Retrieved from:
The European Journal of Psychoanalysis
Feb 9, 2023
https://www.journal-psychoanalysis.eu/articles/a-case-of-vaginismus-a-discussion/

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A Case of Vaginismus: Discussion

Comments on " A Case of Vaginismus "

Paolo Migone (Parma)

Porcelli's clinical account allows us to formulate specific hypotheses on the psychological dynamics, in all likelihood responsible for the sharp improvement that occurred. I shall comment only on some of the more significant of these.

The patient says she "grew up alone and precociously" and is described as efficient, hard-working, "very strong… very down-to-earth… a very able and intelligent woman… the one to see to any problem, faces it, attacks it and solves it" and so on. We can make the hypothesis that she is a "*parentified child*", i.e. a woman who "as early as the age five… made up for her mother's functional 'deficiencies'" (her mother also suffers from psychic disorders) and who therefore always takes on strong roles, ones that put her in control, because in many of her life's experiences weakness and passiveness were associated to situations of danger. This woman then manifests the symptom of vaginismus, a difficulty in "letting herself go" with her husband–who, not incidentally, is a dependent and immature individual she has to look after like a child.

Against this background, the therapist makes his first interesting move: he *prescribes* for this woman a behaviorist desensitization technique based on exercises, daily efforts and work to defeat the symptom. A woman whose "behavior is directed at maximizing *efficiency*" is prescribed with a technique based on "*efficiency* tests" [my italics], i.e. on *Evidence Based Medicine*–a serious technique, not the usual psychoanalyst chatter. This may at first come across as a counter-therapeutic move, insofar as the model the therapist offers is similar to the transference pattern, and could therefore reinforce it. On the other hand, immediately offering the patient an opposite model, i.e. not prescribing any model and simply encouraging her to "let herself go", showing her with the facts that it is quite possible to live an alternative experience to the one she is used to (for example, by encouraging her to follow the golden rule of psychoanalysis, free associations), could in itself be a therapeutic model that wrong-foots the patient. But instead the therapist, to make his patient feel more at home, decides to approach her with the weapons she's most familiar with. He does not hide the fact that this is a skillful device, to have more chance of "guaranteeing a good working alliance and sustaining her motivation". His is a seduction technique: he empathetically responds to her needs in the best way possible, because at the time this gave more guarantees of getting on to her, enter her world and then take her out of it painlessly. The therapist used a *judo* technique, using the strength and thrust of others to drag them where we want. This was an intelligent and sophisticated technique.

But it cannot be ruled out that the same results could have been reached by simply reassuring the patient (who, incidentally, mistrusted the usefulness of a cure based on words) and encouraging her to behave in

sessions in the opposite way from how she behaved in everyday life, i.e. ignoring the goals to reach, effort and work. Paradoxically, prescribing these new objectives (the paradox is implicit in the free associations technique), giving her this new "task" that she was to accomplish as only she could do, is in itself a "behavioral" technique. A therapy can also work in this way, as Eysenck pointed out in his behaviorist reading of psychoanalysis[1].

From then on the therapy proceeds well, with a couple of regressive crises (one marked by "hysteric" conversion), crises that are normal in psychotherapy, and are therefore interpreted by the therapist in the light of Weiss & Sampson's *San Francisco Psychotherapy Research Group*'s *Control-Mastery theory*. In psychotherapy, crises and temporary deterioration are hardly ever negative signals, but actually proof that patients *are moving on*. The most serious danger is for them to remain motionless in the fixedness of their pathology. It's the process you have to look at, and highs and lows are typical of all improvement processes. In fact, the patient makes her earliest significant progress after the first of these crises, after passing a transference "test".

I now want to discuss the question posed in the last paragraph: as a technique that is behavioral has been used for vaginismus, how can one say that this was a psychoanalytical therapy?

This is the question that pushed the therapist to publish the case. One cannot help thinking that it is a provocative question, considering how sophisticated this therapist is. This question alludes to an unfortunate tradition, one that classifies types of psychotherapy according to their descriptive aspect, as if it were possible to deal with psychotherapy in the same way as DSM dealt with psychiatry. Such an operation is problematic for psychiatry, let alone for psychotherapy. Still, the psychoanalytical establishment has been capable of nothing better than posing the problem in this way, leaving it conceptually helpless. Among the various examples of this, see Wallerstein's vain attempts to differentiate between psychoanalysis and psychotherapy (for example at the two Rome IPA conferences of 1969 and 1989) or Sandler's (at the time also IPA president) when he said that one can often solve the problem tautologically, defining psychoanalysis as the therapy practiced by psychoanalysts and circularly defining as psychoanalysts those who practice psychoanalysis (and we could add that behaviorism is what is practiced by behaviorists, and so on; with one fixed point: *belonging to an institution is what really counts*, even if this means the loss of the discipline's scientific status). But Luborsky too, in his 1984 textbook (*Principles of Analytic Psychotherapy*), attempted to emulate Spitzer by drawing up a kind of DSM-III of psychoanalysis, coming to internal contradictions; and he fully realized this, admitting that the division, which held the whole framework of the textbook together, between "supportive" and "expressive" techniques was impossible solely on the basis of the descriptive criterion (given that, for example, interpretation, the expressive tool *par excellence*, strengthens the Ego and is therefore supportive). And see also Kernberg's recent proposal (*Int. J. Psychoanal*., 6/1999), when he too was IPA president, for "an integrated conception of three psychoanalytical therapeutic modalities": "standard psychoanalysis", "psychoanalytical psychotherapy" and "psychoanalytically-based supportive psychotherapy". Institutional needs forget even the implications of Ego Psychology, which, already over half a century ago, assigned a precise role to work on defenses. For example, if one is supportive when a patient could allow himself an expressive attitude, is one doing supportive therapy or bad psychoanalysis?[2]

So, I believe that the therapy which was practiced here was a psychoanalytic one (or, in any case, psychodynamic in the broader sense), as intervention in vaginismus did not aim plainly at the mechanical dilatation of an organ, but also paid close attention to the impact of that type of intervention on the relation. In fact, behaviorist intervention was used intentionally so that it would also act at other levels (for example "to guarantee a good working alliance"), therefore in the theoretical hypothesis, whether wrong or right, that elimination of the symptom could also be achieved, perhaps even more effectively, by intervening at the source on determined personality variables (the "letting oneself go"). This hypothesis is of a dynamic type and is not necessarily implied in a behavioral approach in the narrower sense.

Paolo Moderato, Francesco Rovetto (Parma)

We will consider this case on two levels. One more specific, the other more general, dealing with the epistemological consequences produced by the use of different therapies.

First of all, the motivation for choosing the systematic desensitization technique: "above to all to guarantee a good therapeutic alliance". There doesn't seem to be a connection between the two. In cognitive-behaviorism the need for a therapeutic alliance and an adherence to what is prescribed is perceived as very important. In this case, however, the choice of the technique doesn't come across as critical for the objective, in which there is no mention of an "*attribution*" phase, i.e. of the explicative hypothesis on the historical genesis of the problem, the absence of which, considering the continuation of the case, is very noticeable.

