Perspectives on Perversion

WORKING WITH PROBLEMS OF PERVERSION

HEATHER WOOD

Psychoanalytic psychotherapists increasingly find themselves treating patients who present with problems of compulsive sexual behaviour or sexual perversions. Drawing from clinical examples and theoretical perspectives, the author delineates six key themes which encapsulate her own learning when commencing work with perverse patients. The first is the heterogeneity of this group of patients, both in terms of symptoms and presentation, but also in terms of the depth and developmental implications of the pathology. Further themes are the patient’s fear of the object and the inability to bear separation. The author explores the significance of negative countertransference which may be experienced in relation to perverse patients, as well as the risks of being drawn into exhibitionistic or voyeuristic dynamics. Finally, the nature of the superego in perverse patients and the impact of this on the transference are discussed drawing on O’Shaughnessy’s notion of the abnormal superego.

KEY WORDS: PERVERSIONS, COUNTERTRANSFERENCE, CORE COMPLEX, SUPEREGO, VOYEURISM

Addressing compulsive sexual behaviours is no longer a specialism within psychoanalytic psychotherapy, but has become an integral part of everyday practice. Internet pornography, the use of the internet to facilitate casual sexual liaisons and online sexual encounters have became widespread, and feature in the material of patients seeking therapy for a wide range of problems (Wood, 2011). Whether the easy availability of internet-facilitated sexual behaviours is leading to increasing preoccupation with sexual issues in the consulting room, or whether internet content reflects an existing social trend, is difficult to disentangle. But after decades in which sexuality was eclipsed in psychoanalytic preoccupations by concerns with attachment and early infancy (see Fonagy, 2008), issues about sexual behaviours are returning to the foreground. In some cases, the troubling behaviours reported by patients are compulsive and repetitive; in others they become associated with extreme or perverse sexual fantasies or wishes. In both groups, the search for sexual stimulation and gratification appears to function defensively, being primarily concerned with avoiding mental pain, evacuating unbearable mental contents, and managing the anxieties aroused by intimacy.

© 2014 BPF and John Wiley & Sons Ltd
This paper attempts to articulate the key lessons that I learned in my first five years at the Portman Clinic, working with people with sexual perversions. Through linking clinical observations to some classic theoretical perspectives on perversion, my aim is to assist others who find themselves working with such patients. I have structured these reflections according to six themes.

1. A HETEROGENEOUS GROUP

The clinical problems that we regard as perversions are a diverse group of problems. Limentani (1989) makes the useful point that a perversion is ‘not an illness but only a symptom. As a symptom it can appear at any time in the life of an individual for an infinite variety of reasons’ (p. 237). A sexual perversion is not in itself the underlying pathological process, but is indicative of such a process in the same way we might think of depression as a symptom with a very wide range of potential underlying causes.

Both of the major classificatory systems – the International Classification of Diseases (ICD–10) (WHO, 1992) and the Diagnostic and Statistical Manual (DSM–IV) (APA, 1994) – make a distinction between ‘disorders of sexual preference’ (ICD–10) or ‘paraphilias’ (DSM–IV), and gender identity disorders. The paraphilias or disorders of sexual preference involve fixed, repetitive sexual behaviours involving unusual sexual stimuli, or may involve potential harm to the self or the other. This would include fetishism, exhibitionism, voyeurism and paedophilia. The second group, the gender identity disorders, includes transsexualism or confusion about gender identity; ICD–10 also includes ‘dual role transvestism’ where there is cross-dressing but this is not associated with sexual excitement.

The aetiology of transsexualism is hotly debated at present, with neuro-psychological and hormonal explanations competing with psychological and psychoanalytic explanations (Lemma, 2012). Whatever the pathway to these conditions, the experience that some people have that their brain, psyche or identity belongs to a different gender from their anatomical body contrasts with the situation in which the personality becomes organized around an obsessive sexual fixation on a particular type of person, physical object or activity that we would regard as abnormal or potentially harmful. It is this latter group of problems, the paraphilias, which most obviously correspond to the psychoanalytic notion of perversions, and I will limit the discussion here to paraphilias.

