

EXTREME RISK SEEKING ADDICTION: THEORY AND TREATMENT

Abstract:

Extreme Risk Seeking Addiction (ERSA) is a behavioural addiction manifested as a repeated voluntary search for risk. This article introduces some theoretical reference points to discuss a clinical case study, a once-weekly psychotherapy which extended over more than ten years. The model followed assumes that ERSA is due to the feelings of excitement and “narrow escape” which, if reiterated, bring about the construction of a pathological organisation, a psychic retreat in Steiner’s terms. This organisation is a part of the self which is tyrannical and falsely protective, and is able to create illusory feelings of invulnerability and all-powerfulness. Psychotherapy can offer a benevolent interaction which is sufficiently in tune with the ERSA-affected person to be able to favour self-reflective experiences promoting the mentalization of affect and more generally the skills which make it possible to recognise emotions in the self and in others, and to manage emotional states within relationships effectively and competently.

[KEY WORDS: Voluntary risk seeking; Extreme Risk Seeking Addiction; behavioural addictions; psychic retreats; *psychoanalytic* psychotherapy]

Introduction

The subject of this article is a variety of behavioural addiction which involves repeated voluntary risk seeking. Whilst the literature has called it “risk addiction” (for example, Michel et al. 2003, or in the *special issue on “L’addiction au risqué”* of the French journal *Topique*, August 2009), the term Extreme Risk Seeking Addiction (ERSA) seems more appropriate, as the addiction is caused by voluntarily seeking risks rather than by the risk in and of itself. Risks become extreme when they are continuing, characterise one’s lifestyle, and threaten a person’s possessions, physical integrity, and very existence. When the lucid and pleasant nature of a risky experience becomes a repetitive mode which takes over the individual person, allowing them to distance themselves from day to day reality and internal experiences which are hard to bear, the person is addicted (*Ranieri 2006*). At this point, subjects use risk as a solution to all their problems, prefer action over thought, the production of bodily sensations over emotions, and repeat risky actions without being able to discuss these behaviours (Pedieli et al. 2005).

In an attempt to understand the nature of Extreme Risk Seeking, I propose a model which seeks to uncover how psychological processes belonging to ERSA can exert such a strong hold over an individual’s mental life. I hypothesise that surviving a risky situation is such a strong emotional experience, that if repeated, it can cause an addiction. Clinical work with patients addicted to risk seeking allows for the hypothesis that, within the person, a significant relationship develops with the destructive part of the self. The experience of extreme risks facilitates the birth of a pathologically narcissistic organisation to which the ego submits progressively. In this way, the individual becomes

addicted to the powerful feelings of risk, which entail strong and exciting pleasures, and crucially seem able to protect the individual from distress.

This protection is in truth an illusion. The person pays for these benefits at the cost of a loss of trust in relationships with others, and a progressive isolation. Clinical work with patients who are passionate about risk—and who are incidentally not easy to involve in psychotherapy—is characterised by a constant facing up, within the therapeutic couple, to the parts of the self which take control of the internal world, in subtle ways. Self-reflection appears curtailed in favour of the hunt for extreme sensations able to offer a momentary protection from distress—a psychic retreat (Steiner 1993). In contrast, psychotherapy can offer a space in which to regain the capacity for mentalisation (Allen and Fonagy 2006). This article *includes* a clinical case study which illustrates psychotherapeutic strategies based on the theories outlined above.

Risk seeking as a pathological addiction

Although most studies connect voluntary risk-taking behaviours to personality traits, the thesis that extreme forms of risk taking are symptoms of a behavioural addiction is gradually gaining status. Pannarale (1998) describes a risk addiction and states that it is distinguished from common risk-taking behaviours by a different level of propensity to expose oneself to danger, or rather by different decision-making criteria regarding avoidable risks. Marcelli and Braconnier (1999) believe that risky behaviour, especially when motivated by seeking excess, should be considered alongside addicted conduct. Pedinielli *et al.* (2005), attempting to interpret the psychopathology of risk behaviour, refer to four complementary models. The first considers risk seeking as a mode which favours physical feelings over emotional ones; the second model takes risk-seeking behaviours as attempts by subjects *whose primary narcissism is fragile* to control emotions caused by the libidinal object; the third sees risk as a self-perpetuating “ordalic behaviour” (see below); the fourth as a true behavioural addiction.

A person who is addicted to risk seeking will have had an “initiatory” or “revelatory” risky experience which is the source of the addiction; they will be prone to repeating risky actions; they will be addicted to this, which is to say that they will be driven by their self to carry on taking risks without being able to question their behaviour; they will use risk as a solution to all their problems (a generalised, systematic, and stereotyped solution); they will tend to resort to risk (action) at the expense of mentalization skills; thanks to risky behaviour they will value the generation of bodily sensations over emotions (Pedinielli *et al.* 2005).

Risk seeking is commonly associated with pleasure in the excitement caused by the risky action, but a more careful analysis of risk behaviour uncovers a detailed array of emotions. Balint (1959) describes thrilling situations as moments characterised by a mixture of fear, pleasure, and trusting hope in which the person first abandons and then returns to safety. In thrilling situations, the following elements are recognised: knowledge of a real, external danger; voluntary exposure to the danger and the fear caused by this decision; hope of being able to bear the fear and overcome the danger; and finally the satisfaction derived from returning to a state of safety, and feeling safe and sound. Lyng (1990), based on participant-observational data and semi-structured interviews with parachutists, richly describes the phenomenology of risk, which he calls “edgework”. The

person who voluntarily undertakes risks passes from a state of fear to a condition of happiness and excitement characterised by hyperrealism and perception of time which is focussed on the present. Once the risk behaviour has come to a happy end, a very pleasant feeling of self-realisation develops. The subjects interviewed by Lyng talk about having felt a kind of purification, an amplification of the self and of feeling a higher level of self-determination.

