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CHAPTER SIX

Perverse females

Their unique psychopathology

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The psychopathology of perversion

I shall start with some thoughts about perversion as a psychopathological entity. It is about the *absence* of a capacity to obtain sexual genital fulfilment within an intimate, loving relationship with another adult person. Instead, the individual suffering from a perversion feels taken over by compulsive behaviour (often inexplicable and bizarre to them and others) that provides temporary relief from unbearable and increasing sexualized anxiety. The notion of *temporary* relief is important, given that a feature of a perverse act is that it has to be repeated, yet it is never the hoped-for solution to intolerable psychic pain. Instead it could be thought of as an evacuation and a communication; or a repetition of early, unprocessed traumatic experiences no longer available to conscious thought.

The perverse enactment can dominate the life of the individual or be contained within a split off part of the psyche whilst the individual lives an otherwise successful and often professional life.

The source of perversion lies in a disturbed infant/mother relationship, usually with an absent father; "absent" meaning either physically not there, or physically present but uninvolved and

emotionally unavailable for "containing" mother and infant or for moderating that relationship.

By disturbed infant/mother relationship, I include early or repeated indifference to the child's emotional needs, mental, physical or sexual abuse, cruelty, physical or verbal attacks and indifference to the infant's suffering. This list can also include offering the child up to paedophilic partners, cross-dressing, or subjecting the child to a psychotic parent.

A feature of the perverse individual is a longing for closeness, yet profound anxiety about engulfment and annihilation leading to hostile pulling away from the apparently desired object, usually an object that stands for the mother to the infant. Glasser described this as core complex anxiety as follows:

> In the perversions, then, the ego attempts to resolve the vicious circle of the core complex and the attendant conflicts and dangers by the widespread use of *sexualization*. Aggression is converted into sadism. The immediate consequence of this is the preservation of the mother, who is no longer threatened by total destruction, and the ensuring of the viability of the relationship to her. The intention to destroy is converted into a wish to hurt and control. Sexualization also acts as a binding, organizing force in the internal state of affairs, enabling defensive measures to be more effective and a certain stability to come about.
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> [Glasser, 1979a, pp. 288–289]

Thus the wish to be rid of sexualized anxiety that contains unconscious hatred of the object (or, more appropriately, part object) and the perverse act, could be thought of as "making hate" rather than making love. This is most clearly seen in the paedophile who will talk of loving the child whilst doing the child physical and psychological harm.

The resultant perverse, destructive behaviour enacted in later childhood, adolescence or adulthood is an act of revenge, as if to empty the child-victim, now perpetrator, of unmanageable, still raw and unprocessed emotional pain, by pushing it into the new victim. This is a defence of identification with the aggressor, the original abandoning or attacking perpetrator (A. Freud, 1942). For many years I acted as consultant to a residential establishment that assessed abusive families. A significant number of residents came from great

distances from the Centre and were often single mothers and children who had separated from an abusive man. Many found new partners in the new locality—invariably these were also abusive men. These mothers had all been abused as children and constantly recreated abusive relationships involving themselves and their children.

Clearly a physically, sexually or emotionally abused infant or child does not have the psychic, emotional or physical equipment to process abuse. We are all familiar with the knowledge that what cannot be processed emotionally has to be repeated. This is so with the abused, who—if the trauma of abuse remains unprocessed and denied by themselves and significant others—either engage others in repeating the abuse, creating an illusion of control over the victim-role, or by turning passive into active, abuse others of an age and in circumstances to mirror their own original abuse.

Shengold (1989) referred to infant and child abuse as "soul murder", something that affects and disturbs future relationships. The victim of abuse is not appreciated as a separate being, with age-appropriate capacities and feelings, but as a vehicle for whatever the abuser wants to make of him or her. An incest perpetrator or paedophile, therefore, will talk of a child as though the child had adult sexual capacities and feelings, including the capacity to seduce, desire and initiate the denied abuse.

Thus perverse functioning acts as a survival technique or organized system of defences against the earliest anxieties—for example, psychotic fragmentation, primitive confusion and disintegration, or helplessness.

