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Aspects of the technique in contemporary psychoanalysis with the couple and the family

Rejection feels better than longing: A borderline couple with traumatic lesions[1]

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Summary

This paper takes up the challenges of engaging in object relations oriented treatment, a couple with deep personality disturbances. Several vivid session transcripts illustrate the couple treatment which reveals borderline dimensions and primitive survival preoccupations. The author discusses the couple's suffering characterised by deep psychic lesions, that have dominated 12 of the 14 years of their marriage and family life. Clinical theory concerning borderline pathology

[1] A lesion is any abnormality in the tissue of an organism (in layman's terms, "damage"), usually caused by disease or trauma. Lesion is derived from the Latin word *laesio* meaning injury. Amygdala lesions change the functional pattern of activation to emotional stimuli in regions that are distant from the amygdala (Wikipedia, 2017).

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is examined as a basis for considering proper treatment with such a couple. The paper discusses the distinction between couples who are easier to engage with and those for whom the relevance of the presence of the therapist is minimal. In the case presented although the couple and their four children appear to be in some chaos, couple dependency on the therapist appears vague, and ambiguous, requiring the therapist to remain alert to opportunities to make contact. The couple's misuses of their children's developmental needs indicate they their poor capacity fro relating to others. One session describes an intervention aimed at the abnormal sleeping arrangements of the family, a key indicator of the difficulties in this family group. The case material also demonstrates interventions that highlight intergenerational transmission of psychic lesions, as well as here and now attempts to promote containment and reduce splitting. The author provides his clinical work as an invitation to the reader to think about a way of treating very challenging couples.

Keywords: traumatic lesions, borderline, intergenerational transmission, splitting, projective identification, rêverie.

Résumé. *Le rejet est meilleur que le désir: un couple limite avec des lésions traumatiques*

Cet article relève le défi de faire participer un couple avec des troubles profonds de la personnalité d'un point de vue psychanalytique des relations d'objet. Plusieurs transcriptions de séances saisissantes illustrent le traitement de couple qui révèle des dimensions borderline du couple et des préoccupations de survie primitives. L'auteur aborde le couple souffrant de lésions psychiques profondes qui ont dominé 12 des 14 années de leur vie conjugale et familiale. La théorie clinique du couple borderline est proposée pour fournir une base pour envisager un traitement approprié avec ce type de couple. L'article discute de la distinction entre couples plus engageables et accessibles et couples avec lesquels la pertinence du thérapeute est minimale. Bien que le couple et leurs quatre enfants semblent être en proie au chaos, la dépendance du couple vis-à-vis du thérapeute semble vague et ambiguë, obligeant le thérapeute à rester à l'affût des occasions d'établir des contacts humains. Les mauvais usages du couple quant aux besoins développementaux de leurs enfants indiquent qu'ils vivent en marge des relations humaines. Une séance décrit des interventions modestes dans le système bloqué de l'organisation du couchage.
L'auteur présente son travail clinique comme une invitation au lecteur à apprendre à traiter des couples très difficiles.

Mots-clés: lésions traumatiques, borderline, transmission intergénérationnelle, division, identification projective, rêverie.

Resumen. *El rechazo se siente mejor que el anhelo: una pareja límite con lesiones traumáticas*

Este artículo retoma los desafíos de comprometer a una pareja con profundas alteraciones de la personalidad desde una perspectiva psicoanalítica de las relaciones de objeto. Varias transcripciones de sesiones vívidas ilustran el tratamiento de pareja que revela las dimensiones límites de la pareja y las preocupaciones primitivas de supervivencia. El autor discute la pareja que sufre con profundas lesiones psíquicas que han dominado 12 de los 14 años de su vida marital y familiar. La teoría clínica de la pareja límite se ofrece para proporcionar una base útil

para considerar el tratamiento adecuado con este tipo de pareja. El documento discute la distinción entre parejas límites y parejas más atractivas y accesibles con quienes la relevancia del terapeuta es mínima. Aunque la pareja y sus cuatro hijos parecen estar en cierto caos, la dependencia del terapeuta parece vaga y ambigua, lo que requiere que el terapeuta se mantenga alerta a las oportunidades de establecer contacto humano. El uso indebido de la pareja de las necesidades de desarrollo de sus hijos, indica que viven al margen de las relaciones humanas. Una sesión describe intervenciones modestas en el sistema estancado de arreglos para dormir. El autor proporciona su trabajo clínico como una invitación al lector para aprender sobre el tratamiento de parejas muy desafiantes.

Palabras clave: lesiones traumáticas, transmisión límite, intergeneracional, división, identificación proyectiva, ensoñación.

Introduction

This case cast a dark and ghostly shadow over me for some time. Many couples we work with transmit their trauma into the interpersonal space of our offices, through projective processes experienced in our countertransference and in vivo enactments. I could not directly experience this couple's *insideness* for a long time and felt bogged down from the start by their dysregulated attachment that had a colonizing effect on each of them which could be traced inter-generationally. The couple's associated dissociative defenses will be illustrated by session material described below.

