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4

An overview of perverse behaviour

Arnold Goldberg

Introduction

The nature of perverse behaviour becomes an issue both because of its moral position in society as well as because of its personal relevance to psychopathology. In the latest viewpoint of American psychiatry, perversions no longer exist (American Psychiatric Association, 1994). They have been replaced by a less offensive set of words: the paraphilias. These are defined as preferences for, or addictions to, a specific sexual practice, and so this redefinition removes the moral component that is usually understood to be necessarily connected to perversion. I feel that psychoanalysis needs to define the perversions primarily on the basis of the data of psychoanalysis, and so it should try not to mimic the descriptive efforts of psychiatry.

Psychiatry has surely bypassed psychoanalysis in its efforts to reorganize and classify psychopathology. The manuals of diagnosis up to and including *DSM-IV* are careful collections of descriptive categories that aim to carve out fairly distinct entities that conform, for the most part, to observables and reports. The present state of psychiatric nomenclature is one of description or, perhaps more

felicitously, that of phenomenology. Such a choice for categorization is, of course, dictated by a lack of a more clear-cut set of causal determinants of illness. And the accepted classification of infectious diseases is an ideal counter example, wherein the descriptive efforts are all secondary to the specific agents leading to specific maladies. The hope in psychiatry seems to lie more or less in the direction of concentrating upon neuro-anatomical and/or biochemical foci of disease and thereby ultimately to better delineate categories that will go beyond mere behaviour and unreliable subjective experiences.

Psychoanalysis has a different database. It should, thereupon, have a different form of classification. However, the disease entities that reign in analytic texts are ordinarily either descendants from categories passed on from the writings of Sigmund Freud or else are newer ones borrowed from textbooks of psychiatry. Among the first that we list as examples are the hysterias, and, among the second, the borderline states. Each of such efforts to capture disease entities strains to encompass both the descriptions of psychiatry, along with some special contributions of psychoanalysis. A good example of the resultant lack of congeniality in diagnostic categorization between psychiatry and psychoanalysis is that of the familiar "anxiety disorder", which is handled in one manner in *DSM-IV* and quite differently in the book of *Psychoanalytic Terms and Concepts* of the American Psychoanalytic Association (Moore & Fine, 1990, pp. 25–26). The latter struggles with its allegiance to Freud's "anxiety hysteria", a term that is fairly widely ignored outside of this glossary. As a counter example, one effort that nicely illustrates the analytic struggle to bridge the gap between pure description and so-called "structural" considerations is exemplified by Otto Kernberg (1989), who himself, and with others, offers a range of descriptive criteria, along with or coupled to psychodynamic formulations, meant to encompass the diagnosis of narcissistic personality disorders (Kernberg, 1989, pp. xiii–xiv). This last categorization is, however, stretched to include behavioural disorders that include antisocial behaviour even to the point of murder (*ibid.*, p. 643). The mix is one of folk psychology, social issues, and theoretical jargon, without a clear boundary and a clear guiding principle.

Thus, we see an attempt at diagnosis that employs the descriptive categories of psychiatry and then joins them with one or the other psychoanalytic model to effect a marriage of two disciplines. For a start, a particular category may be described in one manner, such as overt behaviour. This is then elaborated in terms of (say) a psychic apparatus configured in one way, or else in a developmental path traversed in some special manner, or by way of any other vehicle of psychoanalytic conceptual thinking. The result fails to be unified. Although there is an ease of entry to descriptions such as "fixed, repetitive, obligatory behaviours required to obtain sexual gratification", this is clearly only the first step to an understanding of perverse behaviour, and it is only by way of a careful delineation of specific transference configurations that a psychoanalytic perspective allows such behaviour a standing that goes beyond the descriptive as well as the moral dimensions. Therefore, the ideal presentation of perverse behaviour for psychoanalysis comes from the psychoanalytic treatment of patients who both conform to the behavioural descriptions and also demonstrate a fairly clear clinical picture that can be generalized to encompass an improved definition. We have gathered together a number of such cases and propose a three-step requirement for a comprehensive definition.

