

**A metasyntesis of published case studies through Lacan's L-schema:
transference in perversion**

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Abstract

Transference in perversion is characterized by specific problems such as a defiant and polemic attitude, erotic transference, projections, and aggression. Such transference poses particular problems in the treatment of perversion and might render analytical work with these patients impossible. We propose that Lacan's L-schema can contribute to separating productive from counterproductive aspects of transference as it distinguishes between an Imaginary and a Symbolic dimension in transference. In this meta-synthesis of eleven published case studies on sexual perversion, patterns of transference are analyzed. On the Imaginary dimension, we found that patients with perversion tend to (un)consciously engage the analyst in a relationship characterized by identification, fusion and rivalry. On the Symbolic dimension, we found that perverse patients are able to question their motives, lapses, symptoms, and subjective identity. The thematic analysis revealed the importance of the position of the analyst in this work, which is described within the L-schema as being the representative of the otherness in the Other. Implications for clinical practice and recommendations for further research are outlined.

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Transference in perversion

Introduction

It has been noted for several decades that the treatment of perverse patients is characterized by a specific transferential relationship (Clavreul, 1980; Etchegoyen, 1978; Joseph, 1971). Such patients tend to defy the therapist, eroticize the transference and entangle the analyst in their ideological view of sexuality. In a recent study on this subject, Jimenez and Moguillansky (2011) confirmed that such transferential problems can pose particular problems in the treatment in cases of sexual perversion. In this study, we aim to contribute to the discussion on the treatment and treatability of patients with perversion. In our interpretation, Lacan's L-schema provides an important contribution to this discussion as it distinguishes between two dimensions in transference. Below we study these two dimensions of transference by conducting a metasynthesis of 11 published case studies of psychoanalytic treatment in cases of sexual perversion.

The term of perversion has acquired a very broad meaning in the field of psychoanalysis and, according to some, this overextension of the concept is an obstacle to reaching clinical and theoretical agreement (Jimenez & Moguillansky, 2011). Within the context of this study, we do not separate the concept of perversion from sexuality, although sexual deviance is not the distinguishing feature of perversion. The notion of sexual deviance rests on a cultural norm of what are considered normal or acceptable forms of sexual behavior within a specific group. Within Lacanian theory, perversion is essentially characterized by the specific mechanism of disavowal (Freud's *Verleugnung*). In order to diagnose someone with perversion, the criterion is not the deviant sexual behavior per se, but evidence of the mechanism of disavowal, and how it functions in different domains of the individual's life, including the domain of sexuality. Disavowal includes the domain of sexuality, as it emerges in the relation between the child's body and the mother's body. In his short article on Fetishism (1927), Freud describes how a fetish comes to serve as a substitute for the maternal phallus following the boy's perception of the female genital. The fetish is partial evidence for the belief that women do have a penis, allowing the fetishist to triumph over the threat of castration. However, it would be incorrect to say that the perception of female castration is completely erased in the fetishist. In fact, the fetish is a memorial of female castration as it often relates to objects perceived in relation to the female genital (foot, shoe, fur, lingerie). In other words, the fetish simultaneously testifies to and disavows female castration. It is this double stance towards the perception of female castration that is characteristic for disavowal: 'I know it, but all the same it isn't true.' Lacan extends Freud's concept of disavowal as he establishes it as the basic mechanism for all forms of perversion, not only fetishism. Moreover, he claims that disavowal doesn't concern the maternal phallus but the imaginary and the symbolic phallus. We will elaborate this below.

In Lacanian psychoanalysis, the question of the treatability of perversion is considered with skepticism, particularly because of the transference-related difficulties. Clavreul (1980) asserts that such patients often request treatment in search of protection from legal prosecution, to seek approval in the eyes of a third party, or to get rid of some minor problem, with no intension of modifying anything essential. Instead of working

towards change, the analysis gets stuck in what Etchegoyen (1978) coined as “transference perversion,” which he distinguishes from transference neurosis. With this term, he refers to phenomena that appear regularly in the treatment of perversion: the erotization of the therapeutic relation, the use of both words and silence to make the analyst excited and impatient, a (latent) polemical and defiant attitude. In transference perversion, the analyst is forced in one of two positions: the moralizing position or the position of impotent voyeur. The first scenario is described by Joseph (1971) and Etchegoyen (1978) in their portrayal of how sadistic and masochistic fantasies can infiltrate the treatment without being noticed. The analyst’s repeated interpretations have the allure of a sadistic beating and the patient wallows in the inability or unwillingness to change. The second scenario is described by Clavreul (1980). He points out that the analytic setting can become impregnated with voyeuristic fantasies, as the patient equates therapeutic abstinence with impotence, and free association with a form of exhibitionism: the analyst follows the patient’s associations, exploring fantasies and analyzing them, without really questioning the perverse symptom itself.

On the other hand, several Lacanian analysts are more optimistic about the possibility of treating perversion and have recently published case studies to prove their point (Fink, 2003; Swales, 2012). Swales (2012) points out that the patient with perversion cannot be reduced to his symptom. While in cases of perversion, the patient will entangle the analyst in his fantasies, he also suffers from his symptom and wants to change it at a certain level. In this paper, we address the question of the treatability of perversion by studying whether transference in perversion forms an insurmountable obstacle to treatment. Lacan distinguished between a Symbolic and an Imaginary dimension in transference, which correspond respectively to productive aspects (transference as a necessary condition for treatment) and counterproductive aspects (transference as resistance) of transference. We investigate the behavior of patients on these two dimensions by performing a metasynthesis of 11 case studies of perversion. The method of metasynthesis was originally developed to draw inferences from similar or related qualitative studies that, in themselves, have limited generalizability. In psychotherapy research, metasynthesis is advocated as a method for identifying common themes and processes in a set of similar single case reports (Iwakabe & Gazzola, 2009). This method combines the richness of single case research with the possibility of aggregating knowledge from different but comparable studies. Metasynthesis requires a high level of interpretation of findings from carefully selected case studies and it is particularly useful for theory building and theory development.

