The British Association of Psychotherapists

BULLETIN
No. 14
July *1983*

For private circulation to members only

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BULLETIN

NO. 14 JULY 1983

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DIAGNOSIS AND ASSESSMENT FOR SUITABILITY FOR PSYCHO-ANALYTICAL PSYCHOTHERAPY

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In day-to-day work, one draws on principally unconscious skills, knowledge and intuition. But the situation in which you need to be consciously in touch with a whole range of ideas and concepts is the diagnostic interview. Here I would stress *diagnostic* in conjunction with assessment for analytical psycho-therapy; we have to be getting at some sort of diagnostic picture, in order to think about the patient coherently and, if necessary, to be able to discuss him with colleagues to whom we may be referring. This picture has to include, of course, what the patient is *not*.

My main qualification for giving this paper is the amount of consultation I do in private practice. The diagnostic interviews at the London Clinic of Psycho-Analysis were pretty specialised and it is in private practice, where for many years I have done an average of three consultations a week, that my experience of diagnosis and assessment for analysis and psychotherapy mainly lies. Of these consultations, only about 10% turn out to be "therapeutic consultations" in their own right, i.e. do not require referral for therapy, and only about 5% are subsequently placed in full five-times-a-week psychoanalysis.

First, we must consider the "real" role of the psycho-analytic diagnostician in contrast to a mythical role which often exists somewhere around the edge of many people's half-conscious fantasy. I am of the opinion that a good solid block of experience in general psychiatry early along the line of one's own development is a real help; this is principally linked to the fact that I myself had that and, therefore, my view immediately underlines another factor, which is that we cannot expect or even desire that subjectivity be absent from our work in this field. I do not want to imply that one simply does a sort of extended psychiatric interview, or that one operates exactly as one used to do in the acute admission wards; this would be to imply that people without psychiatric experience cannot assess a patient with a view to deciding about analytical therapy, which is not true; but I think it will be found that those who have had it are the people who do do much of the day-to-day assessment work within the body of those who practise as analysts and therapists in London and are the main sources of referral within that body. Also it is a help if one has a full practice and is therefore usually not assessing with oneself as therapist in mind; one is facilitated by a somewhat increased mobility of objectivity if one is not personally looking for a patient. The "real" assessor relies to a certain extent on intuition. He has his own theoretical, philosophical and experiential framework, both personal and clinical. He may hold quite strong opinions - reasonably well thought out, we would hope - on some things such as "The Widening Scope of Psycho-Analysis" (Stone, 1954) or alternatively "The Need

to Limit the Scope of Psycho-Analysis" (Kniper, 1968); or the effects of certain specific traumata; or the possibility of working with a transference psychosis. He must have a working knowledge of alternative therapies and avenues of placement for people who are not suitable for full classical analysis (Baker, 1980), so that there is no pressure at all to opt for analysis as a sort of last ditch and only solution; this is often a despairing view held by non-analysts rather than analysts. Finally, he should have well-thought-out ideas, again grounded in experience, of how and why the odd process of analysis works, and why it may be desirable and appropriate for some people. It has been only too truly said that an expert is someone who knows everything about a subject except what it is for.

The mythical assessor, who does not exist, has an omniscient knowledge of all possible criteria of analysability, a peculiar capacity to predict the full course of treatment, a clairvoyant power to read the whole personal history and potential, both conscious and unconscious, of someone whom he is meeting once in a lifetime for two hours, and a God's eye view of the details of this person's therapeutic relationship for the next five years. This may sound ludicrous when spelt out, but if you examine your own half-conscious expectations, I think you will find that this creature exists somewhere on the fringe of them.

It is important to remember what a momentous thing you are saying to a patient when you seriously and thoughtfully advise analytical psychotherapy as the treatment of choice. You are "involving the patient in an adventure which is not comparable with any other medical treatment (and yet which curiously falls somewhere in the outer boundaries of that category): and furthermore the way in which such advice is presented shows clearly that it is no ordinary prescription." (Diatkine). You try to help the patient to see and feel some psycho-dynamic aspects of his problems. You convey to him your own considered beliefs on how and why analytical therapy might help him, you tell him something of the basic rules, you give no guarantee either of cure or of length of treatment and you leave the ultimate choice and responsibility to him; as a referral source, however, you will probably be instrumental in "matching" him with his therapist. I would stress here that matching is not twinning. It is not necessarily advisable to place, say, the obsessional patient with an obsessional colleague; the turmoils of divorce are not necessarily best handled by the therapist who is also going through this. These examples need not be multiplied; the implication is that a good referrer needs a good working knowledge of his colleagues' capabilities.

Now to criteria: perhaps we should start with certain features which are not exactly controversial, but which in an odd way tend to get left out of discussion, and out of the literature; it is almost as though it is thought not quite nice to acknowledge

them; it may be that in ignoring them we underline our own high-mindedness and nobility of purpose; here, as so often, we find that Freud is an exception. I refer specifically to the features of intelligence, moral character and money. However ethically Utopian or politically idealistic your views, it is no good pretending that these things do not matter, because they do. A case may be argued for the widening scope of psychoanalysis, but we must not ignore the voice of experience and the dictates of our culture. Shortly after the war, before the London Clinic of Psycho-Analysis became organised and structured as it now is, the waiting list there was over 400; this was due to a shortage of experienced consultants, a lack of selection technique and perhaps to a kind of naive enthusiasm about the potential of psychoanalysis; all that it led to was hopeless confusion amongst students taking on cases, endless disappointments among people languishing on the waiting list for years, and interminable analyses for many of those chosen. In 1895 Freud wrote that there was no point embarking on the treatment of "low minded and repellent characters who are not capable of arousing human sympathy." In 1905 he wrote that the prerequisites for psychoanalysis include "ethical development and reliable character", adding, rather mysteriously but evocatively, "We should not forget that there are healthy people as well as unhealthy ones who are good for nothing in this life." A philosophy of treatment is embedded here! Neither intelligence nor ethical developments are easy to define or measure; the fact remains that a good measure of both is a necessary ingredient for the prescription of a workable analytical therapy. Intelligence of the sort I mean is fairly easy to assess in a diagnostic interview, it does not necessarily equate with intellectual brilliance which can be a formidable defence and a nuisance. The intelligence has to be fairly quick and fairly verbal (but not excessively so - slow thinkers often make good patients) and, above all, it has to be linked to two other features which I will come to in a moment. Ethical reliability is not so easy to assess accurately although experience helps to develop a feeling for it. Thirdly, money. It may be a sad state of affairs, but generally speaking a certain amount of money is needed to undertake analytical therapy at present. I believe that the most that therapists can do about this is not to be too rigid about set fees, but to work on a sliding scale which correlates with patients' capacity to pay. I should add that I am of the opinion that it is psychologically much more effective and beneficial to treatment for a patient to pay what he possibly can; I do not propose to explore this statement at length, but I am confident that it is one with which most experienced practitioners would agree.

To return to the two criteria which I linked with intelligence, and for which one listens and searches in an assessment. One is the "will to be analysed". Namnum, in an interesting paper in the International Journal of Psycho-Analysis 1962 refers this vital feature to what he calls the

"autonomous ego" and it will be seen on a moment's reflection that this must join up with the important concept of the possibility of a *treatment alliance* being formed, and put alongside the need to assess the possibility of the creation of a transference neurosis. The will to be analysed is not by any means the same thing as the more random, changeable and drive-motivated "wish for recovery", although in initial interviews they may appear to be the same thing. One should listen with the third ear in an initial interview to search for this potential function of the autonomous ego because this is what ultimately keeps the therapeutic alliance alive, and keeps the analytical therapy an open and going concern; the will to be analysed in the therapeutic alliance will be of vital importance when the transference *neurosis* becomes active and resistant, and opposes treatment, and when the early wish for recovery is forgotten in the day-to-day work of the therapy. A brief way of assessing this potential function in an initial interview is by temporarily going against the flow of the patient's thought and feeling *for* you at some well-judged dynamic moment, often late in the interview.

The other criterion which I was linking with intelligence is what has been called psychological-mindedness. This feature is very much easier to pick up in a diagnostic interview than is the true will to be analysed. There are various ingredients of psychological-mindedness which can be roughly defined and located; with this aim one can usefully hold the following queries in one's own mind while doing an assessment interview:

1. Is there the capacity in the patient to take a distance from his own emotional experience? This must be nicely judged, as obviously it should not be such a distance that one senses there is a great chasm, as in very severe denial, splitting, or repression.

2. If one listens beyond the full-stops in a narrative can the patient go on, and begin to reflect on himself, perhaps in a new way *as a result of* being listened to in this particularly attentive way? If there are no signs of elaboration or extension by the patient on trains of thought, there may be severe inhibitions and/or anxieties, or extreme passive dependency, and a valuable capacity for free association may never develop.

3. Are various memories brought forward with different charges of affect? And are the affects, so far as one can tell, more or less appropriate? If not, a flat and uninflected history may bode ill for analytical therapy and indicate severe affective splitting and blunting. In other words, a lot of memories with no feeling are suspect.

4. Is there a capacity to perceive relationships between sections of

history, and between details that are recounted, and the patient's prevailing sense of discomfort? If the patient starts by complaining of one or more symptoms or states of mind, but shows no sense of related significance when he goes into his history, then again there should be a warning signal in the assessor's mind.

5. Is there some capacity to recognise and tolerate internal reality, with its wishes and conflicts, and to distinguish it from external reality? You will see that this connects up directly with the continuing judgment in the interviewer's mind about the possibilities of maintaining a therapeutic alliance in conjunction with a transference neurosis. Does the patient show some facility in interview to move between the two, that is internal and external reality, in a way which shows a certain cathexis for the value, and the enjoyment, of interpretation and the taking of psychic responsibility for the self?

6. Does the patient show a lively curiosity and a genuine concern about this internal reality, if he has already shown that he got a good glimpse of it? This is a crucial point. Psycho-analytical therapy has nothing to offer a patient who only wishes to be relieved of his suffering. If he can make even a tenuous link with the idea of relief from psychic pain, with an increase in self-knowledge, and if he then shows some real pleasure in finding out some tiny thing about himself in the initial interview, this is one of the best criteria for the analytical approach. This kind of drive and interest about the sources of pain in oneself is the greatest possible help in therapy, and is a sustaining tributary to the therapeutic alliance. It can help to counteract even very severe, including acting-out, pathology.

7. Is there some capacity for the use of the imagination? Fantasies may be presented in a diagnostic interview, but even small signs, such as a striking use of metaphor, or the voluntary reporting of a dream, are positive indicators.

8. Are there signs of a capacity to recognise the existence of an unconscious mental life? Is there some acknowledgment that in some ways the patient is in a state of involuntary self-deception? Are there some signs of a willingness to undo this state of affairs?

9. Does the patient show signs of success or achievement in some, even if limited, areas of his life and some degree of

proper self-esteem in relation to this? It is important truism that he who fails at everything will fail at analysis. Here I would emphasise the areas of study or work and one or more important relationship.

So much for some of the vital questions which are part of one's active inner processes during a diagnostic interview. Now we must consider briefly some of the more or less labelled categories which by a sort of long term consensus of experience seem to be either more suitable for dynamic psycho-therapy, or less suitable. Here again we are up against the fact that much of this labelling derives from psychiatry; this need not be unhelpful or constricting so long as we ourselves do not feel too wedded to our labels or categorisations. It should be remembered that we are using every method at our disposal to marshal information on all sorts of levels in one single interview. I propose to make two quotations, in order that they may be reflected upon in this context. The first is by Glover writing in 1954 when he referred to what he called "signs of analysability" and, in decreasing order of appropriateness, they are "hysteria, compulsion neurosis, pregenital conversion states, neurotic disturbance, character disturbance, perversions, addictions, impulsiveness, and psychosis." There is room for discussion of many of these categories and Glover's placing of them in the hierarchy of treatability. For example, the phrase "neurotic disturbance" is almost too vague to be useful. Personal choices also play a part; some therapists would far rather treat a character disturbance or a perversion, than a compulsion neurosis. There is a most valuable and readable paper in the International Journal of Psycho-Analysis of 1968, written as part of a symposium on criteria for analysability; this is Elizabeth Zetzel's paper "The So-Called Good Hysteric". Zetzel's four categories of diagnosable hysteria and their potential for response to analysis are most helpful for a diagnostician. If at the end of an interview you feel that more or less accurately you can say "This patient is something like a Zetzel Group 1 or a Zetzel Group 2" then most of the questions outlined earlier will have been answered in the affirmative and you can go ahead with the analytic prescription. An experienced practitioner would also willingly take on a Zetzel Group 3 patient. Sooner or later, usually by mistake, one finds oneself referring or treating a Zetzel Group 4 patient and this is a difficult, often disastrous, good learning experience!

I would like to refer momentarily back to Glover's list, with special reference to "character disorder". Since 1954, when the paper was written, extensive and helpful advances both in the theory and technique of understanding and treating severe Narcissism have been made. These advances bring a whole category of character disorders into a more accessible treatment arena. Severe narcissistic character disorders are however extraordinarily difficult to treat and, furthermore, they are sometimes difficult to locate in diagnostic assessment; severe depression allied with a kind of affective flatness, allied again with subtle

projective mechanisms, should make one suspicious of the concealed narcissistic disorder.

