DANCING WITH DEATH

Estela V. Welldon

ABSTRACT The author reviews her 40-year professional career in forensic psychotherapy. She describes her formation at medical school in Argentina, the Menninger School of Psychiatry in Topeka, Kansas, and the Henderson Hospital in Surrey. She reflects on her work, for 30 years, at the Portman Clinic. 'Dancing with death' is a metaphor for seeking serious danger, and she offers an extensive clinical vignette from her early career to illustrate the complexities involved in the assessment and treatment of perversion, reviewing the case in the light of her more recent thinking. Perversion is seen as a manic defence against the dreaded black hole of depression but, as well as being associated with the death instinct, perversion secures survival. Both features have to be born in mind in therapeutic work, and she considers both technical and transference/countertransference aspects of treatment, emphasizing the particular advantages of group-analytic psychotherapy. The context in which *Mother, Madonna, Whore* was written is reprised. Lastly, she surveys the work of the International Association for Forensic Psychotherapy and our developing understanding of severe female psychopathology.

Key words: perversion, manic defence, faulty mothering, group-analytic psychotherapy, female psychopathology

Introduction

I am grateful to the organizers of this event and particularly to the Portman staff for giving me the chance to return 'home' after a few years

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of 'retirement', with the fruits of my clinical practice, to present and discuss my clinical findings with my colleagues.[1] I am also indebted to all the contributors for their generosity and great friendship in making themselves available for the day. It is a great honour to have you all here and I feel both humbled and overwhelmed by the experience of being with friends, colleagues, ex-trainees, and ex-students – who will always be my professional family; and also by the experience of being with my family members – my daughter-in-law and granddaughter – who represent my home life.

I feel extremely proud of all my ex-students and trainees. They have exceeded any high expectation I may have had of them. Here they are, years later, as wonderful clinicians, inspiring teachers, insightful writers, providing us with more and more understanding of the, at times, unthinkable situations that we face daily. So, as much as I had earlier on learned from my mentors, this began, later on, to be reversed and to take an almost opposite direction. As such, I became the recipient of much learning from my students, along with the constant learning from our patients.

I am first and foremost a clinician, deeply concerned about a group of patients who express through their apparently asocial or antisocial behaviour self-destructive traits which tend to be misunderstood or neglected, because of society's concern with law and order. For over 40 years I have spent my professional career in the field of forensic psychotherapy, trying to find a treatment that fits the problems of these patients. Forensic psychotherapy is a relatively new discipline aimed at the psychodynamic comprehension of the offender and his consequent treatment. It involves the understanding of the unconscious as well as conscious motivations for the particular offending behaviour. It does not seek to condone the crime or to excuse the criminal. On the contrary, its aim is to help the offender acknowledge responsibility in order to save both him and society from the perpetration of further crimes.

As I reflect on the past and the present I feel a tremendous responsibility to do well, and hope I can deliver my talk with coherence and accuracy. The title of today's talk tries to convey as much as possible of my clinical findings in the context of the Clinic's vast experience in working with patients who suffer from perversions connected with self-destructiveness and thus associated with the death instinct. Actually the title, 'Dancing with death', came to me as a dream during my sleep and I think it vividly expresses the nuclear or crucial concept I would like to put across; and as you will learn later on dreams play an important part in this talk.

Having started my journey here with some heavy emotional baggage that I feared, I am delighted to share with all of you what has become a delightfully light reverie of experiences.

Some Autobiographical Details

Argentina and the Menninger School of Psychiatry

A few autobiographical details are relevant in order to place my talk in context. Anything I have ever achieved in my professional field concerning the psychodynamic understanding of my patients I owe to my initial training in Mendoza, Argentina, where I qualified as a medical doctor. At that time University was free. There I had my first, most important and influential learning experience with my first mentor in my professional life, Professor Dr Ricardo Horacio Etchegoyen, Professor of Psychiatry in Mendoza. His teaching, courage, generosity of mind and enormous integrity have remained with me over all these decades. They have been a source of endurance at difficult times and of inspiration at the best times. I remember his battle for a better world and his deep concern for the emotional problems created by social injustice.

Mendoza was the privileged spot, with the students at the Faculty of Medicine being the lucky recipients of his invaluable teachings, encompassing and introducing Bion. Bion's group techniques were applied '*in vivo*', meaning experiential groups for students. Of course, there were many transferential issues involved, as Professor Etchegoyen was my first analyst too, and he dealt with these with rigorousness and insight on many different and parallel levels. (Actually I was the first 'psychoanalysed' person in Mendoza.) Little did I know at the time that this group experience was later to become crucial to my technical modifications for the effective group treatment of so-called antisocial or psychopathic patients with the most severely deprived backgrounds, including delinquents, criminals, victims and perpetrators of incest.

I left Argentina very early, in 1962, just after qualifying from Medical School, to attend the Menninger School of Psychiatry in Topeka, Kansas. I was personally influenced by the teaching of Karl Menninger who believed that punishment neither helps the criminal nor protects society. Menninger said that regardless of its futility and expense, punishing criminals gratifies, comforts, and even delights the general public: sadistic attacks in the name of righteousness deal with the public's unconscious guilt about their projective identifications, having conveniently located their aggressive impulses in the criminal, the 'other' (Menninger 1967).

The timing of my stay in Topeka was of particular significance. Neither women's liberation nor the civil rights movements were in existence yet, and it was a dramatic time of learning about racial and gender issues, with prejudice and ignorance as their closest associates. Isolation, exclusion and social injustice were the fertile ground for dynamic changes to be created. It was also when the shooting and killing of President J.F. Kennedy took place. In the midst of the confusion and the great sense of helplessness produced by the assassination of President Kennedy, Karl Menninger was the person who

could start to make some sense of it all. It is uncanny that at the time of writing his article 'The injustice of justice: who is to blame?' (Menninger 1967) he was suddenly and unexpectedly interrupted by the news of President Kennedy's death. In his own brilliant, incisive and insightful way he came close to Winnicott's famous axiom about the delinquent act implying a sense of hope (cf. Winnicott 1965, p. 260). We can see how relevant these two authors are to the complexities in the world of forensic psychotherapy.

Menninger vividly describes the intense conflicts that the legal system and the science represented by psychiatry have in their very different approaches. In his own words:

> What various forces combine to determine a particular antisocial, illegal act – this is no concern of the law. What internal pressures and external events led up to the criminal act as a logical link in a continuing chain of behavior and adaptation – this is not a legal question nor a legal concern. The law is only concerned with the fact that its stipulations were *broken*, and the one who breached them – provided he can be convicted – must pay the penalty. Flaying erred; he must be officially and socially hurt – 'punished'. Then everything will be all right again. 'Justice' will have been done. On the other hand, science, represented by psychiatry, looks at all such instances of lawbreaking as pieces in a total pattern of behavior. It asks, 'Why? What was behind the discovered act which brought the matter to our attention? What pain would drive a man to such a reaction, such a desperate outbreak, or such a deliberate gamble? Can we not put our heads together, and, as we do with other problems that perplex us find a way to protect ourselves from our weaker fellow-men?'
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> (Menninger 1967, p. 332)

In writing about this Menninger takes care to pay all his attention to the neglected 'weaker fellowman', in this case Oswald looking on at President Kennedy. Menninger understands this awful and worldwide tragedy:

> Thwarted in repeated efforts to have someone pay attention to his puffed up insignificance, this nonentity had concealed himself in a warehouse whence he could overlook thousands of his despised fellow citizens. Far below him they were singing hosannas to their radiant, beloved young leader . . . The little man in the warehouse was no longer anonymous.
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> (Menninger 1967, p. 333)

But sadly, Menninger's understanding of the single, insignificant man and his position in a society where he was despised and ignored was not shared by the rest of the population; they were ready to blame almost everything else, and to speculate on extremely complicated international political conspiracies. As Menninger wrote: 'No one blamed the system' (1967, p. 333).

The Henderson and Sound Democracy

On my arrival in the UK in 1964, I was most fortunate in finding a training post at the Henderson Hospital in Surrey. This unit had been founded by

Maxwell Jones with the aim of treating psychopathic personalities, today called personality disorders. The Henderson gave me a renewed sense of trust in a therapeutic environment which existed for the benefit of the patients and not of the staff. The profound challenge of their treatment was met by a sound and adequate structure of democracy, and a division of labour in which everyone – patients and staff – shared not only the burden of their treatment but also the administration of the hospital. It was very saddening to learn last Christmas of the planned closure of such a therapeutic place which has marked us all, not only the patients but also the staff who have been privileged to work there. The experience has been greatly influential in all our future destinations. I am aware that some of my ex-students are still fighting for the survival of the Henderson and I join them in this quest. I am sad and feel grief at the closure of the Henderson just under a month ago.

