TREATING THE LESBIAN BATTERER: THEORETICAL AND CLINICAL CONSIDERATIONS

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I think that once hitting starts, a barrier is broken that afterwards is too easily crossed. What was once unthinkable behavior is no longer. Once hitting starts, it's like taking something precious and valuable and smashing it on the ground, and seeing it lying there broken and knowing it can never be repaired. (Lisa, p.38)

What possesses a woman to cross that barrier - to hit, smash, cut, kick, rape, humiliate, degrade, threaten, or possibly kill the woman she loves? To acknowledge the phenomenon of lesbian battering shatters mainstream assumptions about battering and women's capacity for violence; as a result, there has been a tendency for both clinician's and society at large to deny and minimize violence between women (Coleman, 1994). In order to understand lesbian battering and provide effective treatment for lesbian batterers, clinicians must have an understanding of lesbians and lesbian relationships, as well as a framework of personality development and an understanding of those critical factors that may predispose a woman to batter her partner. The need for such awareness is underscored by Wise and Bowman's (1977) findings in a study comparing graduate level counseling students' responses to a heterosexual (violent male) and a lesbian domestic violence scenario. The researchers found that lack of training regarding lesbian battering and a tendency to minimize lesbian violence considerably impacted participants' responses. Specifically, they found that participants were significantly more likely to rate the heterosexual scenario as more violent than the lesbian scenario and to charge the male batterer versus the lesbian batterer with assault. While these results can not be generalized to all training programs or the field at large, they reflect a lack of training regarding lesbian domestic violence and a bias among mental health providers in which heterosexual

domestic violence is frequently viewed as more serious than lesbian battering.

Violence in lesbian relationships defies traditional, heterosexist[1] ways of defining and understanding battering and demands that we take an individualized, multidimensional approach to partner abuse (Coleman, 1994). To effectively treat batterers, we must develop an understanding of the particular idiom of being (Bollas, 1992) that each of our patient's possess, while holding, on a meta level, an understanding of domestic violence that is informed by sociopolitical factors, social learning theory, family dynamics, physiological factors, and psychopathology (Coleman, 1994). This chapter will focus on the role of personality dynamics in lesbian battering. In particular, I will attempt to illuminate critical considerations in the treatment of lesbian battering by integrating theoretical constructs of personality development with attachment theory, affect regulation, shame, pathological vengeance, and variables specific to lesbian domestic violence. Finally, treatment considerations and two case examples will be discussed.

While I will be referring to various diagnostic categories as a framework to identify some of the personality dynamics involved in the perpetration of violence, in no way do I mean to imply that an individual's essence can be reduced to a diagnostic label, or that treatment should be *strictly* based on that label. Nor am I suggesting that all individuals who suffer from personality disorders are batterers, or that all batterers have personality disorders. Furthermore, in no way am I suggesting that lesbians have higher levels of pathology than other individuals.

Lesbian Battering and Characteristics of Batterers

In a recent review of the literature, Burke and Follingstad (1999) identified 19 empirical/quasi-empirical studies examining violence in same sex relationships, sharply contrasting the hundreds of studies that have examined heterosexual domestic violence. The

[1] the ideological denigration, denigration, and stigmatization of any non-heterosexual form of identity, relationship, behavior, or community (Herek, 1993, p. 89).

available literature suggests that the frequency and severity of lesbian battering is comparable with that of heterosexual and gay male battering (Coleman, 1991,1994; Burke and Follingstad, 1999; Waldner-Haugrud, Gratch, and Magruder, 1997). Researchers have found rates of physical violence in lesbian relationships ranging from 7% (Bryant & Demian, 1994) to 48% (Gardner, 1989). This wide range is due to several factors: differences in methodologies which makes comparisons problematic; difficulty obtaining a representative sample; differing definitions of abuse; and lack of differentiation between perpetrators and victims. In their extensive review of the literature, Burke and Follingstad (1999) note that larger sample sizes tended to result in lower percentages of violence, while those that reported very high percentages tended to have at least one design flaw that could inflate rates of reported abuse.

Overall, studies have found that like heterosexual domestic violence, lesbian battering is a significant problem with rates of verbal abuse typically exceeding those of physical abuse. Similarly, milder forms of violence, such as pushing, slapping, and punching, have been found to exceed rates of severe violence, such as striking with an object or use of a weapon (Coleman, 1991; Waldner-Haugrud, et al 1997; and Burke and Follingstad,1999).

Empirical studies examining the personality characteristics of heterosexual male batterers demonstrate variability in both typology and level of batterer pathology (Gondolf, 1999; Hamberger and Hastings, 1986, 1991; Tweed and Dutton, 1998). However, there are several consistent themes which can further inform our understanding of domestic violence. A number of studies have identified male batterers as having narcissistic (Gondolf, 1999; Hamberger and Hastings 1986, 1991; & Barnett and Hamberger, 1992), borderline (Hamberger and Hastings 1986, 1991; Dutton, van Ginkel and Landolt, 1996; Tweed & Dutton, 1998; Dutton, 1998); and antisocial (Gondolf, 1999; Hamberger and Hastings, 1986; and Tweed and Dutton, 1998) personality types. Researchers have also demonstrated a relationship between battering and avoidant, dependent, depressive, compulsive, and anxious personality traits (Gondolf, 1999; Hamberger and Hastings 1986, 1991; Tweed and Dutton, 1998).

Dutton and his colleagues have examined the relationship between borderline personality

organization, insecure attachment, post traumatic stress disorder (PTSD) and the perpetration of violence. Dutton (1998) has divided batterer typologies into three different groups: overcontrolled batterers, impulsive/undercontrolled batterers, and insturmental/undercontrolled batterers. Most of Dutton's research has focused on the impulsive/undercontrolled batterer, which he argues is the type most consistent with borderline personality organization and the cyclical nature of domestic violence in intimate relationships. In addition, Dutton (1995, 1998) has proposed that impulsive batterers have fearful attachment styles, which he reframes as angry attachment. He found that these men have personality profiles which include jealousy, chronic anger, and PTSD symptoms such as poor sleep patterns, dissociation, depression, and anxiety. Dutton's books The Batterer (1995) and The Abusive Personality (1998) summarize the results of his numerous studies and provide illuminating descriptions of heterosexual male batterers.

There are no empirical studies that have specifically examined the personality dynamics of lesbian batterers, however, clinical and anecdotal reports suggest that abusive lesbians have personality traits similar to heterosexual male batterers (Coleman, 1994). According to the available literature, lesbian batterers frequently feel powerless, have low self-esteem, tend to abuse alcohol and drugs, and are generally overly dependent and jealous (Leeder, 1988; Lobel, 1986; Schilit & Lie, 1990). Leeder (1988) noted that many lesbian batterers fear abandonment, have poor communication skills, tend to be self-absorbed, and are unable to empathically relate to their partners. Consistent with Leeder's descriptions, Renzetti (1988, 1992) found correlations between lesbian batterers' use of violence and levels of dependency, jealousy, and substance abuse.

In a summary of their clinical work with over 30 lesbian batterers, Margolies and Leeder (1995) reported that all of the women described their violence as an altered state of consciousness and their rage as akin to an adrenaline rush. They found that every batterer had experienced violence in their family of origin: almost all of them had witnessed abuse of their mothers, approximately 70% had been sexually abused, and 65% were physically or verbally abused. Typically, the women were quite appealing and charming, however, they all evidenced

low self-esteem, had difficulty expressing their feelings, and utilized splitting as a defense. Margolies and Leeder note that the batterers were extremely dependent on their lovers for attention and emotional support, which led to the batterers feeling controlled by their lover's ability to affect their feeling state and sense of self. At times, this led to a "childlike dependent rage" (Margolies and Leeder, 1995, p. 145). In some instances when a woman felt badly about herself or distanced from her lover, battering became a means of re-engaging and establishing intense contact. The authors observed that

> *"…the batterers' underlying feeling was a chronic fear of abandonment and loss. Avoiding those feelings became the organizing principle of their lives. Most violent incidents took place during threatened separations....Violence in these situations was an attempt to maintain connection to the lover, to hold her both physically and psychically. The batterer was lashing out to protect her fragile self from fragmentation and to avoid abandonment (Margolies and Leeder ,1995, p.145)."*

They also found that batterers had high levels of competitiveness with their lovers, and competed with others for their lover's attention.

In my experience, and as is reflected in the literature, there is not one specific batterer profile but rather a constellation of personality dynamics which may range from a specific personality disorder to a combination of various personality traits reflecting the mosaic of that person's distinctive being. As I have suggested elsewhere (Coleman, 1994), similar to male batterers, many lesbian batterers evidence personality characteristics consistent with borderline, narcissistic, or antisocial disorders. They may exhibit more than one disorder or present with a mix of various personality traits - such as depressive, dependent, passive-aggressive, or compulsive traits. Lesbian batterers with antisocial personality disorder comprise a distinct group and typically engage in criminal behaviors as well as intra and extrafamilial violence. Moreover, they generally do not seek treatment voluntarily. In contrast to batterers with antisocial personality disorder, those with borderline and narcissistic personality organization share a number of characteristics and are often more amenable to treatment. Consequently, I will

address the relationship between borderline and narcissistic character pathology and lesbian battering.

