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CHAPTER ONE

3

# Perversion, perversity, and normality: diagnostic and therapeutic considerations

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What follows is an overview of my current efforts to develop a classification of the broad spectrum of disorders traditionally grouped under the heading of sexual perversions, and now referred to as paraphilias. I hope to provide a diagnostic frame helpful both in establishing prognosis and in developing guidelines for treatment of these patients. Because of space limitations, I must present my views in brief, and, at times, categorical ways, in spite of which I hope to convey my conviction that this field is still wide open in terms of our contemporary knowledge and therapeutic approaches.

## *The problem of "normality" in the sexual realm*

It is practically unavoidable that culturally determined value judgements and ideological cross-currents influence our evaluation of human sexual life. When the concept of "normality" is considered to be equivalent to average or predominant patterns of behaviour, treatment may become a matter of promoting "adjustment", and we lose the usefulness of normality as a standard of health. On

the other hand, if the concept of normality refers to an ideal pattern of behaviour, we run the risk of imposing ideologically motivated measures. If, in ideologically motivated opposition to conventional notions, we proclaim the equivalent nature of any and all manifestations of human sexuality, we may miss significant, even crippling, limitations of sexual enjoyment and of the integration of eroticism and emotional intimacy. An "objective", "scientific" view would appear as ideal, if the human sciences were not, in turn, contaminated by cultural biases and conventionality.

I believe that psychoanalysis, with all its limitations as an instrument for the evaluation of human behaviour, provides an optimal combination of non-conventional exploration of the intimate life of the individual, with an evaluation of how sexual patterns enrich, modify, or restrict the potential for enjoyment, autonomy, adaptation, and effectiveness. The unavoidable ideological and cultural biases imbedded in psychoanalytic theory have been challenged, and have tended to self-correct over time. It is sobering, however, to recall that only a hundred years ago psychoanalysis was at one with a scientific community that regarded masturbation as a dangerous form of pathology, that our literature lumped homosexuality and sexual perversions together for many years without a focus on their significantly differentiating features, and that scarcely any psychoanalytic studies of the affective nature of sexual excitement have been undertaken since Freud's pathbreaking discoveries (Freud, 1905d).

## *Clinical and psychoanalytic criteria of normality*

I would propose as the most general criteria for normality, the capacity to enjoy a broad range of sexual fantasy and activity, to integrate such a broad range of sexual involvement with the capacity for a tender, loving relationship within which the mutuality of sexual pleasure, of the emotional relationship, and of idealization of that relationship reinforce each other (Kernberg, 1995). By implication, these criteria imply control over the aggressive components of sexual behaviour to the extent of eliminating from this spectrum hostile, dangerous, exploitive intentions and behaviour expressed in the sexual encounter. These criteria do not exclude autoerotic sexual activity that is neither dangerous nor actively self-destructive.

From a psychoanalytic viewpoint, normality implies the integration of early, pregenital fantasy and activity with genital fantasy and activity, the capacity to achieve sexual excitement and orgasm in intercourse, and the capacity to integrate into sexual fantasy, play, and activity aspects of the sadistic, masochistic, voyeuristic, exhibitionistic, and fetishistic components of polymorphous perverse infantile sexuality. In fact, from a psychoanalytic viewpoint, the integration of polymorphous perverse infantile sexuality into a tender and loving relationship within which mutual emotional gratification and idealization reinforce and are reinforced by the sexual encounter, reflects an optimum of psychological freedom and normality.

At a deeper level, the capacity for full sexual enjoyment implies the integration of preoedipal and archaic oedipal object relations into the advanced oedipal relationship enacted in a sublimatory way. In every love relationship, an unconscious fantasy life is activated that maintains the idealization of sexual excitement, and gratification in both polymorphous perverse infantile play and fantasy and in sexual intercourse. An aggressive element is an essential component of normal sexual excitement, and, in fact, contributes crucially to the full development of eroticism (Stoller, 1979; Kernberg, 1991).

