The Perverse Subject of Analysis

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In this paper I suggest that the analysis of perversion necessarily involves the elaboration and analysis of a perverse transference-countertransference. Both analyst and analysand contribute to and participate in the perverse transference-countertransference which intersubjective construction is powerfully shaped by the perverse structure of the patient's unconscious internal object world. In the fragment of an analysis that is presented, I illustrate the way in which the analyst makes use of his experience in (of) the transference-countertransference in gaining understanding of the perverse scenario that the patient is utilizing as a form of psychic organization, defense, communication, and object relatedness. I discuss the analyst's use of his own unobtrusive, mundane thoughts, feelings, fantasies, ruminations, sensations, and so on, in the service of understanding the perverse transference-countertransference, which understanding is utilized in the formulation of transference interpretations.

The perversity of the transference-countertransference is viewed as deriving from the patient's defensive use of particular forms of sexualization as a way of protecting himself or herself against the experience of psychological deadness. Compulsive erotization is understood as representing a method of creating an illusory sense of vitality. The subversion of the recognition of the experience of psychological deadness is achieved in part through compulsively enlisting others in the enactment of exciting, erotized, and often dangerous substitutes for the experience of being alive.

It is by now widely accepted that the analysis of perversion is not fundamentally a process of decoding and interpreting the unconscious fantasies, anxieties, and defenses that are enacted in the perverse patient's sexual activity. Instead, it has become increasingly recognized that the analysis of perversion centrally involves the understanding and interpretation of

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transference phenomena that are structured by the patient's perverse internal object world (Malcolm, 1970; Meltzer, 1973). I believe it is important that this evolving understanding be developed a step further: in my view, the analysis of perversion necessarily involves the analysis of the perverse transference-countertransference as it unfolds in the analytic relationship.

In analyzing perversion, one cannot hope to understand what the patient is attempting to communicate without to some extent entering into the perverse scene that is being created in the transference-countertransference. As a result, an analyst attempting to write about the analysis of perversion must describe something of his own experience in (of) the perverse transference-countertransference; otherwise, he must content himself with presenting a desiccated, detached, and ultimately false picture of the analysis that fails to capture the experience of the Siren song of the perverse scene in which he has unwittingly participated.1

In this paper, I will illustrate, through a detailed clinical discussion, the way in which a form of perversity of the transference-countertransference derives from a core experience of psychological deadness. The story of this form of perversion is the fantasied history of the stillbirth of the self resulting from an unconsciously fantasied empty parental intercourse. It is a story that cannot be told (i.e., experienced by the subject) since the subject (as stillborn infant) is dead and therefore the very act of telling (creating) a story is a lie, a charade. Paradoxically, the lie and the recognition of its falsehood in the context of an analytic discourse is the only real locus of truth (the only experience that feels real to both analyst and analysand).

The type of perverse process that will be discussed is understood as centrally involving the subversion of the recognition of the psychological death of the subject (and of the emptiness of the analytic discourse in which he or she is engaged), and the replacement of

1 The perverse intersubjective constructions generated in the course of the analysis of perversion are, in my experience, inevitably (to a considerable degree) inaccessible to the analyst's conscious awareness as they are unfolding. It is therefore necessary for the analyst to “attempt to catch the drift of the patient's unconscious with his own unconscious” (Freud, 1923, p. 239). The analyst must in a sense come to understand the perverse transference-countertransference “after the fact,” i.e., in the course of his doing the psychological work required to become aware of his own unconscious experience of and participation in the perverse transference-countertransference.
this recognition with an illusory subject, the perverse subject of analysis. The perverse subject of analysis is the narrator of the erotized, but ultimately empty drama created on the analytic stage. The drama itself is designed to present the false impression that the narrator (the perverse subject) is alive in his or her power to excite. The perverse analytic scene and the perverse subject of analysis are jointly constructed by analyst and analysand for the purpose of evading the experience of psychological deadness and the recognition of the emptiness of the analytic discourse/intercourse. In a sense, the perverse subject of analysis constitutes a third analytic subject intersubjectively created by and experienced through the individual subjectivities of analyst and analysand in the context of their separate, but interrelated personality systems. Consequently, the jointly created intersubjective construction (the perverse subject) is experienced differently by analyst and analysand. (In a recent series of publications [Ogden, 1992a,b, 1994a,b,c,d, 1995], I have discussed the concept of the intersubjective analytic third as well as specific forms of the intersubjective third, such as the subjugating third of projective identification [Ogden, 1994c, d].)

Perversion of the transference-countertransference occurs in all analyses to different degrees. For some patients, it is the dominant form of analytic interaction, eclipsing all other modes of defense and object relatedness. For other patients, it is in ascendancy only in a specific phase or phases of analysis. For still other patients, perversity in (of) the transference-countertransference represents a background that presents itself primarily in the form of a well-disguised sexual excitement associated with unconscious efforts on the part of the patient to thwart the analysis in fundamental but difficult to recognize ways (e.g., the patient's unconscious excitement associated with his or her chronic inability/unwillingness to generate a single, original thought in the analysis [Ogden, 1994b]).

The understandings of perversion that will be discussed in the present paper rely heavily on ideas introduced by several analytic thinkers practicing in England and France. Khan (1979) has illuminated the way in which perversity represents a compulsively repeated effort to create experience that will disguise and partially substitute for the absence of a sense of being alive as a human being. McDougall (1978, 1986) has discussed the need of the perverse patient to
generate “neo-sexualities” in an effort to construct a self, albeit a self and a sexuality that is felt to be fragmentary, defensive, and unreal. Chasseguet-Smirgel (1984) has described the perverse patient as relying on omnipotent claims that there are no limits to what is possible sexually in an unconscious effort to shield himself from the frightening awareness of sexual and generational difference. Malcolm (1970) has clinically illustrated the idea that the analysis of perversion is not a matter of the dissection of the symbolism of deviant sexual acts, but the analysis of the experience of the perversion of the transference as it evolves in the analytic relationship (see also, Meltzer, 1973). More recently, Joseph (1994) has understood perverse sexual excitement in the analytic setting as a form of attack on the capacity of the analyst and analysand to think by means of a persistent sexualization of the transference and the act of thinking.