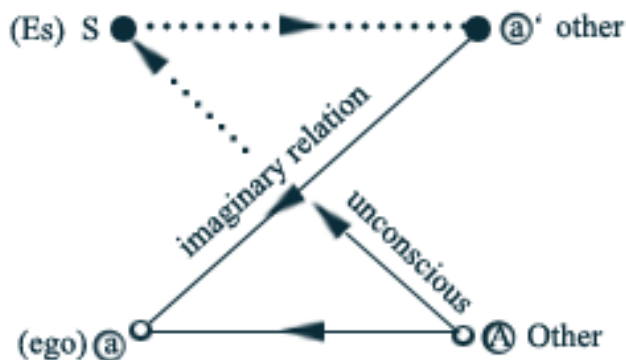
Lacan’s L-schema

One of Lacan’s major innovations in psychoanalysis was his emphasis on the dimension of the Symbolic in analytic practice, something he opposed to the Imaginary (Vanheule, 2011). Lacan was inspired by the structuralist movement that shaped the domains of linguistics and anthropology in the nineteen fifties. For him, both mental life and the process of psychoanalysis are structured around the fact that as people think and speak, they concatenate signifiers in signifying chains. In this context, he adopts the notion ‘signifier’ from the linguist Ferdinand de Saussure. According to de Saussure, speech is composed of signifiers and signifieds. *Signifieds* are the ideas or representations evoked in speech, and thus refer to the semantic content of speech. Since all understanding of the content of speech coincides with building mental images, Lacan qualifies this dimension as *Imaginary*. *Signifiers*, by contrast, make up the *Symbolic*, and are the material linguistic building blocks

to which representations attach. Just as computers can be programmed to make meaningful operations through a mere combination of numerical digits, humans generate meaning by combining syllables in words, and by following grammatical rules and conventions in combining words in sentences. Along this way, signifiers are connected in chains and webs, or structures, which are like skeletons around which bodies of meaning are constituted. Lacan (2006 [1956]) believed that signifying structures can be found at the basis of people's symptoms and behavior. He thus argued that in clinical work psychoanalysts should focus on the dimension of the Symbolic: "imaginary effects, far from representing the core of analytic experience, give us nothing of any consistency unless they are related to the symbolic chain that binds and orients them" (Lacan, 2006 [1957], p. 6).

As an aid for distinguishing between the dimensions of the Symbolic and the Imaginary, Lacan developed the so-called L-schema (Figure 1). He discussed this schema in his second (Lacan, 1988 [1954-1955]) and third (Lacan, 1993 [1955-1956]) seminar, as well as in a synthesizing text on the latter seminar (Lacan, 2006 [1959]). What this schema depicts is that in analytic sessions, all speech is organized along two right-angled dimensions: the Imaginary and the Symbolic, which both consist of two poles.

Figure 1: The L-schema by Lacan (1988 [1954-1955], p. 109)



The axis of a to a' makes up the Imaginary dimension, and stands for the relation between ego (a) and other (in French: 'autre'), or object (a')¹. Lacan (2006 [1949]) discusses the roots of this imaginary relation in his theory of the mirror stage, which states that early in life self-experience is chaotic, and only starts to become organized by recognizing one's self-image in the outside world. Indeed, in his view humans have no innate feeling of self-coherence. Motor incoordination and the primitive organization of the child's libidinal life produce a fragmented self-experience, which is disquieting. The ego comes into being as a reaction against this troubling state: "Based on mirroring (i.e., qualifying images, be they self-images or images of others as mirror images), a subject identifies with a body image and regards this image as its own" (Vanheule & Verhaeghe, 2009, p. 396). By first discerning an external image or other (a'), and considering oneself in parallel with this image, the ego is created,

¹ This object (a') is not to be confused with the concept of object a, which dates from later in the work of Lacan. The object (a') is situated on the Imaginary dimension of the L-schema. The object a is situated on the connection between the Symbolic and the Real dimension and is not represented in the L-schema. In his later work, Lacan approaches perversion with new concepts, such as unconscious fantasy, object a, and jouissance. However, this is beyond the scope of this manuscript.

hence the symbol a . Crucially, this type of identification is not restricted to infancy, but gives rise to a broader mode of social interaction, characterized by a particular self-image and corresponding ideas of others. Indeed, later in life imaginary functioning consists of evaluating the self and other in terms of ideas and roles they ought to correspond with: “the symmetrical world of the *egos* and of the homogeneous others” (Lacan, 1988 [1954-1955], p. 244). Imaginary functioning is efficient in that it allows people to understand each other. When we communicate, we establish an imaginary identification with the other. For instance, when we check in to a hotel, we identify with the role of guest. More precisely, the receptionist functions as a mirror in which we see ourselves as a guest. In fact, the guest needs the receptionist in order to assume his role as a customer, and vice versa. The same goes for the relation between teacher and student, husband and wife, friends,... Along the Imaginary dimension, we claim to know who or what the other is, and inversely we assume to know who we are ourselves. In that way, ego and other are in a reflexive and mutually dependent relation. In transference, imaginary identification manifests when the patient, for example, occupies the position of narrating his/her life as though he/she is the plot of a novel and the analyst makes up the audience, or when a variety of preconceptions guide the interaction between patient and analyst.

While the Imaginary has an organizing role in mental life, Lacan (2006 [1949], 1988 [1954-1955], 2006 [1959]) stresses its quality of misrecognition: It neglects the otherness of the other, as well that fact that in our own subjective functioning the unconscious makes up a dimension of otherness that repeatedly disrupts the smooth continuity of our self-experience. In the L-schema this dimension of otherness is situated along the Symbolic axis, which is made up by the symbols S and A . The symbol S represents “the ineffable experience” (Lacan, 1988 [1954-1955], p. 245) or the subject in its “ineffable and stupid existence” (Lacan, 2006 [1959], p. 459), and indicates that ultimately no human at all knows who he is or what he wants. A , by contrast, is the symbol of the Other (in French: ‘Autre’). Lacan gives quite a specific interpretation to the concept Other, defining it as ‘the locus from which the question of his [the subject’s] existence may arise’ (Lacan, [2006] 1959, p. 459). In other words, at the level of the unconscious each speaking subject – neurotic, psychotic or perverse – is confronted with a basic question ‘Who am I?’ More precisely, this question relates to three issues: 1) the subject’s sex, whether one is a man or a woman and how one gives shape to sexual identity, 2) the fortuity of life and what life means in the light of death, and 3) love and procreation, what it is that really connects people in love, and parenthood (Lacan, 2006 [1959]). As can be seen in the L-schema, the unconscious is sided with the position of the Other. For Lacan, the unconscious is not the true essence of our psychic life or the privileged seat of subjectivity. Rather it is the collective of signifiers and stories that a subject has received from other people and that determine the subject’s identity, symptoms, dreams, lapses, etc. At the level of O , we can situate all of the told and untold stories that constitute a person’s history, stories that surround the birth of a child, family stories, stories about the relation between the parents, whether one was wanted as a child,... As the subject received these signifiers from other people, they are essentially foreign. Moreover, although a subject can use these signifiers to think about himself and to represent himself, the question always remains as to how he must relate to them. The subject does not coincide with these signifiers. Importantly in this context, for Lacan the unconscious is made up of signifiers, hence the idea that the S - A axis is Symbolic: “What unfolds there is articulated like a discourse (the unconscious is the Other’s discourse [*discours de l’Autre*]), whose syntax Freud first sought to define for those fragments of it that reach us in certain privileged moments, such as dreams, slips, and witticisms” (Lacan, 2006 [1959], p. 458-459).

