THE PSYCHODYNAMIC PSYCHOTHERAPY OF A MALE TRANSVESTITE:

A CASE STUDY

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ABSTRACT

The present study provides a description of selected core psychodynamic issues pertinent to a male transvestite patient. Case material from an ongoing 11 month psychodynamically-oriented psychotherapy is used for illustrative purposes. The theoretical roles of the 'core complex', castration anxiety, aggression and a particular ego style are thematically outlined and illustrated by a discussion of the therapeutic process. An attempt is made to demonstrate an increased capacity for depression, increased object-relatedness and disidentification from a symbiotically related female introject as the aim and partial gain of the therapy. The transference, case management difficulties and the therapeutic process of what has occurred as well as what is likely to, are considered. The unexpected outcome, in that the patient has ceased to fetishistically cross-dress, given the short space of therapeutic time is discussed. It is concluded that this be viewed tentatively. Finally, some thoughts are raised as to the utility of the psychoanalytic approach as against the general psychiatric-diagnostic approach.

TABLE OF CONTENTS

1.0 INTRODUCTION

1.1 Aims and motivation for the study

The principal aim of the present study is to provide a description and explanation of the psychodynamic issues pertinent to the psychotherapy of a male transvestite patient. The focus concerns male transvestism in relation to the clinical presentation of the therapeutic process. Subsequent references to transvestism refer to male transvestism only since the scope of the paper precludes an account of female transvestism. Case material from an ongoing eleven month psychodynamically-oriented therapy with a patient of this kind will be used for illustrative purposes. The theoretical themes of the 'core complex' relationship to a symbiotic mother, castration anxiety, the role of aggression and a specific ego style will be ellucidated, and then illustrated by the therapeutic process. Interesting components to the therapy with regard to the nature of the transference, case management difficulties and the process both in the sessions and over time will be considered in terms of what has occurred as well as what is likely to occur in the future.

The study is fundamentally a psychoanalytically informed analysis of a single case. Although it is not the major focus of the paper the utility of this approach as against the prescriptions of the psychiatric-diagnostic approach will be referred to; however other approaches,for example the phenomenological (cf. Burich & McConaghy; 1977, 1978) learning (cf. Money; 1974), medical (cf. Ward; 1975, Pomeroy; 1975) and behavioural (Callahan et al; 1973, Marks; 1968, Serber et al.;1972) amongst others, do not form part of this study.

The body of the study is divided into 3 sections; the theoretical overview, the case data and a discussion of the therapeutic process which illustrates the theoretical base.

Following other writers (Swartz; 1982, Wilson; 1985) the present author has avoided the artificiality of separating the roles of writer and clinician by referring to himself in the first person.

First it is necessary to give a brief account of the patient whose clinical material I shall be discussing because the idiosyncratic features of this patient has resulted in the guided selection of the theoretical material presented in the next section. Given the limits of the study material had to be selected.

1.2 The patient's presenting picture

Lesley was 20 at the time treatment started. Large, brown-haired and clumsy with an awkwardness about his body he presented at a day therapeutic mileau programme in a unit attached to the hospital in which I was working at the time. In his ninth week of the programme he revealed his transvestism to me which he felt to be at the core of his difficulties. He remained in the day programme for 3 months and since then we have met for twice-weekly psychotherapy for just over 8 months.

His transvestite act, which had begun in childhood and increased dramatically since early adolescence, consisted of dressing up as a woman, paying careful attention to detail: the use of black underwear, smooth panties, a tight bra, carefully applied make-up, shoes and a wig - all to ensure that what he saw in the mirror was completely feminine. He would then masturbate as well as penetrate himself with a " thing", arranging himself in such a way that his penis was not visible in the reflection. A frequent fantasy was to imagine himself as a woman being made love to by himself as a man. He could not resist carrying out this act from time to time despite his strong feelings against it- he said it made him feel "abnormal and ashamed" as though he was "not a man" but a "homosexual or something". Apart from the sexual pleasure, it also gave him a feeling of relaxation and a

sense of being "more of a man afterwards". He never carried this role beyond the sexual situation, and moreover never lost his awareness of being male or doubted this fact.

2.0 BROAD OVERVIEW OF THE SALIENT LITERATURE

2.1 Definition

Definitional problems plague reports of transvestism. Stoller (1971) has discussed these problems and has defined the transvestite as a fetishistic cross-dresser who is primarily heterosexual in orientation and initially experiences genital arousal from wearing women's clothes. The transvestite is seen differently from the transexual, homosexual and latent psychotic with borderline features.

This approach has been reified in the American nomenclature, the DSM III, (Diagnostic and Statistical Manual of Mental Disorders; 1980), wherein transvestism has been operationally defined under the paraphelias. (i.e. it is not classified under either gender-identity or psychosexual disorders which it hitherto in general terms implied). Diagnostic criteria for the transvestite condition are (a) recurrent and persistent cross-dressing by a heterosexual male, (b) initial sexual arousal concurrent with the cross-dressing, (c) intense frustration if the cross-dressing is prohibited, and (d) the lack of fulfillment of the criteria for transexualism.

Transexualism is different from transvestism in that the essential features are persistent discomfort with the anatomical sex and a wish to be rid of one's genitals with the absence of the fetishistic aspect. The course of transvestism may lead to gender dysphoria and therefore difficulties persist in distinguishing transvestites who

move on to desiring sexual reassignment (Wise; 1979, Wise & Meyer; 1982). In order to make the differentiation it is necessary to consider precisely the nature of what motivates the individual to wear women's clothes. This implies that the nature of prior sexual object choices, sexual object fantasy, character of past gender identification and presence or absence of fetishistic arousal would be important distinguishing factors for definition. The boundaries between these conditions are blurred and hence each case should be assessed individually. Broadly speaking transvestism implies fetishistic arousal whereas transexualism gender dysphoria.

Kaplan and Sadock (1981) outline a general poor prognosis for transvestism, however they only refer to symptom removal. There is a better prognosis for those whose dressing is solely limited to the fetishistic aspect. Behavioural techniques have achieved "partially successful results" with the symptom, but follow-up studies are poor (Wise & Meyer, 1982). Generally the course is thought to be chronic i.e. the cross-dressing may only resolve temporarily. Single case studies (Glasser; 1979 (2), Coltart; 1985, Coles; 1986) which are psychoanalytically informed therapies demonstrate fluctuations in the dressing frequency. However, their value lies in the improved occupational and social functioning which results from psychotherapy.

2.2 Aetiological Theories (A brief overview)

Whereas the psychiatric-diagnostic classification focuses on symptamotology alone the psychoanalytic tradition in which this study is based has its prime focus on aetiological factors. The psychoanalytic theorists have offered prolific accounts. Although they are criticised in the general Psychiatric and Behavioural schools for imprecise methodology their value rests in their detailed narrative

descriptions of single case studies (Wise & Meyer; 1982). For the present study these are of particular note in that they bear a similarity to the material presented here. It is suggested that psychoanalytic concepts are, in the main, descriptive rather than prescriptive (following the reading of Mitchell; 1974, amongst others). Hence, it is argued they permit the clinician greater opportunity for flexibility in his/her assessment and treatment of individuals.

The fundamental basis from which psychoanalysts have evolved their explanations has been Freud's concept of bisexuality elucidated in "Three Essays on Sexuality" (Freud; 1905). Although Freud intended this as a biological theory , psychological analogues of masculine and feminine identifications remain as a heritage to the early theory (Stoller; 1972). Kubie (1974) resorted to earlier theory to suggest that the drive to become both sexes is an innate human phenomena, which may explain the magical representation of clothes frequently seen in transvestite syndromes. The apparent contradictions in psychoanalytic explanations may be understood if psychoanalytic theory is seen as an *evolving body of ideas.* The original libidinal theory allowed perversions to be understood as the negative of neuroses (Gillespie; 1966). Perverse behaviour was unrepressed expression of infantile perverse behaviour and was the opposite of repressed unconscious elements of infantile sexuality. The persistence of infantile polymorphously perverse behaviour was symbolised in the fetish.

As psychoanalytic theory evolved into a structural paradigm the role of the superego became important (Payne;1939). Transvestite behaviour became seen as a development to defend against guilt from incestual feelings towards the mother as well as a method of delaying castration anxiety from the father's wrath. Freud's (1927) discussion of fetishism makes clear that castration anxiety is the central feature in transvestism. The perverse behaviour avoids

anxiety and guilt towards the object,i.e., the father, in the oedipal triangle. Thus perversion is seen as a "regressive phenomenon" from the oedipal complex due to the arousal of castration anxiety. Fenichel's (1930) review focuses on the oedipal triangle and he views transvestism as different from fetishism, as the transvestite totally identifies with the clothes of the maternal figure. He emphasises identification of the mother with a fantasised phallus. By wearing women's clothes,the transvestite is unconsciously wishing for his father's attention. The symptom is allaying latent homosexual feelings towards one's father as well as defending against sexual wishes from the mother (Fenichel; 1930).