My focus in the clinical discussion that will follow will be on technical problems presented by the perversion of analytic intersubjectivity itself. I shall discuss the challenge to the analyst posed by his attempt to derive understanding of the perverse analytic process from his experience within it while still maintaining his capacity to think and speak to himself about it and eventually to discuss his understandings with the patient in the form of verbal interpretation. The clinical discussion will be followed by an effort to make a set of theoretical statements about aspects of the structure of perversion.

**CLINICAL ILLUSTRATION: THROUGH THE LOOKING GLASS**

Ms. A. began our first session by telling me that she had decided to consult with me because her marriage was a “sham.” She and her husband had not had sex for more than five years. The patient told me that what disturbed her most was that she recently realized that the situation did not bother her. In the past, everything mattered terribly, but now that she was middle aged (she was 43 years old), nothing seemed to matter. Her two children were in their late teens and had recently left home for college. It seemed to me that although Ms. A. was not lying to me during our initial several meetings, there was much more to the story of why she was seeking analysis.
than she was revealing. This, of course, is always the case, but I had the distinct impression that I was being kept in the dark about rather specific important matters about which Ms. A. was consciously aware. There was something about being with her that reminded me of watching (or in fantasy, being in) a detective movie. In particular, I thought of Jack Nicholson and Faye Dunaway in *Chinatown* and several movies with Humphrey Bogart and Lauren Bacall, the names of which I could not remember. I was intrigued by Ms. A. Her choice of words was imaginative and her way of speaking had a vitality that were at odds with her description of herself as a lifeless, middleaged woman.

In the course of the first year of analysis, Ms. A. told me about her childhood in Southern California. Her father was a real estate developer who very quickly became very wealthy and then was forced into bankruptcy as a result of a series of events that were not clear to Ms. A. The patient's father never let the fact of his past bankruptcy be known to friends and colleagues and kept up appearances for a period of more than a decade while he accumulated an even larger real estate “empire” than the one he had previously held. Following the rebuilding of his empire, most of Ms. A.'s father's friends, clients, and business partners were people associated with the film industry. Once or twice a month, the patient's parents would hold large parties at their home, events that constituted the center of the life of the family. Both parents seemed continually to be “consumed”: Ms. A.'s mother devoted herself to the preparations for the next party while the patient's father worked with “feverish intensity” on his next real estate deal.

At these social events at the patient's family's home, there was a great deal of heavy drinking and drug taking. Cross dressing and flaunting of “outrageous homosexuality” by some of the guests stood out vividly in the patient's memory. Ms. A. attended most of these parties and said that when she was not pretending to be an adult, she felt invisible (“as if there weren't a child present”). At times, she felt like a prop in one or another of the guests' displays of his or her “sensitivity to children.” At other times, she was treated as a “mock adult” in such a way that she felt that she was the brunt of a joke, the point of which she did not understand. Very often, she felt terribly bored by the “sheer predictability of it all: everyone could be counted on to be perfectly in role.”
Although the patient did not remember observing or being the object of overt sexual behavior, she said that she felt that there was “far too much kissing going on.” Ms. A. said that she learned over time that this type of kissing was a “social affectation.” Nonetheless, it felt “yucky” to her. The patient described these parties with a thinly disguised sense of pride. She would mention, in passing, names of famous film celebrities who were regular guests at the parties.

The image of the patient's parents that emerged from Ms. A.'s description of her childhood was one in which there seemed to be a couple single-mindedly together in the partnership of creating an illusion of being an integral part of an “in-crowd” of wealthy, glamorous people, while having almost nothing else to do with one another or with their children. The patient's mother suffered from chronic insomnia and other “nervous conditions.” In order not to disturb the patient's father, she would read during the night in the guest bedroom. It was not openly acknowledged that the parents kept separate bedrooms for virtually the entirety of their marriage. In fact, at the outset of analysis, Ms. A. herself was not fully conscious of her suspicion that her mother's “insomnia” was very likely a ruse for her parents' maintaining separate bedrooms.

A good deal of the manifest content of the first year and a half of analysis involved the elaboration of a narrative of the patient's life, particularly her childhood. Ms. A. spoke entertainingly, but left me very little room to comment on what she was saying. There were practically no periods of silence lasting longer than a few seconds. The patient was apologetic about the fact that she was unable to remember her dreams.

Ms. A. was not a beautiful woman in a conventional sense, but there was a compelling, subtle sexuality in almost everything she said and did. I looked forward to seeing her each day and enjoyed hearing her stories. The patient met me in the waiting room with a warm smile that conveyed the feeling that she was glad to see me, but was by no means desperately dependent on me. Ms. A. had a youthful independence about her that seemed to invite me to join her in her rebelliousness. She gave the impression that she just happened to be in the neighborhood and decided to drop by. At the same time, the patient adhered to the format of the analytic frame, rarely being
late, paying punctually, and addressing me as “Dr. Ogden” when on the rare occasion she left a telephone message.

