SEX AT THE MARGINS:
What "Perverse" Sexualities Can Teach Us about Being Alive

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…Because I am no longer a covert enemy of my patients and informants, I can let them open themselves up to the search for an understanding of the origins and dynamics of their erotic practices, And with that flood of new information, I can enjoy giving up previous positions and no longer burn with the fevers of righteousness. (Stoller, 1991b, p. 48)

"Hey, Dad, let's go to the movies"

It was nearly ten years ago that my son, then 15, asked me to see with him a documentary film, "Sick," about the life of Bob Flanagan. He had seen a music video for Nine Inch Nails in which Flanagan played a prominent role and had followed up to learn more about Flanagan on the internet. I agreed, having no idea what I was getting myself (or my son) into. I had heard something of Bob Flanagan as a performance artist with a sadomasochistic bent. I knew my son was busy exploring some of the nastier sides of human nature, this seemed to fit the bill, and so off we went. The movie, the full title being "Sick: the Life and Death of Bob Flanagan Super-Masochist" (Dick, 1998), was in fact made by Flanagan before his death at 43 to cystic fibrosis and completed by Sheree Rose, his long time dominatrix and life partner. In many ways the movie was as much about living in a disabling and terminally ill body as it was about sado-masochism. I was shocked by what began to unfold, remembering the experience now almost as fragments of a dream. There were explicit scenes of Flanagan impaling his body, and his genitals in particular, with clothes pins, needles, and nails. He nailed his penis to a board. Yes, he did, and I am

watching this with my 15 year old son. There were graphic scenes of sadomasochistic enactments with his dominatrix partner, Sheree. I am sitting here with my adolescent son! There were interviews with Flanagan's family members, his reflections of how his masochistic patterns began to develop in childhood, scenes of him singing campfire songs at summer camp for children with cystic fibrosis, films of his performance art pieces which all involved his torturing his naked body in some way before live audiences, and comic self-commentaries. He talked with great insight and compassion about his ill body and the evolution of his masochistic relationship to his body as he struggled to master his illness and the pain inflicted by the medical treatments. I was horrified, entranced, disgusted, disorganized, and deeply moved.

I was trying to imagine what my son was thinking and feeling. How were we going to talk about this afterward? Should I get him out before the film was finished? Get myself out? Enough already! Over the course of the film, Flanagan's impending death was a constant presence. It became clear that even his death was going to be recorded for this documentary. Death to cystic fibrosis is truly horrendous. It was almost more than I could bear, worse than the scenes of masochism and domination. His vulnerability and that of Sheree Rose was portrayed as nakedly as Flanagan's body. By the end, I was filled with tenderness, compassion and respect for Flanagan. I left deeply disturbed and introspective.

As my son and I talked on the way home, it was clear that he, too, had been deeply affected by the movie, though to my surprise (and relief) it was not by the sex. He had expected a movie *about* Flanagan, not one *by* him, something with the self-parodying distance of a music video or horror movie. My son was moved by Flanagan's defiance of death and the scenes of his working with kids in the cystic fibrosis camps.

As a Reichian trained, body-centered psychotherapist, I have had a long-standing interest in the centrality of affective and sensorimotor organization in developmental processes, the place of the body in psychotherapy, and the multiple functions of sexuality. I had thought of sexual perversion in the ways that seemed part of the common wisdom, i.e., defensive strategies to ritualize sexuality, so as to make it more predictable, manage excitement, control the other and depersonalize the intimate potential of sexual relations. My understanding of masochism in particular was grounded in Reich's (1949) character theory and his analysis of the masochistic character. I had found Reich's perspective on masochism clinically wise and useful.

Reich's understanding of masochism was fundamentally relational, emphasizing the defensive compromises that maintained some means of contact with others based on patterns of submission so as to preserve a relationship, warding off the threat of outright abandonment or humiliation and punishment. Reich made it clear that the etiology of masochism was in the actual mistreatment of the infant and young child, the humiliation and punishment of the child's spontaneous love and aggression. Reich's observations were repeatedly confirmed in my work with clients who had variations of masochistic character styles. Reich emphasized the subduing of aggressive impulses into the capacity to endure, and the transformation of passionate and sexual love into submissive loyalty (though he also stressed that this loyalty contained demands of its own upon others) as fundamental to masochism. He observed:

> There is always some kind of wish for activity at the skin or at least phantasies of it: to be pinched, brushed, whipped, fettered, to make the skin bleed, etc. …All these wishes have in common that the patient wishes to feel the *warmth of the skin*, not pain. (p.227, italics in the original)

But what I saw in “Sick,” was a masochism *perversion* quite different from the characterological defenses Reich described. Flanagan’s parents were clearly overwhelmed with the care of three children with cystic fibrosis, but deeply committed to the well being of their children. In an interview discussing his family and childhood, Flanagan (1993) said:

