between neurosis and perversion is radical and clear, contrary to what is suggested by Freud's formulation.

The notion that primitive aspects of mind coincide with pathology is also present in the theory of the second paradigm. Albeit not explicitly, Freud's confusion pervades Kohut's theory, which retains the hypothesis (taken from the psychosexual conception) of a stoppage at earlier stages of development, resulting in an alteration in the cohesion of the self. Perversion, too, is seen not specifically as pathology but as involving primitive defensive phases in search of growth. Such a theory seems to suggest that therapy should go back over the stages the patient has never been able to confront for lack of narcissistic reflecting objects. In such cases, the therapeutic setting would be appropriate for making good the primal fault.

In his interesting paper on this subject, Caper (1998) points out that some schools of psychoanalysis identify the primitive with the pathological, on the basis that psychopathological states contain the concreteness, idealization, grandiose fantasies and anxieties observable in the infant psyche. This equation gives rise to the erroneous supposition that pathology is the expression of primitive mental states. This is not, however, the case: the forces at work in the perversions and in psychotic states are destructive and progressively erode the mental capacities, such as the ability to depend on human objects and the possibility of learning from emotional experience, which is the very foundation of psychic health.

Notes

1. Greenacre (1979) notes that the word "aggression" is derived from the Latin *ad-gradi*, meaning "to advance towards"; it only later took on the meaning of an action with hostile intent.
2. This notion resembles Chasseguet-Smirgel's hypothesis of the mother's collusion in the idealization of the pregenital world.

CHAPTER THIRTEEN

Psychoanalytic therapy of the perversions

So far I have systematically discussed the problems posed by the clinical aspects of perversion, but have had little to say about psychoanalytic therapy with the relevant patients.

I explained at the beginning of this book why analysts have difficulty in presenting clinical accounts of the therapy of perversion in their scientific publications. This limitation, which seriously impedes the exchange of experience among analysts, applies to this study too. However, the presentation of a few psychoanalytic case histories would not only tend to restrict my proposed canvas and its general context, but would also exceed its intended scope. I shall, therefore, confine myself to a few general considerations.

The therapeutic approach to a patient with perversion problems is no different from other forms of therapeutic encounter, except that in these cases the analyst is aware, from the beginning, of the complexity of the clinical situation and of the analysand's problematic position.

In deciding to embark on therapy with a given patient, the analyst formulates reconstructive hypotheses (on the patient's infancy, the objects at his disposal for growth, the causes of blockage in his development, the type of infantile withdrawal that

can be identified, and so on), and seeks to understand the level and kind of suffering that can be relieved through the mutative experience of therapy. The historical-reconstructive hypothesis, which serves as our guide for establishing the elements that are present and capable of development, is an indispensable component of the decision to accept a patient in analysis. The psychoanalytic encounter presupposes the existence of two persons who are both involved in a relational situation; this is essential if there is to be any possibility of transformation, and attention must not be confined to the symptom. In this case, however, the symptom remains a territory to be explored. Symptomatic and structural considerations prove to be very useful in cases of perversion.

The perverse symptom often goes unmentioned in the initial interviews, and tends to be less prominent than the patient's general suffering. It is only later that its full significance emerges. When it becomes manifest, its position relative to the balance of the personality as a whole must be determined.

I have attempted in this book to define perversion and place it in its correct clinical context, and it seems to me that this is a basic prerequisite for settling upon a possible therapeutic approach.

Perversion is one of the possible expressions of an alteration of sexual behaviour, but not every behavioural anomaly in the field of sexuality is regarded as perversion. The complemental series of perverse manifestations, which extend, roughly speaking, from secondary, defensive entities to structured pathological organizations, guides the therapeutic approach and determines the course of the treatment.

I shall now attempt a typology of the patients most frequently encountered, with a view to identifying some possible therapeutic pathways.

As stated, the perverse symptom is sometimes localized. For example, it may consist of a set of imagined scenes that accompany intercourse and permit orgasm. Such symptoms are often hidden in the initial interviews and are communicated only in the course of the ensuing psychoanalytic treatment. They tend to arise in a particular type of sensitive and altruistic woman and frequently involve secret fantasies of submission that erotize the encounter with the partner.