Aggression and violence in the perversions

It is helpful when thinking about the function of violence and aggression in perverse acts to ask the question, as delineated by Glasser (1998), is it self-preservative or sado-masochistic? Glasser describes self-preservative violence as follows:

> We can say that aggression and violence are aroused by anything that constitutes a threat to the physical or psychological self. Thus, in a

> psychological context, this self-preservative violence is a fundamental, immediate and substantial response triggered by any threat to the self with the aim of negating this source of danger. Random illustrations of such various dangers are: attacks on one's gender identity, the danger of castration, the infliction of a blow to self-esteem, frustration, humiliation, an insult to one's self or an ideal to which one is attached, and other such external threats. Violence may also be evoked by internal events such as a loss of identity through inner confusion, feelings of disintegration, the domination by an annihilative internal object, a remorseless castigation by a tyrannical, sadistic superego, and so on. Such internal threats may be externalized so that the attack on a person may appear inexplicable. In self-mutilation or suicide, the relevant parts of the body are related to as "external" objects (see for example Campbell, 1995). Such behaviour may be regarded as a temporary psychosis but I consider it more appropriate to consider it as an extreme regression to the most primitive level of functioning and this may or may not occur in psychosis. Wolff *et al.* subscribe to such a view when they state: "The patient's underlying personality is probably an important factor in many cases of violence, even if they are mentally ill. For example, a tendency for a psychotic patient to become violent may arise from pre-morbid personality traits rather than the psychosis itself." (Wolff *et al.* 1990, p. 634)
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> [Glasser, 1998, p. 889]

Glasser goes on, on the other hand, to describe sado-masochistic violence as follows:

> In the case of sado-masochistic violence, the response of the object is essential; the object must be seen to suffer. For example, in a war a soldier may kill one of the enemy in the interest of his survival, (self-preservative violence), while in different circumstances the soldier might kill his enemy as an act of revenge for what was done to his companions (sado-masochistic violence): or he may subject the captured enemy to bodily torture, often with great conscious pleasure (sado-masochistic violence). Thus another distinguishing feature is that an essential component of sado-masochistic violence is pleasure (which may or may not be manifest or conscious) while pleasure is not a component of self-preservative violence. The nearest self-preservative violence comes to involving pleasure is the relief when the danger is negated. (Glasser, 1998, p 891)

It is interesting to note that some women are currently pressing to be front line soldiers. It is worth thinking about what unconsciously drives this, given what we know about the unconscious motivation of non-conscripted male soldiers.

Resistance to recognizing women as perverse

In our society, perversion and especially paedophilia and incest, have male connotations, leaving women perpetrators without the help they need. The assumption is that "women do not do these things". Of course they do, but it is hard to bear the thought that mothers, our primary objects, can actively abuse or actively or unconsciously fail to protect. It is perhaps not surprising therefore that patients abused by their mothers have psychotic elements in the depth of their psychopathology. Such patients' sense of fury and grievance is often displaced onto male figures (often in a way that gives them a forensic label) with the psychological purpose of protecting the primary maternal object. It is harder to get to this by interpretations concerning the relationship with the mother, and also clinically dangerous, since collapse can be imminent when this is reached.

Perverse women can also be mis-diagnosed since, unlike their male counterparts, they perpetrate on their own bodies, or on their body products, namely their children. When they act out with others, perhaps as prostitutes or in sado-masochistic relationships, they are often regarded as having made a conscious choice, or are looked on as victims, and the solution is frequently seen as removing the male, leaving the perverse woman untreated. In the Oedipus myth the role of Jocasta is that of victim. Yet, she was more likely to have been able to recognize Oedipus as her son than he to recognize her as his mother. As in most perverse acts, the generation boundary was breached.

Since, for many, perversions are seen as the prerogative of males, this mind-set does not encompass how women act out in a perverse way. Like men, they use the reproductive system, which as a concept is more encompassing than the penis.