Current psychoanalytic theorists emphasise pregenital factors (Socarides; 1960). Bak (1953) sees the pregenital fixations of transvestism by viewing pathological identification with an active figure as the explanation of the symptom. Sperber (1973) views transvestism as a method of "imitation" allowing identification with the mother. Transvestism is seen by some writers as a defence against latent homosexuality, who posit this as a core dynamic as opposed to those postulated for fetishism (Lewis; 1964, Segal; 1966,Greenberg; 1978).

The development of modern ego psychology has allowed psychoanalysts to view the defence of splitting as the primary mechanism to explain transvestite behaviour. Freud (1938) alluded to the role of splitting to maintain reality perception despite perverse behaviour. Meyer (1980) notes that transvestites possess borderline personality organisations which are maintained as long as the splitting is effective.

Person and Oversey and Stoller have contributed most comprehensively to modern psychoanalytic explanations of transvestism (Person & Oversey; 1974 (1 and 2) and Stoller; 1966, 1967, 1968, 1971, 1972, 1974, 1975, 1976). They disagree, however, in the aetiology of this condition.

Stoller uses sex and gender theory, patient material as well as transvestite pornography to support his theory that transvestites have been "feminised", often literally in that they have been dressed in women's clothes at an early age. He feels the symptom is a hostile mastery of this early trauma of humiliation and shame from cross-dressing or a more subtle feminisation by the mother. To Stoller the transvestite has powerful feminine identifications but maintains a sense of maleness. Person and Oversey feel that anxiety is the central affect instead of hostility. This anxiety has its genesis in flawed development wherein one's sense of self is incomplete. They see the genesis of transvestism as not the "invention of the mother" but conflict within the child due to environmental vicissisitudes(Person et al; 1976). They utilise Mahler's (1965) constructs viz. early separation-individuation difficulties to explain this. Glasser (1979 [1 & 2]) has made recent significant contributions to the transvestite literature. He emphasises pre-genital factors and lucidly outlines "the core complex" in relation to a symbiotic relationship to the object. The utility of this complex has been outlined in single case studies of these patients (cf.Coles; 1986, Coltart; 1985).

In sum the psychoanalytic writers have devoted the most attention to the aetiology of transvestism. The contributions are limited by imprecise definitions and the use of single case studies. However, it appears this is mainly the concomitant in these studies of individual differences within a broad category of presenting symptomatology as opposed to prescriptive hypotheses concerning underlying psychodynamics within the broad category. In addition this allows for a flexibility in the assessment of individual case material which is precluded by the homogenous classification of the psychiatric-diagnostic model. It is now my intention to review the core dynamic issues which appear pertinent to the case in question prior to presenting some of the therapy material itself. The

problem is the same as that levelled by the criticism above : one is attempting to understand the case material in so far as what appears to fit the individual rather than whether the individual appears to fit the existing literature. It is suggested this is not a problem, but the only method to employ if one wishes to "learn from the patient" as against "teaching them" about their condition (Casement, 1985). It would seem that this is utilising the psychoanalytic approach to full advantage as opposed to falling prey to the attempt of symptom homogeneity. Thus one is looking both to the commonalities (in the psychiatric-diagnostic approach) and the unique (in the psychoanalytic approach) in each case.

2.3 CORE PSYCHODYNAMIC FEATURES IN TRANSVESTISM

The above review demonstrates the extent to which transvestism is a vast and exceedingly complicated psychic structure. Some of the numerous component complexes, each of which are influenced by the other and all of which are affected by their relative positions in the total structure will now be elucidated. Since the limits of this paper preclude an exhaustive account, only those which are felt to be relevant to this case are addressed.

2.3.1 The role of the mother: symbiosis and the "core complex component" (Glasser[1], 1979)

At the centre of this structure and fundamental to it (as in all perversions) is a complex of inter-related feelings, ideas and attitudes - what Glasser has referred to as the "core complex" (Glasser [1 & 2], 1979). A major element of the core complex is a deep-seated and pervasive longing for the most intense and intimate closeness with the object, amounting to a complete merging or union: "it is as if the transvestite has a memory of primary identification and is

trying to regain it. But sought for in this union is not only total gratification and safety from abandonment or rejection ; also desired is a secure containment of his intense, primitive rage and the consequent dangers of disintegration of the self and destruction of the object. In the transvestite this longing for complete union with the object takes a characteristic form, namely the wish to "get inside the mother's body, to be *enveloped* by the object" (Glasser [2], 1979; p.164). This wish is expressed in the act of getting into the women's clothes.

However, such an envelopment does not have the character of a temporary state from which he will emerge; the transvestite feels it carries the implications of annihilation,that is, a total and permanent loss of self, "a disappearance into the object and the loss of his existence as a separate, independent individual"(ibid.). Stoller (1976) argues that a component force in such perversion is the need to escape from this union with the object : freedom from it is a matter of survival. Thus the undressing at the end of the act appears as crucial an element in the experience as any other. However, this freedom is unsatisfactory because it brings with it the feelings which prompted the act in the first place- those of separation and abandonment. This in turn prompts longings for envelopment.

Thus, an intrinsic feature of the core complex is the fantasies that the object in which he desires to be enveloped is always felt as having the opposing attributes of offering fulfilment and protection, on the one hand, but of being engulfing and obliterative, on the other (Glasser [1]; 1979). This "splitting" (Stoller; 1975) of the object is found in the transference of all cases of transvestism either simultaneously or alternately and bears out the portrayal the transvestite gives of his mother as having a marked narcissistic character structure, and that she relates to her son in these terms.

Stoller (1975) claims the mothers of transvestites feminise their boy children, either deliberately or unconsciously, and therefore it is as if the transvestite child recognises that his only hope of gaining his mother's love is to appeal to her narcissism, that is, to be a girl. Glasser ([1]; 1979, p.292) has also mentioned the role of the mother in this connection:".....one characteristic and central feature....is that she has a markedly narcissistic character and she relates to her child in narcissistic terms .....She is both attentive and neglectful and thus disturbs his psychic homeostasis in both ways". Greenson; (1968) posits the importance of "dis-identification" (p.370) from the "early symbiotic fusion with mother"(ibid.) in order for the child to develop a capacity for separation-individuation. Because these boys are feminised due to the mother's narcissicism they cannot separate and thus do not "counter-identify with father"(Greenson; ibid.); instead the symbiosis is perpetuated. The mother may promote or hinder the dis-identifying and the father does the same for the counter-identifying. Fathers of transvestites are reported to be either distant and unavailable physically (i.e. they are absent) or emotionally (Stoller; 1976). Their influence in the face of the mother's narcissism is generally thought to be negligible (Glasser [1]; 1979).

Consequently, in order for the transvestite to appeal to his mother's narcissicism he must give up his identity totally which results in "psychic annihilation"(ibid.). Further, for the sake of his survival he must always have the feeling that however much he is striving to become what his mother wants, he is essentially being an imposter and must thus ensure an escape route. This has profound implications for treatment in that in order to ensure an escape route much of the therapeutic work has a *deceptive* quality which I will illustrate later.

2.3.2 The Castration Complex Component

> "The transvestite is a person whose sexual pleasure is blocked by the idea of castration. Through the perversion he tries to prove that there is no castration. In so far as this proof is believed, sexual pleasure and orgasm become possible again."
>
> (Fenichel;1930,p.327)

The transvestite act, with its prominent features of presenting himself to himself as a woman while at the same time, through his masturbation, emphatically experiencing the existence of his penis, vividly illustrates how the transvestite act serves to deny the absence of male genitals in women and the well known fetishistic function of transvestism (Fenichel; 1930, 1946; Stoller; 1968, Glasser (1 & 2); 1979. The mother features more prominently in these individual's (see 2.4.1) emotions so that the oedipal situation verges on, or remains a 'pre-oedipal' dual relationship rather than a triangular one. Thus, it could be said the mother is often the predominating, castrating figure; and this anxiety may be traced to core complex anxieties. The "engulfment" this implies gives rise to castration anxiety (Socarides; 1973,Glasser [1]; 1979). Most writers concur in their depiction of these mothers' as seductive, sadistic and castrating (Wise & Meyer; 1982). Glasser ([1]; 1979) postulates that the threat of castration gives rise to an implicit tricking of the mother in order to retain the penis - hence the triumph experienced in the sexual act. This deception is the crucial element. It enables the patient to make use of splitting and give expression to the contrary motives he experiences in the engulfing, symbiotic and merged relationship. He is at once castrated and potent, ridiculed and ridiculing, surrendering and independent. This deception and the concomitant *ambivalence /contradictions* it includes has serious implications for psychotherapy with these patients. This will be illustrated in the therapeutic process.

