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A Counselling Psychology Perspective on the Challenges Inherent in the Treatment of Perversions

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Top-Up Doctorate in Counselling Psychology

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December 2014

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Declaration

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To my father Emilios

He lived at the frontiers of an indetermined age

And died for distant things

He once saw in an uncertain dream

Tassos Leivaditis

Aknowledgments

Every single part of this portfolio would have been impossible without the support, encouragement and contribution of many people. I would like to thank therefore, my patients who became the source of inspiration, Helen Morgan, the most influential of all my training supervisors, who was there to guide me and support me during my first therapeutic work with a perverse patient, Evi Papastefanou, my current clinical supervisor who with her warmth, openness and experience allows me to continue to develop my therapeutic identity and skills and Dr. Rawson, my research supervisor, who helped me built my research identity and discover my own voice. I am also greatly indebted to the participants of this study. Without their openness and honesty this thesis would have never existed. Finally, during this challenging experience, I was blessed with friends and family whose continuous encouragement has helped me to go through with it. Kassy and Elena were precious co-travellers during this whole adventure; their constant emotional and academic support made this thesis a reality. Elen and Yianna, with our endless discussions on the personal meaning of the thesis, helped me overcome occasional resistances and identify my biases. Georgia and Nikos with their humour and realistic attitude helped me in times of crises. Anna was a living example of the phenomenological attitude and Yannis restored my creativity and motivation soon after my father's death and made it possible for me to go through the final stages of this project. And as always, a warm and sincere "thank you" to my parents; to my mother, Anastasia, for her belief in me and her lovely food which nourished me in more ways than she could imagine and to my father Emilios who, as if he wanted to make sure that I would finish this thesis, fought with cancer and held on to life literally until the final word of it was written.

Preface

The present portfolio represents my theoretical, therapeutic and research interest in perversions and has as its goal to sensitise counselling psychologists to the challenges and complexities involved in the treatment of this client group. The central piece of work in this portfolio is the research component titled *Therapists' Countertransference Experiences When Working with Perverse Patients: An Interpretative Phenomenological Analysis.* The inspiration for this particular topic emerged directly out of my clinical work and dates back to my early training years and to my therapeutic work with Peter.

Being an inexperienced trainee when I met Peter, I had little visceral understanding of the deeper meaning of the therapeutic relationship. The idea that it is this relationship that becomes the agent of change was just an intellectual knowledge I had acquired reading Clarkson's famous book The Therapeutic Relationship (1993) and Roger's (1959) seminal paper on the Necessary and Sufficient Conditions of Therapeutic Change. At the same time, I had only read about terms such as transference and countertransference in introductory undergraduate texts on psychoanalysis and I had not really experienced in person their powerful impact on the therapeutic relationship. My therapeutic encounter with Peter changed all the above once and for all. In my effort to understand his difficulties and struggling to survive in the relationship, I was at the same time being shaped into a psychodynamic oriented counselling psychologist with a strong interest in countertransference phenomena when working with perverse patients.

Peter, a man in his mid thirties, presented to therapy with depression and complained of extreme isolation and an inability to form any type of relationship. Despite his desperate efforts to bring me into his world and his talking with great anguish about his loneliness, I was fundamentally non-existent; I experienced tremendous difficulty in formulating thoughts, could not find the words to respond to his torment, or indeed sense any feeling in his presence. His story was one of extreme isolation, with older parents who could not connect with him emotionally, and friends who after a few meetings tended to disappear. The first six months of therapy passed with him recounting his story and me desperately trying to relate to him. Yet,

something that would give meaning to this profound difficulty in relating to each other was missing.

It was with great embarrassment and pain that he disclosed to me his "disgusting perversion"; he was sexually aroused by wearing women's clothes. This disclosure introduced us to a new era in therapy, during which he recounted his sexual difficulties from childhood onwards, his extreme exposure to pornography, and his lack of any sexual experiences. What initially appeared to be the strengthening of a working alliance was soon transformed into a sadomasochistic relationship, in which I felt like a sexual object to be abused. The more he explored his sexuality the more hostile he became and I felt I had no right to have thoughts of my own, or a voice that could comment on the drama that was unfolding between us.

The first summer break became another turning point in the therapy, with him experiencing for the first time feelings of abandonment, and desperation in my absence, and me for the first time actually being able to empathise with him on a deeper level. I had started existing in the room, and my empathic reflections were allowed to be verbalised and to reach him. An erotic transference developed which allowed us to explore his relationship with his mother and his need to be held in a significant other's mind. I felt cruel in my analytic way of working through his erotic transference, but strangely alive in the room and optimistic for his development. Although the erotic transference is often considered to be a resistance in therapy, it was my impression that Peter had actually achieved something invaluable; this was the first time he was able relate to a human being on a deeper level, even if that was through the only way he had, by eroticising the relationship.

Our therapeutic work was limited in terms of time by the restrictions of the setting, and after a year of weekly meetings we ended our sessions, with him being psychologically prepared to begin long term psychoanalytic psychotherapy. I have not heard from Peter since and I sincerely hope that he has resolved his difficulties.

Nine years have passed since I met Peter, during which I have completed my training and worked with a variety of patients. What remained unchanged though during these life formative years, was my interest in the nature of perversions and the countertransference experiences

of therapists when working with them. Engaging with the relevant literature was tremendously enlightening regarding the etiology of perversion as numerous established psychoanalytic theorists explored the roots of this phenomenon. With respect to the countertransference phenomena though, apart from few scattered descriptions I was unable to find a detailed description of the way it unfolds during therapy with this particular client group.

In addition, therapeutic work with patients with perversion appears to be either the "privilege" of psychoanalysts who tend to publish case studies on the field, or of psychiatrists who treat sexual offenders pharmaceutically and focus their research on quantitative designs. This means that qualitative research, which becomes increasingly more significant among counselling psychologists, on the countertransference experiences of therapists working with this client group is lacking.

Verhaeghe (2004 as cited in Welldon, 2011) offers a potential explanation for the lack of relevant research as he writes that perversions are among the most difficult clinical categories to research because the researcher has to overcome his moral reaction to these phenomena. Commenting on the overall reluctance of psychoanalysts and psychotherapists to undertake research in the field, Gordon (2008) concludes that in the absence of research data we have no way of knowing whether the psychodynamic theories of perversion are valid or helpful in the treatment of the condition. Questions like: "*How do other therapists experience countertransference with this patient group?*", "*How do they make sense of their experience*?" "*How do other therapists cope with these feelings*" remained unanswered and returned to my mind each time I worked with a similar patient. The present doctoral thesis therefore was motivated by these unanswered questions and by my desire to ground potential answers not on additional theoretical and at times abstract or difficult to grasp constructs, but on therapists' everyday clinical experiences with this client group.

Searching the relevant literature for answers to the above mentioned questions I came across articles regarding the pharmacological treatment of perversions, and as this approach represented the opposite end of my perspective, that is I was researching the relational aspect of perversion in

therapy and these articles presented the bodily and hormonal aspect of treatment, I was immediately intrigued to explore this area further. My exploration of the research in the pharmacological treatment of perversions and my reflections on them became the focus of the Critical Review paper. As the title suggests "*Forty Years of Successful Outcomes or Forty Years of Flawed Research Designs & Potentially Unfounded Hypotheses? A Critical Review on the Pharmacological Treatment of Paraphilias"* the particular paper has as its purpose to present and evaluate research findings on the pharmacological treatment of perversion and consider these findings against the option of psychotherapy.

The Case study, the component of this portfolio that relates directly to my clinical practice, represents an attempt to shed light on the phenomenon of perversions through an attachment theory perspective. I became interested in the links between attachment and perversion a couple of years ago when, searching the literature in order to better understand a client's attachment needs, I came across articles discussing how attachment style relates to adult sexuality. Although I was not able to find literature that linked attachment style to perversion, there was enough evidence in these articles to suggest that perversions could be also understood through this theoretical lens. I explored this possibility in my therapeutic work with William and my thoughts on the issue, as well as how these informed my practice, are presented in this paper which is titled "*The Therapeutic Journey of William; a case study on perversions from an Attachement Theory Perspective"*

Overall, the DPsych Portfolio reflects my interest in the area of perversions as this developed through my clinical practice and reviews of the literature. All three pieces of work differ in that they present the treatment of perversions from different angles. All three pieces of work are interrelated in that they emphasize the challenges inherent in the treatment of perversions. It is my hope that through this work counselling psychologists will become better acquainted with this client group and will become aware of the complexity of and controversy surrounding their treatment.

A Note on Terminology

In the process of writing up this thesis certain decisions had to be made regarding the use of certain terms Although it is true that language can construct reality and affect the way we perceive and think about the world and people, it is my belief that this is the case only in so far as we do not reflect on the deepest meaning of the words we use.

It has come into my attention, that in recent years, we try to be politically correct, haunted by a fear that if we use certain words we will be characterised in certain undesirable ways; so we tend to hide our biases and beliefs behind words that sound neutral. This is the case with the terms perversion and paraphilia. Although I will discuss this later at greater length, I would like to propose that the term paraphilia, which has no emotional impact, was chosen to substitute the emotionally charged term perversion for fear that the latter demonstrates a lack of respect for the individuals which display these conditions

Having worked for years with perverse individuals I have the utmost respect for the drama hidden in their psyche and yet I still refer to the condition that plagues them as perversion, for I firmly believe that something of substance has been disturbed in the way their object relations are organised. Assuming that we have reflected on the power of language and its power to construct reality, when we call someone perverse we are fully aware that we do not put a diminishing or enslaving label on his personality, but, for the sake of efficiency and economy of our communication, we just describe a set of likely clinical symptoms.

A similar situation characterises, I believe, the usage of terms client, analysant and patient. Some colleagues detest the term client because it refers to the business-like aspect of our work; others disagree with the term patient because it denotes that the person is sick and still others argue that the term analysant should be preserved only for people who undergo analysis. It seems to me however, that all three terms hold an aspect of the truth, for the individual that visits our consulting rooms does so because s/he is suffering from a psychic pain and seeks treatment, so in this respect s/he is a patient. At the same time, s/he pays for our services, so s/he is indeed a client. In addition, in our effort to help him, we do help him/her to analyse his situation, albeit each professional in a different way. Unfortunately,

there is still no word in the English language that can encompass all these three aspects and for this reason, instead of identifying) with only one or the other, I chose to use all three throughout the thesis interchangeably in an attempt to represent in this thesis all three aspects of the people who come into our consulting rooms.

Another decision had to be made regarding terms such as counselling psychologist, analyst etc. Although each term describes a certain theoretical education and position towards the therapeutic process, we, counselling or clinical psychologists, psychotherapists and analysts, are all therapists. For this reason I decided to use all the above terms and the encompassing term "therapist" interchangeably in an effort to place emphasis on what unites us rather than on what differentiates us.

SECTION A: RESEARCH

Therapists' Countertransference Experiences When Working with Perverse Patients: An Interpretative Phenomenological Analysis

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Top-Up Doctorate in Counselling Psychology

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Abstract

. The field of perversions or paraphilias has been traditionally the "privilege" of psychoanalysts and psychiatrists, resulting in theoretical understandings that emerged either through case studies or quantitative research involving the pharmacological and behavioural treatment of these conditions. Moreover, although the importance of countertransference experiences when working with perverse clients is emphasised in the literature, no systematic effort has so far been undertaken to explore their nature in more detail. The present study represents the first effort to address the lack of qualitative research in the field, by exploring psychodynamic therapists' countertransference experiences when working with this client group. Employing Interpretative Phenomenological Analysis, ten semi structured interviews were conducted with both male and female British and Greek therapists. The analysis yielded five main themes: (1) Therapists' Understanding of Perversions (2) Development of Countertransference, (3) Ways of Coping with Countertransference, (4) Making Sense of and Using Countertransference, (5) Parallel Process. The findings of the study confirm previous clinical observations in that countertransference and in particular annihilation anxiety is the most challenging aspect of therapy, but it extends previously literature by highlighting the threat to the therapists' identity as well as the risk of traumatisation. In addition, as a result of the present research, a Preliminary Countertransference Model of Perversions is developed and a countertransference based therapeutic approach is proposed for the treatment of these conditions. Furthermore, the implications of these findings in terms of the therapeutic work with sex offenders and counselling psychologists' practice are discussed. Finally the limitations of the study are presented along with suggestions for further research.

Chapter 1: Literature Review

The nature of the present research question, "*how do therapists experience countertransference when working with perverse patients*?" situates the phenomenon under investigation within a particular psychotherapeutic framework. Both the terms "countertransference" and "perversion" are intrinsically connected with the psychoanalytic tradition and as such the content of the present literature review will focus on the theoretical findings of this school of thought. This particular focus does not imply that therapists from other psychotherapeutic approaches are not involved in the treatment of perversions. For example, the last few years Cognitive Behaviour Therapy has developed a treatment protocol for people diagnosed with paraphilias (Brooks-Gordon, Bibly & Wells, 2006; Glaser, 2001). Unavoidably though research questions emerge through our personal experiences and as such the focus of this research reflects my particular interest, engagement and experience in psychodynamic psychotherapy with perverse clients.

Taking the lead from the research question itself then, in this section the major theoretical understandings and developments regarding countertransference and perversion will be reviewed. It should be noted, that the following review is by no means exhaustive, as both these concepts have been explored in literally hundreds of published articles and books (Benedetto, 1991). As it is often the case with qualitative research and IPA studies (Smith, Lowers & Larking, 2009), the role of the present review is not to explore in depth all the theoretical contributions to the phenomena of countertransference or perversion, but rather to place participants' experiences in a general theoretical context so that they can be better understood by the reader in the following chapters of the thesis. For purposes of clarity, the following review is organised in three separate sections; the first section explores the concept of countertransference, the second is dedicated in the various theoretical considerations of perversion and the third presents the two concepts in conjunction.

1.1 Countertransference

1.1.1 "What is Countertransference?" or "What is Countertransference for me"?

Although at a first glance, countertransference appears to be another theoretical concept and as such easily definable, a search through the literature led me to the observation that in reality countertransference is a highly personal experience which authors tend to define according to their own clinical experiences and theoretical orientation.

Conceptualising countertransference as an experience rather than as a clinical concept could explain the variety of similar or contrasting definitions that have been emerging in the literature for decades. For example, some authors understand countertransference as the unconscious emotional reaction of the therapist to the transference of the patient, others as the totality of the emotional experience of the therapist towards the patient, others as being the result of the therapists' unresolved conflicts, while others combine the above mentioned perspectives (Cohen, 1988).

If therefore, countertransference is an experience and as such it is construed through the personal and theoretical lens of each therapist, then the search for a comprehensive definition, as it is implied by the question "*what is countertransference*?" becomes a fool's errand. Entering the realm of subjective experience, definitions lose their strength as absolute truths and become personal understandings that appear to be most adequately reflected in the question "*what is countertransference for me*". Indeed, even after a century of published works on countertransference there is no theoretical consensus regarding its nature and even in recent publications on countertransference, after a historical review of the concept, authors state how they personally understand it (eg. Weiner, 2009; Gelso & Heyes, 2007; Tansey& Burke, 1995).

An exhaustive historical review of the concept, although fascinating as it reflects the development of the psychoanalytic movement (Gabbard & Lester, 1995) goes beyond the scope of this thesis and it has been already done successfully by esteemed authors such as Orr (1954), Kerneberg (1965) Langs (1976), Jacobs (1992) Hinselwood (2002). What follows

instead is a brief critical discussion of the major theoretical contributions since the conception of the term by Freud, until today.

1.1.2 Sigmund Freud & The Birth of Countertransference

More than a century since its conception and after literally hundreds of articles and books published on these concepts, the phenomena of transference and countertransference might appear quite theoretical and dry. If however, we go back to the time when psychoanalysis was being born we can clearly see that they emerged out of real analyses with real patients and many times within trial and error situations. Gabbard & Lester (1995) are right when they state that the history of boundary violations in psychoanalysis reflects the history of the evolvement of the concepts of transference and countertransference.

It could be argued that the first recorded incident of a countertransference reaction was that between Joseph Breuer and his famous patient Anna O. Early in his career Freud had witnessed the catastrophic consequences of Breuer's extreme emotional reaction in response to Anna O's erotic transference when she announced to him that she was pregnant with his child. Breuer stopped her treatment, abandoned the field of psychology, and went on a second honeymoon with his wife (Gordon, 2003).

After this incident Freud continued his work and the whole notion of countertransference did not occur to him until another similar event took place, this time with his beloved disciple Carl Jung. It was in 1909 in a letter to Jung, who had suffered the consequences of a rather stormy erotic transference with his first analytic patient Sabina Spielrein, when Freud used for the first time the term "countertransference", a problematic emotional reaction that the therapist must control,: *"[these experiences] help us to develop the thick skin we need and to dominate on countertransference, which is after all a permanent problem for us*" (Tentes, 2008 p. 234).

A year later in his paper "*The Future Prospects of Psycho-Analytic Therapy*" Freud (1910) introduced formally the term countertransference to denote the way therapists' unconscious feelings are influenced by patients' transferences. His belief that the countertransference is not only a nuisance

in the therapeutic process, but also a cause for failure remained unchanged, as he stated that therapists must protect themselves from its influence by means of self-analysis.

Freud viewed countertransference solely as an obstacle originating in the unresolved conflicts of therapists. It could be argued that such a rigid attitude developed in response to his experiences with Breuer, Jung and later on Ferenzi. The story between Sandor Ferenzi and his patient Elma Palos, was another early psychoanalytic failure, which, according to Dupont (1995), is attributed to the disastrous effects of unmanaged countertransference reactions. Ferenzi began the treatment of Elma in July 1911 and in December he wrote to Freud about his failure to maintain neutrality and the emergence of his erotic countertransference (Brabant, Falzeder & Giampieri-Deutsch, 1994) Freud's response was immediate and to the point : "*First break off the treatment, come to Vienna for a few days. . . don't decide anything yet[...].*" (Brabant et. al, 1994, p.318). It appears that Freud's experience with this case and the above mentioned ones can justify his rigid position regarding neutrality and countertransference which was fully expressed in 1915 in his paper "*Observations on Transference Love*":

> . . . [T]he experiment of letting oneself go in tender feelings for the patient is not altogether without danger. Our control over ourselves is not so complete that we may not suddenly one day go further than we had intended. In my opinion, therefore, we ought not to give up the neutrality towards the patient, which we have acquired through keeping the counter-transference in check. (p. 164).

Recognising the powerful effect of the patient's unconscious on the therapist and the therapist's limitations by his own unresolved conflicts, Freud set strict rules to ensure that the therapeutic process would not collapse under the influence of these forces. Personal analysis and neutrality became the golden rule of psychoanalysis to protect both the patient and the analyst from the daemon of countertransference (Rowan & Jacobs, 2002).

A letter however to Jung in 1911 reveals yet another source of Freud's strictness and rigidity regarding countertransference.

> [...]I gather that neither of you has yet acquired the necessary objectivity in your practice, that you still get involved, giving a good deal of yourselves and expecting the patient to give something in return. Permit me, as the venerable old master, to say that this technique is invariably ill-advised [..]. I believe an article on "countertransference" is urgently needed; of course we could not publish it, we should have to circulate copies among ourselves (Tentes, 2008, p. 386-387)

As the founder and leader of a revolutionary and controversial form of treatment, Freud had to make sure that the public image of psychoanalysis would not be threatened by the inappropriate behaviour of his "students' (Jacobs, 1999). The way a traditional authoritarian father sets strict ethical rules for his children to protect the good name of his family, the same way Freud had to take a strong stance against erotic countertransference to protect Psychoanalysis' reputation.

With the exception of few early contributions such as that of Ferenzi in 1919 who advocated the inevitability of countertransferential feelings and their usefulness for the therapeutic process (ibid), discussions about countertransference remained a taboo for the psychoanalytic community for forty-five years (Tauber, 1954; Tower, 1956). Racker (1968) thought that among analysts countertransference was treated "*like a child of whom the parents are ashamed*"(p. 107)

Reik's (1988) phrase "*psychoanalysts make their observations and put their trust in God and Freud [...]* (p. 52) captures accurately Freud's authority on early psychoanalysts, which in agreement with Gelson & Hayes (2007), I believe it is one of the main reasons why analysts refrained from exploring the phenomenon further. For those early analysts, the experience of feelings towards their patients meant that they had unresolved conflicts which had crept in the analytic process and endangered the therapeutic outcome. Risking a rather psychoanalytic interpretation, it seems to me that the creativity of these early analysts was severely inhibited by the guilt they experienced due to the powerful influences of their harsh superego, as represented by Freud, which demanded the impossible from them; to be as neutral and unemotional as surgeons in a clearly relational situation. This

view is also similar to Racker's (1957) belief that this neglect can be attributed to infantile ideals that pushed early analysts to be perfect with their patients maintaining this way the analytic myth that therapy occurs between a healthy person and a sick one.

1.1.3 Changes in Perception of Countertransference

During the decade of 1950s a shift occurred and numerous authors (e,g, Racker, 1957 Thompson, 1956, Tauber, 1954, Cohen, 1952; Little, 1951, Heimann, 1950; Fromm-Reichmann, 1950 as cited in Epstein & Feiner, 1988) published articles on countertransference offering fresh perspectives. Jacobs (1999) suggests that this shift can be attributed to the aftermath of the Second World War and the resulting traumatic experiences of the patients that analysts of the time had to deal with, which stirred powerful emotional reactions in them as well.

Although the cultural element that Jacobs (ibid) proposes must have had a significant impact on therapists, it cannot be regarded as the sole reason for the change in perspective on countertransference. As Freud's authority lessened, new developments in psychoanalytic thinking emerged, which paved the way for a wider understanding of countertransference (Weiner, 2009; Reik, 1988). The shift of psychoanalytic inquiry from the instinctual- libidinal forces to that of the analysis of defences and resistances, which was pioneered by Reich, Anna Freud and Hartmann (Wolstein, 1988) , the development in the United States of Sullivan's interpersonal approach with its emphasis on the notion of participant observation (Tansey & Burke, 1995) and the emergence of Object Relations theory in Britain (Hinshelwood, 2002) changed the psychoanalytic scene profoundly, as "*psychoanalysts and patients began to experience one another as co-participants in a shared field of inquiry*" (Wolstein, 1988, p. 11). Consistent with this view is also Carnochan's (2001) approach which saw the progression from Freud's classical drive theory to more relational models within the field of psychoanalysis as being instrumental in the shift(towards perceiving countertransference phenomena less as prohibited and detrimental nuisances and more as valuable assets in the course of successful analyses.

Reviewing the literature on countertransference, it became apparent that this change was the gradual result of the work of literary hundreds of authors who bit by bit built a new perspective on countertransference. It seems to me however, that it was the pioneering work of Winnicott (1947), Heimann (1950), and Racker (1953) which revolutionised the field and shaped current views on countertransference.

1.1.4 Donald Winnicott (1949)

As a result of the emergence of the Object Relations school which placed emphasis on the intrapsychic relationships between the baby and significant objects in his environment (Gomez, 1997), the relationship between the analyst and his patient began to be thought of in terms analogous to the relationship between a mother and her infant. In his famous paper '*Hate in the Countertransference'*, published in 1949, Winnicott drew on this analogy to demonstrate that therapeutic work with psychotic patients invokes feelings of hate in the analyst, which must be recognised and contained if therapy is to be a success.

Many authors (e.g. Jacobs, 1999; Hinshelwood, 2002; Tansey & Burke, 1995; Orr, 1954) recognise the importance of Winnicott's paper and indeed it was revolutionary. Firstly, Winnicott dared to discuss feelings of hate towards patients in an era when, dominated by Freud's legacy, analysts were tormented by the ideal of the pure and neutral analyst. Secondly, with his phrase "*Countertransference phenomena will at all times be the important things in the analysis*" (p. 70), Winnicott legitimatised countertransferential feelings, arguing that they are instrumental to the success of therapy.

1.1.5 Paula Heimann (1950)

Winnicott's revolutionary approach to countertransference was followed a year later by Heimann, who in her 1950 paper "*On Countertransference*" described the analysis as a relationship between two individuals characterised by the existence of feelings in both. Tansey & Burke (1995) argue that Heimann was the major proponent of the *totalistic* perspective of countertransference, which advocates that all feelings in the analyst should be understood as countertransference. In contrast to Winnicott (1949) who differentiated between "*objective countertransference*" and feelings in the

analysts related to their own repressed unresolved conflicts, Heimman (1950) argued that the distinction between real and distorted responses is difficult to establish and as such the term countertransference should encompass all feelings experienced by the therapist. Similar to Winnicott however, Heimann (1950) argued that countertransference feelings are invaluable in that they can be "one more source of insight into the patient's unconscious conflicts and defences" (p. 38). Considering all feelings of the analyst as reflections of the internal world of the patient, Jacobs (1999) suggests that Heimann opened the way to understanding the role projection and projective identification play in the creation of countertransference.

1.1. 6 Heinrich Racker (1953, 1957, 1968)

Away from London, in distant Argentina, Heinrich Racker was also exploring analysts' countertransference reactions. In his 1953 paper "*The Countertransference Neurosis*", Racker demolished the Freudian fantasy of the pure analyst by asserting that, like the patient, the analyst brings into the room his own internal world and conflicts which, despite his personal analysis, are never fully resolved. Racker (ibid) argued that just as the patient relates to the analyst through transference, the analyst relates to the patient through his countertransference; that is the analyst experiences feelings and impulses toward the patient whose origins can be located in many different sources. Distinguishing between different types of countertransferences was Racker's pioneering and invaluable contribution to our understanding of these reactions.

In his 1953 paper Racker referred mainly to "*countertransference neurosis*", the aspect of countertransference which disturbs and threatens the therapeutic work and placed its origins in the Oedipus Complex of the therapist, meaning that the therapist has an unconscious predisposition to experience the patient in terms of his/her same gender parent. Whenever a situation in the patient's life and personality resembles the external or internal circumstances of the analyst, s/he is bound, according to Racker (ibid), to repeat the oedipal drama. Aspects of this countertransference neurosis are a) the *direct* countertransference which refers to the projection of the analyst's internal objects to the patient as an individual, b) the *indirect* countertransference, which refers to relating to the patient through

the lens of the analyst's object relationships, that is through the way society, supervisors and colleagues affect how the analyst perceives his work and the patient.

Strongly believing that countertransference can be not only a threat to the analytic process, but can also be an invaluable asset for understanding the patient, Racker dedicated his 1957 article " *The Meaning and Uses of Countertransference*" to exploring the ways in which the analyst uses his emotional reaction to facilitate therapy. In this article he differentiated between concordant and complementary countertransferences. According to the author (ibid) in order for the analyst to understand the patient s/he must temporarily identify himself with the patient and this happens in two different ways. One way the analyst can reach a deeper understanding of the patient is through the temporary identification of each part of his personality with the analogous part of the patient, experiencing and feeling therefore the way the patient does. This experience, Racker called *concordant countertransference*. Another way that the analyst can truly sense what is happening in the life of the patient is through the temporary identification with the internal objects of the patients, feeling therefore the same way significant others have felt towards the patient. This kind of countertransference experience is called *complementary*.

Through his ground-breaking work, Racker (1953, 1957, 1968) liberated analysts from the Freudian guilt that pushed them to deny their countertransference by demonstrating its inevitability and value. By distinguishing between neurotic direct and indirect countertransference, which originate in the therapist's conflicts and as such must be dealt with further personal elaboration from the part of the analyst, and complementary and concordant countertransference that form the basis for empathy and insight, Racker dissolved once and for all the myth of the pure analyst and proved that without attendance to countertransference therapy will fail. Some might argue that Racker repeated what Winnicott or Heimman had already proposed and it is true that he agrees with them in many respects. What however, makes his contribution unique is that he actually gave us the tools to manage and use therapeutically our countertransference. By introducing the complementary and concordant countertransferences, Racker provided the analysts with a map of the world

of the patients, a tool for more insightful and accurate interpretations and a way to avoid repeating the patient's past in the therapeutic relationship

1.1.7 Current Conceptualisations of Countertransference.

Following almost a decade of intense exploration of countertransference, the literature again entered a period of hibernation. Important work was being done however indirectly, as the concepts of empathy and projective identification, intrinsically related to countertransference, became the focus of many authors in the 1960s (Tunsey & Burke, 1995). The past debate on whether or not countertransference was problematic or not had diminished and the term was used in its totalistic aspect more and more often. Echoing Freud's (1912) early perception of the therapist's unconscious as being an organ which is receptive to the transitions of the patient's unconscious and Reik's (1937) urge to consider the therapeutic process less as a cognitive process and more as a space where the therapist's imagination and intuition can lead to a deeper experience of the client, developments in the field of empathy and projective identification led gradually to an understanding of the analytic situation as an interaction in which the individual becomes known not only cognitively and in terms of interpreting what s/he conceals in his/her unconscious, but also relationally through countertransference reactions (Benedetto, 1991).

Indicative of this climate change, is the extraordinary work of Tansey & Burke (1995) who, like Racker in the 50s, explored and advanced the concept of countertransference in a way which, once again, had a dramatic effect on our understanding of the phenomenon. Regarding therapy as "*a radically mutual process*" (p. 85) and adopting the totalistic view of countertransference Tansy & Burke (1995) created an elegant and clinically useful theory on countertransference.

Building, on one hand, on the work of Flies (1942) who described two components of empathy, the first being the therapist's trial identification with his patient and the second being a process of oscillation between the emotional experiences and fantasies of the therapist and his intellectual analysis of them, and, on the other, on the work of Racker (1957) on complementary and concordant countertransferences, the two authors extended the notion of empathic understanding as being the end product of

these two types of countertransferences. During the therapeutic process therapist and patient are in a state of mutually experiencing each other, thus the therapist identifies concordantly or complementarily with the projections of the client, a process which has the potential to result in the empathic understanding of the client.

Abandoning therefore the traditional view that differentiated empathy from projective identification, Tansy & Burke (1995) proposed that in the process of empathically understanding the client, there is always some degree of projective identification involved. The handling of this projective identification will determine the empathic outcome. Empathy and projective identification are "*interrelated aspects of a unitary sequence for the therapist's process of interactional communications from the patient*" (p. 65), which of course it is the reason why countertransference, a term that now encompasses both projective identification and empathy, is considered invaluable.

In developing their theory, the two authors outlined three stages in the unitary sequence for processing the interactional communication that takes place during therapy. : Reception, Internal Processing and Communication. By describing these processes, their subphases and the ruptures that can occur for various reasons at each stage of this process, Tansey & Burke (1995) have not only clarified and enriched our understanding of the phenomenon of countertransference but they have also offered the means through which therapy can be successful. As they point out in the concluding remarks of their book, at those times that the therapist understands what and why s/he feels or thinks in a particular way, then the chances of empathic understanding increase and it is through this visceral, intuitive but also intellectually analysed empathic understanding that the way for accurate interpretations opens and the vicious cycles in therapy can be explored rather than repeated.

Conceptualising countertransference as the vehicle into the psychic world of the patient and as an agent of deeper empathy, therapists do not confine themselves anymore to the role of the investigator of the unconscious. By opening up their mind and psyche to the reality of the patient, therapists encourage a relational interaction between the contents of the patient's unconscious and those of their own with the purpose of

creating an alternative relational experience for the patient. Benedetto (1991) beautifully captured this understanding of countertransference as an agent for therapeutic change when he wrote: "*[countertransference] is above all a process suited to fostering or constructing new affective and relational valences*" (p. 129).

The exploration of countertransference over the years has contributed significantly to the transformation of the therapeutic process itself and has altered our perception regarding the nature of the analytic dyad. Having fallen from their past arrogant pedestal as all knowing authorities, today's therapists acknowledge the influence exerted on them by the patient and regard therapy as a mutually constructed process. Countertransference, being a central component of this process, is regarded not only as a pathway to the deeper understanding of the client, but also the agent of therapeutic change. In this respect, the countertransference experiences of therapists who work with patients with perversions acquire central value in the therapeutic process and unless these are better understood, a significant component in the treatment of this client-group will be constantly missing. In order, however, to explore therapists' countertransferences with this group, we must first have a better understanding of the nature of perversions.

1.2 Perversions

1.2.1 Perversion vs. Sexual Deviation, Paraphilia and Atypical Sexuality; an on-going terminological debate

The last 30 years a debate has been developing regarding the appropriate way of referring to sexual deviations, with most of the psychoanalytic literature retaining the term perversion and most of the psychiatric community adopting the term paraphilias.

Tracing the origins of the term perversion, Nobus (2006) argues that it acquired its general meaning in two stages. In the first stage, the medical community borrowed the term from its original religious context, in which the verb "to pervert" meant to "turn around", in order to describe pathological changes in basic human functions. Perverted hearing, therefore, referred to hearing unusual bad things, whereas perverted eating

meant developing an appetite for unusual ‘foods”, like worms. In the second stage, the term was extended to describe sexuality. Conceptualising the sexual instinct as another basic human function, necessary for the reproduction of the species and for its survival, any “unusual” deviations from this practice could be characterised as perverse.

This early medical notion of sexuality was fully reflected in the work of the German psychiatrist Krafft-Ebing who in 1886 published his seminal treatise “Psychopathia Sexualis” (Brooks-Gordon et al., 2006); a medical text that was destined to become the equivalent of DSM for sexual pathology at that time. Considering the sexual instinct as being in the service of humanity’s reproductive imperative, Krafft-Ebing described four deviations and the resultant pathologies: sexual anaesthesia, hyperaesthesia, paradoxia, paraesthesia. The last category included the perversions (Nobus, 2006).

Critiques of Krafft-Ebing’s work recognise both his brilliance and his limitations. For example, DeMassi (2003) regards Krafft-Ebing’s consideration of infantile sexual experiences as etiological factors in the development of perversions, as evidence of his pioneering and intuitive spirit that paved the way for the scientific understanding of these conditions. Dowing (2006) on the other hand, believes that Krafft-Ebing’s understanding of perversions was limited by his perception of perverse individuals as psychologically and morally sick.

Indeed, despite its appropriation by the psychiatric community of the nineteenth century, the term perversion preserved its religious overtones and, as it was used to distinguish between normal and abnormal sexual behaviours, it was very quickly transformed into an ethical concept used to communicate moral reproach (Benvenuto, 2006). Indeed, the etymological roots of the term when applied to sexuality betray the assumption that there exists only one healthy path in sexuality and that the person who has chosen to divert from it is not only morally corrupted but sick as well. Going against the laws of God and against the laws of Nature (Richards, 2003), the pervert was condemned on both religious-ethical and medical grounds, and as such, it would not be far-fetched to propose, that he was regarded as an abomination.

This clear cut distinction in the nineteenth century between normal sexuality and perversion was challenged by the cataclysmic changes regarding personal and sexual liberties of the 1960s (Gordon, 2008). The concept of normality became ambiguous and its interpretation less certain. The changes began to take place in the early 50s, when the American Psychiatric Association, in its effort to statistically systematise mental health disorders published the first Diagnostic and Statistical Manual for Mental Disorders (Pomeranz, 2014) in which perversions appeared under the name of sexual deviations and were classified as a subtype of the general category of personality disorders. (Milner, Dopke & Crouch 2008). Consistent with the name and the purpose of the Diagnostic and Statistical Manual for Mental Disorders, perversions were now officially regarded as statistical deviations from what was considered normal sexual activity. Since the normal individual, was the statistically average individual, the sexual deviant could be defined as that person who deviated from the norm to any degree (Rosario, 2006). The same term was retained in DSM-II (APA, 1968); sexual deviations were separated from personality disorders and as a diagnostic category referred to individuals whose sexual interests were directed primarily either to objects, did not involve coitus, or coitus was performed under bizarre conditions. As it becomes apparent from DSM- I and the early publications of DSM-II, coitus for the purposes of reproduction was the criterion for normal sexual life, whereas any other motivation or goal was a sexual deviation from that "normal" function (Benvenuto, 2006).

However, with pressures amounting from the homosexual community and with changes in societal attitudes towards sex, coitus lost its authority as the criterion for healthy sexual life and was gradually replaced by the criterion of distress (for the person and others) and impairment. This change made its appearance in the 7th edition of DSM-II where homosexuality, as a sexual deviance, was replaced by the category Sexual Orientation Disturbance which described individuals who were disturbed by their sexual orientation, and continued to gain ground in the next publications (Koziej, 2010)

Instrumental in the change was the American sexologist John Money who, as a result of his research, he concluded that no matter how strange or

bizarre the sexual stimulus or activity, the sexual experience follows the same brain patterns in all and therefore what was called sexual deviations can only be considered in relation to the society He preferred the term paraphilia which is defined against the term normaphilia, the sexual activity that society finds normal (Goldie, 2014).. Perversion therefore, began to be regarded less and less as a disorder and more as a variant of sexuality that society does not approve of. (Benvenuto, 2006)

Due to Money's systematic efforts to popularise the term paraphilia, this was formally introduced in psychiatry in1980 with the publication of DSM-III, where paraphilias appeared under the category of psychosexual disorders. DSM-IV (APA, 1994) and DSM-IV TR (APA, 2000) retained the term, paraphilias were listed under the Sexual and Gender Identity Disorder and were defined as "recurrent, intense sexually arousing fantasies, sexual urges or behaviours generally involving (1) nonhuman objects, (2) the suffering or humiliation of oneself or one's partner, or (3) children or other non-consenting persons that occur over a period of 6 months" (Criterion A), which "cause clinically significant distress or impairment in social, occupational, or other important areas of functioning" (Criterion B). DSM-IV-TR names eight specific paraphilic disorders (Exhibitionism, Fetishism, Frotteurism, Paedophilia, Sexual masochism, Sexual sadism, Voyeurism, and Transvestic fetishism, plus a residual category, Paraphilia—Not Otherwise Specified).[38] Criterion B differs for exhibitionism, frotteurism, and paedophilia to include acting on these urges, and for sadism, acting on these urges with a non-consenting person.

Milner, Dopke & Crouch (2008) in exploring the history of the DSM classification of sexual deviations and later on paraphilias, rightly observe that despite the change in terminology and the refinement of diagnostic criteria, with the exception of the exclusion of homosexuality form DSM-II and the addition of the criterion of distress and impairment in functioning, the general criteria for diagnosis remained the primacy of the preferred stimulus (the individual cannot replace normal sexual behaviour with the preferred stimulus) and the presence/nature of coitus. Indeed, despite the notable efforts of the psychiatric community to neutralise prejudice against particular sexual behaviours, by presenting them as statistical deviations (sexual deviations) or in conflict with established societal norms

(paraphilias), they have failed to avoid the underlying dilemma of sexual normality.

An effort towards this direction was made by the authors of DSM-V (2013) with the introduction of the term “atypical sexual behaviour” which in essence covers all sexual activities that deviate from the average sexual behaviours and do not cause significant distress to the individual or others. For the first time in psychiatric history, paraphilias or atypical sexual behaviours are not considered to be mental disorders and are clearly differentiated from the category Paraphilic Disorder which in order to be diagnosed a paraphilia must be present causing significant distress to the individual or to others. With this historical change, DSM-V by abandoning the normality criterion that underlined previous editions, made an effort to de-stigmatise people with paraphilias

I would like however to propose that DSM-V’s differentiation between paraphilias and paraphilic disorder is problematic as well on a number of grounds and in the end it appears to retain the criterion of statistical prevalence in order to determine what’s a disorder or not. The last decade and as a result of the Lesbian Gay Bisexual and Transgendered Community to raise awareness about minority sexualities and fight for acceptance in society, more and more people are open about their sexual preferences and indeed it appears that a significant number of the population has atypical sexual preferences or paraphilias and an increasing number of people feels the pressure to be open-minded, politically correct and accept as “ normal” sexual behaviours that in the past were condemned either by religion or society. It appears that history has completed its cycle and as people with paraphilias do not constitute a statistical rarity anymore, society feels the pressure to accept these sexual behaviours as evidence of psychological health.

In considering the issue of what constitutes normality and what makes a behaviour abnormal, Pomeranz (2014) raises the question whether typical behaviour can be also abnormal, whether we can really determine the status of a disorder based on what the majority of people seem to think or do and finally whether normality is just a matter of statistical frequency within a society and whether social acceptance of certain behaviours equate with psychological health. At this point I would like to raise my concern

regarding DSM-Vs declassification of paraphilias as mental disorders and join my voice with Widiger & Mullins-Sweatt (as cited in Pomeranz, 2014) who stated "*Simply because a behaviour pattern is valued, accepted, encouraged, or even statistically normative within a particular culture does not necessarily mean it is conducive to healthy psychological functioning*" (p. 360). It seems to me that, when it comes to perversions, sexual deviations or paraphilias, the criterion of statistical deviance from cultural norms which reflects the values and attitudes of each society at a particular point in time and affect the statistical frequency or infrequency of a behaviour is a weak one for it either pathologises or normalises indiscriminately people with atypical sexual behaviours who may or not have deep-seated psychological conflicts regarding issues of intimacy, sexuality and gender. Cultural norms and the consequent statistical mean or deviation cannot easily be applied as a criterion for sexuality, for sexuality in human beings is such a highly subjective experience and rich in meaning, including the person's history and aspirations, that it is impossible in my view to create predetermined categories of average normality without stumbling upon the inherent difficulties that generalisations entail.

Returning to DSM-V and my concerns for the criteria for diagnosing a paraphilic disorder, the emphasis on personal distress appears equally troublesome. Paraphilias or atypical sexual behaviours, due to the sexual pleasure they offer to the individual, are rarely considered to be the source of distress and if there is subjective distress, it is literally impossible to determine whether, or to what extent, it is the result of the paraphilia or the result of being in a society that does not accept the particular sexual activity (Koziej, 2010). In other words, in an ultimate effort of ill-considered, according to my opinion, de-patholologisation DSM-V (APA, 2013) regards the sexual masochist, who engages in consensual sexual activities and expresses no personal distress, as being psychological healthy, as if the underlying issues of psychological control, need for submission and humiliation that appear to defend against emotional intimacy are irrelevant to the psychological well being of the individual.

Aside from the ambiguous criterion of personal distress, for a diagnosis of paraphilic disorder to be given, DSM-V (APA, 2013) requires that people with paraphilias must have a sexual desire or behaviour that

involves another person's psychological distress, injury, or death, or a desire for sexual behaviours involving unwilling persons or persons unable to give legal consent. It seems to me that this criterion best captures the essence of perversions and in my clinical experience as well as in the psychoanalytic literature on the subject (e.g. Stoller, 1975), as it will become apparent later on, the desire to cause harm involves all of those sexual behaviours that DSM-V calls paraphilias or atypical sexuality and has declassified them from the taxonomy of disorders. By reducing psychological functioning to a set of external behavioural manifestations, the psychiatric community has abandoned the notion of the unconscious and in this way paraphilias or atypical sexual behaviours that are motivated by unconscious hostility and desire to dehumanise the other, are regarded as psychological healthy.

The debate on what constitutes a healthy, in psychological terms, sexual life and what constitutes a disorder is on-going and as the experience of sexuality is multidimensional and involves psychological, sociological, historical and political elements, each of which shapes its expression and phenomenology in all of us, there are no simple answers. This difficulty appears to permeate the history of the Diagnostic and Statistical Manual for Mental Disorders. As the previous discussion demonstrated, its authors, at least in the case of perversions, have been struggling for years to determine the best criteria for diagnosis and have been changing the terminology, (sexual deviation, paraphilia, atypical sexuality, paraphilic disorder) in an effort to strike a balance between the sexual freedom and mental disorder.

The issue therefore of terminology is not a simple one and as it became apparent it involves our assumptions about what constitutes mental health, normality and what constitutes a disorder. For this reason, I find it important to explain why I chose to retain the old-fashioned and rejected term "perversion" in this thesis

Despite the introduction of the term paraphilia and atypical sexuality by the psychiatric community and the wide acknowledgement of the psychoanalytic community that the term perversion carries derogatory connotations, many theorists in the field choose to retain it. For example, DeMassi (2003) argues that the term paraphilia is too anodyne and generic failing to convey the central subjective essence of sin and transgression as sources of pleasure which are central in perversions (Stoller, 1975).

Similarly Benvenuto (2006) argues that the term should be retained because its moral connotations reflect the moral conflicts that are indeed part of internal worlds of perverse individuals.

Contributing to the ongoing debate regarding terminology, I would also like to add my concerns regarding the use of the term paraphilia and the more recently added term "atypical sexuality" It is my impression that the very search for a new term reflects the recognition that language, in addition to being a means that enables clear perception and communication in the world of social relations, is also a medium for transmitting moral values, enabling in this way the construction of particular realities (Schafer, 2002). In this respect, the terms paraphilia and atypical sexuality construct a new amoral reality, according to which therapists should stand objective and unemotional against the individual who exhibits these behaviours; a view of the therapeutic encounter that is reminiscent of Freud's rule of neutrality which the deeper exploration of countertransference phenomena has deemed both unattainable and unhelpful.

Emotional neutrality is not only a utopia, but also a dangerously false reality. The fact that we have recognised our past prejudices and that we have coined a new term does not mean that when it comes to perversions we do not internally still react in a critical and emotional rejecting way, or with horror and fear. The usage of the neutral terms paraphilia and atypical sexuality not only do not ensure a prejudice-free attitude, but could also reinforce prejudice; the more we identify with the fantasy of neutrality the less aware we become of our authentic reactions and less able we are to reflect on them and truly put them aside. The term perversion on the other hand brings us face to face with our potential prejudices and keeps us alert as to the possibility of them "perverting" our view of other person. In addition, as it was discussed earlier when considering the value of countertransference, remaining aware of our emotional reactions rather than denying them facilitates our deeper understanding of the perverse individual, protects us from unconscious acting out and enable us to find our way to the roots of the perverse individual's suffering within his/her psychic realm.

In agreement with Benvenuto (2006) and DeMassi (2003), I believe that one of the reasons that the term perversion has acquired its derogatory

connotation is exactly because perversions involve derogation, transgression, humiliation, abuse etc. As Wyly (1989) suggests the word "*conjures up images of the corrupt the fearful and the forbidden*" (p. 319). For example, the intrusive eye of the voyerist, not only attacks and demolishes any sense of privacy, but can also be highly traumatic. In this respect, the term perversion conveys the subjective realities of both the perverse individual (e.g. hostility, desire to humiliate, need for control etc) and the subjective reality of the victim or partner (abused, humiliated, controlled etc.). On the contrary, paraphilia or atypical sexuality do not convey, in my opinion, the overwhelming emotional torment that characterises both the pervert and his victim or partner, in that it just describes a state of affairs devoid of its devastating emotional component.

The above argument regarding the choice of terminology is indicative of the theoretical differences that underlie the terms perversion and paraphilia. The psychiatric terms paraphilia, atypical sexuality and paraphilic disorder are descriptive and used for diagnostic purposes as becomes apparent from its employment by DSM, whereas the term perversion carries with it a variety of etiological psychoanalytic theories that have developed since Freud's conception of psychoanalysis up until the present day.

1.2.2 Psychoanalytic Theories of Perversion: A Modern Babel?

The implication of etiological factors in the understanding of perversion makes any attempt to define the term as complex and intricate as any attempt to define countertransference, for its deeper meaning is largely depended on each theorist's understanding of its origin and course of development (Purcell, 2006; Ceccarelli, 2005). Discussing the phenomenon of Babelisation in psychoanalysis, which permeates the term perversion as well, Jimenez (2004) cites Amati-Mehler's spot on statement "*every time the word perversion is used, we would need a conceptual and clinical redefinition*" (p. 66). Stern (2005) and DeMassi (2003) express a similar frustration and in an attempt to explain the existence of so many contrasting theoretical standpoints regarding perversion, the former suggests that this is due to continuous historical changes, whereas the latter hypothesises that the phenomenon could be so complex that multiple observational perspectives

are required to fully capture it. This complexity will become apparent in the next section as major theoretical contributions are discussed.

1.2.3 Sigmund Freud

Freud's understanding of perversions is mainly presented in his ground breaking and momentous work "Three Essays on Sexuality" (1905/2001) and particularly in the first essay "The Sexual Aberrations".

His theory, essentially a drive theory, is based on the concepts of instincts, libido, erotogenous zones and the Oedipus complex. At the heart of it lie the highly challenging assumption that infantile sexuality is polymorphously perverse and thus the belief that there is a perverse predisposition in all of us. In addition to being exonerating regarding sexual preferences, Freud's proposition regarding a universal human predisposition to perverse sexuality appears quite unorthodox in that normative sexual practices end up appearing as being a variation of perversion. Indeed, in Freud's theory of sexuality, what he considers to be mature genital love appears to be a rather hard to attain goal. Being dependent on the effective passing of libido through all psychosexual stages of development and with all the challenges that present themselves resulting in fixation or regression on some stage (Freud, 1905/2001), normal sexual development appears extraordinarily fragile.

According to Freud (ibid), sexual deviations result from a deviation of the sexual instinct with respect to either the sexual object or the sexual aim. Inversion, the term used to describe homosexuality, paedophilia and zoophilia were classified under the deviations of the sexual object in the sense that the choice of a same gender partner or under-aged victim consisted a deviation from reaching genital mature love. It's important to note here that although Freud (ibid) regarded homosexuality as a sexual deviation, he did not regard it as degenerative phenomenon or a perversion. In fact he retained the term perversion for the deviations of the sexual instinct's aim.

For him, therefore, perversion are "*sexual activities which either a) extend in an anatomical sense, beyond the regions of the body that are designed for sexual union, or b) linger over intermediate relations to the*

sexual object which should normally be traversed rapidly on the path towards the final sexual aim". (ibid p. 150)

In the first essay, "*The Sexual Aberrations*", Freud (ibid) classified under perversions coprophilia, fetishism, voyeurism, exhibitionism and sadomasochism and in attempting to explain them, he developed a theory that situated their origins in the earliest stages of people's psychosexual development. For example, in fetishism the sexual aim is completely abandoned and the sexual object is substituted with a part of the body or an inanimate object. In the case of sadism, aggression, being part of the sexual instinct is exaggerated and by means of displacement acquires primary position.

Noting that some elements of the above mentioned perversions are part of what could be called normal sexual life, Freud (1905) made the remarkable in terms of its open-mindedness observation that "*the pathological character in perversion is found to lie not in the content of the new sexual aim but in its relation to the normal*." (p.159). With this statement Freud (ibid) 1) exonerated individuals' sexual life that might entail some elements of perversion and 2) clarified that in order for a sexual deviation to be pathological it would have to replace completely and at all times the normal sexual aim. Therefore, sexual deviations become perversions as long as they acquire the characteristics of exclusiveness and fixation, leaving the individual unable to achieve sexual satisfaction in any other way.

Perhaps the most widely quoted phrase of Freud (ibid) regarding sexual deviations is that "*neuroses are, so to say, the negative of perversions*" (p. 165); an aphorism which, in agreement with Gillespie (1951) is wrongly thought to epitomize all of Freud's thinking on perversion. Believing that the sexual instinct is innate in all of us, Freud painted the sexual life of individuals as existing on a continuum. On the one end, there are the perversions, in which cases the sexual instinct is expressed unmodified and directly either in fantasy or action, and on the end there are the neuroses, in which cases the sexual instinct has remained in a regressed or an infantile state, has been repressed and can only find expression in the form of symptoms. According to Freud, the individual with a healthy sexual life is to be found somewhere between perversion and neurosis, since in

these cases the sexual instinct has been subjugated to effective restrictions and modifications. Perversion therefore represents the persistence in adult life of polymorphous perverse infantile sexual elements at the expense of mature genital love. Returning to the argument made above and taking into consideration that no individual's early childhood is ever free of unconscious conflicts, it seems that the Freudian mature genital sexuality is a rather improbable outcome or an ideal that can be attained only through analysis, for the)chances are that we all are either perverse or neurotic.

