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Pentheus rather than Oedipus: On perversion, survival and analytic 'presencing'[1]

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Following an introductory review of the main developments in the psychoanalytic thinking on perversion, the author focuses on her own understanding of perversion and its treatment, based on the psychoanalytic treatment of patients with severe sexual perversions. This paper uses the term 'autotomy' (borrowed from the field of biology) to describe perversion formation as an 'autotomous' defence solution involving massive dissociative splitting in the service of psychic survival within a violent, traumatic early childhood situation; thus, a compulsively enacted 'desire for ritualised trauma' ensues. The specific nature of the perverse scenario embodies the specific experiential core quality of the traumatic situation. It is an actual repetition in the present of the imprint of a past destructive experience which is pre-arranged and stage-managed; it thus encounters haunting scenes of dread or psychic annihilation while, at the same time, controlling, sanitising and disavowing them. Hence, the world of severe perversion is no longer oedipal, but rather the world of Pentheus, Euripides's most tragic hero—a world dominated by a mixture of a mother's madness, devourment, destruction and rituals of desire. According to this view, the (difficult) psychoanalytic treatment of perversion focuses on patient-analyst interconnectedness—brought about by the analyst's 'givenness to being present' or 'presencing'—at a deep, primary level of contact and impact (the emphasis being on the ontological dimension of experience). This evolving therapeutic entity creates and actualises a new, alternative experiential- emotional reality within the pervert's alienated world, eventually generating a change in the perverse essence. The author illustrate this approach with three clinical vignettes.

'I have a feeling we're not in Kansas any more', said Dorothy to Toto

The Wonderful Wizard of Oz.

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Drive, object, selfobject: Contextualising perversion in psychoanalytic thinking

The psychoanalytic understanding of perversion[2] has come a long way over the last 100 years, beginning with Freud's early writing **(1905)** on the subject. I shall try to outline briefly its theoretical landmarks and changes over the years, before moving on to my own approach.

The understanding of perversion in psychoanalytic thinking may be divided into two major frameworks: the drive model and the object-relations model (**Pajaczkowska, 2000**; **Harding, 2001**; **Keinan, 2002**).

I

The first, historically, is Freud's classical drive model and its vicissitudes. Initially, Freud understood perversion from the economic point of view, as a primary fixation of libido at pre-oedipal levels. In 1905, he connected and contrasted neuroses and perversions as the positive and negative sides of one and the same process—the developmental process of infantile sexuality. '*Neuroses are, so to say, the negative of perversions*' was his famous assertion (**1905**, p. 165); that is, perversions represent positive, unmodified, non-repressed infantile sexuality, whereas its modification through unsuccessful repression gives rise to neuroses. Thus, in perversions, infantile sexuality persists into adult life in the same polymorphous infantile form as in childhood, at the expense of adult genitality.

Several years later (in the context of a growing interest in the ego), Freud began to recognise that perversions may serve as defensive formulations, especially against an Oedipus complex and castration anxiety, rather than simply as pieces of infantile sexuality that have evaded repression. This was expressed explicitly in his 1919 essay 'A child is being beaten'. But, in neurosis, the repressed phantasy breaks through only as an ego-dystonic symptom, whereas in perversion it remains capable of consciousness, being ego-syntonic and pleasurable **(Gillespie, 1995)**.

In his later writings, especially in 'Fetishism' **(1927)** and in his important unfinished essay 'Splitting of the ego in the process of defence' **(1938)**, Freud postulated other defences in perversion: the 'disavowal' of reality, resulting in a 'splitting' of the ego. These mechanisms bear significant resemblance to those found in psychoses. Yet, throughout his writing, Freud's theory of sexuality and perversion remains a drive theory, focusing on the Oedipus complex and castration anxiety. 'It [the fetish] remains a token of triumph over the threat of castration and protection against it' (**1927**, p. 154).

II

A radically new way of understanding perversion evolved by way of attachment and object-relations theories, towards and during the second half of the 20th century. Rather than endogenous drives, it emphasised disturbed early mother-child

[2] Throughout the paper, 'perversion' refers to actual sexual perversion (cf. *DSM-IV-TR* under Paraphilias) and not to the psychoanalytic expansion of the term over the last decades to perversion of the transference, relational and character perversion (especially in Kleinian thinking).

relations, the mother's pathogenic role, and pathological ego or self development. Perversion was regarded as a primary defence against intolerable, primitive infantile anxieties and traumas, and a self-induced survival solution to preserve a precarious, crumbling ego or self. This emphasis on primitive, psychotic anxieties rather than on neurotic oedipal and castration anxieties brought perversion closer to psychoses. (As early as **1933**, Glover wrote that certain perversions have to be regarded as the negative not so much of neuroses but of psychoses, as they help to patch over flaws in the development of reality sense.)

This 'relocation' of perversion in early disturbed attachment or object relations greatly affected psychoanalytic thinking, especially in Britain, the US and France, as I shall now briefly review.

Imre Hermann **(1976)**, in Hungary, was the first psychoanalyst to relate sadomasochistic phenomena to traumas in early dependency and the primal desire to cling to the mother's body.

In Britain, Khan **(1979)** emphasised a specific disturbed early mother-child relationship in all perversions due to the mother's narcissistic idolisation of the infant-child as her 'created-object' (or 'created-thing'), followed by her abrupt withdrawal—perversion being the ego attempt at a self-reparative solution. Glasser **(1986)** postulated the 'core complex' established in the pervert's early infancy, because the primal longing for complete merging with the object carries with it a threat of annihilation, as the mother was felt to be dangerously engulfing, intrusive or depriving; the perverse solution thus engages the object in an intense relationship, but sado-masochistically controls annihilating merging and intimacy. More recently, Welldon (1988, **2002**) placed the emphasis in sado-masochistic perversions on early experiences with a mother who uses her infant to gratify her own primitive needs and fantasies of power.

In American psychoanalysis, most notable are the extensive contributions (with detailed case studies) of Stoller and Socarides. Stoller (**1974**, **1975**, **1991**) defined all perversions as 'the erotic form of hatred', which convert infantile traumas, especially attacks on the child gender identity, into adult triumph, and are thereby characterised by hostility, revenge, risk-taking and a dehumanised sex object. Socarides (**1959**, **1974**, **2004**), drawing on Mahler's concepts, focused in perversions on a basic pre- oedipal nuclear desire for and dread of merging with a demonified mother in order to reinstate the primitive mother-child unity, which resulted from a pre-oedipal failure to pass successfully through the 'undifferentiated' symbiotic and separation- individuation phase of early childhood. Perversions ensure ego survival in various perverse practices; alternating or combining perversions may indicate a greater tendency to avert psychotic breakdown.

In France, several different parallel lines of theoretical development extended and shifted the understanding of perversions from the area of castration anxieties to the pre-oedipal pathogenic mother and traumatic early experiences. McDougall **(1995)** wrote about 'sexual deviation and psychic survival', arguing that, besides castration anxieties, sexual deviations are desperate attempts to master anxieties of a much earlier phase, when separation from the mother arouses the terror of bodily disintegration, annihilation and a sense of inner death. Several French theories of

perversion developed around de M'Uzan's case of masochistic perversion (which will be described later), primarily because his description of erotogenic masochism disagreed with essential points in Freud's **(1924)** essay on masochism. De M'Uzan himself, in his 1973 paper, and particularly in a later theoretical paper (**2003**; **Simpson, 2003**), focused on excessive quantity of excitation related to fatal irrevocable traumatic situations early in life. Laplanche **(1999)** shifted from Freud's biologistic endogenous drive theory to primal seduction, which affirms the priority of the other, not the Lacanian Other, but the concrete other—the adult facing the child, introducing 'a message to be translated'. Anzieu **(1989)** regarded perverse masochism from his notion of the 'skin ego', as signifying the tearing away and the re-establishment of the infant's shared skin (the symbiotic union) with the mother.