Persistent fantasies included the idea of my having a serious physical illness the nature of which she felt I was hiding from her. There were also fears of breaches of confidentiality, for instance, anxiety that I would talk with her husband if he were to angrily accuse me of engaging in an endless analysis for my own benefit or of encouraging the patient to leave him. These fantasies were discussed at length, including the idea that I was not what I appeared to be and the idea that the patient might feel that she was deceiving me in some way. Moreover, the excitement of such a battle over the patient was discussed as well as the idea of my wishing to steal the patient away from her husband. However, these interpretations seemed mechanical to me. The flatness of these interpretations and the patient's response to them reflected a more general paucity in the analysis of reflective thought. The patient's cleverness and talent in telling an interesting story seemed to serve as a substitute for spontaneous, creative thinking. (I similarly felt the need to be clever and noticed that I would occasionally supply the name of a book or a poem that the patient had momentarily forgotten.)

I attempted to attend to my own “reveries” (Bion, 1962) during the sessions since I consider this aspect of the analytic experience to be indispensable to the understanding of the transference-countertransference (Ogden, 1989, 1994a,b,c,d, 1995). During one of these meetings, the patient was talking about having watched a television program with her husband the previous night. She described how the two of them had sat next to one another on their living room couch in a way that had felt to her like two strangers on a subway train sitting next to one another without the slightest feeling of connection between them. As Ms. A. was talking I found myself thinking about the fact that the attendant in the parking lot immediately next to my office building had begun making preparations to open a car wash in the parking lot. He had recently purchased a commercial vacuum cleaner that made a deafening noise when it was being used. His girlfriend, whom I found to be brassy and abrasive, was helping with the project. I imagined calling City Hall to file a complaint about violations of zoning ordinances concerning noise. Were there such ordinances? How could there not be? Is there
nobody at City Hall with whom I could discuss this? There must be some kind of appeals process. I became increasingly anxious as I imagined this unreasonable, unapproachable couple and the bureaucratic maze at City Hall with nobody at the center of it.

As I emerged from this increasingly ruminative set of thoughts, feelings, and sensations, I was struck by the intensity of the anxiety that I was feeling. I wondered about the parallels between the couple in the parking lot and the patient's parents, each pair with their plans that neither the patient nor I had the power to influence. I hypothesized that the idea of the frightening, disturbing noise of the vacuum cleaner might be related to a fantasy of noise coming from the parents' bedroom, the disturbing noise of an intercourse that was both empty (a vacuum) and consuming (sucking into it the patient's internal object world). My hypotheses concerning the connection between the elements of the reverie and my experience in being with the patient seemed strained and intellectualized. Nevertheless, the reverie left me feeling extremely uneasy and alerted me to the fact that I was feeling disturbed by something that was occurring between the patient and me.

In the period of months following the session just described, I very gradually began to recognize a sense of pride that I had begun to take in the idea that other people might know that I was Ms. A.'s analyst. I both took pleasure in this fantasy and felt deeply ashamed of it (and managed to keep it out of conscious awareness almost completely). Ms. A. wore a great many different hats, coats, and scarves and I found myself feeling interested in what she would be wearing to each day's session. As she entered the office, she would lay her coat on the floor next to the couch (almost at my feet). The designer label would often be in view and I would have to strain to attempt to read it (upside down). (I should emphasize that the

2 Since it requires a considerable span of time to describe the experience of a reverie, the rhythm of the analysis is not well represented in my efforts at describing it in a linear fashion. The thoughts, feelings, and sensations involved in a reverie may occupy only a few moments. Consequently, it is inaccurate to think of the analyst's use of his reveries as reflecting a detached, self-absorbed, inattentive psychological state. On the contrary, the analyst's attentiveness to his own affective state as generated in the context of the analytic intersubjectivity contributes to a feeling of intense emotional immediacy and a sense of the analyst's resonance with the patient's unconscious experience in the present moment.

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countertransference feelings that I am describing comprised a silent background that had not yet become a focus of conscious analysis. In other words, these aspects of the analysis had not yet become “analytic objects” [Bion, 1962; Green, 1975; Ogden, 1994a,b,c, 1995], i.e., elements of intersubjective experience that were utilizable in the process of generating analytic meaning. Instead, this set of thoughts, feelings, and sensations remained a part of a largely unconscious intersubjective field in which I was, at that juncture, more participant than observer.)

It is often difficult to say what contributes to a shift in the balance of psychological-interpersonal forces that makes such background experience available for conscious use as analytic data. In the phase of work under discussion, it was in part a further set of anxiety-laden reveries (in association with the reveries previously described) that allowed aspects of heretofore largely unconscious background experience to begin to be transformed into “analytic objects.” Initially, my anxiety was diffuse and centered on feeling that I would be forgetful. I experienced a sense of pressure to remember to send a card to a relative whose birthday was approaching. I had changed a patient's appointment time and felt anxious that I would not be there at the correct time. I noticed that these passing thoughts during the session with Ms. A. were related to the feeling that there were “holes” in my consciousness. I wondered what it was that I was blinding myself to in the work with Ms. A. The anxiety was now real and immediate, although nonspecific; its meaning in relation to the leading unconscious transference anxieties was still unclear to me. However, a shift in the quality of my self-awareness in the transference-countertransference was taking place.

Over the succeeding weeks of analysis, my anxiety took on increasing specificity. I began to experience anxiety just before the meetings with Ms. A., feeling extremely awkward and self-conscious. Meeting her in the waiting room felt like the beginning of a date.

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I use the term countertransference to refer to the analyst's experience of the transference-countertransference. As discussed above, the transference-countertransference is understood as an unconscious intersubjective construction experienced separately and individually by analyst and analysand. I do not conceive of transference and countertransference as separable psychological entities that arise independently of or in response to one another, but as aspects of a single intersubjective totality (Loewald, 1986; Ogden, 1994a,d).
Ms. A. seemed not to be experiencing anxiety of this sort and, if anything, appeared to be all the more graceful and fluid in her way of carrying herself, speaking, dressing, and so on.

