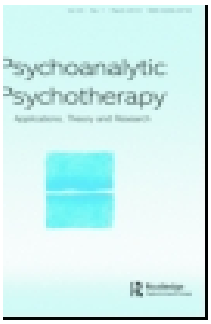

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Female violence and toxic couples

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The author describes the development and expression of violence by women against their own children and against their partners, within a perverse relationship, or 'toxic coupling'. Female aggression against intimate partners can be a feature of these relationships, playing a significant role in the perpetuation of destructive interactions. The fact of female violence in such partnerships is often minimised or denied altogether and the male is identified as the perpetrator while the female is configured simply as the victim: the author describes how such a view of women reflects a failure to acknowledge the reality of female agency and perversion. This, in turn, prevents a full understanding of the complex dynamics of violent relationships and effective psychotherapeutic interventions with them, leaving children exposed to such situations at serious risk. This concept rests on the notion that it is not the individual partners that are 'toxic' but the relationship itself, with its entrenched destructive dynamics. The 'toxic couple' is created by the interaction of two disturbed individual attachment systems in each, revealing the violent impulses and psychic disturbance of the female as well as the male partner. In this paper, the author describes how women, as well as their male partners, can be both perpetrators and victims of extreme cruelty. As with female violence generally, because females are assumed not to be violent, there is a danger that some aspects of toxic partnerships are so taboo as to be unthinkable.

Introduction: female violence and toxic couples

The field of forensic psychotherapy has offered tremendous insight into how the dual role of perpetrator and victim can coexist in the same person, and demonstrated the unconscious motivations that underlie serious acts of violence. These include the wish to be caught and punished out of a sense of unconscious guilt as described by Freud in 1916:

> Paradoxical as it may sound, I must maintain that the sense of guilt was present before the misdeed, that it did not arise from it, but conversely – the misdeed arose from the sense of guilt. These people might justly be described as criminals from a sense of guilt. The pre-existence of the guilty feeling had of course been

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> demonstrated by a whole set of other manifestations and effects. (Freud, 1916, p. 332)

The desire for containment and punishment can lead offenders to commit their crimes clumsily, as if seeking to be caught, and to express a profound sense of relief when this occurs, and they are subsequently punished. The inner world of the forensic patient has been described in rich detail (e.g. Glasser, 1979; Morgan, 2007), in terms of violent and perverse enactments, shaping psychotherapeutic work with men in settings as diverse as prisons, probation settings and outpatient clinics. The Portman Clinic in London is often credited as the birthplace of this thinking, with an important educational and training function. According to its model of forensic psychotherapy, an analysis of the offence can uncover the psychic conflicts of the individual, analogous to the symptom in a neurotic condition; unlike traditional psychoanalysis it gives the role of society in relation to the inner world of the offender a central place. (Welldon, 1996)

This understanding has also been extended to address the roots and expressions of violence and perversion in women, and to challenge the assumption that this occurs in only the rarest of cases. In her seminal work on female perversion, Welldon (1988) introduced the notion of maternal perversion and described the narcissistic use of children to extend a woman's own maltreatment of her body, and to repeat an intergenerational pattern of abuse and cruelty. She challenged the assumption that a phallus was an essential prerequisite of perversion and shocked clinicians with her startling and unsettling discoveries about the potential for mothers to use their own bodies and those of their children in the service of perverse activity. She offers an extensive description of the characteristics of female perversion in her early and later work (Welldon, 1988, 2011).

For women, as for men, the meaning of the offence is not necessarily accessible to the conscious mind, but becomes clearer throughout the course of analytic psychotherapy, manifested through the relationship with the therapist. For this to take place successfully, the therapist must retain neutrality, openness and an acute awareness of the danger of re-enactments.

Female violence and intimate relationships

In this paper, I explore female violence in the context of destructive, perverse and violent partnerships that I refer to as toxic couples. This violence can be understood as a reflection of unconscious forces, often in direct contradiction to what is consciously wanted. Although such violence can be dramatically expressed against her partner, her children or the woman herself, it is often hidden from view, enacted in secret in the private domain of the home, and in unseen places on the bodies or on victims who can not or will not speak about it. Its hidden, clandestine nature is mirrored in the societal response, which is often to deny the fact of such violence altogether, whether in relation to maternal abuse or female aggression within intimate relationships.