2.3.3. The role of aggression

> "The transvestite is characteristically a rather mild man and, in fact, the perverse act may be seen as containing and concealing his aggression and sadism. Many transvestites report their sense of relaxation and relief when dressing up and, on exploration, this is seen to be due to their feeling that their violence is safely contained or negated by the act"
>
> Glasser [2]; 1979).

Much of the psychoanalytic writing has tended to use the concepts 'aggression' and 'sadism' interchangeably which has led to confusion, both theoretically and clinically (Brenner; 1971). To distinguish them I will not attempt to identify the nature of the drive involved, or the developmental level on which the individual may be functioning, but rather the attitude to the object at the time the act is carried out. In the aggressive act it appears the elimination, exclusion, destruction- in essence *negation* - of the object is central. The object's response, real or imagined, is irrelevant unlike in the sadistic act where it is crucial. Glasser ([1]; 1979) would claim fear is always absent in sadism, whereas it is consciously present, or denied in aggression. He elaborates claiming all sadism is ultimately based on aggression, however this argument is beyond the scope of the present discussion (cf. ibid.).

Suffice it to turn the discussion to the role of aggression in the core complex. It plays an integral part - in that, given the earlier discussion where I suggested the wish to merge with the object carried the concomitant loss of separateness as an individual, it stands to reason that the threat to psychic homeostasis would provoke an intense aggressive reaction on the part of the ego aimed at preservation of the self and destruction of the engulfing

mother. However such destruction would result in abandonment, thereby the aggression could be said to add to the abandonment anxiety. This relates to Stoller's (1976) theory of "splitting" in the perversions: primitive ego mechanisms either split affective impulses towards the mother and deal with the aggressive component by denial (the transvestite act serves this function) or by splitting the internal representation of the object into retaining a loving relationship with one part and aggressive one to the other. However, the literature suggests that the former is more characteristic of the transvestite's primitive functioning than the latter which implies later development to sustain the position (Stoller; 1971). It is reiterated that the dynamics discussed here are solely in terms of a two person relationship, the third person (ordinarily the father) is not involved.

Case studies (Glasser [2]; 1979, Coltart; 1985, Coles; 1986) show that as the transvestite moves through therapy, he has the greatest difficulty dealing with the intense rage and destructive feelings which threaten to overwhelm him and negate the object from the most primitive levels onwards. The sexualisation of these forces permits him some control, but the consequent realisations of the sadistic nature of object relationships drives him to elaborate defensive manoeuvres of which his masochism and deception are striking features. The undoing of this in therapy proves to be a hazardous process, as I shall illustrate at some length.

2.3.4 The role of the ego

As has been outlined the transvestite is acting out a sadistic revenge upon a threatening and castrating mother, while at the same time he contains this attack with the masochistic defence of becoming the mother. It is a seemingly perfect solution for a traumatised infantile ego. This points to the question of ego strength and suggests

that the therapy should provide an opportunity for the ego to become stronger before solution or some resolution may occur (Coles; 1976).

Glasser ([1];1979) has put forward a speculative consideration which not only directs the attention of the therapist to certain specific difficulties in the treatment of these patients, but also illustrates that in order to be appreciated adequately, this condition must be looked at multi-dimensionally. This supports the earlier argument that these patients are not a homogenous group. I alluded to the notion that the combination of *opposites/ contradictions* appears characteristic of so much of transvestism (see Section 2.4.1.). Consider: in the act is contained male and female, active and passive, presence and absence of the penis, sadistic and masochistic feelings, defiance and submission, envelopment and freedom. In the analysis of the case, further examples will be outlined, not only pertaining to the act itself but everyday events, thoughts and feelings.

Glasser ([2]; 1979), suggests this way of mental functioning is a distinctive "ego style" which the classical notion of ambivalence doesn't adequately conceptualise. Rather, he appears to posit a specific innate capacity which leads the ego to function in this way. This would form a basis for Stoller's (1971) facility for split-identifications in these patients.

I have not attempted to provide an exhaustive account of the varying components to transvestism. I might have spoken at length about a number of topics which other writers refer to, such as the role of the father,the anal component, the defence against homosexuality, the particular concrete use made of the body(outside the act), the significance of the fear of death etc. Instead, my intention has been to highlight certain core issues pertinent to the following

case discussion as well as to convey an impression of the aetiologically complex structure and specific nature of transvestism. The attempt has been to sketch a dynamic backdrop from which the case may be conceptualised; that is, the role of the mother, castration, aggression and a particular ego style are central theoretical constructs from which the remainder of this paper will proceed.

3.0 THE CASE STUDY

In the attempt to illustrate core issues pertinent to the psychodynamically-oriented treatment of a transvestite patient, an analysis and discussion of some of the material which has emerged during the therapy with this person will be presented in this section. Due to the limits of the study the focus of this account has been restricted to only certain issues I have found important in the ongoing management of a patient with pathology of this kind.

3.1 METHODOLOGICAL CONSIDERATIONS

The subject was selected on the basis of:

(1) his transvestite act;

(2) data that has emerged during an ongoing 11 month twice- weekly psychodynamic psychotherapy, which significantly illustrates issues pertinent to the understanding and treatment of transvestism, and hence extends knowledge in the field through the addition of supporting data.

The term psychodynamic psychotherapy refers to that method derived from psychoanalysis, yet developed over time to include a range of what might be called more directive techniques, in that the therapist is less "abstinent" in his/her relationship with the patient (Malan; 1979). It, in essence, refers to "the giving of insight and the use of this insight in relationships - which includes that with the

therapist - in a one-to-one setting" (ibid. p.4). The original insights concerning transference, working through, and interpretation remain fundamental to the process. Strictly adhered to, the term psychodynamic originates from those dynamics about people described by Freud, therefore what I am referring to here is more accurately defined as psychodynamically-oriented psychotherapy (see Malan; 1979, Couve; 1984, Jacobs; 1985). For convenience the term 'psychodynamic psychotherapy' has been used.

The psychological assessment of this patient included a full Psychiatric History according to the Maudsley Format, Diagnosis according to the DSM III classification (See Appendix 1), and ongoing psychological observation by the team at the day-mileau unit attached to the Hospital where I was working at the time. The original case work-up was done by another clinician at the Unit (Appendix I) and did not include the subsequent knowledge about the transvestism. One can see from this how the picture changed enormously.

Salient features of the presenting difficulties, family and personal history have been extracted from the initial assessment and the ongoing therapy since the nature of the problem changed substantially from that ascertained at the outset. (See Appendix I). A summary of the process of the therapy, which falls naturally for descriptive purposes into three phases will follow the presentation of assessment/biographical material.

The therapy of this patient has been supervised both individually and in peer-group discussion since it commenced. Both have occurred on a weekly basis. Further, a Psychiatric consultation was arranged at a time when management was questioned by the patient's mother. Ongoing contact and review has occurred between myself and the family therapist who has maintained contact with the family.

The ongoing supervision and colleague consultation have provided a forum for constant re-evaluation of the management of this patient. Moreover, in terms of this study it has provided a means of control, evaluation and questioning of the subjective nature of work of this kind.

This leads me to outline the considerations made with regard to why the choice of long-term psychodynamic psychotherapy as the mode of intervention was made. It was instituted as a follow-up to his Day Hospital in-patient treatment. The hospital team felt he had established a relationship with me which facilitated most of his gains at the time, that is, he utilised individual therapy given the complex nature of this problem as opposed to the mileau. Therefore, in Malan's (1979) terms, given his already established 'transference' a "corrective emotional experience" (Alexander & French, 1946 in Malan; 1979, pp. 140-143) was instituted. He did not meet the requirements for planned brief psychotherapy since the focus of his life problem and current needs could not be clearly identified, his motivation concerning the symptom was ambivalent, and there were dangers to brief psychotherapy given the already established transference (ibid. p.243).

In sum therefore, the symptom has not been isolated as the focus for cure. The debate as to which approach is curative in this condition or whether symptom removal as the primary aim of treatment is appropriate or indicated is beyond the scope of this paper. Suffice it to delineate that this therapy and concomitantly this study rests alongside, and hopefully adds to, the body of knowledge which has its bedrock in the pschoanalytic tradition; that is, the process of testing hypotheses through interpretive mechanisms of one kind or another via the single case study method.

3.2 THE CASE DATA

As I have outlined only seminal information will be presented here. The information has been extracted from the initial assessment as well as from the ongoing therapy. For a summary of the case from his Day Hospital stay see Appendix I.

A discussion of the psychotherapeutic process will follow the case data. Within the body of the discussion the theoretical complexes raised thus far will be illustrated in relation to the case material.