Let's take a closer look at this passage: "Anna finished her relaxation exercises one hour ago, but now her legs are paralyzed (…). But that's not the point. Anna has realized that this is her problem, that the problem is her. She had always blamed everything on her husband and was angry with him, but now she realizes that she can't have sexual intercourse because it is her who cannot relax, and she cannot relax because there is something wrong with her". The first observation concerns the relaxation method adopted: it is one that is often very difficult to teach (there's no trace of this in the account) and to achieve, hence the paradoxical effects described. The explanation–perhaps not adequately sought, but found anyway–could be the following: "It is therefore possible that Anna is scared of the deep and has never experienced relaxation (I won't forget that, in general, loosening her grip and control over situations causes her a great deal of anxiety)". People who are scared of "losing control over things" (and the family analysis is in this case correct, even if perhaps insufficient) have opposing and paradoxical responses in relaxation: some countermeasures do, however, exist (e.g. the choice of a particular form of training or relaxation rather than another, whether or not to use certain kinds of images, and so on).

The second observation concerns the analytic unit. Cognitive-behavioral therapy, borrowing from Master and Johnson's couple therapy, which remains a point of reference for us, considers not the individual but the couple as the analytic unit for therapeutic intervention. Any sexual behavior disorder implies intervention on the couple, not on the individual. Here our subject's psychological counterpart is a precocious ejaculator (victim, persecutor or both?): "…penetration exercises are vain because of his premature ejaculation."

As for how the technique is employed, there is no mention of the assessment modalities for the specific troubled situations, nor for how the hierarchy is built or for its presentation. Having no details, we take for granted that the therapist is absolutely master of this technique, even if he belongs to another trend.

Finally, some general considerations. A lot of water has gone under the bridge between the earliest formulations of behavioral therapy and current positions. The birth of any new paradigm implies a traumatic break with previous ones. The earliest phase of the new paradigm was characterized by total contrast with the old: see Watson on introspectionism, or Freud on descriptive psychiatry – like when in election campaigns candidates have extreme positions on particular issues, only to soften them after they're elected. The following phase is the operative, where ideological assertions are mitigated and distances reduced. Today the distance between what in 1965 Eysenck called psycho-dynamic therapies and the *nouvelle* behavioral therapy of the sixties is far narrower[3].

Yet world visions underlying any therapy are always different: these are more on the metatheoretical than on the technical plain. The former is irreconcilable, the latter much less so. Few analysts with any common sense and adequate training would take delirious schizophrenic patients into their care without an accompanying pharmacological therapy or deny the effectiveness of lithium salts for someone with serious bipolar disorders, even while maintaining their theoretical and methodological coherence. After all, the Appendix to DSM-IV has a reference to patients' defense mechanisms as a further diagnostic axis capable of complementing the five official axes. Defense mechanisms have been described and widely used by

therapists of the dynamic trend, but they could also be described so as to sound acceptable to cognitive-behavior therapists too, without their being too upset, as happens with DSM-IV.

Psychoanalysis, particularly in recent years, has not put much stress on its effectiveness as a therapy; rather it has strongly upheld its value as the analysis of internal dynamics. In the case of the couple with a vaginismus problem, there was a pathology for which cognitive-behavior therapy proved very effective. There were well-defined constraints (8 sessions, maximum 16) imposing an effective approach, and the two patients felt a strong need to understand their own personal and relational dynamics. Very appropriately the psychoanalyst only used techniques that could produce results in such a brief therapeutic period. As always happens when you apply effective strategies (whether cognitive-behavioral, psychoanalytical or any other), vicious circles that maintain the pathology in time are broken. Patients learn to look at themselves, their world and their future with different eyes. A cognitive-behavioral therapist, or one of the psychodynamic trends, knows full well that therapy doesn't finish with remission of the symptom, but that it is necessary to help patients understand what and how their lives could be without the defense employed by their illness, and how to deal with any possible relapses. Therapists call all this cognitive restructuring and relapse's prevention. On this occasion phases of stalemate and apparent relapse have actually enabled the therapist to go ahead with the final decisive phase of therapy.

Probably there would be a lot more to do, whether the case is read in an analytic or in a cognitive-behavioral key. However, the new condition the couple are living, and the modification of relations between the patient and her family of origin, could already have triggered off a virtuous circle that may favor the appearance of pregnancy and further autonomy. In the end the world has evolved for thousands of years with no psychologists, psychoanalysts, psychiatrists, medication and formalized psychotherapies. Often a life of simplicity wins. The patient's already remarkable progress may be completed later, and perhaps a formal psychotherapy will not be indispensable.

Furio Lambruschi (Siena-Bologna)

The clinical case of Anna has a wealth of food for thought from at least three points of view:

(1) hypotheses that may be formulated on possible paths for development, the organization of the Self and the related perception of the world upheld by Anna's, as well as on the corresponding implications of a corporeal character;

(2) the analysis of possible strategic lines of intervention and of the more specific technical options;

(3) the analysis of the interesting phenomena that determine themselves within the therapeutic relationship.

My comment is mainly centered on these three aspects, observed and interpreted in the light of the conceptual perspective given by constructivist and developmental cognitive psychotherapy. I refer on the one hand to the line of *cognitive-developmental* research (promoted by Giovanni Liotti), based on ethology, on the analysis of human motivational systems and, in particular, on attachment theory, and on other *constructivist* and *post-rationalistic* developments in clinical cognitivism (promoted by Vittorio Filippo Guidano).

The characteristics of Anna's primary cure-care system (with particular reference to her mother's bipolar disorder) bring to mind scarcely organized or oriented primary attachment models and, due to the high unpredictability and threateningness of the relational context, are imbued with fear. They make way for types of structuring of the self marked by peculiar and consistent integration deficits and, as early as at pre-

school age, the emergence of an internal defensive structure and a range of strategies of procedure (actings functional to dealing with a minimum state of relation with such an alarming context) of the "controlling" type (Main & Cassidy; Wartner *et al*.) or of the high index "coercive active" kind (Crittenden). All energy concentrates on exercising active control over figures of attachment and over the significant other, with the aim of stabilizing perceived discontinuity and danger.

It really does seem that Anna can't give herself a break for even a second, always having to organize her experience through a constant and relentless control of her relations: this via coercive strategies aiming at weighing down relations with others and at making herself always dramatically visible. As is often the case in this type of organization of the Self, the causal attribution of one's ailment is entirely external, with complaints ranging from wild recrimination to skepticism and displayed impotence, functional to soliciting care and rescue from the other (husband, therapist, etc.). Despite her constant moaning and her pessimistic lack of confidence in things and in others, she preserves considerable levels of self-esteem. There are in fact no problems as far as her personal amiability is concerned. Her problems concern her confidence in relations, in the other's being there, in the capability of preserving a stable lasting state of relation. A constant fear of abandonment, of losing the other's gaze, attention, consideration and support if she ever allowed herself to lower her guard, to relax and to let herself go with the other, moves around inside her. The displayed coercive polarity is mainly assertive, harsh, hyper-active, full of independence and skills. However, those who approach such a compulsive option continue to live through, even though in a less articulated form, the underground polarity, characterized by anxiety, deep feelings of fragility due to separation, a continuous unavowable sense of personal vulnerability.