However, for the subject, no inherent answer to the question of identity is at his disposal. That is, no signifier suffices to answer this question and as a result the subject (S) never coincides with the signifiers located at the place of the Other (A). In contrast to the Imaginary dimension, where the ego finds a sense of self-coherence, the subject remains ineffable on the Symbolic dimension: “the question of his existence envelops the subject, props him up, invades him, and even tears him apart from every angle” (Lacan, 2006 [1959], p. 459). In light of this, questions pertaining to the subject’s identity insist, and find expression in the form of symptoms rather than conscious phenomena. Lacan believed that underlying symptoms, such as dreams and lapses, comprise fragments of incoherent or conflictual experiences one has lived through as well as the stories that have been told about oneself.

In Lacan’s view, preoccupations at the level of the Imaginary are actually determined by what plays at the level of the Symbolic: “the images of our subject are buttoned down [*capitonnées*] in the text of his history, they are enmeshed in the symbolic order” (Lacan, 1988 [1954-1955], p. 257). Indeed, in his view “everything that happens in the order of the object relation is structured as a function of the particular history of the subject, and that is why analysis, and the transference, are possible” (Lacan, 1988 [1954-1955], p. 257).

Perversion and the L-schema

We mentioned above that in Lacan’s interpretation, disavowal does not concern the lack of the maternal phallus but the imaginary and the symbolic phallus. The imaginary phallus is the image of an erect penis as a symbol of desire and sexual pleasure. The penis can be the imaginary phallus when it is erect, but any other long, tall object can take its place. For a child, “the imaginary phallus refers to the role that the penis plays in the child’s fantasy and it represents the boy’s narcissistic attachment to his penis and the pleasure it affords him” (Swales, 2012, p. 56-57). In the etiology of neurosis, the imaginary phallus is negativized (castrated) from the specular image in response to the parents’ demand to give up some of the pleasure associated with masturbation. According to Freud this was done with literal castration threats made by the father, but Swales (2012) points out that more subtle demands made by both parents can function in the same way, such as the parents demand “Don’t touch that” or “Don’t do that in company.” These demands are interpreted by the child to mean that masturbatory pleasure is undesirable and prohibited. These demands also have an impact on the relation between the child and the primary caregiver (typically the mother, but the father or any person can take this role). The relation between child and primary caregiver is a bodily relation insofar as he/she regulates, marks and satisfies the child’s drives. A child’s eroticism is related to the primary caregiver who touches, cares for and tends to the child’s erogenous zones. When the parents express disapproval of masturbatory pleasure, they also indicate that sexual pleasure in relation to the primary caregiver is forbidden. Therefore, the prohibition of masturbation implies a desexualization of the contact between child and primary caregiver (i.e. the prohibition of incest). Therefore, the negativization of the imaginary phallus is both a castrating operation at the level of the self-image and at the level of the *child – primary caregiver* relation.

In exchange for the negativization of the imaginary phallus, there is a positivization of the symbolic phallus in the neurotic. The symbolic phallus is a signifier that represents ‘the qualities and pursuits deemed positive or desirable by the Other’ (Swales, 2012, p. 68). In other words, the child gives up the direct access to masturbatory pleasure but instead receives ways to gain the recognition, appreciation and love of other people. For instance, the child might observe the parents and try to detect characteristics in the father that make

him so interesting to the mother. By identifying with these traits, he can try to capture the mother's attention. From that moment, the bodily relation between child and primary caregiver is mediated through the symbolic phallus. For instance, the mother can say to her child: 'If you eat up all your dinner, you will become big (like your father).' In terms of the L-schema, the operation of identification with the symbolic phallus creates the Symbolic dimension between the subject and the Other. By identifying with the symbolic phallus, the subject comes into being in relation to the Other. In the long run, the symbolic phallus will provide the neurotic subject with a framework through which the search for answers to the three fundamental questions of identity can ensue: sexual identity, the relation towards death, and the relation towards others in love and parenthood.

The neurotic subject makes a deal with the Other in which he sacrifices the imaginary phallus but in return he receives the symbolic phallus. The perverse subject, however, makes a different deal. At the level of the imaginary, the phallus is not negativized. The perverse subject clings to the image of an object that allows him to disavow the negativization of the imaginary phallus. The future perverse child is not completely unaware of the parent's demands to give up masturbatory pleasure, but he² does not take these demands very seriously. For some reason, he unconsciously concludes: 'I know what you are saying, but you don't really mean it'. One reason can be that the castration threats are communicated inadequately with the consequence that the child does not take them seriously. Another reason can be that the primary caregiver places great value in the child's imaginary phallus. The future perverse child develops a strong narcissistic investment in the imaginary phallus. The object of perversion comes to serve the purpose of disavowing the negativization of the imaginary phallus. Lacan framed perversion as the *problem par excellence* where the subject is fixed on a specific object or a peculiar image in relation to which he organizes his life. Indeed, in his view, the structure of perversion is marked by a particular "valorization of the image" (Lacan, 1994 [1956-57], p. 120, our translation). This valorisation might be considered equivalent to what Freud calls fixation. Moreover, the relation towards the primary caregiver remains sexualized.

At the level of the Symbolic, the perverse subject does not accept the symbolic phallus offered by the parents. This implies that he has no access to neurotic's ways of gaining recognition and love from the parents. In confrontation with the fundamental questions of identity, the subject of perversion risks remaining empty-handed. However, at this level the perverse symptom itself functions as a solution. The perversion provides the subject with an answer, in the sense that the signifier of the perversion represents what is positive and desirable. In confrontation with questions of sexual identity, the relation towards death, love and parenthood, perversion provides the answer.³ For instance, Fink (2003) describes a particular patient who had a predilection for black, shiny boots. In this man's history, the signifier 'boot' was associated with 'butt' and 'thumb', i.e. two signifiers that do not demarcate the difference between men and women. This patient noted that women in his family had larger behinds than the men did. Furthermore, two neighboring girls once told him that 'boys have one thumb and girls have two thumbs'. Consequently, he

² As sexual perversion is more often encountered in men and all cases involved in this study are men, we will refer to perverse patients in the male form for practical reasons. However, this does not mean that perversion does not exist in women.