The Portman Clinic

A different challenge altogether was offered when I started working at the Portman Clinic.[2] The Portman was founded in 1932 by some psychoanalysts whose main aim was to understand the internal world of the offender patient. At that time it was offering individual psychoanalytical psychotherapy to patients who suffer from perversions and/or who engage in acts of delinquency and crime. I started in 1971 and remained there for 30 years until 2001 when I had to retire from the NHS. The Portman was, in contrast to the Henderson, a formal place with an extremely well-defined hierarchical system. Psychoanalytical interpretations concerning transference and countertransference processes were proffered by well-dressed psychoanalysts in individual consulting rooms. Angry confrontations were the exception, not the rule, with only occasional acting-out behaviour by the patients. To start with, this took me by surprise. Were psychoanalytical interpretations more effective, or were the patients different, less disturbed?

It took me some time to realize that patients who share some personality characteristics nevertheless require, at different times of their lives, treatment in different types of setting. So, not only does treatability have to be assessed but the choice of the appropriate forensic setting is of essential importance. There are those who need much containment, safety and nourishment when younger or more disturbed.

At the Portman I was reinforced in my belief that judgemental or moralistic attitudes (so often used and exploited by the media) play no part and are of no relevance in the assessment and treatment of our patients; on the contrary, they could jeopardize and cloud any real understanding. I continued to develop my knowledge of subtle transferential and countertransferential processes, never abandoning the hard practice of interpreting the

so-called negative transference from the very start – an invaluable piece of initial learning. For example, I learned about patients' abilities to seduce the therapist into a collusive and unconscious participation in delinquent behaviour. Their apparent cruelty and arrogance could well be the result of a need to maintain control, since they had felt so powerless and at the mercy of their carers as small children. Their apparent lack of guilty feelings and their veneer of charm could be seen as an attempt to cover feelings of distress and isolation. At specific times during treatment they fell into confusion which could easily extend to their therapists, in that our own ability to think was seriously, although hopefully only temporarily, impaired. Denial, a defence mechanism often utilized in those suffering from severe and repeated traumas, is used for avoiding 'the black hole' – in other words, the dread of emptiness, represented by 'absence'. Since the mental representation of being wanted and/or desired was never present, we are unable to talk about a sense of loss. The experience is closely connected to the fear of aphanisis, in other words, anxieties concerning annihilation and helplessness (Hopper 1986).

No wonder how important the link with the death instinct is, as well as the constant, irresistible pull these individuals experience towards situations that put their life at risk. 'Dancing with death' is a metaphor for seeking serious danger. When some of them become patients they can be drawn into acting out, negative therapeutic reactions and reversible perspective. As Etchegoyen (1991, p. 764) reminds us these three phenomena are deeply associated, since they create obstacles to the gaining of insight in order to ward off the psychic pain that insight invariably produces. I support Bonner's hypothesis (Bonner 2006) that Bion's (1961) concept of reversible perspective is crucial to the understanding of perversion; this mechanism is in fierce opposition to acceptance of an interpretation leading to a dynamic inner transformation, and to the gaining of insight. The individual is actively trying to defend himself against the unbearable psychic pain that this transformation will inevitably produce in him. We are familiar with these prospective patients who during evaluation and when offered psychodynamic treatment would rather face a prison sentence since they know that the latter will be far more endurable.

Repeated experiences of traumatic rejection are turned into a chronic, masked depression, linked to experiences of deprivation, neglect and abuse. Faced with such trauma, individuals use denial as a defence mechanism in order to ward off psychic pain. Every form of risk-taking could be construed as a manic defence. Paradoxically, people often place themselves in painful, life-threatening, masochistic situations to achieve psychological survival. Because of all the risks involved, doing so reassures them that they are still alive. More importantly, their superficial jocular attitude is deeply connected with massive manic defences avoiding, at all costs, the dreaded black hole of depression. Patients try to use skills and strategies to divert the assessor's

attention from what they see as bad and unacceptable parts of themselves. If they fail to achieve this aim, when faced with an experienced assessor or therapist, there can be great relief when they experience being seen whole, warts and all. They can feel reassured when confronted with projective mechanisms, and this may lead to engagement and some development of trust. If they do succeed in 'cheating' their assessors or therapists this becomes a bitter triumph, in that no possibility of trust will ever develop. They are often skilled at making jokes, and if the assessor is 'too nice' or too naïve or too inexpert, he or she may fall into a pathetic 'benign' response of either smiling or laughing at the patient's jokes, only to realize that the joke has been at the expense of the patient. The assessor colludes with the patient's own sense of self-deprecation, and ends up laughing AT the patient and not WITH the patient; if any sense of emerging hope was on the patient's horizon, it is now lost forever.

The manic defence is one of the elements I expand on later on, but before this I will offer an extensive clinical vignette to illustrate the complexities attached to the assessment and treatment of these patients.

Transference and Countertransference or Perverse Collusion?

I shall always be grateful to my senior colleagues, who enabled their juniors to deal competently with these difficult predicaments. However, occasionally I was also glad to have evidence of their being able to make mistakes too! Shortly after my arrival at the Portman, and anxious to have as many difficult patients as possible, I was allocated a young, attractive, recently married man with an apparently unusual sexual perversion. This, he told me, involved the use of complicated rubber gear all over his body, including his head and limbs, with the aim of producing an almost total sensory deprivation; at this point, uncertain of his own survival, he would reach orgasm. If anything went wrong he would face death. I met this therapeutic challenge with some fear and trepidation, but I was also very curious to know more. I was painfully aware that my knowledge of the subject was scarce and inadequate. In search for more information, I was daring and not very cautious. Hence, I decided on a Saturday morning, while doing my weekly grocery shopping in Soho, to enter a so-called 'sex shop' where I could learn more about the quality of the rubber that my patient desired. To my bewilderment I found out that the rubber, which until then I had assumed to be of the kind used for underwater sports, was actually quite different. It was as thin as a second skin to be used over the body. This new knowledge gave me unexpected but immediate access to meanings and symbolism to which I had been previously blind, although I was already aware of Mrs Bick's concept of the skin containing the self, and of narcissistic or adhesive identifications (Bick 1968).[3] Indeed, I became aware that my patient, despite his apparent success and well-being, was in need of a

second skin to be used not only as a protection against all possibilities of pain but also as a container for anguish and anxiety of paramount proportions. I was overjoyed that my new discovery could be used effectively in the service of a more thorough understanding of the real nature of his problems.

However, there were other unsuspected problems to be faced on the Friday morning when I presented my patient to the rest of the staff in the clinical seminar. In doing so, I explained my sense of inadequacy in understanding my new patient's predicament. Furthermore, I added that my zeal in comprehending it all had taken me to visit a sex shop. This was not kindly taken. Indeed, the opposite happened. Suddenly my seniors were 'up in arms', alarmed at my alleged collusion and 'partnership' with my patient's perversion. I felt humiliated and misunderstood. I was immediately overtaken by speculative 'interpretations' from my older colleagues about my countertransference reaction in being 'seduced' by my patient. I was infuriated and found this very difficult to take.

I got a sudden inspiration and presented a challenge back to them. If any of them knew the exact nature of the rubber employed for this man's perversion, I would without hesitation accept their interpretations of my own 'acting out'. However, if nobody could offer an adequate description of the quality of the rubber, their 'judgement' of the situation had to be reviewed, since my 'detour' in Soho could be considered a scientific one and not an acting out. This was eventually accepted with some reluctance. To my relief and delight, a description of the thick rubber used for underwater protection was offered. I was now able to explain what the rubber was really like and we all were able to participate in a rich exchange of ideas. Anyway, it was a narrow escape. So much for the rough learning about the implications of transference and countertransference in working with the perverse patient.

However, later on during treatment I could not escape my unconscious 'partnership' with my patient. My countertransference response to him was shown in my dream (see below, p. 165), which made me connect with my own memories, allowing further understanding of his particular psychopathology. This clearly demonstrates that 'learning from the patient' could be more available to inexperienced and young trainees as we may be more ready to take on suspect aspects of our own motivations for working with perversion, including our voyeurism and fascination with the unknown.

Pseudo-normality and the Second Skin

I learned a great deal from this patient, particularly in relation to the serious, tragic struggle in which these people find themselves, literally between life and death; and in relation to the ludicrousness of society's

judgemental attitude, devoid of any dynamic understanding or insight, and filled with the notions of morality that I mentioned earlier. My patient felt himself to be literally between life and death and could only continue with his so-called normal life if able to perform his perversion at least once weekly. So his perverse acting-out allowed him to appear as 'normal'. He was a successful professional, well-groomed, handsome and recently married. Having known of his perversion from early adolescence he had never confided in anyone about it. He fell in love and assumed, hoped, wished that he was over his own 'peculiarity', so he never 'bothered' to tell his future wife about it. This is the usual pattern and it obviously involves self-deception and deception of others, such is the degree of denial and self-rejection. Deception, although frequently ignored, is yet another constant characteristic of perversion, also called false self, pseudo-normality, the 'as if' characteristic.