I had to make a paradigmatic shift in my approach due to the seeming impossibility of entering their world and containing in usual ways. Oscillations occurred in acting out and attempts at couple recovery, and the deadness of affects at most other times. Mutual over-regulation of each other's affects was achieved by speaking blandly, quietly, and in a manner which lacked personal references to what had happened between them over a twelve year estrangement. It felt like their realtionship had expired many years ago, and that they were coming to me for a post-mortem. I felt I was in a "dead" zone. They were solidly stuck in an interplay of attachment failures that they could not describe, and I did not comprehend. The couple presented long-term sexual and emotional estrangement, although they had produced four daughters. The wife's had decided to abort a fifth healthy foetus. I use the idea of psychic or traumatic lesions to describe their deeply split off aspects of self and the challenges I encountered.

When individual complaints were volunteered each of the couple accepted them easily at first and were in agreement, but there was no elaboration or details. Among the complaints were no sex, and no affection over twelve years of the fourteen-year marriage. They agreed they were by and large getting along, and taking care of their four daughters. The husband was an able accountant, and his wife a well-regarded pediatrician; they worked hard and had a materially secure family life.

In the early sessions I listened with a waning interest. They were so tightly wound and flat my energy level went flat as well. I noticed that each would turn to me when

speaking; they could not tolerate looking directly at each other for more than a few moments when complaining, seeking me out as a safer receiver of as yet unexpressed affects.

A paradigm shift and theory of the borderline couple

Due to my family therapy training I have a pre-occupation with understanding the effect of transgenerational wounds that have personal relevance in my life and in trauma work. Current psychoanalytic technique is informed by shifting from a usual one generational model suited to some couples. I have found that the one-generational approach may not be as helpful with the most difficult cases. I keep my mind alive long enough to gradually interweave an enquiry into the distant past that is productive when focusing on the couple's too toxic one generational developmental line. In the early sessions I learned alcohol consumption was a buffer and a release at the same time for the wife, which kept her husband at a distance, while she socialized and flirted with men and women in his presence; temporarily escaping from the depressing feelings associated with a marriage that felt deprivational. She could maintain the balance, by letting off steam as an exhibitionist, I noticed, with two divorced women friends in particular.
For her alcohol addiction appeared to have been a source of relief for her significnt unconscious longings whose origins I was initially unclear about. The soma can of course be driven by a secret wish to possess the other. For this couple I conjectured the wife was an exciting object to provide a relief or release from deeper longings of each of the partners for a maternal experience that were denied. The husband tried to rescue the wife, or he had no part to play, except as an admirer of her acting out seductively with others. I speculated further that otherwise the relationship felt dangerous and abandonment terror would emerge.
The role of an omnipotent transferential object (schizoid/narcissist) with a helpless subject (anxious, fearful dependent) can initially evoke an idealisation sufficient enough to start a couple relationship, but disillusionment soon surfaces with a vengeance (Bagnini, 2012, p. 69) as in «I feel, therefore I act». I viewed the severe need for alcohol on the wife's part to function as a narcissistic compensation motivated by disillusionment with her husband and unrealistic marital expectations.
Projective identification has a containing function when driven by "K" (*Knowledge*) emerging from contained experience. Destructive or bad objects are however, dangerous and threaten containment in marriage as well as in treatment, for couples who are more severely regressed. Fluctuations from paranoid schizoid (regressive) to depressive functioning, in more integrated personalities, requires a capacity for negotiation and recovery. These are not ordinary abilities for the more traumatized couple, for whom ambivalence is not easily in reach. Pre-ambivalence is the defence designed for self-protection against breakdown during the earliest developmental period (pre-oedipal disaster) (McCormack, 2000).

Projective processes with borderline couples

Whilst projective Identification has a containing function it also has a –K component (Bion, 1963) when it is fueled by paranoid/schizoid or anal sadistic phantasies (Klein, 1946, pp. 99-110). Such phantasies are associated with hatred and fear of the *needed* and unavailable "good" object. In clinical work with borderline couples care must be taken to tolerate attacks on therapist holding, as ruptures in holding represent expected failures in dependency. Experiences and mistakes with such couples have taught us to recognise these aims for self-protection as primary. Saturated interpretations about why the patient is attacking or defensive are too abstract for pre-symbolic regressed patients, and can cause further splitting or retaliation from the couple.

As appropriate approach is for the object (therapist) to function as a psychic container. The therapist fulfills the need for reparation and re-integration if he is able to identify initially with and tolerate the anxiety associated with counter-dependency when becoming the object of negative transference. As the title of this paper suggests, rejection is more tolerable than longing, and the therapist is expected to resist his longing to become a good and admired object. The therapist must allow the couple the space for testing his reliability and trustworthiness first.