In general, an important prognostic factor in psychoanalytic therapy is the extent to which relational and affective experiences have remained intact in the analysand's life. Our guide should be not so much the severity of the symptom as the affective and relational area that can be brought back to life. In the cases considered here, affective life may be impoverished more as a lasting consequence of a traumatic relationship, which prevents the patient from experiencing emotions, than by the presence of a perversion.

Affective relationships and emotional experiences are kept in a state of suspension: as soon as the patient embarks on her analysis, unexplored themes emerge, such as depression, fear of her own vitality, submission to the authority principle, or fear of affective bonds.

In these patients' dreams and associations, the analyst (especially if male) appears as a feared figure that may impose himself and abolish the interiority of the analysand, whereas female figures stand for absent, unreceptive or confusing mothers.

Therapeutic progress involves a delicate transference configuration in which the psychoanalytic space is gradually constituted as a vehicle for relationships, whereby emotional potentialities that have never before been expressed or experienced can be restructured. Particular attention must be devoted to the subjective experience of real trauma, which emerges in analysis with specific characteristics in each patient's history and must be brought out and distinguished from the world of masochistic fantasies. The therapeutic prospects are generally good.

Another common type of pathology encountered in therapy is a narcissistic personality disturbance coupled with impulsive sexual behaviour, often of a homosexual nature. The patients concerned are usually male. As a rule they feel an irresistible impulse to frequent places where sex can be had quickly (cinemas that show pornographic films, public lavatories, certain areas of parks, and the like). This activity is known as cruising.

Although this impulsive behaviour is more frequent in homosexuals, it is also observed in persons with a heterosexual or fluctuating orientation. The impulse arises at particular moments of loneliness when the existential void yawns. Cruising represents a search for excitation, an antidote to the *ennui* of life, a defence against the threatening depressive void. The subjects concerned

often have a history of deprivation in infancy, and sustain themselves with excited mental states.

In this type of sexual excitation, the partner must be unknown and the encounter anonymous: what is sought is a body or a penis, not a relationship. Any kind of human relationship, even simple courting, would threaten the excitatory progression, which assumes the character of "turning on" to a drug.

Although such sexual behaviour admittedly has perverse aspects, it cannot be regarded as a perversion proper: the common factor seems to be the dehumanized context of the sexual encounter. The dehumanization not only results from a state of need but is also essential for keeping the excitation alive and inducing orgasm, owing to the predatory nature of the encounter.

Such patients have not developed a capacity to enter into relationships with emotionally significant objects; in other areas too, they function with excited mechanisms that are often manifested in impressive performances on the social stage. Their impulsive sexuality seems to be established as an act that is pleasurable in itself and as a defence against moments of existential void. These subjects' perception of emotion is extremely elementary; lacking introspective capacity, they are driven by impulses of whose origins and dynamics they are unaware.

In all these cases, the psychoanalytic relationship—to the extent that it allows the construction of an internal world—enables the patient gradually to cast off the yoke of impulsive sexualized behaviour, which in almost every respect strongly resembles dependence on drugs.

An important determinant of the therapeutic approach to the group of perversions is the presence of acute fits of anxiety, as in the case of borderline patients who engage in anomalous sexual practices as a protection against psychotic breakdown. The perverse act is episodic, acted out in promiscuous and always variable contexts, and thus differs radically from a true ritualized perversion in which nothing is left to improvization.

Some borderlines with very unstable personal and sexual identities alternate between episodes of sexual acting out and periods when they only have perverse fantasies, which become accessible to analysis.

With such patients, the perverse psychic state must be placed in its correct perspective, so as to give the patient an interpretative key to the type of mental functioning that may be unconsciously dominating his life.

For this purpose it is useful to investigate the first infantile fantasies, when they appeared, and how they were limited or, conversely, gained more and more ground. In all these cases, particular importance attaches to the problem of the confusion of meaning.

Since these patients constantly live in a state of potential confusion that may alter and distort the psychoanalytic relationship, it is important for the analyst to be able to protect the relationship with the patient from sexualized contamination. Excessively "neutral" behaviour or inappropriate interpretations may lead the patient to assume that the therapist is a willing participant. When this occurs, sexual acting out increases, and so does anxiety.

Of course, every therapeutic journey is complex and its course cannot be predicted in detail. During psychoanalytic treatment, the symptom becomes linked to the transference, and certain symptomatic acts betray the kind of object relationship structured by the patient with the analyst. This generally involves anti-emotional defences of domination and control.