Definition

The first component of our three-step definition of perversion has to do with the phenomenon of sexualization. This, of course, derives from Freud's original description of the capturing of a non-sexual function by sexual activity. It has been elaborated by Hartmann in terms of his thoughts about instinctualization, and by others who describe it as a defence. I propose to consider it as a manifestation of a structural deficit. The movement from sexualization to desexualization is therefore one of filling in such a structural need. This is seen to occur somewhat readily in most well-conducted psychoanalytic treatments of cases of sexual perversion. What clearly becomes apparent in treatment is the particular function of sexualization, the existence of which usually represents an inability to experience and manage otherwise painful affective states; the sexualization obliterates these negative feelings. If we posit psychic structure as a broad set of capacities or enduring functions, then we can visualize what composes defects or deficiencies

in such a conceptualization of structure, and we can also see how the analyst can serve to fill in for, or temporarily substitute for, the missing structure. Thus, all of our cases of perverse sexual activity are seen as individuals with faulty structure, in whom sexualization is a manifestation of that fragile or insufficient structure. The initial aim in the treatment of these patients is that of desexualizing the aberrant behaviour.

What we have found in the study of a significant number of cases (Goldberg, 1995) is that the supposed pleasure, which is said by other investigators to be of an intense and special experience, is more often directed to the alleviation of anxiety than anything else. Without in any way discounting the anecdotal tales of exquisite pleasure, we more often find that it is in the pursuit of relief from anxiety and agitation that most perverse activity takes place. Here is an example of the desexualization.

The patient was loath to tell of one part of his masturbatory fantasy, wherein he performed fellatio on an older man. This man would instruct the patient as to just what to do and how to do it—much as a tutor—but then as the patient reached his ejaculation the imagined man would ask of the patient the thing that disgusted the patient the most and that he had so long withheld from telling the analyst, i.e., the man wished to ejaculate into the patient's mouth and have him swallow the semen. When this was rephrased into the patient feeling that he had to do more for the other person than for himself, that he had to passively endure a discomfort for another's happiness, he recalled the events of his childhood that seemed best to highlight the scenario. Whenever he would do something with his father, it had to be what his father wanted or else he could see the irritation on his father's face. Once the father took his son, the patient, skateboarding, but he was so miserable watching his son that the boy could not stand it. The events they both enjoyed, from shooting to sailing, were *primarily* those of the father and only *secondarily* for the son. In the sexual scenario, the patient represented this in his being asked (or forced) to swallow the ejaculate. In the transference this occurred prior to a vacation of the analyst's. The desexualizations enable us to see the clarity of the father–child relationship.

A common feeling that follows a patient's participation in a wide variety of sexual behaviours is that of shame or guilt. This highlights the second key element in the study of all behaviour disorders and especially those having to do with sexual behaviour or misbehaviour. This is the existence of the vertical split (Goldberg, 1999). First described by Freud in his elaboration of the mechanism of disavowal in fetishism (Freud, 1927e; 1940a), a wide range of psychological varieties of splitting have been popularized in discussions, particularly of borderline personality disorders, in terms of good and bad objects. The split in the psyche that is characteristic of the disorders discussed, here, has to do with the "side-by-side existence of disparate personality attitudes in depth; those with different pleasure aims, different moral and aesthetic values" (Kohut, 1971, p. 183). The vertical split is an extensive demonstration of disavowal, in which one part of the personality, that which is realistic and subscribes to the usual moral values, looks askance at the other part with an attitude that ranges from disbelief to condemnation.

An example of this can be seen in a physician patient with a perversion of having fellatio performed on him by his pet dogs. Following one incident that occurred after he had had to be rescued from a surgical mishap during an operation by his assistant, who then successfully completed the surgery, the patient acted out with his pet and recounted his experience with this animal with shame and disgust. He felt that it was very much as if another person had committed the sexual act, and he was convinced that he would never again indulge in this sort of "pleasurable" behaviour. Our patients, for the most part, show a range of responses to their aberrant behaviour, but it is ordinarily ego-dystonic and split off from what they claim is the "real me". Such vertical splits of disavowal are to be distinguished from the horizontal splits of repression in that the former remain conscious and fully accessible, but are denied complete ownership by the person. To the degree that there is a good deal of negative affect, usually in the form of shame, there is the greatest promise for effective analytic intervention. Indeed, the first goal of all such treatments is the recognition, and resolution, of this vertical split. In line with the above-mentioned concept of structural insufficiency, this, then, is another form of a defect, in that the patient's personality is unintegrated and requires a structural repair.

