TRAUMATIC OBJECT RELATIONS CONFIGURATIONS SEEN IN VICTIM/VICTIMIZER RELATIONSHIPS

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In the preceding article (Twemlow, 1995), I reviewed the conceptual and metapsychological underpinnings of the relationship between victim and victimizer that are often observed clinically in cases of acute and chronic violence. Both victim and victimizer contribute to the perverse form of negative intimacy that occurs, an understanding of which permits insight rather than politics and blame to decide a course of action most useful to the people involved.

In this article, the practical details of the prototypical victim/victimizer relationships are examined with examples of commonly seen traumatic object relations configurations in clinical practice.

TRAUMATIC OBJECT RELATIONS CONFIGURATIONS

There are at least four basic possible Object Relations Units (ORU) in a delicate dialectical balance:
1. Victim  Victimizer
2. Rescuer  Victim
3. Martyr  Victimizer
4. Detached Observer  Victimizer

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This list is not exhaustive but contains the most frequent dyads seen in clinical practice, depending on a variety of conditions and predispositions, including personality, environmental, and physiological factors as already noted (Twemlow, 1995). All of these roles can be adopted by each individual involved in the victim/victimizer dyad over time, in a chaotic, ever-changing kaleidoscope fueled by volleys of projective identification and counter-identification. In acute attack situations, sorting out whose object relations are whose, and who is more dominant or submissive varies rapidly and confusingly as conditions change as self-preservative responses become more or less successful. Personality and past traumatic experiences interplay to catalyze the victim or victimizer response.

Table 1 summarizes these configurations, but recall that the price of such a static tabulation is that the dynamic dialectical, relational quality is lost. In more chronic violence like hostage situations and domestic violence, these roles are more stable over time. A clinical example drawn from psychoanalytic psychotherapy will serve to highlight these dialectic relationships.