It was during this period of analysis that the patient presented the following dream:

An old man was sitting in his study reading. It was like your office, but it wasn't actually your office. It was dark and had a dank, seedy feeling to it. People were peering through the window at him. I was one of them. It was terribly important to be perfectly still so as not to be caught. I was afraid I would pee. He seemed like a depressed, dirty old man. I thought he was only pretending to read or forcing himself to read. I also had the feeling that he was trying to turn himself on sexually by reading, but it wasn't working. I'm not sure if I thought this in the dream or as I was waking up, but it felt as if he knew how badly I needed to pee.

It was at this point that the very disturbing thought occurred to me that Ms. A. must have been watching me watch her. (The dream was about the excitement of secretly observing and about being observed in the act of secretly and excitedly watching and about the uncertainty of who was observing whom.) She must know that I had tried to read the labels on her coats that she had draped at my feet. How long had she known? I felt intense embarrassment at the idea of having been observed looking. Everything seemed to have suddenly and unexpectedly been reversed: what had been private had become public; what had felt like simple curiosity had become prurient interest; the patient's nonchalance had taken on a feeling of manipulative control; what had felt like intimacy now felt like an experience of having been played for a fool.

For a moment, it seemed to me as if a trap had been carefully set and I had sprung it, but I also understood that I had been a part of setting it. My having sprung the trap was not the thing that was the most humiliating part of all this to me. My feelings of embarrassment centered on the idea that I had sprung the trap long ago and had been unaware of it. I felt as if my own looking (which now felt like voyeurism) had been observed at every step. My secret had never been a secret. In addition, there was an intense feeling of betrayal.

I could now fully acknowledge to myself for the first time that I had unconsciously felt pride, pleasure, and guilt at having been
included in an erotized duet with Ms. A. In the instant of recognition that I am describing, the experience of playing a role in this scene became transformed from an experience in which I had felt like an adult into an experience of myself as caught in the act of being a self-deceiving infant or child. My immaturity had been unmasked. I felt outside of adult sexuality with my nose pressed against the glass as represented in the dream by the patient peering through the window in the dream while experiencing an infantile (urinary) form of sexual excitement.

At this juncture, I began to be able to talk to myself in a fuller way about my experience in the transference-countertransference. It seemed that a shared unconscious construction had been created in the analysis through which the patient had been giving shape to important aspects of her internal object world. It appeared that the intense embarrassment that I was feeling represented a disavowed and projected version of the patient's humiliation at finding herself to be an infantile onlooker in relation to her parents' (degraded) intercourse (which was in part equated with “the parties”). (Less consciously, the parents were felt to be excitedly observing her excitement.) I had experienced both the illusion/delusion of being a participant in the parental intercourse and the humiliation of being revealed to be only an infant who was excitedly pretending to be part of the primal scene.

Ms. A. and I in the (asymmetrically) shared experience of this transference-countertransference drama, had each in our own way insisted that we were not the outsider to the parental intercourse, but were “really” adults participating in it. At this point, I began to understand the patient's dream as reflecting an aspect of Ms. A.'s internal object world about which I had been only subliminally aware: the image of the intercourse in the dream was of a dead intercourse. The old man (simultaneously representing me, the patient's internal world, and the analytic relationship) was depressed and lonely, going through the motions of reading or perhaps attempting to escape his depression by means of solitary, empty sexual excitement.

As I “emerged” from my reverie and subsequent thoughts, I attempted to refocus on what the patient was saying. Of course, I was not returning to “a place where we had left off,” but to a “place”
that had not previously existed. Ms. A. at first spoke about her dream by connecting her perennial fears of my being ill with the fact that in the dream, the illness was a depression. She then said that the dream reminded her of something that had happened in the waiting room at the beginning of the session. She told me that she had looked at me to see if I was tired or sick by checking to see if I had dark circles under my eyes. She had hoped that I had not seen her looking at me “in that way.”

The patient then abruptly changed the topic. I asked her if she had felt anxious when she cut herself off in the middle of her observations and feelings about what she had observed in the waiting room. She said, “I feel all over the place. It felt dangerous to be so specific about looking at you.” (It seemed to me that the patient was unconsciously attempting [in an anxious and ambivalent way] to talk to me about the dangers of the exciting drama of looking and being looked at that had been enacted in the analysis and which were being depicted in the dream.)

I said that I thought that Ms. A. had experienced herself as being in more than one place at the same time in the dream and perhaps also in the relationship with me. Although she had in part experienced herself as one of the people looking through the window, it seemed to me that she was also identified with the dirty old man in my office and was observing him in the act of excitedly watching her. (The connection between the old man and me in the dream was so apparent that I did not feel it necessary to spell it out.)

I said to Ms. A. that she had linked the dream to her having stolen a look at me in the waiting room. I told her that I thought that for some time, she had both wanted me to understand and was afraid that I would understand the importance of a particular type of secretive looking that felt shameful to her. I said that I thought that she was trying to show me in the dream that she felt that an aspect of our relationship involved a kind of excitement that was connected with the experience of secretly looking and being caught in the act of excitedly watching. (I chose not to be more specific at this moment about the enactments in the analytic setting in order not to enter into another form of sadomasochistic activity.) The interpretation led to a palpable sense of relief on the part of both the patient and myself. Ms. A. was silent for several minutes after I
made my comments (the first period of extended silence that had occurred in the analysis). During the silence, I felt relaxed in a way that I had not previously felt with Ms. A.