Le Breton (1991) also offers a detailed description of the feelings produced in the moment of voluntary risk: the sense of vertigo which is sought in, for example, many extreme sports; the facing up to or challenge to oneself in seeking personal reserves of courage, strength, and resistance; the candour which takes the place of the quest for intensity, placing the subject into a sort of temporary autistic state in which social ties are suspended; the powerful emotions due to the awareness of having survived. The thrill sequence is a highly emotional experience in which, as Grasso (2000) reminds us, fear, the hunt for and show of courage, hope of making it, feeling of power (once we have realised we will make it), excitement, and self-satisfaction (for having made it) follow one another, completed by a final freeing and comforting, a feeling of renewed safety.

The various authors agree on the pleasant emotions which complete and conclude risk seeking. Risky conducts generate feelings of excitement, and, once positively resolved, pleasant emotions related to the relief of escaping danger.

The “narrow escape” can be defined as a trauma which has been avoided. In a previous paper (Ranieri 2009), I proposed a comparison between emotions caused by risk seeking, and those which follow a trauma, more exactly due to Post-Traumatic Stress Disorder (PTSD). The emotions described by risk takers seem to be mirror images of those experienced by victims of a psychological trauma. Horowitz (1976), in his seminal paper on the impact of trauma on personality, identified eight psychological themes following a severe trauma. Below, I have outlined the principal markers of a post-traumatic disorder, and compare them with the behaviours and emotions of ERSA, taken from the literature presented above and from clinical experience.

Post-Traumatic Stress Disorder (PTSD)	Extreme Risk Seeking (ERSA)
<i>Pain and sadness</i>	<i>Pleasure and joy</i>
<i>Angry and destructive impulses</i>	<i>Feeling of all-powerfulness</i>
<i>Fear of becoming destructive</i>	<i>Pride in own actions</i>
<i>Feelings of guilt for surviving</i>	<i>Pride in surviving (or overcoming) the challenge</i>
<i>Fear of being identified with the victim</i>	<i>Emulating the actions of other risk takers</i>
<i>Shame about emotions of powerlessness and emptiness</i>	<i>Pride in own abilities</i>
<i>Fear of repeating the trauma</i>	<i>Desire to repeat the experience, to the point of addiction</i>
<i>Intense anger directed at the source of the trauma</i>	<i>Attachment to the sources of one's experience</i>

Studies following Horowitz have emphasised the importance of subjective responses to trauma: PTSD cannot be interpreted solely in light of external stressors. March (1993) summarised the most widely documented aspects of subjective perception, compared below with those in ERSA:

Subjective aspects of PTSD	Subjective aspects of ERSA
<i>Experience of extreme fear</i>	<i>Experience of extreme excitement</i>
<i>Subjective experience of powerlessness</i>	<i>Subjective experience of all-powerfulness</i>
<i>Perception of a threat to life</i>	<i>Perception of invulnerability</i>

In fact, a number of studies indicate that those who have suffered a trauma without being able to elaborate it adequately, may seek out risk and that among the various outcomes of PTSD is a lifestyle which involves risk seeking (e.g., Freeman, Roca & Kimbrell 2003; Bibble et al. 2005; Pat-Horenczyk et al. 2007; Smith, Leslie & Chamberlain 2006; Kingston & Raghavan 2009). The underlying mechanism is probably the need for a method to repair the psyche. People with PTSD relive risky (and hence potentially traumatic) experiences to deal with their feelings of powerlessness and vulnerability. They seem to be unconsciously attempting to regain at least some of their ability to control events and to reduce their sense of powerlessness by exposing themselves to dangerous situations in some way similar to traumatic ones, in the hope of overcoming and forgetting them.

Taking our cue from the relationship between PTSD and risk seeking, and its interpretation, it is possible to propose a psychodynamic model for ERSA. A good starting point is the work of Balint mentioned above. Balint proposed two positions in object relationships: ocnophilia (a push to personal gratification through the relationship with the object) and philobatism (seeking the promotion of the self by means of spaces free from the object). For Balint, those who push their luck through risky behaviour are favouring the promotion of the self (philobatism): by taking risks they fool themselves into believing they have no need for an object. This hyperinvestment in the self is due to an attempt to face up to what Balint calls the “basic fault”—the effects of a portion of the original traumas, among which Balint places birth, the discovery that love objects have an independent life, and the first significant separations from the maternal figure. The intrapsychic motivation for risk seeking is then the need to cushion the distress caused by emotional trauma, and not just the pure pleasure of sensations.

Valleur & Charles-Nicolas (1982), and later Valleur (e.g., 2005 and 2009), have brought together risky behaviour and pathological addiction using an original metaphor, that of the ordeal. An ordeal, or divine judgement, was used in many societies of the past as a judiciary test through which a divinity expressed a defendant’s guilt or innocence. It was usually based on a challenge, for instance a particularly difficult action to accomplish. Valleur and Charles-Nicolas connect risky behaviours to an “ordalic behaviour”: the person who faces the risk is trusting themselves to an external absolute power which will decide the outcome of the risky behaviour. This sort of demand for judgement, due to a need for regeneration, comes with powerful feelings and produces an inevitable process of repetition and progressive addiction. The metaphor of the ordeal can be interpreted as an unconscious meeting between the person and an entity, obviously part of their own inner world, which is able to offer momentary relief through a verdict of innocence. If this interpretation of ordalic behaviour is correct, we can suppose that the ego of risk takers relates to an intra-psychic structure, and attributes to it the power of choosing one’s destiny. The outcome of risky behaviour depends on the decision of this all-powerful structure which, like a god in antiquity, offers forgiveness, protection and safety when feeling magnanimous, but at other times is capable, if angered or crossed, of causing harm, including death, by causing the undertaking to fail.