A middle-aged African-American woman who worked as a janitor with a local insurance company finally decided to bring a suit for sexual harassment against her white supervisor. At the same time her husband constantly belittled her for what he considered her overreactions to the eroticized advances of the supervisor. The patient grew up in a poor ghetto family with at least six known siblings. Her mother was a constant, help-rejecting complainer and her father was an alcoholic who died when the patient was 12. At that time she became the surrogate mother for the family as her own mother became incapacitated. She had been devoted to her father, constantly attempting to get his attention. The family was clearly patriarchal, with the father’s mood swings and drinking having an ongoing impact on how the family functioned. The patient completed high school and quickly married unsuccessfully on three separate occasions, bearing several children along the way, all of whom have had psychiatric and legal difficulties. She herself was not involved with drug or alcohol abuse and claims no physical or sexual abuse as a child but was constantly verbally abused by her father who berated her for her inability to meet his needs. She reenacted this in her marital relationships where there was little she could do other than comply with her husband, who like the supervisor, functioned as a narcissistic tyrant. She was brought up in a family that required highly submissive and traditional feminine attitudes in the women who all complied with
<table>
<thead>
<tr>
<th>Part object representation</th>
<th>Victim</th>
<th>Victimizer</th>
<th>Rescuer</th>
<th>Martyr</th>
<th>Detached Observer</th>
</tr>
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<tbody>
<tr>
<td>A parental object who is hostile and critical projected into attacker.</td>
<td>A parental part object who is hostile and critical.</td>
<td>A parental part object who is helpless, controlling, and inadequate with a reaction formation against the feelings of helplessness.</td>
<td>A parental part object who is helpless, controlling, and inadequate with an omnipotent denial of the feelings of helplessness.</td>
<td>An omnipotently powerful, controlling, parental introject with a dissociative defense against the feelings of being controlled.</td>
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<tr>
<td>+ Sadness</td>
<td>+ Rageful vengefulness punishing</td>
<td>+ Self-satisfied, feelings of pity and sympathy, self-sacrificing</td>
<td>+ Self-satisfied, feelings of pity and sympathy, self-sacrificing</td>
<td>+ Detached calmness</td>
<td></td>
</tr>
<tr>
<td>+ Inadequate bad, ugly, guilty, compliant, helplessness, hopelessness</td>
<td>+ Omnipotently powerful and yet isolated, lonely, and misunderstood.</td>
<td>+ A fragile feeling of powerlessness with underlying inadequacy.</td>
<td>+ A feeling of being the good, passive, compliant child who will be rewarded for compliance.</td>
<td>+ A feeling of emptiness, deadness, and falseness</td>
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Table 1. Possible Traumatic Object Relations Configurations
men who were narcissistic and highly unpredictable in their actions. From this sort of background she came into a job that was essential for the family finances. Her husband pointed out to her on several occasions that it was necessary that she put up with whatever went on so that the money would be forthcoming. Her account of the actual harassment involved daily contact in what appeared to be psychological torture. The supervisor would stare at her unblinkingly while masturbating, corner her in closets and rub himself against her, show her pornographic pictures, make comments emphasizing her helplessness and his desire to humiliate her sexually with the constant undertone that she was "stupid and black" and should be glad that he had any interest whatsoever in her. At times he gave her more responsibility and treated her as if she had some special skills that he appreciated, and she responded to this with alacrity. As she began the spiral toward submission, she exhibited the typical phases of the giving-up/given-up-on syndrome (see Figure 1). Her mind could not focus on anything other than thoughts of the supervisor. She spoke of him constantly to friends and relatives, much to their annoyance. She felt helpless and hopeless and remembered times of loneliness in her childhood when she was the one to manage the family and to provide for their needs; so much so that on one occasion when the supervisor wanted to make advances to her daughter at a company Christmas party, she allowed him to do so in a way that made her feel even more ashamed of herself. She now constantly berates herself for being "dumb and stupid" and asks, "Why did I take it, why did I stay in the job? I should have walked off and left." She began to feel the need to mollify him in a variety of ways, and was consciously aware of performing favors like bringing him food and reading the Bible to him in an attempt to reform his ways. Besides this highly victimized, submissive, and mindless state, for long periods she functioned like a detached observer in which she said she felt "dead; too stupid to be alive." She would almost pinch herself so that she could say to herself, "this is me." She often felt in a dreamlike state as if she was not in her body, but above and behind herself, watching. At other times she felt like a rescuer. She would feel sorry for him and would take breakfast to him in the morning, be friendly to him, and would work especially hard to keep the building clean so that he would receive accolades from his supervisor. At times she felt like a martyr, especially when it seemed almost impossible for her to continue. She would pray and ask the Lord if there was a purpose in what she was doing, had she done something wrong and what could she do to straighten it out? She would talk to him about God and life and how he and she could be different. In this role, she would often feel that he was excessively tired and worn out by the demands of his
work and that she would always be there to help him. She felt she could "straighten it out so that it doesn't worry him." At other times she also felt like hurting him viciously. She would envision herself walking to his office and hurting him "really, really badly." She would feel, when sitting with him, that she wanted to "hit him, and hit him, and beat him." When she would express this to him, he responded with a smile that immediately made her feel submissive. She has symptoms of posttraumatic stress disorder, often precipitated by a smell similar to the smell of his bad breath. Several years later she continues to have nightmares and anxiety with increased startle response and exhaustion.

THE VICTIM/VICTIMIZER SPLIT
OBJECT RELATIONS UNIT

The typical victim/victimizer dialectic will now be described. It can be considered a prototype for the other, less typical responses. I have observed four phases in the victim's response to violent attack:

1. Denial
2. Regression—giving-up
3. Resignation—given up on
4. Surrender

Gabbard (1994a), in a paper on erotic transference, pointed out that dehumanized sexuality, as seen in pornographic fantasies, may be a defense against an underlying wish for intimacy. He also indicated that aggression can similarly be dehumanized. In my observations, the speed with which denial of aggression occurs in otherwise healthy adults points to a much more intensive impact of aggression on unconscious defenses as compared to sexuality. Characteristic features of the denial of danger sometimes reach quasi-psychotic intensity. They are psychotic in the sense that there is an extraordinary capacity to maintain denial in the face of obvious reality in an otherwise nonpsychotic individual. An example follows.