Paraphilias/perversions/disorders of sexual preference appear in a wide range of guises and it is important to have a good clinical description of the problem in each case. This would include the extent to which the behaviour deemed paraphilic or perverse is the exclusive means of achieving sexual gratification, or whether it exists alongside a capacity for fulfilling sexual engagement with another adult who is valued and desired as themselves, and not simply as an instrument in the achievement of sexual pleasure. In assessing readiness for psychoanalytic treatment, the extent to which the paraphilia is ego-syntonic or ego-dystonic may be crucial; if the gratification from the behaviour continues to outweigh any distress or concern about the impacts of the behaviour on the self or others, there may be little motivation for treatment at that point in time.
It is beyond the scope of the present paper to provide a comprehensive theory of perversions, yet it is important to outline a theoretical position since this will structure the clinical approach. With respect to theories of sexuality, Fonagy (2008) criticizes an exclusively drive theory model which neglects the inherent relatedness of sexuality, but also finds an object-relations position wanting, because of its lack of emphasis on the visceral quality of physical sexual experience. In a similar vein, any contemporary theory of perversions needs to encompass the interpersonal or relational (the evident difficulties which many people with perversions have in maintaining sexual and emotional intimacy with another adult, and the often traumatic histories of such patients), the intrapsychic (the function served by these compulsive behaviours), the issue of meaning (the significance of the chosen ‘object of desire’ or ritualized behaviour), as well as the bodily experience of sexual urges and acts and the psychological significance of sexual arousal, pleasure and orgasm.

I have suggested elsewhere (Wood, 2013) that perverse behaviours may be thought of as the enactment of scenarios in the person’s mind, comprising actors and dramas, which function as: a means of evacuating intolerable feelings; enacting punishments on the self and others either in fantasy or reality (Stoller, 1975); avoiding the perils of genuine intimacy with another who is separate and different (Glasser, 1979; Joseph, 1997); and filling unbearable empty spaces in the person’s emotional world with excitement.

When working with patients who present with problems of perversion, there are important differences in terms of the depth and nature of the underlying pathology. The classical psychoanalytic notion that one can trace a problem in adulthood back to a point of fixation in childhood has been irrevocably blurred by insights deriving from the Kleinian school and others concerning the primitive aspects of much psychopathology. Nevertheless, it is still the case that we tend to think of problems in adulthood reflecting degrees of non-resolution of developmental challenges. This highlights the importance of both obtaining a clinical description that may indicate more primitive or psychotic phantasies and taking a clinical history that may identify points of developmental trauma or challenge.

The extent of splitting and denial may be one indicator of the depth of disturbance and the accessibility of the patient for treatment. It was in relation to the subject of fetishism that Freud (1927) first posited the idea of a vertical split in the ego, in which something known in one part of the mind can simultaneously be disavowed and not known. Such splitting and disavowal are often evident in those with perversions, who, may, for example, ‘know’ (intellectually) that child abuse harms children emotionally and is punishable by law, while simultaneously convincing themselves that they are bestowing love, or that they are exempt from such laws. The capacity to reflect on such splits may be significant in an assessment.

There is widespread agreement that perversions are characterized by a fusion of sexuality and aggression, or specifically the sexualization of aggression (Glasser, 1979; Glover, 1933, 1964; Stoller, 1975). If the defence is successful the aggression may be obscured; but the extent of evident or inferred aggression, in masochistic as well as overtly sadistic acts, may be one indicator of the severity of disturbance.
Perversions are often viewed as inherently narcissistic, involving the use of the object in the enactment of the individual’s own sexual ‘script’. While it would be expected that the transference with a perverse patient will involve sadomasochistic and narcissistic elements, the extent to which there is also a capacity for engagement and internalization will be pivotal in the therapeutic work.

A clinical example illustrates some of these issues: the patient, a man in his 50s, sexually abused a boy for the first time in his life when already a grandfather. In the eyes of the law his was a serious crime and he served a significant prison sentence prior to seeking therapy. His history involved a narcissistic mother with whom he had a gratifying, but hollow relationship of mutual admiration. This appears to have primed him to be vulnerable, pre-puberty, to sexual abuse by a tutor who both offered similar admiration and took his education and development seriously, for which he has never ceased to be grateful. The unfortunate consequence was that the abuse was experienced by him as ego-syntonic, as a precious and secret experience. He made two marriages and was successful in his working life, though reliant on manic defences, believing that he could triumph over any adversity. He remained fascinated by the image of the body of a young boy that seemed pure and beautiful. This fascination was only enacted sexually at a time in his life when he was particularly disturbed, in the months after his mother’s death, having witnessed his mother, the ‘beautiful peacock’, reduced to a poor ‘featherless fledgling’ in his eyes. The manic collusion collapsed and he, her ‘Adonis’, unconsciously diminished and enfeebled, found himself with a child into whom he could project both the idealized boy and the unwanted vulnerability, and transformed his experience of loss and depression into one of admiration and sexual excitement. There is a sense when working with him of a man determined to pursue the truth about himself. In terms of the framework outlined above, while his early experience may have set in place a narcissistic pattern of relating, the major trauma of the abuse occurred later, when he could mobilize existing manic defences to deal with it. For most of his adult life his sexuality was not overtly paedophilic. While his action was cruel and destructive, constituting an assault on the boy’s psychosexual development, overt sadism was not a salient feature. On entering therapy he was troubled about his lack of empathy for the boy he had abused, thus expressing concern about a degree of splitting that he recognized in himself. Thus there were many positive indicators in his presentation, which have been borne out by the subsequent experience of working with him.