The idea that perversions are not just ruminants of infantile sexuality but a defensive formation, appeared later in Freud's work and in particular in his 1919 essay "*A Child is Being Beaten*" where he connected a perverse fantasy with the Oedipus complex and the defences against the anxieties it raised, and on the much cited article on "*Fetishism*" (1927), where he described the defence mechanism of disavowal, the denial of the idea of castration. The child's observation that women do not have a penis threatens the existence of his own and as such the boy is led to deny the reality he has observed. He continues to believe that women have penises although he knows that they don't. The confirmation on one hand of the possibility of castration and the disavowal lead to the construction of the fetish, which serves the individual the purpose of substituting in his unconscious the woman phallus. Applying the notion of disavowal to all perversions, Freud suggested that perverse individuals defend against anxieties by a split in their Ego, which allows them to escape a massive conflict by means of deceiving themselves. Freud's conceptualization of perversions was consistent with his overall theory of psychosexual development and as such his conclusion that perversions are the result of a particular management of oedipal anxieties was somewhat expected and in agreement with Glover (1932) repetitive as an observation. In addition, in a critical review the theory, Adair (1993) noted that taking into consideration the universality of the perverse core and the fact that oedipal anxieties are shared by all of us, the theory fails to explain adequately how and why some of us do not manifest perverse behaviours. It appears that this theoretical gap was resolved by later developments in the Object Relations field-which situated the formation of perversion in the pre-oedipal stage (Eshel, 2005). Despite its limitations, Freud's thesis that perversions are the negative of neurosis,

his insight regarding the defensive role played in perversions, the mechanism of disavowal and the splitting of the Ego influenced future understandings in various directions. Partly due to the questioning of his theories regarding phallic primacy and penis envy, partly due to the emergence of an awareness regarding early object relations (Limentani, 1989) and to an increasing awareness of the role of aggressive impulses on the formation of perversion (Gillespie, 1956) the subsequent changes in the conceptualization of perversion were dramatic.

Remaining largely faithful to the Freudian understanding of the psyche and perversions, Edward Glover's early contributions and Chasseguette-Smirgel's more recent understandings transformed the classical psychoanalytic view on perversion.

1.2.4. Edward Glover (1933)

By placing emphasis on the reality sense of individuals with perversions, Glover, a prominent figure in the psychoanalytic world of perversions (Fishmann & Ruszxzynski, 2007), extended Freud's view of perversion as being the negative of neurosis, by linking these conditions with psychoses. More specifically, Glover (1933) postulated that perversions' defensive quality lies in their function as patches in flaws in the development of reality sense.

His conceptualization is based on the suggestion that the development of reality sense should be understood as a series of stages involving the mastery of anxieties in which the roles of aggressive and libidinal impulses alternate. By means of projection and introjection and in light of realistic frustrations of needs, part of a baby's reality becomes distorted for s/he perceives the world as consisting of part-objects who threaten his/her existence. The resulting fear is warded off by libidinisation, which neutralizes sadistic impulses. According to Glover (ibid) whenever an event in adult life triggers an infantile anxiety the individual tends to deal with it by means of primitive libidinisation that is through a perverse enactment. Extending therefore, Freud's notion that perversions are the negative of neurosis, Glover suggested that sometimes perversions are the opposite of psychoses. In perversions the reality sense is preserved by a sacrifice of adult libidinal function, in neurosis by some inhibition in reality relations,

whereas in psychosis the freedom from adult libidinal function is accompanied by gross disturbances of the reality sense.

1.2.5 Janine Chasseguet-Smirgel (1981, 1985)

Reviewing and extending Freud's contributions, Chasseguet-Smirgel (1985) formulated a comprehensive theory of perversions that links together previously advanced concepts such as disavowal and aggression in a creative and unique way. In agreement with Freud, Chassequet-Smirlger (1981) believes that we all conceal a perverse core and similar to him she places disavowal of castration at the heart of perversions. According to her theory, the realization from the part of the child of the complementary nature of his parents' genitality leads him to experience feelings of inadequacy and to perceive not only the difference between the sexes but also the difference between generations. In the developmental history of the future perverted individual there is a seductive mother who at the crucial oedipal phase, promotes the impression that the boy's pregenital penis is sufficient and better in satisfying her than that of the father, creating in this way the illusion that pregenitality is equal or superior to genitality. Pushed in this enchanting trap, the boy's development is arrested for he has nothing to admire or envy the father for, so he does not need to either grow up or mature. Regressing to an anal-sadistic universe all differences between men and women, adults and children and erotogenic zones are abolished. By means of sadistic impulses which attack every notion of difference, dissimilar elements are reduced to a homogeneous mass and are used interchangeably. Escaping the dilemmas posed by the oedipal phase, the pervert creates a new reality, an anal-sadistic universe characterised by confusion and homogenization whose purpose is to overcome the paternal genital universe which is characterised by differentiation, laws and barriers. For Chasseguet-Smirgel (ibid), therefore, disavowal is indeed in operation when it comes to perversions, but for her what is denied is not only the knowledge that women do not have penises and the resulting fear of castration, but also all kinds of gender and chronological differences that arouse feelings of inferiority. Expanding the notion of disavowal however was not the only contribution of the author. In an attempt to explain how the newly created anal reality is preserved, Chasseguet-Smirgel (ibid) proposed

that of equal importance is the process of idealization which enables the perverse individual to disguise from himself and others the anal nature of his psyche, reconstructing once more a different kind of reality.

Concurrent with the developments that were taking place in the Freudian realm, were advances in the Object Relations School which turned the focus away from libidinal understandings of perversion and placed emphasis on the relationship of the individual with significant others. It was in 1976 that sadomasochistic phenomena were linked for the first time with traumatic experiences involving early dependency on the mother (Eshel, 2005), whereas in 1979 Khan proposed that in the history of all perverse individuals there is a mother who first treats her child as a created thing and then abruptly abandons it. The theorists who have occupied themselves with the complex phenomena of perversions are numerous, an extensive and detailed review, however of the literature goes beyond the scope of this research. Instead, what appears to be closer to the purposes of this present project is to explore the ideas of certain prominent figures in the field whose theories have illuminated the conditions in ways that are, therapeutically speaking, significant.

1.2.6 Robert Stoller (1975)

One such figure is Stoller (1975) whose definition of perversions as "*the erotic form of hatred*" has had the same powerful impact as Freud's aphorism that perversions are the opposite of neurosis, for in one short phrase he captured an essential component of these conditions, namely hostility. Interestingly enough, Stoller did not agree with Freud's aphorism as he perceived perversions to be eroticised neuroses. What determines the course of development and whether a child will become neurotic or perverse depends, according to the author, on the nature of the attack s/he experiences. In neuroses, the attack is directed at parts of the body or the psyche that are not related with one's gender or sexuality, whereas in perversions the attack is directed specifically at one's gender and sexual organs. Perversion, "*one more masterpiece of the human intellect*" (p.106) arises as a solution to a repeated traumatisation or overstimulation regarding genitals which has contributed to the consolidation of an agonising mystery regarding their nature. Partly to put an end to this mystery, partly to deal

with castration anxiety and primitive fears of destruction, a perverse act is created in which all unresolved and anxiety provoking issues are resolved. Since the mystery however, has not been truly resolved the perverse act, whose purpose is to alleviate the anxiety it produces, must be repeated.

Having been attacked and humiliated for their gender, perverse individuals harbour hatred and a desire for revenge. Thus, perverse individuals' sexual practices are motivated by a hostility that is derived from a desire to harm the object and gratify the desire for revenge. Using hostility then as a criterion, Stoller (ibid) classified perversions on a continuum starting from these in which hostility is most obvious as in the case of rape and sadism, continuing to those in which hostility is less obvious such as voyeurism, exhibitionism, to those in which the individual appears to be the victim when in reality s/he is the perpetrator as in the case of autoerotic asphyxiation and masochism. At the very end of the continuum are those perversions, such as fetishism and necrophilia, in which hostility appears to be absent. According to Stoller, through the perverse enactments the individual relives the traumatic childhood experience, but this time it is s/he who orchestrates the situation, controls the scenario and by turning trauma to pleasure, triumphs over what has happened to him.

1.2.7 Mervyn Glasser (1979, 1998)

Another prominent figure in the field is Glasser, a psychoanalyst who actively explored the area of perversions and contributed to the establishment of the Portman Clinic (Morgan & Ruszcynski, 2007). He advanced one of the most elegant and useful theoretical concepts in the understandings of perversion. Clearly influenced by the Object Relations School, Glasser suggested that central to the psychic functioning of perverse individuals is a Core Complex. The Core Complex describes a normal developmental stage which all infants need to go through; namely the oscillation between the powerful longing to remain in a state of merging with the mother and the terror that such a union causes for the self is threatened with annihilation. Faced with the terror of annihilation the individual either withdraws, experiencing tremendous isolation and feelings of abandonment, or reacts aggressively in fantasy or reality against the object in an effort to preserve the self. Despite their efforts to protect

themselves from annihilation, the result of both the withdrawal and the aggressive attack is the loss of the desired object, an emotional outcome that pushes them back to a desperate search for closeness and sets the whole dramatic vicious cycle in motion again. The Core Complex, therefore, describes a way of relating to significant others that avoids true intimacy due to claustrophobic and psychotic anxieties that originate in infancy. The apparently unresolved dilemma between engulfment and annihilation on one hand and withdrawal and isolation on the other, finds its tragic solution in the sexualisation, which creates the illusion of true object-relating. This eroticised aggression towards the object is inevitably expressed through is masochistic and sadistic behaviours. More specifically, when the individual withdraws to avoid annihilation, the aggression that was originally directed towards the object, is directed towards the self, giving rise to masochism. Pain, humiliation and abuse are combined with pleasure giving the individual a sense of control over what is happening to him/her. In addition, by directing aggression towards the self, the object is protected from destructiveness saving the individual from the profound depression that would result from its loss. The sadistic perverse solution is equally "ingenious" for both the self and the object are protected once again. When the individual engages in a self-preservative aggression towards the threatening object, the self is protected from annihilation by means of torturing and controlling the other. Experiencing their rage as murderous, the sadistic engagement with the object is preferable for it preserves the object and the experience of loss is avoided.

Glasser's Core Complex presents the perverse solution in all its tragedy for it describes individuals who yearn for intimacy, but at the same time are terrified by it, individuals who experience tremendous isolation and yet the suspicion of getting closer raises the terror of psychic death.

1.2.8 Estella Welldon (1988, 1996, 2011)

Last but not least, it seems important to refer to Estella Welldon, who has extended our understanding of perversions, by exploring their manifestation in women. Theorising that perversions are neither the negative of neurosis nor a defence against psychosis, but a manic defence against profound depression, Welldon (2011) placed emphasis on the death like experiences

of early childhood and the extremely painful nature of such awareness. In her conceptualization of perversions, she retains previously postulated concepts such as disavowal, part-object relating, hostility, dehumanization and terror of engulfment as being the underlying processes which propel the perverse action, but she also sets the "body barrier" as marking of what can be thought of as perverse or not (Welldon, 1996). Welldon (2011) argues that in order for a person to be characterised as perverse, it is not enough to detect perverse elements in his/her sexual fantasies; the body must be used, that is the fantasy must be acted out.

In light however, of Brett Kahr's (2007) extraordinary research on the meaning and function of sexual fantasies in people's life, Welldon's (2011) assertion that perversion can be considered a sexual activity that is bodily expressed can be disputed. Obtaining data on Briton's sexual fantasies from 13.553 computer administered questionnaires on sexual behaviour, health and fantasy and 122 qualitative interviews, Kahr (ibid) concluded that 90% of our sexual fantasies contain elements of traumatic experiences originating in early childhood and appear to serve 14 different functions, of which those that are most related to perversion are mentioned here; self comfort and self-medication (when overwhelmed by feelings), establishment of object relationships (in the face of isolation), as transitional objects and phenomena (to deal with separation anxiety), communicating an inner unconscious conflict, indulgence in masochistic punishment (instead of using fantasies as a source of sexual joy (they are) is used as punishment for a something wrong we've done, either real or imaginary), a defence against intimacy and merger (use of masturbatory activity as a means of keeping other human beings at a distance), discharge of aggression, avoidance of painful reality (fantasising about what is not or cannot do), evacuation of sadistic strivings, mastery of trauma (by means of eroticization) and finally equilibration of the self ((in order to) rescue (ourselves) us (from) form complete breakdown, loss of sense of self). It becomes evident, that before they are expressed in action, perversions pre-exist and can be identified in sexual fantasy as a means of expressing aggression, sadistic impulses and hostility (Gillespie, 1953 & Stoller, 1975), as defences against isolation, engulfment and annihilation (Glasser, 1979) and as a means of triumphing over trauma

(Stoller, 1975). Therefore, Welldon's (2011) assertion that "*true perversion always involves the actual use of the body*" (p.11) is questionable.

Nevertheless, Welldon's greatest contribution in the field is undoubtedly her exploration of female perversion which dissolved the myth that was perpetuated by the psychiatric community and reflected in DSM-IV (APA, 1994) that paraphilias are a male characteristic. In her extraordinary work "Mother, Madonna, Whore", Welldon (1988) established that whereas men use their penises and direct the perverse act towards the outside world, women attack their whole body and the bodies of those of their children as products of their own body. Placing early emotional deprivation and ambivalence towards the female body and the relationship to mother at the heart of female perversion, Welldon (2011) argues that the precursors of abusive relational patterns can be found in adolescence, expressing themselves as eating disorders, drug abuse, promiscuity or cutting which are efforts to attack the body. In adult life, the abusive partner represents that part of the woman which hates the self and therefore he can now take the role of attacking the body. Fantasies and daydreams of taking revenge are often materialised in motherhood, by means of utilising children as dehumanised fetishes over which one can have absolute control. Concealing a deep unresolved mourning which if it were to become conscious would lead to deep depression and suicide, perversions act as defences in that they allow a flirtation with danger, which, by means of the excitement produced, creates the illusion of life in an otherwise deadened internal world.

Reviewing a few of the theoretical contributions to the literature of perversion it becomes apparent that the psychoanalytic community is currently divided into those who hold views that reflect the drive model and those who hold views that reflect the object-relations model. Although the theoretical differences are at times significant, when it comes to the therapeutic encounter what unites theoretically dispersed therapists is their emotional experience of individuals who present with perversions, something which in turn shapes their countertransference reactions.

1.3. Perversion & Countertransference

1.3.1 Countertransference in the research of countertransference in the treatment of perversions!

Although, there is an increasing consensus regarding the importance of countertransference phenomena in the treatment of perverse patients (Welldon, 2011; Jimenez, 2004; Ogden, 1996; Etchegoyen, 1977) and a demand for more research in the field (Welldon, 20011; Gordon, 2008; Jimenez & Moguillansky,2004), health professionals involved in the treatment of this client group have hesitated to undertake this research. More specifically, there are, to the best of my knowledge, only two published qualitative studies that might be thought of as being relevant, the first by Lea, Auburn & Kibblewhite (1999) and the second by Scheela (2001). Although these studies involve therapists' experiences when working therapeutically with perversions, they involve the treatment of sexual offenders in UK and USA prisons respectively, they do not explore countertransference experiences specifically, do not focus on psychodynamic therapists and do not include experiences with patients who suffer from perversions but have no criminal record. Nevertheless, these studies are important for they acknowledge the difficulties of working therapeutically with a similar population and include some findings that could be also understood as countertransference reactions.

In Lea et al (1999) study three major themes emerged, of which the first and the last, attitudes towards sexual offenders and issues around working with sexual offenders, are more relevant to the present research. In the first theme, the authors illustrate how positive and negative elements exist simultaneously (e.g. participants experience both empathy and anger towards the sexual offender) and how training and experience is directly related with a reflexive a critical thought development. Although not interpreted as such by the authors, it could be argued that this tension between opposites is indicative of therapists' countertransference reaction to the traumatised and aggressive parts of these offenders. The third theme explored is the tension experienced by the professionals in both developing a relationship with the sexual offender and at the same time avoiding such a relationship because of personal revulsion at their acts of the offenders. The

authors describe a process whereby the professional achieves "separation" by seeing the offender as an exhibit, which in turn they attempt to overcome with "identification". Both these reactions can be understood as countertransferences. Attempting to "separate" from the patient by perceiving him as an exhibit, is reminiscent of a perverse individual's tendency to dehumanize others in order to avoid deeper relating and can be thought of as a concordant countertransference. Identifying with the patient as a measure to counteract the separation can also be understood as a concordant countertransference reaction in the sense that this identification could portray the merging that perverse individuals long to achieve with significant others.

Scheela's (2001) study explored 17 therapists' experiences and perceptions of working with sexual offenders and some of the findings can be also conceptualised as countertransference reactions. According to the findings, therapists experienced an initial apprehension, fear and antipathy for the sex offender they were working with, but as therapy progressed they separated in their minds the individual from the abusive act and the work became more enjoyable. Therapists reported feeling frustrated with having to report previously unknown offences, worried about relapse, were anxious about being sued, felt suspicious and were concerned with transference and countertransference issues. The positive impact on therapists included the challenge of the work, working as a team, witnessing offender growth and change and contributing to the safety of community. Scheela's (2001) research also explored the coping strategies that therapists developed. These included becoming desensitised to abuse stories, processing problems with colleagues, using humour to balance other feelings at work. As Bibly et al (2006) mention in their evaluation of this study, its significance lies in the documentation of the difficulties and hazards encountered by therapists working with this patient group. Although this is a relevant study in therapists' experiences, its focus on offenders, its inclusion of therapists who utilize an intervention called Sexual Abuse Treatment program (includes individual, group family and couple therapy) sets it apart from the current research which seeks to explore psychodynamic psychotherapists'countertransference experiences with patients who are not necessarily offenders but still suffer from some type of perversion.

Qualitative research therefore in psychodynamic psychotherapists' countertransference experiences when working with perverse individuals is lacking. Ogden (1997) states clearly that any vivid account of an analysis of perversion requires a description of the therapist's experience of transference and countertransference. If we extend his words to research, it follows that any research activity in the area of countertransference and perversion demands from the therapist to share something of his personal experiences. Taking into consideration the personal and evasive nature of these feelings as they are often reported sporadically in the literature; feelings that often leave the therapists feeling violated, exposed, sexually aroused, abused, humiliated, intrigued etc, it could be hypothesised that revealing these feelings creates a guilty feeling in therapists who might still be haunted by Freudian neutrality and the belief that the experience of intense feeling equates with a failure to manage the countertransference.

Lack of research in the field could also be attributed to researchers' reluctance to immerse themselves for months or years on end in a field that brings them face to face with sexual violence, aggression and its consequences. This could be especially true in qualitative research where reflexivity, in the form of examining one's deeper motives for researching the particular topic, personal and cultural beliefs regarding sex and perversion and ways the nature of the material affects the researcher in his daily interaction with it, calls for an emotional openness that might feel at times overwhelming. This reluctance, therefore, could be conceptualised as another form of countertransference, formed in response to the research material itself and the personal significance it holds in the life of each therapist-researcher. This has been at least my own experience throughout this project, when at times I found myself experiencing feelings towards the research project similar to those I have experienced when working with individuals with perversion; powerless, paralysed, unable to form thoughts, disgusted, detached, intrigued, mesmerised, pulled in etc.

Another reason behind the lack of research could be researchers' embarrassment. Discussing a similar reluctance to explore and publish on female therapists' experiences with male patient's erotic transference, Russ (1993) suggests that this might be happening because female therapists might be striving to minimize attention to their sexual identity while gaining

academic status. It could be argued that something similar happens when it comes to researching countertransference experiences with this patient group, namely that attention is called to our sexual identities, conflicts and desires as well as to our darker or more infantile parts that might be dominated by aggressive elements. Although, research offers a somewhat intellectualised and detached way to explore countertransference with perverse patients, the power of the particular material appears to verify Golderberg's (1977) suggestions that "*countertransference may occur both in our consulting rooms as well as in our scientific discussions*"

1.3.2 Transference and Countertransference Perversion

As it is natural, for the two phenomena are interrelated, discussions regarding countertransference in the treatment of perversions almost always begin with a reference to transference-perversion, a term coined by Etchegoyen in 1977. In order for transference-perversion to be understood, we must always keep in mind that adults who unconsciously use perversion as a defensive system, do so because within them there exists a child who has suffered emotional or physical neglect, abandonment (Welldon, 2011; Bach, 1994), physical and/or sexual abuse and humiliation regarding his/her gender, cross-dressing in infancy (Stoller, 1975) and an extremely symbiotic relationship with a seductive mother (Chasseguette-Smirgerl, 1984). Having experienced a real threat to their psychic and biological survival, these children have not only felt extremely helpless since any sense of trust for a caring figure had been shuttered, but are also extremely enraged at what was done to them. Having grown up at the mercy of others, as adults they need to be in control (Welldon, 2011). Having experienced extreme emotional deprivation and abuse of different kinds, as adults they are extremely vulnerable to any situation that might resemble these original experiences and fearful for any relationship of dependency (Glasser, 1979). Their childhood rage finds expression in sadomasochism as a means of taking revenge and inflicting harm (Stoller, 1975). Having experienced death like psychological situations, these adults defend against the deadness inside them by sexualising relationships (Welldon, 2011; Bach, 1994). It does not come as surprise therefore, that the relationship with the therapist will be experienced at times as posing similar dangers and as such it

becomes a matter of life or death to defend their selves. Their past experiences and their defences are all played out in therapy in the context of transference- perversion, the term Etchegoyen (as cited in Moguillansky, 2004) used to describe the eroticization of the therapeutic relationship, the construction of a illusory unity with the analyst and the use on the part of the client of ways of communication whose purpose is to excite the analyst. In addition, in the context of the perverse transference, the patient displays a challenging and polemical attitude and transforms his instinct into ideology. In accordance to Freud's original differentiation, between neurosis, perversions and psychosis, Etchegoyen (as cited in Lauro, 1993) differentiated a perverse transference from neurotic one, on the basis that the first results from the patient's disavowal of reality and splitting of his ego.

Extending this definition, as far as sexualisation is concerned, Ogden (1996) suggested that the compulsive eroticization of the therapeutic relationship is a defence against experiencing psychological deadness and an attempt to generate a sense of vitality; a view that reflects Welldon's (2011) and Bach's (1994) understanding of perversions as being a defence against a deep sited depression that threatens the existence of self. William, a trainee counsellor with a sadomasochistic perversion whom I used to see in private practice, masturbated excessively and in his own words "*these are the only moments I know that I am alive*". Sex and consequently sexualisation of relationships helps the survival of self firstly, by means of hyper-stimulation which brings life to an otherwise deadened world and secondly as an "emergency bridge" (p. 46) to others (Royston, 2001).

As far as the creation of an illusory unity between client and therapist, Bach's (1994) aphorism that " *a person has a perversion instead of having a relationship*" (p. 5) is in accordance to Welldon's (2011) suggestion that , within the transference perversion, these clients protect their inner world by promoting the illusion of a shared reality with the therapist. In reality however, therapist and client continue to exist in two distinct worlds (Jimenez, 1994). In addition, as is well documented in the literature (Mann, 1997; Wrye & Wells, 1994; Khan, 1979) and as has certainly been my own clinical experience, transference perversion develops in such a subtle way that often the therapist is totally unaware of the perverse dynamic that has

transformed the therapeutic process into to a situation which reflects the characteristics of each particular perversion and s/he is of course totally unaware of his/her countertransference. As Kramer-Richards (2003) insightfully points out, the great question is to what extent perverse transference provokes a perverse countertransference and to what extent the perverse countertransference fuels the perverse transference. While working with Peter, I was completely unaware of the masochistic position I had acquired as he discussed in graphic details his sexual fantasies and erotic encounters with prostitutes; I thought that it was my job as a therapist to listen to and tolerate everything he wanted to say and indeed that was exactly what I did, until the day my supervisor alerted me to transference perversion that had developed. As Welldon (2011) has very perceptively suggested, I was unconsciously drawn into a "perverse pact" (p.47). This unavoidable perverse collusion (Jimenez 2004) with Peter's universe maintained between us the illusion that we shared a relationship based on trust and empathy, when in reality we were engaging in what Chasseguet-Smirgel (1981) calls pseudo-analysis, for the illusion of relatedness kept us at distance from his depressive core.

What the above example from my clinical practice also highlights, in accordance with many authors (Mann, 1997; Bach, 1994; Chaseequet-Smirgel, 1984; McDougall, 1978; Stoller, 1975), is that perversion involves not only sexuality but an overall way of relating which finds expression in transference and countertransference perversion and involves, as Coutinho et al (2005) suggest, an attempt on the part of the patient to maintain control. Mann (1997) observes that within the perverse transference-countertransference matrix, therapist and patient might become a perverse couple. The patient seeks to destroy the therapist and the creative therapeutic process and the therapist, humiliated, devalued and enraged might use his interpretations like whips to retaliate. Although, this is certainly one very common outcome, it could be hypothesised that the type of perverse relating depends on the particular individual and the specific perversion, and as such each therapist's countertransference will be unique. Despite the uniqueness of each therapeutic encounter it is possible to identify certain countertransference reactions that have been repeatedly reported in the literature. Again taking into consideration the highly specific

nature of each therapeutic encounter, the following countertransference reactions are by no means exhaustive; they are, to the best of my knowledge, the experiences which so far are those most commonly cited in literature

1.3.3 Feeling like a thing

Perhaps one of the countertransference experiences which is most difficult to manage in the context of this perverse relating is the feeling of being reduced to an object, a thing, devoid of any human or individual qualities (Mann, 1997). Indeed the aggressive dehumanization of others is at the core of perversions (Krammer-Richards, 2003) Consistent with this is my own clinical experience as well, when in the treatment of Peter I experienced for the first time what it means to become a lifeless object. It is an experience beyond our human understanding and as such difficult to put into words, but what perhaps best describes it, is that it was an overwhelming sense that everything that was human inside me was collapsing (similar to the image of a block of flats collapsing), leaving me feeling like a lifeless empty shell, unable to think, feel, or react. Less intense, perhaps because it was clearly expressed, was another client's reaction, whenever I attempted to speak. In a cold voice and with hateful eyes Albert would state: "*I'd like you to know that I don't hear a thing you say, you are this lifeless object (in) at the corner*". Feeling threatened by the existence of a mind different from his own in the room and of any interpretation that might transform his inner world (Welldon, 2011) this patient had to "destroy" not only me, by annihilating my thoughts and dehumanising me, but also the therapeutic process by rendering the exchange of ideas impossible. This particular transference-countertransference dynamic reflects both Stoller's (1975) theory regarding hostility being at the core of perversions, and Chasseguet-Smirger's (1985) theory regarding the anal universe in which the individual with perversion exists; a universe in which everything is destroyed and decomposed, and highlights the destructive influence of transference perversion on the therapist's capacity to think and infuse the therapeutic process with creative ideas (Mann, 1997). Being trapped in a countertransference that transforms the therapist into an object, the process stagnates and nothing can be born out of the interaction; therapist and client

become an infertile couple, destined to maintain the defensive system of the perversion.

1.3.4 Feeling like a part-object

The regressive nature of perversion (Bach, 1994) becomes evident when one considers the developmental stage in which many individuals with perversions are trapped. Operating often from a paranoid- schizoid position, in which objects are not experienced as whole human beings with a variety of antithetical qualities, but as part objects, having only one characteristic at a time, individuals with perversions often relate to the therapist as if he were indeed a part-object, ignoring all other aspects of his being. Part-objects can include either body parts, functions, or aspects of a person (Gomez, 1997). The perverse patient might for example, relate to a body part of the therapist, in the same way which, for example, the fetishist relates to others through their feet. Alternatively, the therapist may be related to as if s/he was a function, being, for example, only a therapist and as such having to offer unconditional and continuous care. Albert, at those times when he was becoming very aggressive towards me, could not understand the question "*how do you think this makes me feel*?" for in his mind I should not have any feeling at all. Identifying in the countertransference with the part-object can be particularly disorienting, for it feels as if something fundamental has been lost from our identity. Relating to the therapist as if s/he was a part-object leads to the creation of what Bach (1994) calls a technical relationship in which the therapist might feel exploited by the patient or used to satisfy his/her needs.

1.3.5 Feeling humiliated and/or useless

In the service of the defensive system of perversion is also the constant criticism and devaluation of the therapist. Carrying in him an internal world populated by objects who either humiliate or are humiliated (Stoller, 1975), the individual with perversion often re-enacts a similar scenario in the transference. By rendering the therapist useless (Mann, 1997) in his mind and in action, s/he can feel powerful and defend against the pain of humiliation he must once have experienced. By provoking the therapists' rage against this humiliation, s/he sets himself up to be put down once more. Feeling devalued, rejected and humiliated the therapist might become

increasingly angry with the client, withdrawing in resentful silences, or retaliating by verbally attacking and diminishing him. I experienced the particular dynamic with William who continually expressed his criticism regarding the set up and decoration of my office, his disappointment in my stupid therapeutic interventions and his contempt regarding the "psychodynamic bullshit" I was producing. Feeling useless in the countertransference, I often caught myself questioning my abilities and my preferred therapeutic model, whereas at other times, feeling tired and exasperated by his constant attacks, I found myself withdrawn in a hateful silence or retaliating by devaluing his own "spiritual" theories with what Ross (2003) calls a "*perverse use of theory*" (p. 79). Unaware of my countertransference, I used impressive interpretations (not) no to further his understanding, but to regain my lost status.

1.3.6 Feeling sexually aroused.

Feeling sexually aroused during the session in response to perverse material might be another reason why research in the field has been limited. On one hand, sexual feelings belong in the private sphere of all individuals and discussing them openly even in the context of countertransference results in us feeling exposed. On the other hand, experiencing sexual excitement with our patients might be a source of extreme guilt for not only does acting out this excitement go against our code of ethics but also what might excite us is perverse. It is guilt similar to the one felt by victims of sexual abuse whose bodies have responded sexually to the abusive violation of their perpetrators. Despite these difficulties in discussing the therapist's sexual excitement, it is a phenomenon that takes place and as a countertransference response it has its own significance for understanding the internal world of the client and the dynamics of the therapeutic relationship. When Peter developed an erotic transference and expressed his "erotic" feelings towards me, I experienced myself being bombarded and attacked by intrusive thoughts of us engaging in sexual intercourse, which prevented me from processing the material. Being overwhelmed by these feelings I was consumed by guilt and panic as I tried unsuccessfully to put them under control and make sense out of them. On reflection, this induced countertransference reaction, was Peter's unconscious way of keeping both

of us away from the excruciating pain involved in his relationship with his mother, that lurked underneath his erotic transference.

1.3.7 Feeling charmed & seduced

Seduction and charm have been reported in the literature to be the primary ways perverse individuals approach others (Ross, 2003). Albert in his mid-thirties presented to therapy well dressed, well mannered, and emitting the aura of a bohemian artist. I was instantly intrigued by his charming personality and shortly after the first session I found myself feeling impatient for our next meeting. Entrapped in this countertransference feeling of charm for a couple of sessions, I found myself admiring his unique and different way of experiencing his sexuality. He was presenting his sexual preferences as a revolutionary ideology that only a few enlightened individuals could understand and if I was good enough then I might also be able to get a glimpse of this wonderful world. This charm however, when it occurs in the context of therapy, is dangerous for it reinforces a way of relating to the client that splits off his aggressive and hostile parts (Ross, 2003) and allows us to perceive only the deceptive reality upon which the client himself hangs.

In addition, as has also been the case in my own clinical experience, seductive and/or charming behaviour might blind the therapist or lead him/her to acting out, such as being unconsciously seductive towards the patient. This might take the form of asking too many details about sexual fantasies or practices, and therefore acting as the seductive mother who sexually excites the client.

Considering all the above mentioned transference-countertransference dynamics it becomes apparent that therapy can be easily transformed into a ground where all that perversion involves will be repeated between the client and the therapist. Since all that is involved has much to do with aggression, hostility, destruction, pain and humiliation it follows that the therapist must find a way of dealing with these feelings, of surviving the attacks and protecting the therapeutic process if anything of therapeutic value is to emerge from this relationship.

1.4 Rational for the research

Despite the fact that the significance of countertransference phenomena in the treatment of perversions has been pointed out by numerous authors (e.g. Welldon, 2011; Jimenez, 2004; Ogden, 1996; Etchegoyen, 1977) and the fact that the gap in the research of this phenomenon has been repeatedly acknowledged (Welldon, 2011; Gordon, 2008; Jimenez & Moguillansky,2004), health professionals involved in the treatment of this client group have hesitated to undertake this research for a variety of reasons. As stated previously, these reasons might involve the researchers' moral reactions to the phenomenon of perversions (Verghaghe 2004 as cited in Welldon 2011), their own countertransference toward a subject that is replete with aggression and violence (Golderberg, 1977) and the researchers' fear of personal exposure to the scientific community and consequent loss of academic status (Russ, 1993). However, as Gordon (2008) insightfully points out, in the absence of research data we have no way of knowing whether the psychodynamic theories of perversion are valid or helpful in the treatment of the condition.

The present research therefore has as goal to fill this gap in the research by attempting to answer questions such as "*How do other therapists experience countertransference with this patient group?*", "*How do they make sense of their experience*?" "*How do other therapists cope with these feelings*" and to ground potential answers not on additional theoretical and at times abstract or difficult to grasp constructs, but on therapists' everyday clinical experiences with this client group. Obtaining answers to these questions by means of exploring therapists' own clinical experiences with this patient group, will shed light to the most central aspect in the treatment of perversions and will facilitate future therapists in their therapeutic work.

In addition, acknowledging that our knowledge of countertransference experiences comes mainly from published psychoanalytic case studies, the present research, by exploring these phenomena through the method of Interpretative Phenomenological Analysis could act as a means of methodological triangulation (Golafshani, 2003) through which the validity of the case studies' findings can be enhanced or not. This validation is of the

outmost importance for counselling and clinical psychologists who seek to base their interventions on research findings.

Furthermore, taking into consideration that the present research is the first of its kind in the field, the findings could become the basis for further research with the goal of developing a countertransference model of perversions and ultimately a countertransference based therapeutic model for these conditions. Such a therapeutic model could be of use not only to psychodynamic therapists in private practice, but also to the growing number of therapists involved in the treatment of sex offenders in prisons and experience a variety of feelings that are difficult to handle, as the afore mentioned studies of Lea et al (1999) and Scheela (2001) suggest.

The present research therefore, inspired by my own difficulties in my clinical practice with this client group and the lack of research findings in the field, has as goal to explore psychodynamic psychotherapists' countertransference experiences when working with perverse individuals with the hope that the findings will add to the theoretical understanding of countertransference phenomena in the treatment of perversions and will be useful to therapists working with this client group in a variety of settings, by offering a solid ground to base their interventions on.

Chapter 2: Methodology

2.1 Brief Summary of the Ontological and Epistemological position

Before exploring in detail in the next section the rational of the epistemological position underlying this research and the research method that I chose to address my research question, I would like in this section to state briefly my own ontological and epistemological stance.

Ontology is the metaphysical exploration of existence, the philosophical study of the nature of being, existence or reality. In other words ontology concerns the nature of reality and our underlying assumptions about the world (Stewart& Blocker, 1996). Convinced that there is no objective truth to be discovered, I believe that reality is highly subjective and each one of us ascribes his personal meaning to his experiences. The ontology therefore that underlies the present research is that of relativism. Relativism holds that, although there is an external world, human beings cannot access it directly, but they can only perceive representations of the world in their consciousness (Willig, 2009). Reality therefore is subjective and relative, construed at each given moment through the meanings and understandings that each one of us develops socially and experientially. In the present research therefore, as I set out to explore psychodynamic therapists' countertransference experiences when working with perverse patients, I do not believe that there is one objective truth to be discovered, but I expect to come across multiple realities, each of which holds its own truth and value.

If ontology is about what we perceive as being real, then epistemology is about the methods that we use for figuring out this reality. Epistemology, the branch of philosophy that is concerned with the theory of knowledge, raises questions such as 1) how reality can be known?, 2) what is the relationship between the knower and what is known, 3) what are the characteristics, principles and assumptions that guide the process of knowing and the achievement of findings (Vasilachis de Gialdino,2009). In other words epistemology is philosophically linked to ontology and offers to the researcher the conceptual frameworks to understand the phenomena under investigation (Holroyd, 2008). Consistent with the ontological position of relativism, the epistemological position that underlies this research project is that of Interpretative Phenomenology. In exploring therapists'

countertransference experiences when working with perverse patients, I assume that a deeper understanding of the phenomenon can only be reached by focusing on the way these phenomena are experienced by therapists themselves. In addition, as it becomes clearer in the next section, Interpretative Phenomenology holds that every description of the lived experiences entails our interpretation of it, or our preliminary assumptions about the meaning of those experiences (Smith, Flowers &Larking, 2009). Therefore, consistent with ontology of relativism, the epistemological position of this research assumes that any kind of knowledge that we acquire about countertransference when working with perverse patients will be subjective, for the participant's descriptions of their experiences entail the meanings and interpretations they have already ascribed to them. Similarly, this knowledge about countrertransference experiences will be reflexive (Willig, 2009) for as a researcher with my own subjective experience of reality and my previously acquired knowledge and preconceptions, I can never escape my own subjectivity and the interpretations of participants' experiences will be influenced by these personal constructions. By adopting, however, an Intepretative Phenomenological epistemological position, I am driven to become aware of the preconceptions and the way they might influence my understanding of the participant experiences.

Directed by the ontological position of relativism and the epistemological position of interpretative phenomenology, I have chosen to pursue a qualitative framework to inform my choice of methods and within this framework I have chosen Interpretative Phenomenological Analysis as the research method that can best answer my research question.

In the following sections the epistemological position underlying this research and the research method are presented in detail.

2.2 Epistemological position

The epistemological position underlying the design of every research project determine the nature of its findings (Coley, 2007) and as such, each researcher is called to explore his own beliefs and attitudes as to what is knowledge, how knowledge is acquired and what conceptual frameworks

are created to understand the phenomena under investigation (Holroyd, 2008). Adding to this, and adopting a Foucauldian perspective on the role of language in constructing psychological understandings (Willig, 2009), the very nature of the language that is used to pose the research question betrays something of the researcher's perception of the world and assumptions about knowledge.

Avoiding Popper's hypothetico-deductive method that has dominated psychological thinking and research for decades (Coley, 2007), this study does not aim to test a pre-existing theory of perversions by means of confirming or rejecting hypotheses. Despite the unequivocal fact that the scientific method, with its carefully constructed research designs, has produced valuable "objective" knowledge in the realm of psychology (Holroyd, 2008), the hypothetico-deductive method can be criticised, on one hand, as neglecting the significance of sociocultural variables in the construction of knowledge, and on the other hand, as preventing the generation of novel theories (Willig, 2009). A further limitation of the scientific methodology appears to be statistics' exclusion of atypical situations as nuances that distort the results. The scientific method appears to recognize the typical as valid and to treat the atypical as non-valid, leaving aside the individual in favour of average findings. Human nature and behaviour, however, are not limited to what can be replicated and generalised, but extend beyond the similarity that statistical results impose on them to encompass unique and equally important ways of being.

Despite their usefulness and the prestigious place they tend to hold in the "scientific" community, quantitative research methods have failed to become researchers' panacea in the field of psychology. In an insightful critique on quantitative research, Silverman (2000) points out the often arbitrary definition of variables, the subjective nature of operational definitions which unavoidably carry the researcher's value systems with them (e.g. intelligence, delinquency) and cautions against the after the fact speculation on the meaning of results.

More importantly, when one considers the applicability of quantitative methodologies in the research of therapists' countertransference reactions, one need to consider what types of answers these methodologies would

produce. In other words we return to the original epistemological assumptions that shape the nature of the researchers' methodologies.

Assuming that there is an objective measurable truth about reactions when working with people with perversions, then, at best, we would be able to establish a cause and effect relationship or a correlation. However the therapeutic relationship, being an interaction, can hardly be considered as one way process in which causes and effects can be clearly differentiated. When it comes to social relationships, causality is difficult to establish and even more difficult to restrict to one or a few variables (Silverman, 2000). A correlation on the other hand would lead us to equally unsatisfactory results as it would just demonstrate that there are two phenomena that tend to occur together. Such a finding discloses very little about the way the phenomena are interrelated as one would expect to be revealed when a relationship is explored and again gives us no information about the quality of that relationship. It appears that a quantitative methodology would be an insufficient approach to explore therapists' countertransferences when working with perverse people, not only because of technical difficulties discussed above, but also because of its underlying philosophical assumptions that dictate to us that we must aim to discover and describe an objective truth.

Holroyd (2008) attempts to explain our fascination with objective truth on the basis of human beings' need to "know" and differentiates "knowing" from "understanding". Hughes & Sharrock (1997, as cited in Holroyd, 2008) alert us to the fact that the origins and characteristics of what we call "knowledge" are rooted in the empiricist tradition, which proposes that our knowledge of the world must be derived from the facts of experience (Willig, 2009). Knowing, however, cannot be equated with understanding, a difference that becomes more apparent when one researches social processes or relational phenomena (Holroyd, 2008). Knowing that a relationship exists between a therapist's countertransference reaction and the client's perversion does not necessarily mean that we understand the nature of this interaction.

In Being & Time Heidegger (1962) challenges the conventional perception of "understanding" as a purely cognitive process and proposes that understanding arises out of our existence through experience. In a quest

for a cognitive knowledge of the other, quantitative methodologies exercise full intellectual control over the object (Taylor, 2002, p.127) with little or no opportunity for the participant to interact with the researcher and for the two of them to co-construct an experience that would facilitate understanding in Heideggerian terms.

The researcher, who chooses to understand rather than know, moves away from the epistemological position of positivism and strict empiricism, abandons any ideas about acquiring an objective truth, and instead adopts a phenomenological position. The *Phenomenological Approach* recognizes that in order to understand the phenomena under investigation, one need to enter the lived experience of the other person, in order to grasp the unique ways the phenomenon is perceived and experienced and thus allow for a new dimension of it to emerge (McLeod, 2003). Instead of imposing pre-existing knowledge on the understanding of phenomenon, the research allows the phenomenon to be seen "*from itself in the very way in which it shows itself from itself*" (Heidegger, 1962 p. 58).

Therefore, adopting a phenomenological approach to the journey of understanding therapists' countertransference experiences when working with perverse individuals means that the present research aims to illuminate the particular experiences in the unique ways that they are lived by the participants.

The phenomenological approach was introduced by Husserl as a new way of approaching the subject of philosophy, a process that demands from the philosopher/researcher to abandon the attitude of taking for granted understanding (Smith, Flowers & Larking, 2009). Husserl's *Transcendental Phenomenology* suggests that a number of reductions need to be put in place in order for the phenomenon to emerge in its totality. Although the nature of the present research question places it in the realm of phenomenology, the language used to pose the question entails seeds of pre-existing theoretical formulations. For example the use of the term "countertransference" implies a psychoanalytic understanding of the interaction taking place between therapist and client, as does the term perversion. It seems that the very act of posing a question necessitates some pre-understanding of the phenomenon under investigation, otherwise the question would not have arisen in the first place (Cohn, 2002). Heidegger,

Ricoeur, Merleau-Pontly and more recently Gadamer all agree that it is impossible to escape our personal way of perceiving the world (Finlay, 2008). In Being and Time Heidegger (1962) argued […] *that the development of understanding has its own possibility-that of developing itself. This development of understanding we call interpretation. In interpretation, understanding does not become something different. It becomes itself. Such interpretation is grounded existentially in understanding (p. 188).*

For Heidegger therefore any kind of description carries with it an interpretation exactly because Dasein, finds himself in the world with a primordial understanding of being (Cohn, 2002) and with an awareness which is interpretative in nature (van Manen, 2002). Adopting a similar position, Ricoeur argued that in our effort to understand we do interpret phenomena through our cultural influences (ibid, 2002), whereas Merlau-Ponty discussed the impossibility of bracketing and called for an exploration of the way we are involved and shaped by, the world in an embodied way (Finlay, 2008).

Accepting therefore the impossibility of reduction, we enter the realm of *Hermeneutic Phenomenology* which acknowledges that the understanding of lived experiences unavoidably entails our preliminary assumptions about the meaning of those experiences (Willig, 2009). In the context of Hermeneutic Phenomenology the researcher's influence and his fore-understandings are explored (Finlay, 2008) and the researcher is recognised as being an active agent in the process of exploration. For example, Gadamer (1975) argues that opening ourselves up to the experiential world of the other requires "[…] *neither neutrality with the respect to content nor the extinction of one's self, but the foregrounding and appropriation of one's own fore-meanings and prejudices* (p. 268-269)

In the context of hermeneutic phenomenology, the task of researchers is not to magically put aside any previously acquired knowledge or understandings about the nature of the world, but actually to become aware of them and to reflect on how these pre-conceptions influence their perception of the phenomenon and how they limit the experiential understanding of the other person's lived experience. Recognising that in our meeting with participants, pre-established assumptions can easily cast a

shadow on the very phenomenon we are researching (Holroyd, 2008), we are invited to adopt a *reflexive attitude* which will enable us to critically examine the influences of our subjective experiences during all stages of the research (Finlay, 2008).

2.3 Method

Placing the present research within the realm of hermeneutic phenomenology was the necessary first step that would enable a decision-making process regarding the specific research method to be chosen. Returning to my original question and taking into consideration my epistemological position it appeared that the most appropriate research method for this research would be *Interpretative Phenomenological Analysis (IPA).*

The cornerstones of IPA can be found in phenomenology and hermeneutics, whereas as a process it is influenced by humanistic psychology and symbolic interactionism (Willig, 2009). With its holistic approach to human beings as affective, physical, cognitive and linguistic agents, IPA demonstrates its influences from humanistic psychology, and aims to discover the internal worlds of participants (Smith & Eatough, 2007). More specifically, IPA, adopting a relativistic ontology, seeks to explore participants' subjective experiences and to discover how they make sense of these, without making any critical evaluations about the "true" or "false" nature of these experiences (Willig, 2009). This aim sits well with my research question whose purpose was to discover in what way psychodynamic therapists experience the therapeutic relationship when working with people with perversion. Therefore, in using IPA for this research, an assumption was made that the therapists' accounts would reveal something about their thoughts, feelings, and/or bodily reactions, which in turn would illuminate their unique experiences (Willig, 2009) with this specific client group.

Furthermore, IPA acknowledges the *double hermeneutic process* that permeates the interview process, as both the participant strives to make sense of his experience and the researcher attempts to make sense of how s/he makes sense of that experience (Smith, Flowers & Larkin, 2009). In

acknowledging this process, IPA positions the researcher within the field of his research, and acknowledges that s/he is always engaging in an interpretative activity (Smith & Eatough, 2007). This interpretative process is thought to be influenced by the social interaction processes that take place which shapes the meaning we ascribe to experiences. IPA therefore, subscribing to a symbolic interactionist approach as well, does not seek to produce objective knowledge, but reflexive understandings (Willig, 2009). In that sense IPA is in accord with my belief that it is impossible to place ourselves outside the object of our interest and that we cannot avoid approaching it with certain pre-conceptions

Smith, Flower & Larkin (2009) describe a second type of double hermeneutics that characterizes IPA. This is borrowed by Ricoer's distinction between the *hermeneutics of empathy*, which attempts to reconstruct the original experience, and the *hermeneutics of suspicion*, which attempts to understand the experience using external theoretical formulations. The IPA researcher combines the two in an attempt not only to empathise and sense the world of participants, but also to maintain a critical stance questioning what it is being said.

The choice of IPA as a research method for this study was also thought to be interrogative in its capacity to contribute to and question existing psychoanalytic understanding in the field of psychotherapy with clients with perversion. Taking into consideration that psychoanalytic schools of psychotherapy have often been criticised for imposing theoretical understanding on patients' experiences, IPA's emphasis on exploring experiences can be thought of being a convergent measure that can verify or question psychoanalytic theoretical constructs.

IPA as described by Smith (2009) involves the exploration of people's experiences and understandings of particular phenomena, and as the author suggests, research questions should be directed towards meaning within specific contexts. In addition, the sample should be selected purposefully because it is people with particular experiences that can offer insights into the particular area of interest. In this respect, IPA is an appropriate methodology to explore psychodynamic therapists' (purposeful sample) countertransference (particular phenomenon) experiences (aim of methodology) when working with perverse patients (specific context).

A contradiction, however, appears as Smith (ibid) states that primary research questions should avoid imposing too many a priori theoretical constructs, but at the same time, because the researcher's concern is the detailed exploration of the lived experience, the research question should not be "on too grand a scale". In this respect, the research question which is inspired by psychoanalytic theory and infused with such a terminology is inappropriate for it imposes a priori a theoretical orientation. A more appropriate research question would then be "what are the experiences of therapists working with people with perversions". Such a research question however moves away from the specific phenomenon that I wanted to investigate, becomes too broad and does not specify a specific sample of people who would be able to reflect on the phenomenon.

It appears that these contradictions arise as IPA is used to explore phenomena that take place in therapy as, by definition, every therapeutic situation is infused by one or more theoretical orientations. Therefore we cannot avoid our exploration of specific therapeutic phenomena without these being driven by theory, for otherwise the research is too broad and meaningless and the sample so large that reflection on meaning might be totally impossible. It seems to me that, when research is directed towards exploring therapists' experiences of particular phenomena within therapy, a meaningful research question should be phrased to reflect the way these phenomena are perceived and verbalised by therapists themselves. In this way, although a theoretical construct, which definitely shapes the way the experiences are construed, pre-exists, a phenomenological stance is maintained in that the researcher remains close to the phenomenon as experienced by the therapists, the questions posed are relevant to the therapists' experiences and the context within which these experiences occur is specific and narrow enough for a detailed examination of the lived experience to be feasible.

IPA utilizes small samples, semi structured interviews and follows a particular protocol of analysing the transcribed material. In the following sections a detailed account of the above is offered in the hope of making the research process as transparent as possible.

2.3.1 Participants

IPA avoids psychology's nomothetic attitude which seeks to make claims at a population level. On the contrary, IPA adopts an idiographic approach which places emphasis on the detail and therefore in-depth analysis of the material. For this reason, as Smith et al (2009) suggest, the sample should be small, purposively selected and homogenous. Following Smith et al. (2009) suggestion that a sample between 4 to 10 participants is sufficient for practitioner's doctorates, 12 British and Greek therapists were recruited. Inclusion criteria for participation in this research were: a) participants had to be either chartered counselling or clinical psychologists, or qualified psychoanalysts or qualified psychotherapists to ensure a minum level of theoretical knowledge and clinical experience b) participants had to have psychoanalytic, analytic or psychodynamic training and orientation in therapy to ensure that they would be able to reflect on countertrantsference experiences c) participants had to have at least five years of clinical experience to ensure that they were experienced enough to work with the therapeutic relationship, d) participants had to have previous experience of working with people with perversion, e) participants had to be fluent in English, to ensure that language would not prevent them from reflecting adequately on their experiences. The specific criteria were imposed for the purposes of constructing a homogenous sample in terms of the therapeutic approach that was used and in order to facilitate the exploration of countertransferences.

One female Greek therapist was interviewed to pilot the interview questions and, due to the fact that the questions were changed, was then excluded from the sample. Another female British therapist was excluded from the sample, for as it turned out during the interview she did not fulfil the second inclusion criterion; although the therapist had experience working with adolescents with perversions, she did not have experience working with adults.