An intelligent young college senior in expressive psychoanalytic psychotherapy was studying one day in her apartment in preparation for a final examination. There was a knock at the door—a door that she had chained. She opened it and a young man asked if she would take some political material. She indicated that she would, and he handed nonpolitical papers through the door. She commented on the fact that the papers
were nonpolitical. Then he said, “Well, can I use your telephone?” She
allowed him into her apartment to use her phone and then became aware
of the fact that he appeared not to be interested in where the phone was,
but was taking off his coat. She reminded him that the phone was in a
different direction than where he was moving, much to her later embar-
rassment, as she was not aware even then that his intent was to rape her.
Right before her realization that she had been denying imminent rape,
she said to him, “I am taking a final exam and you can’t interrupt me
now.” It was not until he had begun to disrobe himself and was moving
more menacingly toward her that she realized that he intended to rape
her. Utilizing self-defense training, she reversed the victim/attacker dia-
lectic and luckily escaped. She controlled her fear with positive affirma-
tions. She expanded her attention to a scanning mode, detached herself
into a self-observation position, and then confronted the attacker with
her intent to hurt him seriously even if she was killed in the process (cold
rage). These techniques will be described in a later paper.*

Although this particular vignette is rather typical of the degree
of the intensity of this quasi-psychotic denial, occasionally it can
reach even more extreme proportions. Another vignette will illus-
trate this.

A well-trained and experienced cottage parent in an industrial school
for violent boys allowed herself to be left on duty with the most violent
young man in her charge while other staff went off to lunch with the
remaining boys. In spite of commenting to supervisors that the shift was
understaffed, she responded to the male supervisor, with whom she was
having an affair, by capitulating and remaining; thus only two women
were on duty. The young man in question, who had been incarcerated
for murder and who weighed several hundred pounds in comparison to
her 100 pounds, did not go to lunch because of knee problems. She had
elected to stay with him since she had been criticized for not being
sympathetic enough to him. As the boys were leaving for lunch, one boy
asked, “Do you want me to stay with you?” She responded negatively.
The remaining charge sat under observation in the lunch room watching

*I have observed several times that such calm disembodiment is possible, even
in brief training exposure: a 60-year-old woman trained in self-defense tech-
niques was confronted in a parking lot when getting into her car. She immedi-
ately back-fisted the attacker on the nose. He collapsed in a pool of blood. She
then quite calmly ascertained that he was not dead and then she drove home. She
had no severe emotional response to this experience.
television, and then began to walk down the corridor. When questioned, he said, "You told me not to masturbate in front of everybody," thus indicating a level of sexual arousal already present. He then sat, mastur-
bating to a bra commercial, and complaining of knee pain. She felt an
ominous foreboding and a churning feeling in her stomach, with short-
ess of breath, and chills up and down her back. When alone, the dan-
gerous charge asked her to get him some shower shoes so that he could
get masturbate in private in the shower. She continued to feel a sense of
foreboding but still went down the hall with a feeling that she should not
get the shoes. The boy followed her to the shower room and began the
rape. She felt unable to resist him.

THE GIVING-UP/GIVEN-UP-ON SYNDROME

The Giving-Up/Given-Up-On complex was first described by
Engel and Schmale (1967) to illustrate psychosomatic and somatic
responses to disease. I have modified this model to apply to acute
violence.

Figure 1 illustrates the phases of this regression during violent
attack. What should be noted is that the steps are characterized by
strong affect, primarily of helplessness and hopelessness. I consider
helplessness to be a self-state in response to a perception of de-
pleted internal resources, and hopelessness, a sense of being failed
by others, that is, environmental as well as intrapsychic failure.
Additional factors are listed below.