It is possible to hypothesise that people who face danger and survive may find the experience so significant not just because it is exciting, but because it is reassuring. This can happen when the good internal objects are devalued, having been accused of failing

to protect the subject from the trauma, and are made untrustworthy. If the subject, sometimes just a child, is involved even by chance in risky behaviour, they will feel something resembling the safety, trust, the sense of protection of a good object. Naturally, this becomes a life experience which is sought out again as soon as possible, beginning a sequence of risky behaviours. By following this theory, we could consider risk takers, or at least some of them, to be people who are trying to get as close as they can to a trauma to feel, after the excitement, the pleasure of having avoided it. The feelings and the emotions which they hyper-invest in their selves can be organised into an internal autonomous psychic structure, a pathological organisation which is able to take control of the person, placing them in their power. It is a dependence on a part of the self which is only on the surface reassuring, and, to follow Valleur, able to guarantee a soothing verdict of innocence. In truth, this part is bullying and can push the person into self-destructive behaviour.

The process is similar to that described by Meltzer (1973) in tracing his metapsychological theory of perversions and addictions. The addictive relationship which ties the person to a bad part of the self and submits to its tyranny comes about when the dependency on good internal objects, which do have reparatory abilities, is made difficult or impeded through attacks which damage them, making them unavailable or unrecognised. The destructive part of the Self then presents itself to the suffering healthy parts, first of all as a protector from pain, then as a servant of sensuality, and only in the face of resistance to regression as a violent tyrant. The narcissistic organisation which is formed through the challenging behaviour and risk seeking is feared, but more importantly sought out for the protection it offers. Without it, there is nothing to check the anxieties which the subject is trying to defend themselves from. Thus, risk seeking takes on the characteristics of a mental space into which one can retreat to escape an unbearably distressing reality, a true “psychic retreat” (Steiner 1993). It is an area of the psyche in which omnipotence is triumphant, and, in fantasy, everything is allowed. However, the relief which comes from this retreat brings with it the risk of isolation and compromises relationships with others, and, in a few very serious cases, causes a loss of touch with reality.

A psychotherapist who undertakes treatment with an ERSA patient will soon have to face the mafia-like despotism (Rosenfeld 1971) which governs the pathological organisation of the personality. He will often have the impression of being a foreigner, who has arrived in a state ruled by a dictatorial regime: he will be able to speak freely to the local people about the things he sees, without hiding criticisms, but his words will be met with embarrassed silences and sometimes small secretive smiles of agreement. Proceedings are slow and cautious. Like Alvarez with her autistic children (1992), the therapist will try to “make the thought thinkable” by presenting himself as a living interlocutor, animated and with the capacity to first name and contain the thought, later placing it in the Self or in the object, and only finally discussing with the patient the reason why he has formulated it.

At certain times during the work, the therapist will feel filled with the distressing and destructive feelings which the patient is evacuating in order to maintain the status quo. Much more commonly, instead, there will be an enactment and the clinician will feel indifference, and a sense of ‘normalness’ about the stories told. This is induced by the patient, who is defensively giving up their mentalization because the ideas are too

terrifying to think and the feelings too strong to be felt. All of this seems to indicate a poorly functioning reflective function (Fonagy & Target 2000). Psychotherapy can offer a benevolent interaction which is sufficiently in symphony with the person. In the psychic space of the session, self-reflective and interpersonal experiences can be encouraged, able to promote mentalization of affects and more generally the abilities that make it possible to recognise emotions in oneself and in others, and an efficient and competent management of emotional states in relationships (Fonagy, Gergely et al. 2002).

The above reflections have been highly useful in clinical work with ERSA patients, especially in the psychotherapy presented in the next section.

Clinical case of Extreme Risk Seeking Addiction: Mr R

This clinical material is taken from the weekly psychoanalytic psychotherapeutic treatment of a patient in love with risk. I worked with Mr R over three periods¹: the first began when the patient was thirty-five years old, the third ended when he was in his mid-forties. R is a man of medium height, with an athletic build. When I saw him for the first time I was struck by his somewhat stiff gait and the way he looked at me, sitting sideways in the chair. He had a tic which made him shake his head from time to time. When I asked what had brought him to me he was not able to give me a precise answer, and yet I also soon felt the sensation of pain and suffering which went with him.

R remembered nothing of his childhood and early adolescence with his adult siblings, but had the feeling that things had gone well up until they left home. His older sister was the person who had taken care of him more than any other member of the family, even more than his mother. It is for this reason that separation from his sister, as we reconstructed years later, had been very painful for R. Throughout his schooling, he was an anonymous boy who did well at school and lived a dull life. In the second year of middle school (aged approximately twelve), R transformed gradually from an unremarkable student to an increasingly transgressive adolescent. He began to neglect his homework, skip class, wander around alone, and hang around with older boys. The situation became progressively worse, and the parents, feeling completely unable to handle things, encouraged his sister to intervene. She took him away to live with her for the whole of the first year of high school (aged approximately 14). With the move, R seemed to be reborn: he went to school regularly, he studied, he passed his exams. But at the end of the year, he was sent back to his parents and took up his old life. The group he frequented used drugs, and fairly quickly R began to use heroin; within a few years he was addicted to drugs. He somehow made it through the rest of high school, and began university, but things got worse and his studies ended for good. One summer R went to stay with his sister. He was supposed to stay there for a week or two, but in reality he never left. After moving to his sister's, R decided to stop using heroin, and he was successful in doing so.