2. THE PATIENT’S FEAR OF THE OBJECT

Working with perverse patients at the Portman Clinic, it is striking how commonly patients are preoccupied with the dangers posed by the therapist. There may be a phantasy that, if they allow the therapist to become close to them, they are bound to be abused or become abusive themselves, that they will seduce or be seduced, that they will be taken over and annihilated, or that abandonment will surely follow. More commonly the underlying fear is hidden beneath strenuous efforts to regulate the distance between themselves and the therapist, by missed appointments and lateness,
and by subtle manoeuvres in the sequence of the session to lead the therapist away from areas where the patient might be exposed to feelings of anxiety, vulnerability or shame. In this context, working in the transference is a necessity if there is to be any chance of patients being held and contained.

Glasser’s (1979) description of the core complex is invaluable in directing our attention to the primitive anxieties regarding object relations that may underpin perversions. What Glasser calls the core complex arises as a response to the frustrations of separation from the object, and we may think of the prototype of this situation occurring in the first months of life. Clinically, however, we can recognize the core complex from patients’ descriptions of acute conflicts and terrors about intimacy. Glasser proposes that, in response to separation, there is an urge to get back inside the object, to have an experience of blissful fusion or merger. However, to get right inside or to fuse with the object arouses a terror of annihilation – to be taken over completely by the other would be to lose oneself. This evokes aggression towards the other, in self-protection. But to express this aggression, which seeks to annihilate the object which poses such a threat, leaves the individual at risk of total abandonment. Glasser suggests that, for people who develop perversions, the solution that is found to this dilemma is to sexualize the aggression, and to convert aggression into sadism. In sadism we do not want to destroy the object, but to control it, to see it suffer and to derive pleasure from its suffering. Thus the object is preserved, the relationship to the object is preserved – though now distorted by sadism – and the individual is protected from total abandonment and isolation.

Glasser’s formulation has a number of important implications. The first is that perversions have very little to do with sex (in the sense of a bodily intimacy between two adults), but are about the use of sexualization as a defence to deal with primitive terrors in relationships. When working clinically with perverse patients it is very easy to get preoccupied with the perversion and the way in which this impacts on the transference. It is more useful to keep reflecting back on the anxiety in the relationship which triggered the flight into perverse fantasy or relating at that moment. This anxiety is often about being taken over, about falling into a state of helpless dependency, and about the therapist knowing about how dependent the patient feels and apparently thereby gaining power over the patient.

The idea of the core complex illuminates the fact that, for these patients, intimacy is not only a longed-for state which promises comfort and gratification; it is a terrifying minefield of primitive terrors and destructive impulses. The cost of obtaining some comfort or gratification may be to entirely lose the self, agency or potency. Freud (1927) noted the centrality of castration anxiety in perversions, and this indeed may be a feature of them, but Glasser draws attention to the way that castration anxiety may actually be founded upon much earlier anxieties about being helpless and overwhelmed in a relationship.

Beyond the need to think and work in the transference, I have also come to see the imperative of taking up the anxieties which underpin the negative transference which often prevails. Glover’s (1933, 1964) and Glasser’s (1979) assertions that perversions are about the libidinalization of aggression are central here. Patients with sexual

© 2014 BPF and John Wiley & Sons Ltd

perversions are struggling with their own cruelty, destructiveness and aggression. They are also likely to have histories in which they have experienced marked cruelty, destructiveness or aggression in others. These are patients who are principally preoccupied with anxieties about the destructiveness that will be unleashed by intimacy – in one party or the other. A therapist who only focuses on the positive transference may be experienced as, at best, naïve and uncontaining or, at worst, as seductive and dangerous.