The other quotation containing compressed information comes from a paper by Knapp in the Psycho-Analytical Quarterly of 1960 and is called "A Hundred Cases of Supervised Analysis." In this paper Knapp considers the following categories to be very difficult or unsuitable for psychoanalysis: "psychosomatic states, delinquents, psychotic signs or behaviour trends, adverse life situations, schizoid borderline psychotics, too long periods of previous treatment, very high levels of anxiety and tension, and some patients older than the analyst." This list should also be reflected upon and reconsidered by each individual diagnostician and therapist. Some therapists like working with psychosomatic states, and recently analysts such as Murray Jackson have extended our knowledge of them; they often get better, and even if they do not, the whole cathexis of the somatic symptoms may change. "A high level of anxiety and tension" may be tackled and contained if the two-pronged therapeutic alliance and transference neurosis can be rapidly established. Many dynamic psycho-therapists in recent years are exploring the treatment of patients older than themselves.

To close, a brief consideration of the style in which one conducts this particular and specialised form of interview - the diagnostic assessment. I would like to quote from a paper by Adam Limentani in the International Journal of Psycho-Analysis 1972: "The accurate forecast of the patient's behaviour before therapy has begun is a challenge to the diagnostician who *nevertheless* has the means of eliciting evidence of the analysand's capacity to move freely within his own psyche. But he will do this only if he is prepared to move freely within the interview situation, so that he can induce fluid responses in the interviewee. The silent and inactive evaluator who clings faithfully to the psychoanalytic model of behaviour will obtain only a partial if not distorted picture of what he is meant to be observing." I would like to stress the important point being made here. Interviewers should not behave, in my opinion, like a caricature of an analyst; such an interviewer does not help to start the patient off, does not ask any questions, does not comment, may write notes during the interview, makes no intervention or summing up, and at the end may mysteriously advise long-term treatment with someone who will be presumed to be like the very cartoon model he has presented. I cannot emphasise enough how counter-productive and to some extent actively sadistic I think this is. In an assessment interview one has to *work*. All the attitudes listed just now may be appropriate to a session when a patient is settled in treatment - all except taking notes that is, which in my opinion should never happen in a patient's presence. The consultant diagnostician must draw on all his skills and use his whole personality with confidence and concern to meet the patient's personality at every possible point in the short time available to him. It seems to me deeply narcissistic to sit and do nothing; it more often happens in younger assessors and is, of course, at a charitable estimate, a defence against anxiety. But it is not good

enough, and not helpful to the patient, for whom this may be one of the momentous days of his life, and whose anxiety level can be guaranteed at the very least to be higher than that of the interviewer. On the other hand, one is not required to make the patient particularly comfortable, nor to seduce the patient into liking or appreciating you, either in a diagnostic interview or in treatment. You need to establish a certain rapport and keep it going, and within that framework, think about and learn to deploy all the skills you have to find out about this stranger's inner world. This may involve a considerable amount of questioning, some interpretation, some link-making comments, sympathy expressed in your whole attitude of extremely attentive listening, and some concise summarising of your own views towards the end of the interview.

It should always be remembered that if you are prescribing psychotherapy on a long term basis you are making a powerful statement, and your respect for the patient should entail that you give him your own insight into his needs and his character, and your reasons for making the prescription.

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THE ROLE OF TRAUMA IN A CASE OF FOOT AND SHOE FETISHISM: ASPECTS OF THE PSYCHOTHERAPY OF A SIX YEAR OLD GIRL

Juliet Hopkins

Fetishism in females is extremely rare. It is therefore of particular interest to attempt to understand its origins in a girl who was only six years old when she started psychotherapy. At that time she was psychotic and believed herself to be a boy. The traumatic nature of much of her early experience was revealed through her psychotherapy; information from her mother confirmed and amplified some important aspects of her history. The paper follows the difficult and dramatic course of treatment and offers an understanding of the girl's presenting symptoms, including her fetishism.

Referral and Assessment

Sylvia Z was referred to our clinic at her mother's request when she was just over six years old. Mrs. Z complained that Sylvia was hyperactive, unmanageable, had many tantrums and wet the bed; she attended a special school for maladjusted children. Sylvia had a younger brother, Enrico, aged four and a half years. Her father, Mr. Z, had died in a car crash just before her fourth birthday.

When the psychiatrist and social worker met Sylvia they were both convinced from her appearance that she was a boy. Mrs. Z explained that Sylvia had insisted on being a boy since her father died. She also mentioned that Sylvia had a very acute sense of smell and that she had a habit of wanting "to love and kiss" shoes; she would even throw herself on the shoes of strangers to kiss them, salivate on them and bite them. Her interest in shoes had been first evident at seven months old when she appeared fascinated by her father's shiny shoes. She would draw herself up to them, salivate on them and then suck her thumb. Later, as a toddler, she adopted the habit of taking a pair of her mother's old shoes to bed with her, a habit which still persisted.

Mrs. Z was a very defensive young woman who seemed eager for her daughter to have help but reluctant to involve herself. She explained that she could talk to no one about her husband or his death, but in fact did give a brief account of the accident. This occurred just after the family had moved house in order to provide a separate bedroom for the children who until then had slept with their parents. Mr. Z had been disqualified from driving so his brother drove him to collect a carpet for the new house. Mr. Z's brother lost control of the car which crashed and Mr. Z died instantly, but his brother was uninjured. Mrs. Z said she felt only blank at the time and had never cried.

Mrs. Z described herself as the only child of Jewish parents. Her father died suddenly of a stroke when she was five years old and her mother never wept for

him. She herself was sent away at once to a boarding school. She could remember very little of her mother during her childhood and now saw her seldom. Her mother had remarried while she was away at school and she never got on with her step-father. After leaving school she worked as a secretary until Sylvia was born.

Mr. Z's family were Italian Catholics who came to England when he was twelve years old. He took many jobs after leaving school, and following his marriage to Mrs. Z he studied in the evenings to become an accountant.

Mr. and Mrs. Z met at a concert, and when she became pregnant they decided to get married, despite bitter opposition from both families.

Sylvia was born early and weighed less than five pounds. She was placed in an intensive care unit for sixteen days and returned home "feeding three hourly, taking an hour and a half to feed, and screaming when not feeding". Mrs. Z attempted to breastfeed her for a week but stopped when she herself became ill. She recalled Sylvia's early months as an absolute nightmare. Nothing would pacify Sylvia and Mr. Z "was driven round the bend" by her screaming, which he said prevented his studies.

Mr. and Mrs. Z had always felt that there was something wrong with Sylvia and this was confirmed for them when a psychologist assessed her at the age of three years and announced that she was eighteen months retarded. She did not speak fluently or become toilet trained until she was five years old.

Enrico was a much easier baby than Sylvia had been and Mr. Z became very attached to him in a way which he had never done to Sylvia. Mrs. Z was clearly proud of Enrico's development, though two years later, at the age of six years, he too was deemed maladjusted.

Sylvia's initial assessment at our clinic was inconclusive. The psychiatrist was not sure whether to describe her as 'psychotic' or 'borderline'. The psychologist found her completley untestable, but deduced from her speech that she was likely to be potentially of at least low average intelligence. Arrangements were made for Sylvia to have twice-weekly psychotherapy with me and for Mrs. Z to meet with Mrs. R, an experienced social worker, for twice-weekly casework. More intensive treatment was not feasible.

Impressions of Sylvia during the Initial Phase of Treatment

Sylvia started treatment with me when she was six years and four months old. There were ten sessions before the first holiday break and during this period I gained the following initial impressions.

My first meeting with Sylvia was dominated by my conviction that she must be a boy. Sylvia succeeded in appearing unmistakably male, although in fact her hair

length and her clothes were equally suitable for either sex and her features were not masculine. It must have been her slightly swaggering gait, aggressive manner and assertive body postures which conveyed her masculinity. When she smiled her whole face lit up and had a radiant quality, which was extremely attractive, but she more often looked angry and menacing.

Sylvia was indeed hyperactive. She rarely pursued the same activity for more than a minute and her conversation was as disconnected as her behaviour. Her dark eyes were intensely bright and she was constantly in the grip of extreme and fluctuating emotions. Love, hate, excitement, terror and rage gripped her in rapid succession. The intensity and passion of her ordinary experience is difficult to convey. She seemed helplessly at the mercy of extremely violent feelings which fluctuated arbitrarily, entirely outside her understanding or control.

Sylvia's first two sessions with me differed from subsequent ones in that she was less disorganized and far less violent than she quickly became. She was excitedly concerned with immersing herself in all the paint and glue provided, and made a number of very messy, sticky pictures called arbitrarily, "Ghost", "Dragon", "Worm", "Machine in the rain" and "Peanut butter spreading on bread". She hit the dragon picture claiming it had hit her, and she called the dirty paint water "wee wee", laughing hysterically as she tipped it over my chair. She expressed the fear that I would hit her like her mother did, and at the end she tried to destroy the light in my ceiling by repeatedly hurling a ball at it.

The first two sessions were only two days apart, but five days elapsed before the third session. When I went to collect her she looked at me in terror and bolted. There followed a long chase through the clinic until I cornered her under a secretary's desk. When at last she emerged she blurted out angrily "Where *were* you? Have you been away on holiday?" In my room she seized her ball and sank her teeth into it. This action ushered in the first of a long series of extremely violent sessions in which Sylvia threatened to kill me and eat me up. She swore profusely, hurled toys and water at me, kicked and spat and flung the furniture about. At other moments she embraced me, spoke affectionately and begged me to visit her home. At all times she was highly involved in relating to me and never withdrew into activities on her own.

In addition to constantly attacking me, usually for no apparent reason, Sylvia was very pre-occupied with fantasies of herself being attacked by monsters. Sometimes she begged me to be her friend and to protect her while she imagined the room to be full of attacking monsters. She called the furniture "Daleks" and seemed convinced that chairs moved across the room to strike her. Her terror was intense and when she kept cowering and ducking as though about to receive a blow from a Dalek or some other monster, I thought

she was hallucinating. At other times, instead of enlisting my help against the monsters, she asked me to play the part of a monster and to frighten her, but she could never tolerate this for more than a minute or two.

I first saw Sylvia's fascination with shoes when I found her embracing and slobbering over another patient's boots in the waiting room. This behaviour often occurred before Sylvia's sessions and Mrs. Z did nothing to restrain it although onlookers found it shocking. It happened that I had been wearing a pair of suede boots when I first saw Sylvia, and she was very disappointed about this because she only loved shiny leather.

Mrs. Z had not mentioned Sylvia's passionate interest in feet, but this was apparent from the second session when Sylvia excitedly paddled barefoot in water she had spilled, exclaiming "Now you can see my foot". Later she begged me to paddle in the sink with her so she could see our bare feet together. She also wanted me to tickle her toes. Sylvia spent much time paddling in the sink in all the following sessions before the Christmas holiday. It made her deliriously happy to sit with the water up to her knees, often playing with wet pieces of paper which she called meat balls, cabbages, fish and lettuces. Most frequently she said she was washing and polishing lettuces, throwing out "the dirty lettuces" and "the nasty kidney" onto the floor. She sometimes remarked that her feet were cheesey and said that she loved cheesey feet.

Sylvia's feet were important to her as instruments of aggression as well as sources of excited pleasure. When wearing her shoes she liked to stamp items underfoot to destroy them and she kicked me and the furniture often and violently.

Sylvia had told me she was a boy soon after we met, when she also remarked that girls were stupid. She did not mind my calling her Sylvia as long as I did not refer to her as "she" or "her".

Sylvia's excitement about paddling at the sink increased from session to session. She wanted to flood the whole room so it would be a swimming pool which she could wee into. At the height of her excitement she stood on top of the sink, pulled down her jeans and pants, and with her hands indicated the invisible arc of urine she supposed to be spurting forth to soak me. I said she really believed she was weeing from a big willy and Sylvia agreed as though she were convinced of it. Next session she announced she was a man diver who would dive into my pool and she managed to take off her clothes and stand naked on the window-sill "so everyone can see me do it". All these activities were carried out with tremendous excitement and laughter.

In a later session Sylvia showed some doubts about being a boy. Revealing her

pink underpants, she remarked "Boys *do* wear these, don't they?". And in the same session she also referred to herself as "her". When I commented on her doubts about being a boy she confirmed them by squatting and urinating on the floor behind a chair "to serve you right", in totally different style from the earlier manic deluded moment when she had indicated that she was urinating from a penis.

Sylvia had inadvertently referred to herself as "her" when we were talking about how she had attacked me in the waiting room. Sylvia explained "That was the other Sylvia who hit you, not me. I socked *her* in the eye". She had previously insisted that there were two Mrs. Hopkins - a horrid one in the waiting room and a nice one in my room. On many occasions she looked at me quizzically as though bewildered about who I was, and asked "Where's the other Mrs. Hopkins gone?" I thought she was the victim of an extreme form of defensive splitting which she used principally in order to deal with anxieties about my return after separation. Mrs. Z reported that Sylvia had become intensely attached to me, spoke of me continuously at home and could not wait for her sessions. However, by the time I saw her, Sylvia could only greet me with terror and rage, attacking me by hurling toys or running away to hide. I had become the horrible Mrs. Hopkins of the waiting room. The end of each session was also unbearable for her. She clung to me or tried to carry on playing until I had to steer her through the door. Then she began at once to scream for her mother and kept this up until they were reunited.

Sylvia's speech was fluent and ranged from the poetic to the obscene. She spoke of inanimate objects as though they were alive, for example "The door won't let me open it", or "I must wake up my sleepy socks - they're falling down". Her endless fantasies about monsters and space were sometimes delightfully expressed. "Be a moon, and we'll have star teas", or "Inside this space is the darkness of the dream monsters". Her use of "I" and "you" was clear and accurate. When she was angry she swore with a range of obscenities which she was unlikely to have picked up from other children.