III

Another important change in the understanding of perversion took place with the development of American self-psychology, and its emphasis on the relation between the self and its selfobject—the primary psychological unit—in the child's early life. For Kohut (**1972**, **1977**), most perversions are desperate attempts to repair the disintegrating self by means of perverse fantasies and activities, as a result of a protracted, traumatic relation with a non-empathically responding selfobject parent. 'The deepest analysis of … [perverse] manifestations does not, however, lead to a bedrock of drives, but to narcissistic injury and depression' (Kohut, **1977**, p. 173). His followers, particularly Stolorow (**1975a**, **1975b**; **Stolorow et al., 1994**) and Goldberg (**1975**, **1999**), further explored the important narcissistic function of perversion, viewing it as an abortive, primitively sexualised attempt to restore and maintain the cohesiveness and stability of a precarious, crumbling self, or to defend against dreaded object situations and affects during the early pre-oedipal era.

Not in Oedipus any more: Perversion—autotomy and survival

Having surveyed the main existing psychoanalytical perspectives on perversion, I would now like to focus on my own search, as a psychoanalyst, for understanding perversion and its treatment. (In terms of the theoretical background, my thoughts and ideas belong to the model of disturbed early-childhood relations.)

The following discussion is based on cases of sexual perversion which I have treated over the years—severe cases which, to my mind, do not fall within the debate over whether they are a perversion or a 'variance' (**Stoller, 1974**), or whether 'perversion is us' (**Dimen, 2001**; **Stein, 2003**). Nor will I be referring to patients whose perversity was expressed only in fantasy, in transference perversion or in character perversion. The following are cases of actually acted, intense perversions (mostly masochistic) of patients who have undergone years-long psychoanalytic treatment (analysis or intensive psychoanalytic psychotherapy) with me. Their sexual perversions were not first disclosed in the course of the treatment, as usually reported in the literature, but they came to treatment because of those very perversions. These patients actually belong to the type of perverts about whom Laplanche, de M'Uzan and many other psychoanalysts write, 'Doubtless, these patients [erotogenic

masochists]—like most perverts—hardly ever consulted the psychoanalyst' (Laplanche, **1999**, p. 201), and about whom Stoller adds, 'analysts dislike and fear perversion … I have never analyzed an erotically perverse sadomasochist' (**1991**, pp. 53-4). Yet, the patients presented here are perverts who did come, who stayed and underwent a long psychoanalytic treatment with me.

Although it is beyond the scope of this paper to give a lengthy, detailed description of these treatments, I will nevertheless briefly describe the patients in order to specify the perversions which form the basis of the following discussion.[3]

The first was a 30-year-old paedophile who underwent intensive psychoanalytic psychotherapy (face-to-face, four times a week) in a psychiatric hospital, following a court order—a coerced treatment, which, following his release three years later, became a voluntary treatment lasting about 10 years. I think that, without this first, most significant treatment experience with a perverse patient, the rest would not have followed.

The second was a young woman who could only have sexual relations with her partner via a blend of fantasies and acts of violence against herself. These practices increasingly escalated, at her own demand, until her partner became fed up with 'these disgusting games', as he called them, and told her that, as much as he loved her, he was no longer willing to continue the relationship. After he left her, she went through a long period of loneliness and despair, during which she vacillated between wanting to ask him to come back and attempting to relinquish her violent practices, on the one hand, and thinking that he may have simply grown tired of her and had found an excuse to leave her, on the other. But she knew deeply, piercingly, that she was unable to desire or have any sexual relationship with him or with anyone else without that preliminary violence. She attempted suicide. Upon returning home from the hospital, she saw a British film about a girl whose boyfriend also refused to continue a sado-masochistic relationship because of his love for her. This made her think that there may in fact have been love along with trepidation on the part of her own partner, and not just rejection, and she decided to seek treatment. She came to me with the request 'to put the demon back in the bottle' and turn the practices of violence into mere fantasies so as not to find it necessary to actually enact them—'let them exist locked up inside'. When this indeed happened and the perverse activities ceased three years into the treatment, she asked to continue treatment (analysis four times a week, on the couch) in order to release herself from the grip of the unrelenting, violent fantasies.

The third patient, the most recent one, was a man in his late thirties, referred to me by a psychiatrist who had treated him with medication. The psychiatrist told me that his severe sexual perversion had intensified over the last few years to the point of becoming life threatening. In the year before he came to her for treatment, he had approached several sex therapists who were all so alarmed by the severity

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[3] I find it necessary to specify the cases of perversion that have led to my ideas on severe perversion; one might metaphorically say, which part of the large elephant's body do I take hold of in order to know the elephant. As Winnicott writes, 'It is not my aim in this paper to give a description of this case since one must choose whether to be clinical or theoretical … Nevertheless I have this case all the time in mind' (**1954b**, p. **280**).

of his disturbance that they would not agree to treat him. When he turned to her, she prescribed medication for compulsive disorders, in an attempt to minimise the compulsive nature of his perverse behaviour. However, this was unsuccessful and produced harsh physical side-effects, some of which she found rather puzzling. She therefore stopped the medication and told him that, in her opinion, the only treatment which might help him would be psychoanalysis, since it is the most profound form of treatment. It should be mentioned that this man had previously never had anything to do with psychology or psychoanalysis, and I do not believe that he had even heard of the word psychoanalysis before. His consent to her proposal was thus an indication of his despair and hopelessness. After several unsuccessful attempts at finding him a psychoanalyst, she approached me, knowing I take difficult analytic cases. She seemed hesitant to specify the nature and extent of his perverse behaviour, lest I too refuse to treat him. However, at the time, I had been crystallising my thoughts about extending the reach of therapeutic work through the depth and intensity of psychoanalysis, and about analysis as *a unique process of becoming*—drawing on the powerful notions of 'a new opportunity for development' (Winnicott), 'a new beginning [in] the basic fault' (Balint) and 'an area of faith' (Eigen). If so, I thought, psychoanalysis should be able to offer a veritable treatment option for this person's distress, and I agreed to accept him for analysis.

Shortly afterwards, the man telephoned me. During the first session, I found out that his severe sexual perversion had started as a shoe fetish of licking and kissing shoes 'that have a woman's feet inside', along with a masochistic element of wanting them to tread on his fingers, a wish which he recalled having had since kindergarten. It escalated over the years into a masochistic fetish as the 'shoe turned into a tool of destruction', and in the past few years had become a particularly severe and violent masochistic perversion. Over the first months of analysis, he gradually presented me with extremely harsh descriptions, told matter-of-factly, of how he frequented prostitutes almost every night, usually a different one each time, to be humiliated and abused by them in increasingly extreme ways with all sorts of torture instruments. He would lie there naked, masturbating until he ejaculated, and would leave the place beaten, trodden upon, wounded, bleeding and burned by cigarettes that had been put out by the shoes that ground them into his naked body. And already he was yearning for the next abuse. He sought treatment because he knew that, in his own words, 'if it goes on like this, it will end in hospital—in a serious injury or in death'.

After a few months of analysis (four times a week, on the couch), when he realised that I would not 'throw him out of treatment because of what he told me', he said, 'This is the last stop for me. Psychoanalysis. After that—it's the cemetery'. Since then he has been clinging to treatment despite some very difficult periods which we have gone through.

In his 'ordinary' life, he was a drab accountant in a non-sexual marriage to a woman he knew from work, an accountant like himself, whom he told nothing about his perversion ('a crazy, wild discrepancy', he described his split reality in the second year of analysis, as he started thinking about his perverse activities rather than just performing them).