Personality Disorders

The borderline and narcissistic personality disorders are both rooted in early developmental failures resulting from maternal/caretaker misattunement and insecure attachment (Freed, 1984; Schore, 1994). Although there are dynamic and structural differences, these two disorders frequently overlap and many individuals with borderline personality disorder have narcissistic traits. Conversely, many narcissistic individuals have borderline traits. In addition, difficulties in regulating shame, fear of abandonment, and rage are common in both borderline and narcissistic disorders.

Because their capacity for self-soothing is severely compromised, individuals with borderline or narcissistic traits are prone to erupt with rage when faced with unmanageable affects such as anxiety, fear, or shame (Wastell, 1992; Wolf, 1988). At such times, the paranoid-schizoid position conceptualized by Klein (1946/1996) predominates and the individual experiences acute persecutory anxiety. In conjunction with this, the individual functions in a self-preservative mode and is unable to access emotions, behaviors and cognitions associated with species preservative behavior (Wang, 1997; C. Lillas, personal communication, October, 5, 1999). Thus, instead of being able to access feelings and cognitions associated with attachment, empathy, compassion and trust, the batterer "experiences the anger and fear of self preservation...in this state, violence can be inflicted upon others without remorse or conflict" (Wang,1997, p. 166). In both the borderline and narcissistic disorders rage and violence become a defense against fragmentation; however, the triggers underlying fragmentation vary based on personality structure. Prior to discussing the relationship between lesbian battering and each of these personality organizations, an overview of attachment theory, affect regulation, shame, and pathological vengeance is provided as a framework for considering aspects of development salient to lesbian batterers.

Attachment Theory and Affect Regulation

In recent years, a number of authors have begun to examine the role of attachment theory (Bowlby, 1973, 1988) in several areas which have significant implications for batterer treatment, such as attachment and psychopathology (Schore, 1994; Pistole, 1995; Fonagy et al., 1996; Sable, 1997; Dutton, 1998); affect regulation and attachment (Silverman, 1998; Midulincer, Orbach, and Ivanieli, 1998; Schore, 1994, 1997); assaultiveness and attachment style (Bowlby, 1984; Wallace and Nosko, 1993; Dutton et al., 1996; Dutton, 1998); stress and attachment (Wang, 1997; van der Kolk, 1996); and shame and attachment (Nathanson, 1987; Wallace and Nosko, 1993; Schore, 1994).

During infancy we build working models of the world and our self in relation to others. A key component of these models is our representation of attachment figures - who they are, where they can be found, and how likely they are to respond to us in times of need (Bowlby, 1973; 1988). This schema also includes a sense of one's value and acceptability in relation to the attachment figure. A "secure base" (Bowlby, 1973; 1988) develops when an individual experiences the presence of an available and responsive caretaker during times of distress. The consistent presence of such a caretaker, usually mother, creates confidence in the availability of others and in the self as worthy and valuable. The infant/child's working model of attachment is a set of conscious and unconscious "rules for the organization of information relevant to attachment and for obtaining or limiting access to that information, that is to information regarding attachment-related experiences, feelings, and ideations" (Main, Kaplan, and Cassidy, 1985, p. 92). In addition, Main, et al. note that these rules related to attachment are revealed in the ways an infant organizes thought and language. As summarized by Schore (1997), during "preverbal development, the infant constructs internal working models of the attachment relationship with his caregivers, and these representations, permanently imprinted into maturing brain circuitries, determine the individual's characteristic approach to affect modulation for the rest of the lifespan" (p.40). Although mother is generally considered the primary attachment figure, the internalized primary object is "a derivative of many experiences with actual others,

some occasioned by environmental stresses...[and] some determined by character disorders of the mother and the father that are condensed into distressed experiences" (Bollas, 2000, p.7). It is important to keep in mind that constitutional factors and innate vulnerabilities can significantly impact an infant's capacity for and quality of attachments. For instance, an infant who is constitutionally unable to tolerate delays in gratification will experience her mother as overly frustrating and withholding (Bollas, 2000), thus negatively impacting her internal model of attachment.

Attachment research examining infant and child reactions to separations from parents has identified four distinct typologies of attachment, one which is secure and three which are insecure: insecure-avoidant (dismissive); insecure-ambivalent (preoccupied); and insecure-disorganized/disoriented (Ainsworth, Blehar, Waters, & Wall, 1978; Main, et al., 1985; Main & Goldwyn, 1991 as cited in Fonagy, 1996). Upon reunion, after a period of brief separation, secure infants will seek comfort, proximity, and contact with the parent(s) and then return to play. Mothers of secure infants have been found to be responsive to their infants emotional signals and to permit access when their child seeks proximity (Ainsworth, et al., 1978; Main, et al., 1985; Schore, 1994). In contrast, "the mother of an insecurely attached infant does not instigate interactive repair nor does she initiate distress relief sequences. As a result, the infant remains stuck fast in stressful unregulated disorganizing states of unmodulated negative affect" (Schore, 1994, p.402). Schore argues that remaining in such a state negatively impacts orbitofrontal brain development leading to deficits in emotionality, affect regulation, and cognitive representational processes. In stressful situations, individuals with such deficits are unable to adaptively modulate their internal states and behavioral responses. In conjunction with other factors, such deficits predispose one to use violence as a means of self-regulation.

Insecure-avoidant infants actively avoid and ignore their parent, often moving away from the parent in what appears to be a defense against rejection (Main, et al., 1985; Schore, 1994). Although they may experience a subjective sense of anger, these infants did not openly express anger or distress (Schore, 1994). Mothers of insecure-avoidant infants are emotionally detached,

insensitive to their infants signals, and consistently reject their child's attempts at contact and proximity (Main, et al., 1985). In contrast to insecure-avoidant infants, insecure-ambivalent infants demonstrated anger and resistance combined with a desire for contact and proximity. However, attempts to comfort them were unsuccessful and they continued to express distress and were typically unable to be soothed. The infants ambivalent behavior was a response to mothers who were insensitive to their emotional signals and inconsistent in both physical and emotional availability (Main ,et al., 1985; Schore, 1994). This attachment style is frequently seen in the push-pull dynamics of batterers with borderline personality organization.

Main, et al. (1985) reported that insecure-disorganized/disoriented infants demonstrated 'dazed' behavior on reunion with the parent and appeared depressed, confused, or disorganized: they sought comfort and security and then became strongly avoidant. These infants also displayed contradictory behavior patterns, such as approaching the parent with their heads averted or gazing strongly away while in contact with the parent. When interviewed, the parents of these infants evidenced repeated positive-negative oscillations in viewpoint, a refusal to remain on the topic, and irrationality. In their follow-up study of attachment style at 6 years of age, Main, et al. (1985) found that upon reunion these children "seemed to attempt to control the parent, either through directly punitive behavior or through anxious, overly bright 'caregiving' behavior (inappropriate role reversal)" (p.83). I suspect that these behavioral patterns may later be seen in the charming, caretaking behaviors evident in many batterers.

Lachmann and Beebe (1997) propose that an individual's organization of experience and social relatedness is based on "the simultaneous influences of mutual and self-regulation (p. 93). In mutual regulation "both partners actively contribute to the regulation of the exchange, although not necessarily in equal measure or in like manner" (Lachmann and Beebe, 1997, p.93). Self-regulation implies a capacity to self-regulate states of arousal and to predictably organize one's behavior. Through the mutual regulation process involved in healthy, secure attachments, individuals are able to develop self-regulatory functions that enable them to self-soothe under situations of stress (Silverman, 1998). This sets the stage for adult relationships and for one's

ability to integrate early emotional experiences, to organize a coherent sense of self and others, and to communicate effectively with others. Thus, under conditions of stress, an infant, child, or adult who has developed a secure base is able to utilize effective coping mechanisms to regulate their affective experience (Mikulincer, et al., 1998; Silverman, 1998) and manage the situation without becoming overwhelmed and dysfunctional.

Bowlby (1973) observed that children and adolescents who experience repeated separations, threats of separation, and other rejections display both anxious and angry behavior. Schore (1994) has explicated the role of anxious attachments and affect dysregulation in the development of borderline and narcissistic personality organizations. He describes that an individual with either of these disorders is unable to access symbolic representations necessary for self soothing: "due to a preponderance of shame-imprinted interactive representations of the self-in -interaction-with-a-misattuned-other, their ability to autoregulate affect is fundamentally impaired. Both of these primitive emotional disorders are particularly ineffective in regulating shame" (Schore, 1994, p. 429).

Shame

Although controversy exists regarding the age at which shame develops, there is evidence to suggest that the earliest triggers for shame are in the misattunements of the attachment relationship (Schore, 1994; Broucek, 1997). While a healthy level of shame plays an important role in socialization, excessive or inadequate shame can become pathological (Schore, 1994; Hibbard, 1994). Pathological shame significantly disrupts an individual's ability to develop a cohesive, stable sense of self and is a central component of rage and violence (Dutton, 1995; Balcom, 1991; Hockenberry, 1995; Wallace & Nosko, 1993).