> I was a good student, never did anything wrong in school and didn’t give my parents any trouble (except by being sick a lot). I was the oldest, so I was ‘in charge of the house.’ I did a lot of cleaning, I cooked dinner, and took care of the rest of the kids. My parents could depend on me from a really early age, because they both worked two jobs. So while I was doing all these weird things, I was also the one in charge. (p.17)

I realized that Flanagan’s masochistic perversion was anchored much more in relation to his own body, it’s illness and frailty, than to the management of relationships. In Flanagan’s words:

> My mother said that when I was a baby and really sick in the hospital, they had to stick needles in my chest to draw fluid out. …the doctors tied my hands and feet to the bed so I wouldn’t hurt myself. And it’s still one of my favorite positions to be in: flat on the bed, tied up. Because of my early, really horrible stomach-aches, I would rub against the sheets and the pillows to soothe my stomach and this became more and more erotic--I started to masturbate this way; slowly it all blended together. (p.12)
>
> I didn’t even relate my secret activities to sex or pornography; if I were caught I thought people would think I was crazy more than some kind of sex fiend. (p.19)

It was not so much the integrity of parental and love relations that seemed at risk (he had both), but it was the integrity and viability of his body that seemed the object of his masochist patterns. I knew there was something fundamental for

me to learn about the relationship between sexuality, even in its most bizarre and disturbing expressions, and the effort to maintain the integrity of one's body. I began to read, and I began to listen to my clients differently (and fortunately I had the skills of my body-centered training to inquiry intelligently about what went in the bodies of some of my clients).

It is important to note that I am writing about sexual patterns that, while possibly being transgressive in manifestation, are *consensual*. Some authors (Verhaeghe and McDougall among them) include pedophilia, rape and other violent sexual acts as examples of perversion. I do not. I understand nonconsensual, sexual violence perpetrated upon an unwilling victim to be psychopathic acts, intended solely to assert control and derive pleasure and arousal from the imposition of pain, helplessness, and humiliation upon another. The psychopathic sex act is a vehicle for an ultimate violation of the other, and the underlying characterological anchors are fundamentally different than in perversion.

Questioning Normality

In attempting to understand those of my analysands who constantly flee imaginative life, consuming every second in action, I have come to refer to them as "normopaths"… Borrowing Stoller's metaphor regarding the ambiguous nature of the near-perverse, we might say that the normopath does ***everything*** *in the missionary position. (McDougall, 1991, pp.183-184; emphasis in the original)*

From the beginnings of her writings, McDougall (1978/1992) has issued a **Plea for a Measure of Abnormality**, arguing that the unquestioned judgments of deviancy blinds therapists to the examination of the pathologies of normalcy. McDougall argues that perversions are an effort to ensure the psychic and bodily survival of the inidividual. Perversion, seeming to celebrate not only sexuality but trangression, makes many people, psychotherapists included (or perhaps most of all) squeamish, maybe a bit envious. Perversion is an easy target for judgment and pathologizing, as McDougall bitingly observes:

> When an analyst, or any other individual, proclaims that this or that theory, practice, or person is "perverse," he may in fact be saying: "Don't look at me, the very model of normality, but cast your eyes over there." The pervert is always someone else! (1991, p.188)

How often do we examine the health of normality? An open-minded inquiry into the multi-layered meanings of perversions brings us up against our beliefs about, and investments in, the normal. Schwartz challenges the rooting of normative theories of sexuality in the conventions of developmental models. He argues that such models are "myths of origin for the modern age, the age of science and the idealization of scientific discovery," providing "sciencelike paradigms of the sources of disturbance, psychopathology, and perversion, the modern era's enlightened equivalents of evil" (1999. p.556.) Schwartz argues for "reemphasizing the elasticity of the capacity to eroticize" (1995, p.124).

The life-long nemesis to the arrogances and inanities of the psychiatric and addiction industries, Szasz (1970, 2003) underscores that "the healing arts—especially medicine, religion, and psychiatry—operate within society, not outside it" and therefore "reflect and promote the primary moral values of the community" (1970, p.27) Verhaeghe extends (and sharpens) Szasz's perspective with a Lacanian razor:

> …psychiatry and clinical psychology become the judges of the social order, with the persecutors of the pathological society at one extreme and the guardians of the public good at the other. With the latter, the practice of psychology becomes transformed in to a form of social coercion and obligatory adaptation. To think naively in terms of adapted or unadapted behavior, or even desired or undesired behavior, is to enter into dangerous waters. Who desires what, and in whose name? (2004, p. 11)

In similar fashion, Bollas and Sundelson 1995) have challenged the compromising of confidentiality, risk, and the right to deviance within contemporary psychotherapy and psychoanalysis when our professions become allied with the guardianship of "the good". I have witnessed many applications of normative forces within the transactional analysis communities over the years--social/professional coercions and judgments that fly in the face of Berne's valuing of personal autonomy and responsibility.