³ The idea that perversion is an answer to fundamental but frightening questions on the subject's identity can be found in other psychoanalytic theories as well. Khan (1979) claimed that perversion represents an effort to create an experience that will disguise and partially substitute for the absence of a sense of being alive as a human being. McDougall (1986) points out that the perverse patient creates a new form of sexuality, a neo-sexuality, in order to construct a self. Chasseguet-Smirgel (1984) stated that perversion is characterised by a denial of the difference between the generations and the sexes.

could only think of the sexual difference in quantitative terms (larger behind, one thumb versus two), but not in qualitative terms. For this patient, the signifier of 'boot' came to represent the ambiguity around the difference between men and women. In this context, the signifier connected to the perversion is the entry into the Symbolic dimension. This is why the perversion typically becomes an ideology: as they disavow the symbolic phallus, the perversion becomes the frame of reference.

The current study

In Lacan's view, the main objective of psychoanalysis consists of bringing a person to articulate the material that makes up the unconscious and of creating the time and space for a person to assimilate these elements of the unconscious: "The spoken clarification is the mainspring of progress" (Lacan, 1988 [1954-1955], p. 255). However, there is considerable doubt as to whether patients with perversion are able to do such analytical work due to problems at the level of the transference.

Based on the previous account of perversion and transference perversion, we can infer that the Imaginary aspects of transference are characterised by intense sexualization. As the perverse subject does not negativize the imaginary phallus from his self-image, one can expect that the Imaginary dimension of the L-schema is marked by the presence of the object of masturbatory pleasure: the patient with perversion sees in the analyst the reflection of the object of perversion. Rather than striving to gain recognition, love and appreciation from the analyst through the symbolic phallus, the perverse subject will strive for satisfaction in relation to the analyst. This will take the form of an eroticized relation towards the analyst, corollary of the sexualized relation with the primary caregiver.

This sexualization may be specific to perversion, but the transference will not be restricted to this aspect. Therefore, our first research question is whether other imaginary aspects of transference can be found in perverse patients. At the level of the Symbolic, we note that the subject of perversion disavows the Other's answers to questions of subjectivity (the symbolic phallus) and instead seeks answers in the perverse symptom. Our second research question is whether the perverse subject is prepared to question his symptomatic solution, as is required in an analytical treatment. In other words, do we find recurrent patterns of analytical work on the Symbolic dimension in these patients?

Method

We first consulted the Single Case Archive (www.singlecasearchive.com). This archive contains 446 individual psychoanalytic case studies from ISI ranked journals (details can be found in Desmet et al., 2013). We checked the diagnostic information and keywords that are available in the Single Case Archive using the search term 'perversion' and sourced 11 case studies. We further specified our search to cases involving sexual perversion and eliminated case studies on character perversion. Applying this concept of perversion, we retained four case studies (Jimenez, 1993; Baker, 1994; Vogelsang, 1999; Houssier et al., 2011). Following this, we consulted Web of Science with the search terms 'analysis AND perversion,' which resulted in 97 hits (search performed in July 2012). We screened all article abstracts for cases of individual psychoanalytic treatment with sexually perverse patients and retained seven eligible cases (Joseph, 1971; Stolorow, 1973, 1975; Torres, 1987; Carignan, 1999; Purcell, 2006; De Masi, 2007; Meyer, 2011). In this way, we gathered 11 case studies in total, all with male patients. The studies retained include cases of pedophilia (De Masi, 2007;

Houssier et al., 2011), fetishism (Joseph, 1971; Stolorow, 1973, 1975), homosexuality⁴ (Torres, 1987), fetishistic voyeurism (Jimenez, 1993), fetishistic cross-dressing (Baker, 1994), exhibitionism (Vogelgesang, 1999), bisexuality (Carignan, 1999; Purcell, 2006), and transvestitism (Meyer, 2011).

In these case studies, we first selected passages in which the author explicitly discusses an aspect of the transference. We also included passages in which the author explicitly discusses the request for help. From a Lacanian point of view, transference exists from the moment that a patient expects to receive an answer from the Other concerning a question regarding his subjectivity (Lacan, 2006 [1955]). Therefore, the inclusion of these passages is necessary to draw a complete picture of the transference. The selected passages varied: some were descriptive (e.g., a literal description of the interaction between the patient and analyst) or theoretical (e.g., the analyst reports his or her psychoanalytic perspective on what happens in the transference); some were very focused (e.g., a transference related phenomenon in one particular session) or general (e.g., a summary of the transferential relation during the first two years of treatment); some passages were very short (e.g., a single sentence) or quite detailed (e.g., a two-page description of a session in which the transference was of particular concern). We tried to select comprehensive units of text, such as complete sentences, paragraphs, descriptions of the interaction between the patient and analyst,..., in conformity with the textual structure that the authors originally implemented. The selected passages were put on a separate document which amounted to 30 pages (single space).

In order to systematically extract the patterns and variability in the themes of these fragments, the first author conducted a thematic analysis on the selected passages following the procedure outlined by Braun and Clark (2006). The author read and re-read the selected passages in order to get familiarized with the data. Then he used the L-schema as a framework for coding what took place in the transference. During the coding process, he continually consulted the complete manuscripts of the case studies in order to place the passages within their broader context. The codes used were descriptive and stayed close to the manuscript. For instance, a typical code used was 'patient places analyst in the role of the father' or 'patient tries to convince the analyst of the superiority of his perversion.' Each code was assigned to the Imaginary and/or the Symbolic dimension. For instance, the examples mentioned above were assigned to the Imaginary axis. An example of a code that was assigned to the Symbolic axis includes 'patient himself interprets acting out' or 'analyst insists on the difference between herself and the attributions of the patient towards her.'

In the next step, the first author grouped the codes from the Imaginary and the Symbolic dimension separately in a new document and searched for resemblances. The initial codes were rearranged into overarching codes and these codes were grouped into general themes. While the formulation of the initial codes was rather descriptive, the final themes were closely adapted to the theoretical terms of the L-schema. Next, the co-authors (MD, FG, RI, and RM) performed a credibility check by critically discussing the codes and the themes in relation to one case study. For this purpose, the case study by Jimenez (1993) was

⁴ Obviously homosexuality is by no means indicative of perversion, nor, for that matter, are sexual traits such as pedophilia, fetishism, transvestitism etc. Such traits of a patient's sexuality are not of primary interest for the diagnosis of perversion, but rather the mechanism of disavowal. In this specific case study, the patient has a physical disfigurement and Torres (1987) situates the perversion in the way that the mother and the child relate to this disfigurement. The author writes: 'The material [of this case study] is structured around the hypothesis that this perversion is based on the existence of a perverse pact between the mother and the son, characterized specifically by a particular exchange of disavowals: the typical attribution by the child of phallic completeness to the mother is returned by her in her transformation by disavowal of the son's physical deformity into an image of beautiful fullness and physical normality' (p. 370).

chosen because of its particular complexity and richness. All authors have a postdoctoral degree, are trained in Freudian-Lacanian psychoanalysis and have varying degrees of clinical experience in psychoanalytic psychotherapy. It was decided that minor changes should be made to certain codes and one theme in relation to the Imaginary dimension. Furthermore, the content of two themes relating to the Symbolic dimension was changed considerably. As a result of these changes, the first author went through the material again, reconsidered problematic codes and reanalyzed the data.