Broucek (1997) proposed that, initially, shame is due to an experience of failure "to initiate, maintain, or extend a desired emotional engagement with a caretaker" (p. 44). The disrupted flow between caretaker/mother and baby results in an early experience of shame related to feelings of failure and rejection. Thus, insecure infants will have experienced an

inordinate amount of shame states in their attachment relationships. In addition, shame has been correlated with experiences of trauma such as physical and emotional abuse, neglect, and abandonment (Dutton, vanGinkel, & Starzomski, 1995; Hockenberry, 1995; van der Kolk, 1996). As noted by van der Kolk (1996),

> *"…shame is critical to understanding the lack of self-regulation in trauma victims and the capacity of abused persons to become abusers...Denial of one's own feelings of shame, as well as those of other people, opens the door for further abuse. Being sensitive to the shame in others is an essential protection against abusing one's fellow human beings, and it requires being in touch with one's own sense of shame. The resulting disorganized patterns of engagement are commonly seen in traumatized people who suffer from borderline personality disorder (p. 15)."*

According to Morrison (1999), "shame is that feeling about ourselves of failure, worthlessness, defect, filth, weakness, that makes us feel isolated, different, unlovable" (p. 92). Hibbard (1994) suggests that in normal levels of shame libidinally determined, inhibitory, and self-esteem attenuating components predominate; whereas in pathological shame aggressive, persecutory, and humiliating shame components predominate. Often in love relationships early shame states are either consciously or unconsciously triggered resulting in shame-rage and defensive maneuvers which are abusive. Shaming experiences are a painful assault against the self and typically lead to states of "shame-rage" or "humiliated fury" (Lewis, 1987). Such rage is "a protective, retaliatory attack aimed at wiping out the offending 'other'" (Morrison,1999, p.93). Another defense against shame is contempt which when combined with rage creates fertile ground for battering. In contempt, the individual projects her experience of shame onto her partner, or another, who is then devalued and denigrated (Morrison, 1999). Although shame develops out of interactions with others and often occurs in front of others, Morrison proposes that once shaming self-object experiences have been internalized shame can be internally induced without the presence of an external other. Many batterers experience feeling shame that

is internally provoked. Frequently, this shaming internal object is then projected onto the batterer's partner who is then experienced as inducing the shame.

In a study examining the effects of shame, guilt, and abuse on male perpetrators' use of violence, Dutton, et al. (1995) found that shaming experiences in conjunction with parental abusiveness were necessary to account for an individual's later assaultiveness. In other words, when shaming experiences were absent, parental abusiveness had no significant correlation with adult assaultiveness and when parental abusiveness was partialled out, shaming experiences were no longer significantly correlated with abusiveness. The researchers also found a significant correlation between recollections of shaming experiences and borderline personality organization (measures of narcissistic personality organization were not included in the study). Based on their findings, Dutton, et al. propose that shame and guilt may develop the abusive-prone personality, but the modeling of abusive behavior is a necessary second step for becoming abusive.

Shame is a particularly salient issue for lesbians. During development and throughout life, lesbians must battle misogyny, homophobia, and heterosexism. Kaufman and Raphael (1996) propose that homophobia (an irrational fear of, hatred for, or aversion to anyone lesbian/gay or to aspects of lesbian/gay lifestyle) results from the magnified effects of shame, disgust, dissmell, and contempt. In lesbian battering, conscious or unconscious internalized homophobia can contribute to a batterers negative affect states and bad internal objects which increase her vulnerability to shame, shame-rage, disgust, contempt, and dissmell. These shame states may then be projected onto one's lover, who is then attacked and denigrated.

In conjunction with homophobia, heterosexism is an ever-present form of cultural abuse which leads to shame and a devalued sense of self, similar to the effects of sexual and physical abuse (Neisen, 1993). Frequently, girls who will eventually identify as lesbian (or bisexual) grow up feeling different and experience great shame about this dissimilarity. In general, neither heterosexual parents nor society mirror homosexuality, which is an integral component of a lesbian's self-experience. In addition to experiencing a lack of mirroring, many lesbians are also actively devalued, humiliated, or rejected (either directly or indirectly) by both family members

and others in society. Thus, experiencing homophobia and heterosexism, along with their internalized components, adds another dimension to shame and the perpetration of violence.

Pathological Vindictiveness

In their description of the effects of homophobia and heterosexism, Kaufman and Raphael (1996) note that humiliation breeds vengeance, and powerlessness magnifies it. In addition to insecure attachments, poor affect regulation, and shame-rage, I have found that batterers frequently manifest pathological vengeance. Although "normal" vindictiveness and a desire for vengeance is a common human reaction to injury and injustice, for the pathologically vindictive person revenge has an addictive quality and it becomes a central organizing principle (Daniels, 1969; Feiner, 1995; & Steiner, 1996). Such pathological vindictiveness can contribute to and enhance the addictive quality of battering and the cycle of violence.

Similar to shame, pathological vindictiveness is rooted in early experiences of humiliation, frustration, deprivation, powerlessness, rejection, and dismissal (Daniels, 1969; Feiner, 1995; Steiner, 1996). One way of conceptualizing vindictiveness is that it develops as a result of the splitting that occurs in an attempt to preserve the good object. As described by Steiner (1996),

> *"…when the self, the good object, or the relationship between them is injured, it is the good object that seems to demand revenge and the patient feels it is his duty to respond as a means of restoring and preserving the lost idealised relationship....Revenge is the antithesis of forgiveness and the patient insists that the object cannot be let off the hook until it has been forced to confess and atone for the injury done. (p. 434)"*

Searles (1965) emphasizes the role of vindictive fantasies as a defense against grief and separation-anxiety, resulting from ruptures in the attachment relationship, which psychologically serves to maintain the self-other bond. Although pathological vindictiveness may initially evolve out of a child's repeated aggressive attempts at getting back the lost object, "to force the

parent to love him again" (Daniels, 1969, p.193), it

> *"…ultimately become[s] an end in itself, nonetheless retaining, in some psychic realm out of awareness, its original aim - reunion with the evanescent loved one. And, in extreme cases, reunion is purchased at the price of the ultimate merger: the death of the rejecting loved one and the death of the vengeful, rejected suitor (p.183)."*

Hence, pathological vengeance is often a central issue underlying the stalking behavior of batterers. Although pathological vengeance is a key dynamic for many batterers, narcissistic batterers are particularly prone to such vindictiveness. As articulated by Schulte, Hall, and Crosby (1994), "self righteous rage requires revenge, or punishment of the offender, in order that humiliation is repaired and a sense of self, although infantile and grandiose, can be reinstated" (p.611).

PERSONALITY ORGANIZATION AND BATTERING

Batterers with Borderline Personality Organization

Although there continues to be controversy about whether borderline personality disorder is a distinct diagnostic entity or a broad category between psychosis and neurosis, there are a number of characteristics which are common to individuals with borderline personality organization. One key feature is that individuals with borderline personality structure are highly conflicted in their relationships and vacillate between a fear of being engulfed when close with another and an experience of catastrophic abandonment when they experience separateness. Sable (1997) suggests that borderline pathology may develop out of caregiving that is anxious and intrusive or conversely distant and dismissing, or a combination of the two.

Other common features of borderline personality organization are: poor boundaries; lack of a clear sense of self; poor impulse control; lack of frustration tolerance; poor reality testing under stress; need for immediate gratification; lack of an ability to self-soothe; fragile self-cohesion; deficits in superego functioning; affect regulation difficulties; an absence of empathy;

dramatic shifts between idealization and devaluation; and lack of a capacity to form stable self and object representations (Goldberg, 1990; Grotstein, 1987; Sable, 1997). These individuals undergo state transitions that can be extremely instantaneous and traumatic - "phenomenologically it is experienced as a precipitous entrance into a shame-associated chaotic state" (Schore, 1994). In quoting Lansky, Schore notes that individuals with a borderline disorder are remarkably compromised in their capacity to regulate shame: "most of the defensive operations of borderline patients are reactions to their shameful self-consciousness among others. Borderline patients are exquisitely humiliation prone. They have a pronounced tendency to experience others as deliberately inflicting shame on them" (Lansky, 1992, p. 37 as cited in Schore, 1994, p. 416).

Object-relations theorists have conceptualized borderline personality disorder as developing in response to severe difficulties during the process of separation-individuation (Goldstein, 1990; Mahler, Pine, & Bergman, 1975). Brown (1990) proposes a revision of Klein's (1946/1996) depressive position, based on current knowledge about infant maturation, in which the depressive position would begin around 14 -16 months and be renamed the "depressive position proper." He suggests a "transitional position" between the paranoid-schizoid position and the "depressive position proper" which coincides with Mahler's differentiation and practicing subphases of the separation-individuation process. Brown postulates that borderline personality organization arises from difficulties in the transitional position which leave the individual "stuck at a maturational point at which they feel neither confused with the object nor do they feel themselves fully distinct from the object" (p. 508). Manic defenses predominate in this position and Brown notes that "the more manic defenses figure into the overall configuration of a borderline's defensive structure the more likely is that individual to appear narcissistically organized in terms of attitudes of triumph and contempt towards the object" (p.508). This type of structure is frequently seen in individuals who batter.