I will discuss the role of female violence within abusive relationships, focussing on those couples whose attraction is based on malignant forces, often unconscious, but always compelling. These perverse couplings can be highly addictive and the bond between the pair appears to be based on a shared need to engage in abusive practices (Welldon, 2002). At times the perverse activity of the couple extends to their own children, or those of others, viewed largely as objects to be used for their own gratification. I will discuss clinical situations in which women were violent within what I have called 'toxic couples' and describe in some detail how this impacts on the therapy

Although we often think of domestic violence as perpetrated by one person, usually a male perpetrator, against a victim (often female), I suggest that within a toxic relationship it is the interaction of the two individuals that creates this destructive force, even when one partner is the principal enactor of the violence. Within some such relationships the woman herself is the primary aggressor, using her partner as an object onto which to project her own feelings of disgust, humiliation and unworthiness. He in turn becomes the 'poison container', filled with shame and a sense of degradation (deMause, 1990). Sometimes women unconsciously locate their own aggressive impulses into their partners, and this frees them temporarily from awareness of their own violent wishes towards others. It is even possible to view the attraction of some women to violent partners, who abuse them, as a form of self-harm, in that their partners enact their own savage impulses towards themselves.

Aggression and intimacy can be inextricably interwoven in these relationships, to the extent that the currency of communication is itself violent: a kiss with a fist. I explore this dangerous dance, revealing the conscious and unconscious dynamics of violence between partners, and its alarming complexity (Motz, 2014).

All kinds of couples can become enmeshed in destructive dynamics, with the potential for serious harm against one another and/or any children within the family. The role of both partners in the dangerous and compelling patterns of interacting that underpin violent relationships requires analysis, and their respective contributions disentangled.

The nature of the bond between women who have been sexually abused and their abuser can be seen as a malignant attachment – this is clearly the case in incestuous relationships, where a child or adolescent has been forced or seduced into a sexual relationship with a parent or sibling. When these abusive relationships are re-created in later life, women as well as men can inflict serious levels of harm on one another, and on children within their household. The consequences of incest are profound for both male and female children, but the stigma of female sex offending can make it difficult for boys to disclose their abuse, especially if members of their own families are perpetrators. This is a gross example of a toxic coupling that has destructive effects, both immediately in the long term As in other cases of child abuse and trauma, a woman who has been abused early in life may go on to perpetrate a similar violation against

another, perhaps only many years later. In so doing she acts in identification with the aggressor (A. Freud, 1936) and attempts to rid herself of shameful and unwanted feelings by treating another person as she herself has been treated. I will turn now to a clinical illustration of this process, where the chosen objects of abuse and humiliation are a male partner, and a female child.

Clinical vignette: between a volcano and a void

When I met her, Paula was 42 years old, referred for psychotherapy because of her long history of violence against others, including her partner, her children and various mental health professionals whom she had stalked and threatened. She had a diagnosis of borderline personality disorder, and been hospitalised on numerous occasions. These admissions had resulted only in further deterioration in her mental health and were characterised by her assaults on staff and frequent 'restraints' which she appeared both to invite and resist. She had been rejected for outpatient treatment by mainstream mental health services because of her violence, and was subsequently referred to the forensic psychotherapy and psychology service.[1]

At assessment Paula was rather withdrawn and flat, presenting as emotionally 'shut down' but with sudden flashes of liveliness, that took me by surprise. She conveyed a powerful sense of discomfort and suppressed violence, so I felt I needed to tread gently. Early on she told me about her struggle with feeling she was 'female' as she tended to regard herself as masculine. She felt she did not possess femininity as she associated this with vulnerability, softness and helplessness. She suddenly commented that she felt that I was 'comfortable' with my femininity and told me she would never be able to wear a skirt or high-heeled shoes, as I was. At this moment I felt suddenly exposed and judged in a harsh fashion, and that there was an implicit accusation in her comment. Her statement highlighted our differences and also that we were two women, together in an intimate therapeutic encounter. I felt that her sudden and sharp comment was unconsciously designed to throw me off balance, and to raise a question about my version of 'femininity'. This gave me an important insight into her distrust of me, and how quickly her mood and perceptions changed. Despite her suspicions, she felt able to tell me about her early life, and her past and present difficulties. Paula felt she was out of control, and was driving her family away with her volatile moods and angry outbursts.