The main difference in male and female perversions

These were characterized by Welldon (1988) as follows:

Male perversions	*Female perversions*
1. Aimed at an "outside" object or person	1. Aimed at themselves or objects of their creation
2. Early organization around a specific perversion	2. Variable enactments of perverse psychopathology
3. No real emotional or physical attachment to the object or part object	3. Some degree of emotional or physical attachment to the object or part object
4. The action does not usually involve adult heterosexual intercourse	4. The action frequently involves adult intercourse for fantasy purposes and as a means to provide the perverse scenario
5. Desire to harm others is usually unconscious	5. Conscious desire to harm themselves. Conscious or unconscious desire to harm their babies

The core complex

Glasser refers to this constellation of anxieties as the "core complex", and writes as follows:

> When we treat perversions, we invariably come to recognize a particularly important complex of inter-related feelings, ideas, and attitudes. I refer to it as a "core complex" because the various elements that go to make it up are at the centre of the pervert's psychopathology and fundamental to it. Aggression is a major and integral element of this complex.
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> A major component of the core complex is a deep-seated and pervasive longing for an intense and most intimate closeness to another person, amounting to a "merging", a "state of oneness", a "blissful union". The specific versions of this longing are as varied as the individuals who express them. Such longings are, of course, by no means indicative of pathology; on the contrary, they are a component of the most normal of loving desires. However, in the pervert it persists pervasively in this most primitive form even when later developmental stages modify its manifest appearance. Such "merging" for him does not have the character of a temporary state from which he will emerge: he feels it carries with it a *permanent* loss of self, a disappearance of his existence as a separate, independent individual into the object, like being drawn into a "black hole" of space. There are individual variations depending on the particular vicissitudes of the aggressive and libidinal elements involved: of being engulfed by the object, of forcefully getting into the object or being intruded into by the object, and so on. But in one way or another the ultimate result is of being taken over totally by the object so that the anxiety is of total annihilation. This wish to merge and the consequent "annihilation anxiety" invariably comes into the transference—for example, as a fear of being "brainwashed" by the analyst, or as intensely claustrophobic feelings in the consulting room.
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> Among the defensive reactions provoked by this "annihilatory anxiety" is the obvious one of flight from the object, retreating emotionally to a "safe distance" (that is, essentially, a narcissistic withdrawal). This is expressed in such attitudes as placing a premium on independence and self-sufficiency. In therapy, it may be encountered as a wish to terminate treatment, as a constant argumentativeness or negativism, or the development of an intellectual detachment.
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> However this "flight into a safe distance" brings with it its own dangers and anxieties consequent on the implicit isolation. Such an isolated state may involve extremely painful affects and is, in my experience, one of the commonest reasons for the pervert seeking treatment. The relief from this state, or threat of it, must ultimately be sought in renewing contact with the object. Both the nature of the anxiety and the intensity of the needs cause this contact to be conceived of in terms of an indissoluble closeness, security and gratification which could only be achieved by "merging" with the object. And so there is a return to the start of the vicious circle of the core complex.
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> The emotional attitudes and fantasies I have described may well put one in mind of the "symbiosis" and "separation-individuation" stages of infant development (Mahler 1968) and since these stages are part of normal development it may be considered that I am not identifying anything specific to the pervert. But I would point out that the pervert differs from less severely disturbed individuals in that

his core complex is fixated at these very early developmental stages. To envisage closeness and intimacy as annihilating, or separateness and independence as desolate isolation, indicates the persistence of a primitive level of functioning. What I have been referring to as the "object" in my description of the core complex is thus ultimately the individual's mother (or the person who functioned in that capacity) during this very early period of development (Glasser, 1979 pp. 279–280).

Case example: a female's perverse use of the body

I shall briefly describe how a young female adult perversely used her own body, both to communicate and to attempt to come to terms with her experience of being sexually abused but not penetrated by her father.

I shall not describe her complicated and initially idealized relationship with her mother whom she felt had colluded in her being abused. Nor will I describe her equally complicated relationship with her father, in which she yearned for him as a good father, whilst her rage at the way he had treated her was coloured by what we can no doubt recognize as familiar, but nonetheless inappropriate anxieties, that she had somehow colluded with him.

She was very bright, with a lot going for her, as evidenced in her being able to observe that all was not well with the way she was living her life, to link it to her earlier experience of being abused and to arrange a referral for therapy. In the referral letter her difficulties were described as follows:

> Psychosexual problems in relationships.
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> How emotional problems were articulated through her body in:
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> A poor relationship towards food.
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> Compulsive/damaging exercising.

Perhaps we need to become accustomed to viewing such self/body relationships as the perverse enactments that they are.