Coherently, for Anna mutuality within the couple is based on assuming an illusory and only apparent one-up position towards her husband, one where she displays a strong Ego, tenacious and competent, and emerges as a figure sure of herself, capable of everything at the practical and organizational level, while her husband comes across as totally dependent. As well as this manifest scenario, a latent one inexorably transpires, where Anna's fragile and vulnerable parts seek legitimacy to exist, want to be acknowledged. But her internal operative models, which are known and reassuring, impose a relentless control over the other, over her own more tender internal states and, of course, over her body. Her body "tells of" the quality of her bonds, it has been "sculpted" in function of the affective regulation it has made possible in her relation with those specific attachment figures: a "tonic", aggressive body, never tender and graceful. As the body is an organ of relation, it is obvious that it is impossible to place oneself physically with a tender attitude if the other is perceived as dangerous and threatening: if you let yourself go at the mercy of the other, the other may hurt you.

This inter-personal style of Anna's seems to mark every passage of the psychotherapeutic process, beginning with the "discovery" of the symptom and its presentation within the therapeutic setting. It is a very expressive presentation, plaintive, dramatic and recriminating (at the age of 28!). She rails against those who have never explained to her how normal sexual intercourse should be, against those who have deceived, betrayed and disappointed her. She thinks: I can't be the one responsible for my emotions, my knowledge of myself and the world, of my emotional regulation. As if Anna were saying: "Someone please regulate me!"

Of course, these same interpersonal cognitive patterns (Safran & Segal) are acted in the relation with the therapist through continuous requests to be reassured and immediate lamentation when something doesn't seem to be working. Anna is capable of making her explicit image of strength and independence consistent by exercising the tightest control over her relationship with the therapist and over every passage of the therapeutic path, but simultaneously asking for rescue without giving the idea of doing so. The therapist is remarkable for having placed himself in an "orthogonal" position in respect to these patterns: for having tuned into her, partly sharing this need for reassurance and support with her, partly accepting being controlled by the patient, without an actual full collusion, but rather by simultaneously imposing the appropriate limits at the appropriate moments.

Just as remarkable is the flexibility of the therapist's technical choices: a "desensitization" procedure taken from a behaviorist set of tools, based on the principles of classic conditioning and mutual inhibition. On the strategic plain and on that of relational wavelength, this procedure lends itself perfectly to being adopted by an organization of the Self such as Anna's, who processes information in a concrete, sensorial way and who feels the need to check every detail of the process of change (inch by inch on her own body, managing the procedure and, moment after moment, limiting in this her husband to her own reactions and needs). In constructive and developmental cognitive psychotherapy primary cognitive-behavioral techniques are used precisely with these goals in mind. Techniques that are placed within a careful consideration on the organization of patients' Selves and their relational context, and that are born not as prescriptions or directives, but rather as exploration and knowledge tools capable of opening important windows on the personal meanings the patients themselves give to their own experiences. In Anna's case, the technique allows a significant drifting of the locus of control and of the causal attribution processes in regard to the problem: Anna shifts focus from the outside to the inside and sets off the processes of internalization and of interior redefinition of the symptoms, which are the fundamental pre-requisite of any change process. "Why can't I relax?", "What is it that's blocking me?", "The problem is mine". New discrepancies open up, pushing her to explore to find new answers.

But the discrepancies have to do with her abandonment anguish; and before Anna's rapid development can be triggered off, both her husband and her therapist (the two significant fronts on which Anna ruthlessly puts her patterns into play) have to pass an important test: her problem is too big to be overcome! Her husband is not involved enough, too superficial and immature! Her therapist takes the situation too lightly! Relaxation is not making headway–her body, molded in those attachment links, does not respond. Anna "switches off": her legs go in a paralysis, her sensitivity is lost! All this is again acted out towards husband and therapist in intensely dramatic sensorial terms. In other words, her interpersonal cognitive patterns emerge, or her pathogenic beliefs, in regard to maintaining the status of the relation: if you trust others, loosen your tight control over them and let yourself go, these others could hurt you.

The test overcome and tacit reassurances in respect to her pathogenic beliefs overcome, the "Anna-cognitive system" rapidly sets itself in motion and churns out new experience. She regains possession of the responsibility for her own body and thus for change too. Anna begins to slow her hyperactivity down, she has a break and confronts her fear of letting herself go: though still as performance and in slightly compulsive terms. Even the terrifying memory image of the shed, evoked in a moment of deep relaxation (beyond any hypotheses on the possible representative content) fits in very well, as sensorial climate (the scorching heat of a summer afternoon, the slowing down, the siesta, the physical abandonment) in this intermediate phase of the therapeutic path, of maximum conflict between the wish to explore in a relaxed way herself and the world and the defensive set-up aimed at control.

Indeed, her mother's serious acute episode of manic excitement that follows is mirrored in a corresponding crisis and symptomatologic relapse for Anna. Anna's interpersonal patterns are again put to the test within the same relation in which they had originally taken form. Active control and constant emotional activation are equal to guaranteeing stabilization and care for the relationship with her mother; loosening control equals the possibility of danger, emotional crisis and unpredictability in her ties. Her mind and her heart go back to her primary affective needs and the black screen reappears in the relaxation phase. But the therapeutic relation which now supports the exploration and validation of this new part seems to have enough intensity and strength to come back into play: "I accept her gifts and tell her again and again how optimistic I feel about the progress she had made". The therapist offers his support once more and partly accepts being controlled, but fixes therapeutic limits and deadlines, asking her to take her responsibilities.

The extraordinary scene Anna stages shortly afterwards, far from being (as she says a posteriori) "a joke", has all the flavor of yet another tough test on the meaningfulness of the therapeutic relation in regard to the personal meanings it implies. How could a cognitive system like Anna's manage the deep abandonment anguish she feels being activated in the relation? Certainly not through making plain her fragility and her feelings of vulnerability, or their metacommunication of some sort. Congruently with her structure, Anna

acts out: she measures herself with an entirely procedural scenic representation that puts together dramatic skills and the fake cognizance typical of coercive development itineraries. The aim of the scene is to solicit huge emotions in the other and capture, not in his words (the semantic area is not Anna's specialty!) but in the lines of his face and in his whole affectional-motory disposition, how reassuring he is in respect to her abandonment fantasy. If you have lived through primary contexts of high danger, you cannot afford "luxuries" such as mentalization or refined metacognitive elaboration. The prefrontal cortex and working memory are too slow for such problems! Far better to resort to the tried and tested and more "effective" self-protective acts.

Anna's representation seems to place itself at an intermediate level, more evolved, between action and the possibility of a clear semantic ordering of experience (and so of giving a definite name to the feelings of fear and a threatened abandonment she feels).

Probably, in virtue of the relation experience already lived with the therapist and the relevant therapeutic cognitive neo-structures being formed (Semerari), it becomes possible to play at a level of "fiction", of "a game" (the experimentation plan of metacognitive functions) and therefore of a related critical detachment from the experience taking place.

In any case, the therapist again passes the test, and this immediately activates new metacognitive and self-reflective competencies in respect to, for example, the quality of her own relationship with her husband. In this field she manages to give a voice to her own buried parts for the first time: her insecurity, her not feeling sufficiently protected in her relationship with him, the wish for cuddles and tenderness.