3.2.1 Identifying Data

At the time of referral (April, 1987), L was a 19 year old single student living with his parents in an upper middle class area of Cape Town. He was referred for generalised anxiety with panic attacks and relationship difficulties and given a diagnosis of Generalised Anxiety Disorder with Avoidant Traits (DSM III;1980,see Appendix I)

3.2.2 History and Description of the Presenting Problems

L was referred to the Day Hospital following dropping out of 2nd year University due to anxiety. The problem is dated from Std.8 when "extremely high expectations" from his parents as well as the school for him to excel academically became "too much for him". "It wasn't so important to be top of the class anymore because other things were worrying me". At this point he explained the "other things" as relationship problems-he had no friends, had difficulty

sleeping and was particularly "frightened of girls". In matric as Head Prefect he felt "lonely and anxious and very self-conscious"; believing he was only noticed for his "abilities and nothing else". He became silent, withdrawn and suspicious, constantly afraid he was a "disappointment". Without the structure provided by school, or a "position of superiority", the above social problems were exacerbated. He found University a "nightmare". Anxiety with panic symptoms occured in tutorial settings, but was "worst" in informal peer situations particularly with women. He suffered physical tension, sweating, heart racing, tightness of breath, headaches and was often unable to speak. The sleep difficulties continued with the result he had difficulties concentrating in the day. Despite this he completed first year successfully (2 firsts), but with increased demands in the second year as well as a move from home to an all-male residence with concomitant increase in anxiety and lack of motivation he left after 2 months deciding he needed help. The move was seen as the major precipitant to referral.

L revealed his transvestism to me in our 9th therapy session. For details of the act see the Introductory Presenting Picture and the Discussion. Emerging from the therapy was an understanding that his anxiety and withdrawal results from the shame and guilt he has about it, as well as the fear he will be discovered. To date he has told no one besides myself. His suspiciousness, self consciousness and persecutory feelings have their root in his constant preoccupation that "others know ....or will find out,.. I'm sure they(others) can tell there's something strange about me". Sleep difficuties are the result of him engaging in the act in the early hours of the morning so as not to be discovered. He dates the onset from early childhood where he claims "faint memories of putting on his older sisters'clothes ....or , at least wanting to". He talks often with strong resentment about having to wear a lot of his sisters "hand-me-downs"; something he was teased about as a youngster. At puberty (13years) he began to dress for the fetishistic aspects: he found it sexually exciting in a

masturbatory way. The behaviour has persisted since then with increasing regularity, "about 4-5 times a week". He cannot relate a conscious precipitant, feels it is "habitual and compulsive". At varying times during the therapy the frequency has decreased.

3.2.3 Family History

He is the youngest by 10 years of 5 children born to a middle-class family. His siblings are all women who are married and living away from the home. Claims he has "superficial but amiable" relationships with them and they've never been close because he was always much younger". Resents his father's "great love" for them and their children.

Both parents are in their late-fifties. Reports no relationship with a "weak, silly, distant and stupid" professional father (F). Believes his F has never been interested in him, and is "quite scared" of his "close relationship" with mother (M). Has always found him "insipid, incapable of discipline and disinterested in everything about me(him)". Recalls wanting F to show some involement, if "only to shout". He tends to blame M for this at times:"I've always been hers and the girls his".

His relationship with his M is characterised by ambivalence. On the one hand he describes her as "loving, strong, interested and very concerned with everything about me (him)", while on the other he resents her "intrusiveness, bossiness and constant demands to know all about me(him)". Claims they have always been "best friends" and that she's "all I've got". Has reported countless examples of their over-involvement: she brings him meals at whatever time in bed, she still insists on lying with him in bed at night, cries and phones all the time when he goes to stay with his one sister, confides her irritation with F and insists he confide everything he thinks about with her. This he does, besides his transvestism. Another striking feature is the

extent to which he feels he ought to "protect" her, since the "rest of the family only tolerate her, I'm the only one who loves her". He is often guilty and concerned with this, particularly at times when he becomes aware of angry feeling towards her in the sessions. He usually retracts becoming visibly distressed at the "betrayal". He confesses to loving their "closed relationship", but also hating it because "it's not like other sons have with their mothers". He is constantly preoccupied with what he'll do when she dies, which forms a major part of his motivation to learn to be separate from her.

He has had no significant involvement with any persons beside her,"I feel like an only child with no F". Home atmosphere has been characterised by distance and some conflict between the parents, "excessive interest in the church and being nice and good to others,....without worrying what's happening to us", as well as "keeping up the appearance that everything is fine". L has himself described his relationships with his parents as a "triangle where I want my M and my M wants my F, but can't get him, just like me".

3.2.4 Personal History

He was a planned, wanted baby when M was in her late-thirties. Pregnancy and birth were normal, breastfed for 6 months. Early development included sleep difficulties, restlessness and constant screaming. Neurotic symptoms in childhood: nightmares and nightterrors, fears of the dark, floods, tidal waves and destruction. Described as always "scared and nervous", sickly with numerous respiratory tract infections, bouts of tonsillitis and some "feigning illness for attention". Suffered severe separation anxiety, M attended Nursery School with him for the first 6 months. To date, L has difficulties separating for longer than a few hours. Performed well scholastically throughout school (always top of the class) until Std.8 when his performance

decreased marginally. Peer relationships have been an ongoing problem: "constantly teased and bullied for being a sissy" as a child; and increasing withdrawal and isolation due to the fears and preoccupation he has with his "dressing up as a woman". Class captain in Std.7 and Head Prefect in matric. Enjoyed tennis and hockey until Std.8 when he lost interest in activities he previously enjoyed. Has a consuming interest in chess which he has recently begun playing competitively. Completed first year Social Science towards an LLB, and has returned to University this year to study towards an Arts degree, majoring in English. Has had no sexual contact of any sort to date. For a description of his sexual fantasies and his transvestite act see the Introduction and Discussion.

3.2.5 Mental State

L's presentation, interpersonal style and personality characteristics have been outlined and alluded to through the paper. He is both articulate and eloquent and evidently of superior intelligence. Some compulsive phenomena eg the checking of doors and windows, and in relation to his transvestite act were noted. His fears and preoccupation with this suggest a ruminatory quality at times. However, sensorium and reality contact has at all times been intact.

3.3 DISCUSSION OF THE THERAPEUTIC PROCESS

The psychotherapy as it emerged, which falls naturally for descriptive purposes into three phases will be presented here. Although there is a natural division in the issues presented in each phase there is also considerable overlap between them. For the sake of clarity this is not addressed through the discussion. For the most part theoretical complexes outlined in Section 2 will not be re-evaluated or quoted again. Instead the reader is referred to the original sections in which the particular concept/argument

appeared. This has been done to facilitate an understanding of the flow of the therapeutic process.

An attempt will be made to demonstrate the development of a capacity for depression, increased object relatedness and to some extent disidentification from a symbiotically related female introject as a result of the therapeutic work. Attention is directed in this account to the use of here-and-now as well as past interpretation, the occurrence of passive resistance and it's hinderance to therapy due to the inability to express anger directly, and the particular aspects of the transference. The main therapeutic aim has been the attainment of a more independent male self, who could begin to move out into relatedness with the world both socially and occupationally as opposed to remaining "locked up with only myself" (himself).

3.3.1 'THE FIRST PHASE'-Attachment in the therapy: Envelopment and merging ('the core complex') with gradual separation from M

This period constituted the bulk of the therapeutic time (6 months) where the theoretical concepts of the core complex, castration and ego style (See section 2.3) are highlighted.

Initial sessions were characterised by an extraordinarily intense 'analytic' dialogue. L was a day patient at the time (1st 3 months) and consequently had daily contact with me in group work, activities and informal contact besides our individual sessions which occurred once-weekly until discharge. He demanded responses and ventillated frustration about not getting them evident in his sense of me as "detached, unconcerned, not interested in helping him and not being "clever or gentle enough". At the same time he responded to my interpretations of these feelings as representing the lack of care and interest he had always felt. This permitted a joining between us where he soon

came to view me as a figure for himself as opposed to "working for them (his parents) because they want me here". We began to explore how he had to be "something else" (the head boy) in order to feel some response of love or respect from them. Through my tolerating his abuse (overtly because he had had another therapist for one session prior to my joining the unit) and remaining with him at the same time offering underlying possibilities to this "rejection", he came to experience that what lay beneath his "achieving veneer" were feelings I could accept. He began to understand through being frustrated with my apparent lack of responsiveness, in that I would not offer him cues,the extent to which he had always needed his mother and concomitantly others to structure, take responsibility and decide for him.