The integration of such splits is best seen in analytic treatment wherein the perverse behaviour becomes an active participant in

the analysis. Here is a clinical example. A physician patient had a routine perversion of having female patients who were undergoing a physical examination perform fellatio on him. For the most part these women were unknown to him before these routine physicals and remained so afterwards. During his analytic treatment the incidence of this activity diminished and seemed to disappear, until one day he reported a recurrence. He told of this with a great deal of shame and remorse. In the analytic session he associated to a wish to ask for a substitute appointment, a wish that he had decided not to allow to surface. He said that he felt that he did not want to trouble or upset me by making a request for a schedule change so he had squelched his desire. As a young boy this patient had suffered from a severe, undiagnosed osteomyelitis, which caused him extreme pain and distress. He often cried out at night to his parents, who took him to a number of physicians, none of whom could diagnose this malady. Finally, one of the doctors had told him to stop complaining and thereby to just live with his pain. Not surprisingly, this advice was superimposed upon a family setting of suffering in silence and not sharing one's feelings with others. Stoicism became the familial mark of correct behaviour and no one ever complained or even asked for very much. In the particular act of fellatio performed by this man it was necessary that the anonymous woman remain completely silent, just as did my patient. Only when his wish to ask me, as the ungiving mother, for a response of care and understanding (i.e., the changed appointment) was admitted was he able to realize his wish in the treatment. Thus, the previously split-off act of perversion became joined or integrated into the analysis.

A further complication is introduced into our understanding of the vertical split, in that to say the split-off sector is readily available to consciousness is not quite true, since it seems in some individuals to remain periodically concealed and so is perhaps better called descriptively unconscious. It may appear, at times, literally to burst into consciousness after a period of quiescence, and we see this especially in certain forms of perversion that enjoy long periods of absence. Thus, we see that a rather complicated set of relations exists between these two sectors of the ego or the self, and the so-called split is maintained only under certain conditions and at a certain psychological expense. The connection between these sectors is therefore functionally unconscious, the appearance or emergence of the split-off sector, which may be termed unreal or primitive, is not under the control of the reality self, and the reality sector experiences a wide variety of reactions to this sometimes alien presence. Thus, the fundamental feature of these disorders is the condition of non-integration. This is what allows us to claim such behaviour disorders as those of the self, or as narcissistic; i.e., the persistent lack of a consolidated or cohesive self. All of our further concerns about the proper treatment of these conditions, as well as the problem of delineating the essential transferences involved, ultimately refer back to the fundamental failure of the establishment of an integrated self that is evidenced periodically but is present, albeit hidden from view, persistently.

The third element that is crucial to the understanding and treatment of sexual perversion has to do with what has heretofore been the somewhat singular interest of most psychoanalytic investigators: that of the individual dynamics of the patient, more often than not some variation on the theme of the oedipal conflict. I think that most analysts who have worked with these sorts of disorders have found that a very wide variety of psychodynamics are seen, that they include both oedipal and pre-oedipal problems and, perhaps most significantly, usually show profound narcissistic disturbances. An individual analyst's preferred use of one way of seeing clinical material over another will ordinarily shape the particular story or narrative that emerges in describing a patient, but our own experience has been rather telling. It is, essentially, that these patients have multiple problems with no unitary set of dynamics specific to any particular manifestation of pathology. Some exhibitionists, for example, show more early problems with their mother, as do most cross-dressers. But one should be very cautious in making any generalizations. The transferences that occur are rarely of one stable form, and one is well advised to follow Stoller (1975), whose list of "specific indicators" leads us to conclude that one can readily fashion any story to explain some perversions, but the story will equally explain other disorders, too, and will not explain many perversions that seem to defy neat categorizations.

The study of sexual perversions can be seen as a part of a larger group of behaviour disorders that includes delinquent and addictive behaviour as well. Contrary to some authors, our experience in

the treatment of these patients reveals that some do shift from one sort of behaviour to another, both within the sexual sphere and outside it. No doubt there are patients with a single, devoted type of sexual perversion, but there also exist others who move between thievery, drug abuse, and sexual misbehaviour. I think it very important to recognize that the caseload of any single analyst is often not capable of generalization, and our own group of a dozen psychoanalysts who share their experiences seems much more revealing in terms of the analytic treatment of this group.