At the end of the three-session assessment, we agreed to work together over a period of eighteen months in weekly psychotherapy. Her violence was not a threat to the general public, but, as is typical of female violence, was targeted towards herself in savage acts of self-harm, her partner, her children, and towards those in a 'caring' position in relation to her, like the psychiatrists she had threatened and the nurses on the wards.

The oldest of four girls, Paula had been subjected to physical harm by her own mother for much of her life and frequently left alone or with unsuitable carers from

an early age, to care for her younger siblings. Additionally, and significantly, an older male relative, in whose care she had often been left as a small girl, sometimes with her siblings and sometimes entirely alone, had sexually abused her. This sexual abuse had continued for several years, beginning when she was six years old and continuing until she was eleven, by which time her abuser was engaging her in penetrative intercourse. Paula's attempts to tell her parents were met with disbelief and indifference. She had a troubled adolescence, displaying aggression to others at school, alongside sexual promiscuity, substance misuse and cruelty to animals. At 16, she formed an attachment to young man several years older, and later married him. He was devoted to her but suffered from depression and intermittent substance misuse, himself the only child of a mother who was an addict, and who had been physically violent to him during his childhood. Paula became pregnant with their daughter when she was 18. Her partner promised to support her to care for the baby. Paula hated the feelings of discomfort, nausea and heaviness that she experienced during pregnancy, and the sense of being invaded by an alien creature; it was only her strong belief that abortion was wrong that prevented her from terminating the pregnancy. After childbirth, she had found the care of her baby girl intolerable and became withdrawn and angry, feeling that she had been robbed of her freedom and that her body had been destroyed by both the pregnancy and the labour, which left her feeling 'torn apart and broken'. The pregnancy had been unplanned.

She had later had a second baby, a son, to whom she felt far closer, enjoying a loving bond that she had not been able to establish with her daughter. Paula described her guilt feelings about her violence towards her partner, and her physical abuse and neglect of her children, particularly her daughter. Despite her palpable sense of shame, she was articulate and insightful as she recalled her disgust with her daughter's constant need for feeding and described a powerful sense of persecution related to what she perceived to be her insatiable needs. She described a sense of guilt about this estrangement and recognised that she treated her daughter much as she herself had been treated, with a degree of cruelty and a wish to be rid of her. Her partner, like Paula's own father, was the more affectionate and stable parent, which she both envied and valued. Acknowledging this painful mix of feelings was difficult for her.

Although Paula had enjoyed some time with her son, she noted that her volatile mood swings had worsened with the birth of each child and she found herself alternating between self-harming and violent assaults on others, sparing him. Her partner, who was effectively the main carer for both their children, subsequently became the target of her rage. He, in turn, withdrew into greater substance and alcohol misuse, generally at night time when the children were asleep, and when she would discover this, she would physically assault him. As the relationship grew more volatile he sought solace in friendships with other women, which he claimed were not sexual but offered comfort in his loneliness and shame. These associations, in turn, fuelled Paula's sense of rage, jealousy and underlying feelings of abandonment. Her violence towards him became more

frequent and also more severe, and he would sometimes retaliate through physical aggression. Their relationship became a fraught and violent, as their fights escalated, and, on occasion, it seemed to Paula that her partner was taunting her with evidence of his intimacy with other women, as though goading her into a jealous frenzy. Her own terror of abandonment and wish to control her partner, led her into becoming an 'intimate partner terrorist' (Johnson, 2008) who wanted to exert her will on every aspect of her partner's life. Unsurprisingly the needs of their young children were neglected within this toxic coupling.