What these proposed criteria for normality leave out is the question of the exclusiveness, the duration of the relationship with, and the gender of, the sexual object; and it is in this area that a scientific approach is particularly vulnerable to contamination by ideological and cultural bias. There are good theoretical reasons for considering a stable heterosexual relationship to be a normal outcome of the oedipal conflicts and their sublimatory resolution in adulthood. However, biological determinants and a primary intrapsychic bisexuality may powerfully influence object choice and, under the influence of cultural factors, co-determine different paths to object choice in both genders (Kernberg, 1992).

## *Definition and psychodynamics of perversion*

Clinically, perversions can be defined as stable, chronic, rigid restrictions of sexual behaviour characterized by the expression of

one of the polymorphous perverse infantile partial drives as an obligatory, indispensable precondition for the achievement of sexual excitement and orgasm (Kernberg, 1989b, 1991; Stoller, 1975). All sexual perversions combine severe inhibition of sexual freedom and flexibility with idealization of the sexual scenario derived from the particular polymorphous perverse infantile drive that is dominant. The diagnosis of sexual sadism, masochism, voyeurism, exhibitionism, fetishism, and transvestism is not difficult if one keeps this definition in mind. It also applies to cases of episodic perversion in which dissociative phenomena permit the expression of perversion alternating with and completely split off from conventional, though somewhat impoverished, sexual behaviour.

From a descriptive viewpoint, perversions can be classified along a continuum of severity, according to the degree to which aggression dominates a particular perversion and dangerous, even life-threatening behaviour invades the potential object relationship within which the perversion becomes manifest. In addition to the potentially dangerous manifestations of the severe cases of the various perversions already mentioned, such aggressive infiltration is particularly marked in the cases of paedophilia, and the rarer perversions of zoophilia, coprophilia, urophilia, and, of course, necrophilia.

From a psychodynamic viewpoint, a consensus has been evolving in the psychoanalytic literature dividing the perversions into two major groups according to the level of severity of the illness. Here the work of André Lussier (1982) on fetishism, I believe, has become a standard reference. Both levels of pathology have in common the rigidity of the perverse pattern, the development of an idiosyncratic "scenario" linked to the particular perversion, and a remarkable inhibition of sexual fantasy and exploration outside the realm of this scenario. An important common feature of perverse scenarios at the higher or less severe level is the containment of aggression; in fact, the recruitment of aggression at the service of love and eroticism. This containment provides a sense of safety as well as an intense erotic experience within which a fusion with the object in sexual excitement and orgasm is reinforced by the sadomasochistic fusion, the internal identification as perpetrator and victim. This higher level of the psychodynamic structure of perversions is best described by the classical constellation originally conceptualized by Freud (1905d, 1919e, 1927e, 1940e). Here, the fixation at a partial drive serves the purpose of denial of castration anxiety by means of the enactment of a pregenital sexual scenario as a defence against oedipal genital conflicts. Genital sexuality is feared as a realization of oedipal wishes; there is severe castration anxiety linked to powerful aggressive components of the positive oedipal complex; all sexual interaction becomes a symbolic enactment of the primal scene; and whatever regression has occurred to preoedipal levels of development has a clearly defensive nature. Preoedipal aggression is not a major component of the aggressive aspects of the oedipal conflict in these patients. Clinically, perversions at this level appear typically in the context of neurotic personality organization, that is, in patients with obsessive-compulsive, depressive-masochistic, and hysterical personality disorders (Kernberg, 1996).

The second, more severely pathological level of organization of perversion, described in more recent psychoanalytic literature (Chasseguet-Smirgel, 1984; Lussier, 1982), has a typical two-layer defensive organization, with oedipal conflicts condensed with severe preoedipal conflicts whose aggressive aspects dominate the clinical picture. These perversions are typically found in patients with borderline personality organization. In fact, the characteristic psychodynamics of borderline personality organization I had described on the basis of the experience of the psychotherapy research project of the Menninger Foundation (Kernberg, 1975) turned out to overlap dramatically with the dynamics of the severe level of perversion described by André Lussier (1982) in his study on fetishism.