What was to become the predominant transference relationship was present the first time I met her. She talked as if this was her only chance and she had to get it all out (and hopefully across to me) whilst she had my attention. During the course of the treatment, we

came to understand this as me being experienced as if I were an emotionally absent, self-absorbed mother, as well as a predominantly physically absent and (when present) abusing father. My patient's experience was one of attempting to convey what it felt like to be her, but with the expectation of no real or sustained interest in her and what it felt like to be her.

The three main areas of difficulty she had described at the beginning preoccupied her throughout the treatment. We came to understand how each of them re-enacted and communicated her trauma as well as her unsuccessful attempts to master it, and her core complex anxieties which she defended against through an unconscious sado-masochistic way of relating with herself and significant others.

The difficult psychosexual relationships she referred to emerged as her having friendships that contained no sexual contact and sexual relationships that contained no friendship. These represented on the one hand her wish to have a good non-sexual relationship with a man, unconsciously representing her father, and on the other, a re-enactment of an abusive non-loving sexual contact with him. It also allowed her to turn the tables on the young men involved by breaking off sexual intercourse and telling them they reminded her of her father, which would leave them devastated, as she had been by her father's abuse. The difficulty with intimacy, which led to barren or abusive relationships, expresses core complex anxieties that, in young men, often lead to violence but in young females are frequently expressed by subtle violence against the body. She came to understand her triumph over these young men, her victims, and her own role in this as an abuser in identification with her father, as well as how her stopping something in the here and now represented her wish that she had been able to stop her abuse in the past. Also, for similar unconscious reasons she used to dress very provocatively and then repel the advances she attracted as a way of trying to process her unconscious and inappropriate self-blame.

This young woman's second preoccupation was, as she put it, emotional problems centred on her body. Whilst she recognized this she somehow managed not to see her vegetarianism moving onto veganism as an expression, for her, of emotional problems. She was, however, concerned about her compulsive exercising to the point of causing physical stress damage to herself. Again, the complexity of what this symbolized was unravelled in the treatment.

In general, both her diet and exercising were an attempt to feel an ownership of and control over her own body—what was taken in by it, and done to it, unlike her experience in relation to her father and her mother. However, both the food intake and exercise re-enacted an attack on her body. Her food intake amounted to anorexia and the exercise caused stress damage. She thus repeated, in different forms, the incestuous attack. Her non-meat eating was an unconscious attempt to control her mounting aggression towards her mother as represented by the non-consumed flesh (breast) and this was extended through veganism to anything thought of as animate.

The results of the eating pattern and exercise caused her mother considerable anxiety. In this way the young woman was able to elicit the concern she felt she had not received at the time of the abuse. It also sadistically punished her mother by causing her to feel tormented with anxiety and powerless to stop what was happening, which was how the patient felt whilst she was being abused. In many ways this young woman was more angry with her non-protective mother than with her abusing father. This has been my experience of most abused and abusing patients.

The dieting disturbed the patient's psychosexual development in as much as it stopped her periods and kept her, she thought, "child-like". This defended her against the full impact of growing up into an adult sexual woman. However, she was also concerned about this. We came to understand it as representing her anxiety that damage had been done to her "insides" by the abuse, i.e., in abusing herself she identified with her abusive father and non-protective mother. Here she felt her "insides" to be her physical body, rather than damage done to her internal world—her psyche.

From her referral, it was clear the patient understood she was seeking psychoanalytic psychotherapy. Further, there was a healthy part of her able to form a treatment alliance with me as we struggled to address the abusive her, in identification with her abuser and her non-protective mother. Central to the therapy was my need to maintain a thinking-ego/good parents' state of mind so that she could eventually mentalize rather than enact. The need to maintain a thinking stance despite intense pressure in the transference to be harsh or indifferent (abusive or non-protective) is ever present when working with patients suffering from perversions. In this case, it needed thoughtful care not to be drawn into superego-ish comments when I was the container of her anxieties about the damage she was doing to herself, not to re-enact in the therapy room the maternal object who asserted "it's *your fault*". Equal care to think and not to act–re-enact was essential in not defending against these anxieties by being experienced, like her father, as indifferent to her suffering.