How did this come into the open? Well, as with incest cases it is as important to get to know of the disclosure as it is to get to know the starting point of the activity (the disclosure can provide us with many answers about the family dynamics that may have been responsible for the incest in the first place). After the wedding they moved to a new home and all his previous mail was forwarded to the new address. Amongst other items, many magazines and publications on auto-erotic asphyxia appeared, to his wife's utter dismay. There is anecdotal evidence that these magazines, even then, had quite a high circulation, so it is not such a rare phenomenon as I had previously assumed, considering that this is one of the most lonesome perversions, performed in complete isolation. 'Dancing With Death' is therefore not just a dream glam title; it is the basic and raw truth. So much so, that most of what is factually known about auto-erotic asphyxia comes from research on post-mortem findings, done mostly in Canada (Hucker & Blanchard 1992). Revealingly enough the corpses usually have evidence of association with other perversions, such as wearing babies' clothing, being cross-dressed, or – as in a famous case of a Member of Parliament in London – wearing suspenders and with an orange protruding from his mouth.

Transference, Countertransference or Rubbed Together?

Back to my patient. Under his wife's threat that either he sought treatment or the marriage was over, he undertook psychotherapy with much trepidation but also with a great deal of curiosity. He invested himself and began to work very hard, trying to be an ideal patient, but to no avail. All was rather sterile and I may also have been too anxious to be the perfect therapist, trying to be too clever. Eventually something began to emerge, which felt to be rather strange. It was positioned in the world of affects and feelings and was communicated between the two of us without words.

It emanated powerfully from the consulting room, which was the very small one that I had at that time at the clinic (of course I was then a junior). It was as if we almost became one; a sort of a fusion or overlapping was taking place between the two of us, reflected concretely in the mood of the session.[4] The small consulting room had become almost like a containing uterus, and at the end of the sessions I could be left with the feeling that his life was actually endangered. At the end of one Friday session (the patient was one of the few selected for a three-times weekly treatment) I made my traditional weekend separation-anxiety interpretation, along the lines that he would resent being without me as he would like me to take care of him over the weekend. Without hesitation he responded: 'Of course, I'd love that – shall I ring up the wife and tell her about it?' This left me speechless. The concrete answer was such that I quickly learned how to shut up, and how make a better use of my countertransference.[5]

Houdini Box Triggering Off Sexual Arousal

A few sessions later my patient told me he had had a very strange experience which had made him feel extremely embarrassed. The previous night he had been watching television with his wife in the lounge and suddenly and unexpectedly had felt taken over by an overwhelming desire to make love to his wife there and then and on the floor. He said it was most peculiar because the screen was showing nothing remotely romantic or even erotic. It was actually a documentary on Houdini, the escapologist. There was Houdini in a box, going up and down the rapids in Canada; this had produced in my patient an influx of sexuality which he couldn't control at all. As soon as I heard this I associated to the circumstances of his birth, and suggested to him: 'It seems to me that the TV screen did represent something very important, actually basic or crucial to your own survival, which may even go as far back as your own birth'. He brusquely turned his head away from the couch and said: 'I know it was very difficult, how difficult I am not sure but I'll check with my mother'.

Since his mother was alive he was able to talk to her and he was told of the very serious circumstances of his birth. Before his birth he was recognized as a bad breech presentation. Initially, they tried to use external manipulation of his mother's body to modify his position, but without success. He was born three months prematurely, a baby of one and a half kilos. There was much uncertainty about his survival; he was considered to be between life and death and immediately placed in an incubator. He remained there for 6 months, such was the uncertainty of his survival because he began to lose weight despite his being artificially fed. Only at the age of 6 months was he thought to be safe enough to be out of the incubator and to be fed by his mother. This left him in a precarious predicament of which he was clearly

intellectually unconscious. He was emotionally extremely fragile, and had recourse only to bizarre scenarios which were not of his own conscious design. The essential aspects of these bizarre scenarios included, initially, the uncertainty and unsafety of the womb, offering a precarious, faulty position, then being subjected to a violent expulsion without any holding space. Only a rigid box, the incubator, could offer a sense of survival.

The incubator may have been partly responsible for an illusion of omnipotence but the price paid for his survival was represented by unconscious suicidal and homicidal fantasies where he was either evicted (destroyed), or emerged, still alive but trapped in a paranoid–schizoid position from which he developed a false sense of autonomy. The false sense of autonomy was repeatedly re-created through his perversion, with its repudiation of intimacy and its false protection. He had been imprisoned for so long in a compulsive, repetitive behaviour experienced by him simultaneously as alien and as strangely familiar and reassuring. This was certainly not ego-syntonic. As in most perversions, his fragile ego had to persuade his superego to succumb to this strange activity, which was experienced as the only strategy for his survival.

Is this what Marucco (2007) had in mind when referring to the metaphor of the drive embryo, that corresponds to archaic memories of a quasi-primal trauma, and the need to repeat that is connected with the death drive? If so, it becomes clearer why my patient decided to leave therapy when his wife was pregnant (see below, p. 164); his state of terror that something akin to imminent death might take place again had to be avoided at all costs. It is only now, 35 years later, that I have become aware of this possibility! In clinical practice Marucco sees these archaic stages of life, need for repetition and memories finding their expression in a monotonous, unvarying repetition that is also a re-petition (a request for help) for something that is not only buried but furthermore is actually entombed. It seems to me now that my patient was repeating something from such an archaic time when no language, and no conscious or preconscious memories, would ever be available. If you work hard at the understanding eventually it pays off. Even if the understanding comes decades later on. It now makes sense when Marucco states: 'Pure repetition expresses a time halted by the constant reiteration of an atemporal present, and as such the act is the "royal road" for the expression of the unrepresentable' (2007, p. 315). Of course, for my patient his birth situation was the unrepresentable, but the Houdini box actually re-presented him with his need to capture, catch hold of life and his virtual 're-surrection' even before his own life started as such.

Does Morality Exist in Perversions?

I wonder what on earth this has to do, if anything, with morality? Nothing, nothing whatsoever. It is so archaic, so primitive that even if on the surface

the perversion appeared to be so self-destructive – of course in many ways it was closely associated with the death instinct – it was also securing my patient's survival. We have to keep in mind that judgemental responses are of no use and are the expression of intellectual laziness. We have the duty, if and when working with these patients, to have a much more enquiring and open mind, and to feel privileged to be the recipients of primitive fantasies that will enable us to learn more about the dynamics of the deviant mind. Professor Paul Verhaeghe (2004), whose book *On Being Normal and Other Disorders* has become a sort of alternative DSM–IV, eloquently argues that: 'Perversion is without any doubt one of the most difficult clinical categories, as well in matters of study as on the level of the treatment' (p. 398). He warns us that, in order to be able to study perversion as such, we have to overcome at least three difficulties of which the first is an ever-present moral reaction. He reminds us that, whereas we can liberally talk about our patients 'as a "good neurotic", and probably a "good psychotic", the idea of a "good pervert" is a contradiction in terms' (Verhaeghe 2004, p. 398). As Simona Argentieri asserts:

> The pervert, today as well as yesterday, is not someone who concedes himself an extra pleasure, but a sick person who, with great difficulty and many rigid restrictions, tries to reach (often at the expense of others) that minimum of pleasure compatible with his pathology; what he does is less significant than what he cannot do. A compulsive impulse forces him to periodically discharge his internal tension, experienced as an unbearable threat of implosion, through sexual acting-out. There is never true fulfilment but only a superficial sensorial outlet that, because it is not a real relationship with the other, constructs nothing inside.
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> (Argentieri 2007, p. 70)

Manic Defence

In my view, perversion is neither the negative of psychosis nor a defence against psychosis or a psychosis itself (views held by Glover, Klein's followers and Etchegoyen). It is a manic defence against the dreaded black hole of depression, concealing unconscious suicidal ideations or the risk of a completed suicide. As usual, Winnicott provides much enlightenment in all areas of psychic exploration filled with paradoxical situations. In 'The manic defence' he states, 'Here the key words are dead and alive' (Winnicott 1935, p. 134). Thus, it can be said that the key quality of perversion is a *sexualized manic survival*; not the disavowal of castration, but the disavowal of annihilating destruction. Perverse acting out is always self-destructive, in that patients take many serious risks in which they also experience, or from which they derive, a great sense of excitement that acts as a reinforcement that they are still alive. What Ogden calls flirting with danger (Ogden 1996) I prefer to call dancing with death since in dancing, as with perversions – and as opposed to flirting – the body is always engaged. When death takes place is

that an accident? Or is it a response to a well-concealed desire to die, in order to avoid too extremely painful an awareness of an earlier near-death experience? This may be linked to Winnicott's (1974) notion of the fear of breakdown as the dreaded event, an event that has already occurred, but has not yet been experienced: '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' (1974, p. 105).

Living in Two Different Worlds at the Same Time

Clinicians have diverse views as to the common elements in the 'normality' adopted by the pervert to prevent his darkest secret world from being found out (although when eventually it is, he experiences both a great sense of shame and simultaneous relief). For example, Verhaeghe (2004) argues that dissociation is the same thing as splitting; the result of the division between bad and good parts. He adds that in these cases, denial and dissociation create two different worlds, each one functioning on its own. Svetlana Bonner (2006, p. 1550) observes that these people simultaneously inhabit two parallel worlds: one more visible and acceptable, and the other secret, which hides away their worst fears about themselves.