The following sessions could be seen as the beginnings of *envelopment* (see Section 2.3.1) in the transference, necessary for him to reveal his transvestism. Significantly he arrived and closed the curtains as well as turned his chair (usually at 45 degrees to mine) to face me directly. This he continued to do until 6 weeks ago (the 3rd phase), which him and I have come to understand as an outward manifestation of his unconscious wish for secrecy, privacy and hence envelopment with me. Thus, what had evolved was the symbiosis with M being played out in the transference. His direct facing had significance in his "preoccupation with mirrors": and was understood recently as me as the therapist-mother and concomitantly self in the transvestite act, indicating the extent to which in the therapy he had to become enveloped with me to reach or see (as with the mirror) his central conflict.

Further indications of the *symbiosis with M* continued to emerge: He modelled a clay figure in Projective Art of his mother as an enormous phallic object with the whole family including father inside her, all peeping out except himself. This distressed him as he did not at the time understand the unconscious significance of what he was doing. It permitted

me to lay the ground, although I too did not understand the full implications at the time, for work at the level of his evident symbiotic relationship with mother. He contradicted himself about almost everything he said in relation to this which I suggested was a defence against taking himself and his feelings seriously. He agreed with this, and the *deceptive nature* of this for him and the therapy was highlighted - an ongoing difficulty in the work to date. At the time I did not know that the deception was related to him hiding his transvestism from the therapy. (See Section 2.3.4.).

Being controlled by mother was explored in the transference i.e. how he both "hates" and "needs" me to take control. It became clear that I had to be all knowing ,"perfect" and in control like M, thereby permitting him the deception in not discussing things pertinent to him (eg. his sexuality). He came to see, over time, as he often spoke of "being little, a child" when confronted with his sexuality that this was his means of excluding the adult parts of himself (sexuality) from himself. Right through the first phase his constant demands for my trust, perfection and reassurance as if to guarantee I would not "betray" him were evident. This was seen in his jealousy of my other patients; "I want you all for myself". One might say the central theme of this time was his wish to merge with me (like M) and remain hidden (like being inside her) from the world by closing the curtains. This was constantly interpreted to him which appeared to increase his anxiety as well as the working alliance, and retrospectively permitted him some separation from his "boundupness with M" in the second phase.

At the 9th session (3 weeks from Day Hospital discharge) he exploded upon entering the room saying that I had "betrayed him and everyone knew" since in group that morning he had expressed confusion with regard to sexual orientation facilitated by the co-therapist. I was in group at the time. He was extremely angry, and not so much with the

"betrayal" as he saw it, but that I was "too stupid to understand" that his sexuality had something to do with his checking "compulsions" he had previously described. Banter ensued around my not knowing and him expecting me to know what he meant by this; despite my efforts to ask him what would make it easier for him, how he fears telling me because I may not understand or help, or that I may become alienated from him if he does tell me....at which time he blurted out that he feels regularly "compelled to dress up as a woman" which he finds sexually exciting (See Section 1.2). The cardinal feature after he has dressed fully as a woman paying attention to the finest detail, would be to scrutinise himself closely for "a long time" in the mirror. He would "adore" this woman and what would follow would usually be the fantasy of seducing her "slowly, tenderly and passionately" , at which time he would not "use his penis". He would then masturbate while fantasising this women being made love to against her will by himself as male. She would eventually "begin to like it" at which time having won her over, he would "comfort and love" her by further intercourse. His penis was now of prime importance -and- at which time, it is hypothesised, he achieves an ecstatic union between his male self and female self. During the latter part of the act he would invariably penetrate himself with "a thing", which he months later told me is an "old top of a fire-hydrant" which "makes a perfect phallus". Claimed he felt "relief" and "more like a man afterwards". Interestingly, at the present moment in the therapy his fantasies about women in the world (external reality as opposed to internal) follow similar lines, however he has no fantasy of penetration. (See Section 3.3.3.).

L's manner in which he relates often appears to have a peculiar emotional quality, particularly at the times when such material is discussed - a somewhat masochistic humiliation and self-denigration to the point of presenting himself as insignificant. There are a number of examples of L feeling himself not appreciated as a male and having been unjustly humiliated by women - his mother, sisters and girls

at school. We have eventually come to tentatively see, as is clear in the second phase,that a vital purpose to his self-denigration is a wish to hide his violent phallicism from his superego as well as his castrators. (See Section 2.3.2.).

L, now an out-patient in twice-weekly psychotherapy, retracted in the following sessions presumably due to anxiety about telling me "the dreaded secret", and his coming to the end of his stay at Day Hospital. He impressed upon me the magnitude of "*relief*" he felt about telling me and demanded reassurance that I saw him no differently. His relief seemed to indicate that it was almost as if his maleness had been temporarily restored through the act, not unlike the experience of undressing at the end. (See Section 2.3.2. paragraph 2.). He constantly referred to the act in hidden ways, i.e. I came to understand that his being "tired" at the outset of a session meant he had been engaging in the act the night before. Doing "it" at other times meant the same thing. However, he consistently refused to discuss "it" directly for a number of months post telling me, despite my opening the opportunity when appropriate to the material. This highlights the *deceptive* quality I have described - however much I outwardly alluded to the 'unspoken knowledge' between us he persistently played at not knowing, even though he was at pains to make sure I did not forget for a single moment (eg. through the above cues). I respected this, yet found I constantly needed to make sure I did not collude with him in this i.e. I could not pretend to let it go unnoticed by me. My unwillingness to participate in the deception, in that I alluded to it when the material suggested he was, was met with increased resistance and frustration on his part, and I now think, paved the way for the second phase.

His relief just post telling me was clearly only temporary. As his wish to *merge* with me as a result of the increased rapport between us deepened, he contrived to make it seem that he was the injured person for me having "forced it out

of him" and then as if I was punishing him with it, in order to conceal his underlying fear. His maleness which was temporarily restored initially was thwarted and his *castration anxiety* ("you don't see me as a man anymore") was being relived in the transference. Revealing the transvestism to me took away exactly the function it had for him , that is to preserve his maleness. It was only during the second phase of aggression that he could bring the transvestism directly back into the therapy.

Valuable insights were gained, despite the "undercurrent" which he referred to due to his being unable to talk directly about "it" even though he "wanted to but (was) too scared". Through frequent references to the "head-boy" metaphor he became increasingly conscious of the extent to which his M had deprived him of "being himself", a term he used early in the therapy and still continues to. The latter sessions of the first phase represented a departure from working directly in the transference, and the content revolved primarily around parent issues, particularly with regard to mother - his intense need for her and concomitant resentment as the main theme. L battled with this , regressing to the needy child whenever there were any realisations of *separateness* from her. He recounted the childhood memories of separation terror - significantly his start at Nursery School where M had to remain with him for the first 6 months. Eventually the teachers "forced" her to go, and "tricked" him into thinking she was coming back. He relived this in the here-and-now, with an evident panic not unlike he must have felt then: "I'm exactly the same, nothing's changed". This enabled me to lay the ground for further exploration of his envelopment with her, and consequently his attempt to recreate this with me. He saw me as those teachers, i.e. I was taking him away from M by helping him to move towards, in his words," security and independence". This work culminated in him separating from her for the first time in his life by going away on his own to their holiday house for 3 days - becoming "terrified" and returning after 2 days. At the time, he was able to

acknowledge the step towards separateness as well as the terror it implied, feeling he had to be back with her. (Section 2.3.1). This is an example of his experience of *opposites* - his description was clearly one of both freedom and imprisonment in the same experience.

Soon after, he had to undergo a minor operation to his foot tendon. He was in plaster for the duration of this period which necessitated his M bringing him to therapy. We discussed, at some length, his "enjoying the attention" the plaster permitted. His foot in plaster became the metaphor for "the parts of himself" that he can "only experience when he is alone and locked up" in that the gratification by being different and "sick" represented outwardly by his foot was explored in relation to how " great he felt about being with himself when engaging in the "sick" act. The plaster hid the reality as did the locked door. This was not directly discussed in that the act itself was not mentioned but only alluded to by inferences of him "doing it, being locked up in himself, early hours of the morning, having to hide, being tired ". He struggled with this, only offering cues which clearly implied he was both regularly engaging in the act as well as preoccupied and worried about it. When asked directly about this he would disintegrate visibly, becoming exceedingly distressed and needing to move away from the subject - claiming talking about "it" (how the act was constantly alluded to) would make it "real", i.e. without talking about "these parts" he could deceive both of us. (See Section 2.3.4. paragraph 2). Further we saw "it" as the only thing he had for himself and talking about it directly would take it away, another example of his relating to me like he does M with his deceptive ambivalence. Examining the fears revealed an intense belief I would be "alienated from him by these parts" (his own alienation and castration fear), "reject him" (dismiss his need for envelopment/merging) and see him as "abnormal" (separate).