The therapy had the outcome of her giving up her symptoms. She ceased the compulsive exercises, improved her diet so that her menstrual cycle resumed, and she formed a more loving sexual relationship. However, like many young women, she left treatment "to get on with her life" when her symptoms had abated, whilst in part knowing further therapy was needed. Some years after treatment ended she wrote a moving letter in which it was clear that the work still to be done was recognized by her, but was able to be experienced as psychic pain, rather than enacted as self-abuse, or abuse of those to whom she was attached.

Transference and counter-transference and issues of technique

The perverse patient has a particular relationship to her superego that is not experienced as benign. Instead it can be cruelly abusive, attacking or corrupt. The relationship to such a superego demands compliance or is dealt with by defiance—there is no hope of the to and fro of dialogue, since it is made up of narcissistic, or abusive, or absent and therefore non-protective internalizations. The perverse female has in childhood become the container, rather than the contained. Such patients might be designated as borderline. Rosenfeld (1978) puts this succinctly, albeit referring to males, as follows:

> The borderline patient who is dominated by confusional anxieties and pathological splitting processes has to be clearly distinguished from *the destructive narcissistic patient*, as he is unable to face interpretations of a destructive self even if it is clearly exposed in dreams. Detailed examination reveals that he is in the grip of a primitive superego structure where positive, often highly erotic and seductive features are mixed up with omnipotent, sadistically overpowering ones. The demands of this superego are very contradictory and

> therefore confusing and impossible for the patient to cope with, as it creates at first some doubt, but ultimately complete uncertainty and confusion in the patient. When this primitive superego is projected on to the analyst and he interprets destructive aspects in the patient that are clearly shown in the material, in dreams and in projection into other people, the patient is overwhelmed with anxiety because he hears the analyst saying that he is 100 per cent bad. This threatens his whole self with death, disintegration and madness, for he will try to find omnipotent ways of escaping from this danger. The patient in this state is unable to think about his own problems and impulses because he has lost the capacity for self-observation, and all his attention is focused on the analyst who, in the patient's perception, sees the patient as extremely bad and destructive. To defend himself against this catastrophe the patient becomes icily defensive; in addition, he identifies himself with the primitive superego and accuses the analyst in a very violent manner. The patient is severely shocked in this situation because interpretations have a terrifying effect on him; he feels that the analyst, like his mother, had not been able to introject and understand the patient's projected primitive superego. At that moment the process of projective identification gets out of hand and a transference psychosis becomes manifest where the patient misperceives the analyst and sees him as his superego.
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> [Rosenfeld, 1978, p. 217]

Therapists may need a supervisor's help in framing interventions in a way that is as free as possible from being perceived as abusive and humiliating. However, since this is inevitable, consideration of how to take up the patient's feeling when this happens is crucial. For the perverse patient, the very fact of being in therapy, of coming to a session, can feel terrifying since the transference is to an abusive or non-protecting object. For example, I recall a patient who, regarding herself as trans-sexual, engaged in sadistic attacks on myself and the therapy by threatening to go to Charing Cross Hospital "to have the operation" and on one occasion graphically described to me what would happen to me if I went and had the operation. Thus I, not her, was subjected to this cruel and mutilating process. It was then essential to be able to think about both process and content rather than get caught up in it by feeling exasperated and at the patient's mercy, or sadistically retaliating, thereby enacting her violent superego. At times a supervisor's capacity to think

about how the therapist can be pulled into enactment and what this is defending against is vital since it triangulates the interaction.

Such patients will, by projection, pull you into being superego or id if at all possible, when what is needed is good ego functioning. In the experience of most perverse patients there has been an absence of triangulation in their early histories. Parents have not been available as a thinking (ego) couple but instead there has been the experience of a cruel, superego figure and an id—"anything goes" figure. It needs to be remembered that to the child, the parent who does not know abuse is being perpetrated is experienced as giving permission for the abuse to take place.

The sado-masochistic compliant/defiant transference is very subtle. We may offer an interpretation or insight and feel it is welcome and used, only to discover it is used as a defensive compliance to avoid *real* contact, a *real* relationship which for most perverse patients is a profoundly dangerous experience, against which a great deal of their overt and covert acting out defends. The force of the attack on thinking and the pull towards superego or id responses are powerful in the transferences. Putting it another way, the pull towards acting out (as for example the patient provokes the therapist in the counter-transference to act as the abuser, or non-protector) is ever present at the expense of thinking and containing.