Self-cohesion is extremely fragile for lesbian batterers with borderline personality organization and they lack effective affect-regulation. As a result, seemingly minor disruptions

or psychic injuries in relation to their partner can lead to fragmentation (Coleman, 1994). As a result of early experiences and environmental influences, such as witnessing or being the victim of domestic violence, rage and violence become one way batterers defend against fragmentation. Other common borderline defenses frequently used by batterers, include: splitting, omnipotent control, idealization, devaluation, and projection (Goldstein, 1990; Ogden, 1979).

Abandonment fear is a central issue for batterers with borderline personality organization. Although these individuals tend to seek merger with their partner in an attempt to avoid either real or perceived abandonment, merger leads to loss of self and fears of engulfment (Coleman, 1994). In addition, closeness intensifies their feelings of need and the fear of abandonment, resulting in periodic episodes of withdrawal (Goldstein, 1990). Individuals with borderline character structure are caught in a constant state of tension between closeness and distance - this is the adult version of the insecure-ambivalent infant, and possibly the insecure-disorganized infant. Krestan and Bepko (1980) have suggested that in an attempt to create distance and avoid the stimulation of abandonment fear, lesbians may resort to the use of verbal or physical fights.

Wolf (1988) has conceptualized individuals with borderline personality disorder as "merger hungry personalities" who merge with their partner in lieu of maintaining their own self-structure (p.74). Batterers with borderline pathology are prone to becoming enraged by their partner's attempts at separation and independence, resorting to violence in an attempt to avoid fragmentation and abandonment depression by controlling her and assuring her continued function as a selfobject. In addition, manipulative, self-destructive behaviors, such as threats of suicide, may be used as a means to control one's partner. One way I have conceptualized these dynamics in relation to the cycle of violence (Walker, 1979) is as follows: the beginning of the relationship is typically marked by idealization of the love object and pressure from the batterer for increased closeness/merger. This is then followed by a threat to the batterer's self-cohesion, either related to fear of abandonment or fear of engulfment, which stimulates the internal representation of the bad object. In an attempt to protect and maintain the good internal object, the bad object representation is projected onto the battered partner who is then attacked. During

the honeymoon phase there is a return to merger with the good object, which provides the batterer with the needed self-object and leads to restabilization of the self (Coleman, 1994).

In general, during the honeymoon phase the batterer is apologetic, remorseful, and makes promises of change. At the same time she typically blames her lover for her abusive behavior. Many batterers genuinely feel remorse and regret; however, rather than being motivated by true guilt and a desire for reparation characteristic of the depressive position, they are typically motivated primarily by shame and a desire for reunion with the good object. As noted by Wallace and Nosko, guilt "requires an ability to enter into and empathize with the other as an individual to whom harm has been done" (p. 49). Although batterers may have moments of such guilt, concern for the object cannot be sustained.

In lesbian relationships, struggles around intimacy and autonomy may be intensified as a result of how girls are socialized to define themselves in relation to others (Chodorow, 1978). Thus, women typically have less rigid ego boundaries and a greater capacity for identification with others (Burch, 1986). Elise (1986) has observed that "the lesser degree of differentiation of the female ego may result in a greater capacity for the lesbian couple to relate intimately, but also leads to a tendency for the couple to become more intrapsychically merged" (p. 309). This propensity toward merger may also be increased by the small size and minority status of the lesbian community - which lends itself to becoming a closed system (Coleman, 1994). Consequently, there is an increased potential for dependency and loss of individual identity. As previously mentioned, internalized homophobia, heterosexism, and misogyny can lead to feelings of shame, powerlessness, and self-hatred which may then be projected onto the battered partner. Through projection, the batterer is able to rid herself of unbearable affects and intolerable shame states. This defense is readily identifiable in the batterer's devaluation, contempt, and shaming of the battered partner.

Case Example - A

Maria, a 34 year old Latina Lesbian, came to me for psychoanalytic psychotherapy at the

urging of her friends. She had been obsessing about and threatening to kill her ex-lover. Although the majority of Maria's abusiveness had been in the context of intimate relationships, she had engaged in criminal behavior up until her mid-twenties. Furthermore, she had an ongoing history of assaulting friends and acquaintances when she felt abandoned or disrespected by them. Maria owned a gun and just prior to beginning treatment had demanded it back from a friend who had been "holding" it for her. When I went to greet Maria in the waiting room for our initial consultation, I was met with hostile glares and a swaggering, tough persona. The first several sessions were quite tense and Maria vacillated between expressing a desire for me to help her with her homicidal ideation and proclamations about how the "bitch deserved to die" and there was no point in trying to stop her. During the first two years of treatment there were often such vacillations, combined with frequent testing of me, our relationship, and the treatment frame. After gaining some confidence in me and our work together, Maria agreed to have a friend hold her gun. I strongly recommended that Maria also participate in group treatment, however she refused. In response, I told her that I was not certain that individual therapy alone would be effective, but that we could start at twice a week and then re-evaluate. She agreed and we began a treatment plan that included dynamic exploration and didactic work on violence and anger management.

Maria grew up in a second generation, middle class Latino family with two older step-brothers and two younger biological siblings. Her father was a dentist and mother a school psychologist. It soon became clear that the way her family appeared to the external world was very different from what happened within the family. At home, Maria witnessed a great deal of domestic violence and was also the victim of her father's violent rages. During the early phases of treatment, Maria would angrily vent about her hatred of her father. Her parents had divorced when Maria was a teenager and she had not seen him in many years. She described numerous incidents in which he severely battered her mother, chased and beat up her brothers, whipped her, and killed two family dogs. Her father's verbal abuse was virtually constant and he frequently shamed Maria and her brothers. He also deprived them of food and adequate

clothing.

For at least the first two years of treatment, Maria's descriptions of these incidents were devoid of any affect other than anger; she was completely cut off from any experience of terror, pain, or shame. Her relationship with her mother, while fraught with anger, was much more ambivalent - ranging from erupting in rages when spending time with mother to idealizing her and seeking support from her. Maria's anger toward her mother stemmed primarily from experiences of abandonment - mother choosing father over protecting the children, buying special gifts for the other children but not for Maria, and minimizing Maria's physical and emotional pain. There had also been numerous ways in which mother was, and continued to be, overly intrusive and controlling.

There was a family history of mental illness and Maria's mother had been hospitalized several times for psychotic episodes - however, she had always refused treatment. Mother was hospitalized on two occasions during Maria's treatment and each time was fraught with much confusion. Maria was aware of her mother's paranoid thinking and at the same time would become merged with her mother in her beliefs about the medical and psychiatric establishment; she felt that she must somehow rescue her mother. At the same time, Maria found herself fraught with anxiety about her own stability as she continued to rely a great deal on her mother emotionally and financially.

In conceptualizing Maria's early attachment relationships, she demonstrated traits consistent with both insecure-ambivalent infants and insecure-disorganized/disoriented infants. Maria's experiences of being shamed and abused by her father were central in her use of violence as a means of self-regulation. Her early attachment relationship with mother, as well as later experiences of abandonment and shaming by mother, were dominant in her underlying depression and propensity for fragmentation. For Maria, identification with the aggressor, her father, was a primary means of escaping intolerable affects related to shame and abandonment, as well as a means of feeling power and control. This would often be demonstrated in manic, omnipotent "highs" in which Maria would contemptuously devalue and taunt women whom she

felt had “wronged” her. This is consistent with Brown’s (1990) conceptualization of individuals with borderline personality disorder as being stuck in a transitional position between the paranoid-schizoid and depressive positions. Underlying Maria’s omnipotent aggression was a great deal of shame. On many occasions, she stated that backing down from an altercation made her feel like a “wimp...I hate myself for acting afraid...I’ve gotta show them I’m not gonna take that crap.”

Maria’s relationship history was fraught with conflict and disappointments. In virtually every relationship her verbal abusiveness had quickly progressed to physical assaultiveness. Although Maria’s violence during her early 20's was often linked with drinking alcohol, her abusiveness continued after she joined Alcoholics Anonymous and stopped drinking. Prior to coming to treatment, Maria’s homicidal ideation developed after a relationship ended and she experienced feeling “completely abandoned” by her ex. lover, Annabelle. In addition to being hurt and angry about the break up, Maria felt that she had been replaced Annabelle’s new friends.

Initially, Maria would become enraged and defiant when I suggested exploring the feelings underling her rage. Gradually, I realized that this was partly due to the fact that she lacked an ability to identify and express her feelings; thus, my desire to explore and help her identify the underlying issues was experienced as a invitation to be shamed and humiliated. In addition, exploring these issues meant having to own and integrate her split off and projected bad objects and bad object experiences, such as powerlessness, shame, contempt, disgust, devaluation, pain, and terror. Maria would also become enraged whenever I would refer to her homicidal ideation as her “fantasy” about killing Annabelle - there was no difference for her between fantasy and reality; no capacity for symbolic representation or play.