Paula spent much of the early part of the work describing how she would take out her anger on her daughter, alternating between physical abuse of her, and neglect, demonstrating what I have termed an oscillation between 'the volcano and the void'. Her daughter became clingy, distrustful and markedly unhappy, in contrast to her son, who remained rather more settled, apparently confident in his mother's love, but fearful of the violent rows he witnessed between his parents. Paula found her daughter's clinginess and anxious outbursts when she left her persecutory, seeing them as evidence that she was 'an unfit mother', and avoided time with her. She told me that at one level she had been, aware at of the harm she was inflicting on her, but, at another, had turned 'a blind eye' to the cruelty to which she subjected her. This seemed to be her way of defending herself from acknowledging her violence towards her daughter, with whom she powerfully, and destructively, identified. Over the course of therapy she also described vivid memories of emotional and physical violence between her parents and her mother's physical assaults on her.

Countertransference issues

It was clear that there was a risk of becoming another 'toxic couple' with Paula, and having the therapy become a hostage to her assaults on the work. She and I needed to find a way of collaborating and enabling the therapeutic space to be one in which thoughtful exploration could take place, rather than an intense, fraught environment that relied on actions rather than emotional engagement. She often arrived at sessions in a highly guarded fashion, and sometimes argued with reception staff on the way in, as though discharging difficult feelings before meeting with me. This put me in the position akin to a child, watching parents fight, and feeling helpless, collusive and slightly frightened. She walked robotically to the room and held herself stiffly, showing me she was 'on guard'. During the course of the treatment, I found myself warding off indirect threats, in the form of attacks on the efficacy of the work or through elaborated fantasies of what she would like to inflict on other professionals, and on people who let her down. I was in her good books, but I was aware how quickly, and dramatically, this could switch. In her rigid paranoid-schizoid functioning, it was impossible for her to hold the awareness of mixed feelings in mind, or to forgive me my imperfections. In this sense I did feel a hostage, frightened to miss a session or show any kind of weakness, but was able to interpret this

to her, as it showed us clearly how intolerant she was of any vulnerability of her own.

At other times I was left in anxious suspense, told about the violent feelings that Paula had towards neighbours, her husband and herself, and her wishes to act on them. As her children had left home, I was not distracted by child protection worries, though her treatment of them in the past had been of serious concern, as she herself acknowledged. She was adamant that she did not want to engage in couple therapy with her husband and that she only wanted this individual therapy with me.

At times I felt quite battered by her, and scared to speak, but when I suggested to her that she was communicating her wish to silence me, alongside her hope that I would be able to bear her anger and threats, she softened and became accessible to exploring her own fears of vulnerability, shame and abandonment. I felt that I needed to summon up all my strength and courage to confront the power of her intimidation and aggressive and destructive feelings conveyed through a real threat of violence in the room. It seemed essential that I could bear and articulate this, but it was, at times, difficult for me to keep this thought alive. The unconscious wish for me to stay strong and thoughtful was in sharp contrast to her conscious challenges to me, and the threatening manner of her direct, personal questions to me. At times, I felt in identification with her frightened husband, and the children who had both relied on and feared her.

At other times, I found myself anxious before her sessions, almost hoping she might miss them, which she never did, and this alerted me to the sense in which I could become as neglectful and abandoning as her own mother. The part of me that wished her away, for my own peace of mind, was in clear identification with her rejecting parent, and also informed my understanding of her sense of being unwanted, unloved and unworthy. It would not have been difficult to repeat the pattern of other services and reject her out of fear, and an unconscious wish to retaliate against her. When she did appear, I would experience mixed feelings, both apprehensive and relieved, pleased she was able to bring herself to the session and ashamed of my own fear.