Bollas delinaetaes a "normotic" personality disorder (1987, pp. 135-156) in which a person "seems unable to experience evolving subjective states within himself." Such a person is extremely "well-adjusted", but is such adjustment "healthy"? Bollas observes:

> …the normotic person is nurtured in an environment in which the parent avoids responsiveness to the core of the child's self. …Instead of being mirrored by the parent, the child is **deflected**. This is accomplished by diverting the child from the inner and the psychic towards the outer and the material.
>
> Normotic families develop a library of material objects, If a child is working on some inner psychic problem or interest, the family usually has an external concrete object available for the transfer of the psychic into the material. (p.151, emphasis in the original)

I suggest that perversion is an alternative, a more creative and vitalizing alternative, to normative collapse and psychic deadness. In my work with clients (and my own self-examination) I have found that often when children are more ignored than deflected and diverted, threatened with a true psychic disaster of emptiness and disorganization, these children often turn to their own bodies for both solace *and* stimulation. This seemingly paradoxical intertwining of solace and stimulation, calming and exciting, is one of the enduring functions of sexual perversion. Perverse strategies develop from the child's discovery of the autistic, sensate, and ultimately sexual stimulations that declare ***I am alive***. The normotic

"passes" easily, unobjectionable and unknown; the pervert stands out, objectionable and disquieting. Is normalcy healthier than deviancy? Is the acceptable healthier than the disturbing?

Questioning Perversion

"Open your eyes," I whisper. He does. "Where?" I whisper. "Here?" I touch the skin above his nipple. "Here?" I run my hand along his breast bone. "Here?" I touch the flesh on the uppermost part of his abdomen. "Yes." "Where?" "There." …I cut lower on his belly and we watch. Wait and watch. …This is what he wanted. What he has waited for. The blood runs more freely, past his nipples, his rib cage, each rib showing as his body stretches, over his belly and down onto his cock and balls. It runs down the foreskin, slowly. He watches in silence, rapt with the extraordinary grace of it. Lost in some silent reverie. This is what he wanted. (Bronski, 2002, pp. 287-288)

Perhaps more than anyone else in the clinical literature, Robert Stoller (1975/1986, 1979, 1985, 1991a, 1991b) has undertaken the most systematic study of sexuality and perversion inside and outside of the consulting room. Stoller was never one to mince words. He saw no need to turn away from the term perversion. Quite to the contrary, he embraced it emphatically:

> Paraphilia: how clean, how neat, disinfected, sanitized, and tidy. Science triumphant. Change the sign on the door and the activities inside change.
>
> *Nonetheless*, I want to retain the term *perversion* just *because* of its nasty connotations. *Perversion* is a sturdy word, throbbing with assumptions, while *paraphilia* is a wet noodle. In trying to say nothing, it says nothing. It is not neutral; it is neutered, pithed. It does not contain the quality I believe the person we would call perverse finds essential. (1979, p.6, italics in the original)

Perversion, as a clinical term, has been edged out of the diagnostic lexicon, often now to be replaced by the language of sexual compulsion and addiction (Carnes, 1991, 2001a, 2001b, 2003; Cooper, 2001). Jacobson (2003) argues that

addiction is “by definition passive” (p.107), while the concept of perversion conveys a meaning that is “more active, and the ominous elements are in the person, not in some external master” (p.107). The model of sexual addiction collapses the sense of the individual’s interiority and intentionality. The addict is viewed primarily as a victim of forces stronger than his or her will and morality (“I am powerless…”), while the pervert is the carrier of an internal force, the source of his or her desires and choices. The sexual addiction models tend to be full of normative, moral judgments. The seminar series, “Treating Compulsive Sexual Behaviors,” designed to provide continuing education units to therapists and counselors in the United States takes the position that the only healthy form of masturbatory fantasy if that of sex with one’s wife. There are those in the sexual addiction field who argue that any masturbation is a form of sexual compulsion. The addiction/compulsion treatment models routinely focus on sexual *behavior* and its control, with rigid, overly certain definitions of what is healthy (normative) or unhealthy (pathological). There is little to no exploration of the psychological and somatic functions of sexual patterns that are seemingly irresistible in their force.