As Maria’s homicidal ideation began to resolve she became extremely depressed and suicidal. There were also some psychotic symptoms, hearing voices and paranoid ideation; which is not uncommon in individuals with severe borderline personality disorder. She agreed to a medication consultation and found an antidepressant, which regulates both dopamine and

serotonin, to be quite helpful. In addition, there were times when she benefitted from a mild dose of anti-psychotics.

Treatment began twice weekly, with one session devoted entirely to addressing her violence through Sonkin and Durphy's (1982/1989) handbook - Learning to Live Without Violence - which we adapted for gender. I also included exercises from a variety of other sources and created a relaxation tape for her to use at home. In sum, the didactic work combined readings on violence, stress, timeouts, assertiveness, and feelings, with anger logs, anger intervention worksheets, identification sheets (ex. identifying use of threats, intimidation, emotional abuse, etc.) and the Iceberg Exercise
(this exercise is described in the section on Treatment Considerations).

The integration of these didactic exercises with psychodynamic psychotherapy provided Maria with a structured holding environment, which enabled us to explore her family and relationship dynamics, as well as issues related to homophobia, heterosexism, and racism. While much of Maria's violence was rooted in her family's dysfunction and abuse, she also struggled with shame around her sexual orientation and ethnicity. During both elementary and junior high school, Maria was made fun of for being different. She described herself as having been the "typical tomboy." She articulated that she had always been male identified and considered herself to be a "butch" lesbian. She didn't dress like all the other girls and she didn't tend to socialize with the other little girls in the neighborhood. In addition, Maria was often the brunt of racist jokes. As a result, she struggled a great deal with her ethnic identity and typically preferred spending time with, and was attracted to, women from other racial/ethnic groups. However, as she began to integrate various aspects of herself and her racial background, Maria found herself more attracted to other Latinas.

Another important dimension of the treatment was helping Maria to affectively access and address her early trauma and then cognitively link these experiences with her assaultiveness. This was extremely hard for her because getting in touch with early experiences of pain and longing felt inordinately shameful. Furthermore, tolerating vulnerability was quite difficult for

Maria. In addition to addressing the defensive function of her violence, we repeatedly discussed the ways in which Maria experienced her rage and violence as a "high." There was an addictive quality to her abusiveness that was self-reinforcing - making it a difficult cycle to break. Gradually, she was able to affectively recall incidents of being abused by her brothers and father, as well as desperately having wanted her mother to intervene to no avail. Other situations included times that she was blamed for getting injured when abused and then humiliated for crying. For instance, once her father broke her hand and she was shamed and blamed for crying and making a "big deal" out of the incident.

While there were many important variables in Maria's treatment, I believe that the core of our work together was in the mutual and self regulatory aspects of the therapy. Early on in our work together, Maria began to ask questions about my life and my relationship. My typical style is to ask patients to reflect on such questions and for us to use them as a window into their internal world. However, Maria could not tolerate such a stance - she became anxious, demanding, pouty, and threatening. I realized that I needed to shift my analytic stance considerably and provide a relational experience in which she could use me as an idealized self-object. Responding to her questions directly and openly was very effective and over time Maria began to tolerate more reflection and exploration. She also began to develop a capacity for fantasy and play in the treatment relationship.

At one point during the treatment, she tenaciously began testing the boundaries of our relationship - requesting that we go for walks instead of staying in the office and demanding that I take her camping. She became very frustrated by my refusals to give into such arrangements and at times was quite threatening. Slowly I began to engage her in fantasizing about what such experiences might be like. Gradually, Maria was able to start to express these desires in the form of fantasy and then to elaborate on the fantasy; for instance, we would take a walk and I would buy her ice cream, or she would be my baby and my partner and I would set limits on her tantrums, and raise her lovingly.

Much of our work around transference-countertransference dynamics centered on

separations. In general, tolerating the breaks between sessions and vacations was very difficult for Maria. It would have been ideal if Maria had been able to attend sessions more than twice a week; however, I believe these core dynamics would have been played out regardless of frequency of sessions. For the first few years, my vacations were fraught with regulatory problems and provided fertile ground for violent explosions in my absence. On one occasion, Maria ended up in jail for assaulting a woman who had ended their brief dating relationship. Over the years, we did a great deal of work on anticipating vacations and developing ways that Maria could access her good internalized object representation of me during separations. We created a safety plan which helped her to recognize any escalating potential for violence and identify appropriate steps to get support. This improved her frustration tolerance and impulse control, and reminded her of our connection.

As in the course of any treatment, we had numerous incidents of disruption and repair. One key enactment occurred at the end of a session when all of a sudden (so it seemed at the time) Maria refused to leave my office. She began taunting me with "what are ya gonna do if I don't leave?" and " you can't make me leave.....there is nothing you can do." She also threatened to destroy my office and to return and burn down my office building if I tried to have her forcibly removed. In response to her bullying behavior and threats I found myself experiencing a range of emotions. Initially, I was quite anxious and fearful about my safety, and worried about what she might do once I did get her leave my office. I was also worried about my next appointment and uncertain about the best way to handle the situation. For several minutes it seemed as if I could do nothing right. I felt powerless, ineffective, and afraid. Gradually, I also began to get quite angry and I had to take a few minutes to calm down and reflect on what was happening.

Thankfully, I was able to re-engage some of my reflective capabilities and recognize that underneath Maria's threatening and abusive behavior was fragmentation due an inability to regulate her intolerable affects and bad internal objects which were being stimulated as a result of the ending of the session (and my impending vacation). Finally, I was able to articulate that

she must be feeling very frustrated and angry about the ending of our session and the fact that I had another appointment. I wondered aloud if perhaps she was feeling unimportant and imagined that I did not truly care for her. In response Maria stormed out leaving behind a hail of verbal threats. Remarkably, she called a short time later and left a message on my machine apologizing and assuring me that she did not mean the things she had said. We were able to process this enactment in several subsequent sessions - using it to better understand the dynamics embedded her early experiences and how these played out between us, as well as with others.

Frequently, when overwhelmed by her dependency needs and the pain of separation, Maria utilized projective identification - inducing terror, shame, confusion, and powerlessness in the other. When we discussed the aforementioned rupture, Maria was able to take in my acknowledgment of having failed her by missing subtle signs of her distress. She was then able to hear and acknowledge the ramifications of her temper tantrum in terms of my experience. Maria expressed feeling badly about her hurtful behavior and worried that she could or would do something to ruin our relationship. I had always been very clear with Maria that although I valued her and our relationship, I could not work under conditions of threat or abuse. I considered her expression of worry and remorse, in conjunction with the shifts occurred subsequently, as indicative of movement toward the depressive position. This was in contrast to her previously relating almost exclusively from the paranoid- schizoid position, where there was no true empathy or concern for others.

Play was another important aspect of self and mutual regulation in the treatment. Maria had a good sense of humor and through play we were able to address many issues that would otherwise have been too shame laden for her to acknowledge. For instance, sharing examples of some of my own feelings when angry or scared created a space where I could joke with her about how she protected herself with the "gunslinger her." At times, I would playfully imitate her glares or her tough posturing to give her a flavor of how she presented. In response Maria would laugh in acknowledgement and express feeling glad that I had lovingly seen through her defenses. In combination with the Iceberg (Volcano) Exercise [see treatment section], this

created a space where we could talk about the protective nature of her defenses and the affects underlying them.

Another salient segment of the treatment occurred when Maria began to have mixed feelings about a new supervisor at work. She felt attracted to this woman and had developed a "crush" on her. However, she also felt unappreciated and mistreated by her supervisor. She began to have vengeful fantasies of "getting back" at her by physically and sexually assaulting her. I told Maria that I sensed there was something very important for us to understand about these revenge fantasies. I suggested that her feelings of powerlessness and her desire to make her supervisor feel vulnerable and helpless were rooted in earlier experiences of being treated unfairly and feeling vulnerable and powerless. In response Maria began to recall times she had been mistreated and abused by her father and brothers. In contrast to previous recollections of these memories, this time Maria was able to access the feelings associated with those incidents.

For example, in session Maria re-experienced sitting at the dinner table as a young girl and having two of her brothers kick her so hard and so many times that she had bruises up and down her shins. In spite of her crying and pleading with her parents to stop them, Maria's mother told her to "shut up and stop whining" and then sent her to room without dinner. In re-experiencing this abusive incident with me, Maria was able to have a new object experience in which her both feelings and the injustice of the situation were mirrored and validated. However, shortly thereafter she was flooded by her shaming and condemning internal objects for being "a stupid, weak baby." Furthermore, Maria felt humiliated that she had shown me this weak and vulnerable part of herself. We were then able to discuss this characteristic pattern in which her internal saboteur (Fairbarin, 1952) attacks and humiliates her vulnerabilities and attachment needs. These dynamics needed to be addressed and re-lived between us many times before new patterns of object-relating were firmly established, enabling Maria to self-regulate without utilizing her defensive, abusive behaviors.