R had truly adored his older sister, a woman with a strong character, and her husband. The couple decided to keep the young man with them for good, whilst still keeping their autonomy. The brother-in-law looked for a flat and a job for R. R got a job as a worker with duties which required a great deal of physical effort. R set to work with great energy, taking on tasks as if they were a sporting challenge. His secret hope was of redemption and a career. He found a girlfriend from a high social class, and began to go

out with a group of well-off peers. Before long, however, R, who in the first few years was held in high esteem for his sporting prowess, felt a deep sense of discomfort for having a lowly - paid job which to his eyes offered no prospect of development.

As I got to know the patient, I found out that R had always loved individual and non-competitive sports which required dexterity and strength, and that revealed to be dangerous such as skiing, motocross, and free-diving for fish. R applied himself to sport in an extreme way. His favourite discipline was wave windsurfing, in which the athlete surfs very large waves. As I listened to R, I understood that he practised surfing in a solitary way and made every effort to avoid contact with other surfers. Practising this sport during winter, in the open sea, involved a high risk of drowning. Although R was decidedly reticent, I guessed at the type of relationship he had with the sport: it was the only thing able to make him forget everything, giving him the feeling of being capable and powerful. After a Sunday spent at the sea, the tone of his mood clearly improved, R worked with ease and lightness, and was more affable with others. Unfortunately, the effects did not last long. When I pointed out to the patient that he frequently and willingly risked his life, R made light of it.

Session after session, I became increasingly struck by the patient's dependency on his sister, his brother-in-law, his girlfriend, but also by the almost pleased tone in which R spoke of the physical pain of his work, almost as if he felt pleasure and dependency on the large machine to which he was assigned. Although R got home worn out after hours spent alone working with this machine (he usually worked many more hours than the other employees), he took assiduous care in its maintenance, and repaired it quickly every time it broke. When I pointed out the destructive aspects of this approach to work, R justified it by talking about the company's needs. Whilst R emphasised work, he carefully avoided talking about sport. When I asked a question about sport, he usually smiled embarrassedly, trying to quickly change the subject. It was obvious that risk seeking through sport constituted a source of violent excitement which R tried to hide from me, rather as a drug user might. R participated regularly in the sessions, without being late or absent. I perceived in our relationship a certain reverence towards me associated with a barely concealed attitude which subtly belittled our work. R seemed to want to tell me that in the end, ours were fine words, but that nothing would change, because nothing could change. I nonetheless noticed that something was changing bit by bit. I had the impression of earning his slight admiration, little by little, through clearly spelling out what I thought of the situation. Of course, he would never have "done as he was told", but he began to admire this doctor who said things clearly which he had thought many times secretly inside.

After eleven months of psychotherapy there was an abrupt change. Suddenly R seemed in a hurry to reach a conclusion one way or another. I felt transformed into a sort of swindler who kept his patient in psychotherapy with a few tricks, maybe for a fee or for a devious desire for power. The patient's attitude did not change in spite of my attempts to discuss our relationship. After a few sessions, R told me he was worried about a new work commitment beginning soon. The company had had some orders, and the pace of work had to increase. He was not at all sure he was up to it. Despite my expressions of concern, after thirteen months R stopped the treatment, claiming he felt well enough.

A few years later R called me again. At the meeting I found a distraught man. R appeared tense, his hands trembled, his facial tic had come back. He began by asking me to deal, this time, only with “practical things”. He told me that he had begun medical treatment for a serious condition which commonly results from heroin addiction, and this had been going on for several months. The heavy treatment had caused him to be frequently feverish, and terribly tired. Despite this, R had carried on working regularly without lessening the physical effort involved. The load had soon become gruelling, an extreme challenge. After a few months R had collapsed, and had had to give up work. One morning in front of the shaving mirror he had begun to tremble and felt a devastating feeling of suffocation which had trapped him at home. The panic attack symptoms were repeated in the following days.

For many weeks the psychotherapy swung between the necessity of remembering what had happened and the pain and distress which these memories provoked. In particular, R dwelt almost every session on the days of his collapse. He felt a profound sense of guilt for having left work.

The medical treatment, which had not been interrupted, came to an end a few months later with the best possible results. In the meantime, the panic attacks became less frequent. R resumed work, but with a gentler routine. After about six months, he had regained most of his capacities, he felt less distressed, and even his facial tic had lessened. R began to ask himself, hopefully, if what had happened to him had just been a one-off. At this point his girlfriend, now that the worst was over, suggested redecorating the house R lived in, and she was immediately backed up by the patient’s sister. The whole family talked of marriage. His anxiety increased to the point that not even outings at sea were able to contain his feelings of inferiority and inadequacy, which were by now extremely strong. The patient began to torment himself, telling himself he was a good-for-nothing with no hope of a career. Feelings of inferiority and guilt combined to suffocate R. I suggested to R a different way of interpreting his story. R had managed to save himself by distancing himself from drugs, but had nonetheless remained a dependent person, and his new drugs were his sister’s idealised family, his work, and risk seeking.