In her provocative essay, “Perversion is us: Eight notes,” while Dimen (2001) deconstructs and depathogizes the concept of perversion, she asks the reader to wonder with her, “why do we still talk about it?” (p.827). She delineates the pairing of ever-changing definitions of perversity against ever-changing definitions of normality and the socially/professionally sanctioned expressions of sexuality. She concludes, “the label of perversion is as clinically superfluous as we know understand the label of homosexuality to be” (p. 853). Dimen’s sweeping critique underscores the difficulty of any definition of perversion that is not held in contradistinction to a culturally sanctioned norm. But Dimen also finds her own limits in the Michael Bronski’s essay, “Dr. Fell,” from which the epigraph introducing this section is taken. In an exchange with Bronksi, Dimen (2002), writes:

> Dear Michael Bronski,
>
> You know, this is going to be very hard. I mean, *cutting?* I've read "Dr. Fell" many times, gasping all the way. No doubt you intended exactly this reaction, in all its intensity. Do you too react like that sometimes? Disbelieving. Horrified. Fascinated. Repelled. (2002, p.295, emphasis in the original)

The interchange between Bronski and Dimen is remarkably frank and hence powerful, raising many questions about aesthetics and psychopathology, certainty and ambiguity, loss and control, intrapsychic forces and cultural influences. The interchange is rather unforgettable. I have dramatically abridged the depth of their dialogue but wish to portray it in part. Bronski replies to Dimen:

> It is important to remember that I wrote "Dr. Fell" with an almost entirely gay male audience in mind. When I wrote about how the cutting and blood sports, as well as my attraction to the dangerous image Jim projected, related to my being a gay boy in high school I had concrete specifics in mind: the constant verbal torments, being pushed against the lockers, taunts from some teachers, the unending stream of petty and minor humiliations experienced every day. Almost every gay man I have spoken to about "Dr. fell" understood this is what I meant; this is the shared experience of so many gay men my age.
>
> This brings me to what I found most surprising about your response. For me as a writer—although not as "the narrator"—and a reader, "Dr. Fell" is hardly about sex at all. It is, rather overwhelming, about AIDS, loss, and death; words that I don't think appear once in your response. Just as you are curious about what I have left out of my story intentionally or unconsciously, I, as a reader, am interested in why you do not address AIDS or death. (2002, pp. 318-319)

Dimen (2001) confronts the labeling of perversions in the creation of stigma and shame, following Foucault's admonition that the power to name is the power to blame. Can we name without creating blame? I would suggest so and further suggest that the concept of perversion persists in the clinical literature in an effort to comprehend a crucial aspect of sexuality anchored in primary sensate and sensorimotor organization. I think that there are elements of "perverse" sexualities within the patterns of sexual arousal, fantasy and relating even among those who strive to attain the most normative and unobjectionable life styles. In my efforts to understand the meanings and functions of "perverse" or marginalized modes of sexual experience, I have learned a great deal about disruptions and repairs to the cohesion of the somatic self.

In the psychoanalytic literature on perversion, Stoller's first book on transgressive sexualities, **Perversion: The Erotic Form of Hatred** (1975/1986), is often referenced and quoted. Interestingly, while that was his first book on the subject, by the last, **Pain & Passion: A Psychoanalyst Explores the World of S&M** (1991b), his views had changed significantly, though this book is rarely quoted.

Stoller, unlike most psychoanalysts and psychotherapists, left his consulting room to talk with people in their actual sexual habitats. He was much more motivated to understand patterns of sexual expression than to normalize or fix them. There is much to learn not only from Stoller's hypotheses and conclusions but also from his means of study and his demonstrations of respect for those whose behavior often made him quite unsettled and judgmental.

In this later work of Stoller's there is an almost uncanny echoing of Bob Flanagan's film and words. In talking with a group of sadomasochistics, Stoller found that "they had consciously forced themselves to master what at first, in infancy and childhood, was uncontrollable physical agony and terror by taking the pain and working with it in their heads, eventually via daydreams, altered states

of consciousness, or genital masturbation, until it was converted into pain-that-is-pleasure: voluptuous pain…their triumph is their perversion" (1992, p.25) Stoller observes that "no sadomasochists like all kinds of pain" (1992, p.16), or as Flanagan says it, "Even people who are into SM are not turned on by getting their hand slammed in a car door" (1993, p.35). Stoller continues:

> Consensual sadomasochism is theater—an amusement park—not only in its pornography but in its playgrounds in the real world. …Erotic excitement is a vibration, an oscillating between two possibilities—one positive, the other negative—such as pleasure-unpleasure, relief-trauma, success-failure, and danger-safety. …Every detail counts in increasing the excitement and preventing true danger or boredom. (1991b, pp.17-18)

Again, mirrored in Flanagan's words:

> If the pain is too heavy, or if it escalates too quickly, it'll psychologically destroy whatever illusion you're working up to, or whatever feelings are being increased. …You have to get on a wavelength with a person, plus you have to get on a wavelength with your own body. And you build up the pain threshold, you don't just immediately get together with somebody and start flailing away at them… But in general most people want a scene to be an erotic, sensual experience, not a *brutal* experience. (1993, p.35)