The final sample therefore consisted of 10 therapists, (6 females & 4 males) which were identified as chartered clinical or counselling psychologists, psychoanalysts, psychotherapists and or psychoanalytic psychotherapists, with clinical experience ranging from 8 to 27 years. Two female participants were British and the remaining 8 were Greek. Table 1

summarizes participants' characteristics in detail. As it becomes apparent from the nature of the sample, this is comprised mainly of Greek therapists. Although my initial intention was to interview British therapists only, due to my relocation to Greece during the initial stages of my doctorate, this proved particularly difficult, for my visits to London were few and short. A decision was then made to include Greek therapists who fulfilled the inclusion criteria and were fluent in English as well. My decision to conduct interviews in English reflected the fact that this was ~~a~~ research conducted within a British University and as such the original interview material should be available to British or English speaking reviewers and also reflected my attempt to control the language variable. However, due to the low response rate, two Greek therapists who were not fluent in English but met the rest of the inclusion criteria were included. These two interviews were conducted in Greek and were later translated by the researcher. In translating the interviews, an effort was made to retain the exact verbal expressions of the interviewees, although in few occasions these had to be altered to preserve the meaning of their communications.

Reflecting on participants' low response rate, it could be hypothesised that the nature of the interview put participants off because, on one hand, it involved a potentially embarrassing topic such as sexuality and perversion, and, on the other hand, because it required participants to discuss material that is highly personal and emotionally powerful.

2.3.2 Data collection

Participants were recruited through the research flyer (Appendix A), which was either sent to them via their email or office addresses that were public on their professional associations' websites (British Psychological Society, British Association of Psychotherapists, British Psychoanalytic Society, Greek Psychoanalytic Society) or was posted to the associations or clinics (Portman Clinic). The research flyer was distributed in Greek as well (Appendix B)

Participants were interviewed at their consulting rooms, a decision which reflected the researcher's wish to make the interview process as convenient as possible, and to facilitate the participant's memory and reflection. It was thought that therapists would feel more relaxed and safer

discussing potentially embarrassing and emotionally powerful material in an environment which was familiar to them (Smith & Eatough, 2007). The familiarity of the environment was also thought to be instrumental for this research, as it could facilitate participants' ability to recall their experiences more accurately and engage in those more fully.

Prior to the actual interview participants were asked to consider the Information Sheet (Appendix C, D), which informed them about the procedure and were asked to sign the consent form (Appendix C, D). The interviews were digitally recorded and lasted between 45 minutes to an hour. At the end of the interview participants were debriefed (Appendix E, F) on the aims of the research and asked if they had any questions.

The main part of the interview was guided by a semi-structured interview schedule (Appendix G), consisting of open-ended questions half of which were designed to facilitate participants' reflection on their experiences and half of which were designed to engage participants in imaginary scenarios. Questions were designed in an effort to eliminate the possible response bias created by leading questions (McLeod, 2007) that can potentially impose the researcher's meanings on the participants' experiences. Due to the aim of the study, which was mainly concerned with exploring participants' perspectives and feelings, closed questions were avoided.

The development of the particular questionnaire was the result of a pilot interview during which ineffective questions and questions that were missing and could have enlightened the procedure were identified. For example, one question in the original questionnaire that was replaced was "*What was your experience of the therapeutic relationship as that was unfolding during therapy*". During the pilot interview it was noted that the question was too broad and despite the probes, the participant found it difficult to gather her thoughts. The question then was broken down to three questions *Thinking about the beginning (middle, end) of therapy, can you remember what was happening in terms of the therapeutic relationship?"* It was believed that a more concrete but equally open ended question would facilitate the participants' reflections on their experiences. This questionnaire was also translated to Greek for the two interviews that were conducted in Greek (Appendix H).

In keeping with IPA guidelines the interview schedule was used flexibly. Questions were adapted in response to participants' discourse and the schedule was not always followed in the same order and/or the questions were not asked in exactly the same way (Smith & Eatough, 2007). Moreover, the interview style was non-directive, but a process of reflecting and probing was employed. The intention was to encourage each participant to talk about their countertransference reactions and to explore them as fully as possible. In this manner, the content of each interview was dictated by the participant and the interview schedule was therefore used only as a loose guide, with the sequence of topics being slightly different in each case.

2.4 Reflexivity & the Interview Process

Acknowledging the inescapable tendency of human beings to constantly create meaning and engage in interpretations, Finlay (2008) describes hermeneutic phenomenological research as a dance between reflexivity and reduction, where the researcher moves constantly between becoming aware of subjective meanings, experiences and interpretations and striving to contain them, in order for new pre-understandings to emerge and the process of "*containing their seductive power*" (p. 17) to start again.

In the present research and during the interview process there was an unavoidable and continuous tension between, on one hand, pre-existing psychoanalytic understandings about perversions and the nature of countertransference, and, on the other hand, the phenomenological attitude that requires an openness to participants' subjective experiences. Psychoanalytic formulations that have influenced my thinking had to be put aside, to allow participants to disclose their own understandings of perversion. Personal countertransference reactions when working with people with perversions had equally to be put aside, a task which was particularly difficult given-that it was the strength of those experiences that motivated me to conduct this research. There were many instances during the interviews when I caught myself responding with enthusiasm when a participant appeared to describe an experience similar to mine and it took the exercise of a lot of discipline not to assume that our experiences were identical and continue the exploration. At other times, I caught myself being

frustrated with participants for not responding the way I had hoped and again it required all my strength to remove myself from such a position and allow the participant to fully discuss his experience. Bracketing theoretical knowledge and subjective experiences proved significantly more difficult than I had expected.

An additional particularly challenging task was to find a balance between being "scientifically removed from" and at the same time being able to empathically dwell in the participants worlds, as Churcil at al. (1998) suggest. This challenge was reflected in my striving to retain the phenomenological researcher's attitude at moments during the interviews that were so powerful that they triggered my therapeutic identity, not only in empathically sensing the participants' felt experience, but also in interpreting it according to my psychodynamic therapeutic framework.

Chapter 3: Analysis

The analysis of the interviews proceeded in accordance to IPA's guidelines, as these are provided by Smith, Flowers & Larkin (2009), and was conducted with both Yadley's (2000) and Smith's (2011) evaluation criteria regarding validity in mind.

3.1 Stages of Analysis

The first stage of the analysis involved the detailed reading and re-reading of each interview in order for a comprehensive understanding of each participant's account to be reached. During this stage, I allowed myself to be influenced by the material and noted all my thoughts and reactions on the right margin of the transcript without judging whether these were meaningful, right or wrong. The comments made at this stage were both phenomenological and interpretative. This free-association allowed my own preconceptions and beliefs to surface in order that they could be examined and eliminated and this helped me to identify those points where that I was too interpretative and to re-examine them. In this way the phenomenological stance towards analysis was enhanced.

The second stage of the analysis involved the identification of themes. At this stage terminology consistent with the psychological thinking that underlined participants' accounts was used to "translate" their experience. The fact that the participants were therapists themselves, who used psychological terms to describe their experience, helped me to stay close to their experience as I named themes and sub-themes using the same terminology they employed. In this way a balance between the phenomenological and interpretative aspects of IPA was achieved

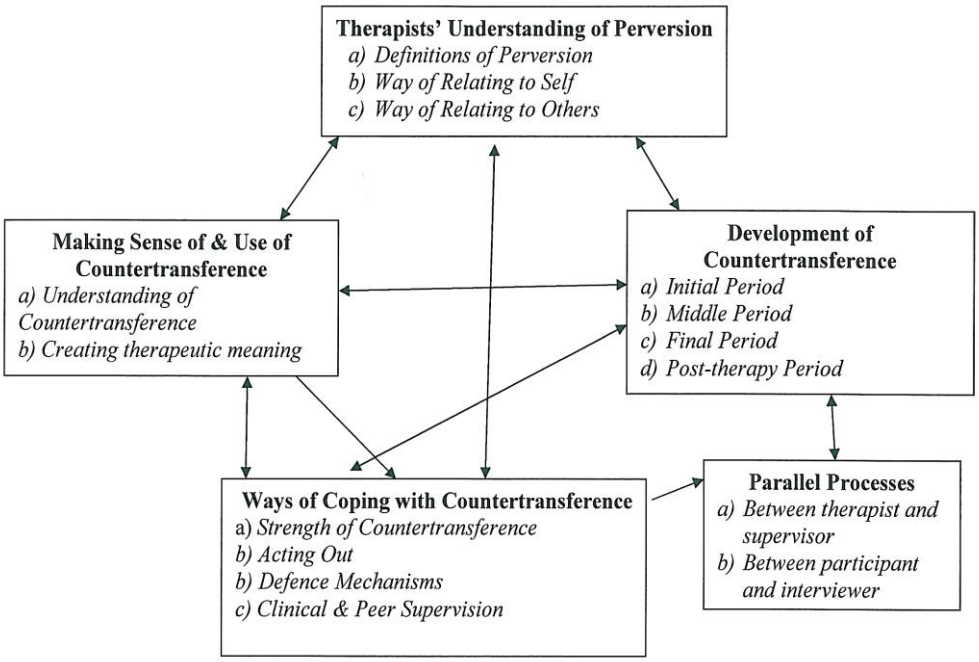
The third step in the analysis involved listing all the themes and reflecting upon their potential relationship. Themes that were conceptually related were organised into clusters, superordinate themes, which were subsequently labelled in a way that attempted to capture their essence (Willig, 2009)

The final stage of the analysis involved listing superordinate themes with their respective sub-themes in a summary table (Smith & Eatough, 2007) At this stage some themes were dropped because they appeared to be

marginally relevant to the phenomenon under investigation (Willig, 2009) or because it was not possible to analyse them due to lack of space. Of those themes that were directly related to with the research question, some appeared consistently across participants making the decision to retain them straightforward, whereas others appeared less frequently, or were unique. The decision to drop some themes was not an easy one due to the fact that each of these themes reflected a person's experience. In attempting to resolve this dilemma, prevalence of emergent themes had to be balanced against the personal judgement of significance (Smith, Flowers & Larkin, 2009).

The final stage of the analysis involved the production of a final Master Table (table 2) consisting of those themes and subthemes that emerged through the above mentioned analytic process. Although the majority of the emergent themes in the final table are strongly represented in participants' accounts enhancing validity (Smith, 2011), there are a couple of subthemes, which were considered to be significant, despite the fact that they reflect few participants' experiences

The following diagram is a pictorial demonstration of the relationship between all the emergent themes. As becomes apparent, all themes are interconnected in the sense that the one appears to affect the other, creating the overall complex experience of the therapeutic process, further informing participants' perception of perversions. For example, the way therapists understand perversions is directly related to the way they perceive and interpret their countertransference experiences throughout therapy, which in turn influences this understanding. These countertransference experiences trigger specific ways of coping which in turn illuminate further their countertransference, influence the way therapists make use of them and add to therapists' understanding of the overall phenomenon.



3.2. Reflections on Translation, Interpretation and Validity

A major concern regarding validity has been the translation of two interviews from Greek to English. IPA acknowledges that the process of the analysis involves a double hermeneutic process (Smith &Osborne, 2003) in the sense that the researcher is attempting to make sense of the participant's experience as s/he attempts to make sense of it. In translating however, the interviews, there appears to an additional level of interpretation on the level of language. During the interviews the participants engaged in interpretations of their experiences, then I translated their accounts from Greek to English and then I interpreted their experiences for the purpose of the analysis. In this context then, validity depends both on translation and interpretation, two concepts that are closely related and as such it is important to explore their dynamic interrelationship further.

Etymologically, the term translation refers to the process of "carrying cross" or "bringing across" and has traditionally been conceived as a way of transporting the meaning from one text another and from one language to another (Akkurt, 2011). Such a definition assumes that the text is a static

entity, its meaning is found in the actual words, and that, if there is an accurate translation of the words from one language to another, then the meaning will be "carried across" safely as well. Despite the fact that this view dominated the translators' work for literary centuries, Akkurt (ibid) points to the suspiciousness that people from all cultures and times have experienced towards translators regarding their objectivity and fidelity, as if they knew experientially that which hermeneutics and post-structuralism made evident later on.

For example, Heidegger (1959) in his effort to uncover the essence of language proposed that language is Saying as Showing. This means, that when there is a motivation to speak, language gives is self to the speaker in order to bring to presence that which is there to appear. In this way, language deflects attention from itself to that which is to make its appearance, transforming the linguistic experience in to one that both something is revealed and something remains concealed. Language therefore, governs human mind for it is in the language's self-giving that mind can construct thoughts.

Following Heidegger, Derrida, one of the most influential thinkers of post-structuralism, also believes that language shapes us. In developing deconstruction as a technique for uncovering the multiple interpretations of a text, he concluded that the meanings of words are largely imbedded in language use itself such that how we talk, write, and read largely determines what we end up saying. Derrida argues that meaning is forever elusive and incomplete in the sense that language can never perfectly convey what is meant by the language user. (Agger, 1998) Moreover, as language carries within it and at the same time shapes our assumptions about the world, a text can be re-interpreted in many different ways and as such there is no objective or conclusive interpretation.

These views have ultimately reshaped our understanding of translation. In Deconstruction and Translation Davis (2011) suggests that if a text is no longer a static entity, then the process of translation can be best understood as a process of transformation in which the translator plays an active role. The act of translation, therefore, does not involve the transportation of words from one language to another, but it entails unavoidably interpretative choices from the part of the translator. Indeed, if we consider language as

the agent through which reality is constantly encoded and we take into consideration that reality is subject to our interpretation, then it follows that in our lived linguistic experience we use our cultural and personal experiences to decode the reality that is being transmitted through language. In translating a text therefore, there is a constant process of decoding and recoding for at least two cultures or realities. In this view, the imposed ethical of obligation of the translator to remain neutral and objective is an illusion as it disregards the fact that the translator is unavoidably embedded in his personal and cultural situation as well as in the language he speaks.

The above discussion on translation highlights the dilemma I faced as a researcher. Taking into consideration that transparency is one of the most significant criteria for qualitative research the interviews that were conducted in Greek were translated and certified by an independent translation agency. The certified translations of the research ensure the transparency of the research material and facilitate the process of inspection from English speaking reviewers, should such a request is made. The analysis of the material, however, was based on my own translation, as I thought that being a psychologist and having conducted the interviews myself, I was more qualified than the translation agency to transfer the meaning of the participants' experiences from one language to another. Taking into consideration that being the translator, one is also the interpreter of the the language and the meanings it carries within it, the process of translating the interviews can be viewed as a process of blending realities. Although the translation agency translated the words accurately, it seems to me, that having shared with participants the reality of the interview, I was in a better position to translate and interpret their experience. The reasons for this are explained through the Theory of Scenes and Frames Semantics and though Foucault's theory.

The Theory of Scenes and Frames Semantics, as developed by Fillmore in the 1970s suggests that when we read a text the linguistic frames (linguistic signs) trigger certain scenes in our mind, creating this way a kind of a world that depends on our private and cultural experiences. According to this theory, the meaning that we derive from a text depends less on our knowledge of the language and more on our experiences with the culture within which the language is embedded. It follows that a native speaker of a

language when reading a text will have different and richer associations in his mind than a non native speaker. The translator, therefore, needs to be able to understand the scenes that are activated behind the frames in order to be able to convey the meaning, which means that s/he must be competent in both the languages and the cultures. (Akkurt, 2011)

Fortunately, being Greek and having lived in UK for many years I believe that I have an understanding not only of the two languages, but also of the two cultures. In this sense, and following the Scenes and Frames Semantics theory, I believe that in my engagement with the participants I had available scenes from both cultures to intuitively understand the rich meanings that were conveyed through language. In my effort to translate therefore, from Greek to English, as a native speaker of Greek I had available the necessary scenes to establish a common experiential ground with the participants, and as a non-native speaker of English who has lived in the British culture for many years, I had available scenes to translate the meaning in English for the English readers.

In the case of the interviews, however, it is important to consider not only the familiarity with the languages and the cultures, but also the familiarity with the "culture" or "institution" of psychoanalysis. In the Discourse of Language, Foucault (1971) proposes that language is being used to construct discourses, authoritative ways of describing and controlling reality. Psychoanalytic discourse, through its own language, private terminology and definitions is such a way of presenting the reality of human mind and relations. For example, by establishing the term unconscious, psychoanalysis constructs a view of human mind which does not have immediate access to its contents and on the basis of this notion disorders are invented and treatments are applied.

Having trained in both Greece and Britain and having being influenced by the psychoanalytic discourse as it appears in both countries, I believe that I was able to share with my participants their psychoanalytic culture and reality and my mind was able to trigger associative scenes from both psychoanalytic worlds, translating therefore the meaning effectively.

The importance of the familiarity with the psychoanalytic discourse and terminology becomes apparent Jason's interview in which he discusses the importance of neutrality as a means for gaining emotional distance and

being able to reflect on countertransfere feelings. In my translation, I use the terms "countertransferential feelings", whereas the translator used the terms "counter transfer emotions"

The reference to the effective translation of meaning might appear to be in conflict with all the arguments raised above regarding the impossibility of an objective translation and the dynamic status of texts. Indeed, the interviews would have been translated differently by someone else and the translations, infused by our subjectivity would differ. Does this mean that multiple translations from different people are required to reach the truth of a text? Frank&Timme (2011) in their work "The Translator's Approach-Introduction to Translational Hermeneutics" argue that "the objectivity of a translation is not obtained by multiple contributions, but by "*flexible thinking of one observer who phenomenologically tends to be as broad as possible*" (p. 96). This is an important point as it is directly linked with validity. It appears that any effort from different translators to translate the interviews would have created confusion, because their interpretative understanding of the text would have been different, influenced by their own subjective and cultural experiences, their own discipline's discourse and the lack of experiential information that they could have access to, had they conducted the interviews themselves.

The following is an example from Jason's interview. During the interview, Jason was saying that he did not believe to have worked with a similar patient during his carrier in mental health organizations or psychiatric hospitals. Having not been the one to conduct the interview, but translating the transcript, the translator thought that the participant had never t been employed in mental health organizations and for this reason he had never had a similar patient before.

Researcher: "*I don't think I have ever worked with such a case before in large organizations or psychiatric hospitals… so I was immediately attracted to it… how can I say it…it intrigued me.. theoretically I mean*

Translator: *I don't remember if I had seen before because I have not worked with in large organization, in a psychiatric ward…whereby that immediately attacted me…well how do they say it…theoretically it intrigued me*.

This is a significant change in meaning and had I had utilized the agency's translation this aspect of the participant's experience, which became apparent during the interview, would have been lost.

Therefore, I believe that by utilizing my version of translation in the analysis of the participants' experiences, I lessened the confusion that might have been created by utilizing the agency's translation or by utilizing multiple translations. Moreover, it seems to me that by using my own translation for the analysis, I preserved the participants' accounts by being able to carry within the translation my phenomenological understanding of their experience, which depends not only on what was transcribed, but also on our unique interaction.

The question then that is raised is whether there are any limits to the subjectivity of the translator. After all, we are constantly engaging with translated literature and speak in different languages and we seem to be able to reach similar understandings. Akkurt (2011) argues that these limits exist and are provided by the text itself as the translator is limited by the content of the author's words and cannot diverge grossly. This limitation by the text itself can become obvious through the comparison of my own translation of Jack's interview and that of the translation agency.

Researcher : "*The idea is the use of sexuality, for reasons that are not necessarily sexual, but it could be for narcissistic reasons, or for the purposes of maintaining self and identity integrity(1. 12-14)*

Translator : The idea is the use of sexuality for reasons that are not precisely sexual, but it could be for narcissistic reasons, for the reasons of the self's integrity, identity

Although there are some differences in the translation, there is a limit in both my subjectivity and that of the translator's which safeguards the meaning of Jack's account.

Taking into consideration the illusion of objectivity, but also the limitations of subjectivity in translating a text, I believe that in the translated interviews, by being faithful to the content of the participants' accounts, by keeping with the psychoanalytic discourse that permeated their accounts, and by maintaining a Heideggerian phenomenological stance, I preserved the meaning of the participants' accounts and as such they are valid accounts of their experiences.

Apart from the issue of the translated interviews, I had to consider the issue of validity regarding the emerging themes. For this issue validity was sought through an independent audit (Smith, Flowers & Larkin, 2009). The choice of using auditors for this research was not made to ensure the accuracy or 'truth' of the initial analysis of the master themes, but rather to ascertain that the descriptions are justified in terms of the information gathered (Smith, 2003). Two counselling psychologists familiar with the IPA method, but with no knowledge of the research topic, reviewed 3 interviews and their emergent themes, as well as the final master table of themes. The auditors concurred that the master themes proposed by the researcher were warranted on the basis of the transcripts. Additionally, participants' quotes were examined by my supervisor who identified certain instances where these were not clearly demonstrating my descriptive and/or interpretative claims. These quotes were reviewed and their meaning was clarified.

In order to enhance validity and to further satisfy Yadley's (2000) criterion of transparency, an analysed transcript (Appendix I) is provided as an example of the analytic process. In the provided transcript, the reader can identify all the stages of analysis and follow the researcher's rational during her interaction with the material.

Chapter 4: Results

The results presented below focus mainly upon those themes which are relevant in understanding how therapists experience, make sense of and cope with countertransference feelings when working with patients with a perverse psychic structure.

4.1 Therapists' Understanding of Perversion

Interestingly enough, when asked to reflect on their understanding of perversion, most participants provided a definition which they subsequently complemented with a description of either the way people with perverse personality dynamics relate to themselves and others.

4.1.1 Definitions of Perversion

Proceeding to explore the nature of these definitions, it becomes apparent that these were theoretically diverse reflecting participants' different psychodynamic approaches. This diversity is consistent with the numerous psychoanalytic understandings of perversion in the literature (e.g. Ermann, 2005).

Some participants referred to perversions as constituting a psychic structure, a concept which refers to enduring aspects of the personality that remain stable across a variety of situations (Schwartz, 1981). For example, Georgia thought that "*perversion is emanating from a perverse state, a perverse psychic structure"* (p.1, 8-9), Nikos stated that "*all human beings have the potential to develop a perverse psychic organization*" (1. 15)

The second category of definitions that emerged involved mainly the intrapsychic needs that perversion appears to serve. Perversion appears to be a meaningful symptom, a childlike solution (McDougall, 1995) to avoid psychic suffering or mental breakdown. Jack, for example, by referring to "*self and identity integrity*" appears to perceive perversion as defense against psychosis.

The idea is the use of sexuality, for reasons that are not necessarily sexual, but it could be for narcissistic reasons, or for the purposes of maintaining self and identity integrity (1. 12-14)

Eva, on the other hand, appears to believe that the perverse scenario is enacted in an attempt to deal with unconscious fears of intimacy and hostile feelings. In her account sexuality is powerfully portrayed as being *"hijacked"* and used to serve specific purposes.

So actually, the sexuality, if you like, is hijacked by needs that are more about anxiety and aggression, rather than about a desire for attachment and intimacy and expression of love within a relationship (1-2.22-30)

Similarly, Elen perceives perverse sexual behaviour as serving a function and she provides Stoller's definition (1975) which describes perversion as the erotic form of hatred whose purpose is to convert childhood trauma to adult triumph.

Stoller's definition comes to mind. Perversion is the erotic form of hatred (Elen, 1, 8, p.1)

Other participants defined perversion in light of the Freudian theory, according to which perversion involves either "a deviation regarding the sexual object or a deviation of the sexual aim" (Freud, 1962. p. 136).

… right… on the basis of the Freudian theory, perversion is the deviation from the object …the drive changes its aim… (Jason, 1. 19-20)

… the aim of sexual feelings is not what we would expect, for example a person…eh.. it could be an object or a part of a person, or the self, or the purpose of the sexual act is not what we would expect. (Anna, 2. 26-29)

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The multiplicity of definitions in participants' accounts appears to highlight the complexity of the phenomenon of perversions and as such their spontaneous response to provide definitions could point to a countertransference reaction; for definitions appear to provide participants with a theoretical safety net and to act as an intellectual and psychological compass for therapists who enter the dark labyrinth of perversion.

4.1.2 Way of Relating to Self

Participants complemented their definitions with descriptions of the ways patients in this group relate to themselves and others. The importance of the relational component becomes apparent in Nikos' account. He takes issue with DSM's definition as being too focused on the nature of the sexual act. His phrase "*in reality*" implies that in his own clinical experience

perversions involve the way individuals construct internal and external relationships.

"*DSM places perversions under the sexual disorders, but in reality perversion has less to do with the sexual act itself and more with the way the person relates to parts of himself and others* (2.35-36).

Beginning the exploration of participants' accounts, it is interesting to note that once more they invoke theoretical understandings to describe the nature of the way people with perversion relate to themselves. Indicative of therapists' reliance on theory is Jason's account in which while discussing the defence mechanism of disavowal as a factor in the way perverse individuals deceive themselves, he introduces his ideas by saying "*in psychoanalytic theory*"

for example in psychoanalytic theory, in fetishism the individual denies female castration, the individual believes that women have male sexual organs, therefore it is the individual who is castrated…so the whole issue is if we can reverse castration (9.250-253)

Self-deception as a major way of relating to self becomes apparent in both Georgia's and Eva's accounts. In the latter's account, in particular, the almost frantic repetition of the verb "*know*" communicates something of the anxiety these individuals would experience should a part of truth became available in their consciousness.

I think another issue with this kind of patients is the issue of deception[…] and untruthfulness that, you know, they may have splits within themselves about what , you know, what they believe to be true or know and then maybe things that they can't let themselves know (Eva, 15.349-355)

Georgia believes that the unconscious need for self-deception is the result of "a *reaction to trauma of some kind that caused splitting and projection and once you establish a psychic split intrapsychically, you're deceiving yourself" (1-2. 24-27).* Interestingly enough, Georgia's account is also permeated by psychoanalytic terminology like "splitting", and "projection" which give her account an authoritative resonance and result in it reading like a firmly believed theoretical postulation.

Jack and Joanna retained the idea of splitting but this time as a factor in shaping a loose internal reality about themselves. Both seem to refer to a discrepancy that perverse individuals have experienced in their childhood

between what they experienced and what was acknowledged. Joanna in particular appears to empathise with the predicament of these people as she characterizes the discrepancy in their experience as "*horrible*".

These people… live a horrible split which is what they experienced and what they are told to experience (Joanna, 13. 340-341)

In discussing the effects of splitting, Jack says that these people come across, *as if they lack meaning, you feel them loose and as if one is here the other is there" (18, 393-394)* pointing to fragmented and dissociated aspects of themselves. He also appears to empathise deeply with the agony they must have experienced in their childhood. The repetition of the verb "*acknowledge*" is indicative of the injustice he feels these individuals have experienced as they never had the opportunity to build a solid sense of self.

No one takes responsibility for the idea of splitting in a family that will raise such a child, so what is split off is as if it doesn't happen. Your father doesn't acknowledge it, your mother doesn't acknowledge it, who did? No one. So this just stays there, a (loose) lose thing that does not acquire a subject, does not take responsibility for it. (18. 397-402)

What appears to be common in all five participants' accounts is the idea that the perverse individual's Ego splits in an attempt to cope with unbearable realities. This splitting, allows the person to deny or alter aspects of the reality but at the terrible cost of its own self-coherence and knowledge about themselves. With the exception of Jack and Joanna, however, who allowed their feelings to permeate their accounts, others maintained a rather detached and intellectualised stance. It could be argued that the use of clinical terminology acts like a theoretical wall which helps them keep some emotional distance from the horrible experiences of these people. It could be hypothesised that these participants could have been unconsciously enacting during the interview a similar countertransference splitting between their intellect and feelings, "deceiving" therefore themselves as they propose their clients do.

4.1.3 Way of Relating to Others

Participants' accounts regarding their understanding of perversion included the way in which people who exhibit perversions relate to others and the reasons for constructing such relationships.

Both Georgia and Anna experience the first contact with their clients as entailing something dangerous. Georgia appears to locate the source of danger in that the therapist might be seduced into a false reality, colluding therefore unconsciously with their client's self-deception.

Charm is the other side of perversion, that's how perverse people tend to operate, that's how they seduce (15. 378-379)

For Anna the nature of danger takes a different form and appears to involve the very psychical survival of the therapist. In her account the therapist appears like the naïve animal which, being tricked by the charming appearance of a hunter, falls into a trap only to be devoured later on. The world of horrors that Anna describes as being the internal landscape of perverse individuals contrasts sharply with their charming appearance, making the element of manipulation in the way they relate to others even more prominent.

You know there is something charming… seductive about these patients. […]I have often thought that there is something manipulating about this, it's almost like a trap, you get into their world and then all the horrors reveal themselves and you find yourself among them trying to survive…. (24. 511-516)

Moving on to a more general way of relating to others, some participants placed emphasis on the way these individuals relate to others as objects to be used according to their needs. In her account Georgia describes such relationships as "*technical*", specifying that this way the other "*is being used rather than related to his own full person (2. 38-41).* Andrew seems to refer to the dehumanising aspect of this type of being with others by giving the example of Jews who were used by Nazis as "*experimental material*". Referring to the events of the holocaust, Andrew demonstrates in a powerfully emotional way the disastrous consequences of this type of relating.

The victim in a perverse interaction becomes an object, for example the Nazis used the Jews as objects. They stopped being human beings with rights, people who love or have feelings. They were just experimental material. (2. 32-34)

Four other participants focused on the humiliating, aggressive and violent way people with perversion tend to relate to others. It is however, in

Elen's account that this is most clearly described as she links the violence present in sexual act with an overall aggressive way of relating to others.

[…] in my experience any individual who has experienced a relationship with a perverse person, does sense the hostility, the violence the control on many different levels. (2. 24-29)

The need to perceive the other as a part-object, or the fact that the other becomes the target of humiliation, aggression and violence, is explained by other participants on the basis of intimacy fears and the need to keep the self safe. By repeating the word "*fear*" Eva manages to convey something of the overwhelming nature of those peoples' feelings

[…]these are patients that are so anxious about intimacy that sexualisation is used defensively […]it is defending against fears of being attacked, fears of being seduced, fears of being abused, fears of being abandoned, or whatever […](13. 294-295, 298-300)

Similarly, Elen discusses fears of intimacy but she explains them by what appears to be Glasser's (1975) Core complex. In her account the drama of relating becomes apparent as perversion is discussed as a tragic solution to a terrible dilemma between the longing to merge with a significant other and the fear that such a union will result in annihilation.

He is in touch with the object but in a totally controlling way, in a way that allows him to feel powerful and express his rage. Isolation has been avoided, annihilation has been avoided and the person manages to exist in the relationship (1. 19-22)

Another source of these relational difficulties is presented by Eva who proposes that they result from the fact that "*development stages break down"* This is reminiscent of Chasseguet-Smirgel's (1988) conceptualization of perversion as a regression in an anal universe where all barriers break down and the individual relates in an enmeshed way. In her account, Eva describes very vividly such a kind of undifferentiated and confused way of relating to others which brings to mind Picasso's cubism paintings in which objects are broken down, re-assembled in abstract form and depicted from multiple perspectives. The disturbing powerful emotional resonance of these paintings is similar to the unsettling feeling one experiences reading the following account regarding the way people with perversion relate to others.

Well I think the underlying object relations of these patients are often very primitive so it's about getting inside the object, or the object getting inside them, or taking on the skin or the identity of another, getting right inside bodies, a confusion of biological functions[..] development stages break down all sorts of… the sort of notion.., any distinction between good and bad breaks down by definition in the perversion. Distinctions between men and women or between adult and children break down, so that actually you are dealing with a very confused universe […] (16. 385-396).

4.2 Development of Countertransference

During the interview participants were asked to reflect on the way they experienced the therapeutic relationship at the beginning, middle and final stage of stage.

4.2.1 Initial Period Countertransference

In discussing the way their patients related to them during the initial phase of therapy, participants reported three main types of transference; some were experienced as being a protective mother, some as being a part-object and others as being a dangerous object. In response to these transferences, participants reported a variety of countertransference feelings, which for their most part appear to have the effect of placing the therapist under the control of the patient. According to Elen the source of this control is fear "*He felt so much scared by my presence, by the relationship that was about to be begin, that he attempted to control each aspect of it" (p.8. 107-108)*

The Protective Mother

Eva and Jack talked about the maternal transference and countertransference that emerged during the initial period of therapy with their patients.

[…] he was like a boy eager to please in a way, talked a lot… sometimes in a way that was quite disclosing, sometimes in a way that was quite controlling of the session. (Eva, 3. 69-72)

It was like the child with his mother. He wants her there, he talks and talks and talks and she listens (Jack, 5.108-109)

Interestingly, both therapists referred to the fact that their patients talked a lot "*in a way that was quite controlling of the session"* according to Eva. The controlling element becomes apparent in Jack's account as well, as he presents himself acquiring the enchanted passive position of a mother

who is content to admire her child speechless as "*he talks and talks and talks and she listens*".

Discussing their countertransference, it seems that Eva and Jack experienced their patient as being "*vulnerable*" and "*helpless*" respectively, which in turn raised feelings of protectiveness and passivity. Being "*all too aware of his vulnerability*" Eva appears to say that this countertransference blinded her to other, perhaps less likable, aspects of her patient, whereas Jack by saying that "*he was a seductive young child"* appears to realize that he was pushed to engage in a symbiotic relationship with his patient that would ensure perhaps that the patient would not be abandoned.

I think my countertransference was primarily sort of maternal reaction to this sort of vulnerable eager boy […]I found him likable and I was all too aware of his vulnerability (Eva, 4. 75-80).

[…] I had the impression that he was helpless, like a helpless child. He was a seductive young child as well. It turned out that he has been in his mother's arms for many years, since he was a baby, which meant that this type of hugs he found in his life. Someone who was very willing […] That is how I was myself (Jack, 4. 72-75/5-6. 110)

The Alienated and Sexual Part-Object

Five other participants discussed how their patients related to them as being part- objects, that is as if they have only one function. However, it is in Georgia's and Jack's accounts that this impersonal and dehumanising way of relating (Goldberg, 1995) becomes clearer. Georgia "*was the job really*" whereas Jack was just a set of functions rather than a whole human being. Both seem to say that their patients related to them as if they were some kind of tool or machine which if operated correctly could fix them or produce the desired result.

I wasn't much of a person to him, somebody to be polite to, to treat responsibly and that I was the job really. I was there to help him, not to relate to him really (Georgia, 5.100-102)

it was more about my function than who I was as a person, (Jack 13. 286-287)

The experience of being treated in the transference like a part-object, whose only function is to fix the client, is powerfully described by Anna as affecting therapists at the very core of their identity. In her account, her complex and multifaceted self shrunk and she experienced her being as

having only one dimension. Referring to herself as being a "*being*" and talking in the second person could further point to the alienation from herself that she experienced in her countertransference.

It s like not being yourself…not being whole…as if you are one thing…eh..the complexity of your existence is lost and you are reduced in a sort of one dimensional being (12. 242-243)

Joanna, on the other hand, described how her patient related to her as if she was solely a sexual part object. The intensity of this very primitive sexualised transference becomes apparent as she describes a moment in their session when the patient paralleled a flower to her vagina.

he would touch a flower that was next to the place he was sitting and he would start caressing the flower and he would say it is as if I am caressing the lips of your vagina (5. 103-109)

In response to this very provocative transference Joanna experiences an induced countertransference feeling, as she admits "*Yes, at the beginning I had also sexual feelings" (14. 371).* Similar feelings were reported by Jack as well who said "*I could feel this pleasure, the homosexual pleasure (12. 265)".* It seems that under the influence of countertransference these therapists were indeed transformed into sexual part-objects, who having lost their therapeutic self, responded automatically to what was projected on to them by the patients.

It could be hypothesised that these countertransferences limit the therapists' capacity and therefore serve the purpose of avoiding true relating. As Eva says *"There wasn't really a true and genuine engagement. It was more as if he had to manage me" (4-5.95-96).* In this respect, the therapist is controlled by the patient, for s/he is kept either at a safe distance or in a situation familiar to the patient (sexuality).

The Dangerous Object

An explanation as to why the therapist must be controlled is offered by many participants who suggest that the therapist is experienced as a threatening figure.

In Elen's account the fear of what might be produced by the therapist and the effect that this might have on the patient becomes very clear.

[…] he was relating to me as if I was the dangerous object, as if I was posing some threat and therefore he had to control me to make sure that I would not speak. (8.155-156)

Nikos' patient on the other hand appears to have attempted to neutralize the danger he felt by deceiving his therapist, whereas Andrew's patient needed to devalue him.

He had lied to me, he never had panic attacks, he had never had the family he had described to me. (Nikos, p. 8 165-166)

He said in a rather dismissive way that he thought psychotherapists were charlatans and that he knew all about the Freudian bullshit[…](Andrew, 4. 64-65)

Interestingly enough, both therapists experienced a tremendous countertransferential anger which fuelled fantasies of physically hurting their clients. It could be hypothesised that these therapists felt attacked and psychologically bruised by their patients and that is why in their fantasy they felt compelled to retaliate on a physical level.

Actually, I felt like I wanted to jump on him and punch him in the face, to wipe out that arrogant ironic smile of his (Nikos, 8. 154-157)

What made the whole thing infuriating was the constant rejection. No matter what I said, it was wrong. Even if I didn't say anything it was wrong. There were times that this drove me mad. I had phantasies of punching him and kicking him. (Andrew, 7. 141-144,)

However, both therapists appear to be unaware of the fact that they were under the influence of a concordant countertransference; for as their phantasies also point out, in the same the way as their clients experienced them as being dangerous, these therapists experienced their clients as posing a danger to them and for that reason the therapists had to attack. What appears to have been at stake, was Andrew's professional status due to the fact that he experienced a "*constant rejection"* and Nikos' sense of reality.

The anchor with reality is not there anymore […] It's like being in limbo, like floating in the space with no sense of direction. (10.199-201)

The Humiliated Victim

Other participants reported feeling humiliated as a result of their interaction with the patient in the initial phase of therapy. People who have developed sexual perversions have usually a history of humiliation in their families of

origin and they tend to humiliate others in order to feel safe and powerful (Stoller, 1975) . This concordant countertransference feeling of humiliation is clear in Georgia's account, who during the interview discussed how she and her client had agreed to email her his dreams and how his dreams were full of humiliating material. Although for Georgia "*there was something humiliating about receiving them (13.329)"* she does not seem to have thought about stopping this process.

Nikos on the other hand felt humiliated because he was so tragically deceived by his patient. In his account the element of aggression and hostility that lurks behind the need to humiliate others (Stoller, 1975) becomes apparent as he experienced both feelings in his countertransference.

I felt furious for being the object an experiment and humiliated for not figuring out what was happening earlier. (10. 212-214)

It could be hypothesised that feeling humiliated, both therapists took up an additional countertransferential role, that of the victim. Being a victim, Georgia felt powerless to stop the humiliating exchange, whereas Nikos appears to have directed part of his anger towards himself, blaming himself for not being able to protect himself better.

Fear of Annihilation & Feeling Annihilated.

Other participants experienced in the countertransference a threat to their psychological existence that in the psychoanalytic literature appears under the term annihilation anxiety and involves primitive concerns over survival, self-preservation and safety (Gomez, 1997). This fear was experienced by Andrew who "*was scared that his [patient's] anger and his desire to control me would not only crush my body, but my sense of self (10. 220-221).* The death-like nature of Andrew's terror becomes evident through the verb *"crush*", which he used to describe the violence and forcefulness of the threat he experienced for his whole being.

Elen experienced the same fear of annihilation. She equates ceasing to exist in the world of her client with losing her sense of being, suggesting that our psychological survival and indeed perception of our existence as infants depends on us being acknowledged by a significant other. Not being

acknowledged by her client, Elen experienced this very early and primitive annihilation anxiety.

And there is something tremendously unsettling about ceasing to exist in the world of the other… it questions for those moment your existence as a whole (7. 130-132)

Some participants discussed the experience of actually feeling annihilated. Jack and Kassy felt emotionally paralysed, that is for those moments when they were under their patients' control they were unable to feel, think or say anything; they ceased to exist as autonomous psychological entities.

I listened and listened and it was difficult to stand above the situation and interpret (Jack p, 5)

[…]as a therapist I would tend to have all sort of feelings from empathy to sympathy to anger, with him it was nothing, it was empty, it was….and that was…it made me feel really paralysed (kassy, 5-6,. 117-123)

It is however, in Elen's account that the devastating and overwhelming experience of annihilation is best portrayed as she describes both the feeling of the gradual disappearance of her physical self and the paralysis of her internal world. Feeling annihilated Elen could not continue to exist either as a body or a mind; her existence lost its essence and much like a ghost she felt as if she was fading away.

On a physical level it was like I was gradually fading, my existence was becoming thinner and thinner, I had less weight…at the same time I was feeling numb (8-9.167-169)

<u>*Emotional Exhaustion & Resignation*</u>

The difficulty of working while experiencing such powerful and overwhelming countertransferences during the sessions appears to takes its toll, as some participants described the exhaustion they felt as a result of the emotional demands posed on them by their patients. As Joanna says "*sometimes when the session ended I would feel my whole body aching* "(3. 61-62)

In Jack's account individuals with perversion appear to be so much emotionally depleted that they can actually totally consume the therapist who ends up feeling drained. *Psyche keeps borrowing and borrowing, this becomes larger and keeps demanding for more. It is exhausting.* (16. 342-

343).Another source of emotional exhaustion is provided by Andrew who had to face aggressive devaluation by his client

[…]I was so tired of his attacks that I was tempted to just let him put me down for an hour without making any effort to help him get insight into his anger and hostility. (7. 132-134)

Reading these participants' accounts one experiences a sense of resignation resulting from emotional exhaustion, a countertransference feeling that could indicate how, due to fears of relating, perverse individuals can destroy therapy, by means of inactivating the therapist.

Self-doubt

The complexity of the therapeutic work with this patient group and the emotional rollercoaster that some participants experienced in the countertransference appears to be the source of yet another countertransference, that of self-doubting. Nikos felt as if he *had lost the capacity of understanding what is happening on the most superficial level and was seriously questioning myself as a psychotherapist (9.195-196).* Similarly, Andrew *"wondered about my abilities as a therapist" (11. 238),* whereas Georgia questioned herself regarding *"how adequate am I in this job" (11. 260-262).*

Charmed

Last but not least, some participants discussed how charmed they felt by their patients, a countertransference reaction that points to the seductive nature of some perverse people (Ross, 2003)

Georgia felt charmed by the external appearance of the patient

[…]I reacted to his body in that he came very nicely dressed and very very nice clothes. So he had this very sort of pleasing external manner (Georgia, 6. 132-133, p.6)

Elen felt charmed by the external appearance of the patient and his personality.

He was a charming man though, well mannered, well dressed, clearly educated and intelligent (66. p.4)

Jason on the other hand felt charmed by the very nature of his patient's pathology which would expand his theoretical horizons.

I don't think I have ever worked with such a case before in large organization or psychiatric hospitals… so I was immediately attracted to it… how can I say it…it intrigued me.. theoretically I mean…

4.2.2 Middle Period Countertransference

As therapy unfolded and reached its middle phase, participants reported some countertransference feelings similar to those of the initial phase, in addition to new ones. This is understandable considering that clients' issues are worked through over and over again during therapy before they are resolved.

The Humiliated Victim & the Sexual Object

Elen for example expressed the countertransference feeling of humiliation in response to her client's humiliating way of referring to his girlfriend *"when he talked in the most humiliating way about her, I think I felt I was going cold inside like a layer of glacier was covering my heart[…] Like a cold hand holding firm my heart and it stopped.* (11. 212-218). Having identified with her client's girlfriend, and having experienced her client's hatred like a powerful cold hand, Elen appears to have experienced humiliation like death.

Another countertransference experience which was common to both the initial and middle phases was reported by Kassy who felt like a sexual part-object. Interestingly, Kassy was alerted to her client's perverse transference through her dream and it was only through the dream imagery that she became aware of her own countertransference as well. Like a part-object which has only sexual function, Kassy could not reflect on her situation and realize what was happening to her.

[…]he was keeping me as a prisoner in a place and he was both abusing me psychologically and physically...ah...and it was in that dream that I think I felt that he was relating to me as a sexual object as a part object...he was really abusing me (10. 230-234)

Both participants resorted to imagery to either become aware or convey their countertransference, which might suggest that something about their experiences could not be verbalised either because it was still unconscious, as in Kassy's case, or because it was as incomprehensible as death, as in Elen's case.

Fear of Annihilation

Another countertransference experience which was common to both the initial and middle phases was reported by participants who felt a fear of annihilation resulting from experiencing their patients' hatred, anger and violent parts. Reading participants' accounts I was stricken by the similarity of their experience as conveyed by the repetitive emergence of words like "*powerful*", "*wipe out*" and "*crush*". For all three participants, their patients' hatred or anger was experienced as a powerful and unstoppable force whose purpose was to destroy their essence; that is their capacity to think and critically reflect on what is happening. Nikos' "*his powerful wish to wipe you out of the map"* and Andrew's *"his tremendous power wiped out my capacity to think"* similar phrases bring to mind a nuclear bomb eradicating everything that has ever existed in the place where it was dropped, justifying the intense fear for their psychological survival that both therapists experienced.

You sort of sense the other's desire to destroy you, his powerful wish to wipe you out of the map. If you stop existing then he is safe. And there were times that this hatred sort of scared me and I stopped existing in the room as a psychotherapist that can reflect on what is happening. (Nikos, 17.364-366)

His anger was tremendous, I could sense it filling the room and threatening to crush me, I was aware that I was afraid of him once more and yes there were times that his tremendous power wiped out my capacity to think. (Andrew, 13. 291-295)

The powerful and disastrous effect of this hatred or anger is also communicated in Andrew's and Anna's accounts which both included exactly the same phrase "*threatening to crush me".* For both therapists, their client's anger appears to have a suffocating quality as it fills the room as Andrew says, or as an iron wall closing in as Anna says, leaving no mental space for them to exist.

[…]as if I was pushing against an iron wall […]that's how I experienced (sometimes) some times his powerful will, as a heavy iron wall closing in and threatening to crush me… (Anna, 17.359-362)

As therapy continued participants experienced a new set of feelings

Anxiety due to lack of control

Some therapists reported feelings of anxiety. Although these were discussed in response to different events, it seems that for all participants the

underlying reason was the lack of control they experienced in their therapeutic encounter with their patients.

For Eva and Joanna, who had to deal with their patient's erotic transference, the anxiety primarily involved the management of this dynamic. Both therapists appear to feel anxious because of the unpredictability inherent in a therapeutic situation coloured by the patient's sexual phantasies. Comparing this period to a turbulent airplane journey, Eva discussed the two faces of her anxiety. As the pilot of this plane who has to carry his passengers safely to their destination, Eva has to "*have your wits about you in terms of your analytic work".* She appears to experience the responsibility of the therapist to help her client go through a difficult emotional situation and safely arrive to his new self. However, when she says "*it's like fastening your seat belt",* it appears as if she acquires the position of the passenger where all she can do in an airplane stirred by someone else is to fasten her seat belt to protect herself.

I think when the patient is on the couch expressing sexual fantasies about you, you know there is a sort of sense that you have to have your wits about you (laughs) in terms of your analytic work […] there is a sort of, it's like fastening your seat belt, you know (laughs) because this is a turbulent (laughs) in therapy sort of thing that one has to manage it well.(7. 159-165)

Eva's anxiety appears to result from the same lack of control that Joanna implied in her account when she said:

Scared of this sexualised transference that I didn't know what would happen next (6. 137-138)

Similarly Nikos felt the same anxiety as becomes apparent from his need to be present in therapy "*emotionally and theoretically prepared*" to the point of rehearsing what he would say. Not being able to withstand the unknown and the lack of control that it entails, Nikos appears as if he needs to have his intellectual weapons ready to both control the situation with what he has rehearsed to say, but also to be prepared in case of unexpected events.

I had carefully chosen my intervention, I revised my wording again and again […]I felt I had to be emotionally and theoretically prepared. (12. 251-255)

Masochistic feelings

Another countertransference experience reported by participants in response to their patient's disclosure of sexual fantasies or experiences appears to be that of masochism. Discussing how it felt for them, both Kassy and Nikos appear to regret having endured the detailed and graphic accounts of their patients despite feeling uncomfortable. Kassy's countertransferential masochism becomes apparent as she says "*I thought as a therapist I need to listen to everything my client is saying to me otherwise I do not know I am a bad therapist" (8. 186-189).* Similarly Nikos, felt compelled to endure feeling uncomfortable and disgusted, as a "*martyr"* endures hardship in order to attain a higher goal.

I was convinced that I needed to understand his point of view,that perhaps I heard too much at the cost of me feeling uncomfortable and disgusted. On reflection, perhaps we could have reached the same outcome, without me tolerating this as a martyr (22. 471-474)

The confusion created in the therapists who were thrown into a masochistic position becomes clear in Elen's account. The "torture" all three therapists went through, was not experienced as an abusive experience that humiliated them. On the contrary, it was turned to pleasure in the sense that withstanding the abuse, made those therapists feel good, strong and morally advanced as saints who acquired their position after martyrdom. Although Nikos and Kassy, appear to regret not having being able to manage this countertransference, Elen appears to be confused still

There was a feeling of satisfaction in me for actually enduring all this. Perhaps that was my masochistic part, perhaps it was a justifiable feeling. We both went through hell, but at least we managed to build a relationship that at times it felt safe (13. 254-257)

Masochistic Guilt

Guilt was another feeling that participants reported experiencing during the middle phase of therapy. For some therapists this was in response to interpreting the client's erotic transference, for others for "abandoning" their patients, and for others for pushing them to become aware of painful feelings. Interestingly enough most participants attributed this feeling of guilt to a maternal countertransference, but it could be hypothesized that this is also closely related to their masochistic countertransference.

Both Kassy and Elen, were afraid that interpreting the erotic transference would be experienced as another rejection and although they were aware of their maternal countertransference, their feeling of guilt was not neutralised. It could be hypothesised that this was because the source of guilt was not the maternal but their masochistic countertransference. For making the other feel scared to hurt us, or guilty for causing us pain, might be an excellent way to control them. Daring to escape from this control, by means of interpretation, creates feelings of guilt. Instead of feeling controlled by their clients, these therapists turned their experience around and experienced themselves as being in a higher and more significant position, that of a mother, than the one they actually had – being punished for thinking that there was a different reality than the one proposed by their clients in the transference. Kassy felt cruel and clearly anxious, as it becomes apparent from her disorganised speech, whereas Elen was so scared of hurting him that she counted her words and postponed interpreting what was happening.

yes I did feel cruel interpreting his erotic transference but ..ah.....but as another defence against mourning the loss of the good object...eh...I think, I think he really needed a caring mother...and the pain of not having experiencing a love enough...(Kassy, 13. 308-311)

I was proud for him in quite a maternal way (laugh), but I was also very much scared of hurting him. I remember being very much careful in how I was phrasing things, I was very tentative in my interpretations and I hesitated for a long time to interpret his erotic transference for fear that he would feel rejected (Elen, 14.281-284)

Similarly Anna and Andrew felt guilty for "abandoning" their client and again they attributed this feeling to their maternal countertransference. Although this might certainly be case, the same hypothesis could apply here, for making someone feel guilty about abandoning you, is an excellent way of controlling them and ensuring that they stay

Distressing… a part of me was feeling guilty for abandoning him and I had an urge to comfort him. Exactly like a mother (Anna, 20. 420-421)

There were times that I almost felt guilty for not being there 24/7, you know like a mother might have felt. (Andrew, 20. 453-454)

Empathy

Despite the apparently challenging and overwhelming countertransferences that participants experienced in the middle phase of therapy, nine out of ten began to experience feelings of warmth, sympathy, compassion and empathy. This shift is evident in Georgia's account, as, having abandoned the idea of "treating" the perversion, she was able to accept her client and perceive him as a whole human being with whom she could relate and experience feelings of warmth.