Very quickly, over a handful of sessions, I witnessed an abrupt change. From one week to the next, a rush of rage erupted from the patient, directed towards his sister, his brother-in-law, and in part towards his girlfriend. I feared for a psychotic breakdown on the part of R, and for his sister’s safety. R claimed he could no longer bear the closeness of his family. The anger quickly became associated with a desire for independence, fantasies of a different job, of moving to other cities. Then R, having regained some control of his emotions, abandoned his plans of escape and set himself to proving his independence. The patient, never having felt the need for a car of his own, decided then to buy one with his own money. From a psychological perspective I knew this was no simple thing. R had to choose for himself the model and evaluate its features, bearing in mind the amount he had saved. The purchase of the car filled several months of psychotherapy. Finally, R bought the car and not long afterward – about a year after the eruption of rage - asked me to bring our work to an end. I believed that the end of psychotherapy represented for R a further confirmation of his independence. I felt trust in R’s capacities, and in harmony with his need to do things “by himself”. We agreed a date and prepared for our separation. Far too optimistically, I neglected one thing: R was still practising extreme sports.

R called me again after almost four years. When we saw one another again he told me immediately that this time he needed something else, he had to “dig” within himself. He told me that he was very worried by loneliness. The patient was feeling attracted to the powerful emotions he got by isolating himself and which gave him a sense of contentedness, pushing him to distance himself from others. R had tried to reject the deep call of this feeling, first by relying on all of his rationality, then by phoning me.

Over the four years, R had secured a better job within the company, in the office, and had rebuilt his relationship with his sister, although with much less contact than before. About one year previously, and following a long cohabitation, he split up with his girlfriend. Despite still feeling attached to her, R had experienced this choice as a liberation. Now R lived alone, awaiting a new partner whom he declared he could not find. In fact, he had established a relationship with a woman on a strictly sexual basis, which the patient kept up to avoid any emotional engagement. As regards extreme sports, R had increased his participation in dangerous sporting activities. The windsurfing outings at sea had become more frequent. R had also purchased a powerful motocross motorbike and had begun to race on his own, taking on increasingly impenetrable wooded tracks. Motocross had led to several mild injuries, and one serious one, fracturing his shoulder. Another sport he had taken up alongside motocross was downhill mountain biking. This sport is practised on obstacle courses which cut through hills or mountains, long descents down which participants hurl themselves in an attempt to reach the valley at the highest possible speed. Here too, falls and injuries.

The first few months of psychotherapy were difficult. For many weeks in the first winter I think I was the only person with whom R spoke. Sometimes I asked myself how much R thought about suicide. A couple of times I tried to talk to him about this and R declined to discuss it, saying ‘It is too heavy. I don’t want to speak about it’. I took this as confirmation of some risk; at the same time, I considered that the patient did have a capacity to stay alive and I put my confidence in this. The patient seemed set in his desire to reclaim the past. He had erased a large part of his childhood memories; in our sessions he repeated with distress that he couldn’t remember anything, either from his childhood or from his adolescence. In this phase our therapeutic relationship was strengthened thanks to the associative work and to the reciprocal awareness of a shared therapeutic goal. Week after week we began to gather a few pieces of the jigsaw. His parents re-emerged, and the house in which he lived until his older siblings’ departure, with the silence of the now-empty rooms. The patient continued to attack our shared work: he claimed not to remember anything for many sessions although he added new elements to his personal history, session after session. On other occasions he was resistant to acknowledging the value of the therapeutic work being done, considering our progress unintentional or solely the fruit of his own efforts. Nevertheless, after several months the sense of subjective relief seemed to be the sign of a genuine therapeutic advance. R, seeing himself again as a child left alone too soon, confessed to feeling lighter. He had always felt that he was the only person responsible for his life, full of mistakes. A memory emerged of a school skiing trip aged twelve, perhaps his first encounter with the pleasure of risk. Sometimes R spoke about sport, usually using words which were supposed to reassure me: he made light of it, reducing his stories to the bare bones, avoiding lingering on the most dangerous episodes. I asked him during one session if

taking part in such sports could not be a way to seek death. He explained that for some people it is, but not for him.

Summer came. The holidays, in the past feared as a break in the psychotherapy, filled R with enthusiasm. In the mountains the patient met a woman, and a mutual friendship developed. R did not want to go beyond friendship but was happy to see that it was possible for him to start a new relationship. In the second year, the tone of his mood certainly changed. R no longer felt drawn to solitude: he was tired of being alone. He was still solitary. Sea outings carried on. After one weekend, R told me he hadn't been able to handle the board and he had ended up in a stretch of sea best avoided because of the current and the waves. He did not hide from me that this time he could have died. I said to him that he must have been very afraid. This wasn't the case: in times of difficulty, even when he was aware of the danger, he was always calm. Anxiety hit when he got back on dry land, at the idea of stopping to chat with some of his (few) companions. We spoke for a long time about the disinclination for relationships beyond the superficial due to the fear of the *object* being unreliable. The experience of risk, unlike human relationships, was experienced as reassuring, as it was believed to be controllable.

In the winter of the second year, R told me that according to him, the work of remembering was over. He was pleased with the result. Shortly afterwards he began to redecorate the house in which he lived. R had always left the flat just as he had found it. Now was the time to change. R took the task as a challenge, and did many things for himself, or helped the tradesmen. To my surprise, the patient told me that the interest in the house was driving him away from sport. He had given up both the motorcycle and mountain bike, and over several weekends he stayed behind to work when he would usually have gone to the sea. I was struck even more by the fact that R spoke of windsurfing as 'just a sport', recognising that previously it had been something he could not do without. Naturally, when I tried to speak of an addiction, perhaps past, R declared he had always been in control of himself. As work on the flat drew to an end, R brought a new theme to the sessions. The patient began to ask himself if anyone would ever come to live with him in his new home, and slowly slid into a depressive crisis. Work on the flat, which was almost complete, ground to a halt. The patient called upon everything he had learnt in his long years of living with psychic pain and he defended himself skilfully, avoiding being taken over by negative fantasies.