In a challenging paper, Ofra Eshel (2005) explores the Greek tragedy *The Bacchae*, specifically in relation to King Pentheus and his mother Agave. Pentheus is disguised as a woman and joins a celebration over which Agave presides. His mother does not recognize him and he is torn to pieces and devoured by her. After the killing, when she recognizes her own son, she is overtaken by grief and madness. According to Eshel:

> Severe perversion 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.
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> (2005, p. 1080)

Where Eshel concentrates on the perverse aspects of Pentheus I'd like to concentrate on Agave, that is, on his mother's actions. Clinicians familiar with women who have hurt and damaged their children in different and varied ways are used to being witness to their tremendous sorrow, emotional pain and despair following those actions that are now experienced as though somebody else had taken over. The sentence 'If only I could turn the clock back' is a constant reminder of their pain, shame and remorse.

Eshel regards perversion as a defence organization – through splitting, externalization and compulsive sexualization – against a violent, devastating, unbearable, deadening early past situation. She uses the term *autonomous solution*, borrowed from biology, to explain a process 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, and emotionally impaired. The other part – the self that she compares to Pentheus – is offered up to be devoured and suicidally attracted to whatever conveys the dark violence and sadism that are within both the psyche and self–other relations.

Encapsulation

I believe that encapsulation is a more accurate term than splitting or dissociation, since the person knows what is being hidden. He has enormous fears of being found out in this self-imprisonment, but the self-imprisonment is also combined with an intentional self-deception. In this I am arguing that the 'right arm' knows what the 'left arm is doing', and I am leaving this idea open to arguments against and in favour. In other words, what is unconscious and unreachable is the symbolic meaning of the action, but the pervert is only too painfully aware of what he is doing. He feels he is trapped, unable to escape his 'destiny', and he tries to deceive himself and others about his supposed 'normality'. He plays with death by compulsively getting himself into situations in which trespassing against the law will be harshly judged and penalized. He convinces himself that now he is in control and no longer a passive victim of abuse, as he has unconsciously set up the punishment situation. However, even here this well-constructed 'safety' is an illusory one since it has no firm foundations; it is only scaffolding that is being used temporarily. Suddenly and without previous notice the scaffolding will collapse, leaving him open to derision, humiliation and mockery. This is due to a tyrannical superego. I am using encapsulation as used by Hopper (1991) as a 'defence against the fear of annihilation (p. 607).

From Fame to Shame

We are all made aware of these 'famous' figures that suddenly succumb to their 'destinies' and are exposed to public scandal and general shock. I have called this frequent phenomenon 'From fame to shame' and we usually discover it in reading the daily newspapers. (Corollary: It is vital to read the daily news in order to understand the extent of this particular condition.) In a way the shocked response from society is a reaction to feeling tricked by someone who had appeared to be 'so normal' as opposed to the expected monster. Nobody knew about it, not even his closest or most beloved ones. This pseudo-normality or, as Joyce Mc Dougall terms it, the situation of the 'normopath' (McDougall 1995, p. 160), is achieved through a process of encapsulation far more than by a process of splitting.

Why is the shock so profound? The shock reflects the fact that these individuals have frequently been widely known for their very conservative and moralistic views. These views are for the most part most prejudicial and damaging to others, usually those from minority groups and most vulnerable to abuse. The views emanate from what they really fear is inside themselves,

and their mechanisms of projective identification are now flagrantly open to all. Let's think of American Senator Larry Craig, with his family values and strong homophobic attitudes (Lewis 2007);[6] and Governor Eliot Spitzer and the anti-prostitution laws (Bone 2008).[7] These are just the most recent public media monsters/victims, but certainly far more are and will always be in evidence. What they were so vocally able to attack outside themselves was actually a part of themselves which was utterly loathed. As such it had to be vomited, expelled onto others. Their barely contained sense of self-disgust was covered as a hypocritical overcoat. From accusing others and being in a position of almost feudal power, they are now in the lowest echelons of society and are made objects of punishment and derision. They will either fall into deep depression or try without success to conceal the facts and, feeling trapped, will deny the facts even further.

Blaming vs. Understanding

Family members, usually in complete and blissful ignorance of the condition of those so close (and at the same time so far apart!) also react with shock and a great sense of betrayal. In no time they also become unwitting objects of public exposure and humiliation. They are left with few choices: to stand by the individual, now a victim, or to go away and leave; but whatever they do it will be considered wrong. There are no rights. There has been a complete role reversal, for the family members as well as for the perpetrators/victims. Even when the individual makes the most extreme decisions – such as to commit suicide, as has frequently happened – it only leads to more judgemental conclusions. Family members are seen as having been indifferent to what really goes on inside these individuals' minds. As a matter of fact, usually these individuals are denied the right to have a mind. The public decide that they are 'monsters'. They have become monsters to us because we feel so cheated by them; they have deprived us of our loved or hated idols, and deprived us of our ideals or just our prejudices. For the perpetrator, there is a cycle of repetition of the same scenario: there is an attempt to avoid falling into the black hole of depression, but to no avail, and as such a new repetition is required. For society, there is also a strong process of dehumanization. According to Bonner, it becomes a compulsion to protect oneself from terror by secretly contriving ways to reduce all experience to a script and to foreclose the possibility both of thinking and of genuine engagement with others: 'Anybody can be perceived as being unidentified and objectified as anybody else' (2006, p. 1560).

Treatment

During treatment the negative therapeutic reaction is the rule, with its concomitant feature of envy, as I learned early on under the supervision of

another mentor here at the Portman, Adam Limentani. I got much insight about the NTR, including its positive aspects, from him (Limentani 1989). He also, along with my patients, alerted me to my first insights about the mother's role in perversions. Limentani developed Rosenfeld's (1987) ideas about envy and narcissistic disturbance in the mother's rejection of the infantile part of her self, and introduced the idea of an identification with a mother who does not allow independence, making this responsible for iatrogenically induced negative reactions.

Returning to my patient. After his revelations he was left feeling despondent and estranged, but also greatly relieved and able to participate in his therapy with a more lively attitude. We were able to reconstruct some of his early experiences, which in previous sessions had left us both rather confused. This new insight was utilized to understand the stuckness of everything. Lack of time and other priorities in this talk do not allow me to go further other than to say that he eventually experienced a great liberation from his unwanted actions. I felt that the work was then about to start since, in Bion's terms, this could have afforded him a process of deep-seated transformation. We could then allow for unthinkable sensations and emotions to become thinkable and contained by means of thinking activity, instead of being purely and simply evacuated in action, or deflected in somatic afflictions. But the patient decided that this was enough. His main priority was to become a father and he decided to stop. We could speculate that the sessions provided him with a new type of nurture and liberated him not only from the compulsive practices, but also from his wife's threat that had 'sentenced' him to treatment. Of course I was disappointed and offered interpretations as to his repetition of his premature birth by going away alive – but only just. However, the patient's right to terminate treatment is to be respected and honoured. In addition, I consider of crucial importance an assessment of the risk of suicide, which in our clinical experience is a much more likely event than a psychotic breakdown. My patient may have stuck to his perception of myself as a persecutor to consistently avoid the possibility of the development of a depressive position that could have led to suicidal thoughts. His premature termination suggested other possibilities too. He may have needed to escape in order to preserve me as a good object to avoid the risk of my becoming a fetished second skin. Or he may have felt the need to protect me from his desire to enclose and suffocate me (Anna Motz, personal communication, 2008).

I hope that sharing these clinical vignettes from a patient I had in psychotherapy a long way back, when I was still inexperienced but very eager to learn, may open the way to ideas regarding the psychodynamic understanding of perversion. Although I have never written about him before, he has never been far away from my mind, especially when faced with deriding or misleading comments about people being 'caught' by the media or the courts

when malicious, ignorant judgements are so easily made. He and his treatment also come to my mind when teaching students.

My Dream in the Countertransference

If you are wondering how I made the link between Houdini and his own birth I must confess as an important footnote that I owe this insight to my early psychoanalysis. I was subjected to a repetitive, highly anxiety-producing dream. In the dream I am lying in a suspended hammock with a great sense of space and depth underneath, and I am able to move in a soft and pleasant way. But the movements of the hammock become faster and faster and I no longer feel in control. I look underneath and to my consternation and great alarm the space is becoming narrower and narrower, so much so that I am really scared since I now notice sharp, cutting surfaces just below me. The hammock shrinks and disappears and I am left falling into a precipice. (Not at all unlike the situation of the Mexican diver in Acapulco who makes his living risking his life by plunging from high up into a small hole of water, which requires a great deal of practice, expertise, courage and the need to survive.) In my own case, I wake up in panic in a cold sweat, relieved to be alive. When reporting this dream in my session, I hear my analyst suggesting, in a quiet and confident way, that this was perhaps a birth dream representing a very fast delivery, and that this might account for my own separation anxieties. My mother was no longer alive but the midwife, a family friend, was, so I asked her whether, by any chance, she remembered assisting at my delivery. Her answer was immediate and devoid of any doubt: 'How could I ever forget it, you came up like a champagne cork, so fast and so boisterous, I had never seen anything like it'. So, I had 'known' about it all along, without really knowing. I remember later on sharing this experience with R.D. Laing, after hearing him giving a lecture at the Royal College of Psychiatrists in London: he was speaking about psychic regression to the blastocele stage in very early foetal life, just after the egg is impregnated. Once more I have to be grateful to Professor Etchegoyen, my first psychoanalyst, for providing me with such important insights.