Therapist conscious receptivity to primal material may occur before the therapist participates in an enactment of the primitive projection process; one example is an unconscious seduction as part of an early contextual transference. Here the patient functions as the childhood based rejecting or negating *parental object.* In this situation the therapist immediately feels like the patient felt as a child-therapist has become the subject of the patient's parental persecutor. Hopefully the therapist is capable of a temporary acceptance of the action of the transference in order to understand its link to infantile trauma and neglect in the presence of the other. The therapist must recognize the reverse of the patient's paradoxical identifications with the primary object, when he feels like the *subject*-the patient *as* a child. Attention to the details of transference and countertransference are crucial in working with couples with traumatic lesions. We keep in mind that the above processes can include both partners, so the treatment system becomes complex and emotionally intense.

The treatment couple

The couple, Julie (age 44) and husband John (45) have been sexually and affectionately estranged for 12 years of a 14 year marriage, while insisting they were still great friends and parents. They have four girls, aged 4, 6, 8 and 11 years. Child-bearing took up six years of their 14 year marriage, by mutual agreement, after the wife completed medical training. Her husband operated a successful import-export business.

I spent two sessions gathering up their concerns and individual and couple histories. In general they offered information in a matter of fact, and cooperative manner, and showed little expression

of anxieties or emotional distress. Their reserved style of presentation allowed for an easy exploration of personal histories.

One significant event emerged when I asked about their current family status. There was one miscarriage and an abortion of a healthy foetus, stated unemotionally by the wife; her decision to abort having to do with refusing to give birth to another female. The desire for a male child had been conscious and explained as a need to know how it would be to understand closeness between a mother and son, since as a child, she and her father had been marginalized by the her mother, who was devoted to her brother. When discussing these "facts" and motives behind the abortion of a healthy female foetus, there was no affect, but her face flushed when I commented that this decision appeared driven by a lot of hurt and fury at her mother as much as by a wish for a solution to painful estrangement in the family. At this point, I noticed she began to become tearful. Her husband said he was not consulted about this important decision, and that he went along with her believing that the woman has the ultimate choice. He showed no emotion during the discussion.

I thought that estrangement in the couple carried traumatic inheritance which paralleled the wife's story of family estrangement. When she was 14 until she was 17 years of age her mother completely ignored her husband and her instead devoting herself to the son, who was reported as accepting the arrangement until he left for college. Her husband did not put up much of a fight either when his feelings were ignored over the abortion of his "baby".

Later on I admitted to the couple I was holding two different but related concerns: the first was about any and all matters pertaining to their long term estrangement, and secondly a concern that realted to the fact that as I was exploring the wife's painful adolescence and her long standing refusal to re-think the later choice to abort her female child I was experiencing a degree of emotional distress that I believed was present in the room. I commented on what I saw to be a very delicate emotional situation that needed close attention in order to determine if we could free them up to reclaim their marriage.

My impression was that the wife behaved like an emotionally impoverished derelict, living in a bastion of a lost childhood, incapable of recognizing her murderous aggression towards her objects. There was no sense she was ever distraught because she was immune from feeling her experience, an omnipotence protected by ignorance. The shield of innocence beneath the dissociative defence transcended human responsiveness to her suffering and that of her husband. It appeared that she wanted the world to accept that she did not want to bring another daughter into the world; what was split off was any feeling about killing a healthy foetus. Early in the treatment the wife's dissociated experience was palpable. I felt exposed to horrible emotional reactions in myself about *murdering* a female baby.

What could not be known or felt by the couple was experienced by me in sense impressions in my countertransference. A feeling came over me, a dread that the couple was a "no breast" couple in which a complete absence of attunement was my fate. I had no coherent thoughts at first. It was complicated for me to hold two powerful states of mind: one about the baby who was destroyed due to being the wrong gender. I experienced a *merciless* and ruthlessness in her that felt psychopathic; and the husband appeared adjusted to his loss. He had not experienced a loss as yet. At the same time I felt a small amount of empathy for the wife as a child who had been the likely recipient of murderous hatred from a mother who not only preferred the son, but whose cruelty must have had unbearable effects on the wife's ability to see any goodness in the world, much less herself.

As time went on the husband's coping demonstrated a similar pattern. In Ogden's sense of a "mechanical, self-sufficient omnipotent world" (Ogden, 1997, p. 60), and Tustin's "*autistic*

objects" (Tustin, 1980, pp. 27-40). I felt their impoverished dependency on each other, but nothing of a personal regard. In my countertransference I hated the wife for the *psychopathic* deliberate cruelty and destruction of a viable life. I was caught in a primitive emotional state: one part of me painfully identified with the baby who was the wrong gender and was sacrificed; and thought of my abortive attempts to give birth to a viable treatment. I felt helpless about not preventing the abortion as did the husband. The other side of the split was the rage at the mother that hated my female patient. As a male therapist I was a witness to the wife's total abandonment from her mother; and the horrific consequence. I was shaky in believing I could provide a setting for addressing the deeper issues, with little confidence the couple were capable of experiencing what the past meant.