Sergio Benvenuto (Rome)

What struck me (and amused me) most in Porcelli's great comedy with a happy ending is the cognitive-behavioral language: *the systematic desensitization technique*!

Isn't this term in itself a little "hysteric"? Porcelli shows us that it practically implies the exact opposite: to *sensitize* (the female genital organ? or a subject with a female body?) to the other sex, and not even *systematically*, as it is just genitality that creates the problem. Anna's real problem is not even maternity: once she discovers her femininity, she no longer cares about getting pregnant… Some will say: scientific terms are always frigid, no surprise there. But the suspicion arises that a behaviorist approach employs frigid terms and styles precisely because it slyly winks at female frigidity too. Paraphrasing Karl Kraus, we could say that "cognitive-behavioral language is affected by the same frigidity it would like to cure".

For those who, like me, come from a psychoanalytical background, this vaginismus case is a textbook example of hysteria (but for others it's not so. After all, everyone has their own textbooks). This by no means implies that I consider the case irrelevant–quite the contrary, or else I wouldn't even bother writing about it.

At the end Porcelli poses a question, "I still keep asking myself what type of therapy I have done with Anna". A rhetorical question, because he then gives himself the answer (the right one, in my opinion), i.e. that that isn't the really interesting question. The interesting question–rather than knowing the statistics (which are often biased anyway) on the relative effectiveness of the various techniques–is rather "what really happened in this period of cure?" In slightly more metaphysical terms: What was *the real cause* of Anna's change?

Eysenck's behaviorist interpretation of psychoanalysis is often quoted–but why not attempt a psychoanalytical interpretation of behavior techniques? Psychoanalysis interests me more than other methodologies not just as another technique, but rather because it puts forward a theory on the possible causes of change that is not banal.

Some time ago scientific research was done in Britain on the effectiveness of prayer on organic diseases. Let's suppose that it was statistically proved that, for example, Muslim payers are efficient. Such data would have caused a storm, but would only have been the earliest stage of true scientific research. These are the facts–Muslim prayers are effective–but then the question is to come up with hypotheses as to the *why*. Mutatis mutandis, a discussant on that case assured us that "systematic desensitization" is the most effective cure against vaginismus. I don't hesitate to believe him, but the interesting question then becomes "why?". That Anna becomes reconciled with her femininity is a fact, but what really causes this reconciliation remains an enigma. Psychoanalysis has its conjectures, other theories have others (after Popper we no longer talk of hypotheses, only of conjectures).

What is a Freudian conjecture on cases like this?

To put it very briefly, it is to see things *from the housemaid's point of view*. Faced with cases such as these, I always wonder "what would a smart housemaid like those from Molière's plays think?" Those shrewd little servant girls understand their young mistresses far better than the bombastic physicians who talk in Latin of *systematica desensibilitudo*. This is because the young servant girl is "Freudian" to the bone: she knows that *le cul a ses raisons que la Raison ne connaît pas* (the French *cul* means sexuality in general). Now, what would the *bonne* think of this Anna character? She'd say: "the poor girl won't give it to that man-child, who, what's more, comes in a flash". She won't give it to him because she wears the trousers in the home (what's more, she buys them for this teddy bear husband)–and not only in her new home, but also in her family of origin.

Psychoanalysis is not a science, it is a figuring out already practiced by the common people. It is true that many analysts around the world now pontificate with scientific Latin–which today is English–but if you dig deep beneath the doctor's white overalls that many analysts wear, you'll often find the little servant girl who listens through the keyhole. Something Porcelli actually does (he himself talks frankly of his role as voyeur): he participates in the intimateness of the ménage, he watches over and checks on the sexual intercourse of this "blank" couple. My conjecture is that the therapy works for this very reason: *ménage à trois as the cure*. The ABC of hysteria psychoanalysis.

After all, it is this that makes us appreciate the wisdom particular cultures seem to offer proof of, those that have the first marital coitus held in public–or that commission the task to a king, priest or witch-doctor… today, possibly, to a psychiatrist. A transcendent initiation to genitality is for many women a condition for being able to function as women.

The fundamental Freudian conjecture is that the hysteric doesn't resign herself, not to being a woman, but to being a female–ergo, she doesn't want to be penetrated. Better said, she wants to be a woman and a mother, but not a female, i.e. she's keen on keeping her body "empty". Fidelity to one's own emptiness is the great enigma of hysteria.

Porcelli doesn't mention any extra-vaginal pleasure on behalf of our Heroine (has she ever, for example, experienced clitoral orgasm?). This silence of his–we don't know if it's a choice or just his not knowing the facts–is a sign of the fact that for him, as for Anna, the crucial problem here is how to sustain a feminine role.

Therefore I cannot agree in full with some commentators on the case, those who speak of "the need for the therapist's strong, direct and immediate attention to the patient's symptom before concentrating on the 'deeper' aspects of their mental life". Because, in my opinion, symptoms are what's deepest in a human being. If psychoanalysis never concentrated on treating symptoms, that's simply due to an apparently technical reason that is in fact ethical: to avoid prescriptions. But, just as Porcelli suggests, psychoanalysis is a technique only secondarily: it's a certain "vulgar" way of looking at things. And the symptom probably tells us the deepest truth about Anna: her difficulty to accept herself as a female.

This probably explains why historically psychoanalysis has never concentrated on the symptom, thus forgoing spectacular recoveries: because fundamentally it doesn't want to *remove* the symptom as quickly as possible. The symptom–unless it's unbearable–is precious, because it exhibits the "crux" of the subject more than a thousand forms of metapsychological chatter. Annoying but eloquent.

Anna's is a text-book case [in my text-book], as I said, because it brings out two pathognomic traits of the hysteric, which I would call "Prejudicial Therapeutic Skepticism" ["Anna chills me by saying she is highly skeptical–writes Porcelli–that I take the situation too lightly…] and "Massive Love Request". Many still wander why the hysteric often shows this lack of faith in such a provocative fashion. The most realistic conjecture is that in this way she is saying obliquely: "I have no intention of changing!" And why should she? Freud already described the hysteric's *belle indifférence*: despite her moaning she appears to be doing alright as she is after all. We see this same blatant *belle indifférence* in Anna with her unbelievable ignorance in matters sexual. In 2000 she has no idea of (it suited her to have no idea of) phallic penetration, because it is in this a-sexuality of hers that she found the right balance. We can therefore read her pessimism as her challenging the therapist: "You really think you're the male who'll make a female out of me, don't you?"

So, as soon as she starts to do violence to herself by following her doctor's prescriptions–when medical strength penetrates her–"her legs are paralyzed", i.e. she feels they're as "straight and as stiff as dried cod". What would our Freudian maid think of such a situation? She'd think: if she already has the "dried cod" inside her, why on earth should she try and obtain it outside?

Yet the therapist male shows more strength than her: "Anna turns up to the next session wearing make-up, her hair carefully brushed, wearing very smart clothes; in other words with a decisively more feminine look". That is to say that she got rid of her trousers and "plays the woman"–something that's dangerous for her, because it means "letting herself be possessed" by masculine activity, giving up control over the other.