Batterers with Narcissistic Personality Organization

Similar to borderline personality organization, the specifics regarding the etiology and diagnosis of narcissistic personality organization remain controversial. Individual's with narcissistic character organization fall between the borderline and neurotic in level of psychopathology (Goldstein, 1990). Although these individuals are considered to have better ego functions that those with borderline personality organization, they exhibit very fragile self-esteem, are prone to shame-rage when narcissistically injured, and utilize primitive defenses, such as splitting, devaluation, idealization, omnipotence, and projection. Other characteristics central to narcissistic personality organization include: grandiose self-importance; constant need for admiration and affirmation; hypersensitivity to criticism; lack of empathy; interpersonal exploitation; a need for power and success; a sense of entitlement; feelings of envy; and arrogant or haughty behaviors (DSM-IV, 1994; Rosen, 1991). Although not all batterers have a narcissistic personality disorder, many of these traits are frequently seen in individuals who batter.

Some authors hypothesize that narcissistic personality structure - in which self and object representations are fused - results either from a fixation during the symbiotic phase of development or as a result of regression to symbiosis due to unsuccessful negotiation of separation-individuation during the rapprochement phase (Freed, 1984; Masterson, 1981). During the symbiotic phase of development the infant perceives herself as magically controlling the environment in a narcissistic, omnipotent state of oneness with mother (Mahler, et al., 1975). Serious traumas or disappointments during this period interfere with the infant's ability to move into the development of healthy, adaptive narcissism (Coleman, 1994). The child is unable to tolerate the real world and the needs of others and defensively remains linked with the omnipotent object - stuck in a state of infantile narcissism and grandiosity (Masterson, 1981).

In referencing Kernberg (1993), Hockenberry (1995) notes that early experiences of narcissistic injury related to trauma, misattunment, abuse, and abandonment result in heightened states of anger and rage which are unable to be metabolized. These result in superego deficits

and derailed development of the self. Schore (1994) contends that the narcissistic individual's ability to access positive affective states, reflected in their grandiosity, indicates that they have successfully negotiated the symbiotic stage and the early practicing period. He argues that it is "late practicing shame transactions that are central events in narcissistic pathogenesis" (p. 423).

Shame has generally been considered to be the core of narcissistic pathology. However, there is some evidence that persons with narcissistic personality organization can be divided into two primary categories which differ in their relationship to shame: a grandiose, egotistical, and entitled narcissistic type, and a narcissistically vulnerable type. The vulnerable type is consistent with Hockenberry's (1995) symbiotic style narcissist and Broucek's (1982; 1997) dissociative type. Hockenberry (1995) observes that

> *"…fundamental to both styles is a need to maintain an illusion of personal omnipotence and control, in regard to both self-perception as blameless and perfect and to the treatment of others as self-objects. Both types share a propensity for viewing themselves as tragic victims in a hostile, unappreciative world (p. 307)."*

Symbiotic or vulnerable narcissists rely on merger with others to regulate self-esteem and maintain their sense of self (Hockenberry, 1995). Because they tend to split off their grandiose aspects, these individuals often present as vulnerable, self-depreciating, and shame-prone. However, their underlying omnipotence, grandiosity, and rage is demonstrated by their control of selfobjects, veiled arrogance, projection of anger, and passive-aggressive behaviors (Hockenberry, 1995).

In general grandiose narcissists tend to be more limited in their ability to experience and express shame and pride, and they rely more on projection as a means of regulating their anger/aggression (Heiserman & Cook, 1998; Hibbard, 1992; Schore, 1994). It has been suggested by Schore (1994) that whereas vulnerable/symbiotic narcissists are prone to overt shame experiences, and manifest low self-esteem and sensitivity to rejection, grandiose narcissists are unable to regulate shameful affect because it is "bypassed" and defended against

through grandiosity, entitlement, and contempt of others. However, Hibbard (1992) found that when he partialled out denial of shame, grandiose narcissism continued to be negatively correlated with shame. Thus, it is unclear how much grandiose narcissists actually experience conscious or unconscious shame. This suggests that in the treatment of batterers who present with grandiose narcissism, the therapist must determine whether there are super-ego deficits resulting in a lack of shame or whether the individual is utilizing primitive defenses to defend against shame.

Studies comparing gender with high and low levels of narcissism have found that women were more prone to shame regardless of level of narcissism. (Heiserman and Cook ,1998; Hibbard, 1992). In contrast, highly narcissistic men exhibited significantly less shame. While male narcissists may tend rely on selfobjects to mirror their grandiosity, female narcissists may be more likely to obtain and maintain their self-regard, self-worth, and validation through identification or merger with idealized others (Heiserman and Cook, 1998; Hockenberry, 1995). Thus, in contrast to heterosexual male batterers, lesbian batterers with a narcissistic disorder may be more likely to rely on merger with their partner, or attuned mirroring of their experiences as a means of sustaining their sense of self.

Schore (1994) proposes that the grandiose narcissist's early experiences are reflective of insecure-resistant attachment; whereas insecure-avoidant attachment was predominant for the vulnerable narcissist. He conceptualizes that narcissistic dysregulation occurs due to "the failure to evolve a practicing affect regulatory system which can neutralize grandiosity, regulate practicing, excitement, or modulate narcissistic distress" (p. 427). Because they do not have the ability to tolerate and recover from narcissistic wounds these individuals are predisposed to shame and narcissistic rage.

In Kohut's (1972) view, narcissistic rage results when there is loss of control over the mirroring self-object or the idealized, omnipotent self-object is unavailable. The intensity of narcissistic rage is much greater than that of normal aggression and the individual will resort to any means to right a wrong, undo a hurt, or obtain revenge (Kohut, 1972). Hockenberry (1995)

observes that,

> *"…latent hatred for internalized objects (for example, due to a frustrating or shaming mother) characteristically leads the person on a search for other objects in which his own mistreated self can be projected and can be similarly attacked, depreciated, or humiliated. Unconsciously, there is an identification with both the suffering, shamed self and with the hated, internalized persecutory objects (identification with the aggressor). However, to avoid painful feelings of unconscious shame, the shamed and vulnerable self is typically dissociated and projected onto the partner....In this way the partner becomes the target of the grandiose narcissist's attempts to triumph over internal shame through "revenge" and victimization (p. 309)."*

Consider a batterer with narcissistic personality structure who experiences feeling wounded because her lover has a difference of opinion or takes a phone call at what feels like an inopportune time for the batterer. This rupture in the merger with her selfobject and/or the lack of mirroring attention is experienced as a selfobject failure which threatens the batterer's grandiose, omnipotent (but fragile) self-cohesion. On an unconscious level there is a reactivation of the original trauma and she experiences overwhelming feelings of shame, powerlessness, and worthlessness. Rage and violence then become a way to regulate these feelings and return to a state of omnipotence and grandiosity by exerting power and control over her partner. From an object-relations point of view, one could also conceptualize that the bad self-states are split off and projected into the partner who is then devalued, shamed, and attacked as a means of restoring the omnipotent, grandiose, good self and object representations.

There are issues specific to the lesbian community which may heighten the difficulties inherent in narcissistic personality organization. In addition to the increased potential for merger in lesbian relationships, the mirroring and idealizing functions of the selfobject may be intensified by virtue of the fact that it is a same sex relationship.

As discussed earlier, shame issues are particularly salient for lesbians and the experience of both

external and internalized prejudices can easily activate shame states in narcissistically vulnerable batterers. Other issues which may be exacerbated include those of envy and jealousy. In contrast to male-female relationships where a woman's female friendships don't typically imply potential romantic interest, in the lesbian community friends are not implicitly distinct from potential lovers (Coleman, 1994). This can become very threatening for individuals who are prone to jealousy and lack a stable and separate sense of self and other.

Case Example - B

Marilyn, a 38-year-old Caucasian woman, called for couples treatment at the urging of her partner, Joan (32-years-old, also Caucasian), because they were having "relationship problems". In the initial session, Marilyn stated that she was not interested in therapy and had only come at Joan's insistence. Marilyn dominated a large part of the session however, and was very focused on how for the past 3 years of their 5 year relationship Joan had been emotionally insensitive and often physically cold and uninterested in sex. Joan was very clear that she was not sure she wanted to continue the relationship and stated that while she still loved Marilyn she wasn't sure she wanted to live with her. My attempts to clarify the nature of their difficulties were met with bickering between the two of them. It was not until the second session that it became clear that Joan was threatening to end the relationship if Marilyn did not stop her "tantrums." Exploration revealed that three weeks prior they had had a fight in which Marilyn punched Joan in the stomach, shoved her against the wall, and threatened to beat her up if she continued to "flirt and act like a slut" every time they went to a party. Marilyn stated that she was aware that her behavior could be "over the top" but proclaimed that it was a justified response to Joan's disrespectful and insensitive behavior. Contrary to many stereotypical assumptions about lesbian batterers, both Marilyn and Joan were quite feminine and Marilyn was significantly smaller than Joan.