Even more than the previous two cases, perhaps because they did involve sexual relationships, this analysis flooded me with feelings of incomprehension. How can one understand the desire for and the addictive submission of a human being—in fact, of any living creature—to such abuse, to such a violent web of humiliation and physical injury?

It is interesting to note that Freud, too, opens his 1924 essay with the incomprehensible, mysterious nature of masochism:

> The existence of a masochistic trend in the instinctual life of human beings may justly be described as *mysterious* from the economic point of view. For if mental processes are governed by the pleasure principle in such a way that their first aim is the avoidance of unpleasure and the obtaining of pleasure, masochism is *incomprehensible*. If pain and unpleasure can be not simply warnings but actually aims, the pleasure principle is paralysed—it is as though the watchman over our mental life were put out of action by a drug.
>
> Thus masochism appears to us in the light of a *great danger*, which is in no way true of its counterpart, sadism. We are tempted to call the pleasure principle the watchman over our life rather than merely over our mental life (p. **159**, my italics).

I recall that at the beginning of this analysis, and also later on, I read anything I could find about severe masochism in an attempt to understand it, make some sense of it. However, nothing I read felt truly relevant or provided me with an unmediated understanding, except for the expression, 'the desire for ritualized trauma', coined by Benyamini and Zivoni **(2002)**. Even Ghent's compelling 1990 paper, which views masochism as a perversion of the deep-seated human need for surrender, did not lend meaning to the violent, harsh masochism described by my patient. Thus, I realised that I would be able to find a tangible, *unmediated understanding* only within and through the treatment itself.

In order to explain my understanding of severe perversion formation, as it evolved within me through the analytic experience with these patients, I will draw on a term from the field of biology—*autotomy*, and introduce a moving poem about it by the Polish poet Wislawa Szymborska.

Autotomy is a biological term that designates the capacity of some living creatures to waive the wholeness of their body as a means of survival. They divide themselves, in times of great danger, into two disconnected parts—one that is left behind to be devoured by their predator, and another that thus succeeds in escaping and surviving, and later regenerates. The gecko, for instance, saves itself by releasing its tail and leaving it twitching behind for its predator, and the holothurian (sea cucumber) splits itself in two, as described in Szymborska's poem, in words which I find so very accurate and captivating:

> In danger the holothurian splits itself in two: it offers one self to be devoured by the world and in its second self escapes.
>
> Violently it divides itself into a doom and a salvation … into what was and what will be.
>
> In the middle of the holothurian's body a chasm opens and its edges immediately become alien to each other.

> On the one edge, death, on the other, life. Here despair, there, hope …
>
> To die as much as necessary, without overstepping the bounds. To grow again from a salvaged remnant.
>
> We, too, know how to split ourselves but only into the flesh and a broken whisper …
>
> Here a heavy heart, there *non omnis moriar*, three little words only, like three little plumes ascending …
>
> ('Autotomy', 1983, translated by Czeslaw Milosz).

Non omnis moriar (Latin)—Not all of me shall die! Through these words, I would like to describe the perverse solution as profound, massive splitting and dissociation in the service of survival and the preservation of psychic existence, albeit in a more difficult, complex manner than the holothurian.

A child needs and wants to be loved, protected and admired by its parents. It is my view that at the root of severe forms of perversion lie primary desperate attempts in early childhood to overcome the intrusion of brutal situations, of unbearable psychic or psycho-physical violence and abuse, which could be neither endured nor escaped. In such situations of traumatic destructiveness, the infant-child has to split, dissociate and remove from within itself the sensations of violence, pain, dread and annihilation, since the significant other on whom it depends introduces terror or reacts to him with indifferent, sadistic imperviousness rather than providing protection, holding, containment and belief in the possibility of repairing these violent situations.

Thus, an *autotomous solution* comes into being, of massive dissociative splitting into two disconnected parts, alien to each other, as a means of psychic survival. One part continues functioning in the world, surviving by inertia, emotionally impaired, lacking and dull, lifeless and alienated from the inner core of its experiences. At times, it seems as if only a husk remains—'that's all there is', says my masochistic patient dryly of his daily life; at times, materialistic success or intellectual functioning somewhat compensates for the splitting and the dissociation from the emotional parts that were left behind to be devoured—'To grow again from a salvaged remnant', in Szymborska's words.

The other part—the self that was offered to be devoured—is stuck in that devouring state, suicidally attracted to whatever wounds and preys, to whatever embodies and actualises (at times to the point of total actualisation) the dark violence, the devastation, devourment, sadism and imperviousness, both within the psyche and in self-other relations.

Actualising and not actualising—the most intense experiences and sensations are invoked here, by the attempt to convert an unbearable traumatisation that occurred in the past into an exciting perverse scene that takes place in the present. It thus becomes a perverse ritual, frozen, repetitive and violent, an anticipated, self-induced and stage-managed pain which focuses on the body (rather than the psyche), and therefore offers no real solution, no relief, no cure.

It is a compulsive repetition, an addictive desire for a ritualised trauma which continually enacts the intrusion of dread, violence and humiliation, in an effort to gain control over the trauma, to produce it, appropriate it, overcome it, deep down to even yearn to repair it; anything but to leave it as an unbearable, uncontrollable trauma. Thus, the perverse act seizes and clutches, preventing in its corporeality, in its actuality and intensity, a collapse into dread, psychic deadness and total internal annihilation. Perversion is the pervert's last-ditch attempt to halt the fall into the abyss.

'Physical pain is better than spiritual death', says the patient who repeatedly asks her therapist to hit her, in Stolorow et al.'s **(1994)** article on masochism. My fetishisticmasochistic patient would repeatedly say in the first year of analysis, 'It sustains you more than anything else. You won't let anyone or anything take it away from you. If you give it up, it will be unbearable, since there won't be anything else'.

Stoller **(1975)** suggests that perversions may be a defence against psychotic depression, and Kaplan states,

> What distinguishes perversion is its quality of desperation and fixity. A perversion is performed by a person who has no other choices, a person who would otherwise be overwhelmed by anxieties or depression or psychosis … to prevail over these otherwise devastating emotional states. Therefore, the kinky sex … is actually an appeasement of personal demons … more a trial of survival than a quest for [sexual] pleasure (**1993**, pp. 10-2).

And more specifically. Freud **(1927)** maintains that,

> when the fetish is instituted, some process occurs which reminds one of the stopping of memory in traumatic amnesia. As in this latter case, it is as though the last impression before the uncanny and traumatic one *is retained as a fetish* (p. 155, my italics).

I am reminded in this context of a story by Jules Verne in which the murderer is discovered because the homicidal incident was frozen, in the second preceding death, on the victim's retina, thus becoming the pre- and-post-death moment. The dead eyes register the deadly encounter in a way that the living cannot.

It is my view that severe perversion registers and freezes a haemorrhaging traumatic core experience of self-with-significant-other. The perversion embodies the *specific experiential-emotional key quality of the traumatic situation*, and stops at the near-hit, last impression before reaching the full intensity of dread, annihilation and psychic deadness—*making present the imprint of the past destructive experience*, over and over again, concretely, unremittingly. The perverse scenario exposes the horrors of the dissociated, either as doer or done-to. But perversion enables an externalisation and a return under the perverse guise to the site of devourment and to an extremely bad object (bad either in its way of relating or not relating), while it sanitises and obscures the horror, the alarm or the betrayal, the longing for what might have been different, the loss and the destruction—the annihilation of life and hope. The attacked, ruptured subject becomes a split object, dissociated from the memory of a past traumatic horror, and perverse—not all of me shall die!