In light of the above, our diagnostic category takes on the definition of all of those behavioural aberrations that exist in a parallel sector of the self. The person with a narcissistic behaviour disorder, in particular a perversion, has a vertical split involving a side-by-side personality configuration with different ambitions, goals, and values. This parallel sector appears either occasionally or persistently, and is met by a variety of critical reactions from the non-participating sector. Thus, a conforming and seemingly well-adjusted married man who has episodes of bizarre sexual behaviour is a prototype of an individual split into sectors of adaptation and misbehaviour, with the one viewing the other with emotions ranging from puzzlement to fear. All of our cases of perverse behaviour have this psychic structure, and so all satisfy the triad of unacceptable, split-off action. They vary in terms of (1) the dominance, or extent, of the split-off sector, (2) the particulars of the behaviour, and (3) the reaction of the reality sector to its parallel companion.

The split-off sector

In certain forms of narcissistic behaviour disorders or perversions, the reality self is almost without a voice. Perhaps best seen in cases of severe substance abuse, we often find that the appeal to reason seems futile, and all of our therapeutic efforts are geared to handling the wayward behaviour, usually by a variety of suppressive techniques. As we move towards a midline from this extreme of misbehaviour, we find a mix of reason and pathology that exemplifies the peculiar state of co-existing persons who can seemingly both agree to behave and simultaneously to misbehave. It is only in those individuals who seem to display a narrow and infrequent display of behaviour disorder that we ordinarily consider psychotherapeutic or psychoanalytic efforts. For the most part, this depends upon an appeal to reality; i.e., we speak to the realistic sector about the misbehaviour. In the case of an episodic perversion, the interpretation becomes directed to the division of the person that is both curious and critical about his or her waywardness. In the case of an eating disorder we join forces with the segment of the personality that looks upon the anorexia or bulimia with disdain and disgust.

As essential as this may seem as a therapeutic manoeuvre, by itself it has a rather regular failing in its effectiveness, except as a short-lived measure or as a device that seems to require a continuing or sustained emphasis. Thus, much of our therapeutic effort is without effect, either because the misbehaviour so dominates the psyche that the periods of its absence are too infrequent to be reliable enough for treatment, or else because during its absence it seems not to attend to our interpretive efforts.

To better comprehend the dilemma in our understanding of these narcissistic behaviour disorders, it is necessary to have an altered view of the nature of the transference in these conditions. And, accordingly, the transference is of a different configuration than in those disorders that are singular or integrated. In the behaviour disorders with a vertical split, the transference is also a duality.

The dual transference

It is usually best to begin a discussion of transference with the disclaimer that it is a word with many definitions and much disagreement about those meanings. However, in the usual sense of the term it refers to unconscious ideations, either fantasy or drive derivatives (or whatever else one assigns to the unconscious), which become somehow lifted into the preconscious and thereby assigned to the person of some individual. Since transference is ubiquitous and universal, this assignment may be to a casual acquaintance as well as to a therapist or analyst, but it is upon the latter that we ordinarily focus for our therapeutic work. Thus, the transference to the analyst (say) is a manifestation of a distorted or contaminated vision of that person, although certainly we now know that a kernel of justified perception seems to accompany each

and every supposed misperception. With such a minimal agreement upon the use of the word, we can turn to examine how we meet and deal with transference.

In the usual and sometimes caricatured case of the interpretation of the transference, there is an unpacking of the mistaken (or deviant or wrongful) attribution of a trait or perception to the analyst or therapist. This recognition by the patient of seeing the therapist as a figure from the past is followed happily by insight, and there ensues a new and better vision of reality. Putting aside for the moment all the many qualifications of this scenario, there does seem to be some agreement that the unconscious ingredients of the transference become reorganized into a more conscious (and therefore better understood and controlled) perception and consideration of the therapist. He or she becomes more of what they really are rather than what the patient hoped them to be. The clarification that results resides in one person.

It is not the same in the narcissistic behaviour disorders, in that the split does indeed involve two sets of transferences that, although they may derive from some unified unconscious material, play out in distinctly separate fashion. It is also different in the sense of these transferences more properly being considered self object transferences or partial aspects of the self. These are self disorders, and so the usual problem is a failure of structuralization leading to action and/or disintegration. In perversions, the failed structuralization gives rise to a sexualization, and so most of the activity or misbehaviour of the split-off sector is a manifestation in one form or another of this sort of structural deficit. But the deficit lies not only in the sector of behaviour. It is most telling in the very existence of the split, which itself can be seen as a defect in need of filling in or of healing.