Perversion and Female Perversion

Some of you may be familiar with the object of today's presentation, that is, my ideas about female perversion and the shift from a focus on the penis and castration anxiety for the aetiology of perversion, to a focus on reproductive functioning in both genders (Welldon 1988). I have also given consideration to the specific attributes of the female body and its unique mental representations, especially regarding motherhood and babies. I became aware that in Freud's conceptualization of the resolution of the oedipal complex in girls, in the fantasy of having Daddy's baby, the acknowledgement of the equation

between penises and babies was made for the first time. From there I began to listen, and to remember having listened but not really heard women talking about their difficulties in raising children. At times they would voice, in rather tentative ways, the escalation they experienced in response to their babies' demands. They would start with irritation and reach profound extremes of murderous fantasies. I remember how these mothers' voices and statements were suffocated by others, even in group therapy (where I began to learn of this predicament).

Nobody ever wanted to hear or facilitate these cathartic pronouncements. This made the feelings even more difficult to bear and as such more liable to be acted out. Much of this had to do with the glorification of motherhood and the complete resistance to acknowledging that at times pregnancies might be created as a result of vengeful conscious and unconscious designs whereby women felt for once empowered and in complete control! Of course the power and control were completely and utterly reversed as soon as the women realized they were devoid of skills or internal emotional resources to deal with the unpredictable situations emerging from the growing demands of babies who are able to make those demands in such vociferous and desperate ways. Not what the young woman who feels unwanted or undesirable expects, when she needs to have a baby to have 'somebody who will love me'. Is it so shocking that in looking at the other (the baby) as the needy and desperate self she does not want/cannot acknowledge as her own self, she feels murderous and wants to kill off that part of herself which was previously denied? The denied part has been replaced by the need to have somebody who can take care of her. This is the core of the problem. She is that desperate needy baby who never had proper care, attention, let alone love. That is why it is essential to understand the process of faulty mothering as part of a three-generational process.

Our Male Patients

Of course I and others had always heard our male patients constantly talk about their deprived early experiences. At other times these were denied – 'As a child, all was great' – but they appeared clearly in the transference. Repetitions that at the time made no logical sense later on, by means of working through and the gaining of insight, become obvious screen memories for more traumatic, earlier and hidden events. These went back to early and primitive times, and accounted for very severe psychopathology.

I had never previously connected the patient whom I have discussed in this talk with faulty or perverse motherhood. But why not? I now wonder. It is not as if one chooses to be or to become a 'perverse' mother. If I really mean to be without prejudice in this regard, and to consider the consequences of earlier generations of women being subjected to faulty motherhood processes, why my refusal to see my patient as the unwanted foetus

which had to be expelled from the maternal womb so much earlier than it would normally be ready to be delivered, and delivered properly?

I began to think that he could trust nothing but a rigid box to contain him and his needs. After all that was what brought him into life. Then his decision to leave therapy when his wife was pregnant became clearer, as I mentioned earlier. So we may have to start thinking in terms of conception as opposed to birth. In his psychic economy he may feel nearer to his moment of conception. This observation links with research that I am presently involved with. I am looking at the extent to which, in both male and female perversions, the object of attack and murderous envy is mother's body. These attacks are usually perpetrated in symbolic ways but on occasion the actual body is attacked in concrete ways. This is even more clearly evidenced and experienced in the most sadistic way against the pregnant body. The matricidal wish has recently been studied by a British academic, Amber Jacobs, in a rich and enlightening work. *On Matricide* (Jacobs 2008) is in a way the counterpart of the ideas put forward 20 years ago in *Mother, Madonna, Whore* and of the theories prevalent at the time, the outcome of the denial of a conceptualization of female perversion and even more so if this was associated to the idealized version of motherhood.

In psychoanalysis it is commonly acknowledged that a particular symbolism is also present in incidents where breaking and entering into houses takes place with no financial gain being made. The incidents usually involve a few youngsters who break into a stranger's house. Once inside, they indulge in all sorts of revolting behaviour, such as taking food from the fridge, making a mess of the home and its contents, urinating and defecating. They leave the house in complete disarray, although to the owners' further bewilderment nothing is missing. In other words there is no financial gain; the youngsters have not stolen anything. It leaves the owners of the house experiencing much humiliation and anger, while the police are completely disconcerted and left with puzzled anger.

The Primal Scene Par Excellence

These are sadistic actions against the mother's body, symbolically represented by the house they have trespassed against. The pregnant body is more than the sum of its parts: it represents the embodiment of fulfilled desire, the sexual longing for the Other, and the completion of that union represented by the new being. The pregnant body is a unique combination of the power of the sexual union, which is so envied, and the vitality and vibrancy of the new being (leaving to one side both traditional penis envy and its counterpart, envy of the womb, which is easily forgotten and not easily acknowledged). There is an explosive realization that both female and male organs are together in the act of consummation, and that there is potential for a new cycle of emotional and physical maturation when the partners realize they

will become parents. However, we are also familiar with the fact that pregnancy triggers violence and that pregnant women are much more prone to physical abuse from their male partners and also from strangers (Aston 2004; Bacchus 2004; Foy *et al.* 2000; Mezey 1997; Royal College of Midwives 1999; Stark & Flitcraft 1996; Taft 2002).

This is the primal scene *par excellence*, and it leaves vulnerable, immature individuals in a most curious predicament. Even the men responsible for the pregnancy may be subject to powerful and opposite emotions. Consciously they are proud and excited by their own potency in having impregnated their partner. But, as usual, things are not that simple in our unconscious minds, and a paradoxical operation is at work. Some men return to the position of being the humiliated and excluded child. We have learnt from James Gilligan (1996; see also Gilligan 2009, this issue) that any violent act is always preceded by the subjective feeling of being humiliated. The problem is that we don't know what would constitute, for the individual man, exposure to the feeling of humiliation when early traumas are being re-enacted in full, such is the power they had when they were children, feeling powerless and defenceless. It is the same for women, after their partner has gone and has left them injured emotionally and at times also physically; they experience a great sense of humiliation. They can easily act this out against their defenceless, powerless children. So the cycle of violence and abuse is forever perpetrated.

I'd now like to offer my definition of perversion, which leads on to the concept of female perversion, and then I shall continue with treatment implications, particularly with reference to group treatment.

The Internal Circular Motion of Perversion

In perversion, sexual anxiety appears as a result of conflict between the id and the superego, in which the id titillates the ego with a bizarre fantasy. The id puts pressure on the ego to be partly, or temporarily, corrupted by its increasing needs (see Figure 1). The ego, supported by the superego, fights against the acting out of the fantasy since it is felt to be incompatible with the ego's sense of integrity. Thus anxiety increases, and immediate action is demanded. Eventually, under the increasing pressure from the id, the ego is corrupted and succumbs to the 'acting-out'. The action has become temporarily ego-syntonic, thus allowing the perversion to take place. The goal, which is the release of hostile sexual anxiety, is essential. The hostility is related to revenge for an early trauma associated with early gender humiliation and/or a tremendous fear of not being in control when facing the imagined loss of the most important person (primary object). However, the sense of well-being that is achieved is of short duration. It is immediately superseded by feelings of guilt, self-disgust, shame and depression. The 'acting out' is again experienced as ego-dystonic, and the circular motion