I am drawing here on Winnicott's 1986 profound paper 'Fear of breakdown', in which he describes even the most psychotic illness syndromes as a *defence organisation* against breakdown and unthinkable primitive agonies that have

already happened, but which the patient 'has not yet experienced' and does not remember. 'It is not possible to remember something that has not yet happened, and this thing of the past has not happened yet because the patient was not there for it to happen to' is Winnicott's unique description of the dissociative state (p. 176). Thus, the patient must go on fearing it and compulsively looking for it in the future. The breakdown that has no experiential existence in memory haunts, grips and insists on actual realisation.

In much the same manner, I regard *perversion, too, as a defence organisation— through splitting, externalisation and compulsive sexualisation—against a violent, devastating, unbearable, deadening early past situation*. 'Desire is the opposite of death', says Blanche when she explains her deviant sexual behaviour in Tennessee Williams's *A Streetcar Named Desire*. Winnicott, in his 1935 paper 'The manic defence' writes, 'Here the key words are dead and alive' (p. 134). Thus, it can be said that the key quality of perversion is a sexualised manic survival; not the 'disavowal of castration', but the 'disavowal of annihilating destruction'.

In my view, the world of severe perversion is no longer oedipal. In Greek tragedy, there are three renowned sons whose fates are very different from each other **(Verhaeghe, 1999)**: at the one extreme is (Aeschylus's) Orestes, who murdered his mother, Clytemnestra, to avenge the murder of his father, Agamemnon; yet Orestes is judged to be innocent and escapes the revenge of the Furies, who then become the Eumenides. In the middle is (Sophocles's) Oedipus, who is unable to escape his fate, discovers that he killed his father and slept with his mother, and therefore blinds himself and goes into exile. And, at the other extreme, the most tragic and gruesome, is Pentheus, in Euripides's last play *The Bacchae*, which, like the story of Oedipus, takes place in Thebes. King Pentheus, disguised as a woman, attempts a peek at the Bacchantes' revelry headed by his mother, Agave, and her sisters. He is exposed and caught. Despite his pleas, he is torn to pieces and devoured alive by his mother who in her frenzy sees him as a wild beast, and by the mad devouring Bacchantes or Maenads who savagely celebrate the rite of Bacchus (or Dionysus)—himself a God who dies and is resurrected each year; it is a rite whereby any male creature that passes by is devoured.

Severe perversion, in my view, is no longer rooted in an oedipal world, but rather in the world of *Pentheus*, which has its beginnings in transvestism and voyeurism, continues on to exhibitionism, and goes as far as sado-masochistic violence and cannibalistic murder. It is a world dominated by a mixture of a mother's madness and devourment,[4] derangement and orgiastic intoxication, and the combination of rituals of desire with destruction and death.

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[4] It is interesting to note that, as regards female sexuality, Freud could write, 'Our insight into this early, pre-Oedipus, phase in girls comes to us as a surprise, like the discovery, in another field, of the Minoan-Mycenean civilization behind the civilization of Greece. Everything in the Sphere of this first attachment to the mother seemed to me so difficult to grasp in analysis—so grey with age and shadowy and almost impossible to revivify—that it was as if it had succumbed to an especially inexorable repression … It does indeed appear that women analysts … have been able to perceive these facts more easily and clearly … for this germ appears to be the surprising, yet regular, *fear of being killed (? devoured) by the mother*' (**1931**, pp. 226-7, my italics).

Is perversion treatable?

Extending the reach of the psychoanalytic process

I shall now address the difficult question of the psychoanalytic treatment of perversion and the possibility of change.

Let me start with words written very early on, at the threshold of the development of psychoanalysis. This is the opening passage of Freud's very early paper 'Psychical (or mental) treatment', written in 1890. (It was believed to be written in 1905 until it was discovered that these astounding arguments were written as early as 1890 **(Berman and Rolnik, 2002)**.) The young 34-year-old Freud, neuro-physiologist and soon-to-be psychoanalyst, writes,

> 'Psyche' is a Greek word which may be translated 'mind' ['*Seele*'—a word which is in fact nearer to the Greek 'psyche' than is the English 'mind' (Jones Strachey, translator's note)[5]]. Thus 'psychical treatment' … might accordingly be supposed to signify 'treatment of the pathological phenomena of mental life'. This, however, is *not* its meaning. 'Psychical treatment' denotes, rather, treatment taking its start in the mind, treatment (whether of mental or physical disorders) by measures which operate in the first instance and immediately upon the human mind.
>
> Foremost among such measures is the use of words … A layman will no doubt find it hard to understand how pathological disorders of the body and mind can be eliminated by 'mere' words. He will feel that he is being asked to believe in magic. And he will not be so very wrong, for the words which we use in our everyday speech are nothing other than watered-down magic. But we shall have to follow a roundabout path in order to explain how science sets about restoring to words at least part of their former magical power (**1890**, p. 283).

It is no small matter to believe—especially when thinking about the treatment of perversion—that 'psychical treatment' is not 'treatment of the pathological phenomena of mental life' but rather treatment originating in the psyche, by measures which operate in the first instance and immediately upon the human psyche. And how much more so, as the analyst's search is for words that are not 'watered-down magic', but for words that have regained 'a part at least of their former magical power'.

Rolnik argues on this point,

> It is true that Freud would later attempt to close all apertures through which the theological and mystic draft might enter his writing, but he never succeeds in completely sealing them … In any case, it is my view that had that mystic opening chord—a psyche treating a psyche— not continued to reverberate in psychoanalytic theory and to nourish it, it would not have lasted a hundred years **(2002)**.

I would like to link Freud's words to words written much later by Guntrip, who uses Winnicott's distinction between 'being' and 'doing', and writes

> Technique is a matter of what the analyst is 'doing', how he is operating his protocol for interpretations and so on, *but the therapeutic factor lies in what the therapist 'is', what he is 'being' unself-consciously in relation to the patient* (**1968**, p. 312, my italics).

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[5] The Greek word *psukhé* is indeed translated 'soul, breath' (*Collins Dictionary*).

Let me combine these words of Freud and Guntrip into one sentence—that *the therapeutic factor* (restoring to words their former magical power) *lies in what the analyst's psyche is 'being' in relation to the patient's psyche*, in this case the pervert patient's. It is from here that I will proceed to my own thoughts regarding the therapeutic factor and the analyst's 'psychical' being in the treatment of perversion.

In presenting my approach, my point of departure will be, rather radically and paradoxically, the famous case of masochistic perversion described by the French psychoanalyst de M'Uzan, who emphasises the very early, irremediable fatedness of severe perversion.

De M'Uzan's case of masochistic perversion

De M'Uzan **(1973)** describes a profoundly perverse masochist, Monsieur M. He met him not in treatment, but in two consultations, following referral by a radiologist who, during a medical examination, noticed indications of the patient's perverse practices. M accepted the radiologist's referral without reservation. Yet, writes de M'Uzan, although a psychoanalyst would be expected to immediately apply himself to study a case of erotogenic [enacted] masochism, which is rarely seen in psychoanalytic practice, it took him 10 years to write this paper; he did not wish to follow the case further, and postponed the writing of a theoretical discussion of it. (In fact, he wrote the theoretical discussion of the case 11 years later, that is, 21 years after the two consultations with M.)

M was 65 years old when de M'Uzan met him. At that time, M had retired from work, having been a highly qualified and respected electronic engineer. He lived in a small house in the suburbs with his adopted daughter and her husband, and appeared to have led a well-adjusted life, both socially and professionally, unmarked by moral masochism. But, when he bared his damaged body, the contrast was overwhelming, and it confirmed his descriptions of his extremely masochistic practices. (De M'Uzan gives a detailed, page-long description of the extreme self-inflicted damage to M's body.)