The patient then told me that what I had said had made her feel “understood, but not exposed, if that distinction makes sense.” She said she would have expected to have felt painfully embarrassed by having this aspect of her spoken about by me. She was silent for the remaining few minutes of the session.

Ms. A. began the following meeting by saying that she had had a dream the previous night. In it she was herself as a child. She woke up in the dream to find that she had polio (a disease about which she had been quite phobic from the time she was a small child). On waking (in the dream) she could not move her legs, nor did she have any feelings in them. She was both extremely frightened and surprisingly calm. She imagined that she would never again be able to move her legs or have sensation in them.

The patient said that she felt the dream was a response to what had happened in our session the previous day. She said that the dream had been quiet in a way that reminded her of the silences in our meeting. The feeling in the dream was also a very odd combination of terror and relief connected with the fact that the thing that she had most feared had finally happened. I thought of Winnicott's (1974) notion that the dreaded event (the fear of breakdown) is an event that has already occurred, but has not yet been experienced. I also thought, but did not say, that the patient's emotional/sensory deadness (paralysis and loss of sensation) was beginning to be acknowledged without immediately being buried in entertaining stories: the silence for the moment, was not being filled with noise. It seemed that the patient was evidencing the rudiments of the capacity to observe and to be able to think about what she was experiencing, i.e., her sense of deadness. There was for now an aspect of her (represented by the sensing/nonparalyzed part of her in the dream) that paradoxically could feel the deadness of another aspect of her and experience the lie (the noise) as a lie.

It is not possible in the space of this paper to describe in detail the events of the analysis over the succeeding months and years. The transference-countertransference shift just described was followed by a discussion of the central role in the analysis of the patient's
experience of secretly looking at me in a sexually exciting way and her fantasy of secretly, excitedly, dangerously observing me in the act of excitedly observing her. Gradually, in the course of this period of work, details of the acting in (for example, the patient's observing me observe her laying her clothes at my feet) were discussed. Again, these discussions were not conducted in a way that served to create the effect of an embarrassing/exciting undressing of the patient, the analyst, or the analysis. Instead, the predominant feeling was that of the patient's loneliness and hopelessness about ever being able to experience herself as other than a “made-up person.”

Ms. A. began to understand the ways in which the elements of the perverse defense had been invaluable in protecting her from an experience of deadness that she had feared would be unbearable. In the course of the analysis, the patient described aspects of her life to which she had previously alluded, but had hardly existed in the analysis as “analytic objects,” i.e., as events that carried meaning that could be experienced, noticed, considered, and thought about in the context of the network of meanings that were being elaborated. It would be inaccurate to say that these perceptions of past events had been unconscious or had been consciously withheld; rather, these largely unspoken aspects of her life (that will be discussed) had felt so disconnected from the entertaining storytelling that “it just never occurred to me to talk about these things.” (See Freud [1927] for a discussion of the process of radical psychic disconnection involved in perversion. An analogous form of splitting was reflected in the countertransference experience of being “in the dark,” “flying blind,” and having “holes” in my consciousness.)

Over time, Ms. A. told me that from the time she was a child, she felt “consumed” by the need to get people, both boys and girls, men and women, to find her mysterious and sexy. It became a “fullblown obsession” in high school to get boys to chase her.” “Everywhere I was and in everything I did, I was looking out of the corner of my eye to see who was looking at me.”

Ms. A. had been extremely promiscuous in adolescence. In high school, she thought of herself as a “liberated rebel,” but it became distressing over time to feel that she was driven by something that she could not control. Moreover, she was unable to speak to anyone about feeling out of control, which led her to feel intensely lonely.
Ms. A. attempted to compensate for her sense of isolation by never being alone. She recalled talking with friends in college well into the night until they finally fell asleep, at which point the patient would sleep on their floor.

During this period of promiscuity and isolation, the patient was almost completely unable to think or talk with herself or with anyone else about what was happening to her. Instead, what might have become a thought or a feeling was experienced as extreme muscular tension in combination with a variety of psychosomatic illnesses including chronic amenorrhea, dermatitis, and severe headaches. Ms. A. said that she was unable to read or concentrate and managed her schoolwork by frequently cheating on exams and plagiarizing the work of other students. The cheating itself became exciting. Ms. A. took pleasure in “showing off” to her friends the risks that she was taking.

The patient said that she felt a mixture of shame and pride as she told me about her exploits. She said that what made it easy to be so daring was that, “I genuinely did not give a shit if I were caught. What could they do to me?” Ms. A.’s choice of words surprised me in that she had not previously used scatological language. I wondered (silently) if she imagined that not having a body that needed to engage in ordinary human functions such as defecation (“not giving a shit”) would provide her with a way of escaping from the emotional and bodily trap in which she felt caught and in danger of being physically killed. I later suggested (in small bits over several weeks) that Ms. A. was indirectly telling me that her defiant claim to be alive “outside of the system” (beyond the law and outside of her body), had been for a long time an important way of attempting to protect herself from being taken over by the internal lives of other people. I said that it seemed that she had felt terribly privileged and special while at the same time feeling as if she were ceasing “to be anybody.” The patient began to recognize the profound confusion that she had felt about whose desire it was that was fueling her wish/need to be at the parties. It no longer seemed possible to separate out in any meaningful way her own desires from those of others. The transference implications of these recognitions were explored including the confusion about whose sexual excitement was whose in the dream as well as in the transference-countertransference events that had occurred in the analysis.
In discussing this set of feelings, the patient became aware of the way in which it had served her defensively to create the illusion that the power to “do anything” she wished set her apart from everyone else. The anxiety associated with the confusion of not knowing whose desire it was that she was experiencing was somewhat allayed by the illusion that she “occupied a different universe from everyone else.” Ms. A. came to understand that hidden by her sense of power was an unconscious feeling of impotence (paralysis) to think, feel, and behave outside of the terms of her exploits, machinations, and manipulations. Hers was a world of unreflective action and reaction. Ms. A. said that there had been periods of her life, especially during the latter years of college, during which she had for brief periods recognized the bizarre nature of the way she was living and felt horrified by it and deeply ashamed of it. Although she had a great many sexual experiences, she felt bored by the sex. During intercourse she felt as if she were watching what was happening in a way that felt like “watching a television program that wasn’t very interesting.” Ms. A. at times became disturbingly aware of the inhuman quality of this and other aspects of her life. However, the feeling of despair associated with these moments of self-awareness was short-lived.