As for the love request, we see a dramatization of it in the crucial session where our heroine tells the therapist that she's got something going with another man, elderly but rich, and has decided to dump her two impotent men… On this point I disagree with Porcelli's note that he doesn't consider this a "hysterical scene" just because it was a set up. Yet many a great clinician has always had doubts on the voluntary nature of "hysteric histrionics", often somewhere between a staging and an involuntary attack.

Anyway, the "scene" follows not therapeutic failure but, on the contrary, an authentic turning point in which Anna gives herself–for the first time–as a woman. How to account for this reaction to such impressive progress? I think with the pressing "proof of love" the hysteric requests continuously not only to the therapist but to any other significant person in her life. The hysteric demand is essentially a demand for love. Here she is challenging the therapist because she realizes that she's "recovering", which means (1) the end of their therapeutic idyll, and (2) she has to admit that this time a man "had her".

The fantasy of the "other" elderly rich ideal man (presuming it is a fantasy) is a classic feature too: it's so common for the hysteric to dream up some man who has the power to satisfy her material and social needs (money and prestige) without him actually penetrating her (thus he is conceived as old and impotent). Here we come full circle: to finally find an ideal Man who sets her up as a woman without penetrating her… but in the end, is it not what the therapist is doing in this case?

I realize that these conjectures of mine remind more of the language of South American *telenovelas* or soap operas than that of science so many colleagues use. The cognitive-behaviorists talk the Latin of Molière's doctors, the psychoanalyst uses the vulgar of the servant-maid, who knows just how love trivia is crucial to our lives. Freud thought a part of us lives in a soap opera.

So, what's the therapeutic factor according to the psychoanalytic conjecture? Here too Freud discovered hot water: *non medicamentum, sed medicus sanat*. That's all there is to the celebrated "transference".

Psychoanalysis doesn't really believe it was all this "systematic desensitization" that produced any change, but that by simply prescribing it the therapist entered Anna's erotic family, so to speak–after all, she writes moving letters to him, in the style of a lover. Therapy–whatever its setting–works because the therapist somehow enters the patient's affective economy, and for this very reason he is capable of modifying it. "A seduction technique" says Migone crudely, who also compares it to judo (it's true, all of psychoanalysis is a psychic judo). But in the end, this maid-servant discovery had already been made in what we consider the true beginning of psycho-therapeutic science: the 1784 Royal Commission Report–in which Benjamin Franklin and Antoine Lavoisier took part–on the prodigious recovery by Franz Anton Mesmer.

This *Rapport des commissaires chargés par le roi de l'examen du magnétisme animal* is considered a masterpiece of scientific literature. Mesmer–already a behaviorist, in his own particular way–argued that the hysteric attacks he produced (his patients were mainly women) in Paris, were due to animal magnetism. The Royal Commission, on the other hand, proved convincingly that crises were due to the hypnotist's charisma. It proved that *the cause* of hysteric effects (thus of mesmeric cures) was not magnetism but the therapist himself. But what has Freud discovered that's any different from that?

From Lavoisier to Porcelli–via Charcot and Freud–it's the same old story: it is above all in the relation with the therapist (and from the image of the Therapy) that one should see the cause, rather than in technique or other mysterious forces. In the end, with hysteria we always return to the starting point: to the Royal Commission that investigated Dr. Mesmer's spectacular recoveries.

After all, if Porcelli concentrated on the symptom, it is not for "scientific" reasons: he had to solve a problem in a few sessions according to Health Authority rules. If he worked in Germany, where the state refunds 300 sessions or more, he may have adopted a different approach. I think, however, that such external limitations–such as a time limit–could do analytic therapists some good too, weaning them away from a certain cozy indulgence of taking so long over therapy. Ferenczi already prescribed the end of analysis as early as the '20s. Just the fact that it is possible to do an "analysis" in 24 sessions says a lot against a psychoanalysis of the orthodox variety, the sort that identifies analysis not only with a precise setting (of the four forty-five-minute sessions per week type) but also with an extremely long and contorted mentalist introspection.

But is it then classical analysis that can be explained in cognitive-behavioral terms, or can cognitive-behavioral techniques can be explained in analytic terms? The challenge–an exciting one–is open. The epistemological victory of one or the other will depend on various factors, some of which cannot even be imagined today. Today we think that Molière's little house-maid saw right, whilst the doctors of the time were wrong. But the wheel can always turn the other way.

Tullio Carere-Comes (Milan-Bergamo)

The meaningful question, in this case, is probably not: What kind of therapy was done?–but rather, as Benvenuto suggests: What happened in that short time span? Or, also: Which was the crucial therapeutic factor? Was it a cognitive-behavioral technique (like systematic desensitization), as some commentators and the therapist himself seem to believe, or was it the therapeutic relationship, as Benvenuto suggests from a psychoanalytical perspective? And how are we to decide between these two views? And finally: Should we consider these hypotheses as mutually exclusive, or should we see them as parts of a broader and more complex view?

Let us begin with the psychoanalytic hypothesis put forward by Benvenuto: *non medicamentum, sed medicus sanat*. Whatever the setting, argues Benvenuto, a therapy works to the extent to which the therapist enters into his or her patient's affective economy. But how could Porcelli enter into his patient's affective world? He used a "seductive technique"–as Migone interprets this special homework given to the patient.

From a psychoanalytic standpoint, the behavioral technique employed by the therapist did not work as such, or not primarily as such, but because of the affective meaning it brought with it in the first place. The therapist's assignment could be seen as seductive in two ways: firstly because it was a task to perform, and this woman was supposed to be very much at ease if she was given something to carry out; and secondly because of the special nature of the job, which consisted of a manipulation of her genitals.

Now, let us assume that this interpretation is correct. That is, let us assume that the patient was healed by the staging of a *ménage a trois*, as Benvenuto suggests. If this were the case, we should presume that the therapist's clinical flair could more or less consciously intuit that this was precisely what his patient needed, or that he unconsciously enacted the triangular affair his patient pushed him to enact. In both cases, either consciously or unconsciously, the therapist did what had to be done to set the stage for therapeutic change.

Had Porcelli not used the technique he used, would the *ménage a trois*, whose necessity we have assumed, have developed anyway? Maybe it would have, but surely not in 24 sessions, symptom resolution included. It follows that, even in a psychoanalytic reading of this case, the use of active behavioral intervention was an advantage. More than that, it seems highly unlikely that such a good result could ever have been achieved in so little time without recourse to some active form of engagement.

What happened then? It is safe to state that the patient went through a new experience, and this new experience was accountable for therapeutic success. The process that led to change cannot be adequately understood in strictly psychoanalytical terms (the therapist's stance was way different from the classical blank screen, and his basic attitude was far from interpretive). Is it then reasonable to take it for granted that it was the behavioral technique of systematic exposure that made the difference?

Let us take the cognitive-behavioral standpoint now, to see if it can account for therapeutic change better than the psychodynamic. No *ménage a trois*, no economy of desire is relevant here. Things are much simpler in this view. A woman who suffers from vaginismus is a woman who is afraid of being penetrated. Her fears are surely rooted in her past experiences, most probably from her childhood, but there is no need to undertake a deep and long journey in her past or her unconscious, because what she needs now is just to learn that she need no longer be afraid.