I shall merely point out here that many borderline patients in psychoanalysis exhibit "perversions", the understanding of which calls for a differentiated response. With borderline patients, in whom states of perverse excitation are accompanied by simultaneous manifestations of disintegration, the therapeutic prognosis is quite favourable as regards the perverse symptom. In analyses that are going well, it is quite common to observe an attenuation of the perverse excitation and an enrichment of the patient's relational life. Conversely, the unforeseen occurrence or recrudescence of perverse behaviour should give rise to concern about the course of the treatment.

Analysands with a genuine perverse structure—who are in fact seldom encountered—are solitary persons lacking affective relationships, who feel aroused only by the practice of a certain kind of sexuality.

Anxiety is absent in these cases: perversion has become a state of mind coinciding with a vision of the world dominated by the power principle. Although he may cultivate and secretly idealize pleasure,

the patient may, deep down, be terrified by the strength of the perversion as he finds himself crossing the boundary into destructive acting out. The fear arises from the risk of losing control and of rashly exposing himself. The anxiety relates to the consequences and not to the behaviour itself.

When the patient's perverse fantasies are nurtured in secret and never acted out, the reason may be terror at the possibility of losing control of his mind and of going mad; in this case it is the consciousness of the disturbance and the struggle between conflicting aspects of the personality that lead to the request for psychotherapy.

The course of the psychoanalytic process is likely to be different in a patient with a structured sexual perversion. Beyond sexual behaviour, perversion corresponds to an internal world devoid of emotions and affective bonds, and the analyst will have his work cut out in his attempt, through the relationship with his patient, to reclaim a cynical, desertified area of the mind.

The subtle destruction of values and compassion typical of the perverse patient tends to induce in the analyst a counter-transference hatred that is seemingly justified by the daily tortures inflicted by the patient on his love objects.

Joseph (1971) describes the constant attack on the analyst's mental stability with its aim of impairing his capacity for understanding. This attack on the analysis is mediated by the creation of a psychoanalytic atmosphere alternating between excitation and frustration. The patient appears to have a finely tuned ability to arouse expectations and then to dash them. The analyst may respond with negative interpretations that lend themselves to inclusion in a sadistic relationship, which the patient experiences as exciting.

In other words, since the patient uses his analysis in a perverse register, the analyst risks reproducing a sadomasochistic cliché with him.

A typical defensive response by the analyst to his own aggressive counter-identification is apathy or boredom, with the concomitant danger of a prolonged impasse in the psychoanalytic process.

The fundamental characteristic of the psychoanalytic treatment of perversion is the gulf between the two protagonists. In so far as the analyst is capable of understanding and listening empathically, the world of perversion appears to him incomprehensible and desperately remote. How can he reach a patient in whom all human values are desertified or subverted?

The innermost core of perverse acting out in analysis is subtle perverse propaganda. The analyst is not immune to it and becomes the target of the prevailing cynicism: psychoanalytic understanding, the symbol of the human relationship, is the butt of prolonged devaluation or is subtly mocked. The patient actively pursues the goal of paradisiacal withdrawal, which he sees as one way of achieving total self-sufficiency and avoiding dependence on a human object.

Many years of analysis are necessary before the patient can escape from the power of the sexualized area and open himself up to the world of emotions and the experience of the positive transference. When this occurs, we realize how the patient has been totally deprived of the experience of emotional relationship, and how the state of withdrawal really has laid waste his mind. The appearance of the human relationship finds him totally unprepared and exposes him to emotional storms that throw him off balance.

To analyse perverse patients, the analyst must constantly maintain an equilibrium, as well as an interest in the world of perversion, its mysteries and singularity; he must adopt a position of simultaneous strength and tolerance, so that the hope of a possible transformation is not thwarted by the wilful cynicism with which the patient will defend his position over long periods.

We are not completely lacking in resources in the therapy of perversion if we succeed in "understanding" it properly. Even in our most seriously ill patients, there are healthy areas with which it is possible to work with good prospects of success. I contend that the failures or crystallizations occurring in our therapies are partly due to a lack of clarity about the incomprehensible and unacceptable aspects of perversion. These threaten our affective world and our stability, giving rise on the one hand to rejection and condemnation and on the other to an edulcorated and spuriously domesticated vision that enfeebles the attentive determination demanded of us by the patient.