives further evidence for the omnipresence of the passive response to danger with his conceptualization of night terrors (pavor nocturnus). He sees night terrors as a morbid, passive, shock response to a preceding nightmare, and is thus a developmental failure of the ego to attribute meaning to a state of tension from the preceding nightmare; a response he called "catatonic."

In the split object relations unit, van der Kolk (1989) has said, "Something has disturbed the organism’s capacity to modulate the extent of arousal" (p. 396). There is a basic sympathetic/parasympathetic disturbance of homeostasis that can provide a cartography for the psychophysiological components of the regression seen in victimization. When I use the term "psychophysiological," I am also referring to a series of *cognitive and perceptual shifts* that accompany the autonomic physiological regression. The victim of fear experiences a narrowing of the visual world as if putting on blinders, the tache-psyche effect (Steiner, 1987), so that there is a cone of vision focused obsessively on the attacker who becomes the sole object of that attention. At the same time most other thoughts are absent from the conscious mind except for intrusive thoughts about the attacker. Frequently there is also reduction in attention to external auditory stimuli. A high level of anxiety causes a concretization of thinking with reduction in capacity for abstraction and symbolization. There is a deficit in learning to escape novel adverse situations that has been demonstrated experimentally with a decreased interest in new learning options and a decrease in reality testing (Maier and Seligman, 1976). Thus, there is a one-pointed impoverished concrete attentional focus that reduces the capacity for the individual to adapt creatively and flexibly to new situations.

Physiologically, the body has two counterbalanced homeostatic mechanisms: *one to alert and the other to calm* the body (Asterita, 1985). The classical research of Cannon (1915) has shown that the fight/flight/freeze response involves the sympathetic adrenomedullary system, which leads to a series of reactions that are potentially adaptive: increase in blood supply to voluntary muscles; increase in heart rate and blood pressure; reduction in nonessential blood supply to the skin and nonvital organs; an increase in red cell mass due to increased contraction of the spleen; increase
in blood sugar from the liver; increase in depth and speed of respiration; dilations of the pupils to increase sensitivity to light and an increase in coagulability of blood and stimulation of the immune system, including white cells and lymphocyte response to aid in tissue repair. If, however, the stress is prolonged, or, according to my speculation, if the individual has a preexisting traumatic split ORU, a different response occurs: the adrenal glands quickly become exhausted and the response of the parasympathetic system, which normally would act to adaptively calm and return the body to a normal state, becomes highly maladaptive. This “calming” mechanism, mediated through the pituitary gland, is set in motion by glucocorticoids, inducing reduction in immune response and especially antibody production, and an anti-inflammatory action with delay in tissue repair and healing, a reduction in blood supply to voluntary muscles, reduction in blood sugar, a reduction in general metabolic rate and a reduction in electroencephalographic (EEG) activity with the presence of delta waves of sleep. The muscles of such an individual become flaccid and weak. In other words, the individual’s psychophysiological state is about as far from being prepared for self-defense or self-preservative activities as one could imagine! This “freeze response,” a state of tonic immobility, has been observed in combat soldiers (Bradshaw et al., 1993) and in animals. In the latter, it is felt to represent an adaptive immobility to reduce the animal’s chance of being seen (Sluckin, 1979). Shear and colleagues (1993) propose an interesting psychodynamic model of neurophysiological irritability to explain extreme sensitivity to fearfulness in patients with panic disorder. This model speculates that constitutional factors are augmented by early defective object relationships around dependence and independence. Such patients are seen as having weak self-representations and powerful object representations predisposing to immature defenses with guilt and anger (and submission) when threatened with abandonment.

Victims of chronic and acute abuse clearly describe altered states of consciousness induced by their experiences with state-dependent recall of earlier trauma (van der Kolk, 1989). Spiegel (1974) described patients with a “Grade Five Syndrome” as being highly hypnotizable and comprising less than 5% of the population. Such “High 5’s” have a pathological compliance pattern, are uncritical, and use a “trance logic,” a form of unawareness of reality (failure to see logical incongruities). They also have a morbid interest in unusual events and are most refractory to treat-
ment. Ganaway (1989) suggests that such a syndrome might be present in multiple personality disorders, a group with a very high prevalence of previous physical and sexual abuse. Although Spiegel implies an inherited predisposition to his “High 5” group, the personality constellation is also remarkably prevalent in victims of chronic physical abuse who comprise more than 5% of the population. This syndrome possibly represents a conditioned response to repeated abuse.

I believe that a state of exhaustion can be reached very quickly, if not instantly, in previously traumatized individuals, with immobility and exhaustion that can ultimately result in mutilation and death, although genetic factors such as anxiety threshold and resilience are also likely to be important in this response.

For a variety of reasons, possibly including the fact that there is a preponderance of females in psychiatric treatment, victim responses are reported more commonly by women. Studies have shown (Carmen et al., 1984; Jaffe et al., 1986) that abused men and boys tend to identify with the aggressor (become the attacker) and abused women tend to become attached to abusive men and are often further victimized. Chasseguet-Smirgel (1986) describes a type of woman who, although intelligent and successful, tends to assume a victim role to brutalizing men. She sees this form of masochism as an example of the failure of these women to incorporate a paternal phallus symbolically. The father is described as weak and devalued. Lester (1992) considers that this type of woman is counterpointed by a much larger group in whom “the central pathology lies in the lack of an optimal, self-object differentiation and the persistence of the unconscious fantasy of a merger with a primary object.” Berman (1992), in reviewing the concept of machismo in Mexico, felt that this cultural stereotype typified in the violent male/submissive female, common in Mexico, derives from the idealization of the father by women, and an identification with the devalued and depressed mother who is seen as weak and incapable of defending herself. Thus, it is likely that despite the gender differences noted in the literature, both men and women are equally capable of reexperiencing the effects of traumatic split object relations units in situations of external danger.

CONCLUSIONS

This article sets the theoretical stage for a clinical exegesis in the companion piece (this volume) about some varieties of object relationships seen in situations of victimization. The fundamental
dialectical ambience of this conceptual framework allows for a more fruitful psychoanalytic understanding of the etiology and effects of the interaction, rather than a politically flavored blaming and advocacy that often contaminates contemporary clinical management.

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