One man verbally attacked me on and off for the best part of nearly three years, seeing me as a devouring spider, a witch, or as completely helpless and useless in the face of his omnipotent destructiveness. When this omnipotent destructiveness was in control he described it as ‘the fucker in the driving seat’. He would set me challenges: how would I deal with his religious beliefs, how would I cope with his badgering questions? And then, if I refused to answer and gratify him, he would berate me for being withholding and cruel when all he wanted was this one bit of reassurance that would relieve his intolerable distress. He surprised me when, having landed a particularly good job, he told me that this would not have been possible two years previously, and that he felt he had been ‘wrapped in love’ during that time by me and his partner. This did not seem as though it was said entirely sarcastically, but it was soon brushed aside and, in a subsequent session, he said he felt he and I had been snarling at each other like dogs from opposite corners of the room for the last two years. And then he added: ‘Well, I’ve been snarling at you’. For this patient, understanding his attacks without retaliating may have been a kind of ‘love’, but to have talked about a loving or positive transference would have evoked his scathing contempt when he was primarily concerned with his own snarling aggression and the fear, based on projection, that I was snarling back at him.

This does not mean that it is not appropriate at times to take up the way the patient may attack the therapy on which he depends, or which may be, for him, a lifeline; to that extent one can acknowledge that the therapy might represent a valued object. But it does mean holding in mind that, for these patients, intimacy does not herald comfort, fulfilment and pleasurable connectedness. They imagine that their sense of themselves, their whole being, may be at risk if they allow anyone to get close to them, or that they may do some terrible harm to the other.

Glasser’s framework also draws attention (and interpretation) away from the aggression and destructiveness per se, to focus on the underlying anxieties which it defends against. In Glasser’s view, sadism and masochism are two sides of the same coin and express profound core-complex anxieties about intimacy. A therapist who focuses unduly on the aggression and destructiveness risks being experienced as sadistic and retaliatory, and the sadomasochistic dynamic may be perpetuated. Glasser’s focus on the underlying anxiety underpins an analytic stance that is less likely to be experienced as persecutory or punitive.

Patients who are constantly preoccupied with what is in the therapist’s mind are often trying to second-guess what the therapist may do next, lest it pose a danger to them. In such cases the patient’s agenda may be to get through to the end of the session unscathed. The therapy can then become a kind of pseudo-therapy in which the patient
has just enough material to fill the time; they may appear to become anxious on realizing there are 10 or 15 minutes of the session left, as if the prepared script has run out and they are now going to have to improvise for the remainder of the session. This may be when the fear of the therapist as an object really becomes apparent. Steiner’s (1993) notion of patient-centred and analyst-centred interpretations is often useful: someone who is not yet ready to understand himself might first be able to tolerate interpretations which communicate understanding of how he experiences the analyst or therapist.

3. INABILITY TO COPE WITH SEPARATION

We are all used to recognizing the impact of breaks on patients, who may experience separation in a range of ways. It is probably true for most patients in therapy that it is only in the later stages of the work that they are able to experience the absence of the therapist as the loss of a whole person who can be missed, reproached and with whom the relationship can be repaired on reunion. We are probably all used to the patient missing the odd session before or after the break. What I have been surprised to experience at the Portman Clinic is patients disappearing over a break and never making contact again. The level of enactment either side of the break is striking.

In Glasser’s two seminal accounts of the core complex (1979, 1992) he starts to describe this phenomenon by describing the longing for fusion, ‘the fantasy of fusion [his italics] with the idealized mother as a means of meeting the person’s (originally the infant’s) deep-seated longing for satiety and security’ (1992, p. 496). In his 1979 account, he describes ‘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” ’ (1979, p. 278). What this presupposes is that there has first been a separation from the object, which is experienced as intolerable; thus the core complex becomes a response to the experience of disturbing separation (Don Campbell, personal communication).

Whatever the therapist may represent for the perverse patient in the transference at a particular time, the impact of a break is to enforce the therapist’s separateness and to confront the patient with their dependence. When perverse dynamics prevail, the therapist’s absence may be experienced as a deliberate act of cruelty, a retreat from a patient experienced as disgusting or repellent, or a sadistic flaunting of the therapist’s other relationships. The person who resorts to sexualization to manage the unconscious terrors of separation from the object is unlikely to be able to manage separation from the therapist without some enactment. The enactment may take the form of a retreat into the perverse act – an increase in the use of sadistic pornography or exhibitionism, for example – or retaliation.

4. THE NEGATIVE COUNTERTRANSFERENCE

We may think that, as therapists, we are above the perception of sex offenders or people with perversions as ‘creepy’, ‘disgusting’, ‘vile’, and even ‘monstrous’, that
we are immune to reactions of contempt and disgust. But there is no doubt that this is a reviled group, and sometimes they confront us with shocking or disturbing histories or behaviours, and both personal reactions and countertransference reactions that are hard to bear.