During the phase of work in which this narrative and set of understandings unfolded, I felt an increasing sense of continuity between the content of Ms. A.’s verbal symbolization and the matrix of the transference-countertransference (Ogden, 1991). The initial years of the analysis had in retrospect been marked by a discontinuity of manifest and latent, of verbal content and experiential context. The manifest and acknowledged aspect of the analytic relationship had been quite disconnected from a troubling, exciting “second narrative” that resisted symbolization, and instead remained a powerful, erotized (predominantly unconscious) intersubjective construction.

**DISCUSSION**

Ms. A.’s very first statement to me was about her marriage (unconsciously, her life) being a “sham.” It took a long time for me to
understand in any depth what it was that she was unconsciously attempting to
tell me. From the outset, there was a subliminal seductive coyness to Ms. A.'s
presentation of herself. There was also a quality of mystery conveyed by all
that was not being said, which contributed to my feeling of being “in the
dark,” perhaps unconsciously in a darkened bedroom. In retrospect, my initial
thoughts about the patient and me as characters in a detective film can be
understood as a reflection of my then unconscious sense that the analytic
relationship was being constructed on a foundation involving a confusing
mixture of grandiose erotized fantasy, prevarication, self-deception, and the
background theme of a perverse primal scene (the sadomasochistic incestuous
relationship depicted in *Chinatown*).

I had found the patient's accounts of her childhood (her stories) to be not
only interesting, but often fascinating. There was a way in which the patient
continued to be captivated (and captivating) by her experience of having
occupied a privileged position in which she could pose as a child while not
feeling like a child in a secret world of adult sexual excitement and
exhibitionism. She observed and participated in (from a distance) the
“parties” (that were unconsciously equated with the primal scene). The
patient felt that no ordinary child would be allowed to have knowledge of,
much less see, hear, smell or touch these extraordinary events. Ms. A.
imagined that she knew important and frightening secrets, for example, the
secret of her father's financial, sexual, emotional bankruptcy, and the secret
that some people had succeeded in remaining both male and female, as
represented by the homosexuality and cross-dressing that she observed and
vividly remembered.

Less conscious to the patient in her initial accounts of her childhood was
the central role of the illusion of her not being “only a child,” and instead
being a part of an adult intercourse in which, in identification with the
homosexual and transvestite figures, she was not limited to being a member
of a single sex nor fixed in a single generation (*see Chasseguet-Smirgel, 1984*).

As exciting as Ms. A. found the adult discourse/intercourse which she
observed and in which she in fantasy participated, the intercourse was at the
same time experienced as dead. The patient unconsciously knew of her
parents' separate sleeping arrangements and sensed the emptiness of the
partially drug-induced, hypomanic,
exhibitionistic sexual scene which she found to be frightening, repulsive, other worldly, and yet repetitive and tedious. This paradoxical flatness of the “exciting” experience represented a powerful element of the transference-countertransference. Both the patient and I attempted to disguise and enliven the persistent absence of spontaneous thought in the analysis with unconsciously erotized cleverness, for example, the pressure to which both the patient and I were responding in our name dropping and in the effort to use “just the right, knowing phrase.”

My reverie about the opening of the car wash in the parking lot provided an important medium through which to experience elements of the transference-countertransference that had been present from early on, but had been very little available to either Ms. A. or to me for generating verbally symbolized analytic meaning. My reverie involved the fantasy of a loud vacuum cleaner being operated by a diabolical couple from whom I was helplessly cut off. The couple seemed to operate in a realm that was above the law and beyond the reach of words and human emotion. In the reverie, not only was there no law at City Hall, there was no human presence at its core.

This reverie represented an important development in the evolution of the analytic process in that it allowed me something of a foothold in a perspective that was both outside of and yet informed by the intersubjective construction in which I was participating (the perverse subject of analysis).

The meaning of the “car wash reverie” felt quite disconnected from my experience in the transference-countertransference, and yet the reverie had a profoundly disturbing effect on me and led me to be alert in a qualitatively different way to what I was experiencing with this patient. I began to notice, with a considerable degree of shame, both the pride that I was feeling in being Ms. A.’s analyst (the pleasure in “being seen with her”) and the pleasure I was taking in observing her clothes that were being laid at my feet. At the same time, I became aware of the feeling of a “hole” or blind spot in my awareness that made me feel all the more that I was blinding myself to something important in my role as analyst for Ms. A. (See Steiner [1985], for a discussion of the meanings of “turning a blind eye” in the Oedipus myth.)
The accretion of experiences that I have described led the rather diffuse anxiety that I had been experiencing to be transformed into a much more clearly defined and consciously articulated sexual anxiety associated with seeing and being seen. I experienced this anxiety in the form of the unsettling (conscious) fantasy that each time I encountered Ms. A. in the waiting room I was meeting her for a date.