M, the only son of relatively elderly, 'kind' parents, started his masochistic practices at age 10 in school, searching for corporal punishment. This escalated in the following years as he became the object of his schoolmates' acts of brutality, and assumed its full development upon marriage at the age of 25 to his 15-year-old cousin; she too was a masochist (since age 11, before meeting M), and their common perversion brought them together. Torture was generally inflicted on the two of them by one or two men, with M and his wife assuming the role of victim. M was very attached to his wife, whom he described as sweet and loving, and their eight years of marriage as 'eight years of happiness with never a dark cloud'. But his wife, exhausted by the extreme torture, died of pulmonary tuberculosis at the age of 23. M was deeply affected by her death; he entered into a depressed state, and contracted pulmonary tuberculosis, from which he recovered completely after two years in a sanatorium. His masochistic practices then began anew. He married a prostitute in the hope of finding an experienced partner, but divorced her soon afterwards when her involvement in criminal activities rendered him liable to criminal proceedings.

> From this marriage he retained nothing except a young servant girl, whom he had adopted as his daughter. *This was the point at which his perverse practices stopped completely* … Even the content of his dreams, which had been strictly masochistic, became entirely heterosexual and less and less masochistic … From there on his life unfolded within the family milieu which he had created, to which he was very strongly attached, and in which nothing was known of his peculiar past (**1973**, p. 458, my italics).

In explaining this perverse masochism, de M'Uzan focuses on the constitutional factor of 'excess of instinctual quantity' which leads to an irresistible tendency to discharge tension (regarding M, his first wife who was his cousin, and his father, after whose death M discovered from his correspondence that he too had been a masochist). According to de M'Uzan, the role of the instinctual excess is manifested in the chronology of M's perverse practices. They began at puberty and, as he approached the age of 50 'with the approach of old age and biological alternations', all perverse practices disappeared, and the dreams and fantasies finally became entirely free of masochistic representation. To this he adds that, if this excess of quantity becomes associated with an early object-deficiency or primitive and brutal 'tearing apart' of the 'me' from the 'other', it threatens the individual capacity for mental integration, and renders the ego much more dependent on elementary experiences at the bodily level, and especially on physical pain, in an effort at reorganisation. Thus, the coexistence of the constitutional quantitative factor along with early object-deficiency or brutal separation 'puts the seal on the destiny of the subject' (p. 465). Later, de M'Uzan **(2003)** describes M as a 'slave of quantity' of excitation, which is fatal and irrevocable because of a traumatic situation very early in life that cannot be psychologically elaborated. 'Quantity is destiny when it is constituted in actual trauma' (p. 716).

In my view, de M'Uzan's explanation of the sudden, drastic change in the fatedness of M's erotogenic masochism surprisingly lacks any reference to the possibility that this radical change was effected by the changes that took place in M's human environment, and mainly his strong, years-long relationship with the girl that he adopted as his daughter. It is here, according to de M'Uzan's description, that he began leading a quiet family life, free of all masochistic activities, and even, gradually, free of masochistic dreams. Is the excess quantity of excitation and the early object-deficiency or early traumatic separation influenced only by the age factor rather than the formation of significant, very different object relations? Although not explored any further by de M'Uzan, I find it difficult not to take into consideration the emergence and influence of these different relations as basic, new experiences which negate the seal of fate of early traumatic situations,[6] suggesting that 'all is foreseen, but freedom of choice is [still, yet again] given'.

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[6] I am reminded here of Winnicott's emphasis on the significance of the correction of 'failure of early basic environmental provision' in severe mental disorders: 'It is in the psychoses—not in the psycho- neuroses—that we must expect to find examples of self-cure. Some environmental happening, perhaps a friendship, may provide a correction of a failure of basic provision, and may unhitch the catch that prevented maturation in some respect or other' (**1963**, p. **258**). According to Winnicott, this corrective provision is not enough in the analytic process, and should be supplemented by a correction of the early traumatic failure—now relived through the analyst's failure ('failing the patient's way')—in the treatment.

It is in this place, where new, basic experiences and a correction of 'failure of early basic environmental provision' **(in Winnicott's words, 1963)** come into being within the world of perversion, that I am endeavouring to situate the psychoanalytic treatment of severe perversion, as will now be described. This approach also embodies—in an essential, broader sense—the search, the striving for and, in my view, the possibility of extending the boundaries of psychoanalytic treatment. I shall draw heavily on experiential modes of being and apply to this treatment of perversion fundamental and broader assumptions of mine regarding analytic technique and therapeutic action in clinical psychoanalysis.

'Presencing'

First is the analyst's 'givenness to being present,' or 'presencing' as an essential means for treating perversion. I proposed the importance of the analyst's 'presencing' several years ago **(Eshel, 1998)**. I argued that the fate of massive acting out, acting in and enactment in therapeutic work is determined largely by the analyst's willingness and ability to give himself over to being 'in there', to being present in the acting situation and communing with it—listening to it, experiencing, withstanding and processing it from within, thus transforming it from resistance to treatment into a way of understanding, remembering and communication. For the acting conveys, in non-verbal ways, inner areas of traumatic experiences which are cut off and lost to words. Furthermore, I emphasised that the analyst's 'presencing' in massive acting situations becomes a powerful holding, containing and protective factor whose existence and cumulative effect changes the self-other field, the inner experience of terror, of traumatic lack and emotional failure in the patient's world. It thereby enables the breaching, from within, of the repetitive cycle of pathological self-other relations and defences.

This is markedly so in perversions, wherein the acting—defined as acting out, enactment or performance—is a central element (**Goldberg, 1975**; **Khan, 1979**; **Kaplan, 1993**). From this perspective, I understand the reactions of the psychotic masochistic patient Anna (**Stolorow et al., 1994**, mentioned earlier), who repeatedly and unceasingly requested of her therapist to hit her, hit her, until eventually she was able to write to him that 'physical pain is better than spiritual death'. Through her 'hit me' request, I think, she was asking her therapist over and over to enter, share and effect by his presence her lonely and alienated masochistic solution and her dread of psychic deadness. Thus, 'presencing' means, first, the analyst's deep acceptance of the necessity of becoming an embedded, fundamental and sustaining factor in difficult situations and enactments.

Moreover, in view of object- and selfobject-relations models of the development of perversions, it seems to me particularly significant in treating perversion to establish this sort of presence—namely, the analyst's basic, functioning 'presencing' that focuses on attunement, holding and containing rather than proffering interpretations of patient-analyst relationships (object or subject relationships) and especially of patient-analyst separateness.

As described in the theoretical section of this paper, object- and selfobject-relations perspectives on perversion formation (including my own) anchor it primarily in disturbed, traumatic core experiences in the early developmental stages as a defence

and survival organisation of the infantile ego or self. Therefore, the analyst's givenness to attuned, functioning 'presencing' takes on great relevance in the treatment of perversions. This relevance is *ontological-experiential* and *developmental* rather than epistemological, for it opens up a new way of facilitating, living through and restoring *primal relatedness and functional dependence*. The analyst's 'presencing' enables a *remobilisation* of the patient's primary and fundamental need for a connected, merged existence with a holding, containing and protective presence. At the same time, it also enables the *actual*[7] *becoming of a new, primary interconnectedness* with the analyst— who is 'there to be used' (in the Winnicottian sense), steady, sustaining and experience- near to the patient's needs, fears and inability to relate.[8] Balint similarly describes a new beginning as '(a) going back to something 'primitive', to a point before the faulty development started, which could be described as a regression, and (b) at the same time, discovering a new, better-suited, way which amounts to a progression' (**1968**, p. **132**).