1. The individual feels less intact, less competent, less in con-
trol, less gratified, and less capable of functioning in an auto-
nomous way.
2. Relationships with objects are felt to be less secure and grati-
fying and individuals may feel given up on by objects or may
themselves give up.
3. The environment appears typically unstable, certainly not an
environment of safety and is unpredictable and not useful as
a stabilizing frame of reference nor guide for current or
future behavior.
4. There is a loss of concept of future possibilities and an inabil-
ity to project oneself into the future with hope or confidence.
The future may appear bleak and unrewarding.
5. There is a tendency to revive feelings, memories, and behav-
ior connected with occasions in the past that had similar
affective charge. Affect seems to trigger the flashback, rather
### GIVING-UP/GIVEN-UP-ON SYNDROME

<table>
<thead>
<tr>
<th>Phases</th>
<th>Psychophysiology</th>
<th>Existential Dilemmas</th>
<th>Thought Processes</th>
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</thead>
<tbody>
<tr>
<td><strong>GIVING UP</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>DENIAL</strong></td>
<td>Homoeostatic balance.</td>
<td>Everything is alright.</td>
<td>Stable.</td>
</tr>
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<td></td>
<td>Tunnel vision. Focus on attacker.</td>
<td></td>
<td>Obsessive rumination.</td>
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<tr>
<td></td>
<td>Silence.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>REGRESSION</strong></td>
<td></td>
<td>I can't do anything about this.</td>
<td>Helplessness.</td>
</tr>
<tr>
<td><strong>FREEZE</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td><strong>RESIGNATION</strong></td>
<td></td>
<td>I have no future.</td>
<td>Hopelessness.</td>
</tr>
<tr>
<td></td>
<td>Tonic immobility.</td>
<td></td>
<td>Feelings and memories of helplessness and abuse.</td>
</tr>
<tr>
<td></td>
<td>Sleepiness.</td>
<td></td>
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<tr>
<td></td>
<td>Shaky knees.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Flaccid muscles.</td>
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<td></td>
</tr>
<tr>
<td><strong>SURRENDER</strong></td>
<td>I'm by myself.</td>
<td>Everybody has given up on me.</td>
<td>Thinking slows and is impoverished, uncreative.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>I deserve this, please get it over with, I can't stand it anymore.</td>
<td>(Feels deserted) (Feels worthless)</td>
</tr>
<tr>
<td><strong>DEATH</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>EXHAUSTION</strong></td>
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</table>

**Figure 1.** Giving-up/given-up-on syndrome.

than ideational material. Flashbacks of child abuse and deprivation, war, and accident traumata may be revived, especially if they have the trauma-bonded quality described by van der Kolk (1989).

Figure 1 illustrates how the physiological accompaniments, already described, interpenetrate and result in a situation that I have called resignation/surrender, a state of passive acceptance of death. As seen in reports of interviews with concentration camp
and hostage/torture victims, individuals often feel that they are not worth rescuing or saving and plead for a merciful euthanasia. The mind becomes essentially nonthinking and attentional focus is drastically narrowed. As Hyland (1978) pointed out in his excellent paper on “Death by Giving Up,” voodoo death and death by fright are not uncommonly reported. The literature is replete with reports of individuals who die at points of impasse when there is no hope of improvement. Recovery from this form of regression becomes more and more difficult with spiraling toward surrender. By the time the phase of resignation—surrender is reached, it is very difficult to reverse the situation without outside help or fortuitous circumstances. Psychological recovery from such a state may take many hours. An example of this follows.

A patient in psychoanalytic psychotherapy, who, while a tourist, had ill advisedly remained by herself in a rented house in Puerto Rico, was one evening attacked by a gang of young thugs who broke into her house, raped and slashed her with a knife. While they were pillaging the house, she was able to crawl into a closet and hide herself. Although not severely physically injured, she was able to elude the gang as they searched for her throughout the house. It was approximately 4–5 hours later that she felt sufficiently psychophysio logically reconstituted to crawl out of the house and obtain help.