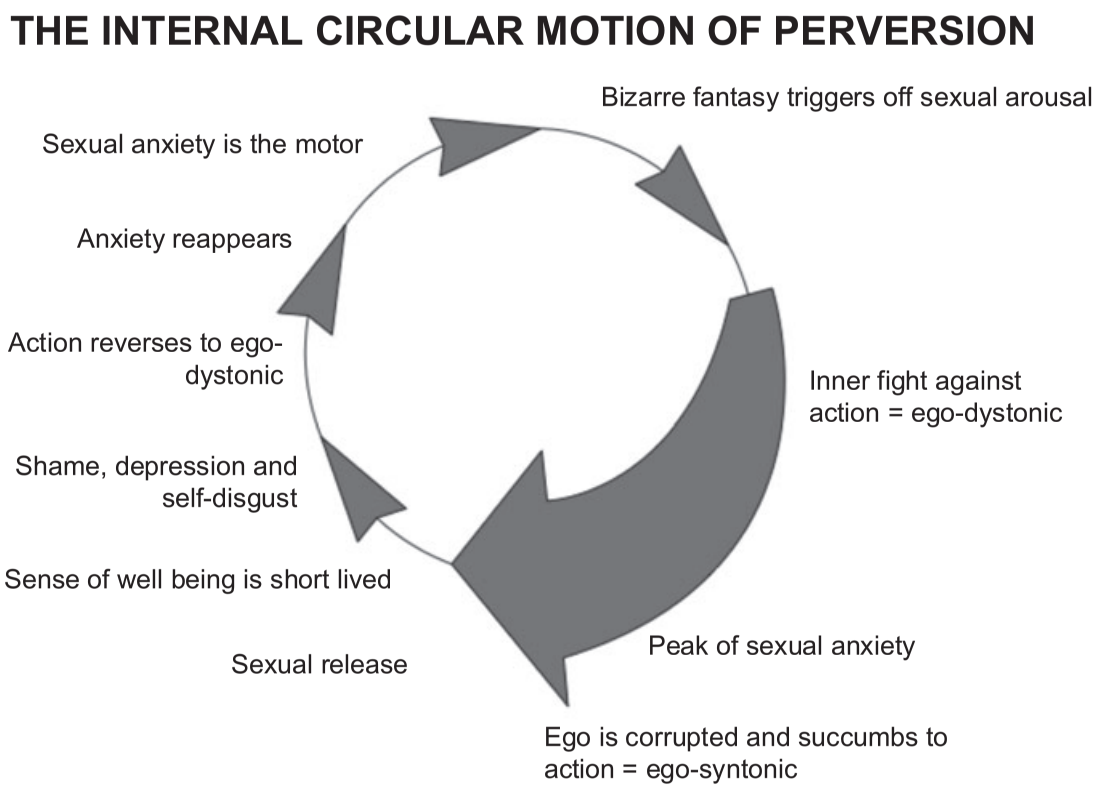

Fig. 1: The Internal Circular Motion of Perversion

starts up once more. Perversion is therefore only transiently ego-syntonic. It is compulsively repelled although compulsively repeated. Again, the need to repeat the action is deeply linked to the death instinct. But something is being preserved and kept alive, and this is also part of the function of the perversion. It is this paradox which makes perversions so compelling for the patients.

In order to assess treatability for psychotherapy accurately in these patients we must modify terms and concepts that are used in assessing neurotic patients. As we can see in Figure 1, the fact that the criminal action is committed clumsily makes the person especially susceptible to detection, since the action has become so clearly ego-dystonic. As such the criminal action has become the equivalent of the neurotic symptom. This is associated with the Freudian notion of the crime as an expression rather than cause of guilt. The offender may also express fears of a custodial sentence. This may in fact denote his motivation for treatment, and could signal that it is the appropriate time to start treatment. He is now ready to own up to his psychopathology, and may have an incipient capacity for insight. From this therapeutic standpoint, it is not unfortunate that a patient has to face prosecution, but what is unfortunate is that just when he is ready for treatment he may instead have to face punishment. The patient may actually acquire a criminal record for the first time while in treatment or on the waiting list. Ironically, the very success of our treatment may produce this result. So, in a way, it may be said that psychotherapy results in a higher rate of official, statistical criminality!

A frequent finding in perversions is that the individual is aware of 'being taken over' and attempts to fight his or her perverse action but usually fails, and succumbs to the action. Afterwards, he or she experiences overwhelming shame, self-disgust and depression. There is a repetitive cycle in which the person afflicted by a perversion succumbs to the action, in order to be relieved of a powerful sense of sexual anxiety, only to return to the previous predicament of increasing sexual anxiety, which, after being assuaged in the short-term, once more demands the execution of the same bizarre and 'illogical' act. Alongside the repetitive cycle of shame, self-disgust and depression exists an unconscious desire to humiliate or hurt another person. In sadomasochism there is particular denial of this cycle of feelings.

Conceptualization of Female Perversion: The Body as the Torturer

Experience at the Portman Clinic has shown that female patients also dance with death and that female perversion exists, but that there is an important distinction between male and female sexual perversions. In both men and women the reproductive functions and organs are used for perversion; the man uses the penis to carry out his perverse activities, while the woman uses

her whole body, since her female reproductive–sexual organs are more widely spread. Their different psychopathology originates from the female body and its inherent attributes, including fecundity. As we know, as early as 1968 Rascovsky and Rascovsky noted that the neglect of this area in psychoanalytical literature could be regarded as: 'an aspect of the universal resistance to acknowledging the *mother's* filicide drives, undoubtedly the most dreaded and uncanny truth for us to face' (Rascovsky & Rascovsky 1968, p. 392).

The psychopathologies most frequently associated with women are syndromes of self-injury associated with biological/hormonal disorders affecting reproductive functioning: for example, anorexia nervosa, bulimia, and forms of self-mutilation, where the absence or presence of the menses can act as indicators of the severity of the condition; self-abuse; some forms of prostitution and the sexual and physical abuse of children, including incest with children of both sexes (see Figures 2 and 3). Ethel Spector Person has coined two terms: 'the body silenced' (meaning the lack of sexual desire) and 'the body as the enemy' (meaning hypochondriacal symptoms) in a rich and comprehensive study of the beating and sado-masochistic fantasies in women (Person 1994; Person & Klar 1994). I believe that a fitting term for my female patients' specific predicaments in relation to their bodies and babies could be 'the body as the torturer'. This term would signal the compulsive unconscious urges these women experience towards their bodies, making their bodies function as the effective torture tool in victimizing themselves and their babies. Victims can experience an addiction to trauma that induces self-destructiveness. There are also present different degrees of disassociation, the most severe corresponding to Munchausen's syndrome by proxy. At other times, the partner is unconsciously designated as the torturer.

Again, dancing with death is very much present in women, either directed against themselves or against their children, and at times both are involved. Anna Motz (2008) describes vividly the way in which self-harm is a defence against intimacy, binding a woman to her own body to the exclusion of the other. She makes a connection in women 'cutters' between the cutting of the skin and the creation of a barrier between therapist and patient: 'Women locate their sense of identity in their bodies, which may be their most powerful tools of self-expression. For many women, painful experiences are literally inscribed on their bodies' (Motz 2008, p. 250).

The main difference between a male and female perverse action lies in the object. Whereas in men the act is directed at an outside part-object, in women it is usually directed against themselves, either against their bodies, or against objects which they see as their own creations, that is, their babies. In both cases, bodies and babies are treated as dehumanized part-objects, and babies are used by some mothers as transitional objects with fetishistic characteristics (Welldon 1988).