During the sessions, Paula would often invite frank appraisals about her physical appearance and describe her discomfort in relation to it, only to become visibly unsettled after asking these questions, and expressing her own self-contempt. I thought that this also put me in the place of someone who looked at her, in an objectifying and potentially desiring manner, as if considering her for sexual use. This seemed to relate to her unconscious need to re-enact a relationship with her own abuser, perhaps in order to 'master the trauma' in the here and now. She was able to think about how she had herself identified with her abuser, treating her body with contempt and retaining a sense of suspicion about herself. We were able to consider how she had internalised him, constantly surveying her own body and then attacking it, through brutal acts of self-harm. I felt that I was unconsciously invited to both participate in and become witness to her perverse self-treatment.

Paula would describe in some detail her attacks on her husband, who seemed to tolerate these, in what seemed a form of masochistic surrender. When she eventually made a clear link between her own parents' violent interactions and how she treated her husband, she seemed to become less wedded to her own aggression, and more in touch with her wish to engage in loving interactions with him. Over the course of the therapy, she gradually reduced her violent assaults on him and she self-harmed less frequently and with less destructive methods. By the time that the therapy ended, she felt less frightening, and less frightened, but still retreated into her world of violent fantasies at times of stress. Interestingly, she controlled the timing of the ending, and chose to leave just short of the 18 months we had originally agreed. Perhaps because her growing sense of vulnerability was too uncomfortable for her. I noted my sense of sadness that this complex and difficult work was ending, in contrast to the apprehension with which I had begun the work.

The development of perversions, including the sadistic use of violence and threats, can be a means of securing a false sense of confidence in one's capacity to manage the threats posed by intimate relationships. The need to control the other is a central feature of perversion and offers the promise that the object will not pose a threat to psychic integrity of the individual, through abandonment or engulfment (Glasser, 1979.) Giving pain felt far safer than facing the risk of receiving it, and returning to a place of humiliation and fear. In the work with Paula, it was essential that I was not pulled into a sado-masochistic relationship but remained able to think with her about the feelings that underlay her violence.

Viewing domestic violence as simply an expression of the male wish for power and control is both reductive and inaccurate. Some feminist analyses risk this when it is accepted unquestioningly, as Dutton and Nicholls (2005) argue in their review of the literature: 'A case is made for a paradigm having developed among family violence activists and researchers that precludes the notion of female violence, trivializes injuries to males and maintains a monolithic view of a complex social problem.' (2005, p. 680). In the following clinical vignette, I describe the particular situation of a woman who hurts her child within the context of a violent relationship.

Clinical vignette: Maja

In some cases of domestic violence, the mother turns her anger against her own children, not simply because of own identification with the battered child, and an expression of her unhappiness, but as a form of revenge, comfort or to draw attention to the crisis of her relationship, by creating a situation in which other agencies become involved. She may be unaware of these unconscious motivations for her actions.

In one such case, a young mother, Maja, came to me for therapy as a result of social services' involvement with her seven-month old baby son. He had suffered a fractured arm, whose causes were determined to be non-accidental. Maja had

taken him to hospital and was thought to be a devoted and gentle carer, while her husband, who had a violent history and a criminal record for charges of assault, theft and driving while disqualified, was at first suspected of causing the injuries. Social services responded by placing him on the 'At Risk Register' and recommending to the parents that the father seek anger management and the mother help for depression. Both parents were recent immigrants to the UK and the father had been given legal status when he had arrived as an unaccompanied minor, having then met the mother through friends from the local community of people from their community. Although the mother had a sister here, with whom she had been when she had met her partner, she had little other social or family support in the UK and was isolated, appearing vulnerable and depressed.

Although it was initially difficult to engage her in the therapeutic work, as she seemed so flat and distrustful, she gradually become more alive in the therapy, sustaining eye contact and talking to me about the difficulties of her early life, and her sense of displacement in the UK. She described the violence and control that her husband inflicted on her, and how she wished she could take her son and return to her family home. However, after six sessions she also revealed to me that it was she who had hurt her son, unable to bear his screams when he was, she now recognised, teething. She was so timid in daily life, and in her presentation with me, that this revelation was truly shocking, and hard to believe. Maja began to give voice to her anger, sense of displacement and revulsion at the way her partner treated her and flirted with other women, while constantly accusing her of sexual infidelity. Her own mother had been promiscuous and left her family when Maja was nine, leaving her largely in the care of her older sister. Her father had been depressed and hardworking, but not emotionally present for her.