In Winnicottian terms, the process that I am elaborating upon here can be described as the transforming of the patient's withdrawal and dissociative organisation—in this context, the perversions[9]—into regression to dependence (Winnicott, **1954a**, **1988a**), through the

analyst's 'presencing'. According to Winnicott, in the withdrawal state, it is the patient who is holding the self. But, if the analyst proves himself capable of holding the patient and 'putting a medium around the patient's withdrawal self', this enables the patient to dare let go of the withdrawn self-defensive organisation, thereby converting the withdrawal into regression to dependence, which carries with it the opportunity for correction of the failure or inadequate adaptation-to-need in the patient's past. Thus, a new chance for development ensues.

I am stressing *terms of regression* in the treatment of perversion because it offers a radical new possibility for the analytic process to influence and correct the patient's past environmental failures in a deep way that goes back to very early developmental processes. For Winnicott, by regression to dependence in analysis, 'the present goes back to the past and *is* the past' (**1955-6**, p. **298**), and there is a chance for the analytic 'present-day environment to make adequate though belated adaptation' and provide good-enough holding and handling that can actually alter the patient's past (**1954b**, p. **283**). 'Somehow we have silently communicated reliability and the patient has responded with the growth that might have taken place in the very early stages in the context of human care' (**1988b**, p. 102).

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[7] 'Actual' in the two meanings of the word: 'in the present and in the process of actualization, that is, trying to bring into existence what didn't happen' (Pontalis, **2003**, p. 45).

[8] Khan also writes that the 'formidable therapeutic task in the treatment of the pervert … confronts us with the pervert's inaccessibility to influence and change through his object-relations. No human being can do very much in ordinary life for a pervert because he can be as Lewis Carroll's Tweedledee would say, 'only a sort of thing in his dream' (**1979**, p. 30). I believe that the sort of analyst's 'presencing' described in this paper creates a fundamentally new possibility of seeping into, accessing and influencing the pervert's inner world.

[9] Recently, De Masi has deemed early 'sexualized withdrawal [that begins in infancy] to be the nucleus and genesis of perversion—indeed of all perversions' (**2003**, p. 87).

To conclude this description of 'presencing', let me quote a passage from Eigen regarding the treatment of a difficult patient, which conveys in his singular style, ideas that are closely related to my 'being in there, presencing':

> Little by little, I see him [the patient] seeing me out of the corner of his psyche. He is aware that I am there, whoever I am. I am someone not talking him out of himself, someone letting him fall. He cannot get rid of the him-in-me with words. He is perplexed and curious about being part of my inner life. It is strange for him to find himself inside me. It is something new to bump up against another's quietness and find the quietness moulded around himself (**2001**, pp. 134-5).

The point I am making is that, through 'presencing' and regression, patient and analyst enter another dimension of experience.

The dimension of 'quantum' interconnectedness[10]

In pursuing the notions of 'presencing' and regression, over the last few years I have applied to them elements borrowed from quantum physics, and particularly the observer effect (**Sucharov, 1992**; **Kulka, 1997**; **Eshel, 2002**). According to the revolutionary key principle of quantum physics, in the quantum reality of particles one cannot separate the act of measuring or observation, by which an object is studied, from the observed object itself, since *the very act of observation and its method affect the observed phenomena in crucial ways*. Thus, *the observing becomes fundamentally inseparable from the observed*. This is an essential, inescapable property of the world at its most basic level—the level of particles—and it is in direct contrast to classical physics, which was based on assumptions of linear causation, determinism and a sharp separation between observer and observed.

My recent thinking on the psychoanalytic process and therapeutic action emphasises patient-analyst interconnectedness at a deep, emotional level of 'presencing', contact and impact, creating a therapeutic entity, unit or being, which is fundamentally inseparable into its two participants—primary and formative quantum-like interconnectedness. Hence, it is not a one-person or two-person psychology, but a process in which the two become a two-in-one interconnected new entity beyond their separate psychic existences. (**Stark, 1999**, writes in this context of a one-and-a-half-person psychology.)

As in quantum reality, *treatment thus creates a psychic reality rather than just exposing and deciphering an existing reality*. This implies breaching and changing the patient's (and the analyst's) psychic space. Within the deep interconnected existence of their psyches —through the analyst's readiness to be given over to this interconnection—an actual, non-linear (synergic and transcendent) new possibility is created and present. It is the possibility of getting in touch with, experiencing, containing and influencing hitherto unbearable, dissociated or frozen aspects of being and relating that could not otherwise be reached or come into being and evolve (Eshel, **2001**, **2004a**, **2004b**). This new possibility, which becomes part of the

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[10] 'Quantum interconnectedness' is drawn from physicist David Bohm's phrase, 'the quantum interconnectedness of distant systems'.

actual treatment reality, not only revives the original past situation but is a process of becoming, a transformative process of change. For only a breaching of the limits of repetition and reconstruction, and of the patient's psychic space and its familiar defence mechanisms, can allow a new possibility that overreaches the confines of what has existed.[11] (I have referred to this elsewhere **(2004b)** as the 'venture zone' in the becoming of change.)

These are *crucial issues in the treatment of perversion*. Owing to its dissociative, secretive nature, owing to its being a self-induced survival solution of dissociative splitting and a compulsively driven and exciting ritual that does not truly change the deep inner stalemate, the pervert cannot be extricated from these repetitive cycles on his own. But, within and through the 'presencing' of the analyst in the perversion- laden psychic space, as the patient discloses his secrets, anxieties, feelings and desires to the analyst, while also slowly and gradually revealing his concealed yearnings, the voice of a new inner speech is formed, heard and evolves, albeit at times wallowing in the darkest burrows. *A present, alternative experiential-emotional reality is created*. It is a difficult treatment, most difficult. The psychic space of treatment and the analyst's psyche are deluged with the effects of perversion, or with the search for a path in a world of despair, emptiness and losing one's way, especially at the very time when the fierce perverse solution is destabilised and recedes (which is then often compounded when external reality is disorganised by changes in the split perverse structure). At times, the analyst is pushed towards anxious limits of professional and personal abilities.[12]

But I believe that the analyst's 'presencing' and interconnected being with the patient within these experiences—which hold together the 'autotomous' split parts— slowly, over time, erode the power of the blocked, wordless dread, the secrecy, the dissociation and the profound loneliness. They work 'in there' to bear, contain and mitigate the ferocity of the destructiveness, violence, rage, desire; they survive the intense helplessness, the failures, collapses, depression and despair, and the feeling of being fundamentally, irreparably flawed. These are all revived, grasping and clinging to the analyst—to the analyst's presence and the connection with him or her, and they

[11] Quinodoz **(2002)**, in a paper summarising a transsexual patient's analysis, writes of the change in the patient's psychic space from a two-dimensional, flat, concrete reality to a volumetric, three-dimensional internal space when the dimension of psychic reality is added. To my way of thinking, this change is the consequence of the interconnected existence with the analyst's psyche, which establishes the third dimension.

[12] In this context, I would like to relate to Quinodoz's **(2002)** account, in a subsection entitled 'An earthquake prior to the establishment of order', about the extremely strong feelings of dismay, disappointment, collapse and abandonment that she experienced when her transsexual patient informed her, after approximately five and a half years of analysis (which lasted seven years), that s/he plans to go ahead with a series of sex-change operations. She writes, 'For a moment I felt that everything was collapsing; Simone was abandoning me, slapping me in the face, administering the most violent aggression ever: there she was putting everything back on the concrete level, on that of external appearances, whereas I had thought that she was now in search of a more internal, psychic, sense of identity' (p. 787). Quinodoz then describes the way she processed these feelings. Such difficult sessions surrounding a violent return to the perverse solution (also described in the clinical example that I will present below) are familiar to analysts and therapists of severe perversions, and they usually follow a revival in treatment of feelings and experiences of the core traumatic failure **(Eshel, 2002)**.

are difficult, heavy and attacking; one may say that their clinging to the analyst and the treatment replaces their clinging to the perverse solution. At the same time, a possibility is created of experiencing them, processing them and reconstructing them as a different experiencing, being and relating. Thus, a profound change in the perverse essence is enabled, along with a slow, gradual entry of life, of connectedness and hope.