I attempted to make sense of the current situation they reported. A shift was needed to address the longitudinally-repressed and dissociated attachments in both spouse's psychic inheritances, in order to create a new emotional experience. A new emotional experience might re-work traumatic overlays if accomplished in a safe environment.

Each spouse unconsciously identified with a traumatising and likely traumatised parent or parents, but when memories associated with traumatised events surfaced they had no significance in connecting current suffering to past life. Things just happened. Current events were embedded in the dark past, impossible to forget but not remembered; the couple could not process emotion or session content symbolically. Needs for nurturing and comfort were in themselves shame-based. In the borderline sense this was an "anti-coupling" couple. There was a shameful fear of never being able to couple and the impossibility of curing an "incurable" dead place inside them.

Unconscious selection of a mate in borderline marriages

When thinking about this couple I was reminded about the unconscious attractions of personality types in such marriages, namely the *Narcissistic/Schizoid* and the *Borderline/Masochistic* personality types.

The Narcissistic/Schizoid personality type represents an individual that is over-individuated and un-relational, is consistent, obsessional and stable, while so apparently self-sufficient that intimacy needs are masked or not established. Sex on the other hand may be the primary means of connecting and maintaining the relationship; however the other partner has to be willing to provide sufficient sexual gratification to sustain the limited connection. The other partner, is more likely a borderline, and functions as an over-relational under-individuated vibrant, exciting, variable and attentive partner. *The Borderline/Masochist* provides admiration to the other, at least for a time. After children, however, a child may suffice as the displaced idealized narcissistic composite of the borderline's fractured self, leaving the schizoid partner more entrenched in a psychic cocoon, yet missing the sexual services that stimulated the marital interest. Marital and family life are stable enough as long as the children are interactive, affectionate and tightly colonized so as to assure the marital pair that their union has continued value having produced children that represent hope and pleasure. The consistency and stability provided by the over-individuated partner is appreciated by the borderline partner; at least for a while.

Containment in the borderline marriage is established as long as the needed parts that are lacking in each partner are accepted by the other - a reciprocal projective identification (Lachkar, 1992). If the couple types discussed are compatible life goes on; if anything of significance changes the rigid projective matrix undergoes a seismic shift, without sufficient flexibility or integrative capacities to adapt.

Each partner is doomed to provide for aspects of the other partner's sought after needs but deficient capabilities to develop a whole object relationship. Whether oscillating between the tantalising and the emotionally distant dimensions of the two personalities, lurking close to the surface are affects associated with rejecting and clingy elements, because neither partner is developmentally a whole object. Destabilization occurs in the couple system when individuation strivings in the clingy-devoted partner increase, and there is a reduction in specific libidinal supplies, and the seemingly individuated partner becomes more anxious when the devoted audience has turned away. Another possibility is when the more schizoid partner becomes more dependent, say after a loss of position or status in career, or an illness.

Individual and couple polarized states of mind

Borderline couples are destructive of complexity in communication due to high anxieties about "meaning making" or symbolizing emotional experiences (McCormack, 2000). These couples prefer concrete "knowing" so they can be vague and unclear when asked to bring past experiences into the present. Hard-wired beliefs accompany these couples into therapy, with reactive emotions and self-preservation defenses. They have fragile and rigid psychic structures that carry two traumatised pasts into the selection of a mate. The union produces a borderline relationship embodying deeply scarred toxic and reactive dynamics that feature a negative third-meaning because they have in common a psychoid destructive and dissociative anti-libidinal joint personality. As we will see there is a blurring in conversation such that little is known, while much may be stated; emotions that arise are given simplistic references, and disconnections abound during couple exchanges.

With less traumatized couples the dissociative continuum can include mild detachment from immediate surroundings that preserve an in-touchness with the world of emotions and reality, useful in managing stress or boredom, such as in daydreaming. In extreme dissociative states a flight from reality occurs, in a hunkering down with a loss of memory, or amnesia, or identity distortion or diffusion. This is the extreme of dissociation in which traumatic lesions are related to the overuse of dissociation defenses-hence the term psychoid, as this term suggests a psychotic process drives the flight inward as a defence against breakdown or from overwhelming violent affects associated with annihilating objects.

Fear of falling apart through enmeshment/fusion

Fear of over-reliance on a resourceless and unavailable other leads to the defense of over-individuation. Dependencies in a schizoid individual are saturated by the unconscious terror of being taken over and exploited. For the borderline partner abandonment anxieties are a central relational problem. Clinging may be attempted but feared, as it links to the despair associated with patterns of child exploitation that was followed by emotional abandonment.