In this situation there are three main issues that are pertinent. The first is that we live by powerful social rules about when and where sex belongs. It belongs in the bedroom, in private, in intimate relationships, between consenting adults, in mutually consensual engagement. Cross these boundaries and the behaviour might be regarded as distasteful or disgusting. At the more innocuous end of the scale, the man who is inappropriately sexually preoccupied and flirtatious with a work colleague, or who is seen to be harbouring unwelcome sexual thoughts, may be seen as ‘creepy’.

The second factor that may evoke a reaction of distaste is the patient’s distaste or contempt for himself. This may be disguised and defended against, but evident through the countertransference. Sexualization may serve as a manic defence against depressive anxieties to do with guilt, ambivalence or imperfection. It may serve as a narcissistic defence when the underlying anxieties are of inadequacy, of being pathetic or contemptible. Sexualization may also conjure feelings of desirability and serve as a defence against feelings of being disgusting, soiled or tainted.

A feeling of disgust or contempt can be evoked in others, and in the therapeutic context, in the therapist, when the defence is thin or precarious and the self-doubt or self-loathing beneath the defence leaks through or is communicated via the countertransference. For example, a man who feels unattractive and lacking in confidence may foster a sense of himself – through perverse sexual activity – as daring and potent. The discrepancy between the bravado of his inflated, sexualized self-image and the underlying contempt or disgust for himself may evoke scorn or distaste in others.

One man needed at all times to be in control and triumphant, and he achieved this by baiting others, including me, in a sadistic way, or demolishing himself in a cruel way, attacking his physical appearance, longing for cosmetic surgery and feeling himself to be deformed and grotesque. He was able at times to recognize that his feeling of being despicable and repellent could be self-induced. After some time in therapy, he started to talk about how he covered himself in ‘shit’ – in self-loathing and self-hatred – and acknowledged his dependence on his therapy, which was the only way, at that stage, that he felt he could experience this shit being washed away. The power of Freud’s insight about the bodily nature of experience is that at some level this man felt himself to be literally covered in excrement, and talking in these terms seemed to address both the symbolic concerns of the adult and the much more concrete bodily experience that he had had of himself as a child as disgusting and repellent.

This links to a third factor that may engender a sense of disgust. Every culture is founded on rules about what Douglas (1966) has called ‘Purity and Danger’, about separating the clean from the dirty, separating food preparation, for example, from toilets. Some cultures dictate that certain animals or methods of food preparation are unclean. And what is unclean, if it strays out of its allocated place, is seen to be
dangerous. The classic Freudian notion of developmental stages echoes these demarcations: we deal with the oral function, and then we progress to the anal function, and when that is resolved we have the possibility of approaching genital sexuality. People with perversions often blur these safe distinctions. We encounter patients who derive sexual excitement from eating faeces or who are aroused by being urinated on. Chasseguet-Smirgel (1985) has emphasized the anality of perversions. Feelings of nausea or disgust in the therapist may reflect a personal reaction of distaste to the patient’s material. Such feelings may also be a countertransference response to the patient’s communication of their own disgust about aspects of themselves, involving, for example, their confusion of oral and anal functions, or their experience of being invaded, over-filled or overstimulated by an intrusive object (Rob Hale, personal communication). All of these can be challenging to manage.

Similarly, our culture assumes that we can make a distinction between what is life-giving and what is destructive, between Eros and Thanatos. In common parlance, ‘perverse’ has come to mean that good and bad cannot be distinguished, that someone appears to value or idealize something that is corrupt, dangerous or destructive; or, conversely, that they corrupt, attack and spoil that which is good. Returning to Glover’s insight, a crucial aspect of sexual perversions is that they appear to represent a fusion of sexuality and sadism or destructiveness. Thus perversions are inherently confusing and this confusion can be used to obscure the real function of the behaviour. The paedophile may believe himself to be expressing love for a child, while it is evident to others that what is being enacted is envy or sadism. In the countertransference we may feel disgusted by such a confusion of functions, tricked by sudden shifts from constructive to destructive, or cheated as if something we thought was constructive has suddenly been hijacked and distorted.

Some of the anxiety about working with these patients may be that the transference will become sexualized. Freud (1905) applied the term ‘polymorphously perverse’ to the child’s early normal sexual development rather than to a specific group of patients. Yet in clinical practice with perverse patients we often make an informal distinction between those whose perversions seem rigidly scripted and others whose sexual practices and objects are so varied that it appears that variety and novelty are a prerequisite of their achieving sexual excitement. It is this latter group who, as individuals, seem to warrant the description of ‘polymorphously perverse’. They seem to be constantly preoccupied with sexuality, almost every engagement is viewed for its sexual potential, and they often seem to sexualize the transference almost immediately, in a very indiscriminate way. With patients who have more narrowly focused, tightly scripted perversions, I have been struck by how infrequently the transference seems to be sexualized. It is as though the perversion functions to encapsulate and contain sexual feelings, so that there is no risk of them becoming focused on an other with whom there is an affective bond. In this situation, sexual feelings in relation to the therapist would compound the patient’s anxieties about intimacy, and so are largely kept at bay.