In the meantime, we managed to understand the relationship between the project with the flat and the end of his relationship with his girlfriend. R had ended their relationship just as they were about to begin to redecorate the flat at his girlfriend's suggestion. Unconsciously, picking up the building work meant magically finding a new relationship. The crisis had come about when reality imposed itself. The moments of pain began to get fewer, and little by little R regained a certain serenity. The sessions had helped the patient, who had not found much help in the outings at sea. Something was changing. R made a point of emphasizing that windsurfing had become just a sport, and in one of the sessions he revealed that he had not worked out at home for about a month.

One or two sessions later, he spoke for the first time of a new project. R had decided to build himself a large aquarium for tropical fish. I learnt that as a child R had had a classic goldfish bowl at home. As an adult R would have liked an aquarium, but he had never felt able to manage one. The aquarium project revealed itself to be a serious undertaking. R prepared himself methodically. He began researching on the Web; he

visited several shops and consulted experts. The patient told me, somewhat to his surprise, that building the aquarium was involving him in a different way than in the past. R felt calm, methodical with his project, with no urgency about rushing things. The arrival of some “living stones” (stones with micro-organisms living inside, which soon become visible) allowed us to talk with more clarity about this careful return to the living world.

One evening R announced to me that he had taken home his first two fish that afternoon. He was happy. He then said that the day before he had been to the sea windsurfing. As he was out of practice he had only stayed in the water for an hour, with frequent pauses to avoid risks. The sea was very good the following day too, but once there, R decided to return home because of the fish. On the way home he had asked himself for the first time whether the hundreds of kilometres of travel required to get to the beach and back was really worthwhile. I commented that his relationship with windsurfing seemed to have changed. “I am not addicted anymore” answered R, adding “you have been talking about it to me for a long time”. So R suddenly spoke freely about addiction to sport. Many of the things I heard were new to me. Among those who practise extreme sports, the patient revealed to me, there is a lot of talk about addiction to the sport. The theory which carries the most credence among its practitioners is that windsurfing encourages addiction because it can’t be practised all the time, only when conditions at sea are suitable. Many weeks can therefore go by during which the desire gets stronger, but is subject to a kind of abstinence. R revealed to me many other aspects of extreme sports, but the thing which struck me above all was his lightness of tone in the telling, the simplicity and relief with which R talked about the time when, as he said, “my life was extreme”.

In the following months, R’s attitude to psychotherapy became explicitly ambivalent. In one session, R asked to halve the meetings; in another he accused the therapist of being the cause of his stalled condition in relating to others; in yet another he declared that only the therapist could guide him out of the situation he was in. One of the patient’s very rare dreams allowed us to get close to the distress felt in abandoning his addiction. In the dream, R was on a ski lift with two other people, on his way to see a motocross competition. Suddenly the ski lift disappears, his two neighbours save themselves by jumping, and R remains alone balancing on a post at a terrifying height. The patient tries to resist, but in the end falls. R associated the ski lift with both skiing and downhill cycling (the mountaintops from which one hurls oneself down are often reached by this means), and remembered that motocross had been one of his main sports. We noted that stopping practising extreme sports left him feeling terribly endangered, having nothing left to hang on to. R became aware of the pathological organisation which had propped him up and caged him for many years. He represented his internal condition through the metaphor of a wall without gates that was built around him; it was a description of almost physical vividness. He asked to be helped to break through what he now saw as a wall imprisoning him. The psychotherapy, which is ongoing, is now focussed on this theme.

Discussion

In this article I have formulated a hypothesis about the psychological processes which transform extreme risk seeking into a behavioural addiction. I have proposed that ERSA is caused by emotions of excitement and “narrow escape” which, if repeatedly reiterated, bring about the construction of a pathological organisation, a tyrannical and falsely protective part of the self, which is able to create illusionary states of invulnerability and all-powerfulness. The patient of whom I have written suffered as a child because of early separations, and later transgressed as an adolescent, to the point of drug addiction. As an adult, his attempts to regain an acceptable inner balance extracted a high psychological toll and drove the patient to put himself in the hands of various kinds of addiction, among others ERSA.

One could object to the hypothesis by saying that the patient may have developed a real and true behavioural addiction. R’s behaviour could have possibly been determined by aspects of his personality. The hypothesis that voluntary risk taking is a consequence of personality characteristics is a common one and this model has been studied in depth by psychologists who refer to the Theories of Personality Traits, namely Zuckermann (Sensation Seeking Trait – 1994 and 2006) and Cloninger (Novelty Seeking Trait – 1987 and 1993). According to these models certain individuals need intense stimulation in order to reach good tonic levels of humour, general activity and social interaction. This parameter is determined by a biological substrate which regulates reactivity to stimulation. Risk taking is one way to satisfy one’s need of stimuli. In the case study at hand the patient does not present a constant need of new stimuli or novelty: he spends most of his time in a state of solitude and isolation, and is devoted to a job that is both monotonous and repetitive. The hypothesis of psychodynamic processes which result in a behavioural addiction provides a more coherent explanation for R’s risk seeking. In this sense the patient meets all the criteria suggested by Pedinielli and colleagues (2005): at age twelve he experiences “initiation” and “revelation”, which are the start of his addiction; he repeats his behaviours and is addicted to them, or rather he is unable to critically analyse them due to his psychological discomfort; he employs risk seeking as a systematic and stereotyped solution to all his problems; he resorts to action rather than mentalization and seeks physical sensations to the detriment of emotions.