Dissociation and traumatic experience in a couple

Object relations theory assumes that objects can be paired and split, approached and avoided. Ambivalence and pre-ambivalence is expected in troubled to ordinary intimate relating by degrees of repressed, dissociated or split off feelings based on needs that were frustrated or severely thwarted. For example: excitement cannot be integrated with libidinal needs due to its negative or survival function to ward off depressive anxieties. Pre-occupations with health or physical symptoms can similarly join a couple in a relationship in which the body may carry traumatic nuclei in the form of obsessive thoughts concerning bodily changes.

A session illustrating archival resurfacing from childhood histories

Session 13: T-Therapist, H-Husband, W-Wife.

I set the stage for this session by explaining that the information they were sharing had shed some light on the estrangement in the marriage, but that their backgrounds might offer an understanding of how things took a turn from which they had not recovered.

H: I was thinking how my childhood could explain us being so far apart, but even if it did what can we do about it now? After all what's done is done, and I don't appreciate people blaming everything on the past.

T: You might be wondering if I want you and W. to go on a witchhunt. Perhaps you are starting to believe that past events are *so* significant better to ignore them.

H: In a way I have been affected by your approach to us and the way you explore beyond the facts. I'm not used to that and it upsets W. As you have seen she cries easily when the past comes up (I notice the W's tears come and go with no elaborations on what affects her).

T: You become uncomfortable that when she gets emotional about her family experiences you might be drawn in?

H: I don't see her cry at home; frankly I'm not used to this at all. Are you sure we should discuss upsetting things with her?

T: W. can you see any benefit in bringing history into conversation? Your husband may be feeling protective and a bit worried you might become overwhelmed. In the present moment you both appear anxious when emotions run high.

W: When you ask questions about us and how we got this way I don't have memories that much. Maybe my husband. should go first since he had a horrible childhood.

T: Quiet and waiting.

H: O.K. I'll give it a try but I don't see how the past has anything to do with our marriage; after all we are adults and should be able to account for our decisions.

H: I was born in Belgium and there were six of us. Four sisters and my brother and me. I was the eldest. Years later I found out two of my sisters were born to another woman that my father had an affair with. My mother took them in when their mother went to America to stay with another man. I thought they were my sisters. I was the oldest and was supposed to look after the two younger ones. The two youngest were the step-sisters I guess you could say. Then my father left my mother for America and I didn't see him for a long time.

T: What age were you when he left and when you saw him again?

H: (no affect but thinking) I was five when he left and learned later he met another woman in the states on business with two children and they became his new family. I was eight when he showed up for a visit without telling me. I hid under the bed and my mother insisted I had to see him. But first she forced me to write a letter to him that she dictated while he waited downstairs in the lobby.

T: Can you recall the letter?

H: (His wife is looking down at the floor as he speaks) she told me to write: "Dear Dad, Mommy misses you and me too. We want you to come back or mommy will do something bad to herself. Love H.". She pulled me out from under the bed and sat me down. Then I took the letter to the lobby and my father took me out of the building for ice cream.

T: And the letter?

He looks away from me and W. focusing on a colorful needlepoint on my wall of an Eskimo family fishing through a hole in the ice.

H: He read the letter (looking away).

T: I feel as you remember a terrible time you want to crawl back under the bed for comfort.

H: (Looks at me in a moment of recognition). He smacked me in the face, took me back home and left me in the lobby. Not a word. After that my mother married my stepfather and that was it. He was nice to me sometimes but only when I did what he wanted.

T: You did what you had to, what mother demanded. Father physically hurt you for obeying mother; you knew that was not your letter. The shock of seeing him and being treated so badly when he was out of your life for so long. That had to be horrible.

W: He had two crazy parents. Tell Carl what your mother did with the present she got you when you were six.

H. (Smiles as though he has gotten emotionally past the helplessness, the fearful and disturbing exploitation by his parents. The affectless dissociated aspects of his memories shift to a different narrative, partly through his wifes's need to escape from an exposure of traumatic events of her own I suspect); I think she is manipulating H. to suffer the internal catastrophic "day-mares" they might later share, perhaps after years of therapy.

H: I was always treated as mother's favorite and she told my siblings regularly. Once when it was my sixth birthday she brought me a large decorated box and gave it to me in front of everyone. She said it was something I really deserved. When I opened it is was full of dog shit. Everyone laughed but me. I didn't feel anything. She told me I deserved it because she changed her mind and I shouldn't think I was so special anymore. The other kids were complaining to her.

T. (Private thoughts) I was filled with rage and sorrow at the bind that the H. was in from a young age. He had to bury his affects to survive a dangerous and ruthless mother and a father

who abandoned him. The father's narcissistic entitlement produced children on both sides of the Atlantic Ocean. DNA was his only contribution to their lives.

T: From the two stories you have shared I wonder if trusting yourself with a woman might have become very troublesome later on. In my mind I am still with you under the bed where you have led me today. Frankly I can't be sure whether your fear of mother's breaking down due to your father's unannounced visit is as important as the shock of dealing with what he wants from you. Seemed to me you sought safety under the bed. Dealing with both parents was impossible since they each live in their own world. Your instinct to hide was correct but your parents had the power.