Throughout his studies of sexual excitement and perversion, Stoller saw the anchoring of patterns of perverse sexual desire and expression anchored in early childhood experience, motivated more often than not by the need to master and transform early somatic pain and trauma. I see echoed in his description of "increasing the excitement and preventing true danger or boredom" the function of perversion to paradoxically maintain a soothing/cohering level of excitation, positioned between the disaster poles of the true dangers (traumatic intrusion or psychotic disintegration) on the one hand and of boredom (normotic neglect and deadening) on the other. He concludes that elements of sadomasochism or

other forms of perversion are perhaps present in all forms of sexual fantasies and behavior, no matter how normal they may look at the surface.

Perversion and sensory cohesion

A tension arc is created between bodily sensations and the enigmatic other carrying over into adult life and constituting a bedrock for the sense of enigma and unfathomableness and the sense of profound revelation that sometimes accompanies sexual experience. (Stein, 199b, p.594)

Downing (1996) stresses the importance of the infant's development of "affect-motor schemas" and "affect-motor beliefs" that are an elaboration and integration of the infant's sensorimotor development within the relational and affective patterns with the caregivers. These patterns are not encoded in language but in literal affective and motoric experiences, that is, the somatic infrastructure. Downing conceptualizes these affect-motor schemas as forming prelinguistic, sensorimotor belief systems for connectedness, differentiation and bodily effectiveness. He hypothesizes "that certain physical parent-infant bodily interactions…leave a trace.…that this trace can be understood as a shaping, an influencing, of the infant's motor representational world.…that the vestige of these early motor beliefs will later affect adult behavior and awareness." (p. 150). He stresses the importance of the parent-infant relationship fostering for the infant a sense of embodied agency, that "the infant's ability to impinge upon the other must equally be unfolded" and that the infant "must build up a motoric representation of the other as engagable, and of himself as able to engage" (1996, p. 169).

When there is profound and chronic failure of this sensori-motor engagement, I think we often see the "traces" of affectmotor schemas lived out in the sexual realm as "perversion," an attempt, I believe, to keep one's body erotically alive, to maintain the "tension arc" of sensate life. The motoric representation of the other as engagable may never have adequately developed in the first place or may

have been traumatically severed at some later stage. I think that perverse sexualities reflect an unconscious effort to maintain an experience of the intactness of one's own body and remnants (or fantasies) of an engagable/penetrable other.

The rich clinical literature evolving from the work of Frances Tustin (1986, 1990; Mitrani & Mitrani, 1997) and Esther Bick (1968, 1986; Mitrani, 1996) in exploring psychogenic autism offers important insights into the somatic underpinnings of perversion. Bick described the primitive, "adhesive" attachment to sensation as an object, creating a defensive "second skin" (1968, p.484) as a defensive reaction to a disturbance of the primal skin function. The interpersonal membranes of skin to skin interchange is replaced with a protective, depersonalized "second muscular skin" (Anzieu, 1989, pp. 192-199). Tustin states that the physical sensations of one's physical existence replaces that of a less stable, and likely threatening, experience of relatedness to others.

I find the sensory descriptions of Bick, Tustin and their colleagues to offer rich insight into the experience of perverse sexualities. When the early object relational realm goes consistently awry, the forming body is thrown back upon itself. While the parental other is too often out of reach (the depressed parent), too disorganizing a force (the manic parent), or too disgusted (the hysteric parent), the sensate world of the body/self is always within reach in a solipsistic tension arc. Perversions are an effort to maintain life in the face of an endangered body (as we see with Bob Flanagan) or perhaps in relation to sexually deadened (or actually dead) parents. As described by Ogden (1996), perversion may be "an important method of attempting to infuse the empty primal scene with life (excitement and other substitutes for feelings of aliveness) is the experience of 'flirting with danger,' tempting fate by 'flying to close to the flame.'" (p.1144). Stoller would have us recognize that the art of perversion is in the

creation, the flirting with the carefully crafted and maintained illusion of danger, a distance from the flame that is both careful and exciting.

Ogden has modified the Kleinian concepts of developmental positions, removing them from the rigid language of pathological fixation, suggesting instead that these modes of experience, while having deep developmental roots, are also life-long, functional modes of relating to the world and those in it. Ogden describes the autistic-contiguous mode as the "experiences of sensation, particularly at the skin surface, that are the principle media for the creation of psychological meaning and the rudiments of the experience of self" (p.52). LaMothe (2005) has suggested the term "corporeal/contiguous" (pp. 30-41), which comes even closer to what I am trying to convey about perverse experience. Mitrani (2001), too, suggests the link between this mode of organization and what we have come to call perversion.