A second objection may arise from a sociological point of view. The sociologist Lyng (1990) discusses why certain people need to take risks for their well-being and coins the term “edgework” to define the action with which the individual negotiates his or her personal boundaries between life and death, by means of high risk taking. As an alternative to the models which refer to personality predisposition, the author suggests that edgework represents a form of escape and resistance to the prevailing structures of political and economic power (Lyng 2004). For Lyng, edgework serves as a vehicle of escape from social conditions that produce stunted identities and offer few opportunities for personal transformation and character development (Lyng, 2005). The author links risk taking to social alienation rather than internal psychic processes. This model suggests that risk taking should not be interpreted in a purely psychopathological perspective. Therefore, my patient’s behaviour might be considered a creative remedy to social malaise. Unfortunately, clinical work revealed that A’s fears, destructiveness and distress derived from his early life. To defend himself the patient used drugs, work, family relations and also risk seeking, to the point that he became addicted to risk.

One last objection might be that windsurfing is not so risky as to generate an addiction and that the practice of this sport can not be considered one of my patient's symptoms. Thus, we need to consider if there are *activities* that generate ERSA. Unlike drug addiction, ERS addiction arises from behaviours which do not bear specific addictive features but that become addictive if taken to extreme levels. For this reason we cannot define any sport as addictive, although some sports do facilitate risk seeking. R transformed windsurfing into a psychic retreat to stem his mental pain. As time passed R could no longer live without windsurfing and other sport practices. When R experienced a real internal change his relationship with windsurfing also changed. The patient was able to claim: "this is only a sport for me now".

I would now like to discuss a few points related to the psychotherapy. The therapeutic relationship with R, like psychotherapy with other addicts, was a triadic relationship in which the three subjects - the patient, the therapist, and the "substance" (in this case ERS) - interacted, each playing their own role. The patient oscillated endlessly between the therapist and risk seeking, turning to and distancing himself for years at a time from the sessions. I have always accepted the implicit and explicit demands which R has made from time to time, telling me what he felt he needed or could manage (containment, only materials related to the present, work on reconstructing the past, etc.), but at the same time I have kept firm in my mind the objective of exploring the nature of the pathological organisation which we were facing. I have certainly taken a long time to build up a clear enough image in my mind of this part of the patient's self, distracted as I was by its many faces (drug addiction, workaholism, relationship dependency, ERSA, etc.). I am convinced that in the end, being able to formulate a personal theory has strengthened my reliability as therapist-container and turned the psychotherapy around.

The patient's transference changed over time. In many phases of the psychotherapy I have felt filled with the projective identifications which cast me as very similar to the perverse internal object. I was frequently perceived as powerful and insidious, capable of diminishing mental pain, but also subtly of creating dependency. Like a mirror, the patient has tried to manipulate me, to be reassured, to overcome the crisis of the moment, to be judged freely normal. The projection onto the therapist of the perverse object pushed R into avoiding excessive involvement, and into stopping treatment several times, a way of ending a relationship which was experienced as potentially tyrannical. Nonetheless, the patient has managed to leave some room for trust and for the possibility of my being a good enough object. Certain aspects of the psychotherapy have probably helped with this, such as the continuity of sessions, a non-judgemental therapeutic attitude, being understanding but not patronising, avoiding giving advice and direction, and above all, I think, maintaining a flexible position, like a good-enough mother whose baby is beginning to walk.

The countertransference was very useful in guiding my understanding. Among my most significant emotions, I remember periods of indifference towards the dangers incurred by A in his sporting activity, in tune with the veneer of normality which he heaped upon his risk seeking. At the times when I was not feeling indifferent, I felt on several occasions great distress, fearing for my patient's life. In many other moments I felt it was important to remember on the patient's behalf too, and resist the unconscious pressure to make a clean slate, to spend week after week rubbing out the blackboard of what had happened, be that events or emotions. The whole psychotherapy can be seen as

an attempt to increase the regulation of affect and to encourage mentalization. The patient was able use the therapeutic relationship to try out a way of functioning other than the way he had created to defend himself from distress. Progressively, I have extended this mode, reducing the patient's use of risk seeking as self-medication and increasing the use of the reflective function, and so escaping from ERSA.

Finally, I am aware that I have a debt of gratitude towards the patient whose story I have told. Flailing about in the dark, I was forced to read, study, conjecture and formulate theories which I have expressed in this article. Today, I have a different clinical sensibility towards risk seeking, which has been very useful to me when working with other patients who voluntarily seek out risk, and is much more than I expected after that first lukewarm meeting with R.