The patient's telling me her dream of the observed man served to crystallize several powerful unconscious constellations of meaning that had structured the experience of the transference-countertransference to that point. Despite my feeling of sudden recognition, my awareness of the pivotal importance of the experience of secretly observing and being observed had been developing over a rather long period of time (as reflected in my reveries). When the patient told me her dream, a marked affective shift occurred. What I had previously experienced as ideas about erotized observing and being observed now became a detailed, visceral knowledge of the experience of being caught in the act of a particular form of curious, sexualized looking. The nature of the exposure involved in this transference-countertransference event was the exposure of the infant/child excitedly observing (and in fantasy participating in) the primal scene. My feelings of shame associated with this act derived in large part from the feeling of being revealed to be a presumptuous and self-deceptive infant/child pretending to be an adult participant in the primal scene.

The transference-countertransference experience being discussed was not simply an experience of being painfully exposed; it was equally an (unconscious) experience of excitedly tempting the observer and then exposing the observer to be the excluded infant/child that he or she is. Fundamental to the patient's experience of “catching the observer in the act” was her defensive disavowal, splitting off, and projection of her feelings of being the envious, excluded, curious, sexually aroused, self-deceptive infant. Moreover, Ms. A.'s act of tempting me in the way described was a source of excitement in itself in that there was the ever-present danger of her being “caught in the act” of secretly observing me observing her. It must be remembered that all of this was occurring in the context of what was otherwise a dead discourse/intercourse (non-self-reflective...
“reporting” and “storytelling” that was almost entirely devoid of spontaneous, creative thought). In this light, the “excitement” of the exciting/dangerous game being described represented an unconscious effort to create a substitute for a genuinely creative discourse/intercourse. The patient's dream imagery underscored the deadness of the intercourse: the depressed old man in a dark room was only going through the motions of reading and was (unsuccessfully) attempting to use sexual excitement to distract himself from his emptiness and depression. The excitement/danger in the dream (partially experienced as the sensation of being on the verge of involuntary urination) lay in the act of secretly observing the man (his symbolic intercourse) and in secretly being observed in the act of observing. The interpretations that I offered at this point were informed by my experiences in and of the perverse transference-countertransference, which experiences allowed me to understand and feel compassion for both the exposed and exposing aspects of the internal object relationship that so dominated the patient's life and the life of the analysis.

The patient then became engaged in the process of “retelling a life” (Schäfer, 1994), not in the sense of telling it again, but in the sense of recasting the past in the context of a new set of intersubjective experiences that had occurred in the transference-countertransference and were in the process of occurring in the analysis. A new narrative was generated by the patient that held a form of coherence of past and present that was rooted in a less fearful, less anxiously self-deceptive experience of herself and her relations with others. In this period of work, Ms. A. evidenced a capacity for reflective thought. Words were no longer primarily a medium for creating a Siren song and instead were used as a vehicle for participating in an analytic discourse shaped by the recognition of roles of analyst and analysand. In addition, the patient evidenced for the first time, the beginnings of a capacity to contain (live with) her fear of deadness (as represented in her dream of being paralyzed and without sensation in her legs) that she had so strenuously attempted to masquerade through the use of defensive sexualization. Silence could now be tolerated rather than being immediately transformed into the “noise” of the erotized, magnetic storytelling.
At the same time, it must be emphasized that the analytic movement being
described reflects only the beginnings of what would eventually become a
more stable set of psychological changes. The defensive pseudomaturity
involved in the perverse excitement of the initial stages of analysis were
followed by other forms of defense against the feeling of humiliation of being
“only an infant” in a confusing/frightening/exciting/dead adult world. For
example, in the course of Ms. A.’s telling me about the ways in which she felt
“possessed” in adolescence and as a young adult, the transference (as “total
situation” [Klein, 1952; Joseph, 1985; Ogden, 1991]) involved a sense of
anxiously pressured collegiality in which there was an effort to deny
generational and role differences in the analytic relationship. Moreover,
intellectualization was used to protect the patient from feelings of not
knowing, of “being in the dark.” Although the transference anxieties being
warded off were similar in nature to those experienced in the earlier stages of
work, the perversion of the transference-countertransference no longer
constituted the principal medium of communication, defense, and object
relatedness.

Before leaving the clinical portion of this paper, I would like to briefly
elaborate an idea that has been implicit in the foregoing discussion. An
element of technique that is reflected in the analysis that has been described,
is the analyst's use of his mundane, unobtrusive, quotidian thoughts, feelings,
sensations, fantasies, daydreams, ruminations and so on in the process of
attempting to understand the network of intersubjectively generated meanings
constituting the transference-countertransference. The experience of
understanding that evolved in the portion of the analysis just described had the
quality of a disturbing recognition, a sense of sudden reversal. This quality of
psychological movement (i.e., an unsettling recognition of a formerly split-off
unconscious discourse) reflected the nature of the perverse process and its
precarious, potentially explosive tension between honesty and deception,
intimacy and manipulation, the authentic and the counterfeit. It is important to
bear in mind that the use of reverie in the understanding of the
transference-countertransference is usually a much “quieter” process and does
not often lead to such dramatic shifts in perspective or feelings of shameful
self-deception.
SOME THEORETICAL COMMENTS

Building upon the understanding of aspects of the perverse transference-countertransference discussed above, as well as my experience in analyzing similar transference-countertransference enactments in work with other patients (Ogden, 1994b), I shall offer some tentative thoughts about what I believe to be important elements of the structure of this form of perversion. The perverse individual of the type being discussed, experiences a sense of inner deadness, a lack of a sense of being alive as a human being (Khan, 1979; McDougall, 1978, 1986). At the same time, there develops a set of concretely symbolized defensive fantasies that life exists in the intercourse (both sexual and nonsexual) between the parents and that the only way to “acquire” life is to enter into that intercourse (the source of life) from which the individual is excluded and left lifeless (Klein, 1926, 1928; Meltzer, 1973; Britton, 1989; O'Shaughnessy, 1989). Of course, in a literal way, it is the parental intercourse that is the source of the patient's life, but this biological fact has for the perverse patient failed to become a psychological fact.