The concepts of reliability and objectivity, as they apply to quantitative research, cannot be transferred to qualitative research without modification (Marecek, 2003; Stiles, 1993). The concept of objectivity is replaced with permeability, i.e. the capacity of theory, interpretation or understanding to be modified by encounters with observation (Stiles, 1993). The procedures in place to guarantee such permeability in qualitative research differ from the procedures to guarantee reliability in quantitative research. Stiles (1993) notes 'certain procedures seem to be evolving into standards of good practice in reports of qualitative research. These include disclosure and explication of the investigator's personal orientation, context, and internal processes during the investigation, along with intensive engagement with the material, iterative cycling between observation and interpretation, and grounding of the interpretations' (p. 602). Concerning the disclosure and explication of the investigator's orientation, we have outlined the Freudian-Lacanian background of the authors. With regard to the controversial issue of the treatability of perversion, the authors consider this topic with mixed attitudes, ranging from mild scepticism to mild optimism. However, our clinical experience with the treatment of perversion is limited. Prior to this study, the first author conducted several clinical interviews in a prison with sexual offenders with perversion as part of his PhD research. These interviews led him to believe that many subjects with perversion do not seek satisfaction in an unambiguous way, but suffer with their perversion. Moreover, while some subjects with perversion seemed willing to go into analytic treatment, he questioned whether such a treatment would be effective. The current study was inspired by this question. Concerning Stiles (1993) comment on the intensive engagement with the material and iterative cycling; as outlined above, the procedure applied in this study obliged the first author to read and re-read the material. To assess the credibility of the coded material, he had to cycle several times between the passages and the codes. Finally, interpretations (outlined below) are grounded in quotes from the original case studies, short vignettes, and a selection of key references. The results for the Imaginary and the Symbolic dimension are discussed below. For each dimension, a summary table is presented, in which the themes, overarching codes, and key references are listed. The key references are the most illustrative case studies with regard to the respective theme. The interested reader can consult these case studies.

Results

The codes relating to the Imaginary dimension in the transference were grouped into three main themes: 1) identification, 2) fusion, and 3) rivalry.

Table 1: Themes, overarching codes and key references for the Imaginary axis

IMAGINARY AXIS			
Themes	Identification	Fusion	Rivalry
Overarching	Child – parent	Disrespect limits of	Humiliation

codes	Sexual partner	setting Dependency Join in perverse world	Power struggle Aggression
Key references	Joseph (1971) Jimenez (1993) Carignan (1999)	Baker (1994) Torres (1987) De Masi (2007)	Joseph (1971) De Masi (2007) Meyer (2011)

The first theme of identification refers to the fact that the patient repeats former relationships within the transference. The patient recognizes in the analyst the image of an old object and identifies with the corresponding role. The image with which the patient identifies is mostly the image of child, while the analyst as alter-ego is put in the role of parent. For instance, one patient behaves like a 'little saint,' sexless as he was for his mother (Carignan, 1999). Another feels treated as a dog, just as his father treated him (Baker, 1994). The transference relation can also be organized around the image of the object of perversion that is recognized in the analyst: the patient then identifies with the role of sexual partner in the transference. This identification can manifest in explicit and seemingly conscious attributions to the sexual intentions of the analyst. For instance, at a certain period in the treatment reported by Jimenez (1993), the transference is intensely sexualized and the atmosphere is filled with homosexual insinuations: "(...) it was I who had homosexual desires for him! He could read it on my face, in my way of shaking hands, in my "allusions" (interpretations), my silences, and so on" (p. 500). On the other hand, such projections can remain unnoticed for long periods, although they influence the treatment unconsciously. Several case studies demonstrate how patients unconsciously use fantasies about the analyst to block his/her therapeutic influence, as everything the analyst says is heard as coming from this projected image.

The second and the third themes, fusion and rivalry, refer to the fact that relationships on the Imaginary axis are characterized by duality. As a point of reference to differentiate between the ego and the alter-ego is missing, both will tend towards either fusion or rivalry (love versus hate). The theme of fusion means that the difference between the analyst and the patient becomes blurred, and the patient seems unable to conceive that the analyst thinks, feels and desires differently from himself. This can lead to difficult situations in which patients do not respect the analytic setting. For instance, Baker (1994) reports a patient who barges into the room unexpectedly and takes off his shoes and socks before lying down. Patients also feel strongly rejected when the analyst frustrates this tendency towards fusion. Several patients react very strongly to the cancellation of a session, for instance by acting out or by persistently questioning the necessity of this cancellation. In the context of this fusion, the analytic situation itself can become a source of sexual excitement: for one patient sitting face-to-face is experienced as a sexual position, for another patient looking and being looked at on the couch becomes a source of enjoyment, a third derived great anal pleasure from 'stinking out the session,' and another one attempts to provoke voyeurism in the analyst by only hinting at his secret sexual escapades. The perverse patient wants the analyst to join him in his perverse sexuality.

However, this tendency towards fusion comes together with rivalry and a struggle for power. Within imaginary relations, the only point of reference is the alter-ego. As the patient measures his self-image against the image of the analyst, the question automatically arises as to who is superior. This was very strongly present in all case studies. The sole fact of starting therapy and accepting help can be experienced as very humiliating. The patient has great difficulty in 'giving in' to the analyst and in two case studies the supine position on the

couch is experienced as a submission. Sometimes, laying down on the couch has a (homo)sexual connotation. In order to counter this humiliation, some patients start their treatment in a very provocative way by articulating their sexual interests in great detail. Others try to convince the analyst of the superiority of their mode of sexual enjoyment and turn their perversion into an ideology. In the context of this rivalry, forms of aggression towards the analyst can be noted. This can be a deadening silence, a challenging attitude, a tendency to ridicule the interventions of the analyst, or reproaching the analyst's hidden, malevolent intentions. This aggression comes together with a strong fear of being swallowed by the analyst. The analyst is experienced as being envious, egoistic, evil, or wanting to humiliate the patient. The patients also rebel against any supposedly condemning or prohibiting reaction in the analyst. Some patients assume that the analyst disapproves of their sexuality and react with provocation. Others ostentatiously cross the boundaries of the analytic setting.