In considering the options for treatment, I realized that providing couples therapy might run the risk of creating an environment in which Joan could feel the need to censure herself or

where she may be endangered after a volatile session. On the other hand, it was clear from Marilyn's presentation that she was not open to pursing individual therapy or a batterer's group. Given these considerations, I decided to conduct three to four more assessment sessions with them, with a focus on safety. During this time, I also worked to engage them (particularly Marilyn) in becoming curious about the dynamics underlying their relationship problems. While mirroring Marilyn's feelings of hurt and betrayal based on how she experienced Joan's actions, I was very clear and firm about the abusiveness of her behavior and its negative ramifications. I reviewed the rational and procedures for time-out and worked with them on recognizing the cues indicating a need for time out. They both agreed to utilize this technique and in each session we would review their use of it, as well as the times they could have used it but didn't.

Although initially resistant to exploring her behavior, by the end of our fourth couples session, Marilyn began to develop an interest in why she interpreted Joan's conversations with other women as flirting. She also started to demonstrate some mild curiosity about the factors underlying her "over the top" reactions. In addition, Marilyn agreed to abstain from physical violence. Based on my assessment, their cooperativeness, and the nature of previous battering incidents, I felt that there was no immediate danger of severe abuse. Moreover, Joan seemed to be using the sessions verbalize things she could not say outside of the sessions and Marilyn was starting to use me as a selfobject, which enabled her to tolerate Marilyn's feelings and complaints. We were able to examine the ways in which Marilyn's behaviors tended to push Joan away and created passive-aggressive responses on Joan's part - which then led to Marilyn feeling increasingly bewildered, frustrated, and hurt.

Given that the couples therapy seemed to be helpful, I recommended that we continue the couples work and reassess as needed. They agreed and the next several months proved to be very useful in many ways. Marilyn and Joan reacted well to my introduction of the Iceberg Exercise and this was quite useful in helping them both to identify the feelings underlying their reactions during arguments. In regards to Marilyn's rages, the Iceberg Exercise helped her to recognize the shameful and intolerable feelings underlying her abusive behavior. In addition,

our frequent use of the exercise helped Marilyn to separate her feelings from the negative self-talk which fueled her violent reactions. For example, we were able to identify how going to a party was in fact a very stressful event for Marilyn. Underneath her grandiosity and charming facade, Marilyn frequently felt insecure and uncertain of her "popularity" with others. When Joan socialized with other women at parties, Marilyn became afraid that their friends would question the "strength" of their relationship. She also felt untrusting of their friends and expected that several of them would try to "seduce Joan if given half a chance." Such fears reflected her early insecure attachments and the dysfunction within her family of origin. Marilyn's beliefs were also fueled by her internalized homophobia, including negative stereotypes about lesbians and lesbian relationships.

We discussed their notions about the lesbian community, their struggles in coming to terms with their sexual orientation, and the impact of homophobia and heterosexism on themselves and the relationship. We also explored their families of origin and how familial patterns were replaying in their relationship. Other important areas of discussion included experiences of shame and shaming behaviors in their relationship, their past relationship history, and their current support network within both the heterosexual and lesbian communities. In addition, I provided education on the cycle of violence and battering behaviors.

There were many times during the treatment that maintaining my neutrality and focus was difficult. I had to constantly monitor my countertransference and make sure not to collude with the ways in which Marilyn would minimize and justify her abusiveness. I also had to be careful to monitor my connection with Joan and not join with her in shaming or condemning Marilyn. In one session, Marilyn became angry and upset with Joan because Joan would not "honor and respect" her feelings by agreeing not to spend time with a friend whom Marilyn found particularly threatening. In response, Joan became frustrated and expressed feeling hopeless about Marilyn ever "getting over her jealous and childish behaviors." Marilyn reacted by becoming increasingly devaluing and attacking of Joan. The more controlled and devalued Joan felt, the more rigid and belittling she became in response. I commented on this pattern and

mirrored back the frustration and hurt they were each feeling in response to the other.

In reaction to my responding to both of them, Marilyn began to attack me with accusations of not understanding her and she protested that I was not protecting their relationship (from this perceived threat). She stated that I must not be a very experienced and knowledgeable therapist after all and added "what the hell are we paying you for?" As I reflected on my countertransference, I was immediately aware fantasies of attacking back in a shaming rageful retort. I was also aware of feeling confused and thrown off guard by her attack. Rather than responding out of identification with the shaming bad object that had been engendered in me, I said to Marilyn, "I think in my understanding Joan's pain and frustration it felt as though I was disregarding your pain and dismissing how threatened you feel." Marilyn responded with an angry "yes." I added, "perhaps it also feels scary for me to consider Joan's position and feelings alongside yours, in your early experiences only one person could win or have power, and you assume that you are going to be one who will loose and will then be left alone." Marilyn softened and replied, " I know, that's just like what would happen in my family...I get scared and I feel dissed." I noted that in feeling "dissed" she seemed to experience both hurt and shame which then led to her desire to shame the person she had felt hurt by...as had just happened between she and Joan and then between she and I. Marilyn agreed; then, after a pause, she returned to how unreasonable and uncaring Joan was in her desire to keep contact with this certain friend. However, as a result of the experienced rupture and repair, Marilyn was able to have a new selfobject experience with me, which enabled us to addresses this conflict in a more constructive manner. The occurrence of such experiences during the treatment also enabled the two of them to have more frequent moments of empathic connection.

After several months I suggested that they consider doing individual work on some of the issues we had identified. Joan stated that she did not feel a need for individual or group therapy. Although Marilyn did not like the idea of participating in individual or group therapy if Joan was not, she acknowledged that group therapy would probably be helpful. She agreed to explore group treatment while continuing with the couples therapy. This was a big step towards

differentiation for both of them. While it was hard for Marilyn to tolerate feeling like the "sick one," she was now able to use me as a selfobject which seemed to provide her with the ego strength necessary for the pursuit of group treatment.

TREATMENT CONSIDERATIONS

In providing treatment for lesbian batterers, it is essential that the therapist be knowledgeable about lesbian issues and practice lesbian/gay affirmative therapy. Lesbian affirmative therapy takes the position that homosexuality and a lesbian lifestyle are a healthy and normal cultural variation. As stated by Istar (1996), to provide effective treatment for lesbian batterers the therapist "must recognize the various systems that are interconnected, including the family of origin, the family of choice, the extended friendship network, and the lesbian community context that has birthed and nurtured an environment in which lesbian couples can create families" (p. 96). These systems should be acknowledged and explored as part of treatment. It is also important for the therapist to be knowledgeable about lesbian identity development and the impact that homophobia and heterosexism has on lesbians. Similarly, when working with lesbians of color the therapist should consider and explore the impact of racism, and the ways in which racism can compound experiences of homophobia and heterosexism. Another important area for consideration is the assessment of drug and alcohol abuse. Often, particularly in smaller cities, there are few social outlets available for lesbians and bars become a common arena for socialization. Such socializing, in conjunction with the pressures of being a minority in society, has contributed to high rates of alcoholism in the lesbian community.

The therapist should also be aware of forms of emotional abuse specific to lesbian battering. These include: revealing or threatening to reveal the partner's sexual orientation (for instance, to family, at work, or in conjunction with a custody battle); homophobic insults; and threats of heterosexist responses by helping professionals. Examples include, intimidating one's partner to stop her from calling the police or others by telling her that they will not believe her or will not help her because she is a lesbian.

Quite often, lesbians will present for domestic violence treatment as a couple, or only after an initial assessment will it become clear that there is abuse in the relationship (as in the case of Marilyn and Joan, case B). There is often a great deal of internal and external pressure on the therapist, due to safety concerns and the politics of domestic violence treatment, to recommend separate treatment and refuse to provide couples therapy; however, sometimes such a rigid stance can backfire and result in the couple discontinuing treatment or seeking therapy from a therapist lacking knowledge about lesbian domestic violence (Istar, 1996; Margolies and Leeder, 1995).

Although couples therapy can be dangerous in situations of domestic violence, it can also be a viable and effective treatment modality (Balcom, 1991). In considering couples therapy as a treatment option, it is essential that the therapist do a careful assessment of the violence and the risks of providing couples therapy. Balcom (1991) suggests that in addition to a "no violence" contract, couples in which shaming behaviors are prominent should also agree to a "no shaming" contract. While it is likely that these contracts will be broken to some degree over the course of treatment, such contracts create a frame which helps to increase impulse control.

While there are many instances where identifying the batterer in a lesbian relationship is very clear; at times determining the nature of the abuse and who is battering whom can be quite confusing. In contrast to heterosexual relationships, there is frequently minimal difference in strength or size between partners. And, even where size differences exist, the batterer may be the smaller of the two women. In addition, many women use violence in self-defense - sometimes even initiating violence in anticipation of abuse. I have done assessments where initially the battered partner described herself as the abuser because she had used violence in self-defense and, as is common in the cycle of violence, she had internalized the batterer's blaming accusations. A further complication is that batterers may present as though they are the battered partner, due to their experience of feeling victimized. In treatment it is essential that women who batter are helped to recognize how their early experiences and resulting defenses can result in their <u>perception</u> of themselves as victimized by their partner. Furthermore, it is

imperative that they are helped to understand their partner's self-defensive use of violence.