The side-by-side existence of "cohesive personality attitudes with different goal structures, different pleasure aims, different moral and aesthetic values" (Kohut, 1971, p. 183) results in a person living in two different worlds and so necessarily manifesting two different transference configurations in treatment. There is never a singular or unitary transference to the analyst. We do not mean this in the sense of a change over time, but rather in the simultaneous existence of a dual transference: one to the reality sector and one to the sector of action. That the analyst may not be aware of this dual presence is but one problem. The other is the periodic absence of the one or the other sector, which is regularly hidden from view. Thus, we encounter treatments that consist of discussions about the errant behavioural manifestations that are regularly taking place outside of the treatment. A more unfortunate variation of this is the behaviour continuing its course without its being discussed in treatment. Both situations are examples of a failure to engage the duality of the transference.

One common example is that of eating disorders, in which there is an endless discussion about the specifics of the behaviour that often extends to group participation and a variety of other supportive methods. To the extent that such interventions, either in individual or group therapy, are effective, they are often primarily efforts to suppress the wayward behaviour by strengthening the alliance with the reality sector, which surely "knows better" and so will try harder. If a more careful analytic effort is attempted, but still one restricted to the one sector, we find a resulting person who is truly only half-cured. If the patient joins one of the many programmes modelled on AA, we see the major thrust certainly being toward education and suppression of the symptoms but, in certain cases, the other personality organization likewise emerges and participates, albeit without interpretation and so, once again, without lasting benefit.

This, then, is the second form of transference deployment (the first being complete non-recognition) that we see in narcissistic behaviour disorders and especially in perverse behaviour: one in which one sector is more actively engaged and interpreted while the other remains alive but unaddressed. Indeed, it seems that some of this must occur in every treatment, but the *conditio sine qua non* for the definitive co-existence of the dual transference in treatment is the gradual diminution and disappearance of the wayward behaviour. Short of that, we find evidence of alterations in the outward manifestations of the behaviour that are based most probably upon unrecognized and unacknowledged transference enactments.

One sometimes hears of a patient whose treatment was devoted to educational and instructional efforts aimed to alter or modify aberrant behaviour by coercion and suppression. Not surprisingly, this sort of rationalized acting-out by a therapist is ameliorative, and much of this is due not to the correcting action of the therapist

but to the silent engagement of a transference that remains unnoticed and uninterpreted, and results in a rapid recurrence of the behaviour when the treatment stops. This is also, most probably, the explanation for the never-ending need of the above-noted support groups with their high rate of recidivism.

Sole recognition of the narcissistic or self object transference occasioned by the split-off aberrant sector of behaviour is subject to the same problematic issue of a lack of an integrative approach. One way to view the behaviour is to see it as an effort, usually successful, to obliterate painful affects along with unbearable self concepts. When able to fully experience the associated thoughts and feelings, these patients may dream of themselves as hideous animals, or deformed individuals, or in a variety of distasteful and disgusting presentations. Although we may feel that the split-off sector originates from a more basic megalomaniacal fantasy, it is often the case that personal conceptualizations of one's self are imbued with horror and distaste, because of the manner in which childhood fantasies and performance were greeted. Thus, the convenience of pleasurable action, which also serves to annihilate unpleasant thoughts, is a wonderful solution. Viewed in this manner, one can see the split-off behaviour as an absolutely essential and life-preserving solution, which is not and cannot easily be disabused.

The vigour of self-hate experienced by these patients is often matched by the intensity of their acts. A concerted empathic stance that aims to connect with, let us say, the reason for a particular form of perverse behaviour, will often lead to a cessation of the behaviour but, tragically, will also fail to include that sector in a connection to the more realistic part of the personality. The same sort of problem will ensue as noted in suppressive therapy, in that the behaviour, now understood, is still not under the control of an integrated and unified self. In this way we see the plight of the poor soul who, indeed, seems to know the why of the behaviour disorder, but remains at a loss as to its eradication or diminution. Each approach is unilateral, and each fails.

Treatment

In this chapter I can only point to a few salient characteristics in the psychoanalytic treatment of patients who both engage in sexually perverse activity and feel them ego-dystonically enough to consider doing without such behaviour. It is highly unusual to find a happy and successful person with a sexual perversion, such as a shoe fetishist, who is equally happy and successful in his or her psychoanalysis. On the other hand, it is not at all unusual to find analytic success in a patient, such as the previously mentioned surgeon, who suffers mightily because of his or her sexual behaviour. It is also not unusual to find a perversion revealed during the course of an analysis that was initiated for other problems. However, for the most part the presentation of a patient with perverse sexual pathology calls for an immediate reaction from the analyst, the nature of which can often be a decisive factor in the long-term success of the treatment.