There are motorically repetitive, highly patterned, often aesthetic, rituals characteristic of many "addictions". The cigarette, the martini/scotch/bordeaux, heroin needle--each is a sensual partner/nonhuman lover of a sort. These are the realms of behavior that Mitrani (2001) refers to as "sensation-dominated delusions" (p.33) which serve to distract one from intractable anxieties, provide an illusion of safety, strength and impermeability, or create a tranquilizing or numbing effect. In a similar vein, Searles (1960) stresses the reliance on the "non-human environment" has a common means of warding off psychotic anxieties.

Perversions and addictions can provide a means to ward off the frailties of the body and life and the frequency of the breakdowns of relatedness. Kleinians and neo-Kleinians tend to underscore the defensive, delusional, psychotic underpinnings of autistic defensives. These defensive functions cannot be ignored in the efforts to understand perversion, addiction and psychogenic

autism. However, MacDougall sees a primary function of perversion, what she has termed "neosexualities," as providing an *alternative* to psychosis and a sense of aliveness and intactness. We see here an echoing of the Lacanian differentiation of the perverse from the psychotic.

I have come to understand sexual perversions as patterns of somatic/sexual relations (with one's self and/or another) which function to provide cohesion and vitality, a *containing, sensate* process which provides as alternative to a failed or absent containing object/other. The sense of perverse sexualities are compelling alive in the present, often experienced as beyond conscious choice and control, and typically severed from their developmental roots and meanings.

A Case Illustration

Hank, nearing 30, came to see me, complaining of persistent depression and dreading entering the landmark age of 30 still inhabited by a depression that had haunted him since adolescence. In the early sessions I felt somehow tested, though I couldn't quite grasp the nature of the test. I apparently passed the test, though I be hard pressed to say how, when Hank "confessed" that he was gay and that he had really come to see me to resolve his intense conflict about his sexual preference, which he found utterly disgusting. His depression, as he understood it, was directly linked to his inability to maintain sexual interest in women (though he had a number of close women friends) and his refusal to consider a gay lifestyle. His image of gay men was that of selfish predators "only interested in one thing," which was the one thing in which he could not allow himself interest. He lived alone and was lonely. He contented himself with occasional gay porn, frequent masturbation, cheap beer and more expensive marijuana. An engineer by trade, his solitary lifestyle did not seem that unusual to many of his rather asocial coworkers. Inquiries into his porn and masturbatory fantasies were carefully, politely sidestepped. I did not push.

Hank had had very occasional one night stands with bar pickups. He found the whole experience sad and disgusting, “I’d rather be alone. It’s more self-respecting.” He’d had one brief relationship with a young man while in college, which he recalled with pleasure and tenderness, but which he had broken off. He did not believe that men could truly love one another. I set the transference implications aside for the time being as I listened to his anguish.

As he came to trust me and the expectation-less space I offered him, he told me that he had twice been in therapy before. The first with a “reparative” (Nicolosi, 1993) therapist recommended by a minister, which successfully reinforced all of his negative self images while offering behavioral treatment strategies that changed nothing of his sexual fantasies. The second effort was at the local gay and lesbian counseling center where his problem was diagnosed as internalized homophobia, and he was offered a “sex-positive” psychotherapy. He found no interest in or acceptance of his disgust with his homosexuality, and he soon quit with no warning or explanation.

Hank was quite close to his parents and siblings—a large family all living in the area. He was the only one unmarried. When he entered therapy for the third time, his parents expressed concern. This time he told them why he was in treatment. They were quite accepting of his homosexuality and even more so of his refusal to act on it. His mother asked why he didn’t just find a nice girl anyway and marry her. Hank explained that he didn’t think it fair to a woman, whom he thought was entitled to be desired and have sexual intimacy. He had tried it and just couldn’t do it. “Well,” his mom prompted helpfully, “Your father and I haven’t had sex for decades. We don’t miss it and get along fine.” “That was more information than I really wanted, Mom,” Hank replied. But Hank & I got our first flash of insight that his disgust at sex might not be just about gay sex.

What impressed me in hearing of this interchange was the existence of a much deeper anxiety about sexuality and intimacy running through the family. Any real discussion or inquiry into Hank's inner world, an intimate conversation, was deflected outward by the suggestion that he just find a nice girl—the deflection outward that Bollas describes in the normotic family. Perhaps simply enjoying the same television shows should be sufficient to maintain a marriage. Hank took a risk with his parents, but his parents couldn't take it up. They were not hostile—they simply couldn't take themselves into his interior world, which is what he so desperately needed. I could see more clearly what Hank needed from me, and it wasn't solutions.