This severe level of perversion appears in two major personality organizations: first, the ordinary borderline personality organization with dominant reliance upon splitting mechanisms affecting ego and superego, and a combination of sadistic and masochistic features both in sexual behaviour and in the general character structure, reflecting the abnormal "metabolism" of aggression; second, the narcissistic personality structure, in which the perverse scenario is infiltrated by the aggressive aspects of the condensed oedipal and preoedipal conflicts. In the case of the syndrome of malignant narcissism, the aggressive drive derivatives are integrated into the grandiose pathological self with consequent dangerous sadistic deterioration of the perversion (Kernberg, 1989a).

In the psychoanalytic literature on perversion, narcissistic features have been suggested as a general characteristic. From a clinical perspective, however, it is extremely important to differentiate patients with "narcissistic conflicts" in a non-specific sense from those whose specific narcissistic character structure has particular implications for prognosis and treatment. The anal and oral regression at this severe level of perversion is reflected in "zonal confusion" (Meltzer, 1977). Zonal confusion refers to the symbolic equivalence of all protruding or invaginated sexual areas of both genders, with corresponding condensation of oral, anal, and genital strivings. Unconscious anal fantasies dominate the sexual life of these patients, with "faecalization" of genital organs and genital intercourse. The anal-sadistic regression of these patients involves an attack on, and destruction of, object relations, while the oral regression is reflected in the oral-sadistic expression of envy and destructive greed.

The most dramatic combination of all these dynamics can be found in the perversions of narcissistic personalities where the specific dynamics described by Chasseguet-Smirgel (1984) are dominant: the unconscious fantasy of a faecal penis and a faecal vagina, the unconscious equalization of genders and ages, a primitive idealization of the perversion linked with the denial of castration, and the tendency to universal equalization of all object relations and all sexual activities that, in the process, become "spoiled", "digested", and "expelled" as faeces. Here, the perverse scenario may succeed in containing the aggression, but the aggressive impulses overshadow the libidinal ones, threatening to neutralize erotic excitement and to corrode or destroy the object relation. The defensive idealization of the perversion may express itself in a stress on aesthetic qualities of both the sexual object and the sexual scenario, reflecting both the defence against, and the expression of, the image of faecalized sexual organs, and an illusory surface adaptation in the form of "as if" relationships.

From a psychostructural viewpoint, the pathology of perversion may be classified into six major groups, that I shall briefly describe from least to most severe, in terms of the pathology of object relations and the sexual life of these patients, as well as their prognosis for psychoanalytic treatment (Kernberg, 1992). First, perversions in the context of neurotic personality organization: all these cases have excellent prognosis with psychoanalytic treatment. The presenting obligatory "scenarios" vary from patient to patient, but are typically clearly defined. As in all perversions, they are an indispensable precondition for the gratification of the patient's sexual needs and the achievement of orgasm. The idealization of the perversion goes hand in hand with sexual inhibition in other areas. The patient's capacity for object relatedness is deep and solid, and oedipal conflicts clearly predominate in the transference.

Second, perversions at the level of borderline personality organization: here we find typically the condensed preoedipal–oedipal conflicts with dominance of preoedipal aggression. Specific perversions at this level usually are combined with a pathology of object relations that makes the scenario of these perversions less clearly circumscribed or differentiated, and rather blending with the general character pathology of these patients. It is important to differentiate a generalized polymorphous perverse infantile sexuality in these cases, that is, a chaotic combination of many infantile perverse trends, from the consolidation of a typical perversion. Paradoxically, the chaotic combination of polymorphous perverse impulses significantly improves the prognosis for borderline patients treated with psychoanalytic psychotherapy or psychoanalysis. By contrast, a subgroup of borderline patients with severe inhibition of all eroticism carries a poor prognosis because, as the borderline personality organization is resolved in treatment, the sexual inhibition tends to become more intense. A specific perversion in these cases is prognostically favourable, although the treatment is, of course, more complex than in the case of neurotic personality organization.

Third, a perversion combined with a narcissistic personality disorder: these cases are particularly difficult to treat because the idealization of the perversion is condensed with the idealization of the pathological grandiose self in a defensive structure that is often difficult to dismantle.