In sum, this period demonstrates with many examples besides those mentioned, that as his awareness of himself as separate from M increased so did his need to merge with me. It was as if he had to attach himself to me in terms of his relationship to the object to begin to negotiate his conflict. Although this sort of attachment is common to all psychodynamic therapy, it is the particular way in which his core dynamics emerged reflecting the theoretical constructs about this condition which is significant. His lengthy deception, ambivalence and continued use of contradictions were a process of testing whether I could accept what M hadn't. The terror the gradual separation implied resulted in him needing to dress far more often. In turn, his growing distance from her caused her to react and hence attempt to sabotage the therapy - throwing him into a position of feeling himself separate from both of us. This precipitated the emergence of his hitherto hidden aggression (a major feature of the 'core complex' (See Section 2.3.3.) the process of which will now be outlined in the second phase.

3.3.2 'THE SECOND PHASE'- Terror of change through understanding the function of the transvestism: Separation from M and released aggression, the therapy under threat.

At this time, just on 6 months into the therapy, M was constantly demanding whether he was making "progress" and what the "matter" with him was. He was able to strongly acknowledge that she was threatened by the therapy because it implied he was "moving away from her". He demonstrated visible anger with her interference and control, and introduced feelings for his F for the first time which he did not do again until very recently. He described the situation as a "triangle" (see family history, Section 3.2.3.) and became tearful saying "she's messed up everything for me.....if I talk to my F she gets upset". He retracted this immediately. He become withdrawn and evidently depressed over the next few weeks which I kept

pointing out to him. Following this he began talking about his transvestism in a manner quite different from before. It was at this point that he began to become aware of his approaching *sexual aggression.* He was openly enjoying his M being "threatened" by the therapy, and talking about how he'd begun to talk to his F about "things" (he did not elaborate) which "upset" M. As his depression and rumination increased about the act so did his wish to frighten and upset her, but at the same time he was frightened by it. As his aggression towards her mounted, so did his need to contain it: "I have to dress up every night these days.....I fight with her all the time". It could be said that this demonstrates the desperate attempt to keep his male self hidden in order to protect the woman from his destructive power. He spoke of his fantasy that the woman (himself dressed or another) would " never want to be f___ by me, I would force her". This led him to begin to gain insight, not only into his own aggression, but some way into his *sadism* (i.e. sadism in relation to the object where the response by the object is important; (See Section 2.3.3. paaragraph 2), and the importance of him having a penis, i.e. his maleness, in which he had invested a violent, destructive quality through severe castration anxiety.

Through this I was then able to interpret his merging with his M when he is "that person" (how he refers to himself when dressed) as his way of being close to her (the dressing) as well as his way of holding onto himself (the man with the penis) which he is so threatened about. He listened to this and accepted it, saying "that's why I'm so scared of women....she's's always made me feel like a girl". He went on to again express his resentment of his sisters and having to wear their "hand-me-downs", which he is frequently resentful about.

We were thus able to tentatively work out an understanding which Stoller (1968) has expressed so lucidly:

> "Transvestism is in great part a defensive structure raised to protect a threatened but desired sense of masculinity and maleness, and the corollary, to preserve a badly threatened potency. One should not not be fooled by the apparent paradox that he does this via dressing like a woman .Transvestism is in fact a rather efficient method of handling very strong female identification without the patient having to succumb to the feeling that his sense of masculinity is being destroyed by female wishes. The transvestite fights his battle by being destroyed by his feminine desires, first, by alternating his masculinity with the feminine behaviour, and thus reassuring himself even when feminine that it is not permanent; and second, by being always aware, even at the height of the feminine behaviour, when he is fully dressed in woman's clothes, that he has the absolute insignia of maleness, a penis. And there is no more acute awareness of its presence than when he is reassuringly experiencing it as an erection."

Through this time M's attempts at removing him and "getting him to another therapist" increased because he wasn't making "progress" and I "obviously wasn't good enough". In the guise of L's best interests this "attack" on me and the therapy (which made L "mad") was constructed as that L needed a Psychiatrist because he was "obviously endogenously depressed, like F and what he needed was medication". She, without consulting me or L, made an appointment with someone she knew. I objected and made an appointment with a Psychiatrist within the hospital system in order to contain both her 'concerns' and to ensure the possibility he could remain in therapy. From a *case management* point of view it was important the treatment be kept within the same system for consistency which L was to organise this with her. He found it extremely difficult, feeling himself pulled between himself ("thinking" his therapy with me was what he wanted), and "not being able to stand up to his M" because "perhaps she's right and you're (myself) is wrong". His *ambivalence*,

or experience of *opposites* during this time was evident in the way he related opposite opinions in the two settings, playing one up against the other. The opinion had it that he was not depressed but clearly extremely anxious and preoccupied with his transvestism which he told the Psychiatrist. He was placed on Chlormipramine, a stimulating tricyclic anti-depressant known to have an anti-anxiety effect, which the Psychiatrist felt he could benefit from (given the intensity of the therapy) and it was thought it would calm the M's attempts to disrupt the therapy. The Psychiatrist had met the parents and agreed with this assessment of what was happening.

His M's interference precipitated the active aggression. Once the disruption of the period of the Consultation was over he settled into questioning what had occurred - namely what appeared to be her intrusion into our relationship which I commented on. I suggested this further annoyed him because he felt she had got her way in that he was now on medication. These words appeared to help him get more clearly in touch with his feelings of hurt, indignation and rage. He said he felt like going "mad" and smashing up everything in the house and shouting "now you've got your way, leave me alone". He said he felt like "a murderer in a film that enjoyed watching his victim suffer....and then he said he felt like behaving like a Spielberg monster that goes beserk kicking and smashing everything...". The rage that he had eventually come round to expressing was confined to fantasy and *not*, even then, openly directed at the object of it. His reaction in the next session was extreme. All reference to the anger was absent and my pointing this out was not taken up. He said he felt like "a failure" because he did not want to do anything with his life (meaning career) and he should be "punished" for this by his parents. He told me of his terror at school when he "just missed being top of the class" and it was as though he experienced this lack of perfection as an exposure of his sexual inadequacy. He went on to tell me of his shock at being

made head-boy where the headmaster sadistically wanted to "show him up for my (his) incompetence". I could have shown him how this reflected his superego's approach (the punishment) to his recent anger and this could be related to his M's approach to him. He then talked of how he dressed up when he was made head-boy, and how he conceives of it as a "punishment, a form of humiliation ....like being left at home alone". I then pointed out that his wish "to get away with doing nothing with his life", which he often mentioned, by presenting himself as the hard-done-by, unjustly hurt victim of the object's (M) indifference or insensitivity or claustrophobic attention (as he so frequently did) he was setting up an elaborate defensive deception aimed at hiding his intense sadistic and destructive wishes towards the object. It allowed him to remain the "little boy all locked up" which at this stage he was clearly dissatisfied with. We spent the remaining sessions prior to the first long break (over 3 weeks) on this theme, elaborated in relation to historical material and the transference (he was able to acknowledge the anger the material was evoking in relation to me, but continued to stay with it because he felt "things were beginning to make sense"). During this time L acknowledged that the dressing up was something he wanted to do as opposed to being compelled to do it: before he had always felt helpless about changing it. We continued to explore the deceptive nature of the act itself; how its function for him was to keep him "hidden from himself". (Sections 2.3.3 in terms of 2.3.2).

An emerging pattern in the treatment then occurred which has persisted, at times obliquely, to date:

a) A complaint about mistreatment (inconsiderate, uncaring, not there, selfish, not understanding) by the object, and his dealing with this by seeking envelopment, in the form of dressing up;

b) Gradual realisation, as a result of the therapeutic work, of wishes for revenge;

c) This accompanied at the time by energetic, defensive twistings and turnings (contradictions and opposites) to get away from this inner experience;

d) eventually arriving at a greater or lesser confrontation with it;

e) Followed rapidly by a superego response - the need for punishment - and the making use of deception to disown his wishes and present himself as the victim of the object's narcissism, that is, putting himself back to the first step in the sequence.

I suspect that had the break not occurred the fundamental rage and violence would have become more evident. However, me "seeing through him" at the same time as being "not there" (how he described the break on return) may also have been felt as my destroying him. As Gillespie(1979) describes

"..... the defences adopted in perversion involve regression of various kinds - regression of the libido to pregenital levels and regression too in the aggressive impulse; together leads to an increase in sadism, which gives rise to further anxieties specific to the dangers both to the object and to the self which are inherent in sadism"(p.214).

Perhaps his way of controlling the regressive desire to merge is evident in him missing the final sessions prior to breaks, which he has done on all but one occasion.

Prior to the break the therapeutic work had a quality of being slow and sluggish. His beginning to experience his anger as the inevitable separating from M (explored in the transference with the impending break) became a reality for him, left him "low and shattered". He ruminated depressively over a pair of alternatives; he felt he either had to give up his transvestism and what it meant or he had to give up ever hoping to make contact with another woman romantically (the first recognition of a need for someone outside himself, see phase three), both of which he

consciously wanted. At the same time, he was "plagued" by the "little boy" who "had to remain locked up to be himself", hating himself and me for the realisations of what the "function" of the dressing was for him. I felt oppressed by his sense of defeat and his heavy depression, and we ended for the break on a sombre note. He telephoned on the day of his last appointment saying he "couldn't bear to go through what it all meant again". In sum, this phase points to an increased capacity for depression as a concomitant of the therapeutic work.