Winnicott's words on 'a good breast introjection' in analytic treatment complete the circle begun with Freud's **(1890)** early words on 'psychical treatment' and its 'magical power' with which I introduced this section:

> What do we [analysts] want? We want to be eaten, not magically introjected. There is no masochism in this. To be eaten is the wish and indeed the need of a mother at a very early stage in the care of an infant. This means that whoever is not cannibalistically attacked tends to feel outside the range of people's reparative and restitutive activities… *If and only if we have been eaten, worn down, stolen from, can we stand in a minor degree being also magically introjected*, and being placed in the preserve department in someone's inner world (Winnicott, **1954-5**, p. **276**, my italics).

For me, the magic, the wonder of psychoanalytic treatment in general, and the treatment of perversion in particular, is *the magic of the emotional connection created within a profound loneliness*. This connection is difficult, dense, at times daunting, rejected and rejecting, threatening and threatened, both when it transpires and also when it does not; as such it is fragile, woven thread by thread, struggling for its existence, but thereby very powerfully forged. It is this interconnection of patient's and analyst's psyches, and consequently within the patient's psyche, that enables—by dint of its ontological-experiential actuality—a breakthrough beyond the harsh and lonely actuality of the perversion. (I believe that, of all mental disorders, the existential experience of the pervert is the loneliest, most isolated and alienated—both from the outside world and also within the disconnected parts of his internal world.)

These processes transpired slowly and gradually in the treatments of my three perverse patients described above, and manifested themselves concretely in the course of treatment by the cessation of the perverse practices. The 'psychical treatment' that takes place through patient-analyst interconnectedness at a deep emotional level of 'presencing', contact and impact, the vital neediness and vulnerability involved in this process,[13] and the 'Eros' created in it ('Eros' in Racker's sense, **1968**[14]), *eventually dissolve the grip of the perversion*.

[13] Lazar similarly points out, 'The drive is inherently mixed, fused with and created through the other … But this surrendering arouses dread … The longing is sometimes … *for a complete meltdown of the structure in its entirety*, a longing to be liberated from that restrictive, concealing and confining envelope, to suspend and be released of any structure whatsoever. But such longing for something so personal, threatening and fragile from a specific other makes that other both important and threatening' (**2003**, p. 410, my italics).

[14] Racker powerfully states, 'The analytic transformation process depends, to a large extent, on the quantity and quality of *Eros* the analyst is able to put into action for his patient. It is a specific form of Eros, *it is the Eros called understanding*, and it is, too, a specific form of understanding. It is, above all, the understanding of what is rejected, of what is feared and hated in the human being, and this thanks to a greater fighting strength' (p. 32,

my italics). 'To understand is to overcome the division into two … *To understand, to unite with another, and hence also to love*, prove to be basically one and the same' (p. 174, my italics).

In words taken from Ferenczi **(1933)**, these processes recreate the 'passive object-love' and 'tenderness' characteristic of early childhood that were distorted and turned into 'passion' when, at the early stage of tenderness (or at the stage of passive object-love), an adult's passion or passionate punishment were forced upon the child.

Ghent, too, relates to tenderness in his 1990 paper on masochism. He cites the poet Yeats (quoted by Marion Milner): 'Tread softly, because you tread on my dreams', and writes, 'We ought to "tread softly" on patients' masochism and submissiveness. These too are often expressing in a disguised and distorted way a deep yearning to be found and recognized' (p. 234).

In order to illustrate the analyst's 'presencing' and the emotional interconnectedness of patient and analyst in the psychoanalytic treatment of perversion, I will present three vignettes that describe sessions taken from the analysis of perverse patients. The first vignette is from a difficult and critical analytic session with me. The second one is from an analytic session described by Mervin Glasser **(1986)** which I will contrast with my own. In the third, I return to the analysis of my own patient, more than a year after the session of the first vignette.

Clinical illustration I: Expulsion and return

The fetishistic-masochistic patient whom I described earlier, now in the second year of analysis, arrived at the first session following my holiday break. (The gaps created by the analyst's vacations are most troublesome in these treatments.) As soon as I opened the door, I noticed his swollen face.

He lay on the couch and, after a brief 'How are you?', told me quietly and bluntly, in detached detail, that he had gone to a whore that morning, a cheap one who charges only 100 shekels, a most violent type, who went wild and slapped him and beat him madly, incessantly, for five minutes, and he came very fast and hard, went home, washed up and came to the session.

For the first time in this analysis, perhaps because of this inundating wretched cheapness, I felt great tiredness and disgust, although he had already recounted far more violent and bizarre scenes. I was thinking to myself, What is the point of all the hard work, of this entire analysis, the great investment of money and years? Better go to a whore every day, get beaten up for five minutes, pay 100 shekels, and be finished.

And I withdrew, fell silent.

Then I noticed that he became very agitated, in sharp contrast to his former quiet and detached manner. As if he'd heard my thoughts, he said, 'Nothing can be done. I ask you: What? What is there to say? When I'm butchered, I exist. It's like the alien got inside my belly and stayed there, breaking out every time, and that's it. Nothing left to do. There's no solution. Everything just gets worse. I'm finished. I was born and I'll die this way. I'll be dead before I'm 40'.

He sat up, shaken, suddenly looking so withered, shapeless and pitiful, with his beaten-up, swollen face. And I realised he sensed and knew that I had *abandoned* him, left him wounded and lost on the battlefield, and had gone off to save myself.

Thus, I returned to this despicable, despairing and desperate place, his and mine, and said, 'You are so desperate because you felt that I'd given up. And when we both give up there's nothing more to hold on to. It's really very despairing, *but we are going on*'.

He lay back quietly, tears in his eyes for the first time in analysis (perhaps in his life), and said, 'Death can be so cheap. You should lock me up inside the treatment'.

Clinical illustration II: That which was is that which becomes

This vignette is from Glasser's **(1986)** paper and is quoted here verbatim. He embarks on his own concept of 'the core complex' in perversions, and illustrates it by describing a session:

> The core complex is a basic, central, coherent structure established in early infancy and made up of the inner-related ingredients of the longing for intimate gratification and security, the anxieties of annihilation and abandonment, with the attendant depression, and the aggression and sado-masochism.
>
> These ingredients can be illustrated by a condensed account of a session with a homosexual patient:[15]
>
> *He had been complaining about how his mother had been so unforthcoming on her recent visit to him in London. I commented that although he had given me many examples of his mother behaving in this way, I had some doubts about his account because we had seen in many sessions how he couldn't stand her coming close to him and how he was compelled to push her away. He responded by becoming visibly agitated and saying that he found his mother suffocating: she was like a spider on his face (as he said this he placed his spread-out hand over his mouth, nose and eyes and gripped his face). I took up this projection of his 'spideriness' on to his mother/ me, reminding him of his anger over my absences or late starts, and his bouts of compulsive, greedy chocolate-eating, as well as of his bouts of compulsively visiting public lavatories to carry out fellatio on whatever men he could find. Evidently my comments were too intensive, or too effective, because he went on to say that he felt terrible as I spoke and he felt an extremely*

strong desire to turn around and seduce me so that I wouldn't go on saying what I was saying.

The core complex dynamics are well-illustrated: when I challenge his denial of his longings for his mother/me, he feels himself to be invaded and taken over by my comments which, be believes, are aimed at making him be what *I* want him to be, not himself, and he deals with the conflicting wishes of negating me and keeping me by trying to sexualize our relationship into a sado-masochistic one by carrying out fellatio on me, thus gaining control over me and over what he will or will not take into himself (pp. **10-1**).