When we first met, Maja told me that her main source of comfort was her son, whom she loved, but when he cried she found it unbearable, and described how his screams pierced her, and 'broke her'. Although she did not articulate this, it seemed clear to me that his cries resonated with her own internal distress, and traumatised her, leaving her feeling shaky and undone. She eventually told me that she had often handled him violently when he cried, and then felt guilty and scared by her own rage. On the day, she had broken his arm she had been on her own, after a violent argument with her partner, who had called her a whore and hit her. She had tried to call her sister but couldn't find her and felt totally alone and frantic. When her son had begun to scream she couldn't comfort him and said that as she looked at him she saw a reflection of her face. She repeatedly twisted his arm until she felt something snap and was then terrified by what she imagined she had done, calling her partner to explain how the baby had fallen, and going with them to the Emergency Department. This act of violence had brought about concern, help and protection for her son, but also, for herself. Her sense of guilt was profound and, I believe, predated rather than followed her assault on the baby.

Over the course of therapy, she disclosed not only her fantasies of harming her husband, but her own self-harm, and traced this to her hatred of her own body.

The link between her anger at the mother who abandoned her, her own body, signifying as it did her mother's and her husband, became clear, and she decided to leave him, after taking on a job where she made some friends and gained a sense of self-worth. She also took on a nursery place for her son, and found that was very helpful in reducing her wish to use him as a target onto which to displace her anger. Although this work was complex and delicate, her insight and engagement helped her to face the most unacceptable aspects of herself, and to trust herself to parent her vulnerable young son. Within the context of her toxic partnership with a violent, and often absent partner, she displaced her aggression onto her son, an unwitting participant in this destructive relationship. She appeared to use him as receptacle for her own feelings of helplessness and powerlessness, and ultimately as a signal to the outside world that she was locked in a vicious partnership.

Medea crimes

Revenge through murder of children is the cruellest punishment that can be inflicted on the other parent, and on the children themselves; threatening to kill the children is one of the most powerful threats used to make a partner stay in an abusive relationship. Both men and women are capable of killing their own children in order to punish partners whom they feel have wronged them. When the perpetrators turn the murder weapon on themselves, they express a clear wish to die with their children and not to be held accountable for their murder.

In some cases, it appears that the loss of the relationship either precipitated or catalyzes depression, making homicide followed by suicide seem the only solution. The main motive in those cases is hopelessness and despair, rather than a straightforward wish for revenge, although it is well established in psychoanalytic theory (Hyatt Williams, 1998) that the suicidal impulse also contains within it a homicidal one. This can clearly be seen in the cases of women with whom I have worked, who have attempted to kill themselves along with their children, but have 'failed' to do so, although succeeded in murdering at least one of their children. They often describe a sense of deep regret that they are still alive, and feel that their task is incomplete.

Cases of attempted suicide, alongside murder, where the mother appears to have loved the children and attempted to 'take them with her', rather than wanting their deaths to be a form of vengeance may indicate maternal narcissism. In such a case, it is clear that the mother has not been able to conceive of her children's separate and discrete existence, continuing beyond her own life. Her profound inability to know where her body ends and her children's begin leads to these tragic consequences.

Despite the fact that children are most at risk of violence, including death, within their own families, 'stranger danger' is far easier for the public imagination to bear – it is much more palatable to locate sources of evil outside the home, in faceless 'others', than to look at the chilling reality of violence,

sometimes fatal, that takes place in the domestic realm, perpetrated by family members. It is also simpler to place blame entirely on one parent and to locate savage impulses in him. However, it is often the case that, if one partner actively kills a child, the other has colluded with him (or her), by looking away. The accomplice parent may have been aware of their partner's murderous feelings, abusive behaviour and dangerous potential but turned a blind eye, or even facilitated the cover-up, perhaps providing an alibi or helping to hide the body of the victim – her own child. At the point where a child is killed they have become so objectified, so 'other' and non-human, that the disposal of the body is seen as a necessary part of the act. In a sense, it completes the annihilation of their existence that has already taken place.