At the same time, these perverse patients fantasize/experience the parental intercourse (in the broadest sense of the word) to be an empty event, and imagine that the lifelessness of the primal scene is the source of his or her own sense of inner deadness. In part, this fantasy is based on the patient's own envious attack on the parental intercourse. It also reflects the patient's experience (a combination of perception and fantasy) of the emptiness of the bond between the parents. This perception/fantasy of an absence at the core of human discourse/intercourse leaves these perverse individuals feeling that there is no hope of attaining a sense of vitality of their own internal world and in their relations with external objects. What is particular to perversion of the sort being discussed is the compulsive erotization of the void that is felt to lie at the center of what might have been, and pretends to be, a generative union between the parents. The excitement generated by this erotization is used as a substitute for a sense of one's own human aliveness as well as the recognition of the humanness of other people. This erotic substitution is unconsciously experienced as a lie, and other people are compulsively enlisted in the enactment of this sexualized lie.
The unconsciously fantasied empty parental intercourse is defensively rendered exciting in part by attributing to it the feeling of danger. These perverse patients repeatedly and compulsively enlist others in the process of enacting the fantasy of entering into the parental intercourse which enactments are felt to involve a threat to the patient's life (McDougall, 1986). There is at the same time a critical act of self-deception that allows the patient to isolate himself from awareness of the reality of the danger to which he is subjecting himself. The individual deludes himself and prides himself in his belief that he is able to “fly closer to the flame” than anybody else without being damaged. He or she believes him- or herself to be immune to all danger while at the same time being intensely excited by it. The desperate need to extract life from and infuse life into the empty parental intercourse leads the patient to flaunt external reality and unconsciously claim to exist outside of the law, including both the laws of society and the laws of nature (Chasseguet-Smirgel, 1984). Since the individual's psychological life has in a sense already been lost, or more accurately, has never come into being, there is a certain reality to the idea that he has nothing to lose.

The foregoing comments might be briefly stated in the form of the following set of schematic propositions:

1. In healthy development a sense of oneself as alive is equated with a generative loving parental intercourse. Out of this intercourse comes a feeling of aliveness from which the patient derives a sense of the vitality and realness of his or her own thoughts, feelings, sensations, subjectivity, object relations and so on.

2. Perversion of the type being discussed represents an endless, futile effort to extract life from a primal scene that is experienced as dead.

3. Perversion of this sort involves a form of excitement derived from the cynical subversion of the (purported) truth of the aliveness of the parental intercourse which source of vitality is felt to be inaccessible and probably nonexistent. In other words, the seemingly generative, loving parental intercourse is felt to be a lie, a hoax. These perverse individuals introject a fantasied degraded intercourse and subsequently engage others in a compulsively repeated acting out of this set of internal object relationships.
4. In this form of perversion, a vicious cycle is generated in which the fantasied intercourse of the parents is depicted as loveless, lifeless, and nonprocreative; the patient attempts in vain to infuse it with pseudoexcitement from which he or she attempts to extract life (or more accurately, attempts to create a substitute for life). Since the fantasied parental intercourse from which the perverse patient is attempting to extract life is experienced as dead, he or she is attempting to extract life from death, truth from falsehood. Alternatively, the patient may attempt to use the lie as a substitute for truth/life (Chasseguet-Smirgel, 1984).

5. An important method of attempting to infuse the empty primal scene with life (excitement and other substitutes for feelings of aliveness) is the experience of “flirting with danger,” tempting fate by “flying too close to the flame.”

6. The desire of these perverse individuals is co-opted by and confused with the desire of others leading them more deeply into defensive misrecognitions and misnamings of their experience in order to create the illusion of self-generated desire (Ogden, 1988).

7. Analysis of perversion, as clinically illustrated in this paper, fundamentally involves recognizing (naming accurately) the lie-lifelessness that constitutes the core of the transference-countertransference enactment of the perversion. In this way, the patient, perhaps for the first time in his or her life, feels engaged in a discourse that is experienced as alive and real.

8. The initial feelings of aliveness and realness in the analysis arise from the recognition of the lifelessness/lie of the transference-countertransference and consequently are most often frightening feelings of deadness. This experience is different from the deadness of the lifelessness/lie that had not been recognized as a lie and which had been masquerading as truth. Formerly, the lie (the empty intercourse) had to be infused with false/perverse excitement in an effort to bring life to it and acquire life from it. The recognition of the lie is not an experience of sexual excitement but makes possible a state of mind in which sexual aliveness (in the context of whole object relations) and generative thinking and discourse might be experienced.
CONCLUDING COMMENTS

In this paper, I have clinically illustrated the way in which the analysis of perversion necessarily involves the elaboration of an unconscious perverse transference-countertransference which is contributed to and participated in by both analyst and analysand. This intersubjective construction is powerfully shaped by the perverse structure of the patient's unconscious internal object world. The analyst's understanding of the perverse enactment in which he or she is an unwitting participant is developed in part through the elaboration and analysis of unobtrusive quotidian thoughts, feelings, fantasies, daydreams, ruminations, sensations, and so on, which are often seemingly unrelated to the patient. Understandings developed in this way are utilized in the process of the formulation of transference interpretations.

REFERENCES


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