I find myself surprised by the realisation that two analysts (in this case— Glasser and myself) can begin with fundamentally compatible theoretical views (i.e. the model of the disturbed early mother-infant relationship for understanding the development of perversion), yet end up proffering such different actual courses of therapeutic action. For I feel that, in the above session, Glasser, who greatly emphasises the central role of the overbearing mother in perversion formation—the mother whom the child experienced as stifling and annihilating

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[15] I am quoting this account, even though homosexuality has been expunged from paraphilias (perversions) in *DSM-IV*, because it visibly illustrates the therapeutic action of the session.

his profound longing for primary merging, intimacy and security—merely enables *an experiential repetition* with him of the patient's overbearing relationship with his mother. In this session, which started with the patient's complaint about the mother's distance, Glasser does not offer attuned, experience-near reflective listening to what the patient is feeling, which would bring about experience-near understanding, empathic interpretations, and 'Eros' **(Racker, 1968)**. Rather, he gives (imposes) interpretations from the position of an analyst who authoritatively knows the truth about the patient and his relationship with his mother. I, on the other hand, think that, if we accept the ontology of survival of difficult emotional experiences as an integral part of perversion development, the complaints of such a patient about his mother's unavailability and the analyst's absences and late starts become an important venture. The deprived, hurt, fearful, angry, yet longing and needy self begins to work its way out. Therefore, the analyst's words must encompass and express this wavering movement between yearning and dread, between a child's deep longing and terrified mistrust; they must be heard, listened to and met. Otherwise, it seems to me that patient and analyst would not get beyond the patient's sexualisation—to his lonely, deep-rooted distress.

'Tread softly', for we tread upon the dreams, deep yearnings and 'core emotional needs' (in Glasser's own words) that were crushed and distorted at an early age and are waiting to be found and recognised.

Clinical illustration III: Can the warp be smoothed out?

I will now go back to my fetishistic-masochistic patient, in order to illustrate the turbulent nature of the analysis when the perverse practices ceased, the struggle (and yearning) to break through beyond his split world to a new possibility, and the significance of *holding on to treatment instead of to the perversion*. It is difficult, however, to describe the analyst's tacit 'presencing' through a verbatim report. For the sense of connection and understanding in 'presencing' is achieved mainly by letting the patient's intensity speak to us, and listening to and communing with the experience, its voices, imagery and enactments—feeling and evolving with their impact.

The vignettes are taken from two successive sessions that took place in the third year of analysis, over a year after the session I described earlier, and several months after the cessation of the perverse activities:

P began, 'You wanted me to bring myself here. So I am bringing my inner me, my madness, my depression. I'm saying what I said yesterday, although I'm less depressed and sad. In the past, I almost never had any deliberations. I led a very particular life, going for fetish and brutal sado, hiding from my surroundings. I'd come home, kiss the wife on the cheek, everything would be fine. Here too, I'd come and talk logically, and then go on to some brutal fetish. Now I'm telling you everything is shit, it's all nothing, and I leave here and put up a hell of a struggle not to do fetish. It's tearing me to pieces. Now I can't find an opening in all the shit. When I talk to you, it's a relatively good moment, but when I leave here …

'It's all ups and downs, nothing steady in my behaviour and feelings. So even when I tell myself, at the end of the day, 'You're calmer now', I remind myself this

is just until the next downer; it's an illusion. My entire development has been sucked into a whole complex of devious things. It all boils down to feeling like a great big nothing, that I am one big nothing. In the film *Pulp Fiction*, John Travolta takes risks, and eventually dies like a dog. So what nice words will you make up now…'

I said, 'At those moments, when you take risks and feel so insecure, and when you become desperate, my words are needed'. [Note that I said, 'my words are needed' and not '*you* need my words', in order to stress patient-analyst's interconnected, participating being in the process, and not I-you separate experiences.]

P said in an urgent voice, 'And if you won't understand … It's not just the perversion. It's my whole conduct. It's a different world. My whole essence is different, the essence of a world where you don't really exist in normal reality, you're not really there, ever. You're not real; it's all one big show. And the fetish— that's real. But the fact that now I'm not spending money on fetish and brutal sado, that's real and makes me feel good. That's great. Really. But that's just so little. And it shakes you, and upsets everyone around you. It's easier to go to a

brutal fetish, kiss the wife on the cheek and shut up.

'And what if you say, "Why did I take on such a case?" I think that if the treatment, if psychoanalysis, has the slightest chance of taking a person whose development is so perverted from a very early age, and lead him to a normal way of life, *if* such a chance exists—and frankly, I think chances are there's no chance at all—then I believe the treatment will be long. Whether it succeeds or not, it will clearly take years. The treatment is so … I think about it all the time—except for the few hours I sleep at night, it's *with me* all the time. Because I think that, if there is such a thing as moving from one track to another, it seems so very difficult. My inner world is something, Heaven help me, it's something else entirely, a world that in order to penetrate or change it—it's an atomic bomb. My inner world, it's a world where you can't grasp what's going on there inside me. I don't say this in desperation. You're the closest to understanding me. Maybe it can't change, and that's the conclusion we'll come to in the end, that it can't change. It's so different. Maybe it's impossible. My inside is such a totally different world. If I won't get cured, I'll die. Better to die.

'I had no idea where things would go, and no thoughts about the things I think about now. Over the last months I've been bringing to the sessions the madness that happens all the time, that at the moment I'm *alone* in the struggle, there's no God, I get into an absolute panic, all's lost, total despair, everything is just shit. In a real sense, it's the real me. But if I come to you desperate and claim there's no point in the treatment and nothing good is ever going to happen, you are getting exactly what's happening to me. So now, in contrast to the past, you know almost everything—that every day I'm in a state of excitation and my soul is devastated, very sick'.

In the next session he said, 'I'm tied to the fetish to the very core of my being, but something has happened … I want to choose from the start, clean and pure, if such a thing is possible … I very much want a girlfriend or wife, a partner. I can't see how I even get there. It seems too far away to get. It's hard when you start out so low, from the bottom. It's like Mount Everest for me.'

Concluding remarks

I began with a term from biology (autotomy), and I would like to conclude, as well, with a further reference to biology (also influenced, perhaps, by de M'Uzan's biologistic thinking), quoting Darwin who wrote about evolution: 'The structure of every organic being is related, in the most essential manner, to that of all other organic beings with which it comes into competition, from which it has to escape, or on which it preys' (On the origin of the species, 1859).

Furthermore, Weiner **(1995)** follows the discoveries of two scientists, Peter and Rosemary Grant, who spent some 20 years, beginning in the 1970s, in the heart of the Galapagos Archipelago—where Darwin received his first inklings of the theory of evolution—proving to their surprise that Darwin did not fully recognise the strength of his own theory. Weiner demonstrates that evolution is neither rare nor slow, taking place by the hour, and we can watch it. He quotes from Theodosius Dobzhansky: 'Creation is not an act but a process; it … is going on before our eyes. Man is not compelled to be a mere spectator; he may become an assistant, a collaborator, a partner in the process of creation' (Dobzhansky, *Changing Man*, quoted in Weiner, **1995**, p. 267).

I would like to apply the biological-factual words of Darwin and his followers— about evolution and the partnership in the process of creation—to personal evolution as well. I believe that in psychoanalytic treatment in general, and in that of the pervert in particular, if sufficient time is given to 'presencing' and analyst-patient interconnectedness and impact, *the psychic structure of the patient is influenced and changes, in the most essential manner, within the abiding, deep and sustaining connection with the analyst's psyche*.

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