Where there is sexualization of the transference, if one keeps in mind the function of sexualization as a defence – as well as the anxieties about engagement which it
defends against – then the use of sexualization becomes less disconcerting. As with any transference reaction, there are always questions about what kind of object the patient needs the therapist to be at that moment: whether the apparent sexualization is about control, sadism, intrusion, seduction, and so on. There are also questions about what the sexualization defends against: does it defend against a fear/longing for merger; is it an attempt to tame a frightening object; does it defend against destructive wishes or urges, or a fear of abandonment?

Occasionally, after considerable work, there may be the emergence of tentative sexual feelings towards the therapist, which seem to grow out of the intimacy of the therapeutic relationship rather than to defend against it. It may be important that these feelings are tolerated rather than viewed as defensive if true integration of sexuality and dependency are to occur.

5. EXHIBITIONISM/VOYEURISM

A specific and important dimension of the transference and countertransference is the dimension of exhibitionism and voyeurism. As therapists, we may feel that we have had a more satisfying session when we have seen something in the patient that has previously been hidden. We welcome ‘new material’ as if the more we see, the more we will understand. We talk all the time about ‘seeing’ patients. What happens to this therapeutic ‘watching’ and ‘seeing’ with a patient for whom looking and seeing have become highly sexualized?

In all of the patients I have seen who present with exhibitionism there has been a failure of intimacy in childhood, a lack of contact, engagement and experienced affection. All have described an experience as a child of an adult glimpsing their genitals or seeing them urinate, and the child–self imagining that this has stimulated or excited the adult in some way. Suddenly they have the capacity to evoke interest and curiosity in an adult, and it is through exposing their body and being seen from a distance. The eyes and looking become charged with excitement. They also become the means for expressing aggression towards the object for the deprivations and frustrations that have been endured. As the boy matures, he turns from passive to active: by choosing when and how to expose himself he imagines he can now control the interest of another in him; rather than helplessly waiting to be seen or appreciated, he has the power to draw attention to himself, and to evoke strong feelings in the other. He can arrange to expose himself to the particular type of object that meets his unconscious need: a group of boys, a lone woman, a group of animated women out for the evening, or whatever. The conscious intent is often not to frighten but to arouse or amuse the other. But on exploration, the aggression implicit in the act becomes apparent: it is an assault on the person’s innocence, tranquility or indifference.

When a patient such as this is faced with a therapist who is offering them attention, this may be experienced as something highly desirable but also terrifying. The more vulnerable the patient feels, the more likely they are to assume control of the situation in the way they know how: by taking control of what they expose and reveal, deriving
excitement from disturbing or unsettling the therapist, or by trying to arouse an excited
voyeur in the therapist through sexual clinical material.

For the man obsessed with viewing pornography there may be a similar flight away
from contact and engagement towards viewing. One patient who had served a prison
sentence for downloading child pornography had moments of being extremely
insightful and honest about himself. I felt as though I was being given a privileged
glimpse into some of the processes underlying paedophilia. And yet when I tracked
the material through an entire session, often such reflections were followed by him
taking off into a perverse world where he justified his paedophilia or mused about
internet pornography and its rewards. Through him I came to understand more about
the use of sexualization as a defence against anxiety, as well as a defence against
aggression. It was difficult for him to stay in contact with the anxiety of knowing about
his emptiness, his sense of powerlessness, or his fear of becoming subsumed by his
mother’s (or my) needs and concerns.

In the therapeutic relationship it often happens that a moment of apparent engage-
ment is followed by a flight into exhibitionistic display, in which the therapist is made
the excited voyeur watching the images created by the patient. Whether we are being
allowed to see something deeply personal and significant about the patient, or being
treated to a perverse display is often not clear-cut. I have had the experience of
presenting material in a clinical meeting that I had experienced in the session as
searching and illuminating, about how a man had sexually abused a 13 year-old girl,
but some seminar participants heard the material as an exhibitionistic display by the
patient and a sadistic attack on me in the transference. They might have been right but
it also sometimes happens that something that was authentic and revealing leaves the
patient feeling anxious and so they retrospectively sexualize the situation; in this way
what was genuine therapeutic work may be hijacked and turned into a seemingly
perverse interaction. In a clinical seminar, different members may pick up these
different aspects of the session.