Therapeutic Approach

During this early period of Sylvia's treatment I struggled to impose some order on her chaos and on my own confusion by simply trying to describe what was happening and by naming the emotions which she was experiencing with me. When I had identified her feelings I tried to link them with the few sequences I understood, for example, her anger because she had to wait for me and her terror that I would retaliate whenever she was angry. I emphasized that I was *one* person whom she sometimes loved and sometimes hated and feared, and that there were not two Mrs. Hopkins or two Sylvias either. I spoke of her evident bewilderment about whether I and other grown-ups were friends or enemies, whether we would protect her or kill her, and I indicated how she tried to allay her fears that I would attack her unpredictably by actively trying to provoke

an attack under her control. In her quieter moments Sylvia clearly welcomed understanding and found some of my comments meaningful.

Sylvia's enormous erotic excitement about feet, shoes and willies made me very cautious about giving interpretations in sexual terms because of the risk of provoking uncontrollable excitement and exhibitionism. Behind her manifest excitement about sexual matters I sensed an extreme anxiety and this reinforced my caution about interpreting sexual themes, both at this phase and throughout the treatment.

As far as Sylvia's actual sex was concerned, in early treatment I acknowledged that she often needed to believe she was a boy or a man with a willy so she could excite me and feel as close to me as being married. However, I told her that I could see that she really knew she was a girl. I made no comments about Sylvia's excited interest in feet, but I linked her voracious attacks on shiny shoes in the waiting room with her feelings about my absence, the pain of waiting to embrace me and the fear both of my failure to return and of my return to attack her. In order not to excite her interest in my shoes I decided always to wear the same pair of suede boots when I saw her, and I did this throughout the first year of her treatment.

During this first phase of work with Sylvia I did not try to interpret any of her material in relation to her past and present experiences outside the clinic. It seemed essential to reduce her most intense anxieties about seeing me before we could think about the origins of her pre-occupations.

Possible Diagnosis: Traumatic Psychosis

After this initial phase of therapy I found myself wondering whether Sylvia had been traumatised by violent treatment. On reflection this impression seemed to be based on the following lines of evidence which I report in some detail as the importance of trauma in psychotic and borderline conditions may sometimes be overlooked.

Firstly my counter-transference. After each session Sylvia left me feeling emotionally bruised, betrayed and bewildered by the constantly reiterated shocks of her sudden switches from affectionate overtures to violent assaults. I though my experience with her might well reflect experiences which she herself had suffered.

Secondly, my work with three neurotic child patients who had had similarly intense, though more intellectual, pre-occupations with monsters, had led me to recognise that such pre-occupations commonly represent not just the child's own monstrous feelings, but also the adults who were responsible for arousing these feelings. Analysis of the monsters in the three cases mentioned, revealed that they disguised respectively, a history of physical abuse by the mother, a homo-

sexual assault and early hospitalization experiences (Hopkins 1977). In each case the monsters represented a compromise between the child's fear of *real* aggressive attacks and fears related to his own aggressive impulses.

Sylvia had not yet mentioned her father but the nature of her monsters and her response to my absences made me suppose she had experienced him as a terrifying person who would return to avenge his death. She appeared to have dealt with his loss by identifying with him, and it seemed probable that this identification, an identification with the aggressor, had begun before he died in response to her fear of him.

Another suggestive aspect of Sylvia's material was her use of her craziness to camouflage reality. At moments when she was relatively sane she would suddenly escape into distracting psychotic fantasies if I mentioned an aspect of reality she didn't like, such as the coming holiday. It seemed she might be unconsciously exploiting her madness as a camouflage to hide some unacceptable truths. At this stage her capacity for camouflage effectively confused me and prevented me from realising that her terror was a terror for her life, and not a psychotic fear of personal annihilation or disintegration (Rosenfeld 1975).

Several factors corroborate my impression that Sylvia had been the victim of physical violence.

The literature on abused children offers some external support (Delozier 1982). Sylvia was hyper-alert. Her need to be constantly involved with me had a monitoring quality and she never turned her back. Later in treatment when she no longer defensively split me into two Mrs. Hopkins she came to manifest an acute approach-avoidance conflict on first meeting me which is characteristic of abused children.

Stroh's data (Stroh 1974) on seven children diagnosed as suffering from traumatic psychosis, provide an essentially similar diagnostic picture. All of these children suffered from panic rages and extreme contradictory behaviour in which they violently attacked the people they loved, eliciting counter-aggression which repeatedly recreated their early experiences.

Finally, Sylvia's excited, erotic behaviour towards feet and shoes merits description as fetishism, a condition which implicates a variety of physical and sexual traumata in its development (Greenacre 1979, Stoller 1975), but which has not previously been reported in a child with a traumatic psychosis.

When giving her account of Sylvia's early history, Mrs. Z had made no mention of family violence. In fact she had told more in this first interview than she was to reveal for a very long time to come. Although she met twice-weekly with Mrs. R she quickly became extremely withdrawn and often spent whole sessions

in angry or remote silence. She was too threatened by questions to answer any, so many details of Sylvia's history had to remain unknown. However, in her own time she gradually amplified the initial outline she had given with important material to be reported later. But, meanwhile it was to be Sylvia herself who conveyed information about some of her early experiences through her play and behaviour in her sessions with me.

Trauma, Reconstruction and Exorcism. Sessions 11-31

After Christmas Sylvia enabled me to reconstruct some of her experiences before her father died, two and a half years previously.

She increasingly demanded that I should act the part of terrifying monsters who pursued her with roars and threatened to eat her up. "Be a Dalek", "Be a carpet monster" (draped in a carpet), or "Be a lightswitch monster", she said. By this means I thought she was trying to localise and control her terrors of being attacked, but it was never wholly successful for she often screamed out in terror that a chair, a light or an unseen monster was attacking her.

I first interpreted one of her dramas as an attempt to communicate the past in a session when she told me "Be a cross dream!". She made herself a bed and hid under the blanket. "Roar!" she shouted. When I did, she asked, "Are you a *real* Mummy? Are you a Daddy too?". "Yes", I said. "Speak Italian then!" said Sylvia. "I'm Never Mind Boy in bed. I'm not Sylvia. Sylvia was too frightened." I said she was trying to remember what it was like when she was little and her mummy and daddy had had terrible roaring rows in Italian and she had been too frightened to bear it. "Go tap, tap with your feet", said Sylvia urgently. I had to stamp with a regular rhythm. I asked, "Did mummy and daddy go tap, tap with their feet?". Sylvia replied, "*Not* with their bottoms, silly. With their *feet*".

This was the first occasion on which Sylvia revealed her confusion between feet and genitals, and also indicated how she had dealt with night terrors about parental violence and sexuality by imagining herself to be a boy. She was moved by my reconstruction and wanted me to tell her more about what had happened in the past. During part of each session she would enact a drama in a particularly urgent manner which I understood as a request for me to reconstruct past events, which were at first more rows between her fighting parents. Sylvia now claimed to remember their fights. "Dad beat my mummy up," she said with conviction.

Soon Sylvia voiced more memories of her own. One session when she asked me to "Be a fierce daddy monster and frighten me very much", I said I thought she was trying to remember how she had been frightened of her own fierce daddy. Sylvia suddenly looked at me with great amazement and said, "My Dad broke up our house! It was another house. He threw all the furniture". She was perplexed

about where this event had happened and I told her I knew she had lived with her dad in a different house which her family left just before he died. Sylvia replied in a disconnected and cheerful way, "You haven't seen my feet for a long time", and she proceeded to paddle in the sink. She interrupted this activity to say, "Be my friendly dad in my house. Come and listen to my record. Get in my bed". When I came close to her she suddenly changed from friendliness to panic. "My dad was in my bed. A terrible dream! A giant crane was rising up! And now a screwdriver is coming!" Sylvia held out her arms to protect her abdomen. "The crane killed me with a sharp knife", she concluded with a shudder. I said she might be trying to remember being terrified of dad's giant willy. Sylvia didn't appear to listen. She asked brightly "What is paper made of?" and returned to washing her paper lettuces.

Sylvia's vivid recollection of her father throwing furniture helped me to understand her terrors of flying Dalek furniture and her own need to overturn and fling the furniture herself. She quickly responded to interpretation about her wish to throw furniture in order to terrify me so I would know how she had felt when her father did it. She lost her terror of being attacked by furniture and also stopped throwing it.

In her role of Never Mind Boy, Sylvia began to think increasingly about the past. Just as her recollection of her father throwing furniture had laid the Dalek monsters to rest, so her recollection that her father had died in a car accident, collecting a carpet, led to the disappearance of her need to make me attack her dressed as a "carpet monster" (always pronounced by her car-pit). Sylvia's attacks on the lights in my room and her terror of the "light-switch monster" seemed related to her intense fear of the dark and her almost equal fear of turning on the light to reveal her monster parents fighting or banging their feet together. Discussion of these fears stopped Sylvia's attacks on the lights, and the light-switch monster also disappeared.

Soon after this Mrs. Z told Mrs. R that Sylvia had asked her about the old house and Mrs. Z had taken her to see it. Whether or not at this time Mrs. Z and Sylvia were also able to share memories of Mr. Z's violence we do not know, since a whole year was to elapse before Mrs. Z at last confirmed Sylvia's memories by confessing to Mrs. R that her husband had thrown furniture in his rages and had broken the arms off the chairs. She said he had also beaten Sylvia frequently and had thrown her across the room. When Sylvia was a screaming baby he had "kicked" both mother and daughter out of the house "or else he would have killed Sylvia". His violence outside the home had led him into trouble with the police.

As for Sylvia's possible indication of some sexual advance from her father, no external confirmation was ever forthcoming. I return to this subject later.

After reconstructing some of the events which seemed to have contributed to

Sylvia's intense terror of monsters, she began to bring happier memories about her father. She liked to sit on top of my cupboard because it was just like "riding on my daddy's back". She told me with delight how she could now remember going to the park with her daddy and paddling with him in the pool. She began to ask me to "Be a friendly daddy" while she was Never Mind Boy and we went to the park together. Sylvia was now in touch with her love for her friendly father as well as her hatred and fear of her fierce and angry father. At this stage I seemed to represent in turn both aspects of her father and Sylvia had not yet accepted the reality of his loss.

Sylvia continued to express a persistent desire to see and to smell "your lovely white feet". When I told her of the coming Easter holiday she told me how she dreamed of going away with me, taking off my shoes and socks and paddling with me at the seaside. She was very aware of being rejected by me and was acutely jealous of my husband whom she was sure would paddle with me. This holiday was to confront her with the reality of losing me and after it she was able to acknowledge the loss of her father.

By the time that Easter came Mrs. Z reported great improvements. Sylvia had stopped having violent tantrums and now talked about what angered her. She had become much more manageable and no longer made advances to strangers' shoes. She had also stopped bed-wetting and did not insist that she was a boy, though she was still reluctant to admit to being a girl. At school her teacher reported that she had at last begun to learn.

At the clinic Sylvia no longer supposed that there were two Mrs. Hopkins and her behaviour in the waiting room and corridor had become much more controlled. She was still pre-occupied with monsters but no longer possessed by them. After Easter Mrs. R and I both independently observed how Sylvia had lost that radiant quality of beauty which she possessed when she started treatment. A beautiful boy was changing into a plain little girl. The terror and the masculinity had gone and with them the radiance too. I felt as though something comparable to exorcism had happened and I wondered what had been instrumental in achieving this change.

It was my impression that it was Sylvia's recall of past traumatic events, facilitated by my reconstruction, which had alleviated her most florid psychotic symptoms. She became dispossessed of a primitive identification with her father, which had been split into an idealised omnipotent aspect which she embodied and a terrifying persecutory one which she attributed to monsters. Instead of being possessed by images of her father she became able to know about him.

The ready availability of Sylvia's memories had surprised me. Evidently the traumatic events which she recalled must have been registered cognitively by her at the time of their occurrence. My reconstruction effectively gave her permission, in a safe setting, to recall and to share what she already knew. The analytic

literature (Bowlby 1979, Kahn 1972, Rosen 1955, Tonnesmann 1980), suggests that the therapist's ability to construct external events is of particular importance when the patient has taken psychotic flight from reality or when important adults in the patient's life have put a taboo on knowing. In both these conditions, which applied to Sylvia, the therapist risks colluding with the patient's defences if he treats the traumatic events only as fantasies. He may also risk repeating the behaviour of the original traumatogenic adult, for, as Balint (1955) points out, it is common for an adult who has traumatised a child to behave afterwards as though nothing had happened and as though the child had simply imagined it (cf. MacCarthy, in press).

In Sylvia's case the shared acknowledgement of terrifying events in her past provided a key to her plight for both of us. Although we could never know the exact nature of her past experience we had both gained a cognitive framework in which to organise evidence. Sylvia now became sufficiently in touch with reality to learn in school. In treatment she had increasing periods of quiet and thoughtful behaviour when she drew pictures and talked about them. After Easter she moved on to acknowledge further aspects of reality: her lack of a penis and the loss of her father. She grew openly depressed and cried recurrently as she genuinely mourned the dad she had loved as well as feared and hated.

However, despite all these positive developments Sylvia could still suddenly become crazy and chaotic. Her progress at this stage must not be exaggerated. Her moods continued to change arbitrarily and although she no longer fought me as though fighting for her life she remained extremely aggressive.

Fetishism, Incest and Revenge

In the second year of treatment Sylvia continued to make educational progress and behaved well at school. She also gave up her fetishism and began to become aware of some of her emotional problems. She felt herself to be seriously damaged and she feared going mad. This development was associated with less desirable changes. Sylvia felt both suicidal and vengeful and she revelled in punishing and humiliating both me and her mother.

I will now describe and comment on these developments and their relationship to the possibility that Sylvia had been the victim of incest.