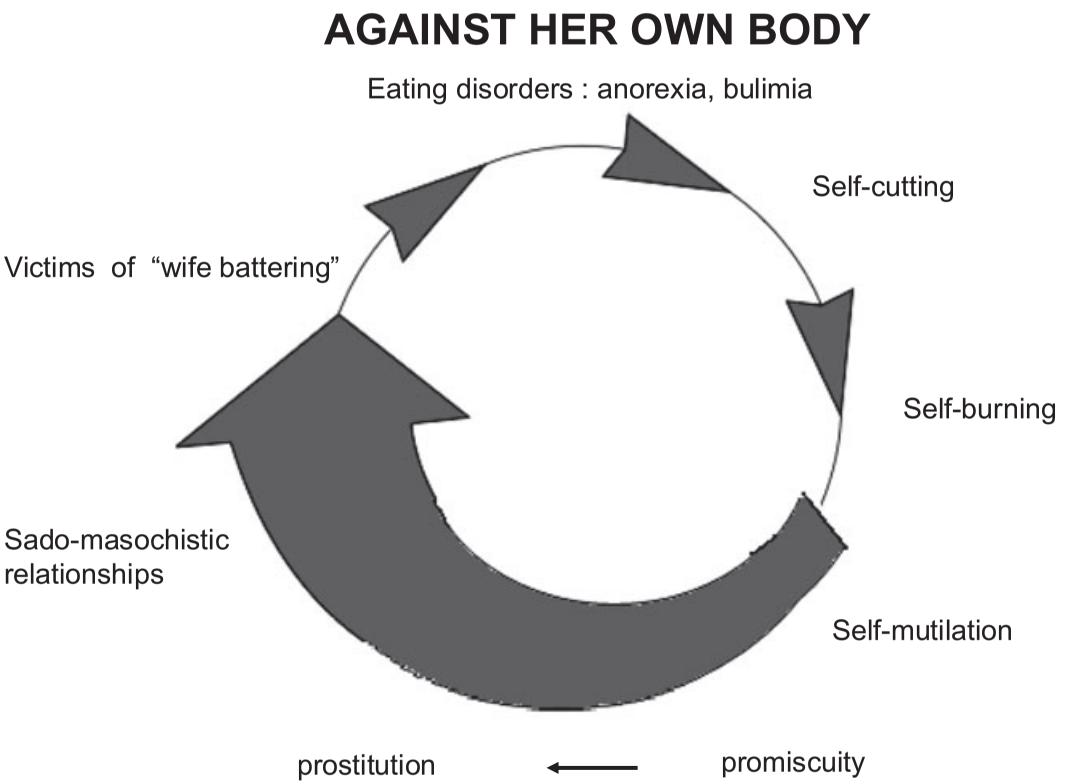

Fig. 2: Female Perversion: Against Her Own Body

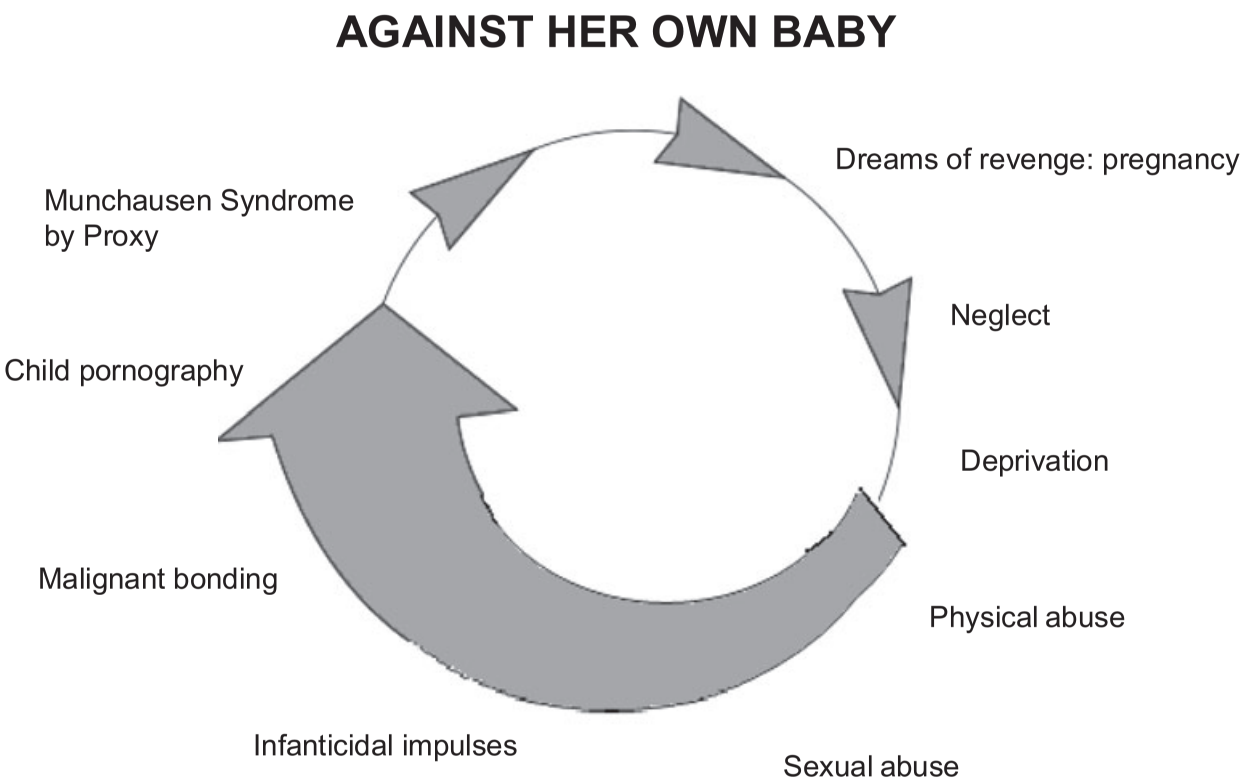

Fig. 3: Female Perversion: Against Her Own Baby

Let me give a clinical example.

> A patient was referred for a psychiatric assessment because of violent behaviour directed towards her second child. Her first pregnancy had come as a surprise to her but she felt the need to go ahead with it, because in this way she felt she was taking out insurance against the dread of being alone. The child could become utterly dependent on her and be totally under her control. When this first child arrived, she was overcome by feelings of repulsion and revulsion against her baby. She felt ready to kick it, but after reflection she decided that in order to overcome these horrid feelings she would fix in her mind the idea of the baby being part of herself. Despite the fact that she hated it, she surprised herself by finding thoughts and actions directed against her baby sexually exciting and eventually the baby became her source of sexual gratification. Some days she would select her right arm as the baby, and at other times it would be one of her legs. In this way she felt able to master her impulses to beat up her first child. Later, unable to do the same with her second baby, she asserted: 'There is no more room in my body for a second one, all has been used up by the first one'.

A strong quality of dehumanization and the reduction of object to part-object, which are features in perversion, were present here. However, concern escalating to alarm and a strong wish to understand, in order to stop the destructive actions, were also present. Kramer Richard's assertion: 'The essential aspect of perversion is the aggressive dehumanization of the object' is a concise and precise evaluation of perversion (Richards 2003, p. 1213).

The Mothering Process

Psychoanalytic authors from Margaret Mahler (1963, 1979) onwards refer to the mothering process in the production of future perverts. Most agree that the mother–child relationship is of paramount importance in understanding the genesis of perversion but recognition of the perversion of motherhood itself is absent. Furthermore, little is said about the *real* pathology of those mothers and one is left uncertain as to whether the authors consider the 'cruel', 'sadistic' mother to be a fantasy of their patients, or an accurate assessment of these mothers. Perhaps the essential problem is that Freudian theory treats perversion as the product of oedipal anxiety. As Paul Verhaeghe says, supporting my own theory in Lacanian terms: 'This is wrong; the anxiety is about the maternal superego. It was the First Other who was in control, and the perverse scenario is explicitly aimed at reversing this situation' (2004, p. 411). Again, when referring to the importance of post-traumatic stress disorder in the psychoethology of perversion, he asserts: 'The pervert's basic distrust of the Other, and therefore of every other. To have been abused by someone who was supposed to be protective means that later on the victim will distrust everyone' (Verhaeghe 2004, p. 411).

This terrible predicament of being cheated by THE person who is supposed to take care of us and be responsible for our well-being is clearly and cannily

demonstrated in artistic expressions of the tricks we face everyday and still find so difficult to come to terms with. I was emotionally hit by the extraordinary insight provided by Juan Muñoz in his recent retrospective show at Tate Modern in London, where in a most subtle way he puts us in touch with violence, disaster and our encounter with the Other within ourselves. Perhaps the most subtle way he demonstrates this binding situation of safety/danger is shown in a piece of art which is so deceptively simple that is usually ignored by those attending the show. It represents a handrail, with its own distinctive twist. In the words of the catalogue:

> The presence of the human figure is strongly implied: the banister is something for the hand to grip, a means of safety and guidance while negotiating a tricky staircase or passageway. But it was precisely this feeling of reassurance that Muñoz wanted to undermine. First Banister (1987) includes an open switchblade, hidden from view and waiting to slice the hand of anyone who holds the rail for support.
>
> (Tate Modern 2008)

This is exactly what happens to the infant who implicitly trusts and relies on mother for his own negotiations with life. If in trusting this to happen he encounters the opposite, his survival is now at stake because his mother, through her own human frailty, is providing him with a life-undermining situation.

Dissatisfaction with the Female Body

It is likely that young women who have experienced early emotional deprivation, and who have failed to learn self-assertion during adolescence, will become increasingly dissatisfied with themselves and their own bodies. This is often manifested during adolescence in eating disorders such as anorexia and bulimia, promiscuity, drug abuse, self-cutting or self-burning. These are the precursors of abusive behaviour to others and constitute part of the psychological profile of the female abuser. Ambivalence towards the female body, and towards mother, lies at the heart of the cycle of abuse. As they grow older, these young women may find enormous internal difficulties in achieving healthy, satisfactory, mature emotional relationships. Instead, the young woman might easily enter relationships with men or other women with whom a sadomasochistic pattern emerges. It is extremely difficult for these women to extricate themselves from these relationships because the dance with death operates in such a compelling and irresistible way.

When and if they do manage to give the relationship up, they do so only in order to start a new relationship, which in no time acquires the same characteristics as the previous one. This happens because the brutish partner represents an internal part of herself, the partner becoming the embodiment of her own self-hate. She might now no longer need to attack her own body in various ways, because her partner has been unconsciously

assigned to perform this role. Heterosexual intercourse with sadistic characteristics becomes the rule. Though on the surface the woman is submissive, compliant and passive, revenge is being harboured in daydreams, dreams and fantasies. Dreams of a pregnancy are engendered, and they have different psychic connotations: for example, falling pregnant as an expression of revenge against the man who is so undermining and contemptuous. Or, if left alone, feeling isolated and despondent, the young woman might want to have a child to keep her company and to provide her with unconditional affection. She is quite unaware that, left to her own devices, she might easily fall into abusive actions against her baby, since she is unable, psychologically and otherwise, to deliver all that is required from a 'good enough' mother. Such motivations are not usually taken into account by those who assume that motherhood is a sign of healthy and mature development.

Treatment Implications

A reason for the compulsive need that individuals have to repeat abuse against themselves and others cannot easily be given, but is usually linked to avoidance of mourning, lack of symbolic functioning and persecutory guilt. It is the belief of those who work with psychoanalytic methods that the only way to obtain long-term internal change is through psychoanalytical psychotherapy, which will provide a psychological understanding of self-inflicted behaviour. We also know that the dynamics of sadomasochism make a therapeutic alliance, almost by definition, a contradiction in terms: dynamic psychotherapy requires painful, emotional self-examination for the gaining of insight – and this runs contrary to the sadomasochist's well-known acting-out practices, far less threatening to them since they are so deeply ingrained. Psychoanalysts also run the risk that the emotional pain of therapy will be corrupted into masochistic gratification.

A few years ago, I received the following self-referral from a woman in great need of therapy:

> I am writing to you in desperation. I need help. I am a 26 year-old woman, with six children presently in care and one due within the next few weeks, which it also looks as though I am going to lose. I desperately want my children back, but also recognize that I'm in this position because of my own abuse as a child. One of my daughters was sexually abused by one of my abusers. I am now experiencing flashbacks, nightmares, and awful depression. I can't bear to be touched by my partner – I also recognize that my relationship is very brutal. I don't want it anymore. P.S. I was sexually abused by 5 different people from the age of 2–12 years, and then raped at the age of 17 years. My mother was physically abusing me at this time too.