References

- Allen, J.G. & Fonagy, P. (2006) *Mentalization-Based Treatment*. Chichester: John Wiley & Sons. (Italian trans. *La mentalizzazione. Psicopatologia e trattamento*. Bologna: Il Mulino, 2008)
- Alvarez, A. (1992) *Live company: Psychoanalytic Psychotherapy with Autistic, Borderline, Deprived and Abused Children*. London and New York: Tavistock/Routledge.
- Balint, M. (1959) *Thrills and Regressions*. New York: International Universities Press. (Italian trans. *Situazioni brivido e regressione*. In *La regressione*. Milano: Cortina, 1983)
- Bell, N.S., Amoroso, P.J., Weqman, D.H. & Senier, L. (2001) Proposed explanations for excess injury among veterans of the Persian Gulf War and a call for greater attention from policymakers and researchers. *Injury Prevention* 7(1): 4-9.
- Bibble, D., Hawthorne, G., Forbes, D. & Coman, G. (2005) Problem gambling in Australian PTSD treatment-seeking veterans. *Journal of Traumatic Stress* 18(6): 759-67.
- Cloninger C.R. (1987). A systematic method for clinical description and classification of personalità variants. *Archives of General Psychiatry*, 44, 573-588.
- Cloninger C.R., Svrakic D.M., Arzybeck T.R. (1993). A psychobiological model of temperament and character. *Archives of General Psychiatry*, 50, 975-990.
- Fonagy, P. & Target, M. (2000) Playing with reality: The persistence of dual psychic reality in borderline patients. *International Journal of Psycho-Analysis* 81: 853-873.
- Fonagy, P., Gergely, G., Jurist, E.L. & Target, M. (2002) *Affect Regulation, Mentalization, and the Development of the Self*. New York: Other Press.
- Freeman, T.W., Roca, V. & Kimbrell, T. (2003) A Survey of Gun Collection and Use Among Three Groups of Veteran Patients Admitted to Veterans Affairs Hospital Treatment Programs. *Southern Medical Journal* 96(3): 240-3.
- Grosso, L. (2000) Un cocktail di emozioni – Motivazioni al rischio e fattori protettivi. *Animazione Sociale* 30(157): 54-60.
- Horowitz, M.J. (1976) *Stress Response Syndromes*. New York: Jason Aronson.
- Kingston, S. & Raghavan, C. (2009) The relationship of sexual abuse, early initiation of substance use, and adolescent trauma to PTSD. *Journal of Traumatic Stress* 22(1): 65-8.
- Le Breton, D. (1991) *Passions du risqué*. Paris: Édition Métailé. (Italian trans. *Passione del rischio*. Torino: Edizioni Gruppo Abele, 1995)
- Lyng, S. (1990) A Social Psychological Analysis of Voluntary Risk Taking. *The American Journal of Sociology* 95(4): 851-86.
- Lyng S. (2004). Crime, edgework and corporeal translation. *Theoretical Criminology*, Vol. 8(3): 359-375.
- Lyng, S. (2005) 'Edgework and the risk-taking experience' in S. Lyng (ed) *Edgework: The sociology of risk-taking*. New York: Routledge
- March, J.S. (1993) What constitutes a stressor? The "criterion A" issue. In J.R.T. Davidson & E.B. Foa (eds.), *Posttraumatic stress disorder: DSM-IV and beyond*. Washington, D.C: American Psychiatric Press.
- Marcelli, D. & Braconnier, A. (1999) *Adolescence et psychopathologie*. Parigi: Masson. (Italian trans. *Adolescenza e psicopatologia*. Milano: Masson, 2005)

- Meltzer, D. (1973) *Sexual states of mind*. Perthshire, Scotland: Clunie Press [for] the Roland Harris Trust Library. (Italian trans. *Stati sessuali della mente*. Roma: Armando, 1975)
- Meltzer, D., Williams, M.H. & Trust, A.H. (1992) *The claustrium: An investigation of claustrophobic phenomena*. London: Karnac Books. (Italian trans. *Claustrium. Uno studio dei fenomeni claustrofobici*. Milano: Raffaello Cortina, 1993)
- Michel, G., Leheuzey, M.F., Purper-Ouakil, D. & Mourensimeoni, M.C. (2003) L'addiction au risque: Une nouvelle forme de dépendance chez les jeunes? *Alcoologie et addictologie* 25(1): 7-15.
- Pannarale, L. (1998) Dipendenza dal rischio. In P. Rigliano (ed.), *Indipendenze – Alcol e cibo, farmaci e droghe, comportamenti di rischio e d'azzardo: le relazioni di dipendenza*. Torino: Edizioni Gruppo Abele.
- Pat-Horenczyk, A., Peled, O., Miron, T., Brom, D., Villa, Y. & Chemtob, C.M. (2007). Risk-taking behaviors among Israeli adolescents exposed to recurrent terrorism: provoking danger under continuous threat? *American Journal of Psychiatry* 164: 66-72.
- Pedinielli, J.-L., Rouan, G., Gimenez, G. & Bertagna P. (2005) Psychopathologie des conduites à risques. *Annales médico-psychologiques* 163(1): 30-36.
- Ranieri F. (2006): Dipendenze patologiche da rischi estremi. *Personalità/Dipendenze*. 2006 Dic; Vol. 12 (III).
- Ranieri, F. (2009) La quête de risques extrêmes. *Psychotropes Journal* 15(1): 115-135.
- Rosenfeld, H. (1971) A clinical approach to the psychoanalytic theory of the life and death instincts: an investigation into the aggressive aspects of narcissism. *International Journal of Psychoanalysis* 52: 169-178.
- Smith, D.K., Leslie, L.D. & Chamberlain, P. (2006) Adolescent girls' offending and health-risking sexual behavior: the predictive role of trauma. *Child Maltreatment* 11(4): 346-53.
- Steiner, J. (1993) *Psychic retreats*. London: Routledge.
- Valleur, M. & Charles-Nicolas, A. (1982) Les conduites ordaliques. In C. Olievenstein, A. Charles-Nicolas & M. Valleur, *La vie du toxicomane*. Parigi: PUF.
- Valleur, M. (2005) Les addictions sans drogue et les conduites ordaliques. *L'Information psychiatrique* 81: 423-8.
- Valleur, M. (2009) Les chemins de l'ordalie. *Topique* 2(107): 47-64.
- Zuckermann M. (1994). *Behavioral expression and biosocial basis of sensation seeking*. Cambridge: Cambridge University Press.
- Zuckermann M. (2006). *Sensation Seeking and Risky Behavior*. Washington, DC: American Psychological Association (APA).

ⁱ The patient gave his permission to write up the case. The author has omitted all information that is not relevant to the clinical report.