Firstly, it should be mentioned that in addition to using shoes and feet as fetish objects, Sylvia had another fetish which she used exclusively for sexual purposes. This was a tobacco tin which she always used when she masturbated. It had been given to her by "Sir", her class teacher, and it contained "magic words", Sylvia's name for flash-cards used for reading practice. Sylvia called masturbation "swimming on my tin". She lay happily on her stomach under my desk with her head on two cushions and her genitals pressed against the tin, rhythmically moving her hips. Ideally she liked me to "tap-tap" with my feet while she did this.

Cases of female fetishism are extremely rare in the psycho-analytic literature, but Sylvia's form of masturbation was reminiscent of that used by an adult female patient (Zavitzianos 1971) who could only masturbate to orgasm if she employed a fetish symbolising her father's penis. However, Sylvia's fetish comprising Sir's magic words in a tin seemed to symbolise the penis in the vagina, while Sylvia 'swimming' under my desk could be interpreted to represent father in intercourse with mother. By adding the rhythmic noise of my feet she reproduced her version of their sexual act, with herself as a participant and not as an excluded observer.

Sylvia gradually gave up masturbating in sessions and I thought this was related to her growing awareness of being a girl. This new awareness greatly increased her envy and jealousy of Enrico and Mrs. Z reported that she had become most intolerant of him at home. She expressed the wish to bite his willy to bits and she tried to steal his masculinity by borrowing his underpants, his cowboy costume and his tie, which she often wore during sessions. His clothes restored her self-esteem and made her confident of winning my affection. Without them, at times when she accepted being a girl, she was liable to complain that I didn't love her at all.

It had been known from the start of treatment that Mr. Z had loved Enrico much more than Sylvia. Mrs. Z now confessed that she had convinced herself when pregnant that Sylvia would be a boy and had bought only boy's clothes for her. When she gave birth to a girl she was glad that the baby was taken into special care and that she could leave the hospital without her.

Sylvia's fascination with footwear slowly diminished for reasons which I did not understand, and I began to be able to wear a restricted variety of shoes without exciting her. However, her desire to see and smell my feet and to paddle with me remained at high pitch. It only abated after more work was done on its meaning. This work was facilitated by information given by Mrs. Z.

I had often wondered what part Sylvia's parents might have played in her choice of fetishes. I had become convinced that she had been over-excited by someone tickling her feet and pretending to eat her toes when she was little. I also thought it likely that she had slept at the foot of her parents' bed so that she had seen their feet move in intercourse.

Mrs. Z now told Mrs. R that her husband had often encouraged Sylvia to play with his bare feet. In particular she remembered Sylvia as a toddler putting marbles between his toes. Mrs. Z also mentioned that he always slept naked and walked around the house naked too. When Sylvia was about two years old she had screamed at the prospect of having a bath and would only take a bath sitting on her father's lap, which she regularly used to do.

On the next occasion when Sylvia played at paddling with daddy I asked her

if she remembered paddling with him in the bath. "Oh yes!" said Sylvia ecstatically, "With his nice friendly willy". Then immediately she enacted a terrified girl in a park, attacked by a nasty man with a crocodile who broke into the park through a hole. He was shot by a bow and arrow. I said she seemed to have two sorts of memories about daddy's willy in the bath. Sometimes it had seemed nice and friendly, but sometimes she had felt it was fierce like a crocodile and would break into her hole and hurt her. It was safer to be a boy with a bow-and-arrow willy, like Never Mind Boy, than a girl with a hole who could be hurt.

If Sylvia had been so frightened of her father's penis, why had she found it reassuring to bath on his lap when she was about two years old? Did she feel safe from assault by seeing his penis between her legs and imagining that this frightening organ was her own? Or did the sight of her own and her father's feet in the water help to reassure her that genital differences did not exist? Such relevant material as Sylvia brought before the next holiday confirmed her focus on feet as a displacement from genital differences. It also suggested that Sylvia had enjoyed sexual stimulation in the bath for she asked me to tickle her genital while pretending I was her daddy bathing her.

The episode of the break into the park through a hole led to my first mention of Sylvia's vagina. She soon brought much more material which could be understood in terms of her having a vulnerable hole which could be violated by her father's penis. For example, she brought three rubber crocodile monsters to visit her in her bed where she greeted them with an orgy of kissing and sucking before she screamed that they were attacking her. Then she pulled down her pants to show me her genital and anus, in a manner intended to be very offensive. "See! That's my blood!" she said. I spoke of her need to convey to me the horrifying shock that she felt when she imagined that her body holes were wounds made by an attacking willy. At this point Sylvia's dominating identification with her father had given way to a more primitive identification with her wounded mother.

Episodes like this were a reminder of the possibility that Sylvia had herself experienced genital assaults or acts like fellatio. Since her early dramatization of attack by crane and screwdriver, which was repeated on three occasions, other suggestive evidence of abuse had come mainly from Sylvia's provocative habit of copious spitting.

When Sylvia spat at me she aimed mainly for my mouth and was triumphant when she hit it. She called her spitting "being sick" and spoke of spitting out poison and of spitting at me to kill me. At first I thought Sylvia's confusion of "spit" and "sick" might arise from observations of her baby brother "spitting" up milk or simply from her phantasy. However Sylvia told me, "Willies are sick" and "I'm sicking out white like a willy". Perhaps Sylvia had experienced ejaculation in her mouth which had made her feel sick, but I never felt sure

enough to suggest it. Certainly Sylvia spat most at times when she was dominated by identification with her father, and as this identification diminished, so did the spitting.

Did Sylvia experience sexual advances from her father or could such mechanisms as identification with her mother and eroticization account for her interpretation of violent sexual assaults being directed against herself? Greenace (1953, 1968) has described how in the pre-fetishist there is a prolongation of the early state of primary identification with the mother, on account of an insecure, unstable body image which impedes separation of the "I" from the "other". In addition to such an identification, Sylvia may have eroticized the many beatings she is known to have received from her father, for it is believed that pain and distress in infancy always arouse both sexual and aggressive drives (Freud 1924, Greenacre 1968).

Although identification and eroticization may help to explain Sylvia's feelings of having been sexually assaulted, it should also be added that Mrs. Z with great reluctance admitted to Mrs. R that as a child she herself had been sexually abused by her step-father; she would not give details. It is known that some mothers who were sexually abused in childhood condone the sexual abuse of their own daughters. Certainly Mrs. Z had not protected Sylvia from viewing full details of sexual intercourse which is likely to have been very violent on occasions.

With hindsight, now that I am familiar with recent evidence on child sex abuse (e.g. Renvoize 1982), I think it very likely that Sylvia had not only witnessed violent intercourse, but had played with her father's penis in the bath and had experienced fellatio and possibly even attempts at penetration. She had apparently enjoyed the sex play and in association to this she played games in treatment in which she was a princess who proudly controlled the erections of a crane (a chair-leg under a blanket). However, fellatio seemed to have been associated not only with excitement but with extreme anxiety, humiliation and disgust, while the risk of penetration was clearly terrifying.

During Sylvia's treatment I lacked confidence to reconstruct her sexual activities with her father explicitly, but I described the themes of sex play, fellatio and penetration in terms of her wishes and fears, and also related them to her difficulty in distinguishing what she had seen happening to her mother from what she had supposed was happening to herself.

Following this work Sylvia lost interest in my feet and her mother reported a similar improvement at home.

It seemed to me that Sylvia's foot fetishism, like her masturbatory fetishism, had represented a recreation of sexual acts. Sylvia's first aim was to see, smell, suck and salivate over a pair of feet (or shoes), thus reproducing the act of fellatio, displaced from penis to feet. Her second, and more important aim,

was to paddle with the feet so that there were two pairs of feet together. When Sylvia had bathed with her father at the age of two years she may have felt that their feet together reproduced the sexual union of the parental couple. The similarity of their feet allowed Sylvia to disavow their sexual differences, while simultaneously Sylvia seems to have been in some ways aware of her father's "friendly willy", either as a possession or a source of stimulation. Freud (1938) describes how the split in the ego of fetishists enables them to maintain two such contradictory attitudes at once. Splitting allows them to disavow their perception of a woman's lack of a penis while simultaneously recognising its absence and experiencing castration anxiety. Freud's fetishistic patients were all men. In Sylvia's case it seemed that she had disavowed sexual differences and armed herself with the fantasy of possessing a penis in order to protect herself from an underlying fear of violation. However, in so far as she still actually believed that she possessed a penis she may have been liable to castration anxiety. Greenacre (1979) claims that symptoms of fetishism only develop in females in whom the illusory phallus has gained such strength as to approach the delusional. Sylvia certainly had a major delusion of this kind when treatment started, and although by this stage she had already recognised her lack of a penis and had wept about it, it is possible that the delusion may still have persisted in the enclave of her fetishism. However, it could also be possible that in females fetishism might arise in response to the terror of violation, and that the illusory phallus and castration anxiety are secondary to this fear.

At the same time as Sylvia lost her excited interest in feet she became conscious of a pervasive sense of bodily damage. For example, she identified closely with "a squashed rabbit bleeding from its bottom" and a hedgehog alleged to be torn apart and eaten up by a Turkish family. She dramatized herself as the victim of terrifying forces which had destroyed her bodily integrity. She also became aware of being psychologically damaged and expressed the fear that she would grow up crazy.

Sylvia had been reasonably well-behaved at the clinic for some time, but now when she had an audience she delighted in displaying her disturbance. She aimed deliberately to shock people and show them she was damaged. She spat on other patients and shouted obscenities, "So they think I'm mad" and "So they'll know it's all your fault". "*You* broke me". "*You* tore me apart". She repeatedly threatened to throw herself down the stairwell, "So everyone will know how horrid you've been", and at home she talked of strangling herself. She drew obscene pictures of me and attacked me with her faeces. She revelled in humiliating me and was revengeful and trimphant. In these moods, which mercifully never dominated treatment, her intense hatred had a new and vengeful quality and I found her loathsome.

Although Sylvia now felt seriously damaged she made no intellectual connection between this and her traumatic history. Perhaps it was too distressing to think that her loved parents were responsible. The earliest and most serious trauma

she had suffered was probably her mother's failure to protect and comfort her. Now that I had helped to remove the protection of her fetishism Sylvia took revenge on me.

These detrimental changes baffled me until I understood them in Stoller's terms (1975). He describes fetishization as an act of cruelty whose unconscious aim is to seek revenge on the original loved traumatising object, to desecrate it and humiliate it. The accompanying excitement is not due to voluptuous sensations so much as to "a rapid vibration between the fear of trauma and the hope of triumph". The trauma feared is the repetition of a childhood event, sensed as life-threatening, and the triumph is the fantasy of revenge on the original loved traumatizing object.

When Sylvia ceased to express these complex feelings through her fetishism it seems that they became expressed instead in object relationships. The triumph of the fetishistic re-enactment of traumatic sexual scenes gave way to acknowledgement of a sense of trauma and a desire for revenge.

Casework With Mrs. Z

Mrs. Z now insisted on stopping treatment in order to take a job, while the psychologist attached to Sylvia's school thought Sylvia was ready to transfer to a school for normal children. Plans had to be made to end treatment after two years of work.

Mrs. R had had a very difficult time working with Mrs. Z who had remained extremely resistant throughout. However it had been possible, to a limited extent, to help her to mourn her husband and to become able to speak about him with her children. Work had also been done on her over-identification with Sylvia, expressed by Mrs. Z as being like one person going into another and dissolving them. Mrs. Z's parents had intended that she herself should have been a boy, so her identification with her own unwanted girl baby dated from Sylvia's birth.

Mrs. R's work with Mrs. Z was crucial to the success of Sylvia's treatment for she managed to maintain her co-operation in spite of her recurrent threats to break off treatment, and also enabled her to make changes which benefited Sylvia. Sylvia must have been further helped by having the same man teacher throughout her treatment, for "Sir" was a kindly father-figure whom Sylvia loved.

Treatment was nearly over before Mrs. Z admitted how "utterly brutal" her own relationship to Sylvia had always been and continued to be. Sylvia was certainly extraordinarily provocative but Mrs. Z's collusion with this was most unfortunate. It seemed that Mrs. Z needed to continue a violent relationship with Sylvia, although she also loved her and wanted to help her.

It had taken two years of patient work with this defensive mother to reveal the extent of Sylvia's rejection from birth and of both parents' murderous feelings towards her. Sylvia's inability to acknowledge that it was her parents who had threatened her life and her misattribution (Bowlby 1973) of this threat to monsters may have been partly due to the overwhelming terror associated with the realization that both her parents had often wished her dead.

At the end of treatment Mrs. Z also revealed that her step-father, who had sexually abused her, had been a shoe-fetishist. This perversion can scarcely have been a complete coincidence, and it may explain the great importance which Mrs. Z had attached to Sylvia's first display of interest in her father's shiny shoes. Dickes (1978) has described how parental reactions influence the development of their children's fetishism. As a rejected baby on the floor Sylvia may have been first attracted to shiny shoes as a substitute for faces with their shiny eyes, but her later passion for shoes seemed to stem from their relationship to feet and from the fact that shoes could be possessed, taken to bed, bitten and sucked without retaliation.

Termination

During the last term of her treatment Sylvia always wore skirts which she now preferred to jeans. She maintained a rigid split between her loving self which appreciated and depended on me, and her damaged and revengeful self which continued to delight in fierce attacks. She still switched from one self to the other without apparent reason or awareness. The main work was done on the conflict she experienced between "wrapping herself inside her mother" and separating from her, and the relationship of this theme to her sexual identity which was still very confused. She began to think more about me as a separate person with a home and family of my own from which she felt painfully excluded.

Sylvia had been very upset by the decision to end her treatment. In spite of her distress she kept the final date constantly in mind and told me with feeling how much she would miss me. At the end she embraced me in tears and said, "I cannot bear to say goodbye".