As in the borderline cases, it is important to differentiate generalized, polymorphous, perverse infantile behaviour from a specific perversion. Such polymorphous, perverse behaviour in narcissistic patients may reflect a replacement of object relations by the compulsive use of sexual behaviour to relieve anxiety.

Fourth, perversion in cases of malignant narcissism: here ego syntonic aggression may infiltrate the particular perversion, and transform it into a sadomasochistic pattern that may objectively endanger both patient and partner. In fact, it is because the syndrome of malignant narcissism is at the very limit of treatability that it deserves to be classified as a fourth group. Here, we encounter the more severe and dangerous forms of sadism, masochism, paedophilia, and anally regressed perversions such as coprophilia.

A fifth group is constituted by the antisocial personality disorder in a strict sense, as originally described by Cleckley (1941), and currently studied by Robert Hare (Hare & Hart, 1995; Hare, Hart, & Harpur, 1991), Michael Stone (1980), and myself (1992). These cases [not accurately conceptualized, in my view, in the *DSM-IV* classification (APA, 1994)] represent the most severe type of narcissistic character disorder, in which superego development has failed entirely. A consolidated perversion in an antisocial personality always has to be considered as extremely dangerous until proven otherwise: here we find sexual murderers and serial killers, in whom the remnants of eroticism are totally overshadowed by extreme forms of primitive aggression. The prognosis of any presently known treatment for the antisocial personality proper is practically zero.

Finally, in a sixth group are perversions as part of psychotic personality organization, in schizophrenic illness, and, particularly, pseudopsychopathic schizophrenia (Kernberg, 1996). A perversion in a schizophrenic illness might be psychopharmacologically controlled if the schizophrenic illness itself responds to such treatment.

## *Perversion and perversity*

The syndrome of perversity in the transference consists, in essence, in the recruitment of eroticism and love at the service of aggression. The fact that this important and severe form of negative therapeutic reaction should have been equated with perversion as a specific sexual pathology is due to a semantic confusion to which, unfortunately, psychoanalytic literature has contributed. In fact, some of the most important contributors to the study of both perversion and perversity, such as Herbert Rosenfeld (1987), Donald Meltzer (1977), and Wilfred Bion (1968, 1970), tend to use the terms *perversion* and *perversity* in the transference as equivalent, or, at least, do not differentiate sufficiently clearly between them. In addition, in both British and French psychoanalytic literature one finds the term *perverse structure*, that implies a particular and unique personality organization or psychodynamic constellation characteristic of perversion that, as we have seen, does not do justice to the broad spectrum of personality organizations in which perversion appears.

At the same time, the same authors I just referred to have given the most specific description of the syndrome of perversity in the transference. This may occur in patients who suffer from a perversion, but it occurs as well in patients without a sexual perversion, such as, characteristically, patients with narcissistic personality disorder or the syndrome of malignant narcissism.

I have pointed in earlier work to some patients' efforts to extract goodness, concern, and love from the analyst precisely to destroy them, in an envious feast that goes beyond the need to demonstrate the analyst's incompetence and impotence, and instead expresses the wish to destroy the sources of the analyst's equanimity and creativity. Because the syndrome of perversity appears particularly in patients with severe narcissistic personality structure who, at the same time, may present a perversion in a narrow sense, both syndromes may go together.

## *The diagnostic evaluation of patients with sexual perversions*

What follows summarizes briefly the diagnostic questions derived from what has been said so far. First, in all cases it is important to evaluate completely the patient's sexual life, activities, fantasies, daydreams, dreams, and masturbatory fantasies, as well as the fantasies linked with actual sexual interactions. The patient's sexual preferences and their continuity or discontinuity, and the entire spectrum of his or her sexual responses need to be evaluated. Second, the basic aspects of core sexual identity, dominant object choice, gender role identity, and intensity of sexual desire should be evaluated, as these four features jointly define the patient's sexual identity

(Kernberg, 1995). Third, it is important to evaluate the linkage between the patients' tender and loving capabilities and their sexual life: does he or she have the capacity to fall in love? Is there a capacity to integrate love and eroticism, or are they usually or always dissociated from each other? Are sexual inhibitions present, and, if so, what type and severity? Fourth, what is the predominant personality constellation, the level of severity of personality pathology? The presence or absence of pathological narcissism and the syndrome of malignant narcissism, the quality of object relations, the presence of antisocial features, the degree to which the expression of aggression is pathological and egosyntonic, should all be assessed.