In reviewing the literature described by Cohen (1988) concerning human behavior in death camps in World War II, it was clearly obvious that, especially in the medical experiments performed by the Nazis, the robot-like compliance (Musselman appearance) of the subjects indicated that they had reached this state of deep psychophysiological regression from which there was no recovery possible and no hope, and would passively “accept” the dreadful medical experiments and mass exterminations by chemical injection or gassing. This “Musselman” state was often induced by forcing inmates to perform the very atrocities that they or their loved ones had experienced.

A case in psychoanalysis may illustrate this point. A 65-year-old woman had been in psychoanalysis for the past 12 years, the latter 7 of which were with the author. During 13 of the early years of her life she had been a victim of perverse daily sexual abuse by her stepfather, confirmed by evidence of severe genital damage and scarring. There was also collusion by the mother who obtained sexual arousal by his ministrations.
The myth that he projected was that he was enlarging and improving her genitals so that when she married, sex would be more pleasurable to her. In treatment, this patient was so much a victim that it was virtually impossible to see her any other way. She had a constant look of submission and terror. At times she would fall out of her chair onto her knees in an abject submissive effort to have the therapist not hurt her with further interpretations and other forms of perceived insult and invasion into the private depths of her mind/genitals. She experienced much of the psychoanalytic work as a form of mental abuse similar to what she had suffered in the earlier phases of her life. The earlier phase of analysis of approximately 5 years' duration had not dealt with the sexual abuse at all. The analyst felt that she simply could not tolerate such horrors in her conscious mind. She had been treated unsuccessfully previously with tractotomy (an attempt to abolish intrusive suicidal thoughts connected with the abuse), Prolixin®, and numerous hospitalizations for psychotic illness. Actually that entire initial phase of analysis supported the idea implicitly that she was, in fact, a hopeless victim of circumstances and that she could not tolerate consciously remembering the abuse that she had suffered. She says of this time, "I had to contort my face and grab my hands so that they don't get in the way of the relentless moves and rhythm and head screaming. Have you ever longed for something with such intensity that you can't understand that no matter what you do, there is no silence, but hundreds of thousands of screams and you waiting?" These thoughts had gone through her mind each evening as she looked at her tear-stained Bible before her stepfather would come upstairs to take her down to the fainting couch (this analysis was not conducted on a couch, but in a sitting position) in the basement of the house for the nightly abuse. The transfer from her previous analyst to myself for continuing analysis five times a week involved a significant self-examination on my part. I knew early on from discussions with her previous analyst that failure to confront the victim role and his fears about it were causing a stalemate in the analysis. I felt confident enough to pursue this in spite of resistance by the patient, which included tears, screaming, throwing of objects, and suicidal gestures, until she finally talked about her own wishes and sexual enjoyment, including use of dildos and perverse implements in the continuing pursuit of the hoped for "perfect genitals." After 3 years of stormy treatment, she began to realize her grandiosity and its role in maintaining her unstable self-esteem with increasing transference rage. Her treatment was eventually quite successful and she was even able to see some positive aspects of the abusive stepfather, as is typical of patients who begin to integrate the bad and good, self and object representations. Although her life continues to
be quite impaired, she is living independently and has been able to divorce her husband of 40 years who was a replica of the stepfather, even to the point of perverse sexual abuse as part of their “normal, heterosexual relationships.”

This case illustrates graphically the ongoing spiral of surrender of the victim who has been “given up on” as well as having “given up.” This response to victimization has been described as “the dead mother” by Green (1986). He felt this response resulted from a serious depressive illness in the mother, as was evident in this particular instance. There is a devitalized passive, empty mother, a mother who is “dead” though still alive, resulting in chronic emptiness and low-grade depression in the patient. Green felt that in situations like this, instead of normal individuation, with a stabilization of self and object representations, the child “... relentlessly endeavors to retain the primary object and relive, repetitively, its loss . . .” (p. 167) characterizing this patient exactly, even to this day. Any loss, even recently the death of a close friend from cancer, was experienced as a reliving of desertion and rejection by the “dead mother”; a mother who was so bereft of good introjects that she is remembered as saying to this patient when she was quite young, “What ever goes on with your stepfather, you will put up with. I don’t ever want to have to work for a living again.”