Follow-Up

Sixteen months after treatment ended, when she was rising ten years old, Sylvia came to see me again at her own request. She asked me to arrange treatment for herself and for Enrico and was angry when I explained that Mrs. Z could not manage to bring them at present. She drew obscene pictures of me to express her rage, but followed them with "a lovely picture" of me to make amends. This was the first reparative gesture I had ever seen her make.

Mrs. Z reported that Sylvia had maintained her gains and there had been no recurrence of her fetishism. She was coping adequately in her normal school

where her behaviour was good, but she took it out on her mother after school and was often very difficult to manage. She was growing in independence and successfully performed errands on her own.

Despite her great improvements Sylvia remains a borderline child who is likely to encounter very serious problems at adoloscence, such as psychosis, promiscuity or attempted suicide.

Summary:

The interest of this paper lies in the unusual nature of the patient's symptoms and in their apparent relationship to early trauma. The patient was a six year old girl with a foot and shoe fetish who was at first psychotic and convincingly appeared to be a boy. In the course of her psychotherapy it emerged, and was later confirmed, that she had been the victim of terrifying, life-threatening assaults by her father who had died before she was four years old. It also seemed probable that she had had an incestuous relationship with him. The paper explores the defensive nature of the girl's psychotic illness and masculine identity, and considers the possibility that her fetishism represented a re-enactment of sexual trauma.

Treatment freed the girl from her presenting symptoms and enabled her to attend a school for normal children.

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A DIFFERENT-SEX TWIN CONSIDERS HER SEXUAL IDENTITY

Reading-in Paper for Associate Membership of the British Association of Psychotherapists

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Some theoretical points.

In the psychoanalytic literature there appear to be relatively few reports dealing with twin cases. In view of the high incidence of neuroses and other psychological disturbances among twins it would be expected that more often twinship would have been described as a major cause of psychosexual developmental defect. According to Leonard (1959) "in the case of every twin whose analysis has been reported, the twin relationship was considered the prime reason for that individual's emotional disturbance".

This apparent misrepresentation of twin cases might be due to the fact that one in every 88 of the adult population has a twin alive instead of the expected one in 60 (Sym: 1979) that should have been the case if the other twin had survived birth or, more important, during the first years of life. This is to say that among this particular group of twins those who come for analysis may well treat the other sibling as if he/she has never existed or has never been influential enough in the patient's life. Although this may be true in some cases it is probably not the rule and twinship should therefore be taken very much into account even in cases when the other twin died early in life. In fact, it is suggested in this paper that the basic psychodynamic make-up of twinship and the very early stage at which it is formed in one's life makes it unlikely that the "other half" - as often twins like to call their twin sibling - has been as unimportant as it is claimed to be the case.

In the majority of twins, however, with both of them alive, similar denial mechanisms, important as they may be, do not appear as the most prominent features. In these cases the feelings are immensely more complex. In a detailed study of identical twins D. Burlingham and A. Barron (1963) refer to what they call "copying games" of the twins; their "love relationship" as well as their aggressivity towards each other; their "intense reactions" to separation from one another as well as their tendency to form "a team" of the two of them whenever one is confronted with a difficult situation.

One might point out that similar observations could equally well have been made for any two siblings of approximately similar age. So in terms of psychic dynamics the above findings do not necessarily constitute sufficient reason to make twinship a special clinical condition. Siblings do identify with one another to a certain extent and they react violently when their own individuality is threatened. If that is the case then it could be argued that twinship is at best different in degree

only from any other sibling relationship and at worst it needs no special mention whatsoever.

Twinship, however, goes well beyond that and it is by no means an exaggerated form of an ordinary sibling relationship. In another of her studies on twinship D. Burlingham (1945) makes the point that most people at some stage during their lives have had a period when they enjoyed the fantasy of having a twin sibling. This remarkable observation throws some light on the jealousy that people appear to have towards twins in general. The way that this is commonly expressed is through enormous "admiration" and "love" that adults show for twins and their mothers; it is almost as if they themselves would have liked to be in the twins' position. In fact, children too have a similar spontaneous reaction when they come in contact with twins, and most certainly brothers and sisters resent their twin siblings who to them appear to enjoy a superior kind of friendship than they can ever have themselves.

In reality though, twins and all those who care for them face many problems which makes their position less enviable. However, the above attitude which M. Leonard likens to "mass repression" has a significant impact upon the mother whose relationship with the twins matters more than any other with the exception perhaps of their own relationship. For a mother who lives in straitened circumstances the bearing of twins will be a great shock, even if it is denied by her environment. On the other hand it is true that there is a degree of narcissistic pleasure for the mother too; everybody expresses interest in her capability of producing two children at one go and her exhibitionistic needs get greatly gratified.

These relatively minor positive aspects of the relationship of twins with their mother, are not sufficient to prevent the relationship of the mother with each of her twin children separately from being affected in a negative way to a greater or lesser extent (D. Burlingham 1946). In the case of identical twins this takes the form of the mother even confusing the twins. With twins of the same or different sex the effect upon the mother is eventually the same even if at first there is no confusion of identities of the children. What has to be appreciated is that the mother in one way or another has to identify with only one of her twins and to reject (at least temporarily) the other one if she is going to go through her own "maturational crisis" (G.C. Bibring: 1961) without too much personal damage. What intrapsychic difficulties of her own the mother may have been going through is often indicated by her expressed wish that she would have liked to have treated her twins alike or equally but somehow for some reason she was never capable of doing so. This is also the complaint that twins themselves express; namely that they have been let down by their mothers. This, important as it may be does not explain enough of their particular psychopathology. So, if twinship is more than an exaggerated form of siblinghood - as it is suggested here - then it is important to look at the most basic intrapsychic conflicts that it represents for the individual twin.

In 1920 Freud made a passing comment which gives a clue as to what these conflicts may have as their nucleus. He wrote: "I once knew two twin brothers, both of whom were endowed with strong libidinal impulses. One of them was successful with women and had innumerable affairs with women and girls. The other went the same way at first, but it became unpleasant for him to be trespassing on his brother's preserves and, owing to the likeness between them, to be mistaken for him on intimate occasions; so he got out of the difficulty by becoming homosexual. He left the women to his brother and thus retired in his favour". What he describes here would have been of no interest if he was referring to a typical case of homosexuality of Oedipal origin. Then the father would have been expected to be the main protagonist in the conflict that the individual experiences. This is not the case in the above quotation; instead the Oedipal father is displaced by the twin brother who thrusts aside the father. This form of Oedipal conflict is a very common one among twins and it is often accompanied by homosexuality. Other authors have also made reference to it. For instance, D. Orr (1941) says that "in the face of severe conflicts between forces calling forth his individuality and other forces cementing his twinship, and between drives to remain passive and other drives to assert aggressive masculinity, the patient compromised by developing a generally dependent, unconciously homosexual personality with many sadistic and passive oral traits". As the main expressions of this patient's conflicts, he goes on to formulate the following questions which are also relevant to the case to be presented in this paper: "Am I an individual or am I only half an individual"; "Am I a boy or am I a girl" and "What happens if I excel my twin and what happens when my twin excels me". While the origin of the first question is archaic and related more to the second main aspect of twinship to be discussed later, the other questions constitute part of the Oedipal dilemma in a modified form.

The unconscious replacement of the same sex Oedipal parent in the analytic situation by the twin sibling is perhaps an important characteristic of twinship. This is so because it can decisively determine the respective role of each twin in the relationship. In the case of male twins it results in what Freud describes in the above extract. With one female and one male twin - which is more relevant to the case for discussion - the roles get reversed, especially when the female one was born second with all the psychological implications of such a disadvantage.

This type of Oedipal homosexuality in twins is not perhaps as simple as it appears to be assumed from this description, which seems to be taking for granted that pre-Oedipal developmental stages have been negotiated reasonably well. This cannot be true in the case of twins. Already in the above quotation mention is made of "passive oral traits".

Traits of this character would be expected to have a decisive effect upon later developmental stages if they are strong enough. For all those practical and Psychological reasons that were mentioned earlier it is reasonable to imagine that

oral frustrations cannot be uncommon in the bringing up of twins. But there is also another reason that orality becomes such an important aspect in the analysis of twins. It has to do with the extended periods of time that twins tend to spend together in very close proximity to one another from the very early days of their life. Leonard points out that from approximately the fifth or sixth month onwards the twins are sufficiently aware of each other so that being together seems to have a quietening effect. The constant close contact that they have is of particular significance because of the way that by visual means it interferes with the oral stage of incorporation of the mother. Normally oral incorporation is a necessary element of the primary identification process (S. Freud: 1921) and excessive visual incorporation endangers this process. Some of the negative effects of this interference are language disturbances, loss of body boundaries and self-identity and incomplete object libidinal cathexis, from which twins so often suffer.

The main inhibitory effect of this "inter-twin primary identification" as it has been named is that it has the strong tendency to be self-perpetuating: once it has started it inhibits progress toward communication with individuals other than the twin sibling and thus the development of object relations in particular, can be hindered considerably. The way that this phenomenon appears in the transference situation is remarkable.

These oral aspects of twinship together with their accompanying ego disturbances is the second major feature that one would expect to find in twins that have been reared together. In order to describe it E. Joseph et al: (1961) uses the term "twinning reaction". According to him it consists in 1. mutual inter-identification and 2. part fusion of the self-representation and the object representation of the other member of the pair.

The twinning reaction does not depend upon the sameness of sex in the twins. Different-sex twins are affected by it as much as same sex twins. However, with different sex twins an additional factor has to be taken into account; to the genitals of the male twin as long as we concentrate on the female one (A. Maechen). In the analytic situation this amounts to a fantasy that the female twin is in the possession of a penis. For if there is to be twinship equality demanded by the very process of intertwin primary identification then it must operate in such a way so that an illusory penis has to be created, presumably through oral means in the fashion described earlier. In clinical terms the existence of such an illusory penis raises enormous defences that may be proved the most critical factor of analytic success or failure. The female twin denies her femininity by making extensive use of projections and rationalisations.

With this psycho-dynamic profile the girl reaches the Oedipal age when equality as such cannot be maintained any longer; she has then no alternative but to compete with the brother on the basis of an illusory penis rather than envy of his penis. It is then by no means unexpected that sex identity can be such an important problem

among twins.

Case Presentation

The case that I am presenting here is of a 28 year old Catholic woman of no particularly religious background. Her father is a medical doctor who was a general practitioner until ten years ago when he gave up his practice after a stroke. My patient feels that she has to blame herself for this. Besides his love for soccer and horse riding he also had an inclination towards excessive alcohol drinking and a dislike for his mentally suffering patients. Her mother, for whom Miss A - as I will call my patient - had made mention only on a few occasions during the first year or so of her psychotherapy has been presented as an almost non-existing person. Lately this has changed and Miss A has suddenly come to appreciate her mother as a painter and director of theatrical productions when she was a child. Miss A has two brothers, two sisters and a twin brother, all of them older than herself. She scarcely ever mixed with her brothers and sisters apart from her twin brother with whom she had "a very special relationship" which would perhaps be described as a symbiotic one. They went to the same school - different from that of the other siblings - she wore his clothes and she was often called by his name because of their similar looks. The whole family in a way was divided into two groups: One led by the father which included the twins and the home help - Miss Mary - and another one led by her mother. Miss Mary, in fact, had undertaken the upbringing of my patient but not that of her twin brother. This was the responsibility of mother and on many occasions during the sessions I have felt that this was the only contact that the two groups had between them. For as far back as two and a half years of age she had vivid memories of her mother taking her twin brother away to feed him in private and herself staying with Miss Mary and feeling very miserable indeed. When it was time for her to be fed she was never fed by her mother. She remembers Miss Mary shaking in front of her eyes a bottle of milk and threatening to drink it while she herself was scared that it would hit her on the head. She could see the connection between the incident and her very strong fear at that stage in her therapy that I had been forcing her to accept my interpretations or to lie on the couch; things that she had passively accepted until then.

But beside her oral anxieties connected with Miss Mary she had also invested her with enormous power which Miss Mary was only prepared to use for those that she loved and in the following instance, for Miss A's father. Her father came home drunk and he asked for Miss Mary to follow him into the bedroom rather than his wife. Later on in the same day her father was in a good mood which indicated to Miss A that it was because of Miss Mary who had somehow made him well. She then connected the "private intercourse" between her mother and her tiny and fragile twin brother with the intercourse that had taken place between Miss Mary and her father. Her fantasies were clearly oral and this was manifested in her fantasy that I could also make her better

if only I wanted to. "I am sure" she used to say "that one day we will have sex together. I cannot see why this should not be allowed in psychotherapy". When I pointed out to her that we did not know what kind of sex her father had with Miss Betty, she emphatically pointed out "I'm sure it was oral sex" and then she added "Why! - is there anything bad with that?" As she got no reply from me she added "Are you one of those sex-maniacs that do not accept oral sex; that you only want vaginal sex; I am not going to have that". When I replied that she would never agree to anything less than her twin brother had, she broke into tears.

Miss A had a characteristic relationship with her twin brother. A typical part of that relationship was first that from the age of two and a half years or so they had mothering from different "mothers" and secondly that she was in charge of the relationship. Both these aspects became obvious from the early stages of her therapy but we had no idea why that was so, especially if one considers that she had been born second. On the other hand, both twins belonged to the same "group" in the family and in many ways their symbiotic relationship was most typical. She was feeling sorry for her twin brother who was "a little backward educationally and he was bullied by other children" so that she had to protect him all the time. She had to teach him the school-lessons and in a way she feels that she spent all her childhood caring for her twin brother. Everybody recognised her superiority intellectually and athletically. For that reason her father, for whom she was the favourite child, bought a horse for her which could not be used by anybody else but only those two. This however, seemed to have precipitated in a way a change in her brother: he suddenly became good at horse riding and as far as she is concerned almost everything else. They were twelve years of age at the time and while he was gaining height she was remaining fat and short. She feels that she has almost remained static since her adolescence and she attributes that to the rheumatic arthritis that she had at that time; this should have been her father's responsibility but he never believed her when she complained. She often brings to me a number of somatic complaints like vaginitis, headaches, and even falling out of her hair, all of them related to that period in her life, and she demands that even if I cannot treat her for these complaints I should not think, as she feels that her father did, that they have any other meaning but are real physical symptoms.