So what we were then working on when we got to that point was how does he live being himself, rather than how does he change how he feels sexually… and that's a kind of warmer place to be… a kind of feeling that I was accepting him… as a ah … the person he was[…] (6.141-145)

Four other participants discussed how during the middle phase of therapy they began to experience feelings of empathy only when they managed to relate to the traumatised child within the perverse adult. This is particular evident in Joanna's account as she discussed how her client's appearance in shorts and the sight of his thin legs and hands helped her relate to him "*as if he was a young boy rather than a sexual man" (8. 216*). Similarly, Jack was able to empathize and reflect back to his client his deep understanding of the discrepancy he had experience between what was being said and what actually happened during his childhood. As it is always the case with empathic understanding, Jack's client felt contained.

His parents used to say one thing and they did another and they never told him "son, you expected one thing but something different happened, how do you feel about that?" When I actually reflected that back to him, that no one ever told you "things didn't turn out the way we told you or the way we had imagined", he appreciated it that a lot. As if he was needing for someone to acknowledge […] (Jack 227-231, p. 11).

It is in Kassy's account however that the significance of experiencing empathic feelings for the client becomes apparent. By repeating the word empathy thrice, Kassy demonstrates that empathic understanding is intrinsically connected with her therapeutic identity and that the moment she was able to experience empathy for the vulnerable child inside her client, she re-discovered her therapeutic self.

as he allowed really the vulnerable boy inside him to speak it was at that time that I was able to express empathy, to feel empathy for him and experience empathy and feel sympathy and actually have feelings for him (Kassy 281-284, p. 12)

The majority of participants referred to the feeling of sadness they experienced as they empathised with their patients. Elen *"felt sad thinking of that frightened child raging for being abandoned" (10. 190-191).* Jason experienced the same sadness but in response to the emptiness of his client's sexual encounters with prostitutes.

Well right now what comes to mind to say is sadness […]his relationship with prostitutes is in reality a denigration of himself and a dead end.(12. 353-355)

Similarly, Nikos and Andrew felt the same sadness as they empathised with their clients' feelings of loneliness, confusion and repeated failures to engage in meaningful relationships.

I actually felt very sad for him. He story was not a sexual story, it was a story about loneliness and confusion (Nikos, 14.299-300)

I felt sad both for the little boy and for the man who had lost many years in his life in repeating patterns of relating that were clearly not working. (Andrew, 18,401-495)

It could be hypothesised that therapists' sadness in the countertransference was the result of them empathising with the depressive and deadened core that Welldon(2011) suggests exists in all perverse individuals.

4.2.3. Final Period Countertransference

With the exception of Georgia, who had agreed with her client to terminate therapy, the rest of the participants moved into the final period of therapy, because, for a variety of reasons, their clients decided to terminate their sessions. Without exception though, all participants experienced some difficulty in letting them go, which can be attributed to a parental countertransference.

The Anxious Parent

Some participants experienced a parental countertransference, characterised by worry and anxiety for their clients' well-being. For example, Eva was anxious that the changes in her client's way of relating were not stable

enough. Like a mother who needs to make sure that her child is able to manage in the world on his own, Eva wanted to be " *sure that he could make an intimate relationship*" (10. 239) before termination, for fear that he was "*at risk of relapsing to his compulsive behaviours and to destructive ways of relating"* (10.241-242). Eva was able to recognize that her anxiety was due to a maternal countertransference she was experiencing, which made her also feel "*drawn to wanting to see someone forever […]* ". (10.223). Taking into consideration that she felt "*very disappointed, terribly disappointed"* (10.220) when her client announced his wish to stop the sessions, it could be hypothesised that her referring to her client as "someone" is indicative of the emotional detachment she unconsciously attempted to achieve in the face of the loss she experienced.

Andrew and Nikos experienced a similar anxiety. Their paternal countertransference becomes evident through their referring to their clients as "*son*" and "*15 year old boy*" respectively. Experiencing their clients as boys, who go out into the dangerous world, makes their anxiety for their well-being justifiable.

I was like an anxious father sending his son away… I was both happy to see him leave having achieved a lot but also anxious knowing that he still had a lot to deal with (Andrew, 11.481-482)

I was very much worried about him, he was like a 15 year old boy falling in love for the first time. I was afraid that he would be let down and that this would be detrimental for him. (Nikos, 20. 423-425)

It could be hypothesised that during this process these therapists became attached to their clients, the same way a parent becomes attached to their child during all those years of helping them to grow up. This hypothesis becomes apparent in Andrew's account

Without realising it myself, I had become attached to him. He was significant and not seeing him again was a loss that I did not want to experience. (21. 473-476)

Because of their difficulty, these patients became significant to the therapists and letting them go was experienced as a loss; a loss mixed with anxiety, similar to that experienced by parents who must let their children go, hoping they have done their best. This hypothesis appears to be confirmed through Georgia's account, as, like a good parent, she appears to

realise that her role has come came to an end and, that although there is always something more to be done, the child/patient must be trusted to enter the world, leaving the therapist hoping that therapy was good enough.

[..]both of us saying this is as far as we've got to and this is as far as it can go between us perhaps and that's what we've decided and it's not anything like perfect, but it is a kind of a compromise. Is it good enough? Is it good enough? Let's hope it's good enough (13. 283-284)

The Guilty Parent

Therapists experienced feelings of hopelessness and guilt regarding the outcome of therapy, which, on one hand appear to have affected their perception of what had been achieved and, on the other, led them to be harsh and critical with themselves, as if they are to be blamed for a failure. Joanna appears to be harsh and critical of herself as she says that she was "*quite frustrated and disappointed with myself not being able to help him*" (7. 190-191).

Similarly, when Eva questions the value of her four years' work with the patient she appears to be under the influence of this hopelessness which leads her to believe that nothing will ever change. As a result she feels guilty, as if what she gave was not enough for him.

So there are moments when you'd think " I've done… what's these four years were for? Maybe nothing's gonna change, maybe that hasn't been enough for this man" (9. 211-214)

Of all the participants though, it is in Elen's account that the guilt and self-blame come across in the full force they were experienced. Certain of her failure, defeated as if all her efforts were in vain, she is desperately trying to comprehend the outcome and looking for a reason which explains it, she finds one in herself and her inadequacy as a therapist.

I felt tremendously guilty and I was trying to figure out where had I gone wrong. Was it the timing wrong? Was it the what I said? I did feel like I was failing him and (it) It did feel as if everything we had gone through was in vain.(296-298, p.15)

It appears that these feelings of hopelessness and guilt are the result of the parental countertransference these therapists experience, for that is how many parents would feel if their child did not succeed in their goals and life.

The Abandoned Parent

Another aspect of their parental countertransference appears to be the feelings of abandonment. In Kassy's account the feeling of abandonment brings to mind the sense of betrayal and loneliness experienced by soldiers who, having gone through hell with their comrades, feel abandoned should their comrades not follow them to the end of their quest. In addition, through the word "*finally*" Kassy appears to expresses some frustration and anger toward her client

I mean I felt abandoned because we had achieved so much together...and as soon as we finally were getting somewhere, I felt that he was now leaving…ah… (14. 325-326,)

These feelings of frustration with the client, become even more evident in Nikos' account, as he seems to perceive them as the result of him feeling betrayed due to his client leaving. Describing his therapeutic encounter with the patient as his "*personal challenge*" Nikos reveals on one hand, how much of regarding his therapeutic identity he had invested in his patient, and on the other hand, he presents the therapy process as being experienced like a heroic quest.

I suppose I realised how much I had invested (in) on him when he announced that he wanted to stop. His treatment had become my personal challenge. Of course this doesn't help, investing so much (in) on the patient will only result in feelings of betrayal(,) abandonment and anger, which I experienced with our ending. (23. 480-483)

4.2.4 Post-Therapy Countertransference

Many participants reported what could be termed post-therapy countertransference; that is they experience feelings in the present about their patients, although therapy has ended, in most cases years ago.

Internalization of the Client

Four participants discussed how they still remember and care for their clients' wellbeing even years after the end of therapy. Through the emotional adventures they went through with them, these therapists internalised their clients and made them part of their being, as Georgia characteristically reports: "*he was part of my life you could say and nothing really goes, he'll always have some little place"(241-242, p.10).* Caring deeply about the patients with whom they had experienced intense

countertransference reactions Andrew "*often think about him and wonder how he's doing" (23. 524),* whereas Kassy often wonders "*what really is happening to him…in, in his life at the moment" (17. 395-396).*

Having allowed these patients to affect them in order for the therapeutic relationship to develop and become the agent of change, these therapists invested so much of their energy in these patients that they became significant to them in the sense that they came to represent an important period of their professional lives during which therapists developed their therapeutic identity further. This interactive and two way development between therapist and patient becomes apparent as Anna says "*He built a new identity and I learned a lot from him as a therapist (22.463-464).*

Similarly, Kassy attributes the significance her patient holds for her to the fact that through him she expanded not only her therapeutic identity but her knowledge of herself as well *"learned so many things about myself…and ah…and about paraphilias and perversion in general, it wouldn't have happened if it wasn't for him"(16.379-380)*

Losing such a significant patient appears to be experienced therefore as a loss similar to that of significant others in the therapists' personal life. However, it appears, that, due to internalization, this relationship with a significant patient continues internally, enriching the therapists' identities. As Georgia says "*nothing really goes" (10.241)*

<u>*Merging with the Client*</u>

Kassy, however, not only internalised her patient as mentioned above, but she appears to have merged with him, in a way perhaps similar to the one that perverse patients long to merge with a significant other (Glasser, 1975). In one occasion, Kassy appears confused regarding who was having a dream "*he came into session and he said he had a nightmare....I mean sorry I had a nightmare"* (10. 222-223). Later on she appears confused regarding their roles, that is who is the client and who is the therapist, a state of mind that reminds Chasseguete-Smirger's (1985) emphasis on the collapse of any kind of differences that characterizes the psyche of perverse individuals. "*I think about him more often than…ah…what I do with other therapists….ah…sorry other clients (16. 371-372)"*. Even after the end of

therapy, Kassy remains under the influence of her countertransference, in a state of merging with her client.

The Traumatised Victim

Although she did not appear to realize it, Joanna, during the interview came across as that traumatised victim she used to be during the treatment of her patient. This became apparent, through her disorganised speech and the emergence of intrusive memories. Reading Joanna's disorganised account, during which she switched almost frantically from one topic to another, one gets the impression that due to their traumatic nature these different experiences remained fragmented, preventing her from forming a unifying whole. This fragmentation is characteristic of traumatised individuals as intense anxiety prohibits the adequate processing of events and these remain fragmented in the individual's brain.

[…], and in those moments I…I didn't know what to say, I tried to say how does it feel at some point…eh…at some point…I must say also that I presented him to many groups I was participating and everybody became anxious and very few people were able to help me, I really don't think I helped him…because the transference and countertransference was re-enacted so often in the session, the only thing he said when he left and he thanked me was that I was the only stable experience in his life, where nothing changed…environmentally I didn't change I was the same person…his parents were hippies and that was another thing, whenever he visited his mother he would, she would receive him wearing a baby-doll without panties, so this was a terrible experience for this guy…I tried to focus on the humiliation that this exposed him to…how helpless he felt… (5. 106-122)

It appears that Joanna felt as humiliated and helpless as her client felt during his childhood and as result of her interaction with him she was traumatised as well. In the way her client carried his trauma within him for years, Joanna appears to carry within her the traumatic experience of that therapeutic encounter.

4.3 Ways of Coping with Countertransference

During the interview participants reflected on the powerful nature of countertransference they experienced and the ways they consciously or unconsciously dealt or coped with it.

4.3.1 Strength of Countertransference

Eight participants referred to the countertransference when working with perverse patients as being the most difficult aspect of the work; so difficult indeed, that Anna exclaims full of surprise "*how on earth I survived?"(13.272),* pointing to the fact that such powerful countertransferences could potentially destroy the therapist, whereas Eva wonders jokingly *"this is such a difficult work, why am I trying to do this?" (17.403-406).* Eva might be joking as she poses this rhetoric question to herself, but as one reads all the other participants' accounts this question keeps coming back. For example, as Joanna recounts how it felt to experience such intense countertransference feelings she describes an experience of absolute powerlessness, similar to that of a defenceless child in the face of danger, which threatened the existence of her identity as a therapist.

it is more than loneliness it is absolutely helplessness, weakness, it's as if you become a child who knows nothing as soon as the chaotic situation gets in the room [...] (16. 419-422)

Anna appears to refer to a similar loss of identity as she discusses the intensity of the countertransference when working with this patient. For her however, it appears to be a matter of stealing rather than losing for she describes the experience of countertransference as a violent hijacking. It's as if some parts of the therapist are captivated and imprisoned while at the same time they have been substituted with those of the patient.

there is something about this patient group that makes it more intense, eh…it's as if they can really get into you and (hijack) highjack parts of you. So you end up being a part object, … or being under their powerful control, or at the recipient end of their aggression and hostility (23. 498-502)

Both Elen and Nikos, as with the participants above, appear to attribute this difficulty to the danger the therapist is in of) losing his identity.

Indeed, the strength and nature of the countertransference can be quite frightening. At those times that you sense like losing yourself, entering those masochistic positions, feeling the other's hatred, you need support (Elen, 17.352-354)

The major difficulty for me is the pull of countertransference. The feelings are so powerful that it is difficult to avoid enacting them. The maintenance

of the analytic mind and analytic stance is particularly difficult when one is under attack. (21, 453-455)

It appears therefore that the nature and strength of countertransference when working with perverse individuals is such that the therapist experiences a tremendous threat to his therapeutic identity and perhaps self. Faced with such a threat, Anna's spontaneous question "*how on earth I survived*" acquires a whole deeper meaning.

4.3.2 Acting Out

Taking into consideration the unconscious nature and the strength of countertransference when working with perverse patients, it appears impossible for therapists to avoid acting out, that is to avoid behaving at times according to the feeling or role projected on them by their patients.

Traditionally, acting out is considered to be an instance of failure from the part of the therapist to manage their countertransference. However, Andrew presents a rather different perspective on the issue when he says *"[…] the essence of countertransference is that it is unconscious. Sometimes you only become aware of it after you have acted out something.* (11.244-245). In this respect, acting out appears to be the only way that an unconscious countertransference feeling can become conscious, giving the therapist the opportunity to reflect on it and subsequently use it therapeutically.

Working with a client with paedophilic phantasies Anna had to constantly evaluate her assessment that her client was not posing a danger to children without becoming the policeman her patient pushed her to be. Managing this anxiety without acting out was at times difficult and there were instances that she failed to contain her countertransference and acted out the policeman, becoming abusive herself. Implicit in her account is the realization of the role that her client needed her to play, which has helped her to better understand his internal dynamics.

[…] unfortunately, because of my anxiety, I turned to the policeman he wanted me to be , when I told him in a rather… paranoid way , that perhaps he was intending to sexually abuse the boys and that … eh.. I could not allow him to do that (149-158, p.8)

A similar acting out was reported by Elen as well, who acted out her anger in a subtle but clear way. Again, acting out her countertransference

appears to have been what alerted her to what was happening and to how she had deviated from her therapeutic role.

[…]There were times that I retaliated, not with the content of my words, but with the tome of my voice. Sometimes my comment would be sharp and I would realize it only after the session (147-149, p.8)

4.3.3 Defence Mechanisms

The strength and evasive nature of countertransference, when working with perverse individuals, appears to be such that the therapists from time to time had to unconsciously protect themselves by means of utilising defence mechanisms.

Splitting

Discussing their experiences with perverse patients, some participants referred to what appears to be the defence mechanism of splitting. During the session Eva was only aware of her client's vulnerability, splitting off his more aggressive and controlling parts perhaps due to the fear that these parts of him invoked within her.

I think sometime when you discuss patients with peers that then you become conscious of the sort of controlling dimension, whereas in the room one is more conscious of the patient(')s vulnerability. (5. 107-110)

Similarly, Kassy, fearful of her client's aggression, needs to focus on the traumatised child rather than the aggressive man in front of her. Although there is certainly this very traumatised child which at some point resorted to the perverse solution to survive, Kassy appears to be believe that the only thing that will help her is (to) perceive this aspect of her client only, splitting off his hostile and aggressive elements.

if I am to think of them as…ah… that there is very a scared "little boy" when they are experiencing this hostility and this aggression that will also help me (19. 449-451)

Threatened by her client's overt sexual references and her own sexual countertransference, Joanna resorted to splitting to neutralize his powerful effect on her. Splitting off his adult aggressive sexuality and by focusing on his child-like parts, Joanna was able to survive that therapeutic encounter.

because he was saying all sorts of very sexual and arousing things…ee…one way to deal with it was eventually to look at his hands who were, which were the hands of a young child, a teenager and then this masculinity that he.. had when he was in the session was kind of contained (3-4,76-80)

Interestingly enough, splitting allowed participants to perceive their clients as being less powerful, controlling and aggressive than they were and more like vulnerable little boys. It could be argued that in those instances, they deceived themselves the same way perverse individuals do, splitting off aspects of reality that felt too threatening to be known.

Intellectualization

Another defence mechanism that participants used unconsciously was intellectualization. Not only did many participants report resorting to this defence, but they also unconsciously employed it during the interview as in the case of definitions of perversion which was discussed earlier in this chapter. Jack stated the purpose of his intellectualizations quite clearly; as he lost his therapeutic identity under the pressures of transference and countertransference and therapy itself was in danger of collapsing his intellectualization served the function of reminding him who he was (a trained therapist, with a set of theories at his disposal) thus securing the survival of therapy.

One thing I did in the beginning, that I didn't tell you, was that I was becoming like an educator, I have such a tendency myself (laughs), but (it) It was over the top. I kept lecturing and he kept using me but I had to find a way to sustain therapy (9. 190-193)

The intellectual interpretations Kassy offered from time to time to her client appear to serve a similar function. Admitting that they had no impact on him, it seems that these intellectualizations helped her regain her therapeutic identity at a time that in her countertransference she experienced a total paralysis and was unable to form any thoughts at all.

my interpretations were very intellectual at times, when I was able to intervene and interpret something…ah…yes I remember there were rather intellectual….and I do not think they had an impact on him at that point, there was no feeling (Kassy, 139-142, p.6)

Elen appears to confirm the above hypothesis as well. Sensing the threat to her being, Ellen, resorted to intellectualisation; that is theoretical understandings of what was happening between her and client, instead of

opening up to her experience as a means of understanding the dynamics of their relationship. Unable to tolerate the anxiety and chaos, Elen needed at times to use theories as a kind of shield that allowed her to safely and cognitively "know" rather than understanding through real experiencing.

I was like instinctively I was avoiding to open up myself to his experience. That was the danger I mentioned. Theoretical understandings could sort of help me control what was happening (4. 81-83)

Dissociation.

Dissociation was used by participants at times that they felt overwhelmed with feelings. Reflecting on how it felt for her to listen to her client's paedophilic phantasies, Anna thought *at the beginning I was coping quite well and I was listening to them objectively (15. 306).* What however she thought was the objective therapeutic stance in reality was a defensive clinical mask that permeated her to protect herself from the horror she would possibly experience.

Gradually though I realised that the clinical way I listened to these fantasies was more a defense from my part. I was sort of … eh…distancing myself from the feeling and reactions that these fantasies could invoke in me (15. 306-309)

Faced with an overwhelming fear and confused by their chaotic emotional reactions, Joanna and Elen respectively attempted to regain some sense of control over the situation by acquiring a neutral clinical persona that helped them both cope with their countertransference.

….I do not think I tried to be neutral with any other patient as much as I tried with him[...] I think that was defensive on my part self-protecting and also I was scared of him..(Joanna, 130-134, p.5)

Confusing I suppose… I struggled to make sense of my feelings in the session, but the more I tried the more detached and clinical I became (Elen, 77-79, p. 4)

Although these participants appear to consider this emotional detachment as defensive, Jason, following the golden rule of orthodox psychoanalysis, considers neutrality to be the key to managing effectively his countertransference. *Neutrality will give us the ability, the emotional distance to be able to reflect on our countertransferential feelings (518-521, p.18).* According to him, the emotional detachment is not a defence

mechanism, as other participants thought, but the required condition for effective management of countertransference. Although Jason's position is in accordance with a significant part of the psychoanalytic community, one cannot but wonder how the maintenance of emotional distance facilitates the reflection on countertransference which by definition requires emotional involvement and openness. It could be hypothesised therefore, that neutrality as a way of coping with countertransference is another defence against fully experiencing overwhelming feelings.

4.3.4 Clinical & Peer Supervision

In discussing their ways of coping with intense countertransferences, supervision emerged as a significant factor in mediating participants' experiences in several different ways.

Emotional Support

First, participants discussed how supervision offered them the support they needed in the midst of their intense feelings. It appears that supervision offers support by means of providing the therapists with the opportunity and space to share their experiences and in this way reduce the emotional weight they carry. *It almost feels too much to go through on your own* (17.354-355) says Elen characteristically. The importance of supervision as a way of coping with overwhelming feelings becomes apparent in Kassy's account as she keeps repeating the word supervision.

I would definitely would want to talk about the support I got from my supervisor and how helpful and useful supervision is…supervision is…and how the therapist needs to attend regular supervision to be able to handle all those feelings that I just described before (15. 349-352)

Being able to share overwhelming feelings with "*another mind*" was one of the elements of supervision that was also helpful for Nikos and Andrew.

I could not keep all these feelings inside me, I felt I needed to share them with another mind. (Nikos, 9.190-191)

I don't think I could have managed to tolerate all those feelings if he wasn't there to share them with him and help me make sense of them (Andrew, 24.554-555)

Balanced View of the Client

Group or individual supervision was helpful for participants in managing their countertransference for the supervisor or other members of the group provided them with all the different aspects of the client that the therapist was at times unable to hold in his mind simultaneously. This appears to be Eva's experience as she was aware of her client's vulnerability but in supervision was helped to become aware of other aspects of him as well.

yeah and I think in the group that one shares it with there will be people that will pick up the hostile, repelling aspects of the patient and people who pick up the vulnerable , engaging aspects of the patient, how one to keep the sort of balanced experienced (18. 432-435).

The way the supervisor or other members of the group help in restoring the therapist's perspective of the client is explained by Joanna and Elen, who seem to parallel the analytic couple with the intense and potentially too close relationship between mother and child, which the father must interrupt by means of stepping in and diffusing the intensity of feelings.

You get support and distance from this abusive dyadic relationship, there is a third person a fourth person that come in (Joanna, 16. 434-435)

There is something about a third person entering the analytic dyad that has the ability to help you regain some perspective (Elen, 17.356-357)

Understanding Transference & Countertransference Dynamics

On a more practical level, supervision helped participants become aware of their countertransference. Kassy, realised that she was being abused by her client and had been transformed to a part-object when she discussed a dream she had in supervision

as I said with the dream when I discussed it to supervision it really helped me acknowledge what was happening in the relationship with my client (18. 417-420.p. 18)

Anna was helped to realize that her clinical and detached way of listening to her client's paedophilic phantasies was a way of coping with her countertransference, when her supervisor experienced some of the feelings she might had experienced should she had been less defensive.

Actually it was my supervisor who sort of picked that up. She was having intense reactions and questioned my clinical objective reaction. So… I realised that I was afraid to experience a feeling listening to these. (15. 309-311)

Similarly Andrew's supervisor helped him become aware of his countertransference something which helped him not to act out. It appears that for Andrew a supervisor who is experienced with this group of patients helps in identifying the patterns of transference and of countertransference and acts as a guide in the labyrinth of perversion.

There were many instances that I was not even aware that I was acting out my (countertransference) countertransference. My supervisor, having experience with these patients was able to see things before I did... (24. 548-552)

4.4 Making Sense of & Using Countertransference

Having discussed their countertransference, participants were asked to reflect on how they made sense of it. From their responses it became apparent that their countertransference feelings were understood as being either concordant (Racker, 1957), that is reflecting how their clients felt themselves or as being complementary (ibid), that is reflecting how others felt in the presence of them. Having understood the source of their countertransference, participants used their feelings to create therapeutic meaning by means of communicating empathy and offering interpretations.

4.4.1 Understanding of Countertransference

Concordant Countertransference

Consistent with current theoretical understandings of countertransference, a series of feelings that therapists experienced in their countertransference were understood as being similar to what their clients felt. It is interesting to note, however that all participants implied that the feeling experienced in the concordant countertransference is a feeling that the client is unconscious of or does not dare to express in words.

This is particularly evident in Jack's account, as, when discussing the guilt he experienced, concluded "*that was the idea for me to feel the guilt that he didn't feel (7.152).* Similarly Andrew experienced the sadness, his client could not feel.

Another part of it [sadness] though was projected on to me. He could not feel anything (18. 407). At those moments, therefore that the patient is about to experience an unbearable feeling, he unconsciously projects it onto the therapist who, as Eva explains in her account, comes to experience it as his/her own by means of projective identification .

through projective identification or projective processes it gets mobilised in you so you do become extremely angry with them […](14. 330-332)

Projection and projective identification appear then to underlie the process of concordant countertransference. Andrew and Elen offer a reason as to why this whole process takes place; that is communication of what cannot be symbolised and verbalised.

Perhaps that was the only way he could communicate to me how much angry he was, you know by inducing this feeling in me, in the countertransference, I mean. (Andrew, 7. 157-158)

We were both scared of each other at the beginning and that was I suppose it was his only way to communicate to me how frightening it was for him to find himself in a relationship. (Elen7. 140-143)

If the purpose of this process is communication, and concordant countertransference becomes the means through which therapists can understand how their clients feel, then what these participants appear to imply as well is that despite the resistances against experiencing a certain feeling, on some other level, these people want to be understood and want to become aware of feelings they avoid. In this respect the therapist is there to make sense of this communication and help the patient to integrate the message.

Complementary Countertransference

In other instances participants understood their countertransference as being the feelings experienced by people who are around perverse individuals and again they appear to believe that this is-an important source of information for it communicates a lot about the relationship dynamics perverse individuals create and in turn experience. For example, Georgia, discussing her experience of being treated like a part-object whose only function is to perform her job adequately, says that *"it communicated a huge amount, so in a sense he told me, it was his way of telling me how life was and how his relationships with people were [5. 111-112)*

Similarly Anna, understood the uncontrollable fear she experienced in the presence of her paedophile client as a complementary countertransference that is as the terror children feel in his presence, sensing his sexual desire. This is not a theoretical understanding of how others feel in the presence of her client, but an experience so intense and real that she "*broke down into tears*", exactly as a child might have cried out of terror.

I remember I broke down into tears. For some reason, unconsciously I was identifying with the children in his phantasies and I was scared to experience the terror (Anna, 312-314, p.15).

It appears therefore that concordant and complementary countertransferences are understood as sources for information about the internal and the external world of the client respectively, a kind of experiential information that adds to what the client consciously discusses during the session.

4.4.2 Creating Therapeutic Meaning

Operating on the assumption that their countertransference provides information, participants reported using their feelings to facilitate the creation of an alternative therapeutic meaning regarding the patients' experiences.

Empathy

Some participants resorted to their countertransference in order to acquire a better understanding of their clients, communicate their empathy and in this way to open up the way for a therapeutic outcome. Andrew describes the process of achieving empathic understanding as the result of temporary identifications with aspects of his client's being, a process which is reminiscent of Racker's (1957) explanation as to how concordant countertransference enhances the therapists' understanding.

I was entering into these countertransferential places momentarily, enough for me to get a deeper understanding of his needs and his own feelings

Once this empathic understanding is achieved, the therapist, as Anna implies, is able to bring unconscious feelings and to communicate an empathic understanding for parts of the self which were neglected. Through exploring the meaning of her feeling like a policeman in the

countertransference with her paedophile client, Anna was able understand that her client was operating from an infantile position of perceiving the world, which pushed him to identify with only one aspect of himself (the paedophile), splitting off and projecting the other (the policeman) on to her. This way she was able to empathise with his hidden feelings of hopelessness and despair and "*discover inside me those words of empathy that would help him face his trauma" (17. 372-373)*

Imagine to identify with only one aspect of you, you are overwhelmed, there is no way out… So I could feel for him. He had identified with the paedophile, he found it difficult to get strength from other characteristics and that created despair (Anna, 12.254-256)

The next step in the process is offered by Kassy. Having felt abandoned by her client and having conceptualised her feeling as a concordant countertransference Kassy was able to empathise with her client's fear of abandonment and having achieved that she was able to "*discuss[with him] his fear of abandonment"(p.14, 328)* giving him this way an opportunity to explore a painful feeling he was avoiding.

A three step process is therefore described by participants which begins with the therapists' using their countertransference as a means to enter the world of their patient, then using it as a means to empathically understand their patients' deeper feelings and needs and finally to communicate this understanding which in turn brings what is to be resolved between the therapist and the client to the surface and creates in this way an opportunity for therapy.

Interpretation

Conceptualising countertransference as a source of information on the client's internal and external world, participants used it to construct more accurate interpretations. The importance of interpretation based on countertransference becomes apparent in Georgia's account as she discusses the feeling of charm.

So that would be one thing to look at and to interpret very early on , cause otherwise you are letting the person down, if they think that you are taken in by what unconsciously they don't want you to be taken in, because consciously they do (15. 377-383)

According to Georgia, the patient will inevitably relate to the therapist according to his perverse internal object relationships, but the therapist must keep in mind that another part of the patient, the one that perhaps is in therapy, unconsciously hopes for a different outcome. Making an interpretation therefore based on the countertransference, might not be easy at times, but as Georgia suggests it is necessary if the patient is to be given an opportunity for therapy.

Dealing with her client's aggression and conceptualising her resultant fear of annihilation as a concordant countertransference, Kassy was able to realize that her patient's aggression was in reality a defence against the terror of losing himself. Using therefore her countertransference as a source of information she was able, by means of interpretation, to give her patient's aggression a different meaning and this way to help him face the underlying fear.

I gained my ability to think and make more sense of my countertransference feelings because the more I was interpreting his aggression and hate as a defence mechanism against really experiencing the terror of losing himself in the other...ah...the more I think he was able to lose himself in the other, the more he was able to hear it.. (11. 262-266)

Similarly Nikos used his countertransference to form an interpretation of the process that was unfolding between the two, which allowed them to escape a repetitive scenario of provocation and retaliation that maintained the relational difficulties of the client. Such an interpretation based on countertransference created the mental space between therapist and client needed to reflect on what is taking place in the interaction rather than to act on it blindly

My whole body was shaking from adrenaline. It was as if I was getting ready for a fight. So I interpreted what was happening between us, as him trying to provoke some sort of reaction from me. Was he perhaps angry with me? (8. 159-161)

4.5 Parallel Process

An important finding of this study was the emergence of the theme of parallel processes in supervision between participants and their supervisors and during the interviews between participants and the interviewer.

4.5.1 Parallel process between therapist and supervisor

The parallel process, a term coined by Ekstein and Wallerstein (Grey & Fiscalini, 1987) for the phenomenon described first by Searles (1955) refers to the unconscious replication of the therapeutic relationship in supervision. Parallel processes originate in therapeutic impasses and find expression in the unconscious re-enactment from the part of supervisee of his client's behaviour. The purpose of this re-enactment is the communication to the supervisor of the emotional turmoil and unformulated therapeutic difficulties the supervisee experiences with his patient. Depending on the situation, the supervisor will or will not unconsciously re-enact the therapist's defensive behaviour. (Grey & Fiscalini, 1987).

Some participants in this study experienced this phenomenon as well. Anna, for example, appears to be quite conscious of the therapeutic dynamic that was repeated between her and her supervisor when the latter unconsciously re-enacted the role of the policeman and she felt as her patient was possibly feeling. Anna recounts the emergence of this parallel process in positive terms

I remember in one supervision, the supervisor…eh… unconsciously took on the role of the policeman and I felt under investigation. This parallel process helped us understand what is enacted between me and my patient (25. 533-535).

Contrary to Anna's description is Joanna's experience. As she disclosed during the interview and as emerged through the analysis of the transcript, Joanna felt completely helpless with her patient, scared of his reactions and utterly lost as to how to handle him. Being caught up in a powerful countertransference reaction she experienced herself as the helpless, desperate victim her client once was as a child. Desperately needing some support and extremely anxious she "*asked for supervision right on and from many different supervisors*" (3.66) but "*it was difficult for them as well and they didn't know what to suggest"* (3. 67-68, p.3). The parallel process appears quite clear, although Joanna does not seem to notice it. She was unconsciously overwhelming her supervisors with her anxiety, and they were unconsciously identifying with the helpless victim she was during her session. Indeed she almost says it herself at a later point during the interview, when she first describes her role in instigating the parallel

process and then mentions the defensive patterns of her supervisors which were the ones she had described for herself in relation to her client.

what I succeeded in was to make everybody defensive (laughs) and rigid…ah…so I really didn't get much help at the time (15. 374-378)

Contrary to Anna, Joanna did not benefit from the parallel process and the reason for that appears to be that her supervisors' countertransference did not allow them to distance themselves from the situation, to acquire a super-vision and "see" what was repeated between them. Sadly, Joanna remained the helpless victim no matter how much she asked for help, perhaps as her client once did.

4.5.2 Parallel process between participant and interviewer

Taking into consideration that parallel processes are almost solely discussed in the literature as occurring in the context of the supervisory relationship, the emergence of parallel processes during the interview was a surprising and unexpected finding. Nevertheless, it occurred with at least six participants and this finding appear to point, partly to the strength of countertransference experienced by therapists when working with perverse individuals and partly to what appears to be an unresolved trauma within the therapist's psyche that surfaces again when the situation structurally resembles the therapy.

With Georgia the parallel process was almost immediately played out at the beginning of the interview when I asked her "*how do you understand the term perversion*" and she responded "*Oh!!!(laughs) Differently from you I think!*" (1. 5-7). Georgia's spontaneous response surprised me for it did not involve her understanding of perversion, but a desire to differentiate herself from me and create an unequal relationship between the two of us. In addition, I heard her laughing as laughing at me. I immediately felt embarrassed and humiliated, as if I was a stupid student. As it was the first time that I was meeting with Georgia, she could not possibly know what my understanding of perversions was and as became apparent when she recounted her own difficulties with her client, this initial exchange had nothing to do with the two of us, but it was an exact repetition of the dynamics she had experienced with her paedophile client. In the assessment session,

when Georgia asked her client how it would feel to work with her he said "*well, I don't really like adults*" *(4.93)*. Georgia felt humiliated because in his words she heard *"well how could I like you?" How can I answer the question because you aren't really anybody*" (12-13. 307-309). In addition, in describing the overall way she felt with him, she related the feeling of imbalance between child and adult that was characteristic of the relationships her client sought in his life and the imbalance that existed between them since she as an adult was different from what he liked and had no significance, to the feeling of humiliation.

"*the feeling of an imbalance in the relationship and of somehow humiliation always being there (12.291-292)"* .

This same imbalance was created between us at the beginning of the interview when she, the knowledgeable authority, stated her difference from me and I, like an insignificant student, felt humiliated the same way she did with her client.

With Joanna the parallel process took the form of me being at times totally overwhelmed by the material to the point of projecting this onto her. This was the case when I told her "*If at any point you feel that this is overwhelming and you want us to stop"(4. 91-92)*" when she was making it clear that she both needed and wanted to discuss the case. At other instances and whereas Joanna is a much older, successful and experienced analyst, I was so caught up in this helpless victim countertransference she was experiencing with her client, that I was hesitating to pose my questions for fear that I would damage her further. This happened at least twice during the interview. The first time, Joanna recounted how everything in her consulting room was displaced after her client had gone and that this was upsetting. Fearful to place her in a position to reflect on a potentially disturbing feeling I said *"…and if I may insist, when you say upsetting what do you mean?" (7.173-174).* At another instance and when she referred to the sexual feelings she experienced in her countertransference, I felt again guilty for asking her to reflect further, as it becomes evident from my response. *"How was that for you if I don't, I am not so intrusive to ask" (14. 373)*. On reflection, I believe that my reactions were part of a parallel

process that was enacted between the two of us. She was unconsciously enacting the countertransference of the helpless victim, and I was responding to her as if I was the overwhelmed therapist she was during their sessions.

With Jack the parallel process took the form of pressure on me to cross the boundaries and seduction. During the interview, Jack discussed the pressure he felt to cross the time boundaries, the seductive power of his patient and the homosexual pleasure he experienced in the countertransference. Without realising it, Jack took on the role of his patient in many instances and I felt a similar pressure. Jack, whom I had never met before, had been informed about the topic of the interview during our first telephone contact. When I arrived for the interview he was very polite, offering me coffee and a selection of at least three different types of chocolates which, as he informed me, had bought especially for me. I felt pressure to enter a social role whereas I was there professionally and I had to deny politely despite his insistence. During the interview, in at least two occasions I experienced him being seductive exactly as he was describing his patient to be. As he was discussing the therapist's need to express the aggression s/he harbours for the patient, he used the following example which, in my view was seductive in that he used me to describe an erotic situation and more over carried the homosexual resonance similar to the one he experienced with his patient. I remember feeling exposed and embarrassed.

Imagine an erotomanic situation that a female patient of yours falls in love with you, not just erotic transference but erotomania and you say as (the) the psychoanalyst could say, I'll turn her away. Go away, I don't want you (17. 363-367)

After the end of the interview, Jack invited me at least four times to stay for coffee and I felt again significant pressure to accept and guilt when I had to firmly remind him that I was there in my capacity as a researcher. It's interesting to note that Jack was unconsciously behaving like his patient who by means of crossing the boundaries and being seductive threatened to push Jack out of his role and destroy therapy, and during the interview I was like Jack, who in his effort to protect the therapeutic frame became rigid at times and lectured his client.

Jason, who described his client as being "*a man with many obsessive compulsive elements, his fundamental characteristic was that he did not express any feeling*" (3. 82-84), someone who "*was very closed, very rational, this intellectualization had to break..eh*" (106-107, p.4) displayed during the interview similar characteristics which made the interview as difficult for me as therapy (was) for him. The highly controlling elements of an obsessive compulsive individual can appear in the amount of information and spontaneity present as s/he talks about things. Although Jason, a researcher himself, was very willing to participate in the research, during the interview he , like his client, appeared closed off, careful with his words and defensive using intellectualization in the same way as his client. The parallel process, although not understood as such at that moment, began early in our interview when Jason appeared almost reluctant to offer any information. For example, when I asked him if he could describe a recent patient of his who presented with perversion he surprisingly responded by describing his doctoral thesis

Someone with whom I have finished? I do have a patient in analysis, …eh…I have done a research and a doctorate degree on incest… but the research protocol there has to do with the psychology of the mothers, not… with…the perpetrators (2.34-37).

When I made the topic clear again and again asked for some information about his patient, he appeared reluctant to allow himself to offer any information he thought was relevant and needed me to tell him exactly what I needed to know. The following exchange makes clear the obsessive compulsive need for exactness and the controlling element it entails as information was were given reluctantly and stingingly.

P: So what is it exactly what you would like me to tell you, what is your focus in other words?
R: I would like few information about a case.
P: When you say information, what kind of information?
P: For example how long have you been seeing the…the particular patient
R: Three years
P: Ok… and what was the presenting problem,…eh his age..
R: He is in his thirties… he came because he was in a… eh… he had difficulties in his marriage… eh… he had met another woman… that was the presenting problem…anything else? (2. 46-61)

The immediate effect this had on me was to feel like a nuisance, as if I were bothering him with questions he did not care or want to answer. If it

had been a social interaction, and had I not had on my mind that he had given his consent for the interview, I would have taken the cue to stop asking because I was intruding. Perhaps this is how Jason felt with his patient as well, when he said that "*there might have been a discomfort*" (4. 105-106) although exactly like his patient, when I asked him to elaborate further on this feeling he did not, resorting instead to intellectualisations.

no... ok… that might be a part of my own… my own personality, my own character, it might not have to do with… it wasn't something.. eh… objective… and what I said earlier about the psychoanalyst's training… the training in psychoanalysis requires the therapist to be analysed, that future therapist or analyst that is… through analysis certain issues have been resolved, so that we can control our feelings, to avoid being too giving or too… distant eh.. (4. 109-115)

Last but not least, I would like to mention the case of Nikos. Nikos' patient had deceived him regarding his presenting problem and life history and only later on in treatment did he disclose disclosed that he was cross-dressing. As I began reading the transcript for the first time and wrote down my first impressions and comments and (up) until page 13, where Nikos discussed how he dealt with his patient's deception and explained in detail his patient's need to cross-dress, I kept confusing the therapist's gender. In most of my comments, I referred to the therapist as being a female, although at times I referred to him as being a male. Later on in the transcript in page 19, Nikos discussed how he himself got confused with respect to his sexual and gender identity. It seems I was confused the same way he was

there was something confusing as well, something that blurred the gender boundaries. In some of his fantasies I was the phallic woman and that was quite strange for me to think about. You see these fantasies placed me in a position to think "what if..?" What if I was this way, how would I feel? And that at times felt threatening to my sexual identity. (19. 384-387)

Although the emergence of parallel processes in supervision has been well documented, their appearance during research interviews is a surprising finding. It could be hypothesised that the negative and overwhelming countertransferences that therapists experience when working with perverse individuals traumatize them, and whenever they discuss or place themselves in similar emotional situations, their unresolved and unconscious trauma resurfaces in the form of unconscious enactment of the traumatic situation.

Chapter 5: Discussion

Having as its focus to explore psychodynamically oriented therapists' countertransference experiences when working with perverse individuals, the present research study has presented an idiographic interpretative phenomenological analysis of ten male and female therapists with clinical experience with this particular patient group. This analysis yielded findings that confirm the existing literature in terms of what perversion is and how it is experienced relationally within the transference/countertransference matrix, adding however greater depth to the meaning of these experiences. At the same time by means of this research, countertransference experiences are placed at the heart of the treatment of perversions and a preliminary model of countertransference experiences emerges that details the potential challenges therapists are likely to face at each stage of treatment, the meanings these challenges are likely to hold as far as the dynamics of therapy are concerned, and the impact they have on the therapeutic outcome and the psychological well being of therapists themselves.

5.1 Therapists' Understanding of Perversion

5.1.1 Definitions of Perversion

As is well documented in the literature (e.g. Purcel, 2006; Bonner, 2006; dos Reis Filho et. al, 2005), there are many different definitions of perversion each of which appears to depend on the particular theoretical framework through which the phenomenon is conceptualised. A similar variation appeared in the participants' accounts, since five different categories of definitions emerged. Perversions were understood as being a separate clinical structure (Goldberg, 1995), as a defence against psychosis (Glover, 1933), as a way of dealing with intimacy fears (Glasser, 1979), as the erotic form of hatred (Stoller, 1975) or as a deviation of the sexual instinct with respect to the sexual object or aim (Freud, 1905/2001). Although this variation in definitions appears to confirm those authors (e.g Jimenez, 2004; DeMassi, 2003) who attempt to explain it on the basis of the complexity of the phenomenon, Kernberg's (2006) classification of perversion into six groups, depending on the level of personality organization, appears to offer an alternative explanation. This classification

presupposes that aggression is the primary characteristic of perversion and depending on its source and destructiveness in terms of object relating, places perversions at the neurotic, borderline, narcissistic, malignant narcissistic, antisocial and psychotic level of psychic functioning.

More specifically, the first group contains perversions that can be found in the context of neurotic personality organizations. In this higher functioning group, Kernberg (ibid) places those cases that were described by Freud (1905/2001) in which oedipal conflicts are avoided by means of disavowal. Aggression is linked with oedipal conflicts, whereas the individual's capacity for object relatedness remains intact. The second group involves perversions that are largely found in patients with borderline personality organization. At this level, pre-oedipal and oedipal conflicts co-exist with pre-oedipal aggression, taking the form of sadomasochistic sexuality and character structure. Object-relatedness is severely affected as splitting affects both the Ego and Superego and the individual's overall functioning. In the third group Kernberg (ibid) classifies perversions which are combined with narcissistic personality disorder. As it is the case in the second group, there is a mixture of pre-oedipal and oedipal conflicts. Here, however, the aggressive drive is integrated with the idealised grandiose self resulting in the construction of more dangerous sadistic perversions. The capacity to relate to others is affected as well, and sexuality is used compulsively as a means to relieve anxiety. The fourth group appears to be a variation of the third in the sense that Kernberg (ibid) places here perversions that are combined with malignant narcissism. Ego syntonic aggression dominates the perversion whose enactment places both the patient and his/her partner in danger. In this group are found the most severe forms of sadomasochism, paedophilia, and perversions such as coprophilia which are rooted in anal regression. In the fifth group, Kerbnerg (ibid) categorises perversions that appear along with the antisocial personality disorder in which superego development has failed completely, and the individual is lacking any moral sense and can disintegrate into becoming a sexual murderer. In this category, primitive aggression has totally overcome the sexual instinct and the patient should be considired dangerous. In the sixth and last group, are found perversions that are part of psychotic personality organization.

According to Kernberg (ibid), these variations in the presentation of perversions demonstrate that they cannot be regarded as a separate clinical structure, since their severity and function seem to depend on the level of personality organization of the individual who presents with them. In this respect, the various definitions of perversion that participants presented do not point necessarily to different aspects of the phenomenon, but to their experiences of perversion with individuals at different level of personality organization.

5.1.2 Way of Relating to Self

Participants' understanding of perversion extended to include the way these people relate to themselves and others. The emergence of the relational dimension as a defining feature of perversions is consistent with the psychoanalytic literature (e.g. Bach, 1994; Kernberg, 1988) which observes significant deficiencies in these people's internal and external object relations in addition to their perverse sexuality.

According to the findings of this study, people with perversions appear to operate on the basis of splitting and self-deception. This finding is consistent with Freud's (1927, 1938) original contribution to the problem of perversion with his discovery of disavowal and with many other authors (e.g. Andre, 2006; Goldberg, 1995; Steiner, 1995; Chasseguet-Smirgel, 1988;) who believe that the simultaneous recognition and rejection of reality, that disavowal permeates by means of splitting of the ego, is central in understanding the way these people operate intrapsychically and how they manage to maintain contradictory aspects of reality in their minds avoiding psychosis. The individual, therefore, lives in two distinct worlds, the fantasy world where s/he remains the powerful idealised self by means of negating any space/time, anatomical, gender, generation differences and denying separation, death and mourning and the real world, which appears too dangerous to exist in (Bach, 1994). As some participants explained as well, splitting and self-deception maintain the fragmented self of people with perversion, by forcing the individual to resist any links in his experience and deny any true knowledge about him/her self (Ross,2003).

5.1.3 Way of Relating to Others

In terms of external object relations, the findings of the present study confirm the literature, as people with perversion were portrayed as initiating contact by being charming and seductive only to later on treat the other as a part-object which can be used or abused accordingly. Jimenez (2004) appears to refer to this dark, dangerous charm, when he refers to the excitement that characterizes the perverse atmosphere. Citing Polanski's film Bitter Moon (1992), he comments on the atmosphere of suspense, mystery and vague promises of pleasures that seducers create to lure their victims in their perverse scenario. As violence creeps in gradually the seduced individuals react in terror, "*appalled at how they could have allowed themselves to become so deeply enmeshed in siren calls that were ultimately revealed to be a trap, a set of lies and a trick*" (p.70). This charming exterior appears to be related also with Chasseguet-Smirger's (1988) assertion that idealization is part of perversion and the observation that the perverse individual is often an aesthete, with great interest in art and beauty. More specifically, she suggests that the perverse individual idealises the anal pregenital universe s/he lives in. Instead of sublimating his/her pregenital libido and thus truly creating, the perverse individual may cover his/her pregenital instincts with an aesthetic atmosphere which endows him/her or the relationship with an idealising aura. Similarly, Glover (2010) believes that the perverse individual's tendency to over-idealise everything occurs because everything that surrounds the idealised Ego is a mirror on which s/he is reflected. This mirror must be of exquisite beauty and taste in order to disguise the chaos, denigration and dirt of the anal universe. This, idealization, which acts like a cover for the pervert's anal universe, could account for the dark, dangerous charm that participants discussed as being part of the way the perverse individual makes contact with others.

What seems to terrify anyone who comes in contact with perverse individuals as the atmosphere of charm fades out is, according to the findings, their tendency to treat others as part-objects which can be used and abused. The other is not seen as whole and separate human being, but as something which is there to provide libidinal gratification (Welldon, 2011). In this dehumanising way of relating, only certain aspects, functions or parts of the other are addressed (Gomez, 1997) and when the perverse tendency is

eroticised, the other is used as a sexual-part object, with the sexual interest being only in the body or part of the body (Ross, 2003). Bach (1994) perceives this lack of capacity for whole-object love to be central in people with perversions who end up creating technical relationships. In this world of dehumanised part-objects a regressive anal economy prevails: all objects are interchangeable and one can scarcely be distinguished from the other.

According to the present findings, in this type of part-object relating aggression and hostility dominate interaction with others as a result of an unfathomed terror experienced by these individuals. Although there are certainly many theories regarding the role of aggression in perversion, in this study the etiological factor is located in Glasser's Core Complex which is discussed in detail in the literature review chapter.

Last but not least, participants referred to an enmeshed and chaotic way of relating to others that once more coincides with Chasseguet-Smirgel's (1988) conceptualization of perversion as entailing a regression to an anal universe where all barriers break down and the individual relates in an enmeshed way denying all existing differences between children and adults, males and females, organ functions, bodily parts etc. In this immature and chaotic universe, everything and everyone is used interchangeably without discrimination.

5.1.4 Theories of Perversion & Countertransference

Although participants' understanding of perversion is confirmed by the existing literature, this appears to be only the first step in the analysis of these findings, for a question arises as to why all but one relied so much on theory to discuss their understanding of perversion. A hypothesis that emerges here is that that resorting to short and clear cut theoretical constructs is a countertransference response to the complex and emotionally disturbing phenomenon of perversion. The idea that theory can be used defensively is discussed extensively by Purcell (2004) who considers therapists' theory as an additional source of countertransference, in that it has the power to organize and shape therapists' cognitive and emotional experiences of their clients, thus acting as a confounding variable in the therapeutic process. Dealing with aggression, the major component of perversions, is emotionally unnerving and anxiety provoking (Ross, 2003).

It could be hypothesised that definitions of perversions which explain the source and function of this aggression help therapists neutralise the feeling of anxiety they may feel, by giving them a sense of power and control that comes from knowing and understanding.

Another source of confirmation of the hypothesis that participants' reliance on theory is in fact an anxiety countertransference response comes from participants' descriptions of the way people with perversions relate to themselves and others. Based on this study's findings that perverse individuals' way of relating to themselves is characterised by disavowal and self-deception, the hypothesis that emerges here is that participants' reliance on theory can be understood as a concordant countertransference feeling of self-deception, for repeating a theory gives the impression of knowledge; this knowledge, however, appears to be employed in order to deceive rather than to inform for it does not relate, in this instance at least, to personal experience. As Ross (2003) says "*deception is about knowing and not knowing and of trying to make sense of different combinations of knowledge and experience*" (p. 20).

It could be hypothesised therefore, that when it comes to perversion, theory can be used perversely (Ceccarelli, 2005) to conceal rather than to enlighten, in an unconscious effort on the part of therapists to remain deceptively unaware of the anxiety they experience as they are asked to enter the aggressive universe of perversion. Theory is turned to a glorified, idealised part-object, similar to those idealised by perverse individuals which is used to conceal the underlying anxiety, the same way that perverse individuals' idealizations are used to conceal the deficiencies of the anal universe in which they live in.