The case study by De Masi (2007) on the treatment of a pedophilic patient contains much material relating to the themes of the Imaginary axis. Aspects of fusion can be noted as the patient developed a strong dependence on the analyst from the beginning of analysis, gave up masturbation, and wanted the analyst to share his belief and enthusiasm in the world of 'boy-ness.' At the same time, the transference was polemic and aggressive and the analyst became the object of malignant projections and fierce criticism. The patient would take the analyst's words and phrases out of context so that they appeared obscure, stupid and offensive. He would then voice his indignation and feelings of being insulted. Furthermore, the patient harassed the analyst with propaganda in order to impose the superiority of his perverse world. As soon as the patient felt that he had provoked the analyst, he would become cold, rational and blame the analyst for his behavior. De Masi also notes that there was a constant risk of being identified with an absent and confusing parent. In one session the patient brought a picture of an adolescent football team in which two of the boys had their hands on their genitals. For the patient this photo was clear evidence that all adolescents masturbate each other. The analyst remarked that the position of the boys' hands might have been casual. The patient was outraged by the analyst's trivializing answer and took it as an invitation to masturbate.

The codes relating to the Symbolic dimension in the transference were grouped into three themes: 1) addressing the Other, 2) the otherness of the Other, and 3) the analysis of the symptom.

Table 2: Themes, overarching codes and key references for the Symbolic axis

SYMBOLIC AXIS			
Themes	Addressing the Other	Otherness of the Other	Analysis of the symptom
Overarching codes	Request for help Talking about the symptom instead of living it	Element of surprise Tolerance and avoidance of countertransference acting out	Questioning motives Questioning products of the unconscious Questioning perverse fixation
Key references	Torres (1987) De Masi (2007)	Jimenez (1993) Baker (1994)	Joseph (1971) Purcell (2006) Meyer (2011)

The first theme, addressing the Other, refers to the fact that the patient, at a certain point in his life, decides to start talking about his symptom instead of merely 'living' it. The moment of engaging a psychoanalyst is important as it demonstrates the point at which the balance between the satisfaction and displeasure derived from the symptom is disturbed, and help is requested. In the request for help, we see the subject (S) that is disturbed by something of which he cannot get a hold and an Other (O) who is addressed by the subject. None of the patients approached the analyst with the sole request to be cured of their perversion. In fact, the perversion itself comprised part of the reason for the initial consultation in only two cases. These two cases involved pedophilic patients who voluntarily consulted the analyst, as they feared becoming completely dominated by their sexual fantasies. The most prominent reason for starting analysis was depression, hopelessness and/or anxiety because of the social isolation that resulted from their perversion. Most perverse patients sense that their perversion has something to do with their relational, professional or other interpersonal problems, but they are unable to grasp the precise nature of this relation. Some patients want 'normal' relationships with woman, others are angry because their partner left them, and still others complain about conflicts with superiors.

The second theme concerns the otherness of the Other and refers to the position taken by the analyst. As we saw previously, the perverse patient puts the analyst under great pressure to identify with a certain image, such as a sexualized image or the image of a parent. In several case studies it is reported that the analyst tries to maintain a distance from this image and to differentiate between the analyst him- or herself and the image that is projected onto him or her. From the perspective of the L-schema, the analyst thereby tries to represent the otherness in the Other, in a sense that the analyst is not what the patient expects him or her to be. Some authors did this by adjusting their technique. Instead of focusing their interpretations on the image that is projected onto them, they noticed that it was more productive to divert interpretations away from the transference. For instance Baker (1994) reports a patient who started to produce anal flatulence in the sessions, with the motive of contacting and soiling the analyst sexually, and for the analyst to join him in his anal world. Instead of interpreting this acting out in relation to the analyst, Baker focused on this self-humiliating behavior as the patient's surrender to a destructive part of himself: "it seemed more pertinent to focus interpretations *away from the farting as an attack on the object* and direct them *towards its manifestations as an expression of self-humiliation*. In that way, the risk of being experienced by the patient as a rejecting or retaliating transference object was substantially reduced" (p. 748). In a similar vein, Jimenez (1993) abandons transference interpretations because they are experienced by his patient as typical of his mother, who was convinced that everything he did was related to her.

Another aspect related to the theme of the otherness in the Other is the extreme tolerance and the difficulties avoiding a countertransference acting out. As described previously, perverse patients sometimes try to elicit reactions in the analyst in a provocative way, after which they can triumphantly claim that the analyst is no better than the rejecting mother, for instance. One of the most difficult tasks in the treatment of perverse patients seems to be enduring the patient's provocations. However, when the analyst succeeds in maintaining the position of the Other, it can have effects on the patient's perverse sexuality. Several passages demonstrated that the patient experiences the analyst as an inhibitory factor in the perversion. Earlier in the discussion of the Imaginary dimension, we saw that the perverse subject places the analyst in the position of the one who prohibits his sexuality. Some perverse patients literally ask the analyst to forbid their sexuality because this would make it easier for them. However, when the analyst does what is expected of him or her by the patient, and announces his disapproval, the patient then starts to rebel against the analyst. On the other hand, if the analyst does not occupy this position and remains the incarnation of the otherness, he or she keeps on functioning as a limit. For instance, in some

case studies the perverse acting out only emerges in the weekends and vacations when the patient is out of range of the power of the analyst. Typically perverse acting out takes place when the analyst has to cancel a session, as if the patient is not able to resist the perversion without the help of the analyst. In certain case studies, the analyst appears in dreams or fantasies as someone who disturbs sexual enjoyment.