W:We never talk about these things at home. It doesn't change anything. I have my old family problems but I push through it and don't think on it. They just come up when we are here.

T: Yes. You learned from your parents to keep everyone comfortable and you stay under the covers like good obedient kids do. If you don't think about how you got to be who you are as a couple you can numb the past in the present. That's how your parents may have dealt with their origins too. Yet, here you are twelve years into a marriage you agree isn't close and hasn't been since before children. You (wife) have relied on Effexor for 12 years, and a lot of alcohol too. You (Husband) stay in another bedroom and sleeps with the girls for companionship. Your marital health concerns me. True it is an act of faith to come here and talk this strange new language of memory and feelings. I appreciate the concerns about how I work. I think we have work to do at a pace you can tolerate. That's my lecture for now.

W: I don't know.

H: I think I have feelings that are kind of coming up.

T: Yes?

H: Like under the bed feelings…I was afraid and did not know it or why. Talking about that is different here. W. has lots of depressing thoughts and blacks out after she drinks at night. I put her to bed and go into the study. In the morning W. cannot remember what she was saying. I think we should continue here-looking at W.

W: You want to work on the marriage? I thought or feared you just wanted out. W. tears up, but stifles words. (We wait)

W: He wanted marriage therapy ten years ago and I said no. I wanted it nine months ago and he said no.

T: You're here now. That's a good thing.

W: Nothing I want happens with him. He stopped being close to me years ago.

End of Session.

Developments during the following two months

The wife has continued to black out at home, consuming one half to three quarters of a bottle of wine at a sitting. It turns out this is usual. She is also getting drunk socially with friends with husband sitting on the sidelines while she dances and blows off steam. She reports it happily and with self-justification. She was angry with her husband in front of her children at dinner at a restaurant when drinking. When she does not drink she is reserved and bland.

She insists in sessions he rides his bike too often and should spend more time with the "family"; not with her alone it appears. He is finally standing up to her about the loneliness he feels in the home. They admit the children sleep with both of them in separate beds. H. is getting more concerned about the sleeping arrangements but has no perspective on issues concerning their

development, such as sexual stimulation and confusion. We have discussed their long term motives for a family sleeping arrangement and the potential effects on the girls. They are mildly interested. The husband admits the eldest pubescent child is very anxious lately and worried they will divorce.

The wife recently accepted my referral to psychiatrist colleague and is weaning very slowly off Effexor. I have insisted she consult with a specialist colleague to evaluate alcohol use as a potentially impaired physician. We discuss detox and potential for in patient recovery program if needed. She appears scared but rationalizes that she thinks she can cut down on her own, and insists she never drinks before or while on the job. I trust that is so as her career is a source of confidence and pride and she isn't self-destructive; at least not yet. The acting out through the children sharing their bed/s, the black outs and drinking, are coming into the sessions more. I think they bring in their individual differences (her drinking suits her and not him, Effexor doesn't suit her now) and similarities (sleeping with the girls) in order to become aware of their neglect and self-centeredness. I interpret that the children are keeping them from re-establishing an intimate connection, which faltered after the consecutive births over a six-year span and the abortion of a healthy foetus. I silently thought the couple was likely colluding to have a large family as a kind of safety cocoon so that sex was for procreative motives, not intimate connecting.

Other consequences of traumatic lesions in this case became known over many sessions. W. was an exciting partner only under the influence of alcohol and consequently become depressed and withdrawn after a binge. The husband was faced with the withdrawal of excitement and is unable to stimulate his partner due to her schizoid core. The schizoid's over-individuated tendency causes a further schism in the couple once the fragile arrangement breaks down. Unable to resuscitate his partner he becomes more emotionally reactive, less attentive and fears losing his partner's admiration. She no longer can keep up the stimulation that keeps the couple synchronized in the dance of limited flexibility and poor attunement. The prior fit cannot be maintained. She no longer dances for her partner but for others and herself; indulging her taste for more alcohol she acts up in social settings, flirts with men and with women, and later blacks out without memory. Her husband brings her back on line after she physically recovers, however there is little remorse over what she has caused. Their pattern of acting out is followed by "parental" admonition. The "stuck-ness" sadly reminds me that difference may be more containing than enmeshment but less satisfying than mutuality.

It takes time in the treatment for the husband's feelings to surface. Now the husband is a bystander, keeping a distance, whining as a hurt child whose needs are no longer important. He is there to witness the partner's breakdown, which causes a regression and panic as he seeks to reason with her and explain the bad she is causing. She is not moved, preferring to mock his frustrated dependency, insisting she needs a good time after a long week of work. He reminds her she has a bottle of wine at family dinners when only he is present and sometimes their children. She pays little attention to the facts as he sees them and insists she needs the attention that he doesn't provide. They bicker over the broken structure that kept them together for 14 years.

Intergenerational material and transmission of traumatic history

Session 31

W: I've been drinking less at night but I am having bad dreams that I don't remember.