Although knowledge of theory is important in order to understand the phenomenon better, too much reliance on theory entails the danger of it being used defensively, constructing a false reality of knowing the other. The therapist might collude with the perverse individual who does not wish to understand or know himself (Bach, 1994), contributing in this way to the co-construction of an illusion of therapy, for everything is already known and understood. Therapy, therefore, can become a repetition of perversion, in which both the patient and therapist use each other as a part-object to satisfy their own needs and hide from their true unbearable feelings.

5.2 Development of Countertransference

In order for countertransference phenomena to be better understood as they unfold in therapy, participants were asked to reflect separately on their experiences at the beginning, middle and final period of therapy. An unforeseen finding of this research was that intense countertransference phenomena can continue well after the end of therapy. The type of countertransferences at the various stages of therapy and their significance will be discussed below.

5.2.1 Initial Period Countertransference: Battle for Survival

Reflecting on the events of the initial period of therapy, participants reported a variety of countertransference feelings. For example, some felt charmed by their patients, others as if they were protective mothers, others as part-objects and sexual part-objects, others as humiliated victims and still others experienced both the fear of annihilation and what it means to actually be annihilated. Although these countertransferences appear unrelated to each other, and each of these holds a particular significance, I would like to propose that they are connected by the end result they produce; they place the therapist under the control of the client. This observation is consistent with Coen's (1992) assertion that the purpose of the perverse individual is to control the other person denying his separateness and autonomy.

Many participants reported that their perverse client perceived them as if they were a dangerous object and for this reason the clients had a need to control the therapists. In this research therefore, the need for control is portrayed as being the result of feeling threatened, a finding that contradicts Tuch's (2008) understanding of control as a means of gaining power for the purpose of harming the other. Other writers, however, support this finding since they describe perverse individuals as having experienced a bodily and/or psychological threat to their existence (Welldon, 2011, Bach, 1994, Chasseguet-Smirgel, 1988) which left them feeling helpless and enraged with a shattered sense of trust for a caring figure and in need of being in control of relationships for fear that the horrors of their past could be relived (Welldon, 2011). Therapists therefore, who present themselves as caring

figures and invite the perverse clients to relate to them and trust them, pose a tremendous danger for them, as their survival is threatened once more and they must defend themselves with whatever means are necessary and available. An answer to what these means of defensive control are can be found in participants' countertransferences.

Some participants reported feeling charmed by their patients during the first meeting. As discussed earlier charm appears to be related with the perverse individual's need to idealize his anal universe and deceive him/her self and others as far as its "beauty" and "efficiency" is concerned (Chasseguet- Smirgel, 1988). It could be hypothesised that under the spell of the perverse individual's charm therapists can be deceived to admire the "beauty" and "uniqueness" of the perverse individual. Having been deceived, the therapist is indeed under the client's control for both of them can avoid exploring the insufficiencies and terrors that are lurking underneath his/her idealised exterior. What appears to be the effect of charm in the countertransference on the therapist is that s/he's placed under the client's control, in the sense that they can both continue deceiving themselves marvelling at the apparent beauty of perversions, instead of dealing with the dreaded anal insufficiencies they conceal.

Other participants discussed how they were controlled by their patient, through what appears to be a protective mother countertransference. Being trapped in this countertransference, participants were often silenced, as their clients talked endlessly and therapists found it difficult to stop them for fear they would hurt them. Kramer-Richards (2003) refers to flooding with words as being one of the ways the perverse patient attacks the analyst in order to destroy therapy, whereas Knoblauch (2007) discusses the seductive nature of verbal communication which lures the analyst into the confusion and excitement of the patient with the ultimate goal being to destroy any possibility of true relating. Indeed, both therapists realised that perceiving their patient as a vulnerable and helpless child, whose narration could not be stopped but only endured, prevented them from perceiving their aggressive and manipulative aspects and consequently explore significant and potentially painful aspects of their patients' being.

Another way therapists were controlled by their patients during the initial phase of therapy was by becoming the part-objects their patients

needed them to be. As discussed earlier, part-object relating is indeed characteristic of the way people with perversion relate to others as they cannot tolerate another human being's totality and they need to fragment and dehumanize him/her (dos Reis Filho, 2005). In the present study, two particular types of part-object relating were emphasised; treating others as being a function, which had the effect of reducing therapists to inanimate machines or tools whose purpose was to fix the client, and treating others as sexual objects which had the effect of throwing therapists out of their role and destroying, momentarily at least, therapy. It appears that identifying in the countertransference with the part-object way of being and feeling like a tool can be detrimental for the therapist's identity, for they appear to be in danger of losing their multidimensional self, which is ultimately their source for creativity and insights during therapy. This type of relating has been termed technical (Bach, 1994) and in this respect it can be hypothesised that therapeutic interventions, if they occur at all, come from a shrunk inanimate part of the therapist, are dry and technical, lacking the vivid emotional and multilayered effect of an intervention that could emerge from the presence and participation of the therapist's whole being in the process. The obvious advantage for the client is to remain safely unaware of anything painful that might surface.

The identification with the sexual part object which made some participants experience sexual feelings towards their clients appears to have the same affect. According to Glasser (1986), sexualisation plays the role of converting aggression and the intension to destroy, into sadism and the intension to harm and control. Therefore, by relating to therapists as if they were sexual part objects, perverse patients intend to control the therapist. Indeed, being trapped in this countertransference, therapists lost their capacity to reflect therapeutically and attribute a different meaning to the events of therapy. The end result once more is one that helps the client remain safe in his familiar way of relating, avoiding the dangers he imagines exist in true relating.

Another concordant countertransference feeling reported by participants during the initial phase of therapy, was that of the humiliated victim. Stoller (1975) has discussed extensively the humiliation people with perversion have experienced during their childhood with respect to their

gender and sexuality and how as adults they need to take revenge by humiliating others. This dynamic is indeed repeated in therapy with patients needing to humiliate therapists and therapists at times ending up feeling humiliated. Although experiencing humiliation can be valuable in better understanding patients' experiences, according to the findings of this study, this humiliation appears to entail the danger of turning the therapist into the victim his/her client once was and either reacting as if s/he were indeed helpless to stop the humiliation, or blaming themselves, as victims tend to do, for what happened to them.

The most powerful, however, way therapists were controlled by their patients was through experiencing the fear of annihilation or feeling indeed annihilated in the countertransference. Originating in Glasser's Core Complex, the fear of annihilation has been documented repeatedly in the literature (e.g. Ruszczynski, 1997; Wood, 1997, Harding, 2001) as dominating the psyche of perverse individuals and as being behind their aggressive and highly controlling way of relating. An insight into how this fear of annihilation is experienced by patients can be gained through participants' countertransferences as it is described like a death-like terror regarding their very psychological existence, in response to their patients' deadly hatred or negation of their existence in their minds. The powerful effect of this appears to be, according to participants, psychological and mental paralysis. Mann (1997) refers to this attack on the therapist's capacity to think as being characteristic of the perverse countertransference, during which the therapist's mental, reflective and creative processes are obliterated. Similarly, Anderson (1992) refers to the therapists' mental paralysis as being a perverse communication, which throws the therapist into a flat meaningless state, while elevating the patient to an omnipotent position of dominance. Trapped in this countertransference, therapists are deactivated, therapy is destroyed and perverse patients can once more remain "safe". Following Bion's (1962) formulation, it could be argued that under the perverse client's attack, the therapist's capacity for reverie, that is his ability to receive and metabolise the split off feelings of the client, is destroyed and as a result s/he can remain forever unknown to the therapist and to him/herself.

Experiencing these indeed very intense countertransferences had additional effects on therapists, who according to the findings of this study, ended up questioning their therapeutic abilities and felt emotionally exhausted. Both feelings can be thought of as contributing to the control and deactivation of the therapist. Therapists who begin to question their abilities to such an extent as the participants of this study discussed, run the risk of stopping trusting their thoughts and insights and/or withdrawing in silence. Emotional exhaustion appears to have a similar effect, since emotionally worn out therapists feel as if they cannot continue the battle to survive. Perhaps when DeMassi (1999) discusses the therapist's apathy or boredom when working with perverse patients, refers to this emotional exhaustion. In this case, according to the author (ibid) therapists' emotional exhaustion and resignation is a defence against them experiencing their own aggression as it arises through prolonged therapeutic impasses. Truly emotionally exhausted on the surface, angry for the apparent futility of their efforts underneath, therapists might be indeed tempted to withdraw. The resignation that might follow is another instance of a therapist who has been deactivated by the patient who can continue this way to preserve his perverse way of functioning.

Experiencing their clients' tremendous need and desire to control them by whatever means available, it does not come as a surprise that, according to the findings, therapists may begin to experience their clients being the dangerous objects. The fantasies of physical abuse that were reported by participants are evidence of the threat they experienced from their clients and their need to defend themselves. A full circle then appears to have been completed, which began with the perverse patients' perception of the therapist as being dangerous, continued with the patients' unconscious attempts to control and deactivate the therapist and concluded with the therapists experiencing the client as being dangerous. It appears, therefore, that during this initial period of therapy, the major transference and countertransference is that of experiencing the other as posing a tremendous danger for psychological survival. In response to this terrifying feeling, a battle appears to take place between therapist and patient as they both strive to remain alive and safe under the threat of the other's perceived attack. It could be hypothesised, therefore, that what is repeated in the initial period

of therapy is the Core Complex, according to which the threat for psychic survival that both therapist and patient pose to each other is dealt either with aggression or withdrawal.

5.2.2 Middle Period Countertransference: Sadomasochistic Control vs. Empathic Understanding

Moving on to the middle phase of therapy and as the battle for psychic survival continues to be a major issue in therapy, participants reported some countertransference feelings which were similar to those of the initial period. One therapist felt humiliated, another felt like a sexual part object, and three others experienced the fear of annihilation. This repetition in the countertransference is understandable considering that clients' issues are worked through over and over again during therapy before they are resolved.

Returning to participant's countertransference experiences which were specific to the middle phase, for Eva and Joanna this anxiety was in response to the management of the sexualised transference, whereas for Nikos, was in response to dealing with the client's deception. According to the findings, this countertransference anxiety appears to be related to participants' sense of losing control as they experience a threat to their therapeutic identity.

More specifically, it could be hypothesised that the anxiety experienced by therapists as they find themselves in the midst of their patient's sexualised transference can be understood as a concordant countertransference, mirroring the patient's annihilation anxiety and frantic need to regain control in order to survive. Although, to the best of my knowledge, there hasn't been a clear theoretical formulation in the literature linking sexualisation in the transference with annihilation anxiety and need for control in the countertransference, it is possible to find support for this hypothesis combining various pieces of the existing literature.

As Etchgoyen stressed, the eroticisation of transference is indeed one of the aspects of perverse transference (Lauro, 1993) which differs from the idealisation and the feelings of love that are part of the erotic transference, in that the clinical material is full of repeated and conscious sexual references. According to DeMassi (1988), eroticisation in the transference is

in fact the expression of the patient's desire for narcissistic fusion with an object that can meet all of his needs. The patient, therefore, seeks to seduce the therapist into a delusional world where the one will be incorporated in the other in an imaginary state of blissful union, eternal containment and satisfaction. This delusion is often experienced by the therapist in the countertransference as a questioning of his abilities and the value of the therapeutic work. In other words "*the patient's power of creating illusion exerts itself by trying to undermine the analyst's sense of his analytic identity*"(ibid, p. 117). Kernberg (1992) on the other hand, believing that in perversions sexualisation is at the service of aggression, suggests that when it finds its way into the transference it reflects the patient's need for sadistic control and destruction.

DeMassi's (1988) and Kernberg's (1992) positions regarding the origins of sexualisation differ, but I would like to propose that they are both in accordance with Glasser's (1979) Core Complex which, in this study, emerged as the etiological factor in perversions. DeMassi's conceptualisation coincides with the longing for fusion and merging with a significant other as described in the Core Complex, whereas Kernberg's formulation corresponds to the defensive aggression with which these individuals react, fearing that this merging will result in their annihilation. Sexualisation then, according to the Core Complex, offers a compromise as it allows the individual to maintain some closeness to his object, but in a way that helps him/her to maintain control. It could be argued therefore, that an aspect of perverse transference involves the repetition of the Core Complex and as a result the anxiety therapists experience is a countertransference reaction that mirrors the patients' annihilation anxiety and need for control.

Nikos' annihilation anxiety and need for control developed as a result of him being tragically deceived by his client with respect to his presenting problem and whole history. Needing to maintain total control over another person's mind and sadistically enjoying his trickery, Nikos' patient created an alternative deceptive reality which allowed him to preserve a sense of omnipotence. According to Etchegoyen (as cited in Moguillansky, 2004), the creation of an illusory bond between therapist and client is one of the characteristics of perverse transference. When deception was revealed,

Nikos' sense of reality and belief in his therapeutic abilities were severely affected and he experienced a tremendous lack of control over the most basic aspects of his life, which translated in him feeling threatened at all levels. It appears that Nikos experienced a similar annihilation anxiety and need for control, but this time in response to another aspect of perverse transference, the one that involves the creation of an illusory therapeutic bond and pseudo-therapy (Chasseguet-Smirgel, 1981).

Researching therapists' experiences when working with patients who deceive themselves, Westland & Shinebourne (2009) identified among other findings, that self-doub was central to therapists' experiences. Feelings of inadequacy and self-doubt were) where explained on the basis of Theriault's & Gazzolla's (2006, as cited in Westland & Shinebourne, 2009) research which suggested that therapists' sense of competence is dependent on the building and maintenance of a strong therapeutic relationship. When deception infiltrates the therapeutic relationship, the therapists' sense of adequacy is severely compromised. Therefore, the perverse illusory bond which is created through deception, threatens the core of the therapists' identity, an experience which can further account for the annihilation anxiety Nikos experienced and his resulting need for control.

Both aspects of perverse transference then, the erotisation of the relationship and the creation of an illusion, appear to create a similar countertransference reaction in therapists; annihilation anxiety and need for control. This is consistent with Mann's (1997) suggestion that the underlying goal of perverse transference is the destruction of both the therapist, as an autonomous and separate entity with a mind of his own, and therapy as a process of a potentially true and intimate whole object relating. It could be hypothesised, therefore, that entering the realm of perverse transference therapists experience a tremendous threat to their psychological survival, which is at the core of their annihilation anxiety and need for control in the countertransference.

In addition to experiencing this annihilation anxiety and the consequent need for control when dealing with their patients' perverse transference, during the middle phase of therapy, participants experienced a masochistic countertransference that at times filled them also with guilt. More specifically, as some participants listened to their client's graphic

descriptions of their sexual fantasies or experiences, they felt obliged to continue listening despite their discomfort. Their masochistic countertransference is revealed through 1) their distorted belief that the therapist's role is to listen to everything the client has to say, 2) their illusion that this way they maintain a relationship with the client, 3) their sense of higher accomplishment as they endured the torture like martyrs.

Masochism in the countertransference can be understood as complementing the sadism in the transference. The analytic couple appears to transform into what DeMassi (1999) calls the sadomasochistic monad. According to the author, in ordinary sexual intercourse there is a fusion of bodies, the relationship is equal and pleasure is shared. In sadomasochism, however instead of a fusion of bodies there are complementary roles (e.g. dominator/dominated, active/passive). Pleasure stems from the exchange of roles during the sexual encounter that is by the coupling of one's sensations as being the dominated with those of the dominator. "*The enslavement witnessed and enjoyed by both sides thus brings about the unity of opposites, whereby all the available pleasure can be appropriated to oneself (p. 82).* Therefore, the individual's focus is on his own body and as s/he has managed to experience both the sadistic and masochistic pleasures, s/he has no real need of the other person. It is clear that DeMassi (1999) utilizes the term strictly to describe sexual intercourse. It is possible, however, to extend the term to describe the therapeutic couple within the sadomasochistic perverse transference-countertransference matrix. As the perverse patient identifies with his sadistic part and attacks and tortures the therapist with graphic sexual details of his fantasies and experiences, he at the same time projects his/her masochistic part on the therapist. The therapist, who identifies with the patient's masochistic part, colludes with him/her to establish an asymmetrical relationship with clear complementary roles; the patient is the active dominator who tortures and the therapist is the passive, dominated partner who endures. Kassy clearly took her complementary role since "*I thought as a therapist I need to listen to everything my client is saying" (8. 186)*. Moreover, therapeutic "pleasure" and elevation was achieved as therapists derived a sense of superiority as a result of enduring like martyrs. "*There was a feeling of satisfaction in me for actually enduring all this" (13.254)* Elen says. It could be hypothesised therefore, that in the

context of the perverse transference, both the patient and therapist can experience a sadomasochistic pleasure and pretend that they actually relate to each other, whereas in reality each of them is a sadomasochistic monad playing a role for their own satisfaction.

As the therapist identifies with the masochistic countertransference, the patient achieves his unconscious goal that is to both attack and destroy the therapist for the danger s/he represents, but at the same time, by sexualising the destructive aggression and turning it to sadistic control, to avoid losing the object (Kernberg, 1992). Once more, as the Core Complex (Glasser, 1979) predicts, the therapist is controlled and the patient remains safe.

Closely related to their masochistic countertransference are participants' feelings of guilt either for interpreting their client's sexualised transference or in separating from them during breaks or after the session.

Since in the patient's prescribed scenario, the therapist must be dominated and conform or otherwise be in danger of receiving relentless aggression, any attempt from his/her part to have an autonomous mind, that could attribute different meanings to the imposed "reality" (Chasseguette-Smirgel, 1988) of the perverse transference, is followed by a masochistic guilt. In this regard, the guilt experienced by the therapist in the countertransference could be the projected guilt of the patient for his own aggression (Kernberg, 1992). The patient manages to maintain a sense of omnipotence and control over the therapist, who by means of feeling guilty, does not exercise his interpretative role and does not separate from or "abandon" the patient. The therapist's masochistic guilt, therefore, appears to serve a double goal for the patient, both to control the therapist and preserve him/her in order to avoid mourning the loss. Since, however, this guilt is part of a masochistic countertransference, and according to Stoller (1975) the masochist is not a real victim for s/he does not truly relinquish control, it could be hypothesised that guilt is also unconsciously used by the therapist as a means of counter-control. This hypothesis is derived by the therapists' impression that their guilt was part of a motherly countertransference.

Although, therapists were in fact under their patients' control, for they could not verbalize their interpretations or "abandon" them, it appears that

they unconsciously altered this negative experience into a positive one by experiencing themselves as protective mothers. It could be hypothesised that in this way therapists could, on one hand, defend against feeling controlled and vulnerable by means of acquiring the superior moral status of a mother who endures and sacrifices herself for her child, and on the other hand, feel powerful and in control, in the same way the omnipotent figure of a mother holds powers of life and death over her child. Perceiving themselves as being guilty, self sacrificing but almighty mothers, therapists were in position to acquire some sense of control over their client, who in their eyes had been transformed to a helpless vulnerable child. Through the apparent double role of guilt, as the patient's projected feeling that controls the therapist and as the feeling which endows therapists with a moral superiority that controls the patient, the perverse sadomasochistic exchange, in which both therapist and client strive to acquire control over each other, in a desperate effort to ascertain their psychic survival (Glasser, 1979) and preserve a sense of pseudo-relatedness, (Bach, 1994), becomes clear once more.

It appears that the battle for the establishment of control that began in the initial phase of therapy as a form of reaction against the perceived threat that both therapist and client posed to each other continues in the middle phase but this time it takes a clear sadomasochistic form that allows them, on one hand to maintain the illusion of true relating, and on the other, to remain safe by controlling each other.

Despite the sadomasochistic relating that appears to dominate the clinical picture of the middle phase of therapy, participants reported developing gradually feelings of empathy for their clients. Taking into consideration that empathic understanding, as described by Rogers (1957), is one of the necessary and sufficient conditions for therapeutic change, this shift in the participants' experience is considered to be significant both for the therapeutic outcome and the therapist. As became evident from Kassy's account, the moment she was able to empathise with her client was also the moment that she regained her therapeutic identity. Indeed, empathy, being at the centre of the therapeutic process, is one of the most basic aspects of the therapist's identity (Rowan & Jacobs, 2002). It could be argued that a therapist, who is overwhelmed with feelings relating to a perverse

countertransference, is not a therapist anymore but someone trapped in a perverse scenario. By inducing these countertransference feelings in the therapist, the perverse client obliterates him/her, not only by attacking his/her capacity to think and reflect on the process, but also by preventing him/her experiencing empathy; a process vital for his/her identity. It could be hypothesised, therefore, that by regaining their capacity for empathic understanding therapists not only recover their identity, but also manage to disentangle themselves from the sadomasochistic countertransference, which does not allow concern and care for the other to emerge and maintains a part-object way of relating.

Exactly because of its "as if" quality (Rogers, 1957) , the capacity to empathise presupposes a level of differentiation and autonomy in that one must first be able to experience himself as a separate entity in order to make the conscious effort to experience what it feels to be in the position of the other. Indeed, Kohut (1984) appears to refer to this underlying differentiation between therapist and client when he suggests that empathy results from a process of comparing the way the client thinks or feels with our internal images and memories. In this respect, it could be hypothesised that the moment therapists achieve empathy for their patients is the moment that they have stopped being the sadomasochistic monad in their countertransference.

A question arises then as to what facilitates the emergence of empathic understanding in an otherwise sadomasochistic therapeutic relationship. According to the findings of this study, empathic understanding emerged when 1) therapists, abandoning the expectation to change their clients' perversion, perceived them as whole human beings instead of perverse individuals, 2) they were able to relate not the perverse adult present in their consulting room, but to the traumatised child within them and 3) they focused on their clients' isolation, loneliness and desperation instead of focusing on their aggression and need for sadistic control.

It appears that as therapy proceeds and therapists become acquainted with the client, not only through his perversion, but also through his personal history and relationships in the world, the part object relating that accompanies the sadomasochistic countertransference is gradually substituted by a whole object relating. It could be hypothesised, therefore,

that the more the therapist is able to differentiate himself from his countertransference and escape the perverse scenario, the easier it becomes to perceive the client as a human being with a particular history, experiences and a whole set of characteristics other than his perversion. In the context of this study, acceptance of perversion as only one of the characteristics of the client appears to become the agent of change, in that it helps therapists return to a whole object way of relating and begin to empathize with their client.

Another factor that facilitated the emergence of empathic understanding on the part of therapists was their perception of the client as being a traumatised child. Again, it could be hypothesised that, as therapy progressed and patients' childhood histories came to foreground in all their dramatic details painting the picture of an abused, traumatised and helpless child, therapists were able look beyond the aggressive perverse adult who seduced them into his perverse scenario and invoked in them all the above overwhelming countertransference feelings. Shifting their focus away from the aggressive and controlling adult to the helpless traumatised child, appears to have helped therapists experience feelings of empathy for the painful experiences their clients went through.

According to the findings of this research, the most characteristic feeling that therapists experienced as they empathised with their clients' experiences was that of sadness. Sadness for what they had to endure during their childhood and for the apparent isolation, confusion and sense of meaninglessness they experience in their adulthood. It could be hypothesised that this sadness is what Rowan & Jacobs (2002) call second level of empathy which they connect conceptually with concordant countertransference. This hypothesis appears to be in accordance to Welldon's (2011) suggestion that the perverse solution is a manic defence against the tremendous depression that lurks within those individuals and their deep seated yet unconscious sense of deadness. It appears that the sadness therapists experience as a result of their increasing capacity to empathise with their clients is a concordant countertransference reaction which reflects their patients' deep depressive core.

The battle for survival that began in the initial phase of therapy continues in the middle phase as well, but as the perverse transference

intensifies, the therapeutic relationship acquires strong sadomasochistic elements that enhance the perverse part-object relating. This type of relating appears to dissolve as therapists manage gradually to identify again with their roles, and experience empathy and sadness for their clients

5.2.3 The Final Period Countertransference: Attachment & Loss

The discussion on the final period countertransference brings to the foreground the experience of ending and as such the experience of being human beings dealing, on one hand, with attachment, separation, loss and mourning, and on the other, with the anxiety and excitement of transition to a new era or psychological reality (Holmes, 1997). Frequently, however, as was the experience of the majority of the participants in this study, the ending is premature and therapists, as Williams (1997) insightfully stresses, have to come to terms with the limited control they have when the patient decides to leave. In these instances, as therapists we may realize that "*some of the most meaningful moments of relatedness in our life belonged in the therapy room, that our capacities for devotion and love were mobilised by someone we have no claims upon at all, and the only right we have is to let the patient go away in complete freedom"* (p.347)**.** As endings often challenge our ability to tolerate uncertainty, to maintain both optimism and sadness in the face of loss, and to preserve realistic perceptions about our strengths and weaknesses (Holmes, 1997), it is not surprising that depressive defenses are evoked in the therapist during the final phase (Williams, 1997).

In exploring therapists' countertransference reactions and depressive defences in the face of ending, Shafer (2002) used the term *false depressive position* to describe a series of reactions that are often observed towards the end of therapy and were part of participants' responses as well. For example, some participants, dealing with their client's decision to terminate therapy prematurely experienced an anxiety regarding their future well being, others felt hopeless about the outcome and guilty for their failure, and others experienced feelings of abandonment, betrayal, frustration and anger. According to Schafer (ibid), all these emotional reactions are evidence of a therapist who operates from a false depressive position and is therefore

unable to abandon premature fantasies of omnipotence as expressed in his/her difficulty to come to terms with therapy's inherent incompleteness.

The issue of therapy's incompleteness and its potentially traumatic impact on the therapist's narcissism was addressed early on in the development of psychoanalysis. For example, in `*Analysis terminable and interminable'*, Freud (1937) refers to incompleteness of psychoanalysis stressing that , despite any amount of transformation, aspects of the patient's unconscious will remain unaffected and that analyst must learn to tolerate their partial successes. Similarly, Jung (1951) points to therapy's limitation to cast out the entire of a patient's unconscious. Indeed, therapy's incompleteness with the frustration it entails for therapists, could be thought of as a reason why participants in this study who, felt that their patients needed more therapy and were not prepared to enter the world, experienced a hopelessness and futility regarding the effect of the therapeutic work and felt guilty and responsible for the "failure" of therapy. Although, Schafer's conceptualization might certainly be true, it does not take into account the history of therapy and as such it cannot be regarded as the sole explanation of participants' reactions towards the ending.

On the contrary, in light of the their middle phase countertransference, during which therapists experienced an empathic understanding towards the traumatised child within their clients, and according to their own accounts, therapists' reactions in the final period of therapy could be understood as being part of a parental countertransference consistent with the attachment they had developed for their patients. Although the significance of this attachment will become clearer in the next section, it should be noted that it is in accordance with Ioannidis' (2004) observations that, on one hand, by means of their own needs and investment in the therapeutic process, therapists tend to experience their clients as love objects, whose loss is feared and raises feelings of abandonment and loneliness, and on the other hand that therapists' are always under the "*principal temptation*" (p. 49) of parental countertransference, for they believe that through their care and attention they will provide their clients with a better experience than the one they had with their parents. Following, therefore, the middle phase of therapy, when for the first time therapists' experienced feelings of empathy for the traumatised child within their clients and succumbed to the *principal*

temptation, therapists in the final period experienced a parental countertransference which made them feel anxious for the wellbeing of their clients, guilty for what they did not manage to offer them and frustrated for being abandoned before major changes took place.

A therapeutic relationship that began with the therapists experiencing their patients as constituting a significant threat to their psychic survival and continued with them unconsciously needing to regain control and keep themselves safe, concludes with the same therapists empathising with the traumatic childhood of their patients, relating to them in a whole object way and developing parental feelings towards them. To the extent that the therapists' countertransference experiences reflect something about the internal world of clients and their object relations, it could be hypothesised that changes in the therapists' countertransference could signify changes in the patients' psychological functioning. Despite them being negative and restrictive as roles, the anxious, the guilty and the abandoned parent in the countertransference also entail aspects of the caring parent and in this respect it could be hypothesised that something of this care was allowed to emerge without being felt by patients as being too dangerous; this in itself can be thought of as constituting a major change for individuals with perversions.

5.2.4 Post-Therapy Countertransference: Traumatisation vs. Professional and Personal Growth

It is well known that the therapeutic relationship continues within the client well after the end of therapy, either because the therapist has become an internal object in his/her world, or because s/he has identified with aspects of the therapist (Shafer, 2002). Similarly, according to Waska (1999), certain aspects of the relationship remain within therapists as well after termination. Consistent with this view, is according to the finding of this study, what could be called a post-therapy countertransference. As emerged through participants' accounts, post-therapy countertransference refers to the conscious or unconscious feelings therapists experience towards their patients even years after the end of therapy. In the context of this study post-therapy countertransference appears to be either positive or negative.

With respect to positive post-therapy countertransference, participants reported thinking often about their clients and wondering how they manage in their lives. Despite the intense transference-countertransference experiences, these therapists achieved a whole object relating with their clients, attached to them, internalised them and made them part of their being. Participants attributed their post-therapy countertransference feelings to the fact that their patients had been instrumental in their professional and personal development, becoming therefore significant figures in their lives.

As therapists discussed, in their effort to understand the dynamics of the transference-countertransference and survive the attacks of their perverse patient, they invested so much of their energy in these patients that they became significant to them in the sense that the patients came to represent an important period of the therapists' professional lives during which they developed their therapeutic identity further. Not only did therapists develop their knowledge about perversions and refine their skills in their effort to handle and make use of their countertransference, but they also increased their awareness with respect to their own personal conflicts and difficulties.

The notion that therapy acts therapeutically for the therapist as well emerged for the first time in 1937 through Glover's survey (as cited in Kantrowitz, 2004) on analyst's perceptions regarding the therapeutic practice. Analysts reported that during their patient's analysis and in response to countertransference reactions they had to re-work their own conflicts as well, a situation that Glover termed "*countertransference therapy*". In a more recent survey of 550 analysts, Kantrowitz (ibid) was able to confirm that it is through therapists' countertransference reactions that the impact the therapeutic process on the therapist becomes more prominent, as personal conflicts are stirred and defences are used. In order to preserve his therapeutic role, the therapist must reflect and work through his/her countertransference in a fashion similar to that of the patient; that is by identifying his defences and the conflicts to which they point. Therefore, by means of this self-therapy, therapists can continue their emotional growth and expand their self-awareness.

The paradox that is observed then, is that, although the unconscious motive of the perverse patient is to destroy the therapist in order to control

him and remain safe, the therapist who survives comes out from this experience professionally and personally richer. It is not surprising therefore, that a perverse patient who has "tortured" the therapist becomes a significant patient, whose loss, according to participants, is mourned, and as a love object (Ioannidis, 2004) continues to be invested with their care and concern even years after the end of therapy.

With respect to negative post-therapy countertransference, one participant demonstrated what appears to be a merging with her client, confusing at times who had a particular experience, or who was the therapist and the client. Consistent with Chasseguet- Smirger's (1984) theory, that perversion involves the abolishment of all differences, this participant's post therapy countertransference points to collusion with a similar perverse functioning. Another participant presented during the interview as clearly identifying with the traumatised victim she was in her countertransference many years ago during her therapeutic work with her patient. It could be hypothesised therefore, that the negative post-therapy countertransference is a residual very intense countertransference reaction which was never resolved during therapy and as such remains unchanged in the present, affecting the therapists' functioning as they enter, through the interview, a similar situation again. If this is the case, then it could be further hypothesised that experiencing such intense countertransferences can be potentially traumatic for the therapist.

This hypothesis leads the discussion on the effects that work with clients, who have been sexually, physically or emotionally abused, such as is often the case with perverse patients, has on therapists. McCann and Pearlman (1990) coined the term *vicarious traumatisation* to denote the negative impact of trauma therapy on therapists. The main symptoms of vicarious traumatisation involve disturbances in therapist's identity and world view, as core beliefs about self and others, the meaning of relationships, sense of trust, safety and personal control are severely challenged. In addition, symptoms of Post-Traumatic Stress Disorder may appear (Jenkins & Baird, 2002). Vicarious traumatisation occurs as a result of intense unresolved traumatic countertransferences (Walker, 2004) as they take place over time and is cumulative from numerous therapeutic relationships (Rasmussen, 2005). Although no claims regarding the

presence of vicarious traumatisation can be made for the participants of this study, the nature of countertransference when working with perverse patients can be certainly thought of as being potentially traumatic. According to Walker (2004) a traumatic countertransference when working with survivors of abuse can be discerned when there are intense feelings of helplessness and powerlessness, terror, isolation, alienation, sense of uselessness, feeling frozen, inability to verbalise what one feels and/or embarrassment disclosing such feelings, difficulties remaining alert during the session, restlessness and boredom. All these feelings bear resemblances to the feelings experienced by people who have been abused during their childhood, and have been reported by the participants of this study. The difference between vicarious traumatisation and traumatic countertransference as emerges from this study is that whereas both can have long terms effects, the first appears to have an effect on the overall functioning, personality and life of the therapist, whereas the second seems to re-emerge in situations that resemble the circumstances in which the trauma first took place affecting the therapist functioning in that moment.

The danger that this traumatic post therapy countertransference appears to entail is dual. Not only could the therapist's wellbeing be compromised, but also there is a danger of transferring their post-therapy countertransference to the next perverse patient or indeed anyone who presents with similar features.

Whether positive or negative, post-therapy countertransference clearly demonstrates how challenging therapists' countertransference experiences are for them when working with perverse patients. These are experiences that by their strength and impact can either enhance the therapists' identity and expand their personal awareness, or haunt them in a traumatic way years after the end of therapy forcing them to re-enact the same perverse dramas. What might differentiate and determine the quality of post-therapy countertransference when working with perverse patients is perhaps the extent to which therapists engage in what Glover (as cited in Kantrowitz 2004) called countertransference therapy, that is the extent to which therapists have the opportunity to explore and work through their personal conflicts as they emerge through their countertransference.

5. 3 Ways of Coping with Countertransference

As countertransference when working with perverse patients emerged as the most difficult aspect of the work with this client group, participants discussed the ways they attempted to cope with these experiences, either during the therapeutic hour or afterwards. According to the findings, when in session, therapists tend to cope by means of acting out and through defence mechanisms, whereas, when they are out of the session, through clinical and peer supervision.

5.3.1 Strength of Countertransference

As has been already reported in the literature by experts and authors in the field of perversion (e.g. Welldon, 2011; Ross, 2003) and as is also confirmed by the findings of this research, countertransference appears to be one of the most difficult aspects of the work with perverse patients. Kernberg (2004), for example, states that in the work with perverse patients, even with those belonging to the neurotic level, the therapist's abilities to work with the countertransference will be severely challenged.

As became clear in the previous theme discussing the way countertransference appears to unfold during therapy, therapists find themselves experiencing a variety of feelings each of which presented them with particular difficulties and challenges. Is there, however, one countertransference experience, which affects therapists who work with perverse patients more than any other? According to the findings, the countertransference that emerged as being the most powerful and threatening for therapists is that of annihilation; participants repeatedly referred to the threat they experienced to their personal and professional identities. Therapists might feel like helpless weak children in the midst of chaos, or as if parts of themselves were stolen by the patient, or as if they have lost themselves altogether under the aggressive and hateful attacks of their clients. Interestingly enough, the countertransference which is most challenging for therapists to handle appears to reflect, according to the Core Complex (Glasser, 1979), the central issue of perversions and the terror these individuals experience with respect to their psychic survival. Therefore, it could be hypothesised that annihilation anxiety emerges as the most challenging of the countertransferences because on one hand, it

represents the deepest and most dreaded conflict of perverse patients and on the other hand, because, as Morgan (2008) states, the exploration of patients' primitive or psychotic anxieties confronts therapists with their own fears around life and death.

5.3.2 Acting Out

Although the fear of annihilation emerged as being the most complex aspect of countertransference, participants clarified that the pull of all their countertransference experiences was at times so strong that it was impossible for them to prevent enacting the roles assigned to them by the perverse scenario. This finding is accordance with Sandler (1976, as cited in Busch, 2006) who introduced the term "*role responsiveness'* to describe therapists' tendency to comply with the role assigned to them by their patient and to create in this way a type of relating that confirms the patient's their familiar object relations. Moreover, taking into consideration Schmideberg's (as cited in Khan, 1989) observation that in perversions the fixation is not in the object but on the activity and that perversions are similar to acting out in analysts, the fact that therapists who work with perverse patients experience a tremendous pull to act out their countertransference appears less surprising. Although Kahn (1989) has detailed the functions that acting out holds for perverse individuals, an extensive review of them goes beyond the scope of this research. It is sufficient to say here, that these people deal with their intrapsychic anxiety by translating it into action (Coutinho et. al, 2005). It can be hypothesised therefore, that with perverse patients whose focus is on acting out their conflicts through the use of sexuality and their bodies, the pull for therapists to act out the countertransference mirrors their patients' way of functioning in terms of coping with unbearable feelings and as such it is particularly strong and possibly characteristic of the work with this client group.

In the context of countertransference, the term enactment refers to the unconscious reactions of the therapist towards the patient, whether these are verbal or not, and as such in traditional Freudian and Kleinian psychoanalytic literature it is presented as being a negative and counter-therapeutic event (Ivey, 2008). The conceptualization of enactments as constituting undesirable events in therapy stems from the basic

characteristic of the therapeutic encounter, as being a mental space with a clear boundary between thought and action, in which what is experienced is verbalised rather than acted upon (Steiner, 2006). Enactments therefore, according to Hinshelwood (1999) are defensive strategies on the part of therapist, who instead of staying with the pain or terror of the experience, evades it by doing something in the relationship. Instead of commenting on what is happening, the therapist not only changes its nature, but also prevents the client from understanding his internal world and way of relating. In this respect, enactments on the part of the therapist delay or forestall therapeutic progress. Consistent with this traditional view of enactment was participants' vague and diffused perception of their countertransference enactment as being something negative.

This however, was only part of their understanding. In their majority, participants perceived enactments as being helpful as well, for through them they became aware of their unconscious countertransference. This aspect of participants' understanding is consistent with Renik's (1993) view that countertransference enactment is often a prerequisite for countertransference awareness, since therapists often become aware of it as they enact it. The split in participants understanding of their acting out reflects the split that exists in the literature as well and the on-going debate that exists in the field.

When it comes to acting out the countertransference with perverse patients, it is perhaps more helpful to avoid thinking about it in terms of right or wrong and in, agreement with Wurmser (2003), to consider it as being unavoidable at those times that countertransference is unconscious, and as indicating that something unbearable in the patient was projected onto the therapist, who in a manner similar to his perverse patient, instead of containing it and reflecting on it, acts on it. In some respects then, this countertransference acting out can be thought of as mirroring the patient's perverse way of coping with unbearable feelings and anxieties. What is perhaps more significant is whether this acting out can be used creatively by the therapist so as to become a source of therapeutic insights for the patient.

5.3.3 Defence Mechanisms

Apart from acting out as a way of coping with unbearable countertransference feelings, participants reported resorting to the use of

defence mechanisms. Money-Kyrle (as cited in Ermann, 2005) described three "primary facts of life" that raise significant anxiety and are often intolerable; the perception of being separated and depending, of being excluded and vulnerable, and of the experience of limitation. Acknowledgment of these facts has the potential to overwhelm some individuals who in their effort to protect themselves from further psychic pain retreat behind a powerful system of defences. Perversion is such a defence in that the perverse way of thinking and functioning, based on splitting and disavowal, permits the individual to operate maintaining in his mind incompatible realities (Ermann, 2005).

According to the findings of this research, as therapists become contaminated in their countertransference by perverse elements and experience overwhelming feelings they appear to defend against them by resorting to splitting as well. Splitting is believed to arise from a preverbal time, when the infant cannot perceive both the negative and positive qualities of his parents, and is used in adulthood whenever in the face of threatening and confusing experiences, one needs to reduce anxiety and maintain his/her self-esteem (McWilliams, 1994) Indeed, participants tended to split off their patients' controlling, aggressive and sexual parts, remaining aware, when in the room with them, of their vulnerable childlike aspects only. This finding is consistent with Ross (2003) who discusses the operation of splitting in relation to perverse patients' sexual material that might be experienced as so overpowering for the therapist that s/he cuts off. It could be hypothesised therefore that when therapists' engage unconsciously or consciously in spitting, they deceive themselves the same way perverse individuals do, splitting off aspects of their countertransference reality that felt too threatening to be known.

Other participants reported using the defence mechanism of intellectualisation as a means of coping with their countertransference. Intellectualisation is a type of isolation of affect from intellect that leads the individual to talk about feelings in a way the listener experiences ~~it~~ as emotionless (McWilliams, 1994). According to the findings, intellectualisation, in the form of lecturing the client, offering technical interpretations and theorising, was used at those times that the therapists' experienced in their countertransference the terror of annihilation. It could be

hypothesised therefore, that this type of intellectualization helps therapists whose identity and role are at under attack, to regain a sense of who they are and to hold on to their role. The idea that theoretical knowledge and its use through intellectualization is central to the therapists' identity is reflected in Ceccarelli's (2005) phrase "*it is we, not our analysants, who need theories to understand what occurs in the analytic process*." (p. 180). In the face, therefore, of an overwhelming annihilation anxiety in their countertransference, therapists might turn to theoretical understandings and intellectualisations as a desperate means of surviving by holding on to a defining aspect of their identity. Unfortunately, as happens with all defence mechanisms which appear to help on one level, but restrict functioning on another, intellectualisation, as a way of coping, offers relief from annihilation anxiety, but also promotes a perverse self-deceptive reality by giving therapists' the impression that they "know" .

Although in the context of the present study, intellectualisation emerged as a way of coping with annihilation anxiety in the countertransference, Ross (2003) discusses it as a type of retaliation on the part of the therapist who feels humiliated, oppressed or victimised. According to the author, therapists' use of theoretical knowledge or intellectual interpretations are intended to impress or seduce the patient rather than help him/her to become aware of his inner world. Although Ross' (ibid) conceptualization differs from the one proposed in this study regarding the function of intellectualization, it appears that for her as well the particular defence mechanism is used as a means of coping with countertransference feelings (e.g. humiliation).

Last but not least, dissociation was also employed by participants to cope with overwhelming feelings. Dissociation offers the ability to detach from unbearable emotional states and it is often expressed through emotional numbing, depersonalisation and de-realisation, amnesia, and identity fragmentation (Bowins, 2004). In the present study, participants engaged in what could be thought of as an initial stage of dissociation in that they used "neutrality" and "clinical objectivity" in order to achieve emotional numbing, that is to block feelings that if experienced might have threatened their functioning. Although neutrality was promoted by Freud as a means of coping with countertransference, the more countertransference was being conceptualised as a valuable therapeutic tool, the more the impossibility of

neutrality was emphasised (Gabbard, 2001). Indeed, one cannot manage his countertransference effectively, if by means of neutrality s/he cannot allow himself to be emotionally affected by the patient. The hypothesis that the so called neutrality is in reality a form of dissociation is also reflected in Steiner's (2006) suggestion that the neutral therapist is a detached figure. According to Cousinhood et al. (2005), the neutral therapist serves the unconscious goals of the perverse patient who is content to maintain the therapist as a passive listener and therefore an accomplice.

Instead of emotional neutrality which appears to be used by therapists defensively to cope with countertransference, Tansey & Burke (1995) suggest a technical neutrality which involves the caution therapists should exercise in not allowing their feelings to be expressed in their interaction with their clients. Similarly, Kernberg (2004) suggests that technical neutrality when working with perverse patients may be helpful in managing countertransference acting out, but warns that this is an ideal working state.

5.3.4 Clinical & Peer Supervision

In researching therapists' countertransference experiences, Kantrowitz (2004) parallels clients' tendency, when intense feelings are experienced in their therapy, to discuss them with others as a means of diffusing the intensity of transference, with therapists' need to discuss their feelings with at least one trusted individual as a means of diluting their intense countertransference. Indeed, participants sought either clinical or peer supervision as a means of coping with their overwhelming countertransferences. Consistent with the view that supervision provides a space where thinking can take place and anxieties can be contained (Astor, 2000) , supervision, in the context of this study, appeared to offer emotional support, helped therapists restore their perception of clients and finally provided them with a space to make sense of transference and countertransference dynamics.

According to the findings, the first significant function of supervision lies in sharing with another trusted mind countertransference feelings that are so overpowering and overwhelming that, therapists cannot contain them in their own minds. Although, therapists' role is to contain and tolerate their patients' feelings and those that arise in themselves (Tansey & Burke,

2005), therapists who work with perverse patients are at times flooded with intense emotional experiences and-appear to need their supervisor to act as a container for all the unconscious anxieties and countertransference experiences which they may not have managed sufficiently during their sessions. This finding is consistent with Ungar's & Busch de Aumada's (2001) container-contained approach in supervision in which the supervisor "*being both outside and inside the psychic turbulence involved*" (p.80) is there to contain the therapist's anxieties.

Having their feelings contained by a trusted figure or group, participants were also able to restore their perception of the client and become aware of their countertransferences and their defences. Ogden (2005), utilising Bion's concept of dreaming as an unconscious psychological work in which we engage while asleep or awake, conceptualizes supervision as being a form of guided dreaming, during which "*the supervisor attempts to help the supervisee dream the elements of his experience with the patient that the analyst has previously been only partially able to dream (his 'interrupted dreams',) or has been almost entirely unable to dream (his 'undreamt dreams')" (p.*1261). Applying these concepts to the experiences of therapists during the session, Ogden refers to therapists' incomplete emotional experience, due to transference countertransference dynamics, as interrupted dreaming, whereas he uses the concept of undreamt dreams to refer to those instances that the therapist is completely unconscious of the therapeutic process.

Following Ogden's (ibid) formulation, it is possible to conceptualise splitting as a form of interrupted dreaming, during which therapists are able to dream/become emotionally aware of only some aspects of their client. As emerged from the findings, supervision as a means of guided dreaming can help therapists become aware of other aspects of their clients and acquire a holistic view of them.

Therapists' perception of their client is also restored in supervision as the supervisor mediates the intense dyadic relationship and helps therapists differentiate from their client and the therapeutic relationship, take a distance and gain perspective on him/her. Although Tansey & Burke (2005) discuss psychological distancing as being part of the process that the therapist engages with during sessions as he works through his

countertransference, their formulation bears significant resemblances to what participants reported as being a facilitating function of supervision. It could be hypothesised therefore, that for therapists who work with perverse patients and at times find it difficult to achieve a sense of separateness or psychological distance from the relationship, supervision can provide the necessary mental space for these processes to take place.

The third function of supervision appears to be, using Odgen's (2005) terminology again, the birth of undreamt dreams. Indeed participants discussed how during supervision they became aware of their previously totally unconscious countertransferences and their defences, in such a way that the therapeutic process and their emotions acquired new meaning.

Supervision has been proved invaluable for all therapists working with all types of client groups particularly through training as it becomes an additional source of education that helps therapists translate theory into practice (Morrissey & Tribe, 2001; Caroll, 2008). In the case of working with perversions however, supervision appears to be valued less for its educational character and more as a container of therapists' overwhelming countertransferences and a means of becoming aware of their defences. Given the disagreements regarding the nature and utility of countertransference, that is, whether it emerges out of therapists' own conflicts or it reflects the patients' internal worlds, there is still debate as to whether countertransference experiences belong in supervision or therapy (Issacharoff, 1982). For example, in a qualitative research study regarding the transmission of psychoanalytical knowledge through supervision, which involved interviews from both supervisors and supervisees, Brito (as cited in Zavlasky, Nunes & Eizirik, 2005) discovered that whereas supervisees expect from their supervisors to help them explore their countertransferences, supervisor themselves avoid emphasising this aspect of their experience. On the contrary, Zavlasky, Nunes & Eizirik (2005) conducting similar qualitative research with four supervisees and four supervisors discovered that there was in fact an agreement between the two parties regarding the significance of addressing countertransference experiences during supervision. According to the authors (ibid), the contrast in their findings can be understood on the basis of rapid developments

regarding the role of countertransference in therapy, enactments and the field of intersubjectivity.

As it becomes apparent through this research, therapists' countertransference experiences parallel the internal world of their perverse patients and were the most challenging but also most enlightening aspects of the work with them. The supervision therefore of therapists who work with perverse patients must take into consideration the therapists' countertransferences, not only because therapists need support and containment, or indeed might be traumatised, but also because in this way the therapeutic dynamics acquire new meaning and we can avoid repeating these perverse scenarios in therapy. The perverse scenarios can be avoided from being repeated in therapy.

Concluding the discussion on the way therapists cope with their countertransference, it can be hypothesised that this coping involves two types of psychic survival. The first which involves acting out and the use of defence mechanisms parallels the perverse solution in that it reduces anxiety by translating it into action and prevents understanding. In this respect, this type of coping can be thought of as a non-adaptive way of survival. On the contrary, supervision, by means of containing feelings instead of acting them out and defending against them and by means of promoting understanding, can be regarded as a psychic process opposite to perversion and as such as an adaptive way of survival.

5. 4 Making Sense of & Using Countertransference

Having become aware of their countertransferences, the next step for participants was to make sense of them it in terms of what they communicated for the client and on the basis of this to use them it in such a way as to provide a new therapeutic meaning.

5.4.1 Understanding of Countertransference

Consistent with the extensive literature, countertransference when working with perverse individuals is understood as being either concordant or complementary. Concordant countertransference (Racker, 1957), by means of projective identification, allows the therapist to experience a feeling that is too threatening for the client to become aware of and as such it is

projected. Receiving their patients' projections and experiencing themselves the way their clients would feel should they allowed themselves to experience the anxiety provoking feeling, therapists acquire additional information about their client's internal world (Gabbard, 2001). Similarly, when therapists experience a complementary countertransference (Racker, 1957), that is they feel the way others in the world of their client tend to feel, they acquire valuable information regarding the way external relationships are organised.

Taking into consideration, on one hand, that perversion involves disavowal of reality and on the other hand, the findings of the present research on the nature of countertransference as it unfolds during therapy, I would like to propose that, in the case of perversions, therapists' concordant and complementary countertransferences can be thought of as the vehicle through which reality can be restored; for what the client disavows, denies to experience and know about himself and the way others are affected, becomes available in the therapist's mind. It could be hypothesised therefore, that by making sense of their countertransferences, therapists who work with perverse patients not only gather additional information about their patients, but also restore, at least in their minds first, aspects of their patients' disavowed reality

5.4.2 Creating Therapeutic Meaning

According to the findings of this study, the importance of countertransference as a means of restoring the disavowed reality in the therapist's mind is found in that it facilitates the emergence of therapeutic meaning. Perceiving and metabolising the threatening reality in themselves, therapists, by means of empathy and interpretation, can help clients gradually become aware of it in a perhaps less threatening way.

More specifically, becoming aware of their countertransferences enabled therapists to achieve a deeper empathic understanding which, when they communicated it to their clients, paved the way for them to become aware of and explore neglected or denied aspects of themselves. This finding is in accordance with Tansey & Burke (1995) who perceive empathy to be the optimal outcome of therapists' processing of their concordant and complementary identification. In addition, as emerged through

participants' accounts, empathic understanding promotes in the client a sense of trust in the therapist. Bion (as cited in Anderson, 1992) suggests that we all have a developmental urge to be known. Therefore, the therapist who is able to accurately perceive and mirror the client's self can gradually become a safe figure.