To put it in the briefest way possible, the analyst must respond to the patient's presentation of his or her unwelcome parallel personality with a recognition that it is both necessary for the patient, as well as something to be removed or at least diminished. The vertical split of the patient must meet a corresponding split in the analyst; one of condemnation and condonement. If one or the other is absent, the analysis will probably not be a profitable one.

The sexually perverse behaviour that takes place outside of the analysis is ordinarily seen to subside and disappear as the analysis proceeds, only to reappear as one begins the working through of the emergent transference configurations. We have a host of reports of psychotherapy that seems to aid perverse activity, but only for a specified period of time, with no lasting results. Our feeling is that in these cases the therapist has temporarily filled in the structural defect, but without analytic work the cure is evanescent. The existence of the overt sexual behaviour outside of the analysis, as seen during weekend breaks, vacations, and failed empathic connections in the treatment, becomes a barometer of the progress of the treatment, in as much as the split-off part of the personality must inevitably join in the conversation with the analyst. Only when both parts of the personality become recognized in the engagement with the analyst as parallel but distinct transference phenomena does the analysis proceed to a lasting successful conclusion. I have no doubt that this happens in many treatments without it being recognized, but the major need for its recognition and monitoring arises from the countertransference reactions evoked by this dual transference.

Sharing analytic experience with a number of trained analysts who treat sexually perverse behaviour has allowed me to recognize a particular constellation of factors that seem quite characteristic of these treatments. In the analysis of such patients I have regularly noted a tendency to act out by the analyst, along with a particular set of countertransference reactions, both of which seem to relate to the particular form of misbehaviour evidenced by the patient. For example, in the psychoanalytic treatment of cross-dressers there is a range of negative responses to the symptoms, with a regular appearance of the symptom in the treatment either in the form of photos or subtle personal appearance changes. The analyst is always being asked to respond actively to the appearance of the symptom. Our thieves seem to provoke dishonesty in some analysts; our stalkers often provoke quite a range of contradictory responses. It is vitally important that one be alert to the pull of enactment with these patients, but it seems equally important to recognize that an effective treatment makes a demand upon the analyst to somehow share the patient's experience. Since no one of us is without sin, it seems fair to say that the successful treatment of the sexual perversions requires an analyst who is capable of knowing and being with the patient. Unless and until we can get in touch with our own myriad perverse wishes, we will be at a loss in getting in touch with those of our patients.

Case illustrations

Here are some illustrations of the particular countertransference reactions. A cross-dressing male in analysis reports an experience of intense depression at the onset of his analyst's brief vacation. He feels this is especially significant, since he connected the feeling to one he had had earlier and forgotten, when his mother left him to stay with a relative, and he attended a new school, when he was around eight years of age. But the newly rediscovered feeling was even more significant in as much as it was followed by an episode of cross-dressing that the patient now attributed to this recalled and re-experienced painful memory and affect. The analyst joined in acknowledging the connection and further noted to the patient how he had turned a passive experience of being left into an active one of cross-dressing. This interpretation was readily accepted by the patient but was followed that night by an unpleasant dream in which the patient was being scrutinized and examined by a strange doctor who probed him with a sharp instrument. The analyst was puzzled as to why a seemingly correct and even effective interpretation would be the stimulus for a dream that to him clearly reflected an image of a misunderstanding and an unempathic treater.

This is an example of a split transference in which the analyst speaks (correctly) to the reality sector about the misbehaviour of the split-off part. But that one-sided division of recognition also needs an acknowledgment of the parallel struggle with the coldness and emptiness of being left. Speaking only to reality makes for a split-off sector that is essentially more estranged, since it is unacknowledged. And so comes the dream of mistreatment. If, alternatively, he had recognized the depression without making the connection, the analyst would allay the negative affect but this would, in itself, not connect the misbehaviour to the parallel sector and so would not achieve the desired integration. The latter interpretation, about the difficulty of enduring the painful emptiness of depression, does indeed connect in recognition with the sector of the self involved in cross-dressing, but it still stands alone as an indicator of a symptom handling a problem. The mastery of that problem can be achieved only by the analyst's directing the patient's attention to the how and why of the symptom. The transference is split: one side needing an empathic acknowledgment of its pained state, another needing an affirming acknowledgment of the cause of the symptom by way of behaviour. Of course, each sector has its own developmental history; i.e., that of turning passive into active and that of dressing like a woman to handle depression. It may seem unnecessary to insist upon a connecting statement, until we recognize that the disavowal that operates does indeed allow the misbehaviour to exist in a seemingly separate manner. The behaviour has, up to this point, effectively obliterated the emotions, and once these are allowed to re-emerge they need a linkage to the sector of the self that has a realistic connection to the analyst.