T: What happens?
W: I don't know but I wake up in a sweat and my pulse is rapid. I must be having a nightmare. I don't want to dream if that happens. I'm almost off the Effexor so maybe that explains my sleep problem.
H: Didn't your mother suffer from insomnia?
W: She used to wander around the house during the night like she was looking for someone, so that's not insomnia, its sleepwalking. My father and she slept in separate rooms for years. My room was near dad and she would come onto my room and wake me up but I have no idea why. My younger brother slept with mom until he was 10 years old. I told you (to T) when I was 14 years old she stopped talking to me and dad until dad died and I went to college; my brother was her favorite and he and I only got together way after he got married years later. Mom was dead by then. What the hell does any of this have to do with bad dreams?
T: One idea I have is when upsetting things in a family can't be thought when they occur they get stored up in the mind for safety and then we dream, or begin to realize there is more to our stories than we thought.
W: I don't know about that - its an interesting theory.
H: I get it. I looked it up online. It is repression, right Carl?
T: Close enough.
W: I think it's the Effexor weaning.
T: What about coming here and our conversations?
W: Maybe you're getting to me you think?
T: Well?
W: I'll take it under advisement, maybe you should talk more with him. He needs it more than me (grins).
Silence.
T: H. mentioned your mom walking about at night and you corrected him. I thought he was wondering if your nightmares could have anything to do with the goings on in your home.
W: Look my mother was never O.K. and we did not get along. My grandmother came for a while to take care of her but no one said what was wrong.
T: Tell me about your grandmother and how that time was.
W: My mother did not leave her room for maybe a couple of years; depression? I don't know. She just withdrew and my dad and I took over the house and did everything. My grandmother took care of her. That's it.
T: Can we explore life before your childhoods? Like where your parents came from, their lives before you, grandparents, relatives etc.?
W: I don't know too much but my grandparents came over from Europe; as Jews they were driven out I think by the Cossacks in Poland. Children were not safe anymore and the soldiers would come and break down the doors and take everything, and my father told me one time if a girl was developed she might be kidnapped in front of the family. My great aunt was forced to marry a Cossack so the family was left alone. My grandfather was a baker and they were ok until the soldiers came. They got out of Poland but were caught later, my father said and sent to a concentration camp. My grandparents split up and I don't know how my grandmother escaped, but she got here and re-married and had my mother. Her husband died when I was two. My mother never talked about him but I was young so what did I know? (No affect present.)
T: Your mother had a mother who managed to survive but the two women lost an entire family in the holocaust.

H: We never talked about this before. All these people wiped out.
W: Yeah, that's what happened.
T: How did your parent's meet?
W: I have no idea. They were working in the same company I guess and got together and got married.
T: Your family history has violence, war, and death without voiced memories. And there is the survival of your mother who lost her father when you were two. I think mother needed her mother when she broke down later on. A delayed grief reaction maybe? Any thoughts from either of you about how the Pogrom affected W.'s mother and the next generation?
W: I'm supposed to feel something about that, but I don't want to.
H: I feel sorry for you and your mother and grandmother.
T: We have to stop for now.

Session 35

W: We wanted to talk about the girls.
T: I wait.
H: Eva (the eldest) is very upset these days. She comes into my room at night and says she can't sleep and I look so lonely she wants to know if we are getting a divorce.
W: And the others pile into my bed even though I can't get a good night's rest.
T: What are your concerns about the children?
H: You explained a few times they are getting more confused and worried about us.
T: And what about you W.?
W: I'd really like them to leave us alone and go sleep in their own rooms; but we never follow through. I get too tired to make the effort. And I think H. likes it that way.
T: Seems like something in each of you keeps it this way. No one wants to make the necessary change. What do you say when Eva shares her worries? (Addressing both parents).
W: I tell her we love each other and will work things out and not to worry.
T: And you H?
H: I tell her it doesn't have to do with her and that it's not her responsibility.
T: And then?
H: She's back the next night with the same anxieties.
T: I have the idea *here is* the oldest child, like both of you. Wonder if she is trying to represent or reassure her sisters, like a big sister might?
H: Never thought that. I don't want her to do what I did. Eva is having enough trouble focusing on schoolwork. Could she be worrying for the others? Jeezus!
He is showing more concern than previously.
W: Well what if we do what Carl tells us and have a chance at getting our bed back?
T: That's the "pardon my expression" a *mother load* issue since the children keep you apart and you have been avoiding sharing the bed together and the nighttime.
H: I don't know how to approach this. We haven't slept together for ages.
W: We could cuddle instead (she giggles for the first time ever).
T: Like take it slow. But what about the girl's feelings at being sent out after all these years? How might you deal with it? Might they be angry, sad, or anxious about sleeping away from you?
H: I'm not used to this at all. I've been rejected for 12 years. I may not have the heart for it, it is so disturbing to realize what I have lost.
H. Appears to be sad.