For the therapist there is always unease about being seduced into the role of excited
voyeur, rather than maintaining the stance of a neutral therapist with an enquiring
mind. To some extent this can be limited in the course of the therapy by avoiding
questions and sticking strenuously to the analytic task of interpreting anxiety and the
transference. However, there are occasions, particularly when trying to gauge risk and
when conducting an assessment, when we might feel we need more factual informa-
tion about what the patient has done; here the tension between professional rigour, and
seeming to be voyeuristic, may be most acute. An assessment that I had conducted
with an exhibitionist was discussed in a clinical meeting. A colleague wanted to know
whether the man’s penis was erect or flaccid when he exposed himself, as this is
typically associated with different patterns of pathology. I had not asked, and would
not have asked, as I think this would have conveyed exactly the same curiosity about
his genitals that he was trying to evoke in his victims. However, to not ask leaves one
waiting to construct a clinical picture in a slow and piecemeal way. This man had
effectively tantalized me with glimpses of what he did. I knew that he had exposed
himself approximately every two weeks in a specific, crowded public place for the last
20 years. I said that he must be very adept at deception to have done this every two weeks for 20 years without getting caught. At this point he let some of the deception slip, and told me, as much as he wanted to, about what it was that he did.

6. SUPEREGO FUNCTIONING

The last feature of this work that I want to address is the nature of the superego. The superego in these patients is often initially evident as a projection onto the therapist: either the therapist is experienced as disapproving and punitive; or as potentially collusive and indulgent; or as corrupt. These dynamics can also become projected into the institutions in which we work, when rules about cancellations and non-attendance, for example, are enforced in an autocratic and unthinking way; or are ignored while we protect and indulge our patient; or the rules are deliberately ridiculed and flouted in a delinquent or defiant manner.

At the Portman Clinic we have a DNA2 policy that states that any patient missing more than five weeks of therapy in one term should have their treatment reviewed by the Clinic. This is considerably more generous and accommodating than the original policy that was proposed, in which therapy was to be terminated after a patient had missed three consecutive sessions. One patient did not return for seven weeks after my summer break. In his first session back my response could be seen as collusive and indulgent: I waited to hear his account of what he had been doing, and learned that some of what he had gained by going away during this time had undoubtedly been positive. I was also somewhat identified with the delinquent flouting of rules, viewing the DNA policy as something that could be overridden by clinical considerations. But when, in the second session, I tried to raise with the patient his failure to keep me informed during his absence, he tried to create a sadomasochistic fight, insisting that I was angry with him, I was trying to punish him, I was going to leave him feeling awful by spoiling everything he had gained from the time away, and so on. Amongst his attacks was a reproach: I was a bad, cruel therapist who was unprofessional and enacting my own anger towards him. Thus, he became a persecutory superego wagging his finger at me. As he attacked me in this way, he succeeded in arousing my irritation was evident. The temptation was for me to enact the punitive superego back: to let him know the repercussions of his actions for the Clinic, that he came close to jeopardizing his therapy, and that it was at my and my colleagues’ discretion whether or not the therapy continued. I managed not to voice these thoughts but I imagine my irritated. Freud’s account of the formation of the superego will be familiar: that the super ego is formed through the resolution of the Oedipus complex as the boy internalizes the authority of the father – conveyed through the prohibition on incest – and forms an identification with the father that enables him to sublimate his incestuous longings. In many of our patients with perversions it is possible to see how this process has been distorted because the father fails to embody the oedipal authority but represents an abusive or corrupt object with which the superego then becomes identified.
While there is often powerful evidence for the impact of external experience on the developing superego, I think one has to look beyond a Freudian model to a Kleinian and post-Kleinian view of superego formation to really understand the ferocity that the superego may have in some of these patients. For Klein, the superego originates in the splitting of the paranoid–schizoid position. The bad object and good object may be projected into both external objects and internal objects (Rosenfeld, 1952). The superego may thus contain elements of early idealization and primitive persecution. Under benign conditions, this superego may develop so that the persecutory elements are modified by the introjection of a good object, so that a ‘normal’ superego may develop which includes aspirations and ideals, and watches over the ego (O’Shaughnessy, 1999). Bion (1962) proposes that if there is a failure of containment or communication between mother and infant, a ‘super’ ego is internalized which destroys links. Bion (1962) describes this superego:

It is a superego that has hardly any of the characteristics of the super-ego as understood in psychoanalysis: it is a ‘super’ ego. It is an envious assertion of moral superiority without any morals . . . (p. 97)

I think this account is particularly pertinent to the superego one encounters with perverse patients. The superego may seem to become fused with a sadistic attempt not to know or understand, not to take an overview or to experience guilt, but to condemn, destroy and invalidate, as in my description of the patient who returned late from the break above. O’Shaughnessy describes how patient and analyst become locked in a battle of ‘abnormal superego’ to ‘abnormal superego’, as I think I did with that patient.