The major themes I have outlined as pertinent to this condition and this patient, namely his symbiotic relationship with M, his castration anxiety and the concomitant underlying aggression had emerged significantly during this phase which lasted just over 3 months. The extent to which he had gained insight in any lasting form given the short space of therapeutic time was questionable. He had certainly made strides in separating from M, beginning to want contact with F as well as coming to understand in real terms the pursuit of "being himself", thus moving to a point, albeit in his characteristic style of ego opposites: to in some way wanting " to get back into life again", which he felt by coming to therapy he had resigned himself to.

3.3.3 'THE THIRD PHASE'- 'Disidentification': a move towards the 'other'

This phase marked the partial fulfillment of the therapeutic aim of movement towards a more independent male self who could begin to have some relationship with the world outside of his hitherto "locked up" self. Increased object-relatedness was thus achieved in part. This outcome was somewhat unexpected given the short space of therapeutic time.

After the holiday his mood had changed. He had "a surprisingly wonderful time" where he had "got on well with the family"; "hardly spent nearly as much time with M as usual" but "chose to be with F and stay out at his sister's and her family". He had decided definitely to return to university and made contact with old school friends, with whom he went hiking. He resumed playing chess and was playing in a Province Tournament, which he was anxious about but pleased to be doing. In addition he had taken a temporary Saturday morning job to "earn some money for myself "because they(parents) keep moaning about how much I cost". This certainly represented a dramatic change from the "little boy" who wanted "always to be looked after".

Further, he had not done "it" again and did not "feel like it at all", saying "I'm probably repressing it, but ever since I realised it was a refuge, I just stopped". I suggested he allow himself to dress up if he wanted to in order to build in the possibility of "failure" which doing "it" would imply (in his terms). I found this outcome highly unexpected in terms of the note we had parted prior to the break. Only 12 sessions have past since the return from the break and he claims he has not done "it" since. Whether this is his ultimate deceptive manouevre in his transference with me as object remains to be seen. It does appear unlikely since the nature of the work he has done during this time suggests a positive and productive working alliance. What appears more likely, given the length of therapy time is 'a flight into health', possibly precipitated by not only the realisation of separateness from M but from me which the break may have represented. He had stopped closing the curtains and facing me directly (see Section 3.3.1. paragraph 3).

His general demeanour was one of control and realistic optimism, and a far cry from the needy, regressed and depressed young man who wanted to do "nothing" only a month

back. His appearance had changed dramatically; he had bought new clothes, cut his hair and had obviously been in the sun ("something I was always too self-conscious about,.. to show my body"). In this short period of time since his return and my going on leave to complete this study, most of our work concerned his return to university. I tended to be more supportive than interpretive since he was, and still is, extremely anxious about "failure" and the "same thing happening as last year". He appeared to be managing well despite social fears which he claimed to be trying to "combat" when last we met.

Besides the anxiety around the return to study there was a particularly striking theme to our last sessions. They could be summarised thematically as demonstrating a strengthening of his wish to grow through his solopsistic transvestite world, and become a more complete man in his own right. He spoke at length about "yearning for contact with a woman". This "yearning for contact" was referred to in all the sessions to date. He saw a movie just after we had resumed therapy where the protagonist at once is portrayed as the helper as well as needing help in the form of a "truly intimate relationship". He related this to both him and me; me as the helper who has helped him "come to realise what I(he's) always missed". He cried bitterly and openly over 2 sessions about the "pain" of never having "tenderness". He had not expressed affect in this manner before. This illustrates an ongoing merging in the transference, however it also points to some disengaging from it in that he mourns what he has been deprived with full awareness that it cannot come from me.

As a consequence he developed a 'crush' (I use the word specifically to denote the adolescent and naive quality it had) on a young woman at the chess tournament. As I mentioned earlier his fantasies (see Section 2.3.1. Paragraph 6) did not involve the use of his penis, but wanting "the tenderness of holding and kissing"; and not as

he reminded me, "the seduction of her against her will". This crush did not remain in fantasy (we discussed the deception this might imply), he telephoned her soon after our present break. He did not meet with success and telephoned me evidently in panic at the suspected "rejection".

I could not make out whether he actually had been rejected or whether this was part of his expected paranoid fantasy. Nevertheless, what this represents is certainly some move from complete involvement with himself to some recognition of a need for 'other'. The extent to which this other is bound up with the issues raised thus far, and the tranferential aspects of being "OK without therapy" since the break as well as with regard to his relationship to the object, is certainly highly complex. What all this portends is too soon to know, however what is significant is the unexpected outcome of the third phase which in my words to him in the recent phonecall is a "beginning" of him making contact with the outside world. This does not imply that the psychodynamics of his early development have been reversed, but it does suggest *partial* disidentification from M has occurred which has freed him to begin relatedness with the world outside of his hitherto purely symbiotic "boundupness" with M.

As mentioned above this phase may represent his greatest deception. This would concur with much of the psychoanalytic case studies illustrating the therapies of patients with similar pathology (cf. for eg. Coles;1986 ,Coltart;1985,Glasser;1979). We may be seeing a moritorium period where he is free of the symptom for the moment and it is likely it will return. However it appears his current state is more likely one of a 'flight into health' than a deception where the process of what has occurred thus far in the therapy, catalysed by the break, has permitted him, if only through cognitive gains to begin to function in a far less regressed state. This patient clearly has ego

strengths; his intelligence, long history of achievement and his response through the therapy indicates this. It is suggested these have aided him in the current gains, which does not imply he will not regress again. It is thus my aim to anticipate these regressed times; with the thought that the spaces between being regressed and not, will increase to a point where he will be able to disidentify from M and ultimately from me. Within the ongoing objectives the symptom will continue not to be the primary focus. His functioning as "himself" in everyday social and occupational settings, as well as ongoing idiosyncratic issues (which he needs to use the therapy for) will take priority.

4.0 CONCLUSION

This analysis of the psychodynamic psychotherapy of a male transvestite patient has clearly shown the emergence of certain core psychoanalytic constructs ellucidated in the transvestite literature. The 'core complex' of envelopment with a symbiotic mother has been vividly demonstrated, as has the role of aggression, castration anxiety and an ego style of deception and opposites (Glasser; 1979 [1 & 2], Stoller; 1968,1975,1976 amongst others).

As highlighted in the theoretical section whilst such core complexes appear to exist, there are also multiple variations in the individual case analyses: this probably suggests not only the effect of differential theoretical constructs but also the effect of idiosyncratic underpinnings in particular individual's problems. Thus the current indications with regard to the present outcome appear novel in terms of the bulk of literature which suggests partial remission of the symptom in such a short time is unlikely (see Coles; 1986, p.156). The value of this study lies, not in whether the symptom has been resolved, resolved partially or bound to return as the literature would suggest. Rather, it resides in the therapeutic aims, that is, should the patient move towards a

more independent male self with increased object relatedness and disidentification from a symbiotically related female introject, which has been partially achieved, it would provide significant supporting data, despite symptom outcome, to the worth of this method of therapy as aiding the development of a fuller capacity to integrate in everyday life.

As argued earlier the tradition of the psychoanalytic approach with its history of allowing the formulation to evolve from the patient as against fitting the patient to a prescription has possibly allowed these idiosyncratic features to emerge. Had one been guided by the psychiatric-diagnostic approach alone which has its ideal in a specific illness with a specific course and management in the form of prescriptive criteria the idiosyncratic features may not have emerged. The therapeutic process is where this study illustrates a non-specific illness, course and management within the prescribed parameters. It is not suggested that the global clustering of symptamotology into categories inherent in the psychiatric-diagnostic approach is not important and useful, but that the Psychoanalytic approach with its emphasis on understanding the individual through an evolving process goes beyond the guidelines of prescriptive classification. It thus permits the ongoing re-evaluation of the idiosyncratic nature of a particular individual's therapy material.

Therefore, and true to the psychoanalytic approach adopted here (there are many variations), the final formulation can only evolve after the whole therapy, that is, retrospectively. At this early stage it would be artificial to make elaborate formulations. Thus the conclusions drawn must necessarily be seen as extremely tentative.

Whilst a number of core dynamics have evolved thus far, further progress in therapy may support other issues in the

literature. Due to the limits of this study a limited and by no means exhaustive account of these illustrated by the therapy has been presented. In the final analysis it is stressed that it is essential not to reify the core issues that have emerged here as there is the danger of reducing their descriptive underpinnings to prescriptive one's, antithetical to their fundamental assumptions and the illustrative attempt in this study.