In order to learn this, a systematic exposure to the feared event, guided by and in the context of a reassuring relationship, is all she needs. A graded exposure must be planned: The penetrating object is firstly her own fingers, secondly the partner's fingers guided by her, then the partner's fingers guided by himself, finally the partner's penis, with a careful monitoring of every passage. Of course, an ongoing involvement of the partner, and an accurate examination of the couple's dynamics, are mandatory, to ensure the partner's cooperation and avoid sabotage. It is not clear whether this protocol was adequately complied with by the therapist but on the whole it was a good treatment, because the specific procedure for this case was coupled with a careful management of the relationship.

It sounds compelling. The only problem is that the procedure described does not take into proper consideration the wealth and depth of meanings that its every single step–like any single bit of interaction–generates in the mind of the patient. It is true that a diligent cognitive-behavioral therapist monitors the procedure step by step. The aim of such monitoring is however not to uncover if by chance a *ménage à trois* has been started, but just to ensure that the procedure is being applied correctly. Yet the effect of a procedure does not depend on the *therapist's*, but on the *patient's* meanings. Cognitive-behavioral therapists, who trust empirical evidence above anything else, should reflect on the results of all the meta-analyses that compare different therapies[4]: the effect of specific procedures on the outcome variance is much lower than common factors (in fact, practically non-existent). And the effect of common (relational) factors is not understandable in terms of procedures, but in terms of the meanings the patient gives to the interaction.

We have then on one side a tradition where the greatest attention is given to all conscious and unconscious meanings the interaction is given moment by moment by both patient and therapist, but virtually no consideration at all is given to the active relational means that can (and should) be used to further the emotional experiences leading to therapeutic change. On the other side another, more recent tradition emphasizes exactly the opposite: specific modes of interacting with the patient are coded as procedures, the final aim being a specific procedure for every disorder. In this tradition the modes of interacting are conceived of as "active ingredients" of the therapy, as in the medical model, with virtually no consideration of the narrative that is created by the therapeutic couple "in search of the Grail".

As a consequence, both traditions only partially account for what happens in *real* treatments, where therapists are not manual-driven, but do their best to meet their patients' needs–as Porcelli does excellently with his patient. *Real therapy is different from psychoanalysis*, inasmuch as the therapist does many things beyond interpreting, and these things are decisive in producing change; *and is different from cognitive-behavior therapy*, inasmuch as the therapist's active interventions, though formally procedural, do not work primarily as procedures (i.e., according to the meanings given by the therapist), but as therapeutic experiences (i.e., according to the meanings given by the patient).

We are therefore not to reject the psychodynamic, nor the cognitive-behavioral perspective, but to include both in an overarching view of the therapeutic interaction. I do not mean that we should integrate the two theories, though – I am not advocating some form of theoretical integration. What I mean is that we owe psychoanalysis the awareness that any interactive event is constantly interpreted by both partners of the interaction, and these interpretations impinge decisively upon the interactive events that follow. And we owe the cognitive-behavior tradition the (re)-discovery that we can greatly improve our capacity to gain access to, and modify, our patients' inner world if we allow ourselves to actively interact with them in a multiplicity of ways. Of course there is much more than that to both traditions – the different psychoanalytic schools have their preferred sets of meanings to interpret the events of the interaction, as the cognitive-behavioral schools have their preferred sets of meanings for their procedures. These preferences have however a limited impact upon an individual treatment, as upon the development of psychotherapy on the whole. There is nothing wrong with a therapist bringing to bear his or her own set of personal and school preferences – in fact, it is an unavoidable occurrence – provided that these preferences do not become abusive and do not prevent the development of a *dialogic* relationship, which is the essence of a genuine therapeutic interaction.

In other words, nothing is wrong if a therapist has her set of preferences, provided that she is not conditioned by them, and is ready to set them aside for the sake of the process that can only take place in its own right, when *both* therapist and patient give up their respective pretences to have it couched on the Procrustean bed of their personal and/or theoretical preferences. If and to the extent to which both therapist and patient are available to bracket out their personal and theoretical expectations, a dialogical space opens up in which the real therapeutic needs can be heard and met: the *logic* of the therapeutic relationship can emerge in the *dia-logue*.

Marta Csabai (Budapest)

In order to get closer to the hidden and often most important details of a psychotherapeutic case-study, it's best to first read it through the eyes of a naive or 'lay' reader and to keep this eye open through the course of further professional evaluation. As Jacques Lacan said in his 7th seminar: "Commenting on a test is like making analysis." He also paradoxically added that it is the *refusal of understanding* that opens the door to psychoanalytic 'understanding.' Besides this consideration, however, we sometimes need the third eye or the sixth sense of a detective, who always maintains the possibility that there is a trick, a mystery or a trap hidden behind the scenes.

My naive reactions, which were evoked by my first reading of this very exciting case, might best be described as both *surprise* and *feeling of lack*. Here I am not speaking about my questions related to the patient (How could it be that she was so *naive* about sexuality? What did she want from psychotherapy at all?) but about my (naive) feelings of surprise at the therapist: why did he publish this case in this way? In our day, psychotherapists as well-trained as Porcelli know endless sophisticated techniques to defend themselves from critical exposure, to keep their boundaries well fortified in public presentations, so at first glace it was really surprising that he made himself so transparent. Was he being *naive*, or brave, or was he just being provocative when he wrote: "…she says, all is lost, all is pointless….*I feel nearly the same*," or "I could interpret these gifts as a transference phenomenon, *but I don't*," or "I still keep asking myself *what type of therapy* I did with Anna"? [my italics, M.Cs.] Should either naivety, courage or provocation be the case, certainly he muse have had a reason. Borrowing the French phrase cited by Benvenuto and applying it here, Porcelli very likely had *raisons que la Raison ne connaît pas*!

Before going further I must speak about the nature of my primary feeling of lack. It comes from some missing details in the case, even though these missing details make the text more interesting and thought-provoking. I will give some examples of the points I found incomplete. First, for me the purpose of the therapy was unclear. Was the purpose to teach the Anna the technique for making a baby or of making love? Second, we know that her husband participated in five sessions. What happened in these sessions? Third, why did the therapist decide to make an exception for Anna and extend the therapy treatment by eight-sessions cycle, Anna didn't ask, rather, she seemed "somewhat struck by (Porcelli's] words"? And finally, what did Anna write to Porcelli in the "extremely beautiful and moving" letter?

While I was reading the case naively, one of the most important observations of Freud came to my (professional) mind. In 1893, in *Studies on Hysteria*, written with Breuer, he'd already noticed that patients weren't telling the complete story, but only fragments of it. It's been common knowledge since then that therapists must figure out the "real meaning" (even though in postmodernity we doubt it exists at all) by analyzing the latent content hidden beneath the surface of a patient's narrative. And, quoting another essay of Freud, like archeologists, we have to be glad to "bring to light only the remains of invaluable but incomplete antiquities." I'm not referring to the case of Dora without purpose. This essay, one of the founding texts of all later psychotherapeutic discourses, is very meaningful even in its title: *A fragment of a case of hysteria*. The most frequently cited, endlessly interpreted of Freud works, it is not an immaculately processed masterpiece but a torso, a disquieting fragment, a report on Freud's failures and frustrations. In fact the majority of later psychotherapeutic approaches trace back to Freud's brilliant recognition that we must always be attentive to the missing details and confusions in patients' narratives. But we have learned more than that from Freud. Although he tried to head it off as an awkward question throughout his later work, it emerges very clearly from the case of Dora that the problem of transference can be best caught in the very act, in the fragmented nature, in the lacks and confusions of the *therapist's* discourse.