Gabbard (1994a), in an elegant essay, expands the idea of “an uninvolved mother” (p. 311) to elucidate dissociative phenomena, particularly multiple personality disorder. Gabbard says, “In the absence of the maternal provision of soothing sensuous experience, the infant may not establish a secure feeling of sensory boundedness” (1994a, p. 313).

**DYNAMICS OF THE VICTIMIZER RESPONSE**

The literature is replete with examples of victimization and the phenomenological and psychodynamic sequelae of attack. But there is little available literature on the experience of being an attacker, primarily because such individuals do not often end up in any form of psychoanalytic treatment but tend to become regular residents of our prison system. In my observation, there is often a clearly demarcated boundary between an initial state of fearfulness and nervousness in the attacker, somewhat similar to
the initial stages of the victim's response, and then there is a dramatic shift in the attacker stimulated in part by the victim's response. Clinically, my observation has been that a fearful, submissive victim stimulates a response in the victimizer that appears to amplify an increasing spiral of grandiose attack responses and omnipotent fantasies. In an experiment by Marques (1981), 12 violent rapists were exposed to audiotapes of simulated rape situations while their penile circumferences were measured. The four experimental situations were: refusal with anger, plea for sympathy, an attempt to establish a relationship, and no resistance at all. The rapists were interviewed for their personal responses. Rapists described that a plea for mercy made them feel more sexually aroused, confirmed by the penile circumference measurements. The most striking result of the study was the dramatically high level of sexual arousal produced by the plea for mercy. The assertive refusal with anger produced decrements in arousal in 10 of the 12 subjects as measured by penile circumference. Other workers have confirmed these findings, for example, Richards et al. (1991).

A most dramatic example of the impact of passivity on the attacker is illustrated by reports of cannibalistic serial killings occurring in this country and in England. Besides the notorious U.S. case of Jeffrey Dahmer, a more literate and articulate case in England is that of Dennis Nilson, now serving a life sentence for murder.

Nilson was a highly intelligent civil servant, who at 37 years of age killed 15 men while seeming to live an exemplary life. He was also a Boy Scout troop leader and lay minister. After killing young men that he had initially drugged, he would have sex with the body and care for it until it became putrid at which point he would dispose of it by dismemberment and burial or by flushing it down the toilet. It was a blocked toilet that eventually led to his discovery. When interviewed about his attitude to killing and particularly his attitude to the Dahmer killings, he said that Dahmer always secretly wanted to be someone and in society felt he was a dispensable nobody. Nilson says, "He achieves 'sexual' fulfillment by acts of power of conquest to render the threatening potency of another man into the absolute and manageable state of passivity. He needs a total, unresisting passive model of a human being" (p. 186). Nilson felt that the serial killer's euphoria comes from the continuing exploitation
of the victim’s passivity. Extreme passivity here, of course, was the dead body representing what he called his “extreme power to possess” (Masters, 1991, p. 186).

Bennett (1993), an anthropologist who examined the gruesome remains of Dahmer’s victims, reported that Dahmer’s attorney noted that “he was always the aggressor with the men he met, usually very pretty men, almost boyish, willowy and effeminate” (p. 1228).

Fonagy and colleagues (1993), in a sophisticated formulation, hypothesized that in cases of senseless destructiveness, aggression may function as a defense against threats to the psychological (reflective) self. He argues that a defective upbringing, combined with constitutional factors, leads to the early use of aggression to organize the self. In later life, threats to the self result in reactive destructiveness instead of emotional relatedness and caring. Besides the well-recognized neurological component of loss of control of violent impulses, in some individuals the unique role of the victim in precipitating murderous aggression has long been recognized by Satten and colleagues (1960), who stated in an examination of four senseless murders committed, that: “when the victim-to-be is unconsciously perceived as a key figure in some past traumatic configuration . . . the mere presence of this figure results in a sudden extreme discharge of violence, similar to the explosion that takes place when a percussion cap ignites a charge of dynamite” (p. 52).