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APPENDIX I

HOSPITAL SUMMARY

Note: This assessment was done by another clinician in the Hospital team. It is included to illustrate the extent to which the case changed during the course of therapy.

DIAGNOSIS

1. GENERALISED ANXIETY DISORDER
2 AVOIDANT TRAITS
3. ACNE
4. MODERATE
5. POOR

REASON FOR REFERRAL: Generalised anxiety disorder and panic attacks/relationship difficulties.

OTHER WITNESS & SOURCES OF INFORMATION: Collateral information from questionnaire completed by patient and parents.

FAMILY HISTORY: Youngest of five children born to upper-middle class family.

Father: (58) years. Pharmacist - cardiac bypass surgery in 1979, slight stroke in 1981 - healed by spiritual experience, very involved with church, lay preacher and Sunday school teacher - involved in Life Line - poor and

distant relationship with index patient. After surgery became severely depressed, better of late.

Mother: (59) years, housewife, previously commercial secretary - overinvolved in church, suffers from depression, recently on Prothiaden - little time for herself. Has degenerative scoliosis. Conflictual overinvolved and destructive relationship with index patient. "Has treated me like a girl".

Siblings:

1). K. (33) years. Married with one child.

2). R. (32) years. Married with two children, "motherly", puts index patient off.

3). S. (30) years. Married with two children.

4). N. (29) years. Doctor living in Durban, engaged - closest to index patient.

5). Index patient, aged 19 years.

PERSONAL HISTORY: Planned, wanted baby, mother aged 38 years - parents estatic to have a boy - one week overdue - normal pregnancy and birth. Early development: Sleep problems, restlessness and constant screaming, fussy eater. Breastfed for six months. Neurotic symptoms: Fears of floods/tidal waves/destruction, nightmares and night terrors - numerous respiratory tract infections, tonsilitis - delirium with high temperature. Separation anxiety in pre-school. Teased and bullied though performed well academically without working hard. Class captain in Std. 7 - head boy in matric - best marks in the class. University

in 1986 - studying law - passed examinations in December. Moved into residence the following year, dropped out in April 1987 due to severe anxiety and panic attacks. No sexual relationships. Refused to discuss sexuality - no homosexual experiments. Difficult to relate to anyone socially - especially women.

BASIC PERSONALITY: Withdrawn, shy, highly competitive, undemonstrative, pessimistic about self - often depressed and anxious, finds it hard to express any emotion except pessimism, self conscious. Rates intellectual achievement very highly which affects relating to people. Can cope in structured situations. Becomes very anxious in informal social situations. Moral values tied to own squeamishness about sex but thinks people should love each other. Uses defence mechanisms of denial, intellectualisation.

SOCIAL SUPPORTS: Nil. Supports outside immediate family.

PREVIOUS MENTAL & PHYSICAL ILLNESSES : Susceptible to respiratory tract infections until five years, especially tonsilitis, age 6-8 years, weekly injections of Histoglabin helped. January 1986 - tonsillectomy, April 1986 - operation for deviated septum - did not stop nasal congestion. Hay Fever. Also suffers from acne which he is extremely preoccupied with.

HISTORY & DESCRIPTION OF PRESENT ILLNESS: L was referred to the Psychiatric Day Hospital, because he was too anxious to cope at University. Problem began in Std. 8 with high

expectations of family/teachers for L to perform well academically. Became withdrawn, had difficulty sleeping, lost interest in the activities he usually enjoyed. In Matric was Head Boy, felt lonely and anxious, "people looking at him constantly", only seen in terms of his abilities and began to fear anything he said would disappoint people. Became silent and withdrawn. Without the structure provided by the school environment L found university "a nightmare", becoming extremely anxious in informal social situations with peers, especially women (he becomes physically tense, cannot move naturally, hands sweat, heart rate increases, breathing tight and shallow, shoulders and neck become tense causing headaches and he is unable to speak). The sleep difficulties continued causing L to be tired during the day with difficulties concentrating. He completed first year successfully, but with increased demands in second year, lack of motivation and increasing anxiety was unable to study at all and dropped out after two months, deciding he needed help.

PSYCHIATRIC EXAMINATION: General appearance & behaviour: Tall, dishevelled looking young man of large build, scruffily dressed who sat slumped in his chair during the interview. He gave a well considered, articulate account of himself, though at times appeared suspicious and anxious. Eye contact good. Talk: Deep hesitant voices no formal thought disorder. Mood: Described as "depressed but slightly hopeful". Affect: Appeared slightly depressed/anxious, but seemed contained by structured questions and relaxed visibly during the interview.

Misinterpretations & delusions: Nil. Hallucinations: Nil. Compulsive phenomena: Nil. Cognitive functions: Orientation: Time: Place: Person: All correct. Memory: Digit Span: 5 digits - forwards & backwards (excellent). Memory tests: 5 objects -STM - excellent. Intermediate excellent. Memory of past events: Good. Attention and concentration: Serial 7's: Excellent. Months backwards: Excellent. World backwards: Excellent. General information: Good. Intelligence: Superior. Abstract thinking: Excellent on two proverbs. Insight & Judgement: Insight good - sees problem as extreme anxiety when informed social situations - difficulty especially with peers and women. Judgement: Good - does not know what the future holds - trying to be hopeful but this is difficult.

PHYSICAL EXAMINATION: Weight: 92 kgs. All other systems: No abnormalities detected. Resume: A tall, dishevelled looking young man who gives a well considered articulate account of himself, with an anxious, rather suspicious manner. He described himself as "depressed but slightly hopeful" and his insight into his difficulties was good. I.Q. estimated to be in the superior range.

HIGHLIGHTS OF PRESENT ILLNESS, MENTAL STATE EXAMINATION AND PERSONALITY STYLE, FAMILY AND PERSONAL HISTORY: L is a 19 year old, single male law student, who has been suffering from anxiety and depression since Std. 8 (1983). Expectations of family and teachers for him to perform well academically have caused him to become increasingly withdrawn and anxious, resulted in him dropping out of

university one month ago. He could not cope with his work and was incapable of mixing socially, especially with women. L. is the youngest of five siblings born to upper-middle class family, who are upwardly mobile and attach great importance to academic achievement. Father is a pharmacist, had cardiac bypass surgery in 1979, became severely depressed, poor relationship with L, very involved with church activities, slight stroke in 1981. Mother: housewife, suffers from depression, (recently put on Prothiaden) - degenerative scoliosis, overinvolved and conflictual relationship with L. Siblings: 1) K. 33 years. 2) R. 33 years. 3) S. 30 years - all married and professional with children. 4) N. 29 years, a doctor living in Durban. 5) Index patient, aged 19 years. L was a planned, wanted baby, parents "ecstatic". Mother's last chance to have a boy (age 38 years), normal pregnancy and birth. Restless, fussy eater, poor sleeper. Early fears of tidal waves, floods, total destruction, numerous respiratory tract infections - tonsilitis and delirium with high fevers, inconsistent discipline. Separation anxiety on starting school, teasing and bullying at Primary school, but performed well academically without working hard. Class captain in Std. 7, head boy in Matric with highest grades in the school. University in 1986. No sexual relationships, refused to discuss it. Tonsillectomy and operation for deviated septum in 1986. L describes himself as withdrawn, shy, undemonstrative, pessimistic about himself, often depressed and anxious with low self esteem. He presents as a tall dishevelled young man who gives a well considered, articulate account of himself, with good insight into his

problems. I.Q. estimated to be in the superior range - uses the defence mechanisms of denial and intellectualisation. Diagnosis: DSM.111: Axis 1: Generalised anxiety disorder. 500.02. Axis 11: Avoidant Traits. Axis III: Acne. Axis IV: Moderate stressor. (4) Axis V: Adaptive functioning over past year - poor (5).

Aetiology: Predisposing: Significantly youngest (10 years) of five siblings (only male child), anxious attachment to mother - distant father. Difficulty during the early years at school (socially); family's upward mobility and expectations for L to perform well academically; inconsistent discipline; frequent family illness.

Precipitating: Move from school to university, home move to residence, tension at home with PGP's stay. Maintaining: Avoidant traits, low self esteem, inability to relate to people outside the family.

Psychodynamics: Hypothesize anxious attachment to mother, overinvolved in only male child. L. unable to develop sense of autonomy, competence or sense of self separate from mother, resulting in early fears of engulfment (tidal waves, floods etc.) somatic illnesses, destructive fantasies. Feelings of anxiety and insecurity compounded by distant father (oedipal guilt), inconsistent discipline and difficulties separating from mother when starting school exacerbated by the teasing and bullying he experienced there. High expectations to perform well resulted in increasing anxiety and isolation and little sense of self separate from intellectual ability, exacerbated by tendency

of family not to communicate at a feeling level - expressing these somatically.