Unlike his gregarious siblings, Hank was quite introverted. Following that interchange with his parents, Hank began to realize that in his introversion, he was typically left alone. In sessions he began to speak of how solitary he was as a child, that no one seemed interested in him or the things that interested him. He spent long periods of time reading science fiction and involved in solitary building projects of one sort or another. He was not so much withdrawn from his family as unknown by them, a pattern that was mirrored in his peer relations at school. But, all things considered, he was a content young man during latency. It was with adolescence and the onset of sexual urges that the trouble began. Still hank struggled to make the surface look at ease, but there was serious trouble within. He survived high school using studying, endless projects, and religion as suppressants. He dates occasionally to ward off any suspicion, using his religious beliefs as an excuse for "not going any further,: as was the constant topic of adolescent posturing among the boys. But his eyes turned toward boys, and his sexual fantasies would not stop, even when he refused to indulge himself in masturbation. His troubles were privately held, as he had to history to suggest that someone would be interested in his struggles. Hank had his first rounds of depression in high school unnoticed by those around him.

Once off to college, sex was even harder to avoid, and homosexuality was quite visible and accepted on campus. This did not represent hope to Hank. Approached by a couple of male students, he tried his first gay sex. He thoroughly enjoyed it and was repulsed by his pleasure. He became obsessed with one young man, the one with whom had had felt tenderness, but he cut off the relationship. His depression deepened. Our sessions during this period began to link his continued tendency to deflect the possibilities of friendship or any form of intimacy (no one had ever been invited to his apartment) out of fear that his bachelorhood would be called into question.

I continued to struggle with my countertransference. While I had no investment at all in Hank's being gay or straight, the thought of this young guy spending the rest of his life alone in varying states of self-loathing was dreadful to me. I quietly described the subtle but certain distance he kept between us. What was he afraid of with me I wondered aloud, though never pushing for a reply. He would change the topic when I spoke of our relationship. I lived with my discomfort and his distance, but I knew my affection for him was registering in him. Hank was coming to trust that I would not push him into any lifestyle choice, that my investment was in understanding the depth and meanings of his conflict.

After three years Hank decided to tell me of his porn predilections and masturbatory fantasies. His preference for porn had very little variation (Stoller, 1991). The movies were sado-masochistic in nature, with the aggressor/top a black male, the submissive/bottom partner white, the sex anal, and Hank identifying with the submissive partner. He often tried other styles of porn, but did not find them arousing. We explored his experience of his own body while watching the action, his experience of his arousal and his orgasm. Typically, his disgust pushed him "to get to the inevitable" (orgasm) as quickly as possible so as to rid himself of his horniness. It all felt very depersonalized. Our conversations, my questions and interest in his actual experience, slightly

opened his experience of himself to himself. He noticed that there was pleasure, not just arousal, while masturbating, and that there was a disturbing desire "in my skin" to be handled the way the men in the porn handled each other. He wanted to be taken over.

We discussed the stories he imagined (never quite conscious until we began to speak of them) about the lives of the men in the films. To Hank these men were not ashamed of themselves; they were defiant, flagrant in their desire. He felt some envy as well as disgust—all very confusing. He was profoundly ashamed of the racism inherent in these scenes but could see that he attributed to the black, underclass man the force, the will he lacked in himself. He disowned it, made it dirty, and again he could feel his envy for both the black possessor and the white possessed. These conversations gradually opened a slight awareness of an emotional experience within him while watching the porn, in addition to the more familiar (and despised) physical arousal. The experience of some emotion made his interest in the movies somewhat more acceptable.

He was then able to tell me of his masturbatory fantasy, which was a singular story: he would enter a public men's room; he would be seized from behind by a man (either white or black); he would be bent over the sink, anally raped while the fucker forced him to look in the mirror to see the fucker's face, saying over and over again, "**TAKE IT. YOU WANT IT. TAKE IT**." The fucker's voice was demanding, humiliating, demeaning. And Hank found it all profoundly arousing. He hated himself for it. But nothing else seemed to work. I asked what he saw in the man's face in the mirror. He'd never noticed, but asked to look and see, he realized that the man's face was full of pleasure and a bit a kindness. He couldn't put the kindness together with the taunting voice. I spoke the same words differently, gently, tenderly, as an invitation, an insistent invitation, a permission. Could he hear it that way? He could.

Hank's shame and self-loathing lessened a bit. His fantasies gradually changed in texture from being forced and raped to being *taken*, almost but not quite *wanted*. I kept my countertransference to myself, but in my fantasies I had Hank going to gay bars, finding some man who wanted Hank enough to overcome his reluctance and disgust. I wanted Hank to finally feel in his body someone else's unbridled desire for him, breaking through and breaking down Hank's disgust. But this was not to be. Hank was able to go to an occasional bar (though drinking with others never gave him the same satisfaction as drinking alone) and to some gay social gatherings. He went home with a few guys, never to follow through with anyone. Although his disgust had lessened in his private sexual activities, he still felt disgust in actually being with another man.