I think it fair to consider both aspects of connecting to the analyst as transference; the first as a mirror to the patient as a woman covering over the depressed affect; the second as a mirror

responding to the growing dominance of the patient over his reversal of passive to active. In an integrated self a single interpretation would suffice. In a split self the parallel interpretations must also be joined. In an integrated self the interpretation of the reversal made by the analyst allows for insight along with the emotional impact, but in a behaviour disorder the affect is unavailable for it to become part of the ensuing insight. However, this is not the split of affect isolated from ideation, but rather one of two separately operating personality configurations that, in turn, divide the analyst into a corresponding duality.

A clinical illustration of the split transference characteristics of a perverse behaviour disorder comes from the case of a male voyeur who visited athletic clubs in order to view the genitals of middle-aged men, whose image he retained until there was an opportunity to masturbate with fantasies of these men. This patient had entered analysis with a fearful conviction of being a homosexual, in as much as he felt aroused only by certain kinds of men with certain very specific physical characteristics. He had never gone so far as to become physically intimate with any man (or any woman), but confined his sexual life to magazines, television, and locker room stimuli, all of which lent themselves to fantasies of fellatio, or variations on a theme of sexual involvement with these men who fulfilled his very specific requirements of age and physique. For the most part he felt disgusted by his voyeuristic life.

In the analysis of this patient, much of the material dealt with his relationship with his father, who came alive as a preoccupied and distracted individual given to periodic angry tantrums. The transference that developed was one of idealization, and, once established, the patient initiated heterosexual relations with a co-worker. This progressed into a deepening relationship with another woman who seemed fairly sexually lively and even aggressive. The patient improved in every area of his life, but his voyeuristic activity—which I considered a behaviour disorder—was ever-present in the background and periodically came to the fore. The outbreaks of his masturbatory activity were regularly connected to an analytic disruption, but there seemed to be an added component of resistance in its persistence.

One day the patient announced that he had masturbated after seeing a specimen of his yearned-for masculine ideal in a locker room of the gym, and he went on to say that this would very likely diminish his sexual appetite and performance with his girlfriend that night. I asked a question, something like how he felt about that. The exact words are lost in time, but it may well have been that they carried along a charge of disapproval of the masturbatory activity and a more favourable consideration of heterosexual intercourse. The patient was furious. He went on to say that at no time had I ever indicated to him that he was to control, or limit, or certainly not to eliminate, his masturbation, and now it sounded as if I was instructing him in some sort of proper form of behaviour. I held my tongue as he explained to me that he had assumed that he could and would have both, i.e., a sexual pleasure looking at middle-aged men and a parallel one with a chosen female. He certainly had never considered having to consciously choose to stop looking and masturbating. To be perfectly honest, he did now and again think that one day the homosexual feelings might simply disappear as a result of his analysis, but he hardly felt that he would have, or need, to do much about them. I found myself preparing a careful rebuttal to this position by way of an analogy of someone eating candy all day and so ruining his or her appetite for regular, wholesome meals, when the patient's rage shifted to a plea for me to be more clear as to just what he was to do and what I expected of him. Thus, he changed from a combatant to an apprentice, and the following analytic hours took on a different form.

It had always been clear to the patient and myself that missing hours were extremely disruptive for him, and often led to his acting out. He had always reported his voyeuristic behaviour with deep regret and shame, together with a wish to get rid of it. It should be clear that he was indeed "of two minds" about his voyeuristic behaviour. In the hours after the sudden and (for him) painful recognition of his now conscious need to curb his acting-out behaviour, his yearning for me seemed to reach an epiphany. He would do anything to get me to talk, he felt at times as though he were delivering a monologue to a black hole, he wanted to hold me, he had a fantasy of my arms around him. Interestingly, for him there was nothing sexual whatsoever in the longing, and he also clearly connected it to an anticipated missing of several days. He next reported that he had been tempted on several occasions to resume his voyeuristic and masturbatory behaviour, but had not done so.