Another way that countertransference experiences were used by therapists to create therapeutic meaning was by informing their interpretations. Interpretation as a therapeutic tool is believed to facilitate the resolution of conflicts regarding love, hate and knowledge (Waska, 2008). Countertransference based interpretations, as they emerged through participants' accounts, appear to hold three distinct functions. As participants discussed, therapists, who, based on their countertransference, can accurately interpret the client's unconscious, present themselves as being different from everyone else in his/her world, in that by means of their deeper understanding, they can perceive the client's true needs and motivations and as such can create a therapeutic opportunity. By means of interpretation then the therapist does not fail the client. Another way that countertransference based interpretations facilitate the emergence of therapeutic meaning is through attributing alternative meaning to clients' feelings. As Kassy explained, she used her feeling of terror to help the client understand that his aggression is in fact a defence against experiencing the terror of annihilation. By attributing a new meaning to clients' emotional states, clients become aware of their unconscious parts and have an opportunity to explore them rather than defend against them. Last but not least, interpretation was used to bring transference dynamics into client's awareness and to help the client understand how he attempts to repeat his past in the present. As a result, clients are given the opportunity to understand rather than blindly repeat their relational patterns. This finding is consistent with Tansey and Burke (2005) and Casement (1986) who suggest that well-prepared and well implemented countertransference based interpretations can throw light on to the patients' ways of relatedness.

Interestingly, participants' use of countertransference as a means of creating meaning coincides with Kohut's perception that the process of cure involves empathic understanding followed by interpretation (Kitron, 2001). It appears therefore, that the effective use of countertransference when

working with perverse patients, by means of restoring reality, providing empathic understanding and facilitating accurate interpretations, can become the means through which new therapeutic meanings and change can emerge.

5. 5. Parallel Process

The final theme that emerged through this research was that of parallel processes. Although the emergence of parallel processes during supervision is well documented in the literature, their emergence during research interviews was a surprising finding with significant implications.

5.5.1 Parallel process between therapist and supervisor

The tremendous shift in the perception of countertransference in the 50s revolutionised not only the field of therapy, but also brought about significant changes in the form and content of supervision. These changes were signalled in Searles' (1955) classic paper on the emotional experiences of the supervisor in supervision in which he discussed the possibility of the supervisor experiencing feelings that belong to the therapist and client relationship. Although Searles (ibid) referred to this event as reflection process, it was the term, parallel process, invented by Ekstein and Wallerstein few years later that became popular. Clarkson (1992) provides the most common understanding of parallel process as a pattern of the client–therapist relationship that is unconsciously replicated in the therapist-supervisor relationship. In more psychoanalytic terms, parallel processes occur when the projections of the patient onto the therapist are then projected on the supervisor, creating therefore in supervision the same powerful, subtle, unconscious dynamics that have not been verbalised in therapy (Arundale, 2007). Therefore, through parallel processes that take place during supervision, the therapeutic relationship is communicated to the supervisor not only verbally, but also experientially at an unconscious and preconscious level (Ogden, 2005)

According to the findings, parallel process in supervision can be either a positive or negative experience in that, if understood, it has the potential to help the supervisee acquire a better understanding of the relational dynamics in therapy, but if not, then it might result in the therapist feeling abandoned,

helpless and unable to make sense of overwhelming feelings on his own. This finding is consistent with Arundale (2007) who discusses the appearances of parallel processes in supervision as being potentially helpful in that through them material can be brought to consciousness and understood in terms of the client's dynamics. However, as the author suggests (ibid) and was certainly Joanna's experience with her supervisors, continuous appearances of parallel processes point to the fact that the therapist is overwhelmed by the patient's material and confused as to what is happening in therapy. Taking into consideration that in the treatment of perverse individuals, therapists experience extreme anxiety, receive tremendous anger and hatred and experience threats and attacks against their very psychological existence, the supervisors' ability to disentangle themselves from their identifications with the therapist during parallel processes is of paramount importance. Furthermore, due to the fact that traumatic countertransferences can take place during the treatment of this client group, it could be hypothesised that a similar traumatic parallel process can occur in the supervisory relationship, exacerbating its negative impact on the therapist as it happened with Joanna, who ended up feeling completely helpless and at the mercy of her client.

5.5.2 Parallel process between participant and interviewer

Taking into consideration that parallel processes are solely discussed in the literature as occurring in the context of the supervisory relationship, the emergence of parallel processes during the interview and the analysis was a surprising and unexpected finding. Nevertheless, it occurred with at least six participants and as such it has implications not only in terms of its meaning for the therapists' countertransference when working with perverse clients, but also for the methodology itself, something which will be discussed at a later point.

In terms of its meaning regarding the thesis' research question, it could be hypothesised that the emergence of parallel processes during the interviews points to unresolved countertransferences that reflect the basic relational pattern that characterised the therapeutic relationship and as such were the most challenging for therapists to cope with. For example, Georgias' paedophile client looked down on her because she was an adult,

thus creating an imbalance in the relationship, and during the interview, she, as a knowledgeable authority, looked down on me because I was a "naive student". Similarly Nikos experienced at times a very unsettling confusion regarding his own gender identity with his cross-dressing client and I was confused as well with respect to the therapist's gender as I analysed the interview. Jason's client was so intellectual and closed off that he felt perhaps desperate at times in his continuous efforts to help him open up to feeling, as I felt in my efforts to help him reflect more on his countertransference experiences during the interview.

As is the case with parallel processes during supervision, which point to clients' projections that remain undigested by and unconscious to the therapist, it could be hypothesised that the parallel processes during the interview point to equally unresolved countertransferences. The implications of this hypothesis for therapeutic practice are significant for once more the powerful nature of countertransference is pointed out, not only as a brief and transient phenomenon during therapy, but also as a potentially lingering long term traumatic experience for the therapist which can be activated whenever the circumstances resemble that therapeutic encounter. It could be hypothesised therefore, that therapists who work with perverse patients carry within them these traumatic experiences which they run the risk of transferring to the next patient.

Another possible answer as to why these particular countertransferences were replicated during the interview can be found in therapists' own conflicts. Taking into consideration that countertransference experiences point not only to the internal world of the client, but also at times to the therapist's own difficulties, those lingering countertransferences might point to issues that therapists themselves struggle with, that is issues of power as in the case of Georgia, gender identity as in the case of Nikos, and control as in the case of Jason.

It is not possible from the current study to differentiate between the sources of therapists' countertransferences as they appear in the parallel processes during the interviews, for, although there is evidence that these resemble their clients' core difficulties, there is no evidence to suggest that it also involves the therapists' conflicts. The latter remains a hypothesis derived more from the existing literature on the nature of

countertransference rather than from the participants' accounts. However, a new opportunity for further research is created which could specifically explore the way perverse patients' personal conflicts interact with those of the therapist giving rise to countertransferences that are co-constructed rather than induced.

5.6 Implications for the Treatment of Perversions

The present research not only confirms the claims in the literature that when it comes to the treatment of perversions countertransference plays a significant role (e.g. Welldon, 2011; Jimenez, 2004; Ogden, 1996; Etchegoyen, 1977) but also, by means of participants' experiences, it places countertransference experiences at the heart of the treatment. Indeed, the understanding of the therapists' countertransference, as reflecting the intrapsychic dynamics of their patients and those of the therapeutic process, emerged as being the most significant factor determining the course and outcome of treatment. Therefore, the findings of this research suggest that therapy with perverse patients could be a countertransference-based therapy. However, taking into consideration that countertransference reactions entail emotional reactions that relate to our own personal histories as well as to those of our patients, it follows that therapists who work with perverse patients and opt to follow a countertransference based therapeutic approach as the one suggested by this research, they must have undergone extensive therapy themselves and participate in on-going supervision.

The elements of the suggested countertransference approach to the treatment of perversions can be found to the preliminary Countertransference Model of Perversions that has emerged as a result of this research, along with its implications for the therapeutic process. (Appendix L.) Although each therapeutic encounter with perverse patients is unique, it could be argued that the particular model touches upon some of the basic underlying issues of many perverse patients and as such there is a high probability that most of its elements will be experienced by the majority of therapists.

Having a model of countertransference experiences that details a) the basic themes and conflicts that might arise in the therapeutic encounter at

each stage of the process and after the end of it, b) the major emotional reactions of therapists and their significance for the internal world of their patient, and c) the major types of defence mechanisms that might be used as well as the ways of coping, might be extremely useful in helping therapists, and particularly those with less experience in the field, to make better therapeutic interventions and equally important, to protect themselves from traumatisation. For this reason, I believe that further research into this model is of great importance.

5.7 Implications for the Treatment of Sex Offenders

Although the present research focused exclusively on the experiences of psychodynamic therapists who work with perverse patients but not necessarily sex offenders, the increasing prevalence of sex offending and the corresponding establishment of systematic programmes for the treatment of imprisoned sex offenders in Britain (Lea, Auburn & Kibblewhite, 1999) and the importance of treatment in minimising the risk of reoffending (Seligman & Hardenhburg, 2000) means that its findings could be relevant to other professionals that are involved in the treatment of this client group as well in various settings.

The treatment of sexual offenders is arguably complex, raising considerable ethical dilemmas for the clinicians, who need to take into consideration both public safety and the needs of the offender. Despite this obvious dual obligation, the approach to the treatment of sex offenders is primarily based on a risk-need model which has as objective the protection of the community by minimising the risk of re-offending (Ward & Steward, 2003)

The major program that has been developed for the treatment of sex offenders that is based on this risk-need model is The Sex Offender Treatment Program (SOPT), a prison-based program that originated in United States and is also in use in England and Wales. It is based on Cognitive Behaviour Therapy and it operates on the assumption that sex offenders cannot be cured and as such goals should be directed at management of risk and self- control. It is perhaps for this reason that SOPT is often called a course rather than treatment. The focus of the course then

is a) on helping the offender to identify cognitive distortions that lead to the rationalisation and minimisation of the severity of their offence, b) on the development of empathy for the victims, and c) on relapse prevention by learning to identify danger signs and situations that might put them at risk of risk offending. The course extends over 85 sessions and it involves mainly group work. Despite some positive outcomes, the efficacy of SOPT is still unconfirmed and further research is required (Evenden, 2008)

Taking into consideration the danger that sex offenders pose to public safety, but also their very complex psychological needs, it comes as a surprise that the delivery of SOPT depends on facilitators; that is prison officers, probation officers and assistant psychologists who undergo a two week training on the delivery of the program and upon completion of the course are deemed able to run groups with sex offenders following the manual of the program. Upon qualification, facilitators are supported through supervision, counselling and further training. In her research on the training and support needs of SOPT facilitators, Brampton (2010) details the training process mentioned above and presents the views of trainees, facilitators and managers on training and support systems in prison services of UK. Before I continue with the implications of my research on the treatment of sex offenders, I would like to briefly present some of Brampton's (2010) findings that I, at least, find very worrying.

Due to lack of psychological background some trainees in the SOPT felt unable to take in the information that was provided. For example, a male prison officer felt *"like a fish out of water*" (p.234), whereas others considered their trainers inexperienced or disorganised and completed the course with a sense of "*how do I do that, and how do I do that?"* (p.236). Another notable concern was the realisation from the part of trainees that they were not prepared for the reality of the treatment with sex offenders. A female prison officer reported: "*It's a lot more tiring than I think we were briefed about*" (p.237), whereas a male prison officer said "*I don't think it actually prepares you in any way for doing it for real*" (p.238).

With respect to their experiences of working with sex offenders, the facilitators of the SOPT that participated in Brampton's research (2010) reported physical symptoms of tiredness and exhaustion, feeling

emotionally drained, angry with offenders' neediness, anxious about personal safety and having dreams about sexual assault. They also reported changes in their personal lives that ranged from taking work home, to difficulties in communication with partners, to experiencing sex as less pleasurable, to experiencing flashbacks during sex. They also reported increase concern regarding the appropriateness of playing with young relatives and increased protectiveness towards their children. In addition, they felt they lacked support, that supervision was poor and expressed anger with the Prison Service.

It is obvious from these findings that SOPT facilitators are not truly equipped to work with sex offenders and that work with the group has very clear negative effects. Although extremely worrying, these findings are not surprising. As a result of the present research, highly qualified therapists with years of clinical experience, years of personal therapy and actual support from highly experienced supervisors, find the clinical work with perverse patients extremely demanding and difficult and struggle with the strength of their countertransference. I can only imagine how difficult it must be for untrained in the mental health field professionals or assistant psychologists with only a two week training, not only to begin working with sex offenders, but also do group work which is even more complex.

On the basis of my research findings I would like to raise my concerns for recruiting untrained facilitators to work with sex offenders because they lack the necessary therapeutic skills and experience to deal with the extremely powerful underlying dynamics that are formed in the interaction with sex offenders and as such it is doubtful to what extend any long lasting changes can take place. For example, as a result of this research it became apparent that deception and the development of an illusory bond with the therapist are some of the ways that perverse patients employ to give therapists the impression that actual work is being done and perhaps progress is being made, whereas in reality their perverse core remains intact. If risk minimisation is the goal of SOPT, then ignoring the way sex offenders can deceive facilitators defeats the purpose of the program. In addition, one of the goals of the program is the enhancement of empathy for the victims. Although, empathy is often portrayed as a skill that can be taught or a technique that could be applied, in reality empathy is a very

complex way of being that depends on a multiple of factors, most of which relate to the personal history of the individual. When it comes to perverse patients and sex offenders, whose personal histories are a record of psychological violations and physical abuse, and for this reason relate to others as if they were part-objects rather than whole human beings, empathic understanding is impossible. It is my view, that the only way sex offenders could develop true empathic understanding for their victims and thus minimise the risk of re-offending, is by resolving their part-object way of relating. Following the findings of this research, this can only become possible in the context of therapy and when the therapist, having freed himself from his crippling countertransference reactions, can empathise with the traumatised child within the sex offender and by means of this empathic understanding to facilitate a whole object relating and resolve the sadomasochistic and hostile aspects that characterise perverse individual's way of relating to others. This is a long term and intricate work with many failures on the way, even for experienced therapists and I cannot imagine facilitators in the SOPT being able to work at this depth. Again, it seems to me that the purpose of relapse prevention by enhancement of empathic ability is defeated, if this work does not take place. I would like to propose therefore, that SOPT should rely more on mental health professionals trained in the field of forensic psychotherapy and with clinical experience with perverse patients and perhaps enrich the cognitive behavioural goals and techniques that target behavioural modification with a relational psychodynamic approach that targets underlying process which often become the obstacle to these behavioural changes.

Another concern that Brampton's (2010) research highlights is the negative effect of the work with sex offenders on facilitators' well-being. My research offers further support to Brampton's findings, since it brings to the foreground the very intense negative countertransferences that therapists experience in the treatment of perverse patients. It could be hypothesised that much of the negative effects that SOPT facilitators experience are due to their countertransference, that is to their emotional reactions as they unavoidably engage with sex offenders on a relational level and receive implicitly or explicitly and in many different ways their aggression and hostility. The present research highlights the danger of traumatisation when

working with perverse patients, so I would like to propose that working with sex offenders without having appropriate therapeutic training and without the support of high quality supervision that can help facilitators process these feelings puts them at risk for traumatisation.

Equally important for the success of the program would be, as it became evident from the present research, the processing in supervision of facilitators' countertransference feelings in terms for the meaning they hold for sex offenders themselves and the treatment process. As it is the case with perverse patients in private practice who have the unconscious need to destroy the therapist and the therapeutic process, sex offenders will be driven consciously and unconsciously to destroy the treatment. It seems to me therefore, that supervision by highly qualified and experienced mental health professionals is of extreme importance for the successful outcomes of SOPT.

Concluding, I would like to stress the power of the underlying dynamics that are developed in our engagement with perverse patients and sex offenders and their critical contribution to the treatment process. As a result of this research, it appears that the treatment of sex offenders cannot fully achieve its goal of minimising re-offending in the long run, without taking into consideration the relational dimension and the psychological restructuring that needs to take place within sex offenders themselves. Obviously this is not a cost-effective or time effective approach, as it requires hiring experienced mental health professionals both as facilitators and as supervisors and requires long-term individual therapy in conjunction with group work. Nevertheless, it might be a safer approach if public safety is the goal and a more ethical approach if the purpose of imprisonment is rehabilitation rather than punishment.

5.8. Implications for Counselling Psychologists' practice

Although the theoretical topic of paraphilias or perversions and the therapeutic practice with individuals with this type of difficulties has traditionally been the "privilege" of psychiatrists and psychoanalysts, the consistently growing number of counselling psychologists employed in a variety of therapeutic settings and in private practice as well, makes the

possibility of working with perverse clients greater than ever, especially since these people rarely seek treatment for their perversion, but are likely to present in therapy for other reasons such as depression, and as such to present themselves not to "experts" in the field, but to general psychology services. This has also been my own experience as a trainee counselling psychologist, when during my placements I got referrals for clients with initial diagnoses of depression, anxiety or relationship difficulties only to discover later on during therapy that these symptoms were only secondary to their true difficulties which involved perversions. Being totally unprepared in terms of training and misguided by the diagnosis or the presenting problem, I initially found myself in chaos, unable to help either myself me or my client.

Therefore, due to the fact that counselling psychologists are likely to come across clients with perversions in their practice without even knowing, I believe that, irrespective of the therapeutic models they use, a basic knowledge of what perversions are, how they might present in therapy and what could be some of the therapeutic challenges, is essential. For example, a client might present with a diagnosis of panic attacks, but in the therapeutic relationship the counselling psychologist may experience unforeseen aggression, paralysis or indeed any of the above countertransference feelings that were mentioned in the present thesis. Although these feelings on their own are not evidence of perversion, a counselling psychologist with a preliminary knowledge of how perversions might present in therapy, could be in better position to develop more informed hypotheses regarding the real nature of the client's underlying difficulties.

Since therapy with this client group is indeed relevant to counselling psychologists, and as scientists-practitioners we seek to bridge the gap between theory and practice (Kasket & Gil-Rodriguez, 2011), research in this field is necessary. Indeed most of our knowledge regarding therapeutic work with perverse individuals is derived from psychoanalysts, who base their observations on single cases and subjective experience. Although clinical experience is a valid source for information, a qualitative research that could verify these insights and be useful to counselling psychologists was lacking. This thesis therefore bridges the gap between what is known

though clinical experience with research, offering counselling psychologists a more solid ground on which to formulate their therapeutic hypotheses.

Not only might counselling psychologists work with perverse patients more often that they are aware of and therefore need relevant research to guide their practice, but as practitioners who place emphasis on the therapeutic relationship as being the agent of change irrespective of theoretical approach (Laughton-Brown, 2010), counselling psychologists can benefit from an understanding of how this relationship with perverse clients can be experienced and used therapeutically in order to offer better services to their clients. Clarkson (1995) identified five different types of therapeutic relationship, the working alliance, the transferential relationship, the developmentally needed relationship, the real and the transpersonal relationship, suggesting that these, rather than being mutually exclusive or sequential states, are overlapping and produce the unique therapeutic relationship we experience with each one of our clients. This thesis has attempted to explore one of these aspects of the therapeutic relationship with perverse clients, namely the one that involves the transference-countertransference and by demonstrating its powerful impact, we can conclude that this is perhaps the component of the therapeutic relationship that might affect all others. This understanding can help counselling psychologists, coming from a variety of theoretical orientations, initially to identity potential perversions, then to survive in the therapeutic relationship and find ways to use this understanding it therapeutically, whistle protecting themselves from potential trauma.

With this goal in mind then, in the remaining section, the major findings of this study will be reviewed finding of this research that is also in accordance with the vast psychoanalytic literature on perversions is that these involve not only sexual behaviours as DSM-V(APA, 2013) imply in the diagnostic criteria, but an overall way of perverse being and relating, which affects interpersonal relations and the therapeutic relationship as well. As much as DSM-V attempts to categorised paraphilias and identify common diagnostic criteria, the variety in the presentation of perversions, as reflected in the multitude of definitions in the literature and confirmed by this research, points to Kernberg's (2006) position that these do not constitute a separate clinical structure, but depending on the level of

personality organisation, they can occur on a continuum from mild to severe and with different relational challenges. Therefore, therapeutic models that place emphasis on behavioural modification, as Cognitive Behaviour Therapies do (Glaser, 2001), are likely to produce minimal or less long lasting results for they do not address the relational dimension of perversions. Irrespective of our theoretical model then, those of us counselling psychologists who work with perverse clients must work with the perverse way of being and relating as well as with the perverse sexual behaviour if therapy is to produce any meaningful long-lasting results.

With regards to the perverse way of being and relating, there are references in the literature regarding the nature of perverse transference (eg. Mann, 1997) and a few scattered allusions to countertransference, but to the best of my knowledge, any systematic exploration of the types of countertransferences that therapists are likely to experience was lacking. This research identified the types of countertransferences counselling psychologists are likely to experience in their practice at the various stages of treatment thus offering them a valuable foresight into to what they might be experiencing and how to make sense of it in terms of their clients' needs.

The Division of Counselling Psychology (2005) notes that counselling psychologists' role is to "*marry the scientific demand for rigorous empirical enquiry with a firm value base grounded in the primacy of the counselling or psychotherapeutic relationship*" (p. 1). Therefore, obtaining research findings on the way countertransference is likely to unfold during therapy with perverse clients, is important for counselling psychologists for it satisfies both the scientist-practitioner and the reflective-practitioner aspects (Kaskett & Gil-Rodriguez, 2011) of our professional identity.

Although knowledge that is derived through this research can certainly inform and enrich counselling psychologists' practice, it should not be followed dogmatically. One of the findings of this research suggests that due to the intensity of our countertransference when working with perverse patients, we might experience an additional countertransference anxiety which we might attempt to cope with by relying extensively on theory. Theory however can be used perversely, since it might give the impression of knowing and understanding our countertransference, when we remain in fact blind to particular dynamics of our client. Adhering, on one hand, to

theory and research findings and remaining, on the other hand, open to our clients' subjective experience and ours as well, creates great tension for counselling psychologists (Orlans & van Scoyoc, 2009) which is only intensified by the powerful countertransferences experienced when working with perverse patients. It is part of the work however to remain aware of this tension and to continue to reflect critically on all theory and research findings and to use them creatively rather than perversely.

Supervision is traditionally viewed as the space where significant learning can occur (Caroll, 2008) and indeed it is regarded as essential for counselling psychologists' ethical practice. According to findings of this research however, supervision is highly valued by therapists who work with perverse patients, not so much for the learning opportunities it offers, but as a container of their overwhelming countertransferences. Counselling Psychology supervisors, therefore, need to be aware of the support that they will be asked to offer, and create a supervisory relationship that will allow therapists to disclose their powerful and at times embarrassing feelings. In addition, being aware of the research finding that overpowering countertransferences can become sources for repeated parallel processes during supervision, supervisors can be more alert to their own reaction to the material presented to them, helping therapists clarify their experiences with their clients. Taking into consideration that countertransference when working with this client group can be potentially traumatic for the therapist, the supervisors' role is extremely important in helping therapists process their experiences adequately, become aware of their unconscious reactions and defences and finally restore their view of the client.

Counselling psychology maintains a pluralistic stance when it comes to the sources of knowledge and models of therapy (McAteer, 2010). This pluralism means that our practice is informed by many different fields of enquiry. In this respect, an understanding of the psychodynamics of perversion and the countertransferences that counselling psychologists are likely to experience in the treatment of this client group is essential for all the reasons mentioned above, even if we do not choose to use these understandings psychodynamically in the treatment. For those counselling psychologists however who choose to work psychodynamically, the findings of this research suggest that paying attention to their concordant

and complementary countertransference when working with perverse individuals is vital, for in this way they can experience deep empathy for their clients and offer more accurate interpretations, restoring in this way perverse clients' disavowed reality and creating new therapeutic meaning.

5.9 Implications for the treatment of other mental health conditions

As it became apparent in the literature review chapter there is a plethora of theories attempting to explain the aetiology of perversions which could actually reflect Kernberg's position that perversions do not constitute a separate clinical structure but can be found in mild or more severe forms depending on the level of personality organisation. Although Kernberg's view was detailed in at the beginning of this chapter, for purposes of clarity, I would like to briefly mention, that he considers perversions to occur either at the neurotic, the borderline or the psychotic level of organisation, with mild perversions occurring at the one end of the continuum and severe perversions occurring at the other.

Following Kernberg's (2006) formulation and bringing into the discussion Freud's (1905) assertion that there is perverse core in all of us, it could be hypothesised that perverse elements can be found in patients with a variety of diagnosed disorders and a variety of presenting difficulties. In addition, if we also consider Welldon's (2011) position that perversion in women could take the form of eating disorders, of being in abusive relationship, and any form of self-harm then the list of relational difficulties and disorders that might be influenced by perverse dynamics is really long.

It could be argued therefore, that the findings of the present research could be helpful in explaining the therapeutic impasses and emotional reactions that therapist experience with conditions such as mood disorders, anxiety disorders, eating disorders, addictions, gender identity disorders, cases of sexual abuse etc. In all these conditions, despite their different presentation there could be underlying perverse elements that could account for a) the underlying aggression and hostility that patients often direct toward themselves by developing symptomatology that cripples their lives b) the need for control that is often apparent not only in the symptoms that bring patient to therapy, but also to the relationships in their lives.

An understanding therefore, of the nature of the perverse dynamics as well as the potential countertransference reaction that therapists might experience when these begin to manifest in the treatment of other mental health conditions, might be helpful

5.10 Reflections on and Critique of Methodology

As discussed extensively in the Methodology section, the use of IPA in researching the particular research question brings to the surface certain contradictions inherent in the method. These contradictions can be overcome without, in my opinion, any transgression as far as the phenomenological stance of the methodology is concerned, and IPA can be used effectively to explore the experiences of therapists' of particular theoretical orientations.

The interview process is as important in IPA as the analysis, in the sense that a well-constructed interview schedule and a skilled researcher can facilitate participants' reflections on their experiences (Smith & Eatough, 2007). Following Smith, Larking & Flower's (2009) suggestion that during the interview the research question should be approached sideways, the interview schedule consisted of questions that asked participants to reflect on their experiences of the therapeutic relationship with perverse patients and not specifically on their countertransference experience. Therefore, participants were not guided to discuss their countertransference, but the discussion about the phenomenon emerged naturally through their accounts. These broad questions allowed the participants' particular stories and experiences to emerge, producing as the authors (ibid) predict, findings that were not anticipated (e.g. post-therapy countertransference, parallel processes) and accounts that were rich with meaning.

The authors (ibid) suggest that effective interviews depend on the creation of a research persona which would differ from our social or therapeutic persona. Being a counselling psychologist myself, interviewing psychotherapists, counselling and clinical psychologists on a topic that involved the therapeutic process and the disclosure of powerful feelings, it was at times tremendously difficult to avoid adopting the therapist role, meaning that I experienced deep empathy for what they disclosed and was

emotionally affected by the material. On one hand, this process allowed me to experience, not through verbal descriptions, but through my own lived experience, how participants must have felt at times in their countertransference, helping me to analyse the accounts in greater depth. On the other hand, there were times that I was so overwhelmed by the material, that I found it difficult to pose my questions or follow them up adequately.

Taking into consideration the importance of the interview process in IPA, I believe it is important to discuss here the finding of parallel process in terms of its implications for the method. According to the authors (ibid), interview processes "*must be viewed as interactions*" (p. 66) and indeed they comment on the way both participants and interviewers might feel during the interview. What was observed, however, as the interviews were analysed, was that this interaction at times could be better understood as a process between the participant and the interviewer that paralleled the therapeutic process between the participant and his/her client.

Interestingly enough, I was not aware of the parallel process during the interview, but I was able to observe it during the analysis of the interviews, perhaps when I had acquired the necessary psychological distance. In this respect, there was a striking similarity between the interview process and supervision as discussed by participants. By means of providing a mental space for participants to reflect on their experiences, interviews became somewhat similar to supervision in that they provided them with a space where unresolved countertransferences could emerge and feelings could be projected on the interviewer. Unlike supervisors however, who most of the times are prepared to work with parallel process, I was not.

To the best of my knowledge there has not been any reference in the IPA literature to the appearance of parallel processes and as such this finding might be specific to this research and its meaning might be restricted to the particular research question. Finley & Evans (2009) however, the originators of relational centred research, acknowledge that during the interview process and, as interviewer and interviewee exist in a relationship to each other, the life experiences and ways of interacting will impact consciously or unconsciously on both. The interview encounter then is likely to involve various co-transferences and parallel processes. Taking into consideration that IPA interviews are construed as interactions during

which personal experiences are disclosed and explored in detail, I would hypothesise that the phenomenon of parallel process is not uncommon in IPA interviewing either. It would be interesting, therefore, for future research to explore whether parallel processes while doing IPA emerge when researching other topics as well and if so, how these can be incorporated in the method.

In his 2004 paper on the development and contribution of IPA to qualitative research in psychology, Smith discusses the various levels of interpretation during analysis and makes a clear distinction between IPA interpretations as being grounded in the data and psychodynamic interpretations as evidence of imposing a particular theoretical framework on participants' experiences. Due to the fact that participants were psychodynamic therapists and their experiences were formed and discussed through the psychodynamic lens, and the research question had as its aim to explore the particular psychodynamic phenomenon, I believe that the description and interpretation of participants' experiences through psychodynamic theories was not an imposition, but a means of staying close to their own experiences and the way they made sense of them. In trying to make sense of participants as they tried to make sense of their experiences, I used mostly psychodynamic theories to remain within their frame of reference. Aware of Smith's above mentioned opinion, a validity check through independent researchers, as discussed in the analysis section, was also done to ensure that these psychodynamic interpretations were not an imposition. Since both my colleagues, who were integrative counselling psychologists, agreed that the emergent themes accurately reflected participants' accounts, I became more confident that the interpretations were indeed grounded in the data and that the analysis reflected both the phenomenological and the hermeneutic aspects of IPA. Under certain circumstances therefore, it appears that psychodynamic interpretations do have a place within the IPA method.

The analysis of participants' accounts brought to the surface an unexpected tension and complexity as far as the third theoretical foundation of IPA is concerned, the ideography. This tension is reflected in the Smith, Flowers & Larkin (2009) phrase "the analysis on the particular (and the focus on grasping the meaning of something for a given person) cannot be

conflated exactly with a focus on the individual [...]" (p.29). Indeed, as the authors explain, the phenomenological view of experience holds that although this is unique for each individual, due to the fact that the individual is embedded in the world, this experience is also worldly and relational and as such is not a property of the individual. Nevertheless, as I immersed myself in the analysis and developed a relationship with each one of the participants, their experiences became valuable and unique in such a way that in extracting them from their overall discourse it always felt as if something of their intensity and uniqueness was being lost. Even more disturbing was the recurring thought that participants had been reduced to few disconnected short verbal extracts.

Paradoxically, it was through Giorgi's (2011) relentless criticism of IPA and particularly through his assertion that if IPA analysis is subjective, then the results tend to say more about the researcher than the phenomenon that is under investigation, that this tension was resolved. Although, it is true that the "end result is always an account of how the analyst thinks the participant is thinking" (Smith, Flowers & Larkin, 2009 p. 80), I could not disagree more with Giorgi (2011) in that the phenomenon under investigation is lost from sight. On the contrary, by staying close to participants' accounts and utilising interpretations that are grounded in the data, it is the phenomenon through the participants' and researcher's eyes that emerges. Reflecting on these issues, I realised that in conducting the analysis and relating deeply with the participants I had at times indeed lost the phenomenon and was concerned more with the participants, that is I had moved away from the researcher's identity and had entered the therapist's position. As Smith, Flowers & Larkin (2009) suggest ideography is about the particular phenomenon, in the sense of the amount of detail and depth of analysis and how it emerges through a particular sample of people. Obviously, my difficulties with ideography in the actual act of research do not reflect a shortcoming of IPA, but another complexity of the qualitative research that the researcher needs to come to terms with and perhaps grasp through experience with the particular method.

5.11 Reflections on the Study

There were three main challenges in conducting the particular research. The first had to do with my research countertransference towards the project, the second, with finding my own voice and the third with the analysis of the transcripts.

Despite my unequivocal interest in the topic of countertransference when working with perversions, my constant engagement with a material replete with references to aggression, violence and humiliation, both in the literature and the participants' accounts, often left me emotionally exhausted and with a deep sense of void. Gradually, I came to realise that I was being so disturbed by the nature of the topic that I had detached the same way some of the participants had detached from their feelings during therapy. This detachment prevented me from being open, creative and intuitive and during those times I had to withdraw, take a distance from it all, regain my balance and then return to the project perhaps few days later. Other times, while enjoying life, I found myself hesitating to return to what appeared like a dark, suffocating room of horrors. Writing down my feelings proved to be a helpful way to relieve myself and an excellent source to use in order to check the extent to which my feelings influenced the way I interpreted participants' experiences. Indeed there were days during the analysis, that through these notes it became evident that I was not at all in position to ground my interpretations on data and again I had to remove myself and gain a psychological distance before I could continue.

The second challenge was discovering my own voice which, between authoritative authors in the literature and participants' accounts, was initially only a whisper. Quantitative research often comes across as being more scientific and serious, but as I discovered, in its impersonal way of approaching the phenomenon under investigation it is also a refuge for researchers, in that it is the experiment or the statistical analysis, for example, that produced the particular results, not themselves. In all its beauty, qualitative research does not provide such a refuge. The researcher, by means of his subjectivity is always in the foreground and the results produced cannot be attributed to an experimental design or a statistical procedure, but solely to him as he becomes the medium through which

participants' voices are heard. This is a freedom, that comes with great personal and ethical responsibility and as it is often the case, responsibility comes with increased anxiety. Making my voice clear, through my critical reflections and interpretations, was a personal challenge which this project helped me face.

Closely linked to this challenge was the challenge of balancing description with interpretation as I analysed the transcripts. Despite the fact that I identify myself as a psychodynamic counselling psychologist, when it came to analysing the transcripts I was hesitant to move from description to interpretation for fear that I would distort participants' experiences with my own personal understandings about perversion. On hindsight, I believe that this hesitation was partly due to my lack of confidence, as a novice in this method, partly due to the anxiety I was experiencing sensing the ethical responsibility to remain faithful to participants' accounts, and partly due to the increased anxiety that stems from taking responsibility for my interpretations. Balancing description with interpretation was a great challenge throughout the analysis and there were instances that I remained more descriptive (participants' definitions) and other times that I became more interpretative (maternal countertransference was understood as masochistic countertransference).

Overcoming these challenges was a matter of personal and professional maturation as a researcher. The present thesis reflects the end result of this journey in the sense that it has produced valid results in an area that research was lacking and as such it can inform and facilitate the practice of other counselling psychologists as well. As discussed extensively elsewhere validity was ensured through transparency in the research process, through an independent audit, and through presenting themes that were in the majority strongly represented in participants' accounts.

Although the present research can claim that it has produced valid results, it does not claim to have reached an objective truth, in the sense that quantitative methodologies offer findings that can be replicated and generalised. Indeed, the present findings as far as replication is concerned are limited, for the subjectivity of the researcher has infused the whole process. As Smith (2010) states however, in his reply to Giorgi's (2010) criticism, replicability is not a criterion that qualitative research should be

judged against. Indeed, the notion that the same interview schedule could produce the same results goes against the whole epistemological position of phenomenological and hermeneutic research methods. A different researcher therefore, would have produced different findings regarding therapists' countertransference experiences. Taken into consideration that the findings are the result of the way I conceptualised the meaning of participants' experiences, the findings should not be generalised either. The idiographic approach of IPA means that these particular findings on countertransference involve the particular sample of participants at the particular point in time.

5.12 Limitations of the study

Considering the limitations of the present research, a possible threat to the phenomenological attitude and validity of the data can be located in the inclusion criteria and the translation of two interviews from Greek to English for the purposes of the analysis. For ethical reasons and in order to enhance the transparency of the research, the interviews were translated and certified by an independent translation agency. However, as discussed extensively in the chapter on Analysis, after careful consideration of the issues that are raised in the act of translating, I concluded that the best way to safeguard the validity of the translations was to use my translation of the interviews myself. I took great care to translate the interviews into English, while staying as close as possible to the wording chosen by the participants and the meaning they communicated. Nevertheless, there were few instances that I had to sacrifice the actual wording in order to translate the meaning. Taking into consideration that the way people express themselves and the actual words they use is indicative of their thought processes, something of those participants' experience might have been lost and at those instances both the phenomenological approach and the validity might have been compromised. .

Considering the topic I was researching, I was surprised by the openness of most of the participants to discuss their experiences since at times these involved embarrassing and painful feelings, weaknesses and therapeutic failures. Nevertheless, the hesitation of couple of them to

disclose their vulnerabilities further makes me wonder whether this was the case with all the participants. Perhaps, they could be open up to a certain point and perhaps there were aspects of their experience that they hesitated to disclose despite knowing that their accounts would remain confidential. I believe that my identity as a counselling psychologist must have played a double role. On one hand, it could have facilitated the process because participants knew that they were talking with a professional who could understand what they were saying, but on the other hand it might have placed them in a position to protect their own professional identities by not disclosing perhaps certain experiences.

Another limitation of the research was that the findings are based on participants' retrospective accounts. Due to the fact that the present research required participants to discuss a completed case, some of them discussed about countertransference experiences they had years ago. It could be argued that participants could not recall with complete accuracy their countertransference, forgetting perhaps some less disturbing aspects of it, or that their memories were altered by later reflections.

Last, but not least, due to the unconscious nature of countertransference, the themes that emerged through participants' accounts cannot be considered as describing the totality of their experience. Indeed the themes that emerged, involve the countertransferences that they were conscious of. Perhaps there were other countertransference reactions that participants were not aware of but which influenced their practice.

The findings of the present research therefore represent participants' reality, as this emerged in their consciousness, was retained in their memory, altered through further reflections, disclosed in the interviews and interpreted through the researcher. This reality is far from being objective. Nevertheless it is a worldly, relational reality and as such significant for all therapists who work with perverse individuals.

5.13 Conclusion & Suggestions for Future Research

The present study represents the first qualitative study on psychodynamic therapists' countertransference experiences when working with perverse individuals and as such it is the first systematic effort to explore how

countertransference unfolds during therapy, what types of countertransferences are experienced, how therapists cope with them and use them. In this respect this study offers support to many extant theories on the field, and as such, it increases the confidence of practitioners who wish their practice to be informed by research findings while urging them to maintain a critical outlook both on the findings and the available literature. The beauty of research lies not only in the findings it produces but also in the questions it raises. As much exciting as it was to work on the findings of this project, I was also excited by all the questions it did not answer and which future research could address. Some of these suggestions are discussed below.

As discussed earlier the findings of this research are based on participants' retrospective accounts. A future research could address this limitation, by exploring participants' countertransference at various stages as they occur in their present. This would mean collecting a sample from participants, who have just started therapy with this patient group, are in the middle phase of therapy, are ending and who have completed their sessions. Such a sample would be indeed large, but the findings would be rewarding.

Another finding that would require further research is the possibility of therapists experiencing traumatic countertransferences when working with this client group. According to the present study, this is likely to occur when the overwhelmed therapist cannot find a space to process traumatic feelings.. Further investigation, however is required to specify the nature of traumatic countertransferences, the circumstances they formed, and their impact on therapists and their practice.

A finding that emerged during the analysis of results but was not analysed both due to lack of adequate material and space, was the role of imagery in countertransference and its significance. Contrasting participants' way of discussing their countertransference experiences in the initial and middle phase of therapy, a qualitative difference was discerned which consisted in them changing their accounts from being descriptive to being filled with imagery. For example, whereas, during the initial phase of therapy, Georgia, referring to her client's dreams coming through email, said that there was something humiliating about receiving them (13.329) during the middle phase of therapy, Elen referred to the feeling of

humiliation she experienced as if "*a layer of glacier was covering my heart […] Like a cold hand holding firm my heart and it stopped"* (11. 213-218). Although it is not clear from these findings what is the role and function of imagery in terms of countertransference experiences is, whether it indicates individual differences, level of awareness or strength of feelings, a definite trend appears in the findings that creates an opportunity for further research for the overall field of countertransference but also perversions in particular.

Additionally, the present research did not address the variable of years of experience. Although the current findings do not suggest that clinical experience makes the countertransference less intense, future research could explore this at greater depth.

Although the present research highlighted the strength and difficulty of countertransference when working with perverse clients, it is my hope that it will inspire more counselling psychologists to start working with this client group, and it will instigate further research in the field. I would like, therefore, to end this thesis on a positive note. Despite its difficulties, therapeutic work with this group is immensely rewarding. By meeting the challenges that our clients pose to us, we have a unique opportunity for personal and professional growth. In my case, my first therapeutic encounter with perversion was through Peter and it wasn't just a matter of growth, but a transformative experience that influenced my therapeutic identity and course. Moreover, according to my clinical experience, and it remains to be confirmed or not by future research, the intensity of negative countertransferences with this client group is matched with the intensity of connectedness one feels with these people as, from time to time, they emerge through the isolation of their perverse world into a world of relatedness. Being a witness to both their drama and rebirth is a privilege and an honour.

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Table 1: Participants' Characteristics

Participant	**Gender**	**Ethnicity**	**Training & Years of Clinical Experience**	**Interview Language**
Georgia	Female	British	Jungian Analyst, 25 years	English
Eva	Female	British	Clinical Psychologist, Psychoanalytic Psychotherapist, 27 years	English
Anna	Female	Greek	Clinical Psychologist, 11 years	English
Elen	Female	Greek	Psychoanalyst, 18 years	English
Joanna	Female	Greek	Psychoanalyst, 20 years	English
Kassy	Female	Greek	Counselling Psychologist, 8 years	English
Andrew	Male	Greek	Psychotherapist, 9 years	English
Jack	Male	Greek	Psychiatrist, Psychoanalyst, 20 years	Greek
Jason	Male	Greek	Psychoanalyst, 15 years	Greek
Nikos	Male	Greek	Psychotherapist, 8 years	English

Table 2: Table of Themes

	Georgia	Eva	Joanna	Jack	Kassy	Anna	Jason	Elen	Nikos	Andrew
1. Therapists' Understanding of Perversion										
a) Definitions of perversion	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes
b) Way of Relating to Self	Yes	Yes	Yes	Yes	No	Yes	Yes	No	No	No
c) Way of Relating to Others	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes
2. Development of Countertransference										
a) Initial Period Countertransference	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
b) Middle Period Countertransference	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
c) Final Period Countertransference	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes
d) Post Therapy Countertransference	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
3. Ways of Coping with Countertransference										
a) Strength of Countertransference	No	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes
b) Acting Out	No	Yes	No	No	No	Yes	No	Yes	No	Yes
c) Defence Mechanisms	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No
d) *Clinical & Peer* Supervision	No	Yes	Yes	No	Yes	Yes	No	Yes	Yes	Yes
4. Making Sense of & Using Countertransference										
a) Understanding of Countertransference	Yes	Yes	Yes	Yes	No	Yes	No	Yes	Yes	Yes
b) *Creating Therapeutic Meaning*	Yes	No	Yes	No	No	Yes	No	No	Yes	Yes
5. Parallel Processes										
a) Between therapist & supervisor	Yes	Yes	Yes	Yes	Yes	No	Yes	No	Yes	No
b) Between interviewer & interviewee										

Table 3: Table of Master Themes & Participants' Quotes

1. THERAPISTS'UNDERSTANDING OF PERVERSION	**Line**
1.1 Definitions of Perversion	
Georgia: I don't think-emotional	1.7-11
I would say-other thing	1.14-17
I think a perversion-isn't it?	1.20-21
That's my theory- satisfactorily described	2.31-38
I think it is something-collective	2. 38-47
Eva: I think it is more-within a relationship	1.22-30
Jack It's something that-act as well	1.11-17
Kassy but in psychodynamic –the sexual act	1.15-20
Anna Perversion is – domination	2.25-30
Jason On the basis of –a woman	1.19-24
Elen Stoller's definition- hatred	1.8
Nikos I suppose I partly-organisation	1.13-15
On the other hand-sexual feelings	1.15-19
I suppose there is –paedophiles	1.19-21
Andrew I agree with-structure	1.15-16
1.2 Way of Relating to Self	1.24-29
Georgia: Well I think of a perverse-relationally	11.265-266
He said he-being in danger	14.325-328
Eva: I mean the other group-extremely persecutory	15.349-355
I mean I think another-want you to know	13.340-341
Joanna: These people-this one thing	7.117-178
Jack The person is-narcissistic balance	2.22-25
There is an inadequacy-fills the gap	16.331-332
You tend to sense them-responsibility for it	18.393-402
They have no-project-split	3.47-48
Anna Some perverse –conceals anxieties	
1.3Way of Relating to Others	
Georgia: somebody who is-it is your fault	19.414-415
I am saying-relating	3.54-55
Charm is the other side-initially	15.378-380
All these people –humiliated as well	12.293-295
Eva: In my experience-tremendous danger	13. 294-303
For this particular- to a benign object	13.317-318
Separations pose- enactments	13.320-321
I think another issue-don't want you to know	15.349-355
I think the underlying-confused universe	16-385-396
Joanna: exercising the power-the other person	1.14-16
I could see-sexualising the relationship	5.128-130
Kassy It does not only – is different	2.38-47
Anna Sometimes the goal is –relate to others	3.49-53
What I mean-half the story	3.55-58
You know there is –to survive	24.511-515
Sexuality –safe	26. 566-567
Jason They are similar –depressive	14.429-431
For example – unconsciously castrated	9.250-256
Elen there's lots of –is implied	1.10-12
It could take –relationship	1.15-22
Yes I suppose –levels	2.24-29
Nikos The fact that- safe	1.22-27
Sexuality is used –external relationships	2.30-32
You see DSM –manipulates	2.35-40

	Most of the times-partners	2.43-45
Andrew	We tend to –is perverse	1.21-28
	The victim-as well	2.32-37
2.DEVELOPMENT OF COUNTERTRANSFERENCE		
2.1 Pre-Therapy Countertransference		
Nikos:	I was furious-the two of us	6.116-118
	It was obvious-before we meet	6.127-132
2.2 Initial Period Countertransference		
Georgia:	I wasn't much-to relate to him really	5.100-102
	He had no interest-to do with the task	5-106-108
	I reacted to his –external manner	6.132-133
	Makes me suspicious- silk socks	16.408-411
	The difficulty was-get him there	11.267-268
	You know it's perverse-to go really	11.271-274
	I got a hint of it-first session	12.305-310
	The feeling of an imbalance-being there	12. 191-192
	I sensed that-possibly know	13.311-319
	He used to email me-receiving them	13.321-329
Eva:	I think at the beginning- making on me	3.69-72
	I think my countertransference-his vulnerability	4.79-80
	I think it was quite difficult-to manage me	4.84-87
	I think my assumption-to be managed	4.94-96
Joanna:	he was a tall guy-rape me	2.42-45
	For instance every move-so provocative	5.103-109
	He was relating to me-please me sexually	3.59-65
	Well I was shocked-rigid internally	3.52-53
	Yes at the beginning-sexual feelings	14.371
	He would touch a flower-feel at some point	5.106-111
	I was feeling –embarrassed	4.84-85
	It was really-body aching	4.86
Jack:	In the beginning-overwhelming	4.110-112
	I listened-you expect this	5.108-109
	It was like the child-she listens	8.173-174
	I attached myself-something symbiotic	13.286-287
	It was more about-analytic functions	12. 262-265
	It was very much homosexual-homosexually tender	16.342-343
	Psyche keeps- exhausting	13.276-178
	Sometimes it is –liberating for me	11.233-235
Anna :	I think he cared-serving this function	4.78-81
	I almost had-needed help	6.111-112
	He was the first-offer to help him	8.160-166
	Partly it was my own-responsibility	7.135
	I felt like a policeman as well	7.146-147
	You see things-was or wasn't?	12.241-243
	How was it –one dimensional being	23.619-621
Jason:	and this is how he-what we owe	4.106-107
	There might have been-had to break	4.120-121
	For me in the particular-soften up	16.467-473
	Let's say that-this is also attractive	5.101-104
Kassy:	he was trying-his own writings	5.113-115
	I was aware-paralysed	5.117-123
	As a therapist-should be feeling	5.103-105
Elen:	Actually at the beginning-as he wants	6.118-120
	he needed to –to stop	8.155-156
	He was relating to me- not speak	8.107-113

	As I said it was like-the setting	4. 67-70
	But I also felt-as he felt	4.70-72
	He was a charming-some sort of danger	5.85-87
	Beneath his charming-exposed to	7.123-124
	I guess there were times-disappearing	7.130-132
	There is something-existence as a whole	7.134-135
	The more he needed-not to react	8.155-156
	And indeed at times-my existence	8.161-162
	It's hard- I said nothing	8.165-169
	I find it hard to find-feeling numb	8.154-157
Nikos:	I felt irritated-smile of his	8.172-174
	I was in shock-told the truth	8.179-181
	On one level-my abilities as a therapist	9.195-196
	I felt I had lost-as a psychotherapist	10.108-121
	It's quite disorienting-no sense of direction	10.212-214
	Having concluded-happening earlier	11.221-222
	It was like I –or what to do	4.81-33
Andrew	But to be called-yelling at him	7.141-144
	What made-punching and kicking him	7.132-135
	There were times-trying for him	11.237-238
	It hadn't been easy-my abilities as a therapist	8.175-176
	And although I knew-professional career	10.218-221
	Like a vampire-relating with objects	
	It's quite difficult-the fear I think	
2.3 Middle Period Countertransference		6.138-139
Georgia:	well that continued-being related to	6.154-155
	I think if I –that was it	6.141-147
	So that we were-warmth	7. 163-168
	It happened because-relationships to people	7. 170-172
	I had a lot of feeling-very hard	8. 174-178
	You know- it is your fault	6.127-132
Eva	There was a phase-sexual relationship	7. 159-165
	I think when the patient- has to manage it well	4.94-95
Joanna	There were also –in the session	5.126-129
	He was trying hard-doing it	10.262-265
	He brought his-tender moment	6.137-138
	I was scared-happened next	6.140
	I didn't know how to handle it	6.145-146
	I was feeling-how to handle it	7.175
	I was very anxious-helpless	7.180-184
	I was anxious- Times Square	10.254-256
	Because it was a lot-will that be	7.166-168
	And now we talk-displaced	8.194
	I was somatising an exhaustion	8.205-207
	Because he was-tormented quite often	8.202-206
	What do –tormented	8.219-228
	Hands and legs-different way	11.227-231
Jack	His parents used –someone to acknowledge	7.156-163
Kassy	He also told me-painful for him	7.169-171
	But I wasn't surprised-cross-dressing	8.172-175
	I found it extremely-paralysed	9.207-203
	My whole body-uncomfortable	8.179-185
	Oh my God-happening in the room	8.186-189
	I thought I had to-bad therapist	10.230-234
	I had that dream-abusing me	10-240-244
	It was the first time-I was an object	11.246