Although in some relationships both partners may be engaging in abusive behaviors, behavior is battering when

> *"…it results in the enhanced control [italics added] of the batterer over the recipient. If the assaulted partner becomes fearful of the violator, if she modifies her behavior in response to the assault or to avoid future abuse, or if the victim intentionally maintains a particular consciousness or behavioral repertoire to avoid violence, despite her preference not to, she is battered (Hart, 1986, p. 173)."*

Determining which partner is the batterer will generally become clear after a careful process of assessing the cycle of violence, including dynamics of power, control, and fear. As noted by Istar (1996) often "witnessing the partners' interactions will enable the therapist to have the clearest picture of the relationship" (p. 104), which will facilitate the development of an appropriate treatment plan. Margolies and Leeder (1995) have observed that often batterers will report feeling high, due to the adrenaline type rush of their rage, whereas the battered partner will be aware of feeling only fear or the sympathetic arousal of a fight or flight response. The addictive quality of rage and the enhanced feeling of power that accompanies it must also be addressed when working with batterers. Similarly, pathological vindictiveness has an addictive quality which must be confronted and addressed in order for the early underlying experiences to be worked through.

In terms of treatment modalities, I have found that group therapy can be extremely useful. The group creates an environment of support and confrontation where batterers can learn new cognitive and behavioral strategies for managing their abusive impulses. Not only is the isolation common in battering eliminated, but new norms for recognizing and expressing emotions are established (Margolies & Leeder, 1995). However, for patient's who refuse to attend group therapy (as in the case of Maria), many of the exercises used in group treatment can be adapted for individual work. In addition to time-outs and power and control logs, one of the

most useful exercises I have used is the Iceberg Exercise. In actual practice I will often refer to this as the Volcano Exercise[2] since the image of a volcano more accurately captures the explosive rage of batterers. The Iceberg Exercise is used to help patient's identify the emotions underlying their anger (Fogelman, 1996). The visible tip of the Iceberg is the expressed or "visible" anger. Beneath the surface are the underlying and hidden feelings. The diagram of an Iceberg is drawn and anger and synonyms for anger are written in the tip of the diagram. A line is drawn to separate the visible emotions in the tip of the iceberg from those "hidden" underneath the water line. The patient is then encouraged to identify those feelings underlying their anger, such as hurt, afraid, powerless, helpless, confused, vulnerable, ashamed, etc. These are then written in under the waterline. Phrases which actually connote thoughts, such as "I felt like a fool" or "I felt she deserved it...she shouldn't have said that" are placed to the side of the Iceberg under the heading of thoughts. Thus, patients are helped to separate their thoughts from their feelings. This also helps in identifying and intervening in the negative self-talk that frequently escalates batterers' aggression.

Although group therapy is an important treatment modality therapy, it is typically not sufficient to create structural changes in personality. In many situations women will stop their physical violence but continue to be controlling and emotionally abusive. In my opinion, the optimal treatment is group therapy combined with long-term psychoanalytic psychotherapy. Moreover, individual therapy can most closely approximate early attachment relationships and allow a reworking of developmental failures. In some cases, analytic couples therapy can also be extremely effective. However, in general the effectiveness of couples therapy is potentiated when combined with either individual or group therapy.

Through the secure base provided by the therapist's consistent presence and relatedness, individual therapy creates an opportunity for the batterer to construct new working models of attachment . According to Schore (1997), in treatment, the "non-verbal transference-

[2] This name was suggested by Maria.

countertransference interactions that take place at preconscious-unconscious levels represent right hemisphere to right hemisphere communications of fast-acting, automatic, regulated, and unregulated emotional states between patient and therapist" (p. 43). He proposes that this can create changes in the orbitofrontal cortex which mediates empathy and the ability to reflect on the emotional states of self and others. This indicates that analyzing the patient's split off, unmetabolized aspects of experience that are enacted in the transference-countertransference can create structural change. Schore (1997) suggests that in patients with borderline and narcissistic disorders, "visual and auditory cues that were perceived during early self-disorganizing episodes of shame-humiliation" are particularly salient and tend to be reactivated in the transference (p. 46). This experience of misattunement and dysregulation in the treatment provides an opportunity for the repair and regulation of states that were previously intolerable and disorganizing. The therapist's ability "initially at a nonverbal level, to detect, recognize, monitor, and self-regulate the countertransferential stressful alteration in his [her] bodily state that are evoked by the patient's transferential communication" (Schore, 1997, p. 48) is an essential component of the treatment .

When treating batterers with borderline personality organization, "attunement and responsiveness offer a holding environment (Winnicott, 1965) that is especially important with the fluctuating rage, anxiety, and panic of borderlines" (Sable, 1997, p. 176). Attuned and responsive holding is also a key component in the treatment of narcissistic batterers, as they are extremely sensitive and prone to narcissistic wounding and rage reactions. Such adaptiveness on the part of the therapist allows for mutual influence and the development of a positive reciprocal regulatory system which enhances the patient's self-regulatory system (Silverman, 1998), leading to the internalization of a good object relationship. Furthermore, these experiences enhance the patient's capacity for affective relating - enabling her to "experience, endure, and regulate affect within a self structure that contains as few disassociated elements as possible" (Ellman & Monk, 1987, p. 85).

Because early attachment relationships serve as a prototype for intimate adult

relationships and are re-enacted in the therapeutic dyad, transference and countertransference enactments can be used to understand early traumas and examine resulting maladaptive patterns and defenses (Sable, 1997). As illustrated in my work with Maria (case A), such enactments can be used to understand the terror and rage that accompanies separations, make connections between current patterns and developmental failures, and recognize the alienating effects of tantrums and abusive behavior. In addition to analyzing the affects and behaviors accompanying separations, for batterers with a borderline disorder it is also important to address the ambivalence around connections and the push-pull dances which often ensue. While the batterer longs for closeness and security within the treatment and within her relationship, this often leads to unbearable fear and anxiety. In response she may pull away and shut down or become critical, hostile, and demeaning. This pattern must be actively confronted and interpreted, illuminating its cycle in both her external relationships and in the treatment relationship.

Another key component of treatment is the identification and confrontation of the individual's defenses against shame and the shame states underlying her abusive behavior. As noted by Hockenberry (1995), for batterers with shame issues it is important "to interpret and bring to greater awareness the tendency many of these individuals have of splitting-off unacceptable or shamed parts of themselves and projecting them into their partners" (p. 321). Typically, batterers are only aware of their rage and much of the therapeutic work entails helping them to recognize their underlying shame and identify their shame-triggers.

Since batterers with narcissistic traits are particularly prone to feeling shamed, interpretations regarding their vulnerabilities and the dynamics underlying their abusiveness are likely to provoke shame and shame-rage reactions. It is essential that the therapist provide a supportive and empathic environment, while at the same time actively confronting the ways in which patients rationalize, minimize, and blame others for their abusive behaviors (Hockenberry, 1995). The most powerful re-working of early shame experiences occurs in those instances of misattunement and shame in the treatment relationship, which affords an occasion for repair and new object experience. Similarly, in cases of pathological vindictiveness the treatment

relationship furnishes an opportunity for the expression of hurt and vengeful rage, "with no vindication, but with the in-built guarantee of no analytic counterattack" (Feiner, 1995, p. 391).

In order to provide a confrontive, yet non-retaliatory and empathic treatment environment, the therapist must constantly monitor countertransference issues. This includes examining and addressing one's own shame, rage, and capacity for violence. One's own fear of violence and the potential to minimize, deny, or avoid addressing the batterer's abusive behaviors should also be explored. In addition, therapists should examine their own internalized homophobia and heterosexism, and be conscious of the ways in which they may impinge on the treatment.

CONCLUSION

Through an integration of personality development, attachment theory, affect regulation, shame, and pathological vengeance, I have attempted to identify and illuminate variables critical to understanding and treating lesbian battering. Providing batterers treatment can be both highly rewarding and extraordinarily difficult. The difficulties presented by batterers are highly complex and effective treatment requires that the therapist be intimately familiar with her or his own dynamic issues around violence, attachment, and shame. Working with lesbian batterers also necessitates that the therapist be cognizant of, and monitor, her or his own homophobia and heterosexism.

Goals of batterer treatment include: improving affect regulation; reducing the use of primitive defenses such as splitting and projective identification; decreasing shame and vindictiveness; and increasing the batterer's capacity for empathy. In conjunction with progress in these areas, the batterer is able to move from part-object relating to experiencing others as separate, whole objects. In other words, the individual is able to move into the depressive position and experience genuine concern for others. A key component of this movement is the therapist's ability to empathically resonate with the patient's affective states and consistently reflect and synthesize her experiences, furnishing the experiential basis which facilitates her

readiness for interpretations and enables her to tolerate her own emotional experiences (Ellman & Monk, 1997, p. 86). Thus, in the exchange between patient and therapist new models for relating develop and are integrated, providing the basis for non-abusive, healthy relationships.

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