This letter was from a woman who had been charged with aiding and abetting sexual abuse. She had taken her daughter to be babysat by her

stepfather, who had previously abused her as a child. A high degree of unconscious identification with her own daughter was present. Also present was a sense of self-loathing confirmed by her sadomasochistic relations and brutal treatment of her own body. This constitutes yet another category in which the abuse is simultaneously active and unconscious. In other words, she was quite unaware of her participation in a cycle in which she was perpetuating her own trauma by placing her child in identical circumstances to those she suffered; the original trauma – her own abuse and the complex mix of feelings it engendered – had been buried away, and only emerged into consciousness when she became aware of her own daughter's abuse.

She was placed in a therapeutic group, and only there, where she was supported by others with similar histories, was she able to look at her own abusing behaviour. There was no chance that she would feel judged by others. On the contrary, she experienced the constant confrontation to address and 'take in' her own sense of responsibility as enlightening and extremely helpful. In turn, her own capacity for internal and continuing change provided the others with reassurance about their own capacity to give positive things. Much cohesiveness, connectedness and mutuality emerged in the group setting. The patient left the group seven years later, having regained the complete custody of six of her children and accepting with insight her inability to take care of her eldest daughter. This allowed her daughter to express her anger and distrust at her mother, and the mother respected her daughter's decision to live apart from her. (The daughter was also taken on for psychotherapy at the Clinic.)

Group-analytic psychotherapy offers particular advantages as a treatment option for victims and perpetrators of sexual abuse, since secrecy and isolation are replaced by disclosure within the contained atmosphere of the group. People confront past pain and abuse, and become aware of their need for revenge, a need that fuels their capacity to perpetrate abuse in their turn. Yet it remains a sad fact that, while the treatment of victims is encouraged and everyone is rightly concerned about their welfare, the same does not apply to the offenders, who are believed to be the products of 'evil forces'. Obviously these patients are difficult to treat and they certainly reproduce dancing with death in the transference. How many times I have felt blackmailed by the easy acceptance of an interpretation, or by the fierce refusal of an interpretation which included a veiled threat to my own survival.

The International Association for Forensic Psychotherapy and the 'Golden Decade'

We knew that these layers of awareness, painfully learnt through years of experience, needed to be shared not only within our varied professions, but within an international community of analysts, doctors, art therapists,

psychologists, prison officers, lawyers and many others who are in contact through their work, and obviously within society in general. That is why in 1991 we founded the International Association for Forensic Psychotherapy (IAFP), meeting annually since then. The IAFP was a development of the European Symposium which started in 1981 at the Portman Clinic, with colleagues from the Continent.

It is important to acknowledge the dangers for therapists of working with this group of patients. The patients are socially excluded and isolated, and evicted from mainstream society. We as professionals are sometimes treated with suspicion in a way that mirrors our patients' situation, because we choose to work with these 'perverts' and 'criminals'. The IAFP aims to create unity by sharing and exchanging information, dilemmas and difficulties that we encounter when dealing with this patient population. Through our meetings we learn and are educated about theoretically informed and internationally recognized treatment methods. In addition, the Course in Forensic Psychotherapeutic Studies founded at the Portman in 1990 provided training for all professions involved with the forensic patient. All students on the Course had to learn how to respect the others in their different fields. This allowed for and facilitated a process of interaction, and the working together recommended by the Cleveland Inquiry Report into child abuse (Cleveland Inquiry Report 1988).

Before I embark on an acknowledgement of my very valued ex-students and trainees I'd like to make special recognition of those no longer present in any physical way – including Tim Scannell, James McKeith and Murray Cox – but whose conceptualizations and ideas are very much alive and remain within the spirit of the work. They dedicated their time to the work, and their original ideas will always be present in the spirit of the IAFP and its expanding work.

I am very proud of what I call the 'Golden Decade' – roughly 1990 to 2000 – from which emanated well-trained clinicians able to disseminate and expand forensic psychotherapy throughout the UK and abroad. They are now responsible for the continuing expansion of the IAFP as an annual forum for discussion of theoretical and clinical issues that is highly respected in other countries. In the last ten years two distinguished publishing houses, Karnac and Jessica Kingsley, have created Forensic Psychotherapy series under the direction of two ex-students, now fully fledged professionals. Well-established authors have produced more and more books in the field of forensic psychotherapy.

Regarding the expansion of the ideas about maternity as a female perversion that originated with the clinical practice at the Portman, the nature of our listening to these women has also changed. We are now more sensitive and aware, and open to listening to women's cries for help in the carrying out of their duties as mothers. Many more books and papers (Adshead & Brooke 2001; Aiyegbusi 2002, 2004; Motz 2008) have been written about

severe female psychopathology, and more adequate help is being provided. We still have far more to achieve but change is under way, and we are seeing these changes not only among the mental health professionals but also, very importantly, from the legal perspective. The expansion of group-analytic psychotherapy at the Portman is most impressive and I am particularly grateful to my colleagues in charge of the group therapy team for the continuation of and belief in this particular kind of treatment for patients who, to start with, were thought to be most unsuitable for group treatment due to their asocial or antisocial behaviour.

I do want to make three specific acknowledgements. The unique and important input by my friend Helena Kennedy, with whom I have a close dialogue about psychoanalytic and legal issues, is of paramount importance. It has promoted better and more adequate justice for women, as their specific problems have been more accurately defined and profiled (Kennedy 1991). I have been sharing incredible trips all over the country doing a double gig with my friend Juliet Mitchell, challenging old stereotypes and using the most provocative titles such as 'Males – Hysterics; Females – Perverse'. And of course starting from the mythology concerning the 'witch' mother, or stepmother, which is the equivalent of the Mother/Madonna/Whore syndrome, my friend Marina Warner took the clinical findings and was able to expand in a different direction as early as 1989 (Warner 1989).

So the journey has been long, not without difficulties but very invigorating and extremely gratifying. My Portman adventure started in 1971 when, as a widow with a young boy of 1 year old, I was advised by the then Director of the Tavistock Clinic, Robert Gosling, to apply for a job at the clinic next door, it would be 'just my cup of tea'. Indeed so much so, that I stayed there for as long as I could – that is, 30 years –leaving only because of my retirement. Now, all these years later all my colleagues and ex-students see me as the grandmother of a lively and dynamic girl who makes me feel both older and younger. And as we can all see I am still thinking hard about my experience working at the Portman, and am trying to construct theoretical models for it. So the creative work goes on and on.

Notes

1. Some new contributions to the understanding of perversion have been included in the published version of 'Dancing with Death', and the paper was prepared for publication by Ann Scott and Estela Welldon. Thanks are due to Angela Haselton, Deputy Librarian, Tavistock-Portman Foundation Trust Library, for assistance with the References.

2. The Portman is now the sister clinic of the Tavistock Clinic, but was not at that time. The two together now constitute an NHS Out-patient Trust.

3. The skin containing the self is further developed by Didier Houzel (1990) in a chapter in which he describes its genesis in the Freudian notion of the ego. Houzel emphasizes the containing structure, not just the contents of the psyche.

4. In preparing this paper for the conference I revisited Joyce McDougall's conceptualizations, in her book *The Many Faces of Eros* (1995). For those familiar with her work it may not come as a surprise how much I am influenced by her thoughts and how much we share similar findings and conceptualizations. She also mentions the protective shield some of her patients use in their daily lives, permitting them to accomplish many intellectual and other tasks. My countertransference regarding my patient could also be seen as a suffocating space in which my patient and myself are completely fused in Anzieu's (1990) term 'psychic envelope'. Tobie Nathan's 'Two dream representations of the ego-skin' offers a transferential–countertransferential phenomenon akin to my own situation. In his words: 'These patients clearly express in the transference the expectation of fusion, which is also displayed by manipulating the analyst's unconscious personality. They seem to surround the space of their session with a single "skin" wrapping patient and analyst in a single envelope. This characteristic often leads them into the phantasy of the pair of twins inside the maternal abdomen, surrounded by a single amniotic membrane' (Nathan 1990, p. 253).

5. I had actually felt he was not safe without me and he may have been unconsciously responding to this, from a fantasy that I *would* look after him. He experienced my interpretation as an offer of help, rather than as a symbolic comment. Now I would be more likely to say: 'It looks to me as if you don't feel safe', and then leave it open for him to make a further comment.

6. Republican Senator Larry Craig of Idaho was caught 'playing footsie with a cute guy' in the next cubicle in the men's room at Minneapolis-St. Paul International Airport in 2007. Senator Craig was a vociferous opponent of the gay movement and believed that a gay lifestyle was a threat to family values (Lewis 2007).

7. Governor Eliot Spitzer of New York, and former New York State Attorney-General, was revealed as a client of an international prostitution ring in 2008. 'Court papers hinted at risky sexual practices'. The revelation followed an FBI crackdown on the ring. Four years earlier, Eliot Spitzer had voiced revulsion as he announced the arrests of 16 people for running a prostitution ring out of Staten Island (Bone 2008).

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