The dialectical interaction between victim and victimizer is too impersonal to be considered mere projection in the classical sense, but is closer to projective identification. Besides the role of projective identification in controlling and disavowing self and object representations, it is also a means of communication and a form of object relationship, albeit pathological, but perhaps better than none at all (Ogden, 1979). In these instances, the victim and attacker are seen to be involved in a barrage of projective identification and projective counteridentification. Ogden (1986) calls these projected parts “self and object suborganizations of the ego” (pp. 149, 150). In the case of Nilson, the dead, unresponsive victim does not act in any other way than a carrier of the attacker’s fantasy with the victimizer being in complete control. A living victim frequently feels a projective counteridentification in which he/she is under the control of the attacker and feels forced against
his/her will to helplessly act out the attacker’s wishes, as is often seen in chronic domestic abuse.

As already noted, that situation can reverse dramatically from time to time even in the same person, as the following case vignette of a patient in psychoanalytic psychotherapy illustrates.

A 35-year-old man who worked as a laborer was admitted after several serious suicide attempts, and was unresponsive to psychopharmacological polypharmacy. He would harass police by following them, tailing them, making notes on their behavior and otherwise interfering with their activities. It was as if he were attacking the police. The police would become angry at this and sit down with him, threaten commitment, and try to dissuade him from harassing them. He would then become suicidally depressed and usually overdose with medication. Here, the sadism produced an excited exhilaration that increased his aggressive acting out, possibly by mechanisms already described, after which he would become profoundly depressed and guilt ridden, and would then need to be punished. He commits the crime and administers the punishment. It was the rapid fluctuation between these two roles that eventually led him into psychoanalytic treatment.

In the case of a self-defense student, a dramatic role reversal was illustrated.

A young mother was involved in car-jacking incident. When she had stopped at a traffic light, a man jumped into her car and forced her to drive into the country where he raped her after menacing her with a knife. She submitted with all of the classical signs of resignation—surrender, until he turned his attention to her young daughter in the back seat. At this moment, she was able to overwhelm the attacker and severely injure him. At the time of his arrest, he was a cringing, submissive, pleading victim.

In this instance, the conversion of this woman from a helpless victim to an outraged and relentless attacker was initiated by the image of her child’s rape and mutilation. This woman described the obsequious, pleading, tearful, submissiveness of the victimized attacker as fueling her wish to sadistically and torturously punish him to the fullest extent of her most perverse and outrageous fantasies. To facilitate the constructive, outraged response in a situation like this, there must be an acceptance by the individual
of the possibility of his/her own death and a willingness to sacrifice his/her life to subdue the attacker.

RESCUER–VICTIM OBJECT RELATIONS UNIT

These roles can also alternate rapidly. The reaction of the attacker as omnipotent rescuer-savior seems to be primarily a reaction formation against the projective identification of the victim–self-suborganization of the victim into the attacker; the attacker’s reaction against experiencing the helplessness of the victim. For example, a case of a psychotherapy patient carrying a diagnosis of posttraumatic stress disorder:

A severely traumatized Vietnam-era veteran recounted torture sessions in which his torturer would offer him cigarettes, soothe him with liniment, and on occasion even cry as he screamed. One guard even helped him escape.

The victim as a rescuer (reaction formation against the abusing object projected into the victim rescuer) is illustrated in the abuse case of the individual being tortured, but who experienced overwhelming feelings of affection and caring for his torturer.

MARTYR–ATTACKER OBJECT RELATIONS UNIT

A martyr–attacker relationship is defined as one in which an individual feels that a higher cause is being served by the attack, that there is a purpose to it, and that purpose is on another, higher plane. There is an other-worldly and omnipotent quality to martyrdom. This is a common feeling in chronic spousal abuse as suggested by the following case.