The third and final theme concerns the analysis of the symptom. By this we mean the work of free association and interpretation that enables the patient to articulate the narrative material that unconsciously determines the symptoms. In the various case studies, we found fragments that demonstrate the progress of perverse patients in unraveling the unconscious associations related to their perversion. Evidence of this analytical work can be situated at several levels: questioning the motives for thoughts, feelings and actions, questioning identity and questioning the perverse fixation. At the level of the motives for thoughts, feelings and actions, the perverse patient demonstrates an ability to work analytically and to be open to the interventions of the analyst. Meyer (2011) reports a transvestite patient who felt 'reduced' to a girl by having to lie down on the couch and no matter how erotic in fantasy, in real life this was the most infuriating thing he could imagine. The patient reacted by secretly starts wearing panties during consultations. Some time later the patient admits to this behavior and the patient and analyst come to understand this act as an effort to protect the analyst from the patient's rage – women do not attack men – and protect himself from retaliation – a man does not hit a woman. The perverse patients develop interest in the products of the unconscious (slips of the tongue, dreams, symptoms) and have a capacity for free association. As a result of the analytical work, patients evolve in the way they speak about their mother and father, new memories emerge and they put things into a new perspective. At the level of the subject's identity, we see that several patients question the signifiers that the mother used to designate them. For instance, Torres' (1987) homosexual patient articulates the signifier that his mother used for him, 'my conchita,' which literally means little shell but is also a girl's name and 'concha' is a vulgar word for vulva. This signifier designates his female position towards his mother. This patient insistently questions his analyst: "what does it mean to be a homosexual? (Pause) The term that my mother used for me was "my conchita." What does it mean to be a homosexual, Doctor? This word hurts me a lot and upsets me..." (p. 359). Finally, at the level of the perverse fixation, in a few passages the patient appears to question his fixation. The case study of Joseph (1971) is interesting in this respect. The transference in this case is characterized by extreme passivity, heavy silences, and repeated intellectualized phrases that hide a sadomasochistic relationship. However, as the analytical work progressed, "there began to be moments when my patient could sometimes feel some vague flickerings of cruel satisfaction as the deadening silence went on" (p. 446). This was worked through again and again and they could see how the sadomasochistic transference was aimed at destroying the analytical work. During this working through, the patient remembers a particular situation in which he kept playing the same tune on the piano over and over again, until his father was beside himself with rage. After this, the patient and his brother went up into the attic and the father was overcome by a choking attack and looked awful, and the boys laughed and laughed until they were nearly hysterical. The analyst connects this memory to his actual behavior in the transference, stressing the intense sexual excitement of driving his father almost to the brink and how this was the situation he was aiming for in the analysis. This intervention makes the patient very uneasy, saying "I don't like you saying these things, and now I've got an erection" (p. 447). This reaction seems to indicate the limit of the analytical work on the perverse fixation. This patient experienced the interventions of the analyst as being kicked around, as is expected within a sadomasochistic relation. Thus, in spite of gaining insight, the patient keeps regressing into the sadomasochistic relationship.

Conclusion

The aim of this study was to examine the patterns and variability of transference across 11 case studies of psychoanalytic treatment with sexually perverse patients. The thematic analysis was guided by Lacan's theory of the L-schema, which distinguishes between an Imaginary and a Symbolic dimension in transference. The results reveal the various ways in which the perverse patient puts the analyst under pressure – sometimes overtly, sometimes subtly – to identify with a certain image on the Imaginary dimension. In this respect, the treatment of perverse patients is difficult for the analyst, and requires a great deal of tolerance and tenacity. From the perspective of the L-schema, we situate this behavior on the Imaginary axis. However, the Imaginary and Symbolic axes are two sides of the same coin and every aspect of transference has to be considered from both perspectives. The imaginary aspects of transference carry signifying material that determines the transference and has to be deciphered during the analysis.

Within the Imaginary dimension, there is no room for a difference between who the patient thinks he is and his subjectivity (i.e., the difference between ego and S), and there is no room for the difference between who the patient thinks the analyst is and the analyst's subjectivity (i.e., the difference between other and Other). This idea is similar to what Jimenez and Mogueillansky (2011) call the symmetrical aspect of the analytic relation. They point out that a perverse collusion between patient and analyst is unavoidable. But the risk is that the analytic relationship becomes an unconscious bond in which analyst and patient enter an unnoticed complicity against the analytic process. Our thematic analysis revealed the different ways this unconscious bond is established: (1) by identifying with the image of child in relation to analyst-mother or analyst-father, by identifying with the image of sexual partner, (2) through fusion with the analyst or by pulling the analyst into the perverse world, and (3) by rivalry as manifested in a power struggle or aggression.

In accordance with our expectations, the imaginary aspects of transference were often sexualized, as the patients try to satisfy the drives in relation to the analyst. However, concerning our first research question, not all counterproductive aspects of transference are related to this sexualization. It was striking to note the strong dependence these patients have on their analyst, leading to confusion with respect to the difference between both parties, violation of boundaries, and extreme consternation when the routine of sessions was in some way changed. This finding is in contradiction with the idea that the perverse patient is self-satisfied and unwilling to connect to someone else. Rather, the tendency towards fusion reveals the patient's need to be loved, appreciated and recognized. As noted in the introduction, the patient in perversion cannot resort to the symbolic phallus to represent him in the desire of the Other. The patient falls back on imaginary fusion with the other, although fusion inevitably leads to rivalry and aggression. This unstable way of relating to the analyst is not specific to perversion, but can be found in other serious forms of psychopathology with narcissistic and borderline features. A comparative study might be useful to determine which aspects of transference are specific to perversion.

According to Jimenez and Mogueillansky (2011), "The progress of the analytic process depends on the functionality of its asymmetrical aspects, ... the interpretation of differences (asymmetries) makes it possible to resolve the transference, and, consequently, to cure" (p. 164). From the perspective of the L-schema, this implies a focus on the Symbolic dimension. Our results indicate that the perverse subject is able to do analytic work on the Symbolic dimension. This work begins at the moment the patient searches for help, which indicates that he notices that something in his life does not work. We saw that in most cases this is

concerned with the relation between interpersonal problems and perverse fixation. The perverse patient is able to suspend the satisfaction he derives from his symptom and start talking about it. Furthermore, he is able to question his motives for thoughts, feelings and actions, his products of the unconscious and the signifiers that make up their identity. For example, one patient identified with the signifier 'conchita' given to him by his mother, but keeps asking the question: am I really this? This type of question illustrates the difference between the position of the subject (S) and the position of the unconscious (O). In this example, the analyst did not answer the patient's question, thus representing the otherness of the Other. The analyst does not claim to understand the patient or know anything about the patient. This position incites the patient into further exploration of the unconscious. Our results indicate that the analyst can function as a representative of the otherness in the Other in the treatment of such patients.

The observation that the analyst can function for such patients as an inhibitor of sexual fantasies and acting out behavior is of particular interest. In relation to the analyst, the patient is prepared to give up a part of his satisfaction. However, here the double stance of disavowal emerges again, as he simultaneously asks the analyst to forbid sexual activities, and rebels against any supposedly condemning or prohibiting reaction in the analyst. The analyst seems to function as a limitation of sexuality to the degree that he does not identify with the position of prohibitor. This result resembles the finding of Swales (2012, p. 214) that the patient often placed her in the role of a lawgiving Other. Her patient admitted to undetected acts of indecent exposure because he assumed that Swales was able to read his mind and knew about his offences. Moreover, he restrained himself from certain aggressive actions because he believed that she would find out afterwards. Apparently, perverse patients sometimes use the analyst to bolster the suspension of satisfaction, without the analyst explicitly asking or forbidding them anything. This means that the pursuit of satisfaction is ambiguous in the perverse patient and some patients want to limit their sexual satisfaction (at least partially). However, it would require another study to investigate whether the analytic work can result in a change in the perverse fixation itself, and if not, how the patient deals with it after analytic treatment. This topic is beyond the scope of our study.