Benvenuto writes in his comment that Porcelli's text gave him the feeling he was reading a classical textbook case of hysteria. I had the same feeling, not only because of the nature of her symptoms–inhibition, paralysis, etc.–but also because of the way the patient presented her symptoms, and even more because of the way Porcelli presented the case. We remember the serious and painful debates and struggles in the old days of psychoanalysis–and even nowadays–over the issues of technique, which were in reality much more about the problem of transference and therapeutic effects and/or specificity. As many of the commentators of the case of Porcelli noted, he questioned not just his technique, but his relationship with the patient. Porcelli's question, however, couldn't have been asked another way: "I still keep asking myself what type of therapy I have done with Anna". We can translate this into: *What did I do with her?* This is the most classical question a psychotherapist can formulate. And the solution in Porcelli's case is hidden in the fragmented answer he gives to his own question. He writes: "If psychoanalysis is meant not as a set of techniques, but as *the analysis of meanings within the therapeutic relationship*, then I believe that this has been an analytic psychotherapy." [my italics, M.Cs.] In my interpretation his answer is not only correct because I agree with Porcelli that the quality of the relationship overwrites technical specificity, but also because we can postulate, in this particular case, that it was the powerful transferential effects that resulted in

the progress of the patient, since it was that that keep the therapist alert, even after the therapy had finished. And as with Dora, we can also recognize the intensive–and effective!–transference relationship from the incompleteness and uncertainties of some parts of the text.

The beginning of the therapy is presented like this: "Anna asks me if I think I can solve her problem. I say I'm confident, but Anna "*is highly skeptical*" "*a response I found chilling.*" [my italics] We may interpret this 'starting of the game' in several ways. Is it simply a call for reassurance at the beginning of the therapy? Or a provocation to the male Other–we see it in fairy tales where the king's daughter sets up an endless number of probes for her suitors? Is the therapist here being a representative of the father whose love the girl wants exclusively, and that's why she provokes him, to make sure nobody else can compete with her? Or, alternatively, does he play the role of the *mother* in the patient's unconscious? Of course we could find more possibilities, but the most essential is to define the nature of transference, "the meanings within the therapeutic relationship" as Porcelli said. We know that a neurotic symptom is not simply self-containment but also self-symbolization, the creation of a secret not so easily disclosed. Anna's symptom is challenging because it gives room for an endless number of symbolic interpretations, only beginning with the most obvious and vulgar ones, and this is why it's especially important to be attentive to her relational behavior in therapy. So my first question would be: "Why does someone like Anna, who has such serious problems with intimate contact, accept so easily–albeit skeptically–the offer of the therapist for a close relationship?"

Depending on one's professional education, as Benvenuto suggests, we may find many sophisticated explanations. We only know for sure, however, that Anna was seeking help and she found it in this therapy. What did Porcelli do with her? Basically he helped her enjoy her own body, to make *autoerotic* love. On a level of psychoanalytic interpretation, we might say that the therapist heard the infant Anna's call (to the mother) to take the self back to care, by rediscovering her own body as something potentially desirable. The therapeutic situation for Anna was then a place for repeated meetings with her own body, where she could connect the therapist's words, as forms of touch and fondling, to her concrete autoerotic experiences. But the therapy did not stop at this point. If it did, it would have consolidated the ideal state of hysterical desire by permitting her to remain sexually excited, yet untroubled by the demands of real sex.

We can detect clearly the moment when the change took place: it was around the time of *relapse*. Its direct antecedent was her mother's illness, when Anna had the chance to take her mother's position at her father's side and live through intensive rivalry with her sister "who accused her of always wanting to be the star of the show, acting as a little mother for their father", and also could feel (enjoy?) the jealousy of her husband. Was this the Oedipal situation *par excellence* the cause of her relapse as well as her consequent sudden progress? We can say that it wasn't. Something also had to happen on the level of her fantasy–something that can be found hidden in the text. Right before the mother's illness, Anna saw an obscure but highly significant image, during relaxation. She saw, as a child on a summer afternoon when the *adults were sleeping*, *something* in a shed that frightened her. Like her therapist we may suppose many interpretations, for example a kind of primary scene fantasy, but it was surely a turning point in the therapeutic relationship. We can feel the therapist's embarrassment and frustration because of the lack of any "real" interpretation: "…until the end I continued having questions about its interpretation".

Sometimes, when we don't ourselves have a good answer, it's good to listen for the patient's fantasy to repeat. We know from psychoanalysis that the unconscious sends every message at least twice. It happened in this case, too. The positive significance of the turning up of the childhood fantasy and the consequent change was confirmed by the "hysterical" theatrical scene, when the patient appeared in her strange hat and glasses. The story about the *other* man might be interpreted as a sign of progress in her Oedipal development. Here Anna wants to tell the therapist that from this point the game is going on with three players. We might say that instead of the mother, as exclusive love object, she found the father, but that isn't the essence. What is more important than the "real" interpretation is that a "third person" appeared on the scene! The glasses might signify the *shame* accompanying the switch from autoerotism to the desire for heterosexual love. From this point sexuality takes forms not previously experienced, and no wonder the

patient now wants *more*. She wants to continue psychotherapy in her newly found—symbolic–world.

And *what type of therapy did the therapist do*? I think that Porcelli did the best he could. He was a combined mother *and* father during therapy, a figure that cured the (hysteric) patient by using the father's symbolic function to evoke and transform her infantile memory of her mother. In this sense even the choice of technique–the apparent combination of behavioral therapy and psychoanalysis–was quite successful, since in this way both her bodily and symbolic processes were activated. Probably the feelings that this case was a "textbook" pushed Porcelli to unintentionally go back to Freud's original dilemma: how to cure the hysterical patient? (And doing this he also repeated Freud's "basic fault": getting lost in the labyrinth of transference.) Through the technique of free association, Freud could–or could at least try to–join the maternal and paternal orders. However the (hysterical) splitting and fragmentation of psychotherapeutic discourse could not be cured during the last hundred years. It makes for many problems in everyday practice, but even so we don't have to regret it. Otherwise we couldn't read such thought-provoking cases as Porcelli's.

Anna Shane (San Francisco)

In *Seminar II: The Ego in the Technique of Psychoanalysis*, Lacan warns his students against *understanding* what their analyzands are saying. He suggests that one can accomplish this best by keeping one's own ego absent, which, he helpfully adds, is the impossible condition of psychoanalysis. In "A Case of Vaginismus" Porcelli comes very close to not having an ego. He also gives an idea of how a patient may 'cure' herself, when her therapist doesn't get in the way.

He presents a young woman who puts great store in her fund of general information and in her problem-solving abilities, but who finds to her dismay that she has no knowledge at all of her own body as sexual. She must therefore go to a physician to learn what she does not know. Porcelli tells us what she tells him, that she's a person who "can't abide failure," and that she has a "strong need for success." Moreover, she "knows how to do what is most appropriate under all circumstances." So, clearly this 'needing help' is an amazing place for her to be in. It might be like finding out everyone speaks Martian except you, and you graduated magna cum laude, and you didn't even know there was a language called Martian. How could this be? How could such common information be available to everyone except Anna?