A 35-year-old administrative assistant who was in expressive psychoanalytic psychotherapy and functioning at a high-management level, had associated herself in a prolonged relationship with a homeless individual who had severe alcoholism. Although she lived in an affluent part of the city, she would frequently visit him in skid row and sit along with his decrepit peers, allowing herself to be physically, psychologically, and sexually abused by all of them as if it was necessary to “save Marty from
himself." During the frequent rape of this woman by this unprincipled hoodlum, she would see him literally in her mind's eye as possessed by a "devil-like" entity and that by allowing him to continue abusing her, she was exorcising him. This relationship had led on more than one occasion to her near death from physical abuse, and was, as is usual, a reaction to a severely sexually abusive father. In all other aspects of her life, this woman functioned very well.

Another case example follows.

A young clerical worker in martial-arts training experienced acquaintance rape by a young African-American man who accompanied her home and proceeded to rape her. To enforce submission, he placed a pillow over her head. She felt that she had deserved the rape and felt guilty for being white. She "understood what he was going through and understood the hatred that he had built up against white people" because of "the misfortunes against blacks for all creation."

The attacker as martyr is sometimes seen in prisoners who express the fact that they deserve punishment and may be redeemed by it and purified by it; for example, the case (The Case of Steven Allen Butler, Time 1992) of a rapist and serial murderer who wished to be castrated as an example to others. I believe his lawyer helped him to eventually change his mind.

DETAILED OBSERVER-ATTACKER
OBJECT RELATIONS UNIT

In this situation, the victim experiences him/herself as in a state of detached self-observation: an altered mind/body perception that we have previously defined as the relationship between mind/body being spatially different (Gabard and Twemlow, 1984). This state is not depersonalization but seems to be an ego syncronic, defensive dissociation to protect the integrity of the self and object against the introjected, abusing-object suborganization of the ego, an out-of-body state. Like the out-of-body experience and unlike the depersonalization in the detached observer ORU, the observing self and functioning self are experienced as one (the physical body is inactive). The individual feels out of body. The experience is real, not dream-like, and is free of anxiety. It has no characteristic age group (unlike depersonalization, which is rare
over the age of 40). It has an even gender distribution (unlike depersonalization which has a 2:1 female gender distribution). This dissociation is healthy from the point of view of self-preservation, and thus is an adaptive equivalent of the uninvolved mother discussed by Gabbard (1994b).

As an example of this configuration, I will continue the narrative account of the case of rape of a staff member in a boys’ industrial reformatory.

When she became more confrontive with him and refused to cooperate, he hit her. As she saw stars, she realized that she was in great danger. He then masturbated himself to an erection with hair grease, smashed her face into the wall, and began to sodomize her. At that moment she entered a detached observer, out-of-body state. She was floating on the other side of the room, above and behind her body. She felt very sorry for that woman down there whom she recognized as herself. She had plenty of time while in this out-of-body state to plan her response after the rape. She recalled that staff would be back from lunch in 5 minutes, and she then planned to calm him down so that he would not feel desperate enough to kill her. She decided to feign love for him; she remembered that he had previously said to her that he knew she was turned on by him because she picked on him. Thus, when she saw him reach orgasm, she then reached forward and touched her own shoulder, reentering her body with immediately accompanying immense anxiety. She was able to carry out the plan she devised in the out-of-body state, however, and was rescued by staff members.

CONCLUSIONS

These relational patterns do not exhaust the possible object relations configurations between victim and victimizer; they merely represent those more commonly seen, at least in my clinical experience. Each configuration has conscious and unconscious elements, and if recognized by the analyst, specific steps can be taken to reestablish boundaries and terminate the spiraling regression so that these traumatic object relations units can be worked through. Patients in less exploratory forms of psychotherapy and those interested in self-defense who are not in treatment, need to recognize these configurations in themselves, so as to best prepare for self-protective responses to physical and psychological vio-
lence. In later articles I will explore specific details about how the self-protective response can be enhanced.

References

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