The control that she tried to exercise upon my thinking was the same that she felt that she had over her father from a very early age. This collapsed somehow, when her twin brother suddenly started, during adolescence, growing faster than herself. Her physical symptoms intensified but her father refused to examine her. There was a precise correspondence of these feelings in the transference: There was then one person who agreed to examine her physically and to see why she was not feeling well; that person was her father's senior lady partner. She had immediately felt better after that. Similarly before she came to me she had been assessed by Dr. Tonnesmann and this she wanted to be repeated. I had pointed out to her that these seemed to have been perhaps

the best contacts that she had ever made with people and they were both with female individuals. She agreed with that and she added that she had some other "unique experiences" with a girl friend some years ago. In that relationship it was the oral element that was determining the relationship. She was passively accepting her friend's cuddles but she was angrily biting her "beautiful stiff breast". She had felt very guilty at the time and she admitted having the fantasy of hurting me while having oral sex with me. By interpreting her apparent confusion between her friend's nipples and her brother's penis, in whose place I was standing in the transference, she felt great relief.

The whole area of oral anxieties emerged as the main problem in her psychotherapy. The problem consists not so much in the nature of her anxieties but in their form. What I mean by this could perhaps better be described in terms of transference and counter-transference: In the transference situation I could often be the depriving mother who always gave her less than she needed or I could be the idealised father or the hated father who rejected her when she was most in need of him. These were fluctuations taking place quickly during the same session; and they showed how unstable her object-relations had been. I could be good or bad, feminine or masculine, handsome or ugly, many times. For instance there was an occasion when, after she had described a painting of hers in which I was in a prominent position, she suddenly started insulting me and walked out of the consulting room. She could not stand me being where she herself had put me a few minutes earlier and she immediately tried to demolish me again from that position. To interprete this and other similar incidents, I was helped by my own counter-transference where I was often feeling lost as to where I stood with her because of the fluidity of her perception of myself and her confusion, which eventually became my own confusion. Then I found that all these figures in her life - father, mother, Miss Mary - were really only need-fulfilling part-objects to be exchanged one for another. They were really used as aspects of another object, namely her twin brother, who after a certain point in her therapy became the main protagonist of her unconscious life. It is this aspect of her psycho-development that I would like now to stress more.

During the first year or so of her therapy Miss A was quite keen to talk about her family but more than anything about her weak twin brother whom she loved so much and whom she had "made into a chemist almost in spite of his alleged stupidity and incompetence". There seemed to be a general consensus in the family and also outside that the twin brother was mentally handicapped to some extent. This was the reason, according to her, that although he managed to start reading chemistry he never qualified. They discovered in the University how little he could do and everybody agreed that he should not have tried in the first place. There were many obvious discrepancies in what she was saying: how for instance, could he be so stupid that he needed special care as a child and was still able to enter the University in the first place? How suddenly at the age of twelve did he start horse riding and how could he work as an assistant chemist in

a pharmaceutical company and be promoted to the manager's post? These were not questions to be put to her in order to face her projections in that phase of her psychotherapy as she was not ready yet to take any of it but they were surely relevant to the way that I was seen in the transference. She denied all that time all my transference interpretations as long as they bore any relevance to her feelings for her beloved twin brother. For everything the responsibility lay with her father and her mother: The father because he never gave her proper medical care and he did not allow her to study medicine and her mother because she was not interested in her. There was absolutely no question about her feelings for her brother; they were benign feelings; so were her feelings for me as long as I interpreted myself in the transference in relation to her mother, Miss Mary and father only.

Another area that she was rigorously defending was around the events that precipitated her self-referral to the B.A.P. When I first met Miss A she said that what troubled her was that she could be very aggressive towards female students in the Art-Therapy College where she was studying and that there had been two incidents that made her think that she could not carry on as she was and that she needed to understand herself better before she finished her studies, which she had interrupted at that time. As it turned out, one of these two students had a long-standing friendly relationship with Miss A since the time that they were at school together. In the College this friend of hers showed exceptional artistic talent and she also developed a lesbian relationship with the other student whom my patient had unpredictably kicked during a psychodrama session. For a very long time Miss A denied the artistic talent of her friend and also she tried hard to compete, with some success, but on the whole she felt that she was failing. In spite of that she saw her friend as weak, perhaps without intelligence and naive; a person whom she really had to protect. She saw the other student as lacking warmth and very aggressive, therefore, she had to be afraid of her. She was competing with her, too, not in artistic work but in the engine-power of the motor-bike that each one was capable of riding. She always came second and she squarely attributed that to her small stature. She finally developed a homosexual relationship with her weak friend which lasted only for a short time. She could have had a relationship with the other student, but she did not want this being afraid of her own intense anger towards her. What was important in that relationship and in another similar one later, was the excessive amount of time that she spent "watching" the other woman's body which she found fascinating. She then painted miniature pictures of two people, one of whom looked like a woman and the other like a man, embracing each other. In many of these pictures I was also present watching them. In her association to the pictures she always confused which of the two she was; most often being the male by a slip of the tongue or a joke that she was prepared to make. However, she was never happy with her paintings because I should not be watching them. Instead she said, I should be in bed with her "if not having sex, at least being together watching each other". I had not interpreted this material for some time until one session when she brought a dream. From this

dream we understood the reason why she was so unhappy in her artistic work: In the dream we were both lying in two different beds while others were around us having something like a party. Among them were her parents. Suddenly all the people disappeared and we remained in our beds with only her mother watching us and ourselves staring at each other.

When I interpreted to her the meaning of this dream as a memory of the past with myself being her twin brother in infancy rather than anybody else, she became terrified and ran into the toilet in the middle of the session. The "weak" friend had also been a twin brother to her while the "aggressive" one was her mother.

However, it was by now clear to me that our relationship was primarily based on her very early relationship with her twin brother which for some reason was experienced by my patient as moving from a symbiotic one to a protective one at around the age of two and a half. Now it was easier for her to accept my position as a twin brother to her. She admitted that she all along wanted to help me as a student of the B.A.P. in my studies, which would have been a sacrifice similar to that she felt she made for her twin brother. At the same time, however, she started missing sessions. Fortunately enough, the first eighteen months of her therapy had passed and she had managed to pass her final exams as a qualified art-therapist. But the realisation that her relationship with her twin brother could have been anything but perfect really shattered her. She bought a bigger motor-bike to compete, more successfully, this time with her boy-friend with whom she had by then managed to keep a relationship going for over a year in contrast to all her previous relationships which had lasted no more than a few days or a week at the best. She wouldn't leave off riding her powerful motor-bike in spite of her continual accidents. She often insulted me and she said that I was right in comparing myself with her twin brother because it was now obvious to her that my intelligence was not any greater than his. She even followed me to a psycho-analytic seminar in the University building which I interpreted as her wish that her twin brother should not have good experiences on his own.

Her frequent acting-out was at times serious enough for me to wonder if her ego functions were able to sustain the psycho-therapeutic process and I therefore questioned whether I should have waited longer before I touched upon her relationship with her brother. On the other hand I knew that at some point she would inevitably have to face her rage against her twin brother around which she had built all her projections and denials. That this should happen in the context of the negative transference was inevitable if collusion between the two of us was to be avoided as a long-term situation.

During the next stage of her psychotherapy a much more realistic assessment of her twin brother as the favourite child in the family emerged. The following dream played a decisive role in that assessment. In her dream she was lying between the front and rear seats in a car and those sitting in the rear seat were resting their feet

on her. Then, everybody had left the car and she was locked inside it on her own. Without knowing why, she insisted that the dream had to do with her twin brother and also myself who had just returned from holiday. She associated that during my absence she often thought of myself being involved in accidents and she visualised me in hospital; she even painted a picture of me being there. I asked her if she remembered her twin brother ever being in hospital. She started crying, something that she had only once done before, and she said that when they were two and a half years of age her twin brother swallowed a toy for which he had to have a major surgical operation as the toy was too big to pass through the digestive canal. During his stay in hospital she was never allowed to go in the ward and when the rest of the family went to visit him she stayed in the car looking at her brother only when her mother took him to the window for her to see him. The memory of that episode was very important for her because she could now put all that had happened between herself and her mother after that age into perspective. Her period of confusion and distrubance after that dream ceased although she continued having accidents with her motor-bike.

Her attendance became much more regular and her work with mentally handicapped children, which for some months had suffered, was now back to normal. More importantly, her displaced anger onto myself went back where it belonged - to her twin brother. "I thought that he had died" she said "and for years after I wished that he was dead". She remembered when they were later playing dead and she tried to bring him close to the traffic whenever it was his turn to be the dead one. What has also changed since she had that dream, from a situation of no relationship whatsoever to a realistic relationship, is that between herself and her mother. After years of very little contact indeed between them they now ring each other regularly.

Then her twin brother got married. At first she would simply not believe that it could be true. At the marriage reception she was sick several times and she started dreaming of being in bed with her sister-in-law. Long periods of silence started making their appearance and she was competing with me about things like who would talk less in the session or if she should lie on the couch any more. Her main preoccupation became the next motor-bike that she was planning to buy and how much bigger it should be compared with that of her boy-friend. She went around all the showrooms of London and in the end she got one that was so big that she had to sell it later on. She felt that I was so much like her twin brother that she could not continue with me because it was impossible to understand how her twin brother could be a man. She therefore wanted to go to a female therapist who would be like herself, but capable of understanding her like a Finnish boy-friend that she had when she was eighteen years old. He was shy and introvert like the "weak" art student and that excited her so much. Here once more she was expressing her very deep doubts about her sexual identity, as well as the sexual identity of her twin brother. In effect, what she was saying was that the male one of the two was herself and not her brother, and it was difficult for her to see me in any other way but as female.

The marriage of her brother reminded her of the fact that that might not be so. The time seemed now the right one for this material to be interpreted accordingly but the risk of her starting acting-out her masculine fantasies was always there. At this time she kept changing flats and she was trying to get rid of her boy-friend while at the same time she was seeking actively female company. She felt that it was my fault that she could not arrange her life as she wanted to because, like her twin brother, I seemed to have decided "that a woman must be married and have children" and she did not think that there was "such a thing as a woman or a man".

That she also wanted a female therapist was very hesitantly accepted even when there was little doubt about it. To separate from me was as difficult as it was to separate from her twin brother no matter how much she wanted to. I saw this as being the result of the "primary intertwin identification" which was created at such an early pre-verbal stage in her development that she could hardly talk about it, thus her prolonged periods of silence. She later, however, started feeling that it was her right to claim that she was as much a man as she was a woman. She constantly lived the experience of having a penis and after her brother's operation she grew up with the fantasy that her twin brother might after all have no penis at all. This is why she used to say that when as children they had a bath together she never remembered having seen her brother's genitals. (Freud: 1927). This probably was related to the time when she saw her brother's abdominal scar following his operation and she thought that during his stay in the hospital they had cut off his penis. So, when he recently got married she, apart from feeling very upset, wondered how her sister-in-law had married a man who she was convinced had no normal sexual organs and was therefore unable to have children. Then she heard that the sister-in-law was pregnant, she could not believe that she could have a baby by her brother. When her sister-in-law actually gave birth Miss A felt compelled to go to Belfast to find out if the child looked like her brother at all. In the event, she felt shocked to see her nephew looking like herself. She did not even touch the child. It scared her to visualise herself as the father of the child, but later her visit to Belfast proved to have a very reassuring effect on her. For if her brother's penis had visually been incorporated into her own body it was now going back to where it belonged. When I said to her that her trip to Belfast was worthwhile if not for any other reason at least because things between her and her brother were now more clear than ever before, she replied that she knew that from now on they (herself and her twin-brother) are two different people who have nothing in common except only that one was born several minutes later than the other - and, unfortunately, she was the one who came second. She then herself related to me how differently she saw me now for the first time. I had now become the one who would "protect" her from her "split self".

This phase in Miss A's therapy has certainly been a very crucial one. It has also been very difficult for me to handle it at times. In the end, it seems to have been the most rewarding one too. Before Miss A made conscious her immense envy for

her internalised twin brother she was in a state of psychological hermaphroditism which she had to defend vigorously. As the result of her being a twin and having experienced certain traumata in her early childhood this was in excess of any similar normal process. However, her fantasies underwent maturation so that as an adult she felt that she had hermaphroditic genitals. Her femininity then became of little importance to her. After the marriage of her twin brother all this had to change to adopt to the demands of reality. This was not an easy task. Under the pressure of facing in the transference a non-feminine twin brother she became totally confused as to her sexual gender and she demanded that she had a female therapist. That became absolutely necessary to her if she was to preserve her masculine identity intact. She interrupted her therapy for five weeks and she even wrote to the chairman of the B.A.P. claiming that I had not paid enough attention in the past to her "need to bite".