And fifth, we are interested in the evaluation of the couple, in cases where marital or couple conflicts are an essential aspect of the presenting symptom. Under particularly complex circumstances, a combined team of a specialist in personality disorders, a couples' or family therapist, and a sex therapist may jointly make a strategic analysis of diagnosis and treatment, a methodology that I have found very helpful in especially difficult cases.

From all these data flow the essential considerations that will determine prognosis and treatment: the level of personality organization and predominant personality disorder, the quality of object relations, the presence or absence of pathological narcissism, the severity of the disturbance of expressed aggression, the organization and level of superego functioning, the degree of sexual freedom, and the particular prognostic implications for the relationship of a couple, as elaborated by Henry Dicks (1967).

### *Psychoanalysis and psychoanalytic psychotherapy*

Psychoanalysis is the treatment of choice for sexual perversions in patients with a neurotic personality organization, and for patients with a narcissistic personality disorder who have sufficient capacities for anxiety tolerance, impulse control, and sublimatory functioning, and who are able to maintain reasonable stability with regard to work, social adaptation, and some degree of emotional intimacy.

Psychoanalysis proper is usually contra-indicated for patients with the syndrome of malignant narcissism, but there are exceptions to this rule. Patients with a combined hysterical–histrionic personality disorder also may respond to psychoanalytic treatment, as do some patients with paranoid and schizoid personalities, although the large majority of patients with borderline personality organization should be treated by psychoanalytic psychotherapy rather than by standard psychoanalysis.

The overall prognosis is strongly influenced by the extent to which antisocial features are present (i.e., the relative integrity of the superego) as well as by the capacity for maintaining object relations in depth over a period of time, neurotic as they may be, as long as they are not purely parasitic or exploitive (Kernberg, 1992).

The most essential aspect of the treatment of perversion, in my experience, is the focus on the activation or enactment of the underlying unconscious fantasies in the transference. The patient may attempt to draw the analyst into being a spectator of the patient's relationship with the external object of his perverse scenario, thus fulfilling aspects of the perverse fantasy itself as it involves the analyst. It is, of course, important to explore the unconscious fantasies experienced by the patient in the course of enactment of the perverse scenario, as long as the analyst remains aware that this is only a preliminary exploration of what eventually will become a transference enactment.

For example, a patient was impotent with his wife, while fully potent in sexual engagements with other women, who had to submit to him in a masochistic scenario. He would tie them up and have them carry out self-demeaning acts that symbolically represented their humiliation and his total control over them. In contrast, he behaved like a shy little boy with his wife. With me he displayed almost a caricature of submissiveness: he became interested in psychoanalytic ideas, sought out my published papers, and, in an overblown identification with me, used the ideas he found there to argue with his friends and colleagues about alternative psychological theories.

In the course of the treatment, as the image of a violent father who was sexually promiscuous and a tyrant at home came into focus, the patient gradually became aware of his inhibited behaviour as a fear of rebelling against such a violent father, and of the fantasy that the only way to rebel against him would be a violent, bloody overthrow. An underlying fantasy slowly emerged in which

he would sexually submit to powerful father representatives and thus solve the conflict with the father by becoming his sexual love object.