Self harm and self harm by proxy

Female violence often takes the form of self harm. The woman's own body can be understood to represent that of her mother, symbolically embodied in her own, and so she turns her violence against herself. This aggression serves both as re-enactment and revenge, creating an addictive and dangerous pattern of activity that replaces thought and prevents intimacy with another. At times the woman's choice of violent partner is also a form of 'self harm by proxy'. For some women, violence by their partners serves as a form of self harm, as they can hurt themselves brutally without using needles, knives, razors or matches on themselves. This rids them of unconscious guilt, fits a pattern that may have been modelled by their own mothers and further erodes any sense of their own self worth. Furthermore, it powerfully reinforces the notion that violent action is the most effective means for evacuating disturbing feelings. This resort to the world of bodily action, reaction and pain is familiar, and can even offer a form of bitter comfort. Physical pain is the conduit for intimate relating and the currency of communication. The contact made through violence is one that shatters the integrity of body boundaries and can leave scars and signs of this contact. It has a visibility and immediacy that is shocking to those who do not operate in this world of visceral contact, and also has sexual connotations and aspects that create their own disturbance and excitement. The symbolism of scarring, caused by self-inflicted wounds or those caused by others would be an important area of psychoanalytic research, drawing on the significance of the skin, as described by Esther Bick (1968) and more recently Ulnik (2007) and Lemma (2010).

Technical considerations in the treatment of female perpetrators in violent relationships

The issue of avoiding a re-enactment of toxic coupling in the treatment with women who have committed acts of violence against their partners or children is central. It is easy to fall into a punitive or protective relationship with the patient in therapy, who can evoke strong feelings of anger or a powerful wish to rescue.

This can be understood as an unconscious projection by the patient of wishes to be either punished in accordance with her own guilt feelings, particularly awakened if she has left or 'abandoned' her violent partner, or to be rescued and transformed. The latter is the unconscious wish to be 'reborn' and to receive the protective and loving care of which they were deprived in early life, and that appeared to be met through the violent relationship that has now broken down.

Both powerful wishes can be projected directly and may resonate with the therapist's own unconscious needs and fantasies. The power of projective identification with these aspects of the patient and her history is intense, and offers a rich source of communicative data. The therapist may, at times, become identified with the controlling, punishing partner, who scolds the other for her perceived weakness and reluctance to leave destructive situations; she may feel frustrated and angry, using interpretations as form of violence. This may leave the patient feeling humiliated and battered. At other moments she may be in danger of enacting the role of the fantasised saviour, who offers endless succour and care. Acting into these wishes is ultimately unhelpful and will not allow the patient to find her own sense of containment and self-efficacy and to express and own the rage she feels. Rosenfeld (1987) describes the powerful force of such countertransference responses as resulting from the therapist's wish to perform 'a corrective emotional experience'. This urge must be resisted if the patient is to be helped, to articulate and process what has previously been unbearable. In the case of violent women, the sense of deprivation underlying their fury can invite an acting out of reparative wishes, coupled with a real fear of awakening their anger.

There is little sense of a shared sadness and joint participation in destruction within these partnerships but a much more dramatic quality in which one party is the victim and the other the perpetrator of violence. In Paula's case, she saw herself clearly as the aggressor and felt infuriated by her passive husband. She found it painful to acknowledge her own vulnerability. The splitting and rigidity of the roles can lead to a reductive understanding of the relationship that the therapist can act into, unconsciously falling into the role of the perpetrator or victim themselves. To help the woman entrenched in these dynamics, it is essential that she can be enabled to recognise the sense in which she has unconsciously allowed her partner to enact her violence for her, or, unleashed her own rage against her children, rather than simply submerging herself in a sense of despairing powerlessness. Enabling this recognition will not be possible if the therapist is judgemental or persecutory but can be assisted by the robust neutrality of a therapeutic stance. As in other cases of forensic psychotherapy treatment, the therapist acts as an auxiliary superego that is not cruel and relentless. The potential for sadomasochistic re-enactments within the therapy itself is significant and must be borne in mind.