In her "straight-forward" way she tells her story, filtered through the unconscious of Porcelli. Her mother didn't like being a mother, she wasn't fond of her two daughters, she leaned on her youngest daughter Anna from the time Anna was five years old. The father is spoken of as domineering and authoritarian, but he wasn't very good at getting his own way. His daughters were able to attend school against his wishes simply by taking summer jobs and paying for their own schoolbooks. His oldest daughter is outspoken and rudely defiant. She won't even pay lip service to the desire of her father, and one can't really think that it's the mother, who didn't enjoy her own children, that wants the grandchildren. This father also acts like he can't take care of himself, something that really annoys Anna's older sister.

Anna picked a boy from her hometown to marry. He's a coddled youngest son, who lacks his older brothers' resourcefulness. She ends up taking care of her baby-husband, holding down an uninteresting yet physically tiring seven-day-a-week job, continuing to help her mother at home, working in a garden, and helping everybody who asks her for help. She's at the center of her world, which is not far from home. Thus, she's fine. She gets to have satisfaction and to misrecognize her own desire. She's revered as a kind of saint by the ones who are dependent on her, and she also gets to complain about them. You might ask, what more did she want? The problem was that she wasn't getting pregnant. Her dad needed her to get pregnant, and it wasn't happening. She needed to learn how to get pregnant. She needed to give her father what he wanted, cause that was who she was.

So, Anna puts herself in the hands of Dr. Porcelli, sort of. One way to diagnose an obsessional is to give a new patient some information, and they listen closely and look like they're with you and/or agree, and at the very end they ask you, "But doctor, are you sure? how can you be sure?" One way to diagnose a hysteric is to give them some suggestion you didn't even know you were giving them, and they follow it, and then you find out later and you feel stupid. Porcelli doesn't diagnose Anna at all. Instead he covers both bases. If she's an obsessional, then he can't get into any power struggle with her. So he speaks from the place of his theory, the cognitive behavioral theory. If she's a hysteric, he avoids giving her any suggestions, or using any influence he may have over her to direct the flow of her discourse. So, there is not much for him to do, and not much for him to say. He either speaks to his confidence in the theory, or to his confidence in his patient. The rest of the time he's silent. And things go well.

So well that people at home begin to change in their ways toward Anna. Lacan tells us this is a sure-fire way of knowing something is happening, when people behave differently toward you. First her mother has a breakdown and has to be hospitalized. Anna is now given another full time job, taking care of her dad, and if she's a hysteric it's probably her hearts desire, and if she's an obsessional, it's probably also her hearts desire, for a slightly different reason. But she's not as happy as she would once have been in this place. Something has happened to Anna, she's 'in transference,' not so much to Porcelli as to the Other. She's discovering something new about her desire, and it's very interesting to her. Then her husband rapes her. This is indeed startling. He'd been passive throughout their courtship, and he'd never forced himself on her before. Anna takes this in stride, making us lean toward thinking of her as hysteric, *la belle indifférence*, notwithstanding her oft-repeated doubt. It's only when she realizes that she's not as special as she'd thought (remember, Porcelli told us her fantasy, that she's highly appreciated by others?), and that Porcelli really did intend to end her treatment per the terms of their contract, meaning that he could live without her, that she had to start thinking. She was either going to have to get sicker, or going to have to get better. As Porcelli said to her, "in or out," in other words 'what's it going to be, the object or the phallus, you have to choose.'

Did Anna resolve it with a flight into health? Or did she really come to a new place regarding her desire? This is what Porcelli wants to know, but he won't find out unless she comes back to him for more treatment. She will come back, I think, because she has a powerful desire for knowledge, and she thinks he sits in the place of language and truth.

You can use this case to teach what not to do in treatment (since there is no way to teach what to do), because your students will have lots of 'understandings' about Anna that wouldn't help her at all, and lots of their own questions for her that have to do with their own desires, and not hers. In contrast, Porcelli wasn't too proud to follow his treatment plan to the letter, including the expressing of confidence about the outcome, even though obviously this could end up making him look stupid, since he'd need Anna's assistance for a positive outcome, and he couldn't guarantee that. He picked the cognitive-behavioral technique, and he went with it. He even used the control mastery theory that's come out of my hometown of San Francisco. Mostly this is a progress-believing theory, dependent on supposing a patient has an unconscious agenda toward mental health, and that the patient will pose tests to her analyst, which if passed adequately by her analyst will lead her to pose higher tests, which will eventually lead her to better and better mental health. Whatever the shortcomings of this theory, it is useful as a technique for not getting in the way of your patient. The theory may be arrogant, but the treatment depends on allowing the patient to win, because passing the test means not falling into the patient's trap for the analyst's narcissism, which kind of means not being fooled by the seductive ploys of a patient, and this is good for everyone to remember. It's also a good technique to help you avoid getting into power struggles with possible obsessionals. Discerning Lacanians might even notice a similarity here with the analyst speaking from the place of the *object a*, as abject.

Porcelli was himself curious about what things meant, but he refrained from directing Anna to speak to his curiosity. He let her talk about whatever she liked, and he didn't indicate his preferences to her. He gave her no suggestion that she might have to follow. Why did he give her eight more sessions? Because she'd had a setback due to a home trauma, and she needed more time. It's part of the cognitive-behavioral plan.

It's as simple as that.

As to his psychoanalytic thoughts, he told us about some of them, but he blessedly kept them from Anna. He didn't burden Anna with his passions, and she still has no idea how he thinks about her. Why did she get better? Here you can think lots of things, but I'd say she came to learn what she needed to know. She learned it, and at the same time she discovered that there was more to her than she'd originally thought, meaning that at least part of her was an unknown. This kind of 'knowledge' is indeed psychoanalytic, and 'understanding' it is no help. Porcelli didn't get in the way of her learning this truth.

Notes:

[1] *Psicoterapia e Scienze Umane*, 4/1993, p. 118.

[2] Remaining on the debate on Kernberg's work in *Int. J. Psychoanal.*, 2/2000, also available on Internet site https://ijpa.org/archives1.htm, and in chapter 4 of my own book *Terapia psicoanalitica*, I present here Gill's proposal, which I think solves coherently this age-old classifying question, not by chance using non-descriptive but intrinsic criteria, i.e. criteria linked to theory.

[3] See Moderato P., A behavior analyst in the land of behavior therapy, or the evolution of behavior science. In E. Sanavio, editor, *Behavior and Cognitive Therapy Today*. Oxford: Pergamon, 1998; Moderato P. & Ziino M.L., Dall'essere al divenire ovvero l'evoluzione del paradigma comportamentista. In P. Di Blasio, ed., *Contesti interattivi e modelli di sviluppo.* Milan: Cortina, 1995)

[4] Stanley B. Messer & Bruce E. Wampold, 2002, Let's Face Facts: Common Factors Are More Potent Than Specific Therapy Ingredients. *Clinical Psychology: Science and Practice*, 9: 21-25.

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Publication Date:

June 28, 2017