What made the analysis of the transference particularly difficult was the surface, "as if" submission of the patient that protected him against an underlying wish for a dependent, sexual relation with me. The analysis of that underlying wish was interfered with by the patient's "guessing" my thoughts, and immediately accepting what he thought were my theories, fully endorsing them in intellectual speculations that raised serious doubts in my mind whether all this had any emotional meaning. It dawned upon me after a period of time that I had become the bound-up victim of the patient's sadistic control in the transference; his ready acceptance of what he thought was my train of thought, his way of disorganizing my thinking had led to a temporary paralysis of all work in the sessions. The analysis of that "as if" quality in his relationship with me eventually induced a sense of confusion and intense anxiety in the patient, and the emergence of fear of me as a threatening father who wanted to keep him in the role of a little child, and stood ready to castrate him if he were to penetrate his wife, who represented unconsciously the oedipal mother.

This case illustrates the "as if" quality of perversion in the transference even under conditions of neurotic personality organization. The patient presented a typical sadistic scenario in the context of an overall psychological functioning that was remarkably normal in terms of the emotional relationship with his wife as well as his capacity for effective and mature object relations in his work and social life. He had initiated the treatment with a hidden idealization of his perversion that he only gradually dared to express in the sessions.

The following case, in contrast, presented a sadistic perversion in the context of a borderline personality organization, a narcissistic personality structure, and polymorphous perverse infantile features strongly reflected in conscious anal sadistic fantasies and behaviours that infiltrated the patient's entire life. He was obese as a result of overeating, abused multiple drugs, and, while he was very effective in his business, the chaotic style of his business management created continual problems with associates and subordinates.

This patient was able to have intercourse with his wife only if he subjected her to physical abuse. Her willingness to undergo significant pain was a precondition for his achieving orgasm. What brought him to treatment was that she became unwilling to continue this situation, not because of the nature of their sexual interaction *per se*, but because of aspects of his behaviour that she considered disgusting, such as not cleaning himself appropriately after defecating, to the extent that small segments of faeces would be found in their bedclothes. He would almost never flush the toilet, and as he used hand towels for cleaning his genitals and anal region, his wife felt obliged to hide the towels that she herself would use.

In the course of his analysis, the patient talked in an apparently free way about present reality and fantasy, childhood memories, and emotional reactions to the analyst and his office, in what might be described as an almost "perfect" style of free association, speculating about deep motivations of his behaviour, and dramatically displaying affects that shifted from moment to moment. What was striking was his "throwing out" ideas and feelings without assuming any responsibility for them, in what impressed me as a thoughtless spreading of chaotic material for me to pick up and make sense of.

It may already become apparent to the reader that it was as if little pieces of excrement were being thrown around, in a general devaluation and equalization of all thoughts, feelings, and behaviours that, unconsciously, were the equivalent of covering the analyst and his office with excrement while the patient maintained an illusional superiority as the producer of this digested material. Any interest I expressed in any particular material would lead to immediate ironic speculations of the patient regarding what I now had in mind, and a derogatory attack on my capacity to understand him. Implicit in these enactments was the fantasy that the analyst would make sense of the faecal chaos, and in so doing bolster the patient's belief in his own superiority. These developments could eventually be understood as the symbolic equivalents of the sadistic attacks on his wife as an essential requirement for orgasmic climax.

Only the systematic interpretation and working through of this massive defence expressed in the patient's non-verbal communications and my countertransference led to the underlying hatred of

the oedipal couple, his effort to deny the possibility of a sexual relation that could be mutually gratifying and creative, and from which he felt excluded forever. He, in contrast, identified with a sadistic and mutually destructive couple, and replicated this relationship in the transference.

It is essential in the psychoanalytic treatment of perversion, I believe, to focus on the areas of significant inhibition in the patient's sexual life. The patient's efforts to draw the analyst into an excited, voyeuristic countertransference engagement may permit a subtle acting out of the transference rather than leading to further understanding. The perverse scenario, with its tightly knit construction and defensive idealization, may successfully resist the analysis of the repressed, dissociated, or projected fears and fantasies against which the perverse scenario serves as a defence. In contrast, the areas of sexual inhibition that perverse patients strenuously attempt to avoid exploring may provide a direct link to the repressed conflicts around castration anxiety and preoedipal aggression that are condensed with archaic oedipal material.