There are other risks for the woman who allows this work to reach her. As she gains awareness of her own hostility, both towards her partner and her children, her defensive structure will be weakened and the resultant threats to her psychic integrity can generate increased self-harm or suicidal feelings. Her sense of guilt

and beginnings of awareness of her own aggression can lead to a persecutory rather than reparative depression and the increased risk of self destructive action is important to monitor. Again, the containment and insight that can be offered within a strong therapeutic relationship can help the woman to survive the emergence of this persecutory guilt.

The link between homicidal and suicidal urges (Hyatt Williams, 1998; Motz, 2001/2008) is particularly strong in mothers who have fragile conceptions of themselves and narcissistic ways of relating to others. Their children are viewed as objects, reflecting aspects of themselves, including hated parts that they disavow. In the case of murderous couples, there is an unconscious contract between the two that enables acts of profound cruelty, deception and betrayal. This creates the conditions for child abuse and murder, as well as the killing of other third parties who pose a threat to the couple, or whose torture and death provide a form of excitement for them. Welldon (2012) describes situations in which children are deliberately killed by a couple as examples of 'malignant bonding'. A couple unites in their desire for cruel re-enactments, sometimes for sexual excitement, in which children are used as objects to be tortured and violated for the pleasure of adults. She explains how in some cases the children's suffering is recorded for the purpose of homemade pornography. The sadomasochism involved in such sexual torture can be seen as a form of rehearsal for the actual killing; the murder has happened time and time again in fantasy before it is enacted in real life.

This powerful link between homicidal and suicidal feelings is essential for the therapist to bear in mind as, when insight increases, so too does the wish to punish oneself. This insight can also be seen when a female accomplice to killing reclaims her projected aggression, and acknowledges her own murderousness. Once she is no longer able to locate these unacceptable and frightening states of her mind in her partner, her psychic equilibrium is jeopardised and suicidal feelings may then surface with catastrophic intensity. Just as a mother who has actually killed her own child, albeit in a psychotic state, may become seriously destabilised as the psychosis recedes and she recovers insight, so too can a woman who has configured herself as a passive, tragic victim in the murder become deeply depressed as she recognises her own active part in the crime. She has also killed off hope, as represented by her child, which may lead to profound helplessness and depression (Adshead, personal communication).

This process of insight is evident when child abusers, who have acted as part of a couple or a gang, begin to recognise the extent of their own individual culpability and cruelty. Through forensic psychoanalytic psychotherapy they can begin to acknowledge their own responsibility and finally give thought to the damage they have inflicted, neither of which will have occurred during their immersion in the abusive activity, and the partnership that fed on such sadism. A psychotherapeutic approach that recognises the painful, paradoxical juxtaposition of both victim and perpetrator in the same person is crucial. This will trace the individual pain and disturbed patterns of relating that is

disguised within the complex and dangerous dance of the couple (Clulow, 2001; Welldon, 2009).

Conclusion

When working with women who are entangled in violent and abusive relationships, it is essential to bear in mind that they too can be perpetrators within these toxic couples. The projection of aggressive impulses into the (male) other within these violent couples can serve to disguise the fact of female violence, but the sensitive practitioner needs to look below the surface and accept the fact of female perpetration in order to allow the woman to speak about her own unacceptable feelings and impulses, and engage her in the real work of therapy. The dual role of the woman as both victim and perpetrator in intimate partner violence can be replicated and re-enacted in the therapy as the therapist feels pulled into the role of victim or aggressor themselves. It is also essential to remain vigilant about the risk to any children in the household, as they can become the targets of the couple's shared rage, or the receptacle of the poisonous feelings of either partner. Working with individuals or with couples who are enmeshed in destructive dynamics requires acute awareness of the possibility of re-enactments in the therapy, and the need to resist these, and to remain still in the eye of the storm.

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Note

1. Details have been changed to protect confidentiality

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