After a few months, Hank announced that he had decided to leave therapy. He was no longer depressed, and he had accomplished a great deal of self understanding and some modicum of self acceptance. There was more fluidity and emotion in his masturbatory fantasies. But he felt he could go no further. "I know you have more hope for me than I have for myself. I know you want me to have a real lover. But I can't do it. Maybe someday, but not now. I need you to accept this and to let me go with your blessings." I did, reluctantly.

I hope that some time in the future Hank will return to me or some other therapist (and in my fantasies he is now working with another therapist) to be able to allow himself full partnership and sexual intimacy.

Conclusion

Transactional analysis is hardly alone in its minimization and inattention to sexuality. While sexuality was once held to be essential to human nature and wellbeing and at the heart of many psychotherapeutic issues, as reflected in the work of Freud, Reich, Kinsey, and Masters and Johnson to name those who have had the most profound cultural impact, sex has been moved to the sidelines

of most psychotherapy models, even those with a neo-Reichian base. Stripped of its transgressive, disturbing elements, sexuality has been domesticated, replaced with ideal visions of attachment, bonding and attunement. Contemporary models of sexual addiction strip sex of its developmental and unconscious meanings and focus on behavioral control. Contemporary psychoanalysis has undertaken a return to an reappraisal of the place sexuality in psychotherapy (Green, 1996; Mann, 1997; Stein, 1998; Dimen, 2003; Caldwell, 2005).

Psychotherapy without attention to sexuality is impoverished. There are few domains of human experience and passion that bring together conscious desire, unconscious motivations, somatic experience and relationality in the way we can experience this intermingling of forces in sexuality. The conference that gave birth to this special issue of the *Transactional Analysis Journal* was a bold move in our community. It is my hope that this issue of the Journal will inspire continuing attention to sexuality in our theories and practices.

Within the realms of sexual expression often labeled “perverse,” there is often a sense of the pure, unrestrained force of the body, the force of sexuality, the force of particular erotic desires that can convey a certain quality of addictive or compulsive intensity, seemingly in the absence of, in place of, or in spite of the other. There is something disturbing, unnerving, paradoxical about our perverse sexualities in the experience of the force of the body quite independent of another. Bollas (1999) captures a quality of this paradoxical tension when he describes the perverse act as “the effort to create the illusion of the self’s mastery of the instinct’s” (p159), a turning away from the reality that sexuality “dissolves us always” (p.159). Such dissolution is much more inviting and, indeed, pleasurable in the embrace with another, when the tension arc is completed with an other. Without the other, this dissolving comes closer to the “breakdown” described by Winnicott. I suggest that perversion is more of an accomplishment than a defense, an accomplishment in the effort to sustain a somatic and erotic

aliveness, a sensate saturation as an alternative to psychosis (psychic breakdown) or neurosis (psychic deadening).

Pathological constructions of perversions and their etiologies narrow vision and heighten anxiety. We are much less likely then to wonder, "What is it like to be in this body?"; "What pleasure and meaning does this way of being offer?"; "What sorts of conflicts and yearnings are maintained in this body's way of being, through its patterns of sexual expression?"; "What is going on in the skin, the muscles, the heart and desires of this person?" When we are able to move beyond our clinical judgments and personal countertransferences--the "eew! factor" (Dimen, 2005), we can be carried to a crucial unfolding and elaboration of enduring somatic and relational motifs, which may or may not be open to change but can always be enriched by engagement and understanding.

Perversion is a refusal to give up on life, even when it may represent a turning away from the other. Perversion is the eroticization of the private body, with fragile, but crucial link to passion. "Perverse" eroticism seeks to sustain the force of libidinal vitality, though sometimes severed (by choice or trauma) from attention to the other. There are times in realms called perverse, when partners fling back and forth between private sensation and reverie to intense contact with the other, from private body to shared bodies.

For many with perverse sexual desires, what life held in store for the young child's body was not so pleasant, and pleasure was not so readily found in the earliest relations. But the developing body in its own sensate vitality and elaborations in fantasy and action can provide both a means of grounding and containing while seeking intensity and vitality through this corporeal-contiguous mode (Lamothe, 2005). To work successfully with perversion, a therapist must tolerate layers of enigma, the disquiet of patterns of desire that may strike one as profoundly alien and quite possibly frightening or disgusting. It is a primary task

of the analyst/therapist to maintain an attitude of bodily curiosity and openness and an intense, mutual searching that will be often aching, sometimes pleasurable. This may be all, and the best, we have to offer.

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