	It was a horrible feeling I was terrified	11.256-259
	I also remember-heart would pound	13.303-304
	I think I often-rejecting him	13.308-311
	I did feel cruel-love enough	12.281-284
	As he allowed-feelings for him	13.292-293
	Because- connect	15.312-314
Anna	I remember I – experience the terror	15.315-322
	He was the source-disturbing	17.357-362
	I always experienced- to crush me	26.557-559
	I felt like a doll-truth in his words	20.420-421
	Distressing –like a mother	12.353-356
Jason	Well right what- this issue	12.364-365
	I wouldn't feel-wasting his life	10.190-191
Elen	I discovered feelings-abandoned	11.212-213
	When he was –cold inside	11.215-218
	Like a layer of- it stopped	12. 225-226
	At times I felt-you little bastard	12.231-234
	It's not straightforward-being an analyst	13.248-249
	I often felt insulted-all the women	13.254-257
	There was a feeling-at times felt safe	14. 273-275
	He was crying-corrective experience	14.281-284
	I was proud of him- feel rejected	12.251-255
Nikos	I had carefully chosen- theoretically prepared	14.299.300
	I actually felt –very sad indeed	15.338-320
	Quite comfortable- afford to do	16.335-337
	I must admit-this happened	16.339
	Perhaps guilt- I had	16.343-345
	It was very painful-working for his benefit	17.361-362
	I found it difficult-toward me	17.364-366
	You sort of sense-what is happening	18.380-382
	As I said quite uncomfortable-deception	19.384-389
	There was something –both male and female	22. 471-474
	Possibly when he was –this as a martyr	17.377-379
Andrew	I was a mixture of –me as a person	13.291-295
	His anger was –formulate thoughts	13.299-300
	You see an object-it's quite dead	15. 343-346
	I think I always-would not survive	15.346-348
	I think I was –in the session	18.401-105
	Well when he was able – clearly not working	20.441-445
	He was like – parenting again	20.453-454
	There were times-might have felt	
2.4 Final Period Countertransference		9.203-205
Georgia:	In a way-really change it	10.205
	So there was-haven't done enough	13.283-284
	Both of us saying-good enough	9.217-220
	The other feeling-a lot of problems	11.281-282
	I might have-not sure	10.252-255
	He knew-should be doing	9.203-204
Eva:	Oh, I think sometimes anxious-things really	9.211-214
	So there are-for this man	10.220-224
	I mean, I felt very- be good for him	10. 231-232
	There was a way –go on seeing him	10.238-242
	But in my mind-ways of relating	11.269-276
	Yes I think it was –come into it	7.189-190
Joanna	I felt quite relieve when he left though	10.250-252
	I think it was also –hard experience	7.190-191

	I was quite-to help him	9.246-247
	I must say –had not helped him	10.248-249
	Because I had asked –means at the time	4.78-80
Jack	I don't know if-erotically	17.358-359
	At some point-say it	14.319-322
Kassy:	the final part –staying in therapy	14.322-323
	On some level- abandoned	14.325-326
	I mean I felt-now leaving	21.444-447
Anna	I just wasn't sure – bit longer	21.449-451
	For me it was-determined	15.296-298
Elen	I felt tremendously –was in vain	15.300-303
	I suppose for –it's not like that	15.308-309
	It was very- happened to him	20.423-425
Nikos	I was very much-detrimental for him	20.431-434
	As I said I was- his own decision	23.480-483
	I suppose – our ending	21.476-473
Andrew	Sometimes we – want to experience	21.481-482
	I was like an –to deal with	
2. 5 Post-Therapy Countertransference		10.237-238
Georgia:	I wonder how-contact with	10.241-243
	He was part –some experience	18.440-446
Eva:	I find at the end- I can do it next time	1.23
Joanna	It was a failure- experience	5.106-122
	Yes he would say-how helplessly he felt	7.185-184
	I was very –in the sessions	7.165-171
	And now that – odour there	8.208-216
	I have to –sexual man	3.65
Kassy	I would never forget this client	16.373-377
	Yes definitely – important to me	17.395-397
	Like care –more therapy	16.379-385
	Because I learned-so in that sense	10.222-223
	Oh yes I remember – a nightmare	21.451-453
Anna	Our ending was –miss him	22.455-457
	Sometimes on the day- someone else	22.459-461
	It's like a void-is lost	22.463-466
	The empty nest-process	23.522-525
Andrew	I would like –with his news	
3.WAYS OF COPING WITH COUNTERTRANSFERENCE		
3.1 Strength of Countertransference		
Eva:	I think that if these are –to enact	16.381-383
	In this work-you'll be in a mess	18.426-428
	Well, sometimes confused-why am I trying to do this?	17.403-406
	There are certainly-anything at all	17.410-411
Joanna:	I felt that my –arousing things	3. 74-77
	I would emphasize –go together	10.272-274
Jack	I felt exhausted –like fatigue	6.129-134
Kassy	I think the most –useful interventions	18.423-424
Anna	Now that we talk – tortured myself	13.272-273
	For me the most –particular way	22.472-474
	Again drawing from –hostility	23.498-502
	I was often thrown –him and me	9.184-189
	All the perverse- it's chaotic	24.516-517
	I believe I now – wipe you out	23.503-504
	You know it almost- wounded	24.524-526
Elen	There are moments-reacting on them	16.326-327
	Indeed the strength-need support	17.352-354

Nikos The major difficulty-to be done	21.453-455
Andrew As it was clear –therapy progressed	22.497-500
The countertransference is –unavoidable failures	22.503-508
3.2 Acting Out	
Eva: Sometimes you enact –you enact hostility	14.340-344
Anna Unfortunately because of –to do that	8.155-158
My way of not –abusive way	8.166-168
And under the pressure- abusive way	8.171-175
Elen I remember feeling- voice heard	6.122-125
There were times-after the session	8.147-149
Andrew: the essence –something	11.242-245
3.3 Defence Mechanisms	
Eva: I found him-his vulnerability	5.107-110
Can you remember-sort of patients	4.90-97
How was that-oedipal object	6.133-134
How is that-tricky to manage	15.358-364
Joanna :because he was -contained	3.76-80
I do not think-scared of him	5.130-134
Kassy : with this client- the two of us	18.433-438
If I am to think –also helped me	19.449-451
My interpretations were-no feeling	6.139-142
Jack One thing I did-sustain therapy	9.190-193
Elen I was like –was happening	4.81-83
Confusing- clinical I became	4.77-79
Jason Neutrality- feelings	18.518-521
I don't think-being influenced	3.90-91
Anna At the beginning-invoke in me	15.307-309
3.4 Clinical & Peer Supervision	
Eva: Yeah and I think in the group-balanced experience	18.432-435
Joanna You get support –in a way	16.434-438
It was very –supervisors	3.66-67
Never stop- feelings	16.428-431
Elen There is something-some perspective	17.356-357
I took all the –on your own	17.354-355
Kassy I would definitely-before	15.349-352
Nikos I could not keep-all these	9.190-193
Anna Perhaps more-helpful	26.569-571
Could I have –between us	24.500-509
4. MAKING SENSE AND USING COUNTERTRANSFERENCE	
4.1 Understanding Countertransference	5.119-126
Georgia: Useful because-that kind of being	14.325-332
Eva: I mean the other thing-from time to time	10.255-258
Joanna: Before he would –same feelings	15.324-327
Anna You might say –in his phantasies	7.138-139
His fear that-evidence everywhere	26.552-553
I was as – himself once	7.151-152
Jack Sometimes it made –didn't feel	9.195-196
Andrew There was –masochistic part	4.82-85
This anger though-retaliating	7.157-158
Perhaps that – I mean	11.227-231
Nikos so on that level – humiliated etc	19.391-393
Quite challenging- to fully understand him	7.140-143

Elen We were both –stop to exist These were – understand him **Andrew** If I surrender –deceive his bosses Part of it was –else's story Sometimes so heavy-relationships	9. 172-176 6.134-140 18.407-409 19.418-421
4.2 Creating Therapeutic Meaning **Georgia:** I suppose one of them-they do **Eva**: I think when he –idealised transference I think it is constantly-subjective reality **Kassy** But at least –able to hear it I mean I felt –therapy with me **Nikos** My whole body –angry with me There was this –he was doing **Anna** If you come-created despair Without having – his trauma When I stopped-trusting me	15.377-383 7.166-171 13.310-313 11.262-266 14.325-329 8.159-161 19.398-403 12.246-256 17.369-373 18.387-381
5.PARALLEL PROCESS **5.1Between Therapist and Supervisor** **Joanna:** It was a very-what to suggest I must also say –helped him It was very difficult-at the time I think it was their-nothing about this **Anna :** My policeman- as well For example-my patient	 3.66-68 5.111-114 15.374-378 15.405-408 9.177 25.533-535
5.2Between Interviewee and Interviewer **Georgia :** so how do you-I think **Joanna** : If at any point-to stop And If I may –mean How was that- to ask **Jack** Imagine an-away **Jason** I am a psychoanalyst- say more Someone with whom-anything else? **Kassy** Oh yes he would –reaction Like care- advise him **Nikos** (confusion with participant's gender)	 1.5-7 4.91-92 7.173-174 14.374 17.364-367 1.5-7 2. 34-61 9.200-206 17.395-399

Appendix A
Research Flyer-English Version

Recruitment for Co-Researchers

My name is Margarita Peteinaki, I am a Chartered Counselling Psychologist, registered with the British Psychological Society and I am currently studying for my *Doctorate in Counselling Psychology at City University.*

My research involves ***psychotherapists' countertransference reactions when working with patients who exhibit sexual "perversions"***. The aim of the research is to explore *psychoanalysts'*, *analysts'* and *psychodynamic* psychotherapists' experiences by conducting semi-structured interviews. The length of the interview is estimated to be between 45-60 min., it will be tape recorded and during that time you will be asked a series of questions whose purpose will be to clarify your experience. Please note that interviews are strictly confidential, meaning that names or any other identifying details will be changed to protect your and your patients' anonymity.

Acknowledging that your time is valuable and that your experiences could advance our understanding of the phenomenon under investigation, ***the researcher will visit you at your consulting room or anywhere (within London) which is convenient for you and you will be reimbursed for your participation with the amount of £30.***

Should you wish to participate in this research, please contact Margarita Peteinaki at [redacted].

Appendix B
Research Flyer- Greek Version

Συμμετοχή σε Έρευνα

Ονομάζομαι Μαργαρίτα Πετεινάκη, είμαι μέλος του Συλλόγου Ελλήνων Ψυχολόγων και Εγκεκριμένο μέλος του Βρετανικού Συλλόγου Ψυχολόγων (Chartered Psychologist).

Στα πλαίσια της διδακτορικής μου διατριβής (City University, London/ Επόπτης: Dr. Don Rawnson) με θέμα την αντιμεταβίβαση στην θεραπεία ασθενών με παραφιλίες/ σεξουαλικές διαστροφές, διεξάγεται σειρά ημιδομημένων συνεντεύξεων, ο στόχος των οποίων είναι να διερευνήσει την εμπειρία, ψυχαναλυτών, αναλυτών και ψυχοδυναμικών ψυχοθεραπευτών με την παραπάνω ομάδα ασθενών.

Η συνέντευξη μαγνητοφωνείται, ενώ η διάρκεια της υπολογίζεται περίπου στα 45 με 60 λεπτά. Κατά τη διάρκεια της συνέντευξης, θα σας γίνει μια σειρά ερωτήσεων, ο στόχος των οποίων θα είναι να διευκρινίσει την εμπειρία σας αναφορικά με τα συναισθήματα που βιώνετε στην θεραπευτική δουλειά με αυτούς τους ασθενείς. Κατανοώντας ότι το υλικό της συνέντευξης είναι προσωπικό και ίσως ευαίσθητο, παρακαλώ σημειώστε ότι η συνέντευξη είναι **αυστηρώς απόρρητη**, ότι η ανωνυμία σας θα προστατευθεί σε κάθε περίπτωση, ενώ οποιαδήποτε λεπτομέρεια που θα μπορούσε να σκιαγραφήσει εσάς ή τον ασθενή σας θα αλλαχθεί.

Αναγνωρίζοντας ότι ο χρόνος σας είναι πολύτιμος και ότι οι εμπειρίες θα μπορούσαν να συντελέσουν στη καλύτερη κατανόηση του φαινομένου που ερευνάται, η ερευνήτρια θα σας επισκεφθεί στο γραφείο σας, ενώ για την συμμέτοχή σας θα ανταμειφθείτε με το ποσό των *€30*.

Αν ενδιαφέρεστε να συμμετάσχετε στην έρευνα, παρακαλώ επικοινωνήστε με την Μαργαρίτα Πετεινάκη, στα τηλέφωνα [redacted], [redacted] η στείλτε email στην ηλεκτρονική διεύθυνση:

[redacted]

Appendix C
Information Sheet & Consent Form- English Version

Dear Co-Researcher

Thank you for considering participation in my research. Before deciding whether you wish to proceed with this, please take a few moment to read some information regarding the nature of this project.

My name is Margarita Peteinaki, I am a chartered counselling psychologist, registered with the British Psychological Society and I am currently studying for my Doctorate in Counselling Psychology at City University. My research involves therapists' countertransference reactions when working with patients who exhibit sexual perversions. The length of the interview is estimated to be between 45-60 min, it will be tape recorded and during that time you will be asked a series of questions whose purpose will be to clarify your experience. After the end of the interview, the material will be transcribed and the text will be analysed using the method of Interpretative Phenomenological Analysis. Please note that interviews are strictly confidential, meaning that names or any other identifying details will be changed to protect yours and your patients' anonymity. The research supervisor for this project is Dr. Don Rawson, Psychology Department, City University ([redacted]) nym

Acknowledging that your time is valuable and that your experiences could advance our understanding of the phenomenon under investigation, *the researcher will visit you at your consulting room or anywhere which is convenient for you and you will be reimbursed for your participation with the amount of £30.*

If you wish to be interviewed as part of this research project, please read carefully and sign the consent form, provided with this information sheet.

Kind Regards

Margarita Peteinaki
Chartered Counselling Psychologist
Research Student, Psychology Department
City University
Email: [redacted]

Informed Consent

I……..(print name) have read and understood the information sheet provided by Margarita Peteinaki and agree to participate in her research project. I agree to have my interview tape recorded and I understand that this tape (and the transcript) is confidential and will be reviewed by the researcher and her supervisor only. I understand that all attempts will be made to maintain anonymity and confidentiality. I also understand that participation in this research is voluntary, therefore, should I feel distressed or wish to discontinue my participation for any reason, I am entitled to withdraw at any time without penalty or loss of benefits to which I am entitled.

Signature

……

Date

……..

Appendix D
Information Sheet & Consent Form- Greek Version

Σας ευχαριστώ που σκέφτεστε την πιθανότητα συμμετοχής στην έρευνά μου. Πριν αποφασίσετε αν επιθυμείτε να συμμετάσχετε στην έρευνα, παρακαλώ αφιερώστε μερικά λεπτά προκειμένου να διαβάσετε κάποιες πληροφορίες σχετικές με την φύση της παρούσας έρευνας.

Ονομάζομαι Μαργαρίτα Πετεινάκη, είμαι Συμβουλευτική Ψυχολόγος έγκριτο μέλος Βρετανικού Συλλόγου Ψυχολόγων και στο παρών εκπονώ τη διδακτορική διατριβή στη Συμβουλευτική Ψυχολογία στο Πανεπιστήμιο City Η έρευνά μου αφορά στις αντιμεταβιβαστικές αντιδράσεις των θεραπευτών που εργάζονται με ασθενείς παρουσιάζουν σεξουαλικές διαστροφές. Η συνέντευξη υπολογίζεται να διαρκέσει μεταξύ 45 και 60 λεπτών, θα μαγνητοφωνηθεί και κατά τη διάρκειά της θα σας κάνω μια σειρά ερωτήσεων με σκοπό να διευκρινιστεί η εμπειρία σας. Μετά τη συνέντευξη, το υλικό θα απομαγνητοφωνηθεί και το κείμενο θα αναλυθεί με τη μέθοδο Interpretative Phenomenological Analysis. Παρακαλώ, σημειώστε ότι οι συνεντεύξεις είναι αυστηρά απόρρητες. Αυτό σημαίνει ότι κάθε λεπτομέρια που μπορεί να σκιαγραφεί εσάς ή τον ασθενή σας θα αλλαχθεί. Ο εποπτης αυτής της έρευνας είναι ο Δρ. Don Rawson, Τμήμα Ψυχολογίας, Πανεπιστήμιο City ([redacted])

Αναγνωρίζοντας ότι ο χρόνος σας είναι πολύτιμος και ότι οι εμπειρίες σας μπορούν να συμβάλουν τη περαιτέρω κατανόηση του φαινομένου που ερευνάται, η ερευνήτρια θα σας επισκεφτεί στο γραφείο σας ή όπου είναι πιο άνετο για εσάς και θα αποζημιωθείτε για τη συμμετοχή σας με το ποσό των €30

Αν επιθυμείτε αν συμμετάσχετε στην έρευνα και να δώσετε συνέντευξη, παρακαλώ διαβάσετε προσεκτικά και υπογράψετε την Συγκατάθεση Κατόπιν Ενημέρωσης που σας παρέχετε μαζί με αυτό το ενημερωτικό φυλλάδιο.

Με εκτίμηση

Μαργαρίτα Πετεινάκη
Συμβουλευτική Ψυχολόγος
Τμήμα Ψυχολογίας
Πανεπιστήμιο City
Email: [redacted]

Συγκατάθεση Κατόπιν Ενημέρωσης

Ο/ Η…….(ονοματεπώνυμο)
δηλώνω ότι έχω διαβάσει και καταλάβει το ενημερωτικό φυλλάδιο σχετικά με την έρευνα της Μαργαρίτας Πετεινάκη και συμφωνώ να συμμετάσχω στην έρευνα. Δίνω την συγκατάθεσή μου να μαγνητοφωνηθεί η συνέντευξη με δεδομένο ότι το υλικό είναι απόρρητο και ότι κάθε προσπάθεια θα καταβληθεί προκειμένου να διαφυλαχθεί η ανωνυμία μου. Κατανοώ ότι η συμμετοχή στην έρευνα είναι εθελοντική και έτσι διατηρώ το δικαίωμα να διακόψω την συμμετοχή μου ανά πάσα στιγμή και για οποιοδήποτε λόγο, χωρίς καμία επίπτωση ή απώλεια

Υπογραφή

……

Ημερομηνία

…….

Appendix E

Interview Schedule-English Version

1) Could you tell me few things about you in terms of the therapeutic approach you are using and the time you have been practicing?

2) How do you understand the term perversion?

3) Could you remember a recent patient with whom you have now ended therapy and tell me few things about this case?

   Imagine that it would be possible to divide therapy in three broad periods - beginning middle and end.

4) Thinking about the beginning of therapy, can you remember what was happening in terms of the therapeutic relationship?
   a) How was he relating to you?
   b) How did you feel in response to his way of relating to you?
   c) Were you aware of those feelings thoughts bodily reactions as they occurred?
   d) How do you think your counter-transference reactions affected you at that time?

5) Thinking about the middle of therapy, can you remember what was happening in terms of the therapeutic relationship?
   a) How was he relating to you?
   b) How did you feel in response to his way of relating to you?
   c) Were you aware of those feelings thoughts bodily reactions as they occurred?
   d) How do you think your counter-transference reactions affected you at that time?

6) Thinking about the end of therapy, can you remember what was happening in terms of the therapeutic relationship?
   a) How was he relating to you?
   b) How did you feel in response to his way of relating to you?
   c) Were you aware of those feelings thoughts bodily reactions as they occurred?
   d) How do you think your counter-transference reactions affected you at that time?

7) If you were to write an article on the therapists' experience of being in the room with this client group, which aspects of that experience would you emphasize?
   a) What are some of the difficulties the therapist might experience in relating to this client group?
   b) Are there any short term or long term effects on the therapist?

8) If you were to supervise a therapist who had a similar patient what would you advise him?
   a) *Taking into consideration your experience, are there any particular issues in the treatment of this client group, which you would like to make your supervisee aware of?*
   b) *Would you be interested in particular aspects of your supervisee's experience with his/patient?*

9) If you had a similar patient in the future, how do think you would react, taking into consideration your recent experience?
   a) *Is there anything you learned about yourself, as a result of your experience that might be helpful being aware of in the future?*
   b) *What would you do differently?*

Appendix F
Interview Schedule- Greek Version

1) Θα μπορούσατε να μου δώσετε μερικές πληροφορίες σχετικά με την θεραπευτική προσέγγιση που ακολουθείτε και πόσο καιρό εργάζεσθε;

2) Πώς αντιλαμβάνεστε τον όρο διαστροφή;

3) Θα μπορούσατε να μου μιλήσετε λίγο για ένα πρόσφατο ασθενή σας που παρουσίαζε διαστροφή/-ες και με τον οποίο έχετε ολοκληρώσει την θεραπεία;

Φανταστείτε ότι είναι δυνατό να χωρίσουμε την θεραπεία σε τρεις περιόδους, αρχή μέση και τέλος…

4) Σκεφτόμενος-η την αρχική περίοδο της θεραπείας, μπορείτε να θυμηθείτε τι συνέβαινε στην θεραπευτική σχέση;

   α) *Πώς ο/η ασθενής σχετιζόταν μαζί σας;*
   β) Τι συναισθήματα (η και σωματικές αντιδράσεις) βιώνατε εσείς για τον/την ασθενή
   γ) Είχατε συνείδηση αυτών των συναισθημάτων τη στιγμή που αυτά συνέβαιναν?
   δ) Με ποιο τρόπο νομίζετε τα αντιμεταβιβαστικά σας συναισθήματα σας επηρέασαν εκείνη την περίοδο?

5) Σκεφτόμενος-η την μεσαία περίοδο της θεραπείας, μπορείτε να θυμηθείτε τι συνέβαινε στην θεραπευτική σχέση;

   α) Πώς ο/η ασθενής σχετιζόταν μαζί σας;
   β) Τι συναισθήματα (η και σωματικές αντιδράσεις) βιώνατε εσείς για τον/την ασθενή
   γ) Είχατε συνείδηση αυτών των συναισθημάτων τη στιγμή που αυτά συνέβαιναν?
   δ) Με ποιο τρόπο νομίζετε τα αντιμεταβιβαστικά σας συναισθήματα σας επηρέασαν εκείνη την περίοδο?

6) Σκεφτόμενος-η την τελευταία περίοδο της θεραπείας, μπορείτε να θυμηθείτε τι συνέβαινε στην θεραπευτική σχέση;
   α) Πώς ο/η ασθενής σχετιζόταν μαζί σας;
   β) Τι συναισθήματα (η και σωματικές αντιδράσεις) βιώνατε εσείς για τον/την ασθενή
   γ) Είχατε συνείδηση αυτών των συναισθημάτων τη στιγμή που αυτά συνέβαιναν?
   δ) Με ποιο τρόπο νομίζετε τα αντιμεταβιβαστικά σας συναισθήματα σας επηρέασαν εκείνη την περίοδο?

7) Φανταστείτε ότι πρόκειται να γράψετε ένα άρθρο σχετικά με την εμπειρία σας με αυτή την ομάδα ασθενών, ποιές πτυχές αυτής της εμπειρίας θα διαλέγατε να τονίσετε;
   α) Ποιες είναι κάποιες από τις δυσκολίες που αντιμετωπίζει ο θεραπευτής στην προσπάθεια του να σχετισθεί με αυτή την ομάδα ασθενών;
   β) Υπάρχουν βραχυπρόθεσμες ή μακροπρόθεσμες επιπτώσεις στον θεραπευτή;

8) Φανταστείτε ότι εποπτεύετε ένα θεραπευτή ο οποίος έχει έναν παρόμοιο ασθενή, τι θα τον συμβουλεύατε;
   α) Έχοντας υπόψη την δική σας εμπειρία, υπάρχουν συγκεκριμένα θέματα στην θεραπεία αυτής της ομάδας ασθενών, για τα οποία θα θέλατε να ενημερώσετε τον εποπτευόμενο σας;
   β) Κατά την διάρκεια της εποπτείας, πιστεύετε ότι θα ενδιαφερόσασταν ιδιαίτερα για κάποια πτυχή της εμπειρίας του εποπτευόμενου σας με τον συγκεκριμένο ασθενή;

9) Αν είχατε έναν παρόμοιο ασθενή στο μέλλον, πώς νομίζετε ότι θα αντιδρούσατε, έχοντας υπόψη την πρόσφατη εμπειρία σας;
   α) Ως αποτέλεσμα αυτής της εμπειρίας, υπάρχει κάτι που μάθατε για τον εαυτό σας το οποίο πιστεύετε ότι θα ήταν βοηθητικό να θυμάστε για το μέλλον;
   β) Θα κάνετε κάτι διαφορετικά;

Appendix G
Debriefing- English Version

Counter-transference reactions are considered a vital source of information about the psychology of the patient. However, undetected, and therefore unmanaged, counter-transference can seriously impede therapy (Eagle & Wolitzky, 1997). As far as perversions are concerned, it is well documented in the literature (Gillespie, 1952, Meltzer, 1973, Khan, 1979, Bach, 1994, Wrye & Welles, 1994 as cited in Mann, 1997) that the development of transference perversion is insidious and almost seems to creep up on the therapists who, most of the time, find it difficult to notice that the transference becomes perverse.

Despite the fact that psychoanalytic theory on perversion is vast, it seems that an in depth and detailed description of the counter-transference reactions which the therapist experiences when working with a patient with perversions, or of how the therapeutic relationship develops, is missing. The purpose therefore of this research is to explore these experiences in the hope that these phenomena will be better understood. To achieve this goal, interviews will be analysed according to the IPA method (Interpretative Phenomenological Analysis).

If as a result of your participation in the interview you feel that sensitive material surfaces, please contact either your supervisor or therapist, or alternatively contact me in order to discuss your experience further.

Kind Regards

Margarita Peteinaki
Tel: [redacted]
Email: [redacted]

Appendix H

Debriefing- Greek Version
Συνοπτική Ενημέρωση

Σας ευχαριστώ θερμά για την συμμετοχή σας.

Η ψυχαναλυτική βιβλιογραφία στο θέμα των διαστροφών/ παραφιλιών είναι πραγματικά εκτενείς και παρά τις διαφορές αναφορικά με τη θεωρητική κατανόηση του φαινομένου, το σημείο που οι απόψεις μοιάζει να συγκλίνουν είναι ότι η κατά τη διάρκεια της θεραπείας/ ανάλυσης, μια διαστροφική μεταβίβαση αναπτύσσεται ύπουλα με τους αναλυτές συχνά να δυσκολεύονται να διακρίνουν ότι η μεταβίβαση έχει αποκτήσει χαρακτηριστικά διαστροφής (Gillespie, 1952, Meltzer, 1973, Khan, 1979, Bach, 1994, Wrye & Welles, 1994 as cited in Mann, 1997). Αν και η Ross (2003) σημειώνει, οτι η σημαντικότερη δυσκολία των αναλυτών που δουλευούν με ανθρώπους με διαστροφές είναι η ισχύς, η φύση και η διαχείριση της αντιμεταβίβαστης, αυτή δεν έχει ερευνηθεί εκτενώς.

Ο στόχος λοιπόν της παρούσας έρευνας είναι να διερευνήσει τη φύση των αντιμεταβιβαστικών αυτών αντιδράσεων των θεραπευτών/αναλυτών και να αναδείξει τυχών στάδια στην εξέλιξη της τα οποία θα μπορούσαν να σχετίζονται με αλλαγές στην θεραπευτική σχέση και κατά επέκταση αλλαγές στο ψυχικό κόσμο των ασθενών. Προκειμένου να επιτευχθούν οι παραπάνω στόχοι οι συνεντεύξεις θα απομαγνητοφωνηθούν και το κείμενο θα αναλυθεί χρησιμοποιώντας τη μέθοδο IPA (Interpretative Phenomenological Analysis), τη πιο σύγχρονη μέθοδο ανάλυσης εμπειριών στις ποιοτικές έρευνες.

Αν, ως αποτέλεσμα της συμμετοχής σας στην συνέντευξης, νιώσετε οτι ευαίσθητο υλικό αναδύεται στην επιφάνεια, παρακαλώ επικοινωνήστε με τον τον επόπτη ή θεραπευτή σας ή εναλλακτικά επικοινωνήστε μαζί μου προκειμένου να συζητήσουμε περισσότερο την εμπειρία σας.

Με εκτίμηση

Μαργαρίτα Πετεινάκη, *Post-MA, MSc, BA*

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Appendix I
Example of Transcript Analysis

Appendix J
Preliminary Countertransference Model of Perversions

Period in Therapy	*Major Theme*	*Major Transference-Countertransference Dynamic*	*Patient's Transference*	*Patient's Means of Control*	*Therapist's Countertransference*	*Therapist's Defence Mechanisms & Ways of Coping*
Initial	Battle for Survival	Core Complex	therapist is experienced as posing threats to psychic survival and must be controlled	being charming, splitting off aggressive parts & presenting only vulnerable aspects, part-object relating humiliation, aggressive attack in therapist's capacity for thinking	charmed, maternal feelings, mentally paralysed, annihilation anxiety, emotional exhaustion and/or anger that lead to withdrawal, aggression in response to perceived attempts to be controlled.	Acting out Splitting Dissociation Intellectualisation Supervision
Middle	Sadomasochistic Control vs. Empathic Understanding	Core Complex Sadomasochism	Therapist is experienced as posing threats to psychic survival and must be controlled- Sadistic Attacks & Development of perverse transference	Part-object relating Eroticisation of the relationship Deception Aggression Humiliation	Annihilation Anxiety Need for control Guilt & Masochistic Feelings Sadomasochistic Monad Empathy as a means of differentiation and whole object relating	Acting out Splitting Dissociation Intellectualisation Empathy as a means of differentiation and whole object relating Supervision
Final	Attachment & Loss	Moving towards whole object relating? *More research is required*	*More research is required*	Sudden Termination of therapy	Parental countertransference • the anxious parent • the guilty parent • the abandoned parent	Detachment Acceptance Supervision
Post-Therapy	Traumatisation vs. Professional and Personal Growth	*N/A*	*N/A*	*N/A*	Merging with the Patient Traumatised Victim Feelings of Loss & Sadness Continued feelings of Care Significant patient for professional growth	Re-enactments Supervision Developing of professional interest in the field of perversions.

Initial Period Countertransference: Battle for Survival

It appears that during this initial period of therapy the major transference and countertransference is that of experiencing the other as posing a tremendous danger for psychological survival. In response to this terrifying feeling, a battle appears to take place between therapist and patient as they both strive to remain alive and safe under the threat of the other's perceived attack. It could be hypothesised that what is repeated in the initial period of therapy is the Core Complex, according to which the threat for psychic survival that both therapist and patient pose to each other is dealt either with aggression or withdrawal.

Middle Period Countertransference: Sadomasochistic Control vs. empathic understanding

The battle for survival that began in the initial phase of therapy continues in the middle phase as well, but as the perverse transference intensifies, the therapeutic relationship acquires strong sadomasochistic elements that enhance the perverse part-object relating. This type of relating appears to dissolve as therapists manage gradually to identify again with their roles, and experience empathy and sadness for their clients

Final Period Countertransference: Attachment & Loss

A therapeutic relationship that began with the therapists experiencing their patients as constituting a significant threat to their psychic survival and continued with them unconsciously needing to regain control and keep themselves safe, concludes with the same therapists relating to them in a whole object way and developing parental feelings towards them. To the extent that the therapists' countertransference experiences reflect something about the internal world of clients and their object relations, it could be hypothesised that changes in the therapists' countertransference could signify a movement towards whole object relationg in the patients' psychological functioning

Post-Therapy Countertransference: Traumatisation vs. Professional and Personal Growth

Although the unconscious motive of the perverse patient is to destroy the therapist in order to control him and remain safe, the therapist who survives comes out from this experience professionally and personally richer. It is not surprising therefore, that a perverse patient t becomes a significant patient, whose loss, is mourned, and as a love object continues to be invested with their care and concern years after the end of therapy. It could be hypothesised that the negative post-therapy countertransference is a residual very intense countertransference reaction which was never resolved during therapy and as such remains unchanged in the present, affecting the therapists' functioning as they enter in a similar situation again. If this is the case, then it could be further hypothesised that experiencing such intense countertransferences can be potentially traumatic for the therapist. There also a danger of transferring this post-therapy countertransference to the next perverse patient or indeed anyone who presents with similar features.

Section B: Professional Practice

The Therapeutic Journey of William; a Case Study on Perversions from an Attachement Theory Perspective

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Rational for the work

Reflecting on my past and present patients for the purposes of presenting this case study, William's image emerged in my mind and took hold of it as if something of significance remained to be processed. Our work, however, was neither successful in terms of its outcome, nor exemplary in terms of my therapeutic technique. Nevertheless, it was a therapeutic encounter that pushed me to expand my theoretical knowledge, considering perversions from a previously unexplored perspective, namely that of attachment theory. Moreover, the intensity of the transference and countertransference forced me to face my own limitations, thus contributing to the expansion of my self-awareness and the enhancement of my therapeutic identity. A year later and after our stormy ending, this study represents an opportunity to review William's case and having acquired the necessary psychological distance to critically reflect on our work.

Introduction to the client

William, a 35 year old man, was the owner of a small jewellery shop and a restaurant. Finding his work somewhat unrewarding in spiritual terms he attended various philosophical and spiritual groups and in an effort to understand himself better he also attended a 2 year training course in counselling with a clear spiritual direction. As he stated, his goal in life was "self-awareness" and "becoming an enlightened individual". At the time that therapy began, William was single and lived in a small apartment

Presenting Problem

The symptom that brought William to therapy was as he said his "compulsive masturbation". He had to masturbate at least two or three times per day and as a prerequisite for sleep. He experienced this activity as being addictive and out of control and he believed that it occurred in response to his existential death anxiety. He masturbated either watching pornographic movies or fantasising. As he explained, he enjoyed "violent sex" during which he could dominate women. He enjoyed humiliating them and causing them pain either by pulling their hair, or hitting them.

History of the problem

William believed that he had always had "excessive sexual energy" which he had to release either through sex or masturbation. At those times that he had the opportunity to have sex, his masturbatory activity decreased in frequency, but never disappeared completely from his daily life. He remembers masturbating daily from a very young age.

William had sought therapy in the past in order to understand his sexuality better. The first time was with a male therapist roughly 5 years before we began our sessions. As William said, he and his therapist ended up becoming friends, going on holidays together and exchanging roles; that is sometimes during sessions, William became the therapist and listened to his therapist's problems. As he reported the one year he stayed in therapy was not helpful at all. However, it was in response to this unsatisfactory experience that he began his training in counselling and attended a few short-term group therapy sessions, where he never disclosed details about his sexuality.

Personal & Family History

William was born in Cyprus just before the Turkish Occupation took place. Shortly after this event, the family moved to Greece where he and his sister, who was two years older than him, stayed until he was 13 years old. As William reported, his father was always violent towards his mother and the couple used to fight frequently. According to him, the father was always the "terrorist" and the mother the "victim". When he was 13, his parents decided to separate, but 5 months later the couple was reunited. Around that time and after another violent incident the father, judging his wife to be unfit to care for the children, took them to Cyprus, where they lived until William was 19.

During those years William's mother visited them often. As William disclosed to me, shortly after they moved and during one of his mother's visits, the two of them had sex. As he said it all began like a game while the two were lying in the bed pretending that he was a baby wanting to breast feed. In this game, his mother responded by cuddling him and laughing. At some point, he started experiencing erotic feelings and as he said "I made love to my mother". The event was never discussed again.

William described his mother as a beautiful woman, pre-occupied with her appearance. He experienced her as being very passive, weak and easy to manipulate but at the same time very controlling for she used guilt to achieve what she wanted. Although he loved his mother, he did not either like her or respect her. As far as his father was concerned, William described him as being traditional and authoritarian, arrogant and domineering. In addition, he reported that the father was very antagonistic towards him. William was never allowed to know better, win in a game, or achieve anything of which the father would be proud. On the contrary, in the eyes of the father he was "stupid" and "worthless".

During his adolescence, William described himself as being disobedient and sexually hyperactive. He spent his free time with gangs and having casual sex with girls. At the age of 19 he moved to Greece, where he attended courses on jewellery design and took over the management of his father's shop. At that time he met Helen with whom he initially fell in love passionately. William described Helen as having a child-like beauty, being shy and content to follow his lead in everything. According to him, their sex life was great but only at those times that sex was violent. A couple of times that they had "romantic sex", he did not experience any satisfaction. During the 10 years of the relationship, William cheated repeatedly on Helen and while he enjoyed a rich and adventurous social life, she was left home on her own. Eventually, Helen met someone else and broke up with him. William was devastated. He went through a long depressive period which as he said was excruciating but helpful in that it gave him the opportunity to realise that he had become exactly like his father; arrogant and violent. Following this realisation, William decided that he had to improve himself and his intense engagement with all the spiritual and self-awareness activities began.

Theoretical Orientation

Our therapeutic work with William was guided by a broad psychodynamic approach, meaning that I operated on the assumption that there is an unconscious mind whose contents can become conscious, thus expanding the client's awareness of himself and alleviating him from his presenting symptoms (Jacobs, 1999). The psychodynamic approach that mostly

informed my understanding and practice was the school of Object Relations. Although it was Melanie Klein who shifted psychoanalytic understanding of human psyche away from drives and instincts to the relationships with significant others, Object Relations theory has been enriched by many other theorists. The basic tenant of the theory is that the infant, born with the death instinct and in an effort to survive, projects his destructive feelings on the mother, with the result of him feeling all good and the mother being all bad. Fearing his own destruction in the hands of such a terrible mother the infant projects aspects of his life instinct onto to the mother, who is then experienced as being all good. Therefore, during this early paranoid schizoid-position the infant relates to the mother in categorical terms as if she were all good or all bad. In addition, the infant relates to her as if she was a part-object, that is with aspects of her rather that with her as a whole being with good and bad qualities. This realisation comes later as the infant matures and enters the depressive position. The experiences of these early phases and the way mothers handle their infants' frustrations are thought to be the basis for the formation of the internal representations of relationships with significant others (Gomez, 1997)

More specifically, following Winnicott's (1960) understanding of the mother-infant relationship, and in light of his very confusing and abusive relationship with his mother, I had as goal to create a holding environment in which William could gradually explore himself and which could act as a container for his feelings (Bion, 1962) to help him process disturbing and painful experiences. These two goals were reflected in the very clear and stable therapeutic frame I attempted to create for William and in my effort to receive, metabolise and empathically mirror his emotional experiences.

It was further assumed that in the context of a holding and containing environment William's transference could be worked through in the here and now and that any insights or transformations that arose from this process would be transferred to his other relationships. In addition, my own experience of William, that is my concordant and complementary countertransference (Racker, 1957), was regarded as an invaluable source of information which informed both my understanding of his internal world and my interpretations (Tansey&Burke, 1995).

Therefore, empathic mirroring (Kohut, 1984) and interpretations of William's material as this emerged in the transference-countertransference matrix, through his defences and his dreams were the major therapeutic tools that I employed to facilitate his understanding of himself.

Referral & Context of Therapy

I first met William a few months after my relocation to Greece, when I was delivering a workshop on psychosomatic symptoms at a school of Counselling and Psychotherapy where he was attending the final year of his training. During the workshop, William was fascinated by the new knowledge he acquired, was deeply touched by the experiential exercises and experienced me as "warm and very good with feelings"

A couple of months later, William called me requesting to begin personal therapy. During our telephone conversation, he demanded to be informed about the fee and I experienced a tremendous pressure to respond. I informed him that the fee is 50E and he replied aggressively that I am too expensive. We ended our conversation with me suggesting to him to think about it and call me should he feel that he would like to make an appointment. I felt attacked and guilty. Three weeks later he called again requesting an appointment. At that time and as I was in the process of preparing my office, I used to see clients at home. Our first 3 sessions with William took place in my home and we then moved in my office in a nearby location where we continued our work until its end.

The first three sessions - Assessment

In my private practice I tend to dedicate the first sessions to the assessment of the clients' situation, exploring their presenting problem in addition to their past and present object relations. I prefer to conduct the assessment in a semi-structured way, allowing the clients to discuss their experiences at their own pace and personal style, believing that the individual way each client chooses to discuss their experiences provides additional information (Cooper & Alfille, 2005). Through my clinical experience so far, I have also found it helpful to assess clients' attachment style and for this purpose I have incorporated in the assessment Hardy, Alrdridge, Davidson, Row & Reilly (2004) Attachment Interview Schedule (Appendix A). This is an

interview schedule developed particularly for therapists, with questions that sit well and facilitate my overall assessment of the client's object relations. Although I regard the clients' assessment as a beneficial therapeutic tool, I conceptualise this process as being on-going rather than final.

Skipping any formalities or other introductions, William began the first session by saying that he was very disappointed in me. He explained that during our telephone conversation he experienced me as being cold, detached, and arrogant. However, following a dream in which he saw that he had an appointment with me, he concluded that his unconscious guided him towards me. Changing his attacking attitude and almost with religious respect he stated that he was now certain that if there was any therapist that could help him at all, it would be me. I thought that William was very ambivalent towards therapy and me. Listening to his narration, I hypothesised that a part of him appeared as if he wanted to devote himself to me but due to the fact that in this devotion lurked the danger of him losing his individuality, he needed to re-instate his independence by rejecting me. One moment he devalued me the next he idealised me. I further hypothesised that this could have been a dynamic in his relationship with a significant other that was being repeated between us in the transference.

In this context he explained that he can only afford to pay 40E per session and that he could have only three sessions per month. I proposed that it would be a shame to lose his fourth session and that I could agree to 30E. The moment the words came out of my mouth, I realised that his initial attack had made me feel guilty and in light of his later religious admiration, I had felt as if I had to prove that I was indeed a caring therapist and that his choice was justified. This enactment of my countertransference led me first to hypothesise that he had a manipulating part and second that he needed to be in control of therapy by being the one who sets the rules. I was also experiencing a familiar feeling from the past; a mixture of fear and excitement which I had experienced with two previous clients with perversions. I wondered when and how his perversion would be revealed.

During this session, William discussed his "compulsive masturbation" and his belief that this was in response to his death anxiety. He believed that masturbating helped him alleviating an anxiety and he had concluded that,

due to the fact that sexual feelings are invigorating and bring individuals in touch with the life instinct, the anxiety must be related to death. I noticed that William had already an answer and a theory to explain his experience and wondered to what extent this theory served as a defence against exploring his experience and feelings.

Towards the end, William warned me that our sessions would be particularly unpleasant and difficult for me due to the nature of the things he has to discuss and stated that although others might have needed two years of therapy to develop the required amount of trust, from the next session onwards, for him it will be as if these two years have passed. He rejected all my efforts to discuss the part of him that is angry and disappointed in me and dismissed as irrelevant my comment regarding the forced trust he placed on himself.

In the next session, William arrived on time and requested to use the bathroom. I felt as if he was intruding on my personal space. Upon his return he began discussing his dysfunctional family and related all the details regarding his father's abusive behaviour and their relocation to Cyprus. As if it was just another biographical fact, William disclosed that he had "made love with my mother". I was shocked both with the information that fell like a bomb between us and with his detached and cold way of reporting it. He said that although he thinks that this event has played a significant part in the way he relates to women, he has reflected a lot on it and he does not carry any more wounds. He quickly changed the topic to his father and his conflicting relationship with him which as he stated is the real source of his problems. Although William was in therapy because there was something to be resolved, he appeared to know everything in advance and in a very independent and self-sufficient way he determined what had hurt him and what his problems were. My views were obviously irrelevant to him. He could be both the client and therapist.

As I hardly knew William and as I was observing my intense anxiety in the countertransference in response to his disclosure, I resorted to listening more and speaking less, offering only few empathic comments as he discussed his experiences of his parents' fights and asking few exploratory questions that allowed me to paint a picture of his childhood. I hypothesised that William had grown up in a very unstable family

environment that threatened his basic sense of safety and cultivated a deep fear for his mother's well-being and towards his father's violent outbursts. Based on the information he had disclosed about his weak and manipulative mother and his terrifying and antagonistic father, I hypothesised that William's mother turned to her young son for love and affection and, rejecting his father, elevated him to the status of her partner. William's way of referring to incest as "I made love with my mother" made me hypothesise that his mother, being seductive, had allowed his oedipal erotic feelings to develop, giving him the impression that he had beaten his father in the most important of contests. Indeed, as William reported, his mother used to devalue his father and spoke of William him as if he were her prince.

Reflecting on the way he reported what I called in my mind sexual abuse, I hypothesised that during the incident of incest, William must have felt triumphant and powerful, for he was taking revenge on his father by acquiring the precious position in bed next to his mother. This feeling, I hypothesised, allowed him to avoid experiencing the humiliation and shame that victims of sexual abuse tend to experience. In light of his disclosure, I understood his visit to my bathroom at the beginning of the session and my feeling of intrusion as an unconscious effort on his part to make me aware of his penis and power, the same way he had made his mother aware of his powerful manhood.

In the third session, William, taking the role of the trained counsellor, began by lecturing me on the influence that clients have on therapists and asked me how I felt after our last session. My hypotheses regarding his need to be in control and powerful and to embody both roles appeared to be confirmed. Avoiding any premature interpretations, I asked him what he really wanted to ask me, and he admitted that after his disclosure he was concerned about the way I might have been be thinking about him. However, he was not willing to stay on this topic and he chose to discuss Helen. He recounted their whole relationship, his sadistic sexual preferences, his cheating on her and his dismissing and devaluing attitude towards her. I noticed that I listened to this material in a totally clinical way, as if I did not want to admit either to him or to myself the fear that lurked underneath. I only became aware of the fear I was experiencing towards the end of the session when I noticed for the first time that his fly was open. He

was not just showing me his penis symbolically anymore, as he did in the previous session by visiting the bathroom, but he showed it to me literally. I felt threatened by his sexuality and by noticing my inability to say something about it, I wondered about my abilities to contain it. I thought that I would have to set very strict boundaries and that he would unconsciously provoke me to repeat the incest in the transference. These hypotheses led me to explore William's previous experiences with his therapist and as he described the major boundary transgression that had taken place and how the two of them exchanged roles as if that were appropriate and without consequences, I hypothesised that William would unconsciously attempt to destroy my therapeutic identity and therapy altogether.

Formulation

Following these three introductory sessions, I felt I had enough material to begin a preliminary conceptualisation of William's difficulties, speculate on their origins and draw a tentative therapeutic plan.

Taking into consideration my original reaction to his charm, my inability to maintain the therapeutic role, the fear I experienced as well as his sadistic sexual preferences and compulsive masturbation, I conceptualised William's sexual behaviour as a perversion rather than as a preference. As Freud (1905) had stated sexual behaviours are perverse when they become fixed and exclusive, that is they are the only way the individual can experience satisfaction. William did not seem to have a choice over what excited him sexually and he had clearly stated that "romantic sex" did not please him at all.

The hypothesis that William's sexuality was perverse was somewhat consistent with Chasseguet-Smirger's (1985) observations regarding the family dynamics of perverse individuals. According to the author, in the childhood of a perverse adult there is always a seductive mother who actively devalues her husband and promotes the impression that the boy's pregenital penis is sufficient and better in satisfying her than that of the father, creating this way the illusion that pregenitality is equal or superior to genitality**.** The boy's development is, therefore, arrested for he has nothing to admire or envy the father for, so he does not need to either grow up or

mature. Escaping the dilemmas posed by the Oedipal phase, the individual creates a new reality, an anal-sadistic universe characterised by confusion and homogenization whose purpose is to overcome the paternal genital universe, characterised by differentiation, laws and barriers**.** Regressing to an anal-sadistic universe all differences between men and women, adults and children and erotogenic zones are abolished. For Chasseguet-Smirgel (ibid), when it comes to perversions, disavowal is in operation and what is denied is not only the knowledge that women do not have penises and the resulting fear of castration, but also all kinds of gender and chronological differences that arouse feelings of inferiority.

Contrary, however to Chasseguett-Smirgel's (ibid) observations, William had entered into a rivalry with his father and, as his adolescent and adult way of relating to women demonstrated, he had indeed identified with him, devaluing and humiliating women through his sexual and other demeaning behaviours. It appeared that William was a rival to his father, but due to his mother's behaviour, he had disavowed the fear of castration and had formed the illusion that in reality he was more powerful than him. In what must have been a very confusing and traumatic experience, William's power was both confirmed and denied during incest. He was led to believe that he was powerful enough to conquer his mother, but this very conquest was the ultimate act of betrayal on her part, leaving him feeling both humiliated and full of hatred for what was done to him.

Following Stoller's (1975) suggestion that in perverse scenarios the individual gives himself an opportunity to relive traumatic experiences in an effort to turn the original humiliation and pain to triumph and pleasure, I hypothesised that William's sadistic sexual behaviour, gave him the opportunity to remain blissfully unaware of the humiliation he had experienced with his mother and retain the illusion of power. Each time he had what he called "violent sex" he could be in control in a way he wasn't when his mother abused him, could express his hatred towards her and experience a sense of power that was constantly denied to him by his father.

Having experienced early in his life a war situation, having lost his home and country and having been tragically betrayed by both his parents, I hypothesised that William's sense of bodily and psychological safety was shattered and that he indeed carried with him, as he had suggested, a

tremendous death anxiety. Following Welldon's (2011) suggestion that perversions are defences against deep depression and fears of dying, I further hypothesised that William used his sexuality as a means to avoid mourning for his losses and experiencing his deep fear of psychological death. Perhaps when sadistic sex with a partner was not available, William had to resort to masturbation to avoid experiencing both his pain and his anxiety.

Taking into consideration that William's mother was being physically and psychologically abused by her husband before his birth, I hypothesised that since his birth he had been used as an object for comfort for his mother. Being treated like an object who served his mother's needs, I hypothesised that William's sense of self must had been threatened early in his life (McWilliams, 1994) and that incest only confirmed on an unconscious level that being one with the mother results in his annihilation. This hypothesis was also consistent with Glasser's (1979) Core Complex. According to this formulation perverse individuals long to merge with a significant other, so they seek to form relationships. Merging however is also experienced as annihilating, so the individual needs to escape condemning himself to isolation. Nevertheless, the ever present need to merge with another makes the experience of this isolation intolerable. The apparently unresolved dilemma between engulfment and annihilation on one hand, and withdrawal and isolation on the other, finds its tragic solution in sexualisation, which creates the illusion of true object-relating but in a controlled and safe way. This eroticised aggression towards the object finds expression in masochistic and sadistic behaviours. William's sadistic perverse solution was "ingenious" for both he and the other were protected from destruction. He was protected by annihilation by means of torturing and controlling his partners, and at the same time he avoided losing them by engaging in a kind of relationship with them.

William's internal drama and way of relating to others appeared to be confirmed by his attachment style as well. According to Bowlby (1969), attachment is a type of instinctive behaviour, which is activated by internal conditions such as fatigue, hunger, pain, illness and cold, and by external conditions indicating increased risk: darkness, loud noises, sudden movements, looming shapes and solitude and has the purpose of increasing

our chances of survival. At those times of internal or external distress, the infant is pre-programmed to seek the support of a caring figure. Attachment theory therefore describes the various ways in which each infant's needs are responded to by the environment giving shape to different styles of relating. Based on these early experiences with others, children develop internal working models of relationships that shape their subsequent behaviour.

The stability of attachment during adulthood is demonstrated by longitudinal studies of infants assessed with the Strange Situation and followed up in adolescence or young adulthood with the Adult Attachment Interview which classifies individuals into Secure/Autonomous, Insecure/Dismissing or Avoidant, Insecure/Preoccupied or Anxious with respect to loss or trauma (Holmes, 2000) As a result of the assessment, I concluded that William's attachment style was best described as dismissing/avoidant People with this type of attachment style tend to dismiss attachment needs, idealise or derogate others and avoid emotional contact and intimacy (Hardy, 2004; Bogaert & Sadava, 2002). As became evident from the assessment and the way he related to me, William preferred to experience himself as being self-sufficient, devalued me and idealised me and attempted to impose on us a false trust that would not allow any true emotional contact.

Research on the impact of attachment style on sexual behaviour has demonstrated that dismissing/ avoidant people, who habitually seek physical and emotional distance from their partners, tend to dislike affectionate pre-sexual activities (e.g., cuddling, kissing) and intimate copulatory positions, preferring both in fantasy and in action more hostile and humiliating interactions (Schachner & Shaver, 2004; Binbaum, 2007). William's constant affairs could have served the function to maintain emotional distance from his partner, whereas his sadistic sexual behaviour served to humiliate her and help him maintain his independence from her.