For example, a patient with a masochistic perversion was able to achieve sexual excitement and orgasm only when he was controlled by two women who would force him into a subservient position while showing their excitement and desire for him when he was physically immobilized and sexually stimulated. This man experienced a total lack of sexual interest in the woman whom he loved and with whom he lived without any sexual intimacy over several years.

At one point I began to focus our work upon the almost bizarre splitting between his intense sexual life with any pairs of women he could induce to participate in his particular scenario, and the total lack of sexual desire for the woman who loved him and was willing to live with him in spite of his avoidance of sexual engagement with her. My efforts to explore what he felt in the relation with his girlfriend, whom he described as objectively attractive and who, in the distant past, had been one of a pair of women engaged in the masochistic scenario with him, at first created intense anxiety and perplexity in the patient. Any effort to explore his thoughts or feelings when she would undress in his presence would lead him to an expression of boredom, to the extent of falling asleep in the sessions when that subject was mentioned. It gradually emerged that he did not dare to depend on his girlfriend because of the unconscious conviction that all women would try to sadistically control and attempt to "brainwash" him if he became dependent on them. Therefore, only intense sexual encounters orchestrated by him with women for whom he had no feelings permitted him any sexual gratification. Fantasies of swimming underwater and being approached by a huge fish that wanted to swallow him up, memories of humiliating experiences with his mother taking him to doctors because she thought his penis was distorted toward one side, alternated with the patient's attempt to talk about the relationship with his girlfriend while, in fact, he could only describe her behaviour towards him. He was completely oblivious of any feeling that he might have in relation to her, or what her internal life might be: the patient described himself as feeling as if a glass wall separated him from her.

The emergence of this strange combination of frightening fantasies of oral castration interspersed with total repression of thoughts and feelings about his girlfriend, and the patient's irresistible somnolence in the analytic hours, permitted me to become aware that some parallel development was occurring in his relationship with me. His empty talk about the actual interchanges with his girlfriend produced a somnolence in me that at various points made me struggle with the temptation to fall asleep. I observed that the patient's attitude on the couch was one of growing tension, and his associations became more and more strenuous efforts to carry out the task of understanding what happened in the relationship with his girlfriend. It was as if he were in some kind of cognitive–behavioural therapy, carrying out concrete tasks of fantasy formation rather than simply letting himself depend on his relationship with me.

In short, powerful narcissistic defences against dependency on a maternal object (because such dependency would mean a dangerous sexualization leading to castration) were the gradual discoveries in the transference that led to the understanding of the idealized masochistic perversion. In that masochistic scenario his erect penis emerged as a most desirable object in the context of humiliation and physical restraint. He allayed his deep fears of castration by arranging for the dependent position to be forced upon him while eliminating any emotional involvement with his paired partners.

He did not dare to depend on his girlfriend, because of his oedipal prohibition condensed with the fear of an invasive, castrating, preoedipal mother, and he did not dare to depend on me, replicating the same relationship. To depend on me would imply a sexual submission to the oedipal father, and to be castrated by an invasive mother at the same time. This case, I believe, illustrates the indirect road to understanding the perversion by focusing on the patient's inhibitions as the corresponding conflicts become activated in the transference. In my somnolence, I was identifying with the patient's masochistic submission to, and avoidance of, a dangerous mother, while his intellectualized speculations implied his identification with an omnipotent and castrating mother.

Patients with borderline personality organization and narcissistic personality structure invariably stir up countertransference responses that are not easy to use effectively. But the analyst's skill in the therapeutic use of his countertransference disposition will be put to serious test in the analysis of all patients with perversions, including those with neurotic personality organization where the idealization of the perverse scenario may be particularly effective. The analyst may either be seduced by fascination with the perverse scenario, or so unable to identify with it that the patient seems strange and robotlike. Countertransference defences against a threatened identification with the protagonist of a perverse scenario interfere with the appropriate subtlety in empathizing with both the patient's and his object's emotional experiences.