I recall a patient organized around a sado-masochistic lifestyle that involved frequenting S&M clubs and parties as well as being known for being available for one-plus-one S&M sessions in the higher echelons of society. She also led an otherwise self-abusive lifestyle including massive debts. She evacuated her anxiety about these into me. In one session she related how her debts were about to be cleared by a highly lucrative S&M engagement. I recall my powerful experience of relief in the counter-transference (id/non-protective) and it took time to recover my capacity to think and not then to react in an abusive superego way.

Thus deception and corruption, attacks and non-protectiveness are ever present in the process and content of therapeutic work with perverse patients. It is imperative to hold on to the knowledge that they are both victims and perpetrators. The perpetration can be on objects or internal objects, parts of self attacking and abusing other parts of self. Invariably, it is a cruel part of self in identification with the abuser or non-protector, attacking and denigrating a healthy,

needy, vulnerable, appropriately dependent and seeking a dependable object, part of self.

It is important to take the patient's anxiety about abuse in the consulting room seriously. This is often present and can be interpreted as the patient's fear of what she may do to you or you may do to her. I recall seeing a patient for a first assessment session. Once in my room she looked at me from a white-mask face that terrified me and it took me time to realize it was her terror I was experiencing. I put this into words and she was able to say she was terrified of what I would say. This is a patient who for many years remained in bed apart from once weekly shopping and once weekly attendance for her sessions. In bed she felt safe and protected from her perverse acting out and fear of attacks from others onto whom she projected her violence. She had been abandoned by her mother at age 2 and left in the care of her violent father. Subsequently, she was abused sexually by a neighbour. She has a criminal history.

Workers may defend against their anxiety by becoming oblivious to the danger or be so anxious that they cannot name what is happening. It helps to be able to say something that takes up both sides of the patient's dilemma, such as, "You want me to be anxious, otherwise I would not know how serious it is, but not so anxious that I cannot be of use to you?" Thus one hopes to re-establish oneself as a container, as ego rather than superego or id, as previously stated, or as parents who can think together, instead of one abusing and one not knowing. This is a different experience from that of the parents of the patients I have described. It often needs a supervisor to name this process.

It is important, when working with such clients, to be in a containing setting and to provide a containing setting—this applies not only to the consulting room and state of mind of the worker, but also demands clarity about confidentiality before treatment starts. If working in an agency or institution it is important to be clear with the patient about the agency's policy of violating confidentiality. At the Portman Clinic, where the patients have so far been assured of confidentiality, we arrange where necessary for a colleague to act as case manager and to respond to the concerns coming from the outside world.

Conclusion

Firstly, I cannot over-emphasize the importance of thought over action in the face of the pressure for action such patients exert on both individuals and institutions. For the therapist, the struggle to maintain a thinking space and a capacity to think is critical in the face of activity as defence. This facilitates the patient's development of a capacity to mentalize.

Secondly, I consider the triangulation of supervision very important when working with such patients who have rarely experienced a good containing couple with consequent difficulties around Oedipal resolution.

Thirdly, I want to emphasize the importance of information gathering and history taking, given the early, indeed pre-verbal trauma and its legacy in such patients. This goes in and out of fashion in psychoanalysis but is essential in the roots of a perverse defence.

Fourthly, the therapist needs containment, hopefully provided by the agency setting to allow work with this difficult patient group.

Finally, perverse women do not in the main turn to outsiders to try to master or communicate their own earlier abuse. They use the whole of their own bodies and their babies for this purpose. What goes into or comes out of their bodies is used to express not love but hate or revenge. What should be creative becomes perverse—the death instinct predominates over the life instinct, bad objects are idealized and good objects denigrated. The aim of the behaviour is to destroy any knowledge of need, dependency and vulnerability again, just as it had been when the original abuse occurred. Thus the penis is denigrated in acts of prostitution or sado-masochism, babies and children are abused or unconsciously offered up to others for abuse, food is not used as nourishment but in the service of bulimia and anorexia, and the skin is not experienced as a containing boundary of self but as something to be attacked and penetrated by cuts and the insertion of (usually) sharp metal objects. It is therefore important that the perverse psychopathology is recognized as such and treated in a way that gives due weight both to the victim and the perpetrator within the patient.