Clinical implications

In Lacan's view, psychoanalytic therapy should mainly concentrate on the Symbolic axis of speech; conditions for change will be established to the extent that the analyst succeeds in bringing the Symbolic axis to the fore in the analytic work. On the Symbolic dimension of the L-schema the patient's subjectivity and the position of the analyst are decentered: the patient's subjectivity does not reside in who he thinks he is qua ego, and the position of the analyst is not as object or alter-ego for the patient, but functions as the Other. As long as the patient talks about his conscious thoughts, feelings and intentions, the analytic work remains on the Imaginary axis. Speech on this axis always intends to provoke a certain reaction in the alter-ego (o'), such as confirmation, understanding, appreciation (i.e., the register of love), or indignation, abasement or rejection (i.e., the register of hate). Within a transference relation, the patient will try to elicit similar reactions to those previously experienced in relation to former objects, such as the mother or father. Take for instance the patient described by Baker (1994) who described his father as a patronizing but generous man who gave him gratuitous advice. The patient reacted to his father with a mixture of feeling put down by the father and mocking the father in a megalomaniac way. This pattern is repeated in the analysis: on the one hand, he felt very humiliated by having to

acknowledge his need for therapy, but on the other hand, he started to behave very provocatively, violating all limits of the analytic setting. Representing the otherness of the Other then means creating a dissonance between what the patient expects in the analyst's reaction and what in fact occurs. Baker did not reject the patient, nor did he react in a cold or aggressive way. Rather, he maintained his analytic stance, listening to the patient's free associations, tolerating the vehement transference and refraining from countertransference acting out. In that way, the analyst destabilized intentional speech in the patient and made it possible for the patient to speak differently. The disruptions in intentional speech make it possible to say something surprising, such as a slip of the tongue, an unexpected association, an unusual metaphor, a joke, etc., which demonstrates that the subject (S) is at work rather than the ego (o). In the case described by Baker (1994), the patient produces a striking metaphor to describe the transference. He says "I am treated just like a dog in here, you offer me a bone, just like my father" (p. 746). This association is informative pertaining to the Imaginary axis (the analyst is compared with the old object of the father), but is revealing when we focus on the signifiers. The patient seemingly identifies with a dog, so what would his associations be to the word 'dog'? Furthermore, he indicates that he feels like receiving a bone from the father-analyst. The signifier of 'bone' with its phallic connotation arouses numerous questions: is the 'bone' of the father insufficient for the patient? Did the mother talk like that about the phallic qualities of the father? Or is the patient hoping to receive from the analyst a better 'bone' than his father had to offer? All these questions inspire further analytical work.

Starting with Freud, numerous psychoanalytic authors have elaborated on the idea that the relation between the analyst and patient does not merely consist of a repetition of intrapsychic conflicts which have their origin in past relationships. Next to this aspect of resistance, there is an efficacious aspect to the therapeutic relation. This has led to a number of concepts, such as the real relationship, the therapeutic alliance, the working alliance, etc., that all broadly refer to the fact that effective therapy is characterized by trust and a positive connection between the patient and the analyst (Thomä & Kächele, 1994). The Symbolic axis in the L-schema can be considered as Lacan's conceptualization of the productive aspect of the therapeutic relation. However, in contrast to these concepts, the Symbolic axis and the position of the Other it assigns for the analyst do not involve the person of the analyst him- or herself. Representing the otherness in the Other is a function the analyst has to fulfill, rather than something or someone he or she has to be. It does not involve any specific personal characteristic of the analyst, such as anonymity, reservation or coldness. Rather, the analyst represents the otherness of the Other by focusing the analytical work on the signifiers and elements of the unconscious that appear in the patient's narrative. This affects the patient insofar as he or she produces more signifiers and questions how to relate to them. Therefore, taking in this position is creating the condition for change, not change itself. Change, according to Lacan, is realized through speech.

Limitations and recommendations for further research

This study is among the first metasyntheses of psychoanalytic case studies. We are convinced that this method has great potential when it comes to empirical research in psychoanalysis. Many psychoanalytic concepts resist operationalization in quantitative terms, which makes research in group designs often problematic. It can be argued that objective and countable data do not touch upon the essence of the analytical experience. Rather, psychoanalysis is about making sense of the patient's free associations within the analytic situation (Colombo & Michels, 2007). Case studies provide such data. However, the

exploitation of case studies as a means to advance psychoanalytic theory and praxis is hampered by the fact that case studies are often only used as an illustration in theoretical studies. For instance, 48% of the ISI published psychoanalytic case studies are presented as an illustration in the course of a theoretical paper (Desmet et al., 2013). Metasynthesis provides a strategy to aggregate insight and experience through the systematic identification of concepts and themes across cases.

As any other scientific method, metasynthesis suffers from several limitations, which also affect this study. The data of this metasynthesis are accounts and interpretations made by the authors of published case studies. The case studies used alternate between detailed descriptions of therapeutic processes and more abstract elaborations. As a result, our study is based on clinical data from different levels of abstraction. Moreover, the case reports greatly varied in writing style, psychoanalytic orientation and level of detail. While some case studies provide almost no information on transference, others contained abundant information. These different levels of abstraction and quality of information constitute a drawback to this study. However, Iwakabe and Gazzola (2009) note that this restriction is not entirely negative. Published case studies summarize the important moments and processes from many sessions. Moreover, the therapist's narrative account is a powerful tool when it covers the therapist's internal experience as well as important events outside the therapy sessions. This information is pertinent for a study on transference.

Other limitations of metasyntheses in general, and this study in particular, are the fact that this method does not permit one to test hypotheses or determine the effectiveness of treatment. In other words, based on our results we cannot conclude that focusing on the Symbolic dimension will be effective in the treatment of perversion, or that treating perversion through psychoanalysis will result in a positive outcome. Future research on the topic of perversion and transference could use primary data (therapist notes, audio-recordings, etc). One particularly interesting option would be to make a systematic case study in which both qualitative and quantitative methods are used to study the process and outcome of the treatment. The method of systematic case studies is more flexible than the experimental case study as it needs no randomization or manualized treatment. In contrast to classical case studies, the systematic case study allows researchers to test hypotheses and establish treatment efficacy. The clinical case study that is currently predominant in psychoanalysis allows us to develop our understanding of psychic phenomena and this understanding can be extended by comparing several case studies in a metasynthesis. However, we are convinced that researchers and clinicians in psychoanalysis will have to keep testing new forms of case study research, and the systematic case study is an interesting possibility.

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