Before I complete my presentation I must refer to a dream that she had after she came back from Belfast which was very important to the preceding period of negative transference as well as to its positive outcome: In the dream she had seen herself being born and her mother was holding another baby in her arms. She had no associations to that dream at all. I pointed out to her that her silence indicated how difficult it was for her to talk about the unspeakable. She responded by taking the pillow and covering her face. The following day she reported that she had started working on a painting in which she gave birth to herself. The day after she lost that painting from the back of her motor-bike. She did not like it, she said, and she started to work on another one which she tore up for the same reason. This was repeated several times. Then I reminded her of her dream and of the fact that she denied its significance by trying to reproduce it on paper with a meaning which was different from that of the dream, which showed her deep anxiety around the facts of her own birth and her brother's birth. When we met for the first time after the period of interruption of her therapy she said that she had completed a new version of her painting. Her mother and not herself was this time giving birth to herself while another baby was lying on the floor and I was watching from a distance all that was happening. I remarked that my presence ensured that her birth was indeed separate from that of her twin brother and that after all she was now a complete and separate individual in her own right.

The fact that she now for the first time wants to have a child herself and to get married, no matter how much it frightens her, is an admittance of the loss of her illusory penis and at the same time of a discovery which she calls "femininity", and which she sharply differentiates from something else which she calls "sexuality", which in many ways still scares her.

Discussion:

I have described here some aspects of Miss A's analytic psychotherapy which has lasted just under three years so far. The initial phase of that period was characterised by an intense positive transference which at times seemed to be followed by a loss of reality and could best be described under the concept of

transference neurosis (S.Freud: 1920). Miss A was ready to accept my interpretations and in many ways she seemed to be making progress. This, however, at some point stopped. She began to sexualise all that I was saying and she even brought to me a lot of dream-material in order to satisfy my needs as a student. She had always been conscious of that as she admitted later. Her very important Oedipal anxieties could now be discussed freely but with minimal affect for most of the time.

Things somehow started changing when her relationship with her mother came into the session. It had taken her at least a year before she was able to talk about her mother as a real person, and it was easy to see the persecutory character (M. Klein: 1952) of that relationship.

In the counter-transference however, I had detected clear signs of collusion with her from around that time. She was in control of the situation. The "love" for her twin brother could not make sense either. When I became aware of my feelings as a twin-brother whom she tried to protect from his weakness a lot of things changed. The collusion was a kind of fusion between us in the sense that is described by E. Joseph et al. The phenomenon of the twinning reaction as a pre-verbal and pre-Oedipal situation, in her case almost superseded the relationship between mother and baby. I would go as far as to say that the visual aspects of her early relationship with her twin brother altered the natural process of oral incorporation of the mother to the extent that "watching" became more important to her than any other aspect of her homosexual or heterosexual relationships. This is probably related to her artistic talent too.

Because of the difficulties in establishing identity and body boundaries that the twinning reaction involves, Miss A became fairly confused as to what gender she was and who she was as a person. The traumatic event of her brother's operation facilitated a fantasy cognition as to who was the boy and who was the girl. All her defences were developed around that area. Her environment did not help her in this respect either. Her father used to call her *Paul* instead of *Pauline* and he used to take her to the pub and to make jokes with his friends about her masculine preoccupations. On the other hand he did not allow her to study medicine through which she might have sublimated some of her need for an illusory penis. Without doubt her dreams and in particular those that preceded the two crises during her treatment made a great deal of difference in the process of her therapy. The marriage of her twin brother helped her through reality testing, to start separating from him as an individual.

As I have tried to describe in this paper all these events have contributed to a process of achieving separation from her twin brother and to her own difficult development as an independent person.

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REFLECTIONS ON WORKING WITH A BORDERLINE PATIENT

Hazel Danbury

Mr F. was twenty nine years old when he referred himself for psychotherapy, a therapy which was to last six years, for the most part three times a week. He was then in a borderline state, unable to form or sustain relationships; he appeared to live in an internal state of chaos, to have no clear idea of where he ended and others began, to have global catastrophic dreams and to see others as projected, fragmentary characteristics of himself. He always felt on the outside looking in: an observer of the world, not a participator.

Six years later, Mr F. left therapy, a happily married man and the proud father of a baby daughter. He had, in Kleinian terms, moved from the paranoid-schizoid position to the depressive position and negotiated the Oedipal phase.

My understanding of borderline states is based on Kleinian theory, developed by Segal (1957) and also on Winnicott's work on the 'facilitating environment' (1965). I also drew on the writings of others, such as Kernberg (1974), Modell (1976), and Kohut (1971) as well as, of course, Freud (1914 et al).

The borderline patient finds the transition from the paranoid-schizoid position to the depressive position unbearable, failing to cope with the anxieties associated with the depressive position, and therefore retreating, using coping mechanisms of splitting and projection. The borderline patient can be said to be using schizoid mechanisms in a neurotic personality. Because of the extent of his projections, he complains of feeling empty and unable to experience what is happening outside him or to feel part of life.

He cannot think futuristically, and tries to create order out of his internal chaos by splitting the world into idealized good and bad objects. Parts of the object may be seen as belonging to the self, and parts of the self may be projected on to the object, thus giving rise to a difficulty in distinguishing between where the self ends and the other begins; this may result in a sense of fusion with the object. An explanation put forward by Winnicott (1965) is that possibly the child was either not disillusioned as to his own omnipotence by his mother, as was the case with Mr. F., or that he was too rudely disillusioned. He remains basically in a world of concrete thinking, having difficulty in symbolising (Segal, 1957). It would be interesting at this point to examine the work of Piaget in relation to this, but perhaps this is the subject for another paper.

The therapy moved through the phases usual to patients of this nature; a state of regression to narcissism, during which I endeavoured to provide a containing environment, lasted up to two years; this was followed by a

transition period of about eight months, which gave way to the final three and a half year part of the therapy, where work was done with the transference neurosis before planned termination. I shall give a brief outline of what happened in this therapy before moving on finally to consider the question frequently raised in connection with borderline patients, namely why some stay the course and others do not.

Background

Mr F. was the only child of warring parents; his very anxious mother was a teacher and she was considerably older than his father, who was an engineer. Mr F. described himself as having been brought up in faceless suburbia where he never had a sense of belonging. His mother was thought by her relatives to have married beneath her into the working class. At school Mr F. always excelled, but made few friends. His activities were solitary and aimed at being at home as little as possible. He had memories of burying his head under the covers at night in an effort to shut out the sound of his parents' incessant quarrelling. He was led to believe that the total responsibility of their staying together lay with him. He was given everything he wanted, as each vied to outdo the other in gaining his love. As a result he saw gifts as a means of self-gratification on the part of the giver and as an insult to himself.

During the first few years of his life, Mr. F.'s father was away in the Forces. He and his mother shared an exclusive relationship, though she admitted to being uneasy and unsure of herself in handling the baby, and always alert to criticism; she confessed to being unable to relax and was awkward and stiff. There were early memories of excited anticipation when his father came home on leave, giving way to disappointment and rage at the intruder who took his place in the bedroom with his mother. This pattern continued throughout his childhood during the summer holidays which he and his mother spent with her family in the country; he experienced his father's two weeks of annual leave in the same way.

Mr F. suffered depression whilst he was an undergraduate, for which he received in-patient treatment. This followed the break-up of a relationship with a girl who could not live up to his projected ideal image. He later graduated and went on to take further professional training.

On completing his post graduate training, Mr F. felt that his ability to form relationships was severely impaired; it hampered him in his work as well as in his private life. He referred himself for psychotherapy, and agreed to come three times a week for at least eighteen months, by which time I had hoped to have engaged him. He always used the couch.

'Narcissistic Relating'

This period lasted for nearly two years. At the initial interview, Mr F. appeared

to be an appealing, attractive, helpless young man who needed mothering. I warmed to him instantly. However, as the weeks went by I increasingly had feelings of irritation and helplessness, and often had difficulty in remembering what had taken place during a session; I would also be assailed by unaccountable feelings of sleepiness. He seemed to have no concept of boundaries, sensing a vague fusion with me. Sometimes he would be very late, whilst at others he would not come at all. He was confused and disorientated when confronted with his behaviour as he did not see us as separate people. In terms of object relations theory, he still experienced life and relationships as a shifting sea of part-objects. He could never remember what had taken place during the previous session; he kept each area of his life isolated from the others. Insofar as I existed at all for him, he saw no existence of mine outside the consulting room or between sessions; I existed only when he was with me; whether he was physically there or not was immaterial to his sense of fusion, so that he could see no point in letting me know if he were to miss a session.

Sessions were characterised by lengthy silences which were in no way uncomfortable for Mr F. as he could not easily differentiate between his inner and outer reality. At times comments from me were felt to be an intrusion.

"My life has no memories", he would complain. "It is a kaleidoscope of shifting images. I want it to be a jigsaw." "I have wasted my life. The only feeling I am aware of is anxiety."

Mr F.'s dreams were all of a catastrophic, annihilating nature; he would spend agonising nights wandering through lifeless concrete jungles, desolated by holocausts.

I soon learnt that any attempt on my part to make transference interpretations was useless. Most of the times I sat listening and the interventions I made were in order to help him recognise the difference between inner and outer reality and to see me as a separate person. My aim was to use Winnicott's technique of providing a containing environment.

Mr F.'s inner chaos was reflected in the way he lived. He repeatedly re-enacted the drama of being the only child holding together warring parents; he could not recognise that the other two had a relationship which did not include him, as triangular relationships were outside his experience. He moved from living with one co-habiting couple to another, sleeping temporarily on the floor and staying there until told to leave. His appealing sadness would touch another couple, and so the pattern continued. He moved two or three times in this way during the first year of treatment.

He had a succession of girlfriends who, like all of his acquaintances, were seen as projected bits of himself, some owned, some denied. He was enveloped in

mild feelings of persecution and unable to recognise the inherent projection.

Transition

The transition phase lasted about eight months. After the summer break, Mr F. announced that he would only be coming twice a week in the future, as he was attending a course on family therapy. It was not until the end of this period that he was able to use any interpretations of this action, when he reverted to coming three times a week.

During this time his attendance at sessions became increasingly irregular. Sometimes I could make meaningful interpretations, sometimes not. He appeared to oscillate around the border of narcissism, and each session I would have to discover where he was by making an interpretation. This would set the scene for the session, dictating whether I could interpret or not.

Often in the transference I was seen as a narcissistic mother, giving to him and demanding from him in order to satisfy my own needs. My sense of outrage at this gave me some indication of the outrage he must be feeling at experiencing his mother/me in this way. Recognition of this would have the effect of dissolving the feeling in me, freeing me to feel some compassion for him and again to be useful as a therapist. However, he continued to be resentful and suspicious, wanting to drift out of therapy not only to avoid the pain of termination, but more pertinently, I thought, to deny to me the possibility of gratification in having completed a reasonable therapeutic piece of work. The denial of his transference to me was evidenced at this time by his succession of girlfriends, each one of whom he suddenly left as soon as he felt himself becoming involved. Breaks were characterised by violent acting out, such as becoming drunk and crashing his car after the final session.

I was feeling increasingly angry and useless as well as never being sure whether or not he was still coming; we seemed to have been stuck for several months with his resistance to acknowledging transference feelings, evidenced by his inability to listen to interpretations, and his acting out behaviour. Eventually I decided to risk losing him altogether by forcefully confronting him and insisting on interpreting. After an absence of two and a half weeks, he returned, coming three times a week again. His attendance was regular and he was punctual thereafter. During the latter part of this period, he had moved into a flat and though it was still a threesome, it was with two girls and on the basis of equal tenancy.

His friends began to assume real personalities and became real people to me when he talked about them. Though he could begin to see me as a separate person, he still could not tolerate the idea that I had a life apart from our sessions, until after I had forced him to face his resistance.

Transference neurosis

Thereafter I was able to work with the analytic model of transference interpretations, relating what was happening between us in the transference to his past, and to his present life outside the consulting room. He had been predominantly concerned with forming and maintaining a permanent heterosexual relationship, thinking and planning for the future and struggling with the change from a two person to a three person relationship, allowing himself some awareness of Oedipal feelings. He discovered that a colleague of his knew me in a different role, and felt "threatened" by the idea that this knowledge must in some way change my relationship with him, but he was equally "threatened" by the idea that the colleague and I had a relationship which did not in any way involve him. Though he could see the links with his own background and the relationships between him and his parents, he still found it painful to look at this in relation to me. Instead he would describe a case from his work in order to tell me what he was feeling towards me. Mr F.'s dreams showed, perhaps, most clearly his growth. No longer calamitous, they became about live situations, telling human stories. His girlfriend was a constant companion and I featured frequently. In one dream he followed a path with us through beautiful country towards spectacular mountains.

Termination

Mr F. had bought his own flat and been living with his girlfriend for a year when simultaneously termination material began to feature in the sessions whilst he was making wedding plans. He was very surprised at this as he had always assumed that external circumstances would cause the therapy to end and that a planned ending would be avoided; the circumstances would be such things as change of job and its location, financial constraints, timetable changes. In this instance it was seen as marriage and the planning of a family which would make therapy unviable for financial reasons. Typical of a borderline personality he had expected to drift out of therapy with no work on termination, seeing himself as a victim of circumstances and avoiding both experiencing the pain of finishing and working on it. This regressive response reminded me of Glover's criteria (1955) for terminal phase, which are:-

a). Regression;

b). Increase in transference - phantasy fixation;

c). Exacerbation of symptom-picture.

He states that evidence for a patient being in the terminal phase is gained from:-

a). Dream reactions;

b). Screen memories;

c). Expansion of infantile sexual theories with a lack of the patient's resistance to this;

d). Psychosexual activity, working capacity and social adaptation.

I find Glover's points to be a useful check list in termination work, though they are not necessarily exhaustive, for example they omit a point usually thought to be vital to have reached by the end of therapy, namely the acceptance and tolerance of ambivalent feelings towards parents and siblings. On the whole Glover's requirements seemed to have been fulfilled.