In other situations, the superego may seem to be hijacked in a more subtle way, so that the patient apparently claims the moral high ground and pronounces on others’ immorality, although the high ground on which he purports to stand may be built from a bogus, perverse morality. One patient, as he was awaiting trial on a second charge of downloading child pornography, responded to feeling persecuted – by the external superego of the legal system and his persecutory internal superego – by setting himself above the legal system and pronouncing on its failings. He sacked his solicitor insisting he would represent himself, alerted the court to the fact that he would be bringing complaints against the solicitor for his initial handling of the evidence, and railed against police incompetence in their dealings with him. He dedicated himself to studying the law and legal procedure, and was gratified when, appearing in the magistrates court for a pre-trial hearing, a security guard mistook him for a solicitor. When in this pseudo-legal, pseudo-moral superior state he was completely unavailable for therapeutic work. One day when he came there was a break in this armour. In a subdued way he was able to talk about how the part of him that railed against everyone had now put him in a position where he risked a further prison sentence; he was able to talk with me about how a prison sentence risked a break in or the ending of his therapy; he was able to talk about how he was terrified of messing up in relationships with women, but how a part of him still hoped he would one day be able to have such a relationship. In this more depressed state, there was more sense of a ‘normal’ superego, that recognized the authority of the law, the destructiveness of something in...
him, but that could still have aspirations and hope. This was quite different from the superior ‘super’ ego of the previous sessions, which was out to triumph and to destroy links and hope.

CONCLUDING REMARKS

Compulsive or paraphilic sexual behaviours are underpinned by widely differing dynamics and levels of disturbance, but have in common the use of sexualization as a defence to manage anxiety, often the anxieties evoked by physical and emotional intimacy with another person. The therapeutic relationship therefore confronts the patient with many aspects of the situation which they find most difficult: an experience of a deeply personal relationship in which they risk feeling taken over, intruded upon, emotionally exposed and vulnerable, and one in which, they imagine, they will have to face their own and the other’s aggression and destructiveness. These are also patients who may provoke or evoke an abnormal superego in others: a persecutory, judgemental revulsion or rejection. If enacted in the consulting room, this can provide the patient with a ‘gratifyingly’ sadomasochistic exchange, but it does not further the therapeutic task of enabling the patient to find and tolerate a different mode of engagement.

As in all analytic work, when working with perverse patients, we are trying to be as accurate as we can be in naming the underlying anxieties or phantasies that drive pathological behaviours. With these patients the things that need to be properly named are frequently about a terror of the object, fears of the person’s own destructiveness, the desolation of failed early relationships and underlying depression. These are often heavily disguised by sexual excitement. They come in and out of focus in the consulting room. But when they are recognized there can be a sense of real contact and productive work.

ACKNOWLEDGEMENTS

I have learned from all my Portman Clinic colleagues, past and present, but want to thank in particular Don Campbell and Rob Hale for sharing their insight and expertise so generously. My thanks also to the BJP reviewers and to those who provided helpful comments on earlier drafts of this paper, including Alessandra Lemma, Stan Ruszczynski and Arabella Kurtz.

NOTES

1. I am grateful to this patient for giving permission for the publication of this material.
2. ‘Did Not Attend’

REFERENCES


HEATHER WOOD is a Consultant Adult Psychotherapist at the Portman Clinic, Tavistock and Portman NHSFT and is a Clinical Psychologist and a BAP-trained Psychoanalytic Psychotherapist (now within the British Psychotherapy Foundation). With a special interest in the compulsive use of internet pornography and the related subject of paedophilia, she has

© 2014 BPF and John Wiley & Sons Ltd

published recent papers on these subjects in *Psychoanalytic Psychotherapy*, as well as book chapters in Lemma and Caparotta (Routledge, 2014), and Morgan and Ruszczynski (Karnac, 2007). She was joint editor and contributor to Bower, Hale and Wood (Karnac, 2013) *Addictive States of Mind*. Her recent NHS work includes the establishment of a psychodynamically-based clinical supervision service to frontline staff in the London Probation Trust, as well as involvement in the development and delivery of the national Personality Disorder Knowledge Understanding Framework (PD KUF) programmes. Address for correspondence: [hwood@tavi-port.nhs.uk]