W: It's not my fault entirely (angry). I have been trying for a few months to hold your hand and kiss you good bye, haven't I?

H: It's not enough. (Looks at me) I wanted W. to come into my room at night not Eva. (He looks pained) I see what you are telling us-the girls are in a panic that Mommy and Daddy will divorce and we let them take over for us. Damn.

T: To help the girls you have to confront your hurts, and hates about the losses of each other. To get them sleeping in their rooms are you willing to learn how to be together in your room? I believe you are very scared of a new experience that will place you in a position of testing whether healing is possible. You are thinking about it... You are reeling from knowing how the old story lines are poor models for being a couple. We have a recognizable pattern with the bedroom cycle. If you make a space as a couple your children may become less anxious and responsible for looking after you. You can free them from the unnecessary burdens of your childhoods; but at a price. Thinking about separating your marriage from the parenting situation increases the pain and grief of lost love for the first time.

We discussed how the children are utilized, as *they* had been, in spite of their good intentions, and how the historicised neglect and absence of attunement in each of the partner's lives is being repeated in the exploitation of safety and comfort, displaced onto the children: Their respective parents had used the couple as pawns to ward off rejection anxieties. Hatred of being without a loving partner was displaced onto the children, whose vulnerabilities were exploited - to serve or be humiliated. I occasionally got their attention, and a dim awareness occurred with the above narrative, followed by a return to ignorance by repression. Benign guilt was difficult to access.

Discussion

The jointly shared couple terror of shame over symbiotic longing and its failures unconsciously haunted the couple; their children are caught up as were they, in repeating unrecognised self-states. Insecurities that link to a lack of safety, and a desperate search for comfort, seeks but doesn't find it in the parental bed. There is no adequate narrative and containment that modifies the repetition; I fear there may be no way that might be put to use to set things right. The generations continue transmitting detachment from thinking minds, dissociated experience, imperiling the future of the youngest family members. Shame over couple neediness and fear of longings were projected onto the children; hence the children became desperate and needy, while the parents remained helpless, and prone to narcissistically driven destructive repetitions.

During these conflicted periods I was not able to accomplish much awareness of the depth of their unconscious disturbances and attachment conflicts. They were blurring the "who" needs comfort as though the children were the focus of efforts to reassure all would be OK. I intervened by positioning the therapy as a possible cause of increased dangerousness to the family equilibrium. If they got their bedroom back what might occur? If they held to the long term arrangement of couple separateness and sleeping with their children what would become of their children's mental health? They could barely take in my observations that they were holding the children so close that all were hostages in the drama of the "un-thought known" (Bollas, 1987). The traumatic lesions

were encapsulated in the family bed. I believed the couple took refuge in the children's terror of a family breakdown. The ordinary breakdown that occurs when a couple is giving up on a marriage for a divorce had no resemblance to this couple's regression. The family bed had always been the couple's refuge from intimate mating.

At the end of a recent session the following exchange occurred:

W: If he will help me send them to their rooms I will stay in the bedroom together.
H: I want what's good for the girls whether it's good for us or maybe not.
T: You have a plan to test your concerns for the children, while making a space to determine whether being closer can be tolerable.

Concluding thoughts

This case illustrated deeply injured individuals in their marital and family relationships, and demonstrated major challenges to effective treatment. The extent of intergenerational neglect, and unprocessed traumatic exposures had insurmountable malignant projected effects on individual and family development. The couple brought its long-standing stalemate to the therapist, seeking some relief, without the capacity to generate sufficient consideration of their common lesions. Instead of realising their shared pain they remained mostly entangled in repetitions of avoidance, rejection, and neglect of dependency needs. The terror related to relying on each other for minimal nurturing supplies lingered beneath and fostered sado-masochistic actions: The wife's drinking and flirting and the husband resorting to accusations and sleeping with the children for companionship. These couples manifest a borderline configuration and are difficult to maintain in treatment due to the high levels of polarization and narcissistic self- regard; rarely are two perspectives allowed to co-exist, including the therapist's separate thinking mind.

We tread lightly attempting to initiate contact with each partner's narrative, and for long periods of time maintenance is the only possible treatment aim. If affects associated with grieving lost objects can be contacted it may open a way for a mourning experience with the couple. In this case mourning was not a developing possibility for both spouses. The husband eventually was able to feel regret and sadness, with increased awareness that he could not change his wife, while the wife continued to act out and eventually broke off the treatment.

What can be learned from traumatic lesions and borderline marriages is that the goals of the therapist must be minimal, and that couple work may inevitably lead to the ending of the treatment and marriage. However, in the conservation of at least one spouse's life there may be the potential for a future not born of the past. In that sense the therapy was marginally successful. The girls in this family returned to their rooms, the mother remained in her bedroom, eventually getting into alcohol rehabilitation, and the father eventually left the residence. Two years later the husband returned to this therapist for help with a new partnership.

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