He mentioned a dream of reporting to a doctor who had casually said something that embarrassed the patient, who soon thereafter became angry with this unfeeling physician.

I saw this transference as manifesting two parallel and distinct forms. In the one there is the wish for a close relationship with the father, which had heretofore been sexualized. As this was interpreted and worked through in the analysis, it started to join with a parallel one of a mentor who prescribed and directed proper behaviour. This seems to indicate a dual transference: one directed to the reality sector, which aims (in his words) to see himself as a normal, heterosexual man, and another that yearns for a more infantile, and likewise a periodically sexualized, connection to a man. This is the nature of the vertical split, and this is the arena for analytic work that aims for integration. I think this vision of a dual transference of simultaneity is not a psychodynamic (i.e., a clashing of forces) or a descriptive categorization, but is more honestly seen as diagnosis by way of transference. I, of course, have no argument or doubt that other formulations are possible, but I offer this as a way of seeing (i.e., diagnosing) and so treating narcissistic behaviour disorders, and also as illustrative of the reciprocal countertransference issues which are divided into parallel views of reality alongside more infantile (and narcissistic) needs. The special way of handling this phenomenon of the dual transference will not be addressed here, except to emphasize that this does qualify the category of narcissistic behaviour disorders for diagnosis by way of specifically recognized transference configurations.

Having noted the variation of the dominance of one split aspect versus the other, and the particulars of the behaviour of one part versus the other, we now turn to the relationship between the one part and the other. This becomes a crucial factor in the evaluation of such patients for the variety of interventions that are considered for behaviour disorders: interventions that range from incarceration to support groups, to psychoanalytic psychotherapy and to psychoanalysis. The delineation of the group, and the careful assessment of the aforementioned structural considerations, allow one to make educated assumptions about recommended approaches to treatment.

The ideal constellation of factors for treatment in a narcissistic behaviour disorder is one in which the reality sector greets the misbehaviour and its parallel sector with a predominantly negative affect, reinforced by an equally negative reaction of the environment. Negative, in this case, need not mean hostile and/or primitive, since that can often be a component of a perverse disorder. Rather, I mean that a connection to a satisfying self object, i.e., one that can gratify the disordered sector, cannot be obtained or retained, and the reality sector does not readily accommodate the needs of the split-off sector for such a connection. This negative, or alien, approach to the behaviour may occur after a treatment has begun.

In a seemingly contradictory way, this distancing stance allows for the emergence of the wayward behaviours' transference needs within the treatment, and so makes for the awareness of the split. If a patient claims a happy acceptance of his or her misbehaviour, as initially seen in some perverse disorders, it may be the case that deeper shameful feelings emerge only after an effective therapeutic engagement takes place. I take it as a rule that claims of greater pleasure in, or resigned contentment with, misbehaviour are always evidence of a significant and, at times, unhealable split, but it is this gap that makes possible the denial of a more genuine affect. It is never a genuine contentment.

In summary, I believe there is a new frontier open in the psychoanalytic treatment of the sexual perversions. They are complex structural disorders that cannot be seen as simple oedipal disasters. They demand a new perspective on psychic structure, a reconsideration of the vertical split and the concomitant formation of a split transference, and a more careful scrutiny of particular countertransference reactions that match the misbehaviour of the patient. With a combined effort in our work on this new frontier, perhaps a reawakened enthusiasm for psychoanalysis will be our reward.

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Perversion and charity: an ethical approach

Sergio Benvenuto

Moral psychopathology

Today, simply using the word "perversion" is not considered politically correct, and rouses suspicions—above all in the USA. "What is perverse and what is not?", people ask perplexedly. "Perversion", it is often said, "is basically a moral category, which varies according to the customs of each epoch." The American sexologist John Money no longer speaks of perversion but of "paraphilia", as distinct from "normophilia". The latter is defined as "a condition of being heterosexually in conformity with the standard as dictated by customary, religious, or legal authorities" (Money, 1988, p. 214). Thus, paraphilia is still defined as sexual behaviour that deviates from the norm.

Nineteenth-century positivist sexology, which produced the term "perversion" for a type of sexuality, gave itself the ethico-legal mission of distinguishing the "pervert" from the "libertine" (Lantéri-Laura, 1979). The former is a sort of sick person, while the latter is a normal subject to be judged according to moral criteria. Today, the distinction between pervert and libertine has been abandoned, and replaced with the distinction between "sexuality