The analyst's access to his or her own polymorphous perverse infantile erotic fantasies and memories is as important in these cases as is the ability in general to identify with both homosexual and heterosexual impulses of patients of both genders. Obviously, when the main purpose of the perverse scenario is a destructive attack on the object, such an identification with the patient's aggressive impulses may be particularly anxiety producing in the analyst. It is important, when the patient actually fantasizes or potentially enacts dangerous perverse behaviours, to apply the general principles for limit setting that are useful in life-threatening situations of borderline patients (Kernberg, Selzer, Koenigsberg, Carr, & Appelbaum, 1989). Concretely, if the patient's sexual behaviour would create a life endangering situation for himself or his object, or threaten the patient or his object with severe social and legal consequences of that behaviour, it is necessary to make it a precondition for analysis that the patient refrain from such behaviours.

For example, one female patient who would walk at night into a dangerous part of town with the wish to prostitute herself as an enactment of masochistic submission to sadistic men, objectively created potential dangers for herself that required limit setting to that behaviour before analysing its unconscious meanings. As I pointed out in earlier work (1993), such limit setting is not only perfectly compatible with analytic work but may, in fact, be an essential precondition for it, if the meaning attached to the analyst's limit-setting behaviour is immediately taken up in the analysis of the transference.

The combination of such limit setting and an analytic approach to its implications in the sessions may provide not only the necessary space to resolve the particular symptomatology, but also the freedom for the analyst to engage in an exploration of his countertransference, where either excitement or disgust with the particular behaviour of the patient may provide important clues to its meanings. For example, one adult male patient's paedophilic perversion, his sexual seduction of little girls, could be analysed only after prohibiting the enactment of the perversion. Limit setting created a safe countertransferential space that permitted the analyst to identify with the patient's excitement with the hairless genitals of little girls that reassured him against the frightening aspect of adult women's genitals, while their submission to him powerfully confirmed there was no danger of castration involved with being faced with a split genital on the body's surface.

The issue of technical neutrality is important in the analytic treatment of patients with sexual perversion because the patient's defiant assertion of the perversion as being much superior to ordinary sexual encounters may provoke the analyst into a countertransference defence of "normal" sex. As mentioned earlier, when discussing normality, it is unavoidable that the analyst's general value system regarding the protection of life, the opposition to destructiveness and self-destructiveness, and the affirmation of enjoyment and mutuality in a sexual experience be considered basic values that might rightly, I believe, limit technical neutrality. Within the context of such broad values, it seems important to me that the analyst honestly tolerate very different ways and solutions to a

patient's dilemma of how to deal with love and the erotic dimension of life. If a patient is happy with a perversion that provides a safe island of ecstasy within a reasonably gratifying and effective context of love and work, there is no reason why the analyst should urge, even implicitly, a different sexual pattern on the patient. If patients seek treatment for their perversion, it is because there are aspects of the perverse solution that are eminently unsatisfactory to them, that limit them both in their erotic experience and love life, and that they intuitively sense as a restrictive imprisonment.

The counterpart of perversion is the deadening of the erotic, a frequent and insufficiently recognized pathology of daily life. That erotic ecstasy, together with the ecstasy stimulated by works of art and religious experiences constitute, as Georges Bataille (1957) has suggested, a fundamental counterbalance to ordinary life focused on work and conventional social existence, would seem an important contribution of psychoanalysis that tends quite often to be neglected.

While the various types of ecstasy all derive, as Freud suggested, from erotic sources, the psychoanalyst's personal experience confirming that erotic dimension of life would seem an important precondition for treating all sexual inhibitions, including the perversions. I would not have found it necessary to say this, had clinical experience not shown how often the antierotic aspects of conventional culture influence psychoanalytic perspectives. The capacity for an object relation in depth is a fundamental precondition for a full erotic capability: this is a contribution from psychoanalysis that, while originally presented in a theoretical frame by Freud, has found an important confirmation in our knowledge regarding the deterioration of the erotic capability under conditions of severe destruction of internalized object relations in severe narcissistic personality structures. The recovery of both normal object relations and the capacity for a synthesis of love and the erotic is a crucial treatment goal with borderline patients. It is also a realistic goal in the treatment of the perversions.

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