During the few months preceding his marriage Mr F. constantly reviewed his life and the course of the therapy; he isolated areas still unresolved and made reference to Freud's paper "Analysis Terminable & Interminable" (1937). At the same time he frequently felt himself not to be mature enough to cope with his new responsibilities.

Between the time of his marriage and the birth of his daughter he regressed dramatically; both his wife and I were once again experienced by him as the self-gratifying mother who used him for her own narcissistic purposes. His attitude to the world was omnipotent and paranoid, as once again he saw himself as the passive victim of hostile circumstances. Negativism predominated in the transference, as he dealt with his envy (Klein, 1957) in this way. His tenuous resolution of the Oedipus complex was lost. He anticipated severe jealousy problems on the birth of the child, as he still had not managed to move successfully from a two-person relationship position to the triangular one; in other words, although he had grown a great deal in the therapy, he still had not fully negotiated the Oedipus complex and his tenuous acceptance of triangular relationships was lost.

This became glaringly apparent on one occasion when his wife and her sister were quarrelling; he experienced it as a deliberate attack on him. He certainly felt safer in being persecuted by them both than in acknowledging they had a relationship in which he did not share and that this in no way threatened his relationship with his wife. This seemed to mark the beginning of the final move into resolving his problems of triangular relationships and of sharing. That his wife and sister could have a row which did not involve him, he found both novel and exciting. This aspect of our work continued after the birth of his daughter until the end of the therapy. He found it infinitely easier to work with his feelings towards his wife and daughter than with his transference feelings in the therapy. He would feel distressed at his lack of growth when he caught himself thinking, "do my wife and baby love each other more than me?": "does my wife love me more than the baby or vice versa?", "does the baby love her mother more than me or vice versa?". Towards the end he was spontaneously relating his feelings and relationships in his present family to that of his family of origin, but only with difficulty could he acknowledge them in transference. This remained a problem area until the end. In the final session he admitted to a real sense of sadness after the excitement of anticipating a planned end; he was able to show me photographs of his

family and to admit to being curious about my feelings on ending; this was one of the few times he acknowledged me as a real person. He showed warmth as he noted with pleasure the change in the last six years, saying "I feel calm and optimistic in a chaotic world: maybe that's a good place for us to end."

There remains the question of why Mr F. continued in therapy whereas many borderline patients find it intolerable and drift away. There were certainly many times when I thought that this might happen or even had happened with him during the first three years when he was going through amazing subterfuges in order to avoid even the hint of pain, yet being in a constant state of pain throughout.

Obviously there must be a complex set of interrelated reasons, and one can only speculate on what they were and the importance if any. However I did wonder if one factor might have been influential in holding him. This was my stipulation in the original contract that he came for a minimum of eighteen months, three times a week, in order for him to gain anything from psychotherapy. I took this risk in the knowledge that such a stipulation at the beginning might indeed frighten him away altogether. It could also be argued that a patient who would be frightened away by this might also be one who gradually could be less frightened and feel increasingly safe as the facilitating environment aspect of the therapy developed. However during the first assessment session intuitively I felt we had achieved enough rapport for me to be able to take the risk. My main reason for doing this was the hope that by the end of eighteen months, if he had managed to stay, we might be in a position to move from a containing relationship into more orthodox analytic therapy. This action on my part did appear immediately to relieve him of the decision whether or not to start therapy and at various times, whether or not to continue. He was also able to refer to it when his inability to make any commitment in life came up, as it frequently did: he had indeed felt I had given him something by believing he could make a commitment, though at the same time of course, I was the narcissistic mother giving him gifts in order to gratify herself.

Even on the many occasions when he did not come, or when he came very late, this was not to do with questioning whether or not to continue therapy; his infantile feeling of fusion with me rendered that question irrelevant: it did not matter to him whether we were physically together or not, as the therapeutic relationship was all-pervasive. The question of whether or not to continue, therefore, did not become confused with whether or not he actually attended sessions regularly. I would suggest, tentatively, that it may have been part of the process of providing a containing environment, to make this kind of contract, thus relieving a patient in an infantile paranoid-schizoid position of repeatedly making decisions as to whether to continue, even though he would experience such decisions as dictated by external circumstances.

Mr F. was able to use therapy to grow from a very infantile position where he could only relate in a fragmentary way to part-objects, to a position where he could tolerate three person triangular relationships; he still has much work to do in this area, and at the time of leaving was still censoring feelings and phantasies relating to me. He also maintained an "ironed-out" affect in the sessions almost consistently to the end, broken only by events such as the birth of his daughter, which triggered off uncontainable excitement and pride.

I received a long letter, full of news at Christmas; it displayed far more warmth, joy in life and excitement than he ever dared show in the therapy.

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OBITUARY: PAULA HEIMANN (1899-1982)

Margret Tonnesmann

Paula Heimann, M.D.,F.R.C.Psych., internationally known as a training analyst and teacher of the British Psycho-Analytical Society for over 30 years, died in October, 1982, after she had broken her hip during a holiday in Baden-Baden.

She grew up in Germany and qualified there as a psychiatrist and psycho-analyst shortly before she came to London in 1934 by invitation of Ernest Jones. He had obtained work permits for some young German analysts in need after Hitler had come to power.

Paula Heimann soon became known as a younger and close colleague of Melanie Klein and their close relationship lasted for over 15 years. When Melanie Klein strongly disapproved of Paula Heimann's pioneering paper on "On Countertransference" (1950) their collaboration diminished and Paula Heimann finally left the Group of Kleinian analysts and joined the Independent Group of Psycho-Analysts in 1956. Her many contributions to psycho-analysis cover papers on Transference, Countertransference, Sublimation, Healthy Narcissism and also deal with problems of Psychoanalytic Training and the Analyst's Working Tasks. They are all clinical papers orientated towards integrating concepts of the Ego and the Self with early Object-Relations Theories to which she remained committed.

Paula Heimann often stated that during a preliminary interview with a patient she would want foremost to find an answer to two questions: 'Can this patient be helped by psycho-analysis?' and 'Can *I* help this patient?' She was always very open to psychotherapy as an alternative treatment for certain patients and she supported the Freudian Training Course of the British Association of Psychotherapists for many years. She was totally committed to the psycho-analytic approach and conceived of "Understanding the patients' unconscious communications through their transference manifestations" as *the* basic tool on which all forms of psychotherapy must ultimately rest.

Paula Heimann's warmth, generosity and humour were enjoyed by many friends, colleagues and students. As a teacher she could be impatient at times but she always had an open heart for people's human frailties and an open mind for her colleagues' and students' creative pursuits into new territories. It was people's narrow-mindedness which could arouse her intense anger. Her manifold interests covered a wide field and she enjoyed life and living most of the time. Those who knew her well enough will remember her colourful personality with affection.

BOOK REVIEWS

PSYCHOGENESIS - THE EARLY DEVELOPMENT OF GENDER IDENTITY

By Elizabeth R. Moberly.
London: Routledge & Kegan Paul. 1983. Pp. x. 111. £8.95.

The author, a research psychologist in Cambridge, has written an ambitious little book. It is, however, a seminal work on the psycho-dynamics of early gender identification, and although clearly written by an academic rather than a clinician, the conclusions will surely be welcomed by educators, therapists and homosexuals alike.

I must admit, as a Freudian psychotherapist myself, this book has totally altered my perspective and jolted many of my own cosy, basic assumptions concerning the development of gender identity. Although repetitive, Elizabeth Moberly has succeeded in making her points most cogently, and her thesis, put briefly, is this. Both transsexualism and homosexuality are seen as originating in unresolved childhood trauma. However, the most important relationship in the early development of gender identity is the same-sex relationship of a child with his parent. For example, for a small boy it is remoteness, absence or loss of his relationship with father, or any major disruption of it, which may lead to compensatory longings for a relationship with a member of the same sex in later life. In the same way, for a little girl, it is not first and foremost father's approval and response to her femininity which determines the development of her gender identity, but rather having mother continuously, safely and attentively *there* to meet her emotional needs as they arise.

Dr. Moberly also describes very accurately the limits of a homosexual relationship. These limits are due to the inherent, unconscious ambivalence felt to the originally frustrating love-object; so that homosexual liaisons which start with such anticipation and hope, so often end in such rancour, bitterness and disillusionment. She also explains most convincingly how the widespread caricature of the homosexual depicted as over-attached to his mother, is merely a symptom of an unsatisfactory and lacking relationship with father. So that, although it is true that there is over-cathexis on mother, this is because she becomes the only channel left available to a small boy who has no father available to him, for whatever reason. Thus, the crucial factor is not the intensity of this relationship to mother, but the original lack of father which caused the boy to over-invest in mother.

Because of this stress on the importance of same-sex attachments, Dr. Moberly points out that the accepted Freudian view that gender identity is harder for a girl, (who has to change her primary love-object from mother, to father, than for a boy, who maintains his focus on mother and-does not have to make this

complex switch), is quite erroneous. Indeed, she maintains the reverse is true. It is the little boy who has to alter his primary object of love and identification from mother to father and it is the girl who has the easier course, maintaining her primary attachment and gender identification with mother, providing the relationship is not seriously jeopardized in any way.

Dr. Moberly creatively recognises the reparation and growth inherent in homosexual relationships, although she realistically observes how the positive aspects are all too often marred by unconscious but powerful aggressive wishes: the negative side of the ambivalence to the originally disappointing love-object.

In one chapter, Dr. Moberly tries to combine learning theory with psychodynamic insights and stresses that in practical terms it is unhelpful for therapists to try and distract a homosexual patient from interest in a same-sex love object, but that they should work with and through this developmental need. In essence, she states, we all have homo-emotional needs and same-sex love is a healthy attempt to search for a relationship which has not reached satisfactory completion in childhood. She asserts that true heterosexuality is only achieved if one's homosexual needs have been adequately met.

This is really a most exciting book and despite the lack of clinical vignettes to enliven the argument, the theory rings true and speaks assuredly for itself.

Judy Cooper

NARCISSUS AND OEDIPUS - THE CHILDREN OF PSYCHOANALYSIS

By Victoria Hamilton.
Routledge & Kegan Paul. 1982. p 284 with index

This is basically a book about child development, exploring theories about how the child approaches knowledge, relationships and the outside world. It compares the approach which says that the child's basic wish is to retreat and avoid reality, with that which says that he is by nature curious, and, given a good beginning and a facilitating environment, he seeks out knowledge and wants to explore. The author supports the latter view, and draws the further conclusion that the approach the therapist chooses influences his attitude to the patient's use of the analytic setting. She argues that the patient basically wants to learn and grow, and make the transition from the transference relationship to knowing about the analyst as a real person, eventually leaving him behind much as one would leave behind a transitional object.

She sets about arguing her case within the framework of two myths, about Narcissus and Oedipus, with an important linking section called Transition. The section on narcissism is by far the longer part of the book. She begins it by looking at the myth again, drawing out a theme of pathological relationships. Firstly, there is Narcissus' relationship with his mother, with the tragic consequence that he cannot relate to anyone but his own image. Then she describes Echo's hopeless attempts to relate to him, a painfully fused two person relationship in which differentiation leads to death. She goes on to look at theoretical views of narcissism in considerable detail in the light of the myth. She draws a continuum along a line from Freud's original theory of primary narcissism, and later theories which relate to it, on to the theory of Klein and her followers, then on to later contributions, including attachment theory and object relations theory. At one end of the continuum the child is assumed to be passive or negative in its contribution, at the other active and positive. Her central theme in this section is that Freud took no account of the child's own contribution to the relationship with the mother, Klein stressed the negative contribution, but that the child in fact brings something active and positive. Here she supports the object relations theory of the two sidedness of the mother child relationship. She also gives a great deal of interesting scientific research material to support this view.

In the section called Transition, she discusses the child's development following the stage of primary fusion with the mother, when the task of development is self differentiation. She approaches this topic firstly from the point of view of attachment theory, and with central reference to Winnicott's thinking about the development and use of transitional phenomena as a third area of space for reaching outwards in the mother's presence. She sets this against the classical Freudian account of the same phase, with the development of the superego or watching agency. Here she argues the importance of recognising that the developments which Freud saw as taking place at this stage take place within the context of developing relationships with others.

The second part, entitled Oedipus, again begins with a re-examination of the myth. She lays her emphasis, not on the reading used by Freud, but on another, which sees primarily the search of a courageous man for knowledge about his identity, amidst a mass of lies. She argues that this is again a pathological situation, the position of an adopted child. She then goes on to see the theme of the Oedipal stage as the search for knowledge. The question she then asks is whether in normal development the quest for knowledge is carried out within a negative philosophical framework, accompanied by fear, or whether the resolution of the Oedipal stage, as she believes, goes alongside a natural curiosity, and a positive seeking out of knowledge. Considering the negative approach, she outlines Bion's theory of the development of thought, and Freud's account of the castration complex. She sets against this a more positive view, with the continuation of exploration and learning within transitional space, actively encouraged by the mother.

It is a dense and ambitious book, to which the author brings the breadth of her own background, including literature, philosophy, a training in child psychotherapy at the Tavistock Clinic, and her therapeutic work with children and adults. It is a difficult book, which tries to encompass far too much, but it provides stimulating and interesting reading, with a persuasive central theme. I think the first part of the book on narcissism works best, giving a very useful summary of the development of thinking in this field since Freud wrote. There is a richness of material throughout, ranging from scientific research and observational studies, to philosophy, myths, and her own interesting clinical material. However, my own initial reaction was of confusion in the face of so much detail, and so many aspects at each stage of the argument. My feeling in writing about it is that inevitably one does it an injustice to be concise, whereas to write about it in all its detail would be far too long. It is certainly a thought provoking book which I was pleased to have read.

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