Perversions are thought to be defensive strategies against experiencing overwhelming feelings of inferiority, humiliation, depression and anxiety and Holmes (2000) suggests that defences from the attachment theory perspective aim at preserving the integrity of the individual's attachments when these are threatened. From an attachment point of view therefore, the perverse solution that William had discovered appeared to use

the body as a means through which proximity to significant others could be maintained and psychic survival could be ensured, but at the same time any potential danger could be avoided.

Since the attachment style persists in adulthood and attachment patterns are activated in relationships, it follows that the therapeutic relationship as well can become the arena that clients' attachment will be activated (Skourteli & Lennie, 2011). Transference, the repetition in the present with the therapist of past emotional experiences with significant others, can be thought of as the way through which clients' attachment presents itself. I hypothesised therefore, that William would repeat with me the way he related to others and that he would attempt to protect himself by remaining emotionally distant from me. His perversion and our first sessions together gave me some information as to how he would attempt to achieve this.

I hypothesised that William would attempt to devalue me and humiliate me in an attempt to minimise the emotional impact I could have on him relationally and through my interpretations. By rubbishing me he could continue to deceive himself regarding his adequacy and power, remaining safely unaware of the traumatised, humiliated, angry and depressed child within him. I also hypothesised that in the context of transference, William in a compulsion to repeat his trauma would unconsciously attempt to seduce me to seduce him. I expected attacks on the boundaries and pressure to abandon my therapeutic role in favour of other inappropriate roles, as had happened with his previous therapist.

Therapeutic Plan

Reflecting on what could be a therapeutic plan for William, I concluded that gradually and gently we should explore his sexual abuse by his mother and the impact this had on his life, as well as the relationship with his father and how he was traumatised by his continuous devaluation. The goal would be for William to gradually become aware of the traumatised and vulnerable aspect of himself and the ways he hid it by being omniscient and omnipotent. Furthermore, by creating and maintaining a stable therapeutic environment and by withstanding his attacks without retaliating or rejecting him, I would gradually help William develop a real sense of trust towards

me and gradually towards others. Feeling less threatened he would perhaps not have to resort to his perverse solution to protect himself.

Initial Period of therapy

The major themes of the initial period in therapy with William were his tremendous difficulty in trusting and his frustration with the boundaries. He often connected the two saying that setting such strict boundaries I was essentially keeping him at distance and did not allow him to develop any sense of trust towards me. An early example of this dynamic was when, while reflecting on a dream, I noticed that he made great effort to stop himself from crying. When I observed that, he said that it is not part of this work to show me his feelings, he only needs me to help him become aware of them and then he can express them when he's on his own. I realised that he related to me as if I was a part object who was there to execute a function, a way of relating that is common with perverse individuals (Ross, 2003). My comment regarding the isolation he condemned himself to made some sense to him, but he responded that the boundaries I set do not allow him to express his feelings. It would be different he said if I sat next to him on the couch and he could place his head on my knees; then he could cry. I responded by saying that he appears to say that he can only trust me with his feelings as long as there is some physical contact between us and when I deny this contact by setting a boundary as to how we can physically exist in the room, he feels rejected and angry.

At another time his fear for me became apparent through the comments he made about my consulting room. He said that he did not like it at all and that with all the books in there it was as if I needed to convey a sense of me being a knowledgeable authority. He felt that my purpose was to create a sense of inequality between us. I was reminded of Chasseguette-Smirger's (1985) notion that perverse individuals need to deny all differences to avoid experiencing inferiority. I hypothesised that he perceived me as his very powerful mother who could destroy him and for this reason he needed to bring me down to his own level, so that he wouldn't feel threatened anymore. If we were equal, that is if we didn't have different roles and I wasn't a therapist anymore, then my words could have no impact on him.

After numerous similar incidents, William arrived in one session saying that he had realised that he does not trust me. He said that he cannot trust me, because each time he used to trust someone in the past, as happened with his parents, he was taken advantage of and was betrayed. He feared that my plan was to expose his vulnerable side and then take advantage of him financially. “I yearn to trust you”, he said with tears in his eyes “but I cannot”. Although William was clearly scared to trust me, I felt that during this initial period and because we had managed to keep the boundaries stable, he began feeling safe enough to tell me about his fear. As a result of this session, William began setting clearer boundaries with his mother and father and felt proud of himself for actually managing to do so..

Middle Period of Therapy

Following the events of the initial period, William discussed the abuse from his mother. He actually used the word abuse for the first time and he allowed himself to cry intensely during the session. My initial enthusiasm for this indeed huge step in opening up himself to very painful feelings was reduced as he came 35 min. late for his next session saying that he had forgotten our meeting. He did not wish to reflect on the meaning on his delay and appeared somewhat angry with me. As we entered the middle phase of therapy and following this apparently premature exposure of his vulnerable self, William began to flood the sessions with dreams. There was always a dream to discuss and he was very proud that he now trusted me enough to bring me his unconscious. I was initially fascinated by this development and I enjoyed reflecting on his dreams. However, gradually I realised, as his associations remained shallow and his dreams were never truly interpreted, that in a manner consistent with perverse individuals, he was unconsciously using them to forge an illusory bond between us (Mann, 1997) and divert our attention away from his real issues. Although we were supposedly working as a team to make sense of his dreams, he never relinquished control so as to freely associate and was never touched by any interpretation. When in one session he brought yet another dream and said that he only had dreams before our sessions, I understood this disclosure as a message his part that he was at least semi-aware that there was some relationship between the continuous flow of dreams and the therapeutic

process, so I invited him to think about it. Although he responded by saying that it meant that his unconscious operated well and that he works hard in therapy, I sensed that I would fail him if I did not interpret the defensive way he used the dream material. As sensitively as I could, I explained that for many sessions he (ha brought huge and complicated dreams that did not leave any time in the session to discuss his life. He got mad, accusing me of wanting to manipulate him into having more sessions during the week and taking advantage of him financially. The issue of trust and betrayal was once more between us as well as the illusory contact in place of true relating so common in people with perversions (Welldon, 2001). Although he left the session frustrated with me, the next time he arrived significantly calmer and without a dream. He said that during the week he decided to stop going to all the other groups he was attending. I thought that he was now able to stop "cheating on me" as he had done with Helen, by taking the risk to stop diffusing the transference in other people and activities, and experience a dyadic relationship with me, which by means of its exclusivity, would most probably bring to the surface all he had experienced in his relationship with his mother. Nevertheless I hesitated to say anything for fear that if he felt "seen" he might feel scared once more.

Following this incident and for many months, our work with William became more substantial. He explored his relationship with women and made links between the way he feels with them and the way he felt about his mother. Gradually he brought the issue of his sexuality in the discussion and in the transference. He became seductive in the way he spoke to me, made compliments about my appearance, observed my body and asked me to have our sessions in the park. I was very conscious of the sexual transference that was developing but I felt tremendous fear of commenting on it. I had seen his anger before and although consciously I was encouraging myself to face it, in my countertransference I was deeply afraid of him. I knew that this is how he must have felt with his father and that this underlying aggression served to control me, but I could not make use of these countertransference insights at all. I was caught up in my countertransference and as the perverse transference was growing, in one instance I took on the role of the seducer and just before he arrived for his session I created a romantic atmosphere in the room by lighting candles. Shocked by my enactment, I

restored the room to its previous condition and realised that I needed to bring the issues of seduction, aggression and control into our session. The next time he was seductive with me I was able to comment on it but he denied everything and laughed in my face at the stupid psychoanalytic ideas I had in my mind.

Feeling threatened once more, William attempted to rubbish me and destroy therapy, this time by attacking my therapeutic model. For many sessions he lectured me on the spiritual side of life and the theories that he believed made sense and a few times he managed to lure me into a theoretical discussion in order to defend the value of psychological thinking. I was furious with him and I was experiencing in my countertransference a tremendous desire to rubbish his spiritual beliefs and devalue him. When at some point I managed to comment on what was happening between us and how we had entered into a competition, acknowledging my part in this, he replied that he had found the process helpful for it showed him that he needs a different kind of therapy. I was not good enough for him and I could not understand him

Ending

Our ending was unexpected and abrupt. In the climate described above, William arrived 15 minutes early for his session. As we stood at the door, I let him know that he had arrived too early and asked him politely to return fifteen minutes later. When he came back, he was furious. He shouted at me, that I was impolite, that I had thrown him out and that he could not tolerate such behaviour. He was determined to stop his sessions and dismissed all my efforts to make him think about the meaning of this incident and my interpretations that this anger towards me was being used as a means to stop coming to therapy because of his fear that therapy threatened to reveal to him aspects of himself that feel painful. He paid me, stormed out of the room and never returned my call. That was the last time I saw and heard from William.

Reflections on the Work

William's childhood traumatic experiences had such an enormous effect on his basic sense of trust and had contributed to the construction of such a massive defensive system, that therapy with me was never experienced as a

secure base (Romano, Fitzpatrick, & Janzen, 2008) from which he could begin to explore his difficulties. On the contrary, due to his perverse way of relating and his dismissing/avoidant attachment style, therapy was a battle ground, in which we both strived to survive; me as a therapist, by keeping the boundaries stable and maintaining my therapeutic identity as much as I could and him, by protecting himself from yet another betrayal and abuse that he expected to occur.

Reflecting on what I could have done differently, I find myself facing the same dilemma I faced when I used to work with William. During our sessions and sensing his tremendous defences and resistances, I felt that the only way that therapy could survive long enough to start working on them was only if I did not challenge them. That is if I sided with the defences and followed him where he wanted to go. His defences however, as I understood it at the time, led directly to the destruction of therapy, for their purpose was to keep him safe by keeping me at distance and perverting the therapeutic encounter. During our sessions, I attempted to resolve this dilemma by what I thought was the minimum challenging of his defences and resistances that was required to maintain therapy (e.g. my interpretations regarding boundary issues). However, it was clear by his reactions, that the timing of many of my interpretations was wrong for it felt intrusive and raised his defences further. Indeed, I believe there were times when I unconsciously used my interpretations as a means to get some sense of control during the sessions or as ways to state my superiority. This was clearly a countertransference enactment that related closely to William's issues and which at times I failed to contain.

Countertransferences were often unconscious and very intense. Most of the times, it was only through supervision that I realised how I enacted perverse elements in the relationship, but unfortunately this did not prevent enactments from reoccurring. For example, although I was very much aware that William's protests that my goal was to take advantage of him financially was a projection of his taking advantage of me financially, for he consistently lied about his financial situation, I was not able to confront him. Discussions in supervision regarding the guilt I was experiencing, and the fear of facing his aggression, were helpful in that I was understanding the

dynamic between us, but was not enough to actually overcome my countertransference.

Although supervision helped me in containing my anxieties particularly regarding his sexual transference and to restore somewhat my belief in my ability as a therapist, my supervisor's difficulty in conceptualising William's case as a case of perversion, rather than a case of sexual abuse, did not help me to deal with the perverse dynamics that infused the therapeutic process and at times overwhelmed me. On reflection, I wonder whether an undetected parallel process was taking place in supervision. Perhaps my supervisor's refusal to perceive William as a perverse adult mirrored his refusal to perceive his having had sex with his mother as abuse. In the same way that William deceived himself regarding the impact of abuse on him and denied any feelings of humiliation and betrayal, my supervisor might had been denying the hostile and aggressive perverse part, taking into consideration only the abused vulnerable child within him. In addition, my hesitation to support my position created an illusory bond between us, I only agreed with her conceptualization on the surface. This false sense of team work that William created in therapy with me, was paralleled by the same false sense of team work I created in supervision. Perhaps it is due to these undetected parallel processes that my countertransference could be understood intellectually but I was not able to manage it within therapy which resulted in me using my interpretations perversely or at the wrong time.

Although William's case was challenging, my experience of working with him, helped me realise that perhaps the way the therapist can intuitively sense the right timing of interpretations is when he himself is, of course, not overwhelmed by countertransference feelings, but also not burdened by personal feelings of anxiety regarding his ability and worth. When I began working with William I was just beginning my work in Greece and I was struggling with feelings of insecurity regarding my therapeutic abilities, for I could not relate at all to the Greek language in the therapeutic context and I had not yet discovered my Greek therapist identity. As a result, his attacks often found ground within me and feeling threatened I enacted my countertransference. William taught me that when working with perversions the therapist needs to have a strong sense of identity and

resolved issues regarding self-worth in order to be able to remain as unaffected as possible by to the constant devaluation that therapists are called upon to face.

As it often happens with "difficult" clients (Kantrowitz, 2004), William contributed to my personal and professional development, by throwing light on the question of the nationality of my therapeutic identity and its impact on the therapeutic work and allowed me to consider perversions from an attachment theory perspective which I had never before encountered in literature, thus expanding my research interests. For example, Critchfield Levy Clarkin Kernberg (2008) discussing aggression in the context of borderline personality disorders stress that an association between borderline personality disorder and insecure forms of adult attachment has been repeatedly observed in the empirical literature as well as the links between aggression and insecure attachment and suggest that attachment theory can be used as a framework for understanding and predicting various forms of hostility in personality disorders.

Taking into consideration that William's attachment style was best described as dismissing/avoidant (form of insecure attachment) and his perverse way of relating was characterised by aggression and hostility, it would be interesting for future research to explore whether attachment theory could be used to conceptualise aggression in perversion in a way similar to personality disorders. If this is the case then insights regarding the best ways to approach insecurely attached individuals in therapy could apply to perverse patients thereby minimising the chances of them dropping out of therapy too soon.

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SECTION C: CRITICAL REVIEW

Forty Years of Successful Outcomes or Forty Years of Flawed Research Designs & Potentially Unfounded Hypotheses? A Critical Review on the Pharmacological Treatment of Paraphilias.

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1. Introduction

In the Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (1994), paraphilias are classified among the Sexual and Gender Identity Disorders, which include Sexual Dysfunction, Gender Identity Disorders and Sexual Disorders Not Otherwise Specified. The term paraphilia replaced previous terms such as sexual perversion and deviation on the grounds that those terms carried negative connotations (Arndt, 1991). It is beyond the scope of this short review to explore the implications of this change in terminology and for this reason these are further examined in the thesis. However, it must be stressed that the neutral psychiatric term paraphilia is in accordance with the medical treatment of these disorders, in that these are regarded as behavioural symptoms resulting from biochemical imbalances.

The diagnostic features of paraphilias include intense and recurrent sexual fantasies, urges or behaviours that involve objects, non-consenting children or adults as well as the humiliation and suffering of one's partner or self, which cause significant distress and/ or affect the social occupational and/or personal life of the individual (APA, 1994). Although Money (1984) reported more than 40 different types of paraphilias, DSM-IV offers diagnostic criteria for those paraphilias that tend to occur more often, such as Exhibitionism, Fetishism, Paedophilia, Sexual Masochism, Sexual Sadism, Transvestic Fetishism and Voyerism and classifies all other types under the diagnostic label of Paraphilia Not Otherwise Specified (APA, 1994).

Due to the significant distress that paraphilias can cause to the individual, but more importantly due to the detrimental effect that some of them have on the general population, health professionals have attempted to devise effective treatment methods. These methods include surgery, pharmacotherapy and psychotherapy. The present paper has as its purpose to examine the medical approach to the treatment of paraphilias, and to critically evaluate its epistemological and ethical background, as well as its effectiveness in reducing paraphilic fantasies and behaviours.

2. Surgical Castration

The treatment of paraphilias began early in the 19th century, at a time when paraphilias were considered to be the object of medical science. The first documented case of medical treatment was reported by Sturup (1972, as cited in Cordon, 2008) and involved a man with hypersexuality, who underwent surgical castration in 1892 in Switzerland. Surgical castration continued to be used extensively in several countries until a few decades ago. Indicatively, Harrison (2007) reports that in the Netherlands 400 men, convicted for criminal behaviour related to paraphilias, were castrated from the 1930s until 1969. In an attempt to explain the widespread use of this controversial method Weis (1995) and Willow & Beier (1989), challenging the established view, point to the remarkably low post-castration recidivism rates. In support of their argument, Rosler & Witzum (2000) reviewed the literature and concluded that among a series of 11 studies in countries like Sweden, Germany, Norway, Holland, Switzerland, Denmark and Czechoslovakia, for a total of 3589 men who were surgically castrated, only an average of 2.2% were re-arrested for crimes related to paraphilias. Despite these unquestionably impressive statistics, it appears that there is no consensus in the literature on the issue. For example, Heim (1981) and Gijs & Gooren (1996) provide evidence to the opposite effect.

This dispute however is no longer relevant, as surgical castration has been abandoned in most countries as a medical method of treating people with paraphilias on ethical grounds (Carson, Butcher & Mineka, 2000). Indeed, the so-called treatment appears to be nothing more than a cruel punishment. As Miller (1998) accurately points out, removing a person's genitals is irreversible, meaning that when penalty is paid and the offender resumes his place in society he is left handicapped for life. Nowadays, surgical castration has been replaced with hormonal interventions, also referred to as "chemical castration" and psychopharmacological treatments.

3. Hormonal Interventions

Hormonal interventions are based on our current knowledge and understanding of the male reproductive system. The hypothalamus in the brain is responsible for the secretion of the gonadotropic-releasing hormone (GnRH) which stimulates the anterior pituitary gland to secrete

gonadotropic hormones, the follicle-stimulating hormone (FSH) and the luteinizing hormone (LH). LH is the hormone that controls the production of testosterone which is considered to be the main sex hormone in males, as it is essential for the normal development of genitals, and is believed to be largely responsible for the sex drive (Mader, 1997).

The obvious hypothesis for the treatment of deviant forms of sexuality was that these could be treated with anti-androgens, drugs that either reduce the production of androgens in the testes or inhibit the biological effects of androgens on the brain or genitalia. Gijs & Gooren (1996) propose that according to this hypothesis, one should expect a sharp decrease in sexual arousability and sexual desire when the androgen effects drop below a certain threshold.

Gordon (2008), in a historical review of pharmacological treatments, reports that in the 1940s and 1950s, the hypothesis that anti-androgens could treat men with paraphilias led to the administration of oestrogen to convicted sex offenders diagnosed with paraphilias. The oestrogen treatment, however, was soon abandoned because it had serious side effects, such as thrombosis, heart infarction and gynaecomastia (Lehne & Money, 2000).

Due to its dangerous and feminising side-effects, oestrogen treatment was replaced in the 1960s by medication to reduce testosterone levels (Gordon, 2008). This change, as Bradford & Greenber (1996) explain, was based on a new hypothesis which stated that reduced levels of testosterone would progressively lead to the suppression of sexual desire and fantasies resulting in either a marked decrease, or abolishment of the paraphilic manifestations. Thus, in the second half of the 1960s progesterone medroxyprogesterone acetate or MPA (Depo- Provera) and cyproterone acetate or CPA were developed (Gijs & Gooren, 1996).

3.1 Cyproterone Acetate (CPA)

Experimentation with CPA on animals began in Germany in the 1960s, the drug was first commercially available in 1970 (Murray, 1987) and, as Bradford (2001) reports, CPA is nowadays the most extensively studied anti-androgen in terms of its effects as a treatment for sexual deviation. CPA is in use principally in Europe, Canada and the Middle East, but not in the

USA where it is not approved for the treatment of any type of disorder (Gordon, 2008). CPA antagonises testosterone at the receptor level and reportedly decreases all types of sexual behaviour, including sexual fantasies, deviant sexual behaviour, masturbation, sexual intercourse and erections (Bradford, 2001; Rosler & Witzum 2000; Bradford & Greenberg, 1996). In addition, CPA inhibits the gonadotropic secretion which results in further reduction of testosterone secretion (Gijs & Gooren, 1996).

The first clinical study to test the effects of CPA was conducted by Laschet and Laschet in 1971 (as cited in Hill, Briken, Kraus, Strohm & Berner, 2003) who used CPA predominately for the treatment of exhibitionism, but in their sample (N= 100) they included males presenting with paedophilia and sexual sadism as well. In that study, some participants were administered 100mg of CPA per day for a period of 6 months to 4 years and results demonstrated that for 80% of them there was a significant reduction in sexual drive, erections and orgasms. Other participants who received 300 mg of CPA bi-weekly experienced a complete elimination of all deviant sexual behaviour and, in some cases, these behaviours did not return even after the treatment was discontinued (Bradford, 2001).

The next year Cooper, Ismail, Phanjoo, Love (1972) reported 3 cases of hypersexual men who showed almost complete inhibition of erectile and ejaculatory capacity after 1 week on the drug, which also had a general tranquilizing effect. Fantasy and other psychological response was reduced but not completely suppressed, except for the homosexual case. Despite the impressive initial results, drug effects were reversible when the medication was withdrawn, suggesting that long term effects require continuing administration, or that the effect was the result of the overall reduced anxiety rates.

In 1974 Bancroft, Tennent, Loucas completed a study of 12 sex offenders and found that 100 mg CPA a day reduced the frequency of sexual thoughts and sexual activity and had a weak effect in reducing erectile and subjective responses to erotic stimuli. However, the authors could not exclude the possibility of a placebo effect and it could be argued that it is rather "dangerous" to report successful results based mainly on self-reports.

A significantly more controlled research study was presented by Cooper (1981). Nine participants diagnosed with deviant hypersexuality

participated in a 20-week outpatient trial with CPA. Participants served as their own controls and received placebo, no treatment, or CPA consecutively for 4 weeks in a balanced design. Clinical assessments were made of sexual interest, sexual activity, spontaneous daytime erections, and programmed masturbations on favourite fantasies. Results demonstrated a statistically significant effect for CPA in reducing libido and sexual arousal as compared to the placebo. However, clinical changes were completely reversed within 30 days. These results appear to offer support to the hypothesis that CPA tends to have a rather holding effect.

Continuing the efforts for valid results, but reporting opposite findings to those of Cooper (1981), Bradford & Pawlak (1993) designed a double-blind crossover study in which 19 subjects participated, all of whom met DSM-III-R criteria for paedophilia. CPA was administered orally in 3-month active-treatment phases alternating with 3-month placebo phases. Self-reported urges of sexual arousal, sexual fantasies and masturbation were all reduced during the active phase but when compared with the placebo phase there were not statistically significant differences.

In a rather scarce article on the treatment of females with paraphilias, Nadal & Algulandern (1993) treated a 49 year old female patient, who was suffering from dementia and presented with hypersexuality, with CPA for 5 months and reported that all symptoms of deviant sexuality were eliminated. Despite their effort to generalise the results by researching CPA effects on a female patient, the fact that they presented a case study in which the patient suffered from a disabling condition, made Nadal & Algulander (1993) study an interesting but rather weak addition to the literature. A similar criticism could apply to Volpe & Tavares (2000) study, in which the case of a man diagnosed with Wilson's disease who also presented with hypersexuality was presented. The patient was treated with 100mg of CPA daily for 4 weeks, at which point his sexual behaviour was significantly improved.

In reviewing 10 published studies on CPA and paraphilias with a total of 127 patients, Meyer & Cole (1997) reported that recidivism rates on therapy ranged from 0 to 33%. Despite the apparently "positive results" reported in the literature, CPA has certain disadvantages and considerable side effects (Hill et al., 2003). Feminisation, with its major symptom being gynecomastia, develops in up to 20% of treated patients, whereas other

symptoms include reduced growth of pubic and facial hair generalised weakness, weight gain, thrombosis, depression, and hepatocellular damage (Rosler & Witzum 2000; Gijs & Gooren 1996). If therapy is stopped the effects of CPA are reversible within one to two months, which indicates that CPA should be administered for life if it is to be effective in suppressing paraphilias. However, such long term administration of CPA has been associated with the development of osteoporosis (Gooren, Lips & Gijs, 2001).

In a critical review of the literature Gijs & Gooren (1996) and Rosler & Witzum (2000) later on, point to the weak validity of most CPA research. Indeed, most studies on the effects of CPA on paraphilic behaviour are either totally uncontrolled, or have subjects serving as their own control, comprise of a small and often heterogeneous sample or are single case studies. In addition, those controlled studies which could be regarded as useful for analysis do not include significant follow–up observations. It appears therefore, that the so called effective CPA treatment is based on either flawed or less robust research.

3.2 Medroxyprogesterone Acetate (MPA)

MPA inhibits the secretion of gonadotropin hormones which results in a marked reduction of testosterone secretion (Rosler & Witzum, 2000). The dosage of MPA administered through intramuscular injections varies between 100 to 1,000 mg per week with the most usual dosage being 300-500 mg per week (Lehne & Money, 2000; Gijs & Gooren, 1996). MPA is administered either orally in the form of pills (Provera) or by intramuscular injections (Depo-Provera) for a long-acting effect (Murray, 1987)

MPA was first used by Money in 1966 (Lehne & Money, 2000) for the treatment of a male cross-dresser, and this first case is paradoxically cited in the literature as a successful treatment (eg. Rosler & Witzum, 2000), and has sparked a series of other studies. In 2000, Lehne and Money published a review of the "successful" case along with the treatment protocol that was followed to further support the usefulness of MPA.

In this review, Jack's traumatic childhood is presented, a childhood which involved him being frequently exposed to his mother's sexual activity with other men, being dressed like a girl as a punishment from the age of 5,

being seduced by an older adult to engage in sexual activities at the age 11 and being involved in homosexual prostitution between 14-17. He reported that from the age of 10 years old and onwards he was cross-dressing to obtain sexual arousal. He got married at 21, but despite his satisfying sexual life with his wife, he continued cross-dressing. When his son was 6 years old he started dressing him as a girl and secretly went to his room at nights to masturbate his son or perform fellatio on him. Jack's treatment with MPA began when his wife decided to contact the police and he was forced to follow the treatment. During the first year of treatment, Jack reported no interest in cross dressing and no attraction to his son. However, nine months after discontinuing treatment he began masturbating excessively and reported an empty feeling inside which pushed him towards cross-dressing. He was given two more injections of MPA and then he stopped treatment reporting that he was feeling better. Three years later he resumed cross-dressing, and a year later he molested his son. After this incident he agreed to resume MPA treatment, but after three months of compliance he started missing appointments. For the next 7 years (ages 38-45) he reported having little interest in sex, cross-dressing or masturbation, although he experienced some dreams and flashbacks of cross-dressing. At the age of 46 Jack reported a change in his paraphilic behaviour, which began with an increase in cross-dressing and homosexual lovemaking which were soon transformed to infantilism. With the consent of his wife, his fantasies of him being an adult baby became part of his real life, as he transformed a spare bedroom in their home to a kid's bedroom, where he engaged in adult baby activities until the age of 65, when we have the last report from his life.

Although it is evident from the review that Jack was never "cured" from his paraphilia and that he relapsed often, Lehne & Money (2000) report his case as a success and present MPA to be highly effective. As Jack's early and later experiences clearly show, he was a heavily traumatised child who grew up to be an adult who was confused as regards his sexuality and a rather lonely man unable to reach true intimacy in his relationships. Based on his horrible story, and on the repeated failures to control his paraphilic behaviour with MPA, it could be argued that Jack should have been referred to psychotherapy in order to explore his sexuality and relational issues in depth, rather than having been left alone to fight his

demons with MPA. Inspired, however, by Jack's "successful" treatment, other researchers experimented with MPA in the treatment of paraphilias reporting successful suppression of paraphilic behaviour and fantasy.

Gagne (1981) treated 48 sexually deviant males with MPA, 40 of whom which showed a positive response to treatment with 33 noting changes within the first 10 days and 7 others within the first 3 weeks of treatment. All of the patients reported some reduction in sexual fantasy and arousal, and a subjective sense of relief. Sexual urges were also reduced as was sexual activity, particularly masturbation. However, most participants reported significant side effects including fatigue, weight gain of up to 19 kg, hot and cold flushes, headaches, nausea, insomnia, and one case of deep vein thrombosis.

The same year, Berlin and Meinecke (1981) reported on a follow-up study of 20 patients treated with MPA. Three of the participants relapsed to sexually deviant behaviour while they were on MPA, whereas 10 of them relapsed after stopping treatment prematurely. In contrast to these findings, Cordoba and Chapel (1983) reported a successful MPA treatment and 18 months' follow up of a hypersexual paedophile. Equally successful results for the treatment of paedophilia, were reported by Wincze, Bansal, and Malamud (1986) who used a slightly more controlled methodology in the treatment of three paedophiles. Following a double blind experimental design, which involved the administration of either MPA or a placebo, the researchers found that MPA was significantly more successful in reducing paraphilic behaviour than the placebo.

Meyer, Collier, and Emory (1992), in an interesting study that attempted to compare pharmacological treatment with MPA with psychotherapy, studied the effects of MPA medication on 40 patients, most of whom were paedophiles, who were receiving group and individual psychotherapy. Twenty one participants who refused to be treated with MPA served as control. Results demonstrated that 18% of patients relapsed while they were on MPA and re-offended, whereas 35% relapsed after treatment was discontinued. Of those who served as control and received only psychotherapy 55% relapsed, making the difference between the two treatments less significant. The authors reported side effects like weight gain, fatigue, depression, hot and cold flushes, elevated blood glucose,

nausea, gynaecomastia, and reduction of spermatogenesis. Although this study does not prove that psychotherapy is better than pharmacotherapy with MPA, it casts doubts on the efficacy of MPA.

Gottesman and Schubert (1993) used low dose oral MPA in the treatment of a variety of paraphilias. The dosage level was 60 mg a day for about 15 months in an open trial of seven subjects. There was a reduction in paraphilic fantasies with the percentage of time spent preoccupied with deviant sexual fantasies dropping between 45% and 100% in the various patients. In terms of paraphilic behaviour the authors reported that all paraphilic behaviour ceased.

Because of the high percentage of patients who develop side effects, the use of this drug has been limited. Therefore, in an attempt to minimise side effects, the current approach has been to progressively reduce the effective dose of MPA, thus resulting in partial control of the paraphilic manifestations (Rosler & Witzum, 2000). However, the recidivism rate on MPA therapy is even greater than with CPA therapy. In a recent review that summarised 334 patients from 11 studies recidivism during MPA treatment ranged from 3 to 83%, with a mean of 27% (Gijs & Gooren, 1996).

The use of MPA in sexual offenders has given rise to much controversy with regard to the ethical aspects of its use and the severe complications from treatment, which have resulted in an increased frequency of patients' damage and malpractice lawsuits against their therapists (Rosler & Witzum, 2000). Miller (1998) reviewed the ethical and legal debate that surrounds the use of MPA in the treatment of paraphilias and concluded that the issues most frequently discussed involve the nature of punishment, informed consent, the right to privacy and reproductive freedom.

With respect to whether chemical castration is a cruel punishment or not Miller (1998) presents the views of authors like Peters (1997), Melella (1989) and Rainear (1984) who argue that when used appropriately, MPA is not a punishment and as such is not cruel. Miller (1998) contrasts this view with the opinions of other authors like Demsky (1984) and Vanderzyl (1994) who point to the detrimental side effects that come with long term administration of MPA and argue that these constitute cruel punishment. Indeed when one reviews the literature and puts in perspective the so called

successful MPA treatments, then it seems that the severity of the side effects appears to outweigh the minimal benefits that MPA tends to have and therefore this treatment feels like punishment.

Marco & Marco (1980, as cited in Miller 1998) argued that MPA treatment is intrusive and offenders cannot really give their consent freely when their other alternative is prison and Green (1986, as cited in Miller, 1980) questioned the extent to which offenders are fully informed about the side effects. Both these considerations seem quite important. Indeed few sex offenders would refuse treatment even knowing the full side effects, when they know that their compliance with treatment will be rewarded with less or no time in prison. This compliance however is forced and as such it does not constitute an internal genuine motivation for those people to change and this could explain relapse to previous condition upon the termination of MPA administration.

Miller (1989) approaches the ethics of the particular pharmacological treatment from the perspective of the right to privacy. The debate here is even more difficult to resolve as authors like Fitzerald (1990) and Rainear (1984 as cited in Miller, 1998) argue that the state's obligation is to protect its citizens and this is more important that the privacy of offenders with paraphilias. This view appears to be significantly narrowed minded. Those lists of "rehabilitated" and therefore safe for the society ex-offenders are hugely controversial, for if society had faith in the rehabilitation it offered then there would be no reason for the public to know the history of those individuals. Indeed those lists that are available to the public interfere with the right to privacy, marginalise people and force them to with a label that affects their lives forever.

Moving on to evaluate the effectiveness of CPA and MPA, both drugs produce side effects that render their use controversial particularly when one considers the relative success they have in suppressing (not treating) paraphilias. Indeed, most studies show that when individuals are on CPA and MPA they experience a dramatic reduction in sexual interest and paraphilic behaviour, but at the cost of severe side effects which affect not only their long term health but also their gender identity by means of feminisation. In addition, the fact that many individuals return to their previous paraphilic behaviour after the termination of treatment suggests

that these androgens are relatively effective in maintaining people with paraphilias in a rather asexual state, rather than actually treating the condition.

It appears extremely difficult to find evidence against the effectiveness of CPA and MPA in the literature, mainly because authors prefer to publish "successful" outcomes rather than unsuccessful ones. It is only when one examines the literature on other medication that failed treatments with CPA and MPA come to light. For example, Dickey (1992) turned to LHRH agonists to treat a male who presented with exhibitionism, because after 32 months on MPA and 14 months on CPA there was no change in his sexual behaviour at all. Similarly, in 1994 Cooper and Cernovsky (as cited in Rosler & Witzum, 2000) reported the case of a man with exhibitionistic tendencies who was successfully treated with LHRH agonists after he failed to respond to MPA and CPA.

The fact that some individuals appear to respond to treatment with MPA and CPA whereas others do not, should be a cause for concern for researchers. For ethical reasons (e.g. it would be unethical to refuse treatment) most studies are either uncontrolled, or use participants themselves as controls. As a consequence, results can never prove, experimentally speaking, with absolute certainty that the observed change in sexual behaviour is due to the effect of the particular drugs and exclude the presence of confounding variables. These confounding variables (e.g. age, typed of paraphilia, personal history, period of presenting the particular paraphilia) could account for failures of treatment reported by others.

Another vulnerability of the studies published on the effectiveness of MPA and CPA in the treatment of paraphilias is the measures used to test their effectiveness. For example, measures such as sexual fantasies, frequency of masturbation, sexual urges and interest in paraphilic behaviour are all based on self-reports which minimise their validity (Grossman, 1985). Participants in many of these studies were sex-offenders, and it could be argued that they had an interest in presenting positive outcomes since their term in prison would be reduced. Although I do not wish to imply that all of the participants lie, I would like to point out that self-reports when combined with high motivation to present particular results, are not necessarily valid measurements. Again, reported successful treatments

based on self reports could explain why some patients fail to respond to treatment and why many patients relapse should treatment be discontinued. Having discussed the treatment of paraphilias with MPA and CPA, I will now turn to another kind of pharmacological treatment which is used when MPA and CPA fail.

3.3 Luteinizing hormone-releasing hormone (LHRH) agonists.

LHRH are synthetic agonists of the hormone decapeptide GnRH, and when present in the bloodstream they reduce the production of gonadotropin hormones. As a result, testosterone secretion is significantly reduced (Hill et al., 2003).

Rousseau, Couture, Dupont, LaBrie & Couture (1990) experimented with flutamide in treating a 35-year old exhibitionist. After 4 weeks of treatment the frequency of exhibitionism dropped by 100% and masturbation by 75%. The frequency of sexual intercourse did not change. After 10 weeks the frequency of paraphilic fantasies dropped from 20 to 2 times a week. Despite these positive outcomes, approximately two weeks after completing treatment of about 25 weeks, the patient relapsed into his former pattern of behaviour. During the 6- month follow up he exposed himself and masturbated very frequently.

Dickey (1992) reported on the treatment with the LHRH agonist leuprolide of a 28 year old man who exhibited himself, masturbated and engaged in telephone scatophilia with 11 to 15 year old girls. The author turned to the administration of LHRH agonists when, after 46 months of treatment with MPA and CPA, his patient failed to demonstrate any improvement. Dickey (1992) reported that a month of treatment on leuprolide terminated the deviant sexual behaviour and reduced frequency of masturbation to twice a week. Despite this report of successful treatment, the content of the man's sexual fantasies remained the same, whereas no follow up evidence was provided to document the long term effects of leuprolide treatment on the patient's paraphilic behaviour.

Thibaut, Cordier & Kuhn (1993) combined the LHRH agonist triptorelin with CPA to treat 6 individuals diagnosed with paraphilia. Treatment duration ranged from 7 to 36 months and was combined with psychotherapy. The authors reported reduction in the frequency of sexual

desire and cessation of all paraphilic behaviour and for a follow up period of 7 months to 3 years paraphilic behaviour remained significantly decreased. In addition, patients experienced only minor side effects like hot flushes and weakness. Unfortunately, it is difficult to evaluate this study, for it is impossible to discriminate whether the effects on behaviour were the result of triptorelin, CPA, or psychotherapy or some combination of these variables. Added to this experimental shortcoming is the small size of sample that does not allow for results to be generalised and the fact that there was no control group.

Similar methodological limitations are found in Brinken's, Nika's & Berner's (2001) study. They used the LHRH leuprolide to treat 11 patients between the ages of 19 and 57 years diagnosed with sadism, paedophilia and impulsive control disorder, who had previously failed to respond to treatment with CPA and SSRI's. In addition to medication, the patients received supportive psychotherapy. The authors reported an overall reduction in paraphilic activities with decreases in frequency of erections, ejaculations, masturbations and paraphilic fantasies. The major side effects were depression, with one patient committing suicide, and weight gain. Although, the Brinken Nika & Berner (2001) study is published as a successful treatment with LHRH, a closer look at their study reveals sampling and methodological limitations, which reduce the validity of their results. The sample was too heterogeneous with patients being diagnosed not only with paraphilias but also with borderline personality disorder and mental retardation (N=5). No details are given about the frequency, duration and modality of psychotherapy, making it difficult to assess the effect of such an important factor in the overall outcome. Last but not least, leuprolide was not the only drug used, as there was a period during which patients were also given CPA and continued their previous medication.

Although the above cited studies reported minor side effects, Rosler & Witzum (2000) draw attention to the side effects of prolonged treatment with LHRH agonists and particularly with triprorelin. They report that males older than 30 years of age tend to exhibit hypogonadism with erectile failure, decrease in testicular volume and body hair and reduction in normal sexuality. Reilly, Delva & Hudson (2000) point to cardiovascular side

effects, like heart failure, changes in blood pressure, phlebitis and thrombosis, associated with the administration of leuprolide

In reviewing the literature on LHRH agonists Rosler & Witzum, (2000) and Gijs & Gooren, (1996) mark the potential positive outcomes of these agents in controlling paraphilias, but they also call for more controlled and larger studies. Indeed, more research is required before we are able to comment on the effectiveness or otherwise of these agents and there is a need for "pure" studies, that is studies in which LHRH is used as sole treatment, to make it possible to obtain valid results.

4. Psychotropic Medication & Selective Reuptake Inhibitors (SSRIs)

The application of psychotropic medication in the treatment of paraphilias began accidentally in 1988 when Fedoroff (as cited in Gijs & Gooren, 1996) treated a 40 year old man diagnosed with generalised anxiety disorder and alcohol dependence who also reported transvestic fetishism with a combination of antidepressants, anxiolytics and psychotherapy. On the 9th day of treatment the patient surprisingly reported a reduction in the urge to cross-dress and 3 weeks later admitted that he had stopped cross-dressing completely.

The same year Cesnik & Coleman (1989) reported on the case of a 26 year old single man who presented with symptoms of depression, difficulty in developing intimate relationships and compulsive autoerotic asphyxiation. The patient had constructed a whole ritual which involved, among other behaviours, putting plastic bags over his head, surgical gloves for his hands and wearing a diving suit to further bind his body. The patient was the youngest of 7 children, grew up without any contact with his father, and his mother used to tell him that she did not love him and wished she had never had him. In addition, one of his brothers physically abused him by, amongst other things, repeatedly restraining him while holding a pillow over his face and at times tickling him until he was unable to catch his breath. He recalled that as a child he was punished by his mother for masturbating and that he had developed a special relationship with a raincoat whose texture felt pleasurable against his skin. In adolescence he dated a girl and tended to fantasise about an idealised marriage but he did not pursue any sexual relationship with her. His first sexual contact was in

the context of an abusive relationship in which he was seduced by an older man. During his college years, and as a result of counselling he had numerous satisfying homosexual sexual experiences, but remained distrustful of people and his engagement in intimate relationships remained "limited, confusing, exciting, passive… fearful…autoerotic and masochistic" (p.280).

Cesnik & Coleman (1989) reported that their decision to treat this patient with medication was based on the fact that soon after he was removed from one to one psychodynamic psychotherapy and was transferred to group therapy, he experienced tremendous anxiety which increased his autoerotic asphyxiation ritual and the authors feared that he was endangering himself. Unfortunately, the authors fail to report why the patient was removed from individual therapy and what the effect of this termination was on the patient. The importance of a safe and constant therapeutic frame is widely acknowledged to be an important factor in successful therapy and any changes in it can easily destabilise a tormented patient (Valerio, 2004). In addition, the authors do not report on the anxiety inherent in any group situation, where one is asked to form multiple relationships simultaneously. Glasser (1976 as cited in Morgan & Ruszxzynski, 2007) points to a core complex present in people with perversion which makes them yearn for close relationships, but when they find themselves in these, they feel threatened and experience tremendous annihilation anxiety. Any type of psychotherapy is about relating to another human being, which means that in any kind of therapy a patient with paraphilias will face the tremendous anxiety of relating and his behaviour will be exacerbated for some time. Interrupting this process with medication appears to be not only an intrusion in the safe therapeutic setting, but also a way of encouraging the individual to continue being detached from his feelings. It could be argued, therefore, that the decision to place the patient in group therapy was either premature or altogether wrong. In addition, one wonders whether the decision of the authors to place the patient on medication was the result of them responding anxiously to their patient's anxiety. Once the decision was made the patient was treated with lithium carbonate to control his cyclical mood disturbances as well. Within 24 hours the patient experienced a dramatic change in his feelings

and felt no further compulsion to engage in his paraphilic ritual. He felt asexual and much less anxious. As the authors correctly suggest this was a placebo effect which allowed the patient to participate in group therapy. Nevertheless, one wonders, whether the patient engaged with the group emotionally or was just present forming safe intellectual relationships. This group therapy was unfortunately time limited, ended after 4 months and the patient was asked to join another group, but once more the change increased his anxiety and once more he dealt with it by engaging in paraphilic compulsive behaviour. Although it is not mentioned in their article, the patient's reaction suggests that the 4 month lithium treatment had no effect other than reducing his anxiety levels, and certainly had no effect on treating his paraphilic behaviour. Despite this apparent observation, once more Cesnik & Coleman (1989) dealt with their patient's increased anxiety and paraphilic behaviour by increasing the lithium dose. Once more the patient reported feeling better and his lithium treatment continued for an unspecified period during which he reported significant decrease in paraphilic rituals. The authors conclude that their case is one that supports the successful effects of lithium carbonate in alleviating autoerotic asphyxiation, but clearly this is an overstatement. It is difficult to determine which variable (one to one therapy, group therapy, medication) had an effect on limiting his destructive behaviour or how these variables interacted to bring him to a state of masturbating alone. Although, it appears that autoerotic asphyxiation was replaced by masturbation, nothing is mentioned regarding this patient's capacity to engage in meaningful intimate relationships. Therefore, one can only assume that the decrease in paraphilic behaviour was the result of reduced anxiety. Moreover, as no follow up evidence is provided one cannot determine whether there was any long lasting effect on the patient's paraphilic behaviour.

In recent years there has been a revival in the use of these drugs for paraphilias, especially the newly developed classes of psychotropic medications and more particularly SSRIs (Rosler & Witzum, 2000). The hypothesis underlying the use of SSRIs in the treatment of paraphilias is that these result from a regulatory dysfunction of sexuality in the cerebellum which is caused by a serotonin disorder. When too much serotonin is re-absorbed in the synapse, then the synaptic transmission of serotonin is too

low resulting in increased dopamine levels which in turn are hypothesised to result in an increase in deviant sexual interest and an increase in the frequency of sexual desire and behaviour (Gigs & Gooren, 1996). This hypothesis is partly based on evidence that serotonin inhibits sexual arousal and reduces orgasmic and ejaculatory capacity, but no link has yet been established between serotonin dysfunction and paraphilias (Hill, et. al, 2003).

Initially there were a few case reports and anecdotal studies indicating ``successful results'' using SSRIs (Rosler & Witzum, 2000), but these studies as Gijs & Gooren (1996) report were "uncontrolled, had poor methodological design and included no follow up evidence". For example, in 1990 Bianchi (as cited in Bradford & Greenberg, 1996) reported on the use of fluoexetine in the treatment of an exhibitionist and provided two months' follow up evidence during which the patient did not experience any urge to exhibit himself. A year later, in 1991 Perilstein, Lipper & Friedman (as cited in Bradford & Greenberg, 1996) successfully treated a patient with paedophilia pedophilia, voyeurism and exhibitionism using fluoxetine. Based on these initial positive outcomes, researchers began to consider the role of the serotonergic system in the regulation of paraphilic manifestations.

For example Kafka & Prentky (1992) reported on 24 men with paraphilias who were treated with sertraline (mean dose, 100 mg/day). Clinically significant improvement was reported in approximately one-half of the men who complied with at least 4 weeks of sertraline pharmacotherapy. Nine men who failed to respond to sertraline were subsequently given fluoxetine. This drug (mean dose, 50 mg/day; mean duration, 30 weeks) produced a beneficial effect in six additional men. Overall, 17 of the 24 men (70.8%) who received pharmacological treatment with sertraline and/or fluoxetine for at least 4 weeks showed a significant clinical effect, at times lasting more than 1 year.

Bradford and his colleagues (as cited in Bradford, 1996) conducted a 12 week study with 18 paedophiles, 23% of whom presented with concurrent depression and 14% with dysthymic disorder. Patients were given up to 200mg of setraline daily and they were asked to complete self-report scales and participate in penile plethysmography tests. Self-reports

revealed decreases in sexual fantasies, paedophilic interest (57%) and masturbation with paedophilic fantasies whereas penile tumescence testing demonstrated that paedophilic arousal was decreased by 53%. In addition to the authors' acknowledgement that the study lacks validity as there was no control group, it could be argued that self-reports cannot be considered valid methods of measurement.

In 2001 Strohm & Berner (as cited in Hill et al., 2003) presented a paper at Munich Autumn Conference for Forensic Psychiatry on the treatment of 16 males diagnosed with paraphilias (8 paedophilia, 4 sadomasochism, 3 exhibitionism, 2 fetishism, 1 paraphilias related disorder) and other psychiatric disorders, such as depression, personality disorders, psychosis etc. Patients were treated for an average of 23 months with SSRIs and received either supportive or more intensive psychotherapy. The authors reported that there was a marked reduction in paraphilic fantasies and masturbation, but unfortunately the observed effects cannot be attributed clearly to the effects of medication. In addition, the fact that all participants were diagnosed with additional mental disorders makes it more difficult to differentiate which is the primary disorder and on which disorder the medication had an effect.

In reviewing the literature on the use of SSRI's in the treatment of paraphilias, one is faced with the same methodological problems (Rosler & Witzum, 2000; Gijs & Gooren, 1996) that are obvious in the studies with CPA, MPA and LHRH. In her 1985 paper, Grossman criticise research in this field and points to problems with sampling techniques and sample sizes, reliability and validity of instruments, lack of control groups and lack of longitudinal designs. Twenty four years later, as becomes evident from all of the studies reviewed in this paper, these issues have not been resolved. On the basis of these limitations therefore, any statements regarding the effectiveness of CPA MPA and SSRI's should be made with caution.

5. Epilogue

The treatment of paraphilias with medication appears to be the result of the that school of thought that tends to consider these conditions to be the result of biological and/or biochemical abnormalities in the brain. The underlying hypothesis is that if testosterone, LHRH hormones or serotonin is controlled

then the paraphilic behaviour will be reduced. Although the hypothesis sounds rational, no evidence exists up to date to link the presence of paraphilic behaviour with either testosterone, hormonal or serotonin abnormalities (Rosler & Witzum, 2000; Gijs & Gooren 1996; Hill et al. 2003). This is consistent with the "holding effect" all medical treatments appear to have on paraphilias which in turn seems to be the result of an effect on the overall sexual functioning of individuals. It is not farfetched therefore, to question the validity of this hypothesis and wonder how a clearly relational issue, as sexual behaviour is, can be reduced to a biological phenomenon.

The traumatic childhood experiences of people who present with paraphilias reveal the way early relationships with significant others form the basis for future relating. Considering sexual behaviour as having a pure biological basis and excluding the relational factor, seems to be an idea that colludes with paraphilics' difficulty in relating to sexual partners as whole human beings and on any other level other than the somatic. Therefore, the medical treatment that results from such a frame of mind continues to place emphasis on the idea that something "is wrong" in them, rather on the fact that something "is wrong" in the way these people related to themselves and others

In reviewing the literature, one is left with the impression that a norm of medical treatment has been established despite the questionable assumptions underlying this an approach, the alarming ethical considerations and the significant lack of methodologically robust and valid experimental studies. On such shaky grounds treatment protocols have been devised (Reilly, Delva, & Hudson, 2000) which advise which medication and at what dosage is appropriate depending on whether the patient falls into abstract categories such as mild moderate and severe paraphilia (Hill et al., 2003) The Algorithm for the Pharmacological Treatment of Paraphilias as it is called appears to be an attempt to create an "one size fits all" universal approach to the treatment of conditions that tend to be highly diverse, focusing on suppressing sexuality, when it is a well known fact that paraphilias and related sex crimes are usually motivate by issues relating to anger, power and fear of intimacy, rather than sexual desires per se (Farkas & Stichman, 2002).

The above mentioned case studies and other published case studies stand as proof of the fact that there is nothing biologically "wrong" with people with paraphilias in terms of sexuality, but there is something "wrong" in terms of relating, one aspect of which is the sexual act. Hill et al. (2003) argue that we are far away from discovering an agent that would selectively reduce deviant sexuality leaving non-deviant sexuality intact and would produce no adverse side effects. Perhaps we will keep being far away from discovering such medication for the treatment of paraphilias, because the direction we are heading in is not the right one.

Behind each person with paraphilic behaviour, there is a traumatised individual with severe attachment failures in his early childhood and shattered and/or distorted relationships with significant others, who experiences tremendous emptiness inside and yearns for a meaningful relationship. This close relationship however is at the same time the trigger of fears of annihilation which cause severe anxiety. The solution to this intolerable dilemma is perversion, a way of relating that permits some kind of contact with the other but in a highly controlled way that keeps the individual safe. When one views the person behind the behaviour, it becomes evident that the only way to help these people is by offering a reparative relationship which can only be achieved through psychotherapy. The reality of the traumatic histories of these individuals makes the point self-evident, yet our society, including the medical profession and the judicial system, avoid acknowledging this and in a similar perverse way they attempt, in the name of justice and treatment, to control those people's behaviour with medication no matter the cost. It appears that the medical profession, with its emphasis on bodily interventions and despite the controversial research findings, maintains the delusion that paraphilias can be treated on a biological level This "delusion" however colludes with the way individuals with paraphilias delude themselves each time they attempt to deal with the internal conflicts and the dilemmas of relating through their sexual behaviour strictly on a bodily level. After 40 years of research on the pharmacological treatment of paraphilias it should have been clear that paraphilias cannot be treated with pharmacological interventions, for these are far more complex relational disorders that cannot be reduced to the effects of hormones.

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