european federation EFPP
for psychoanalytic psychotherapy

EFPP Psychoanalytic Psychotherapy Review

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On the function of bulimia for female adolescents

09/2015

Abstract

In my article I would like to show how, against a background of developmental tasks and crisis situations specific to adolescents, female adolescents are attempting to resolve identification and separation processes temporarily through bulimic behaviour. For a girl, the adolescent developmental process is marked by contradictory elements. On the one hand, a growing differentiation and separation from the mother is necessary, yet on the other hand she is dealing with consolidating her identifications as a female with her mother. This leads to continuous alternation between rebellion and acceptance, rejection and internalisation. The gender-typical physical changes challenge teenage girls with their possibilities and limitations. The developing body, particularly the breasts, points to a similarity to the mother and triggers the anxiety of identity diffusion. Within the framework of adolescent development, the body becomes a venue for conflicts; at the same time, bulimic symptomatology can take over important functions for female adolescents and help them to regulate, affect and stabilise their sense of self.

Introduction

There are extensive studies and publications on adolescent developmental issues. In the following article I will highlight those issues that, on the one hand, characterise female adolescence and, on the other, relate to developmental tasks that could have a link to bulimic symptomatology. Eating disorders occur temporarily in 40–60% of all young girls in industrialised countries. In about 5% of young girls, this results in a long-lasting bulimic illness (Herpertz 2001). Bulimia is thus a widespread symptomatology, which often forms during mid- and late-adolescence (i.a. Williams et al. 2006).

Adolescence is marked by transformations at the physical, psychological and interactional levels; (practically) nothing remains as it was. During this time, adolescents must cope with a number of central developmental tasks, namely, an alteration in the relationship with parents, a change in the relationship with peers, and a change in attitude to the adolescent's own body. At times, the psychological understanding of self and the physical are clearly driven apart during this period (King 2002). The relationship to the adolescent's own body has to be changed (Laufer 2003). Female adolescents experience their bodies as a disturbing element and its physiological processes as unsettling, as a foreign thing. The body's gender-specific changes activate early, archaic partial images of the mother for girls. For this reason, many of them, at least temporarily, are concerned about staying thin: that is to say, boyish. Behind this are fears of identity diffusion as the developing body, primarily the breasts, show the similarity to the mother. This increasing similarity to the mother's body during puberty gives rise to feelings of helplessness and anger because the physical changes cannot be influenced. These then become a symbol of other non-controllable processes. The body becomes an annoying "bad" object (Streeck-Fischer 1997). Within the framework of their adolescent developmental tasks, female adolescents seek alternative female models that help to bridge the fundamental gap in the relationship between their self and their body. For the girl, the adolescent developmental process is always marked by contradictory elements; on the one hand, a growing differentiation and separation from the mother is necessary, yet on the other she is working on consolidating her identifications as a woman with her mother. This leads to a constant alternation between rebellion and acceptance, between rejection and internalisation (Bürgin 2002).

Over time, different psychoanalytic approaches concerning eating disorders have developed. Two main psychoanalytic strands in working with eating disorders can be described: the conflictual model (Wilson et al. 1985) and the self psychology model (Goodsitt 1983). For the former group a symptom "is viewed as the end product of a complex developmental series of childhood wishes and fantasies, and defensive transfigurations and revision" (Schwartz 1988). The instincts, particularly the sex drive lies at the centre of this model. According to the ego psychology, a symptom represents a repressed wish and denial of that wish. For self psychology, eating disorders are understood as a way to supply missing self-object functions (Brenner 1983).

This paper takes an object relations approach as understood by the Kleinian school, where the symptom is seen as occurring within, and emerging as, part of a phantasy of an internal object relationship. Accordingly, a symptom is understood as being an expression of an object relationship, rather than being set off by sexual or aggressive drives, although aggression and sexuality are important. This way of understanding bulimic

symptoms anchors them in the primitive internal world of relations.

Functions of bulimic symptomatology in adolescence

There are forms of bodily use that accommodate adolescent processes. Clinical experience shows that, within the framework of adolescent development, the female body is still often the venue for early childhood conflicts (Krueger 1988). Girls try to compensate highly ambivalent relationships with their mothers and a lack of triangulation processes (Grieser 2008a) with the aid of eating disorders, by which they attempt to avoid these or give them a new setting, namely that of the body. In the long term, this instrumentalisation of the body leads to harm (du Bois and Resch 2005). Bulimic symptoms (just like anorexia or even drug addiction) may form a bulwark for all intents and purposes against further adolescent processing of early childhood issues (Diez Grieser 2004) and lead to pathological development, which may continue far beyond adolescence.

One of the main difficulties that adolescents have to deal with is that they are torn between the wish for fusion and the need for individuation. An ambivalence between a desperate search for, and an equally desperate fear of, closeness influences many relationships during this phase. Bulimic behaviour, just like substance-related use of drugs (e.g. smoking dope), may enable the feeling of having a positively influenced relationship to an object without having to feel dependent (Diez Grieser 2004). In bulimic symptomatology, the figure of the mother, who is at the same time both longed for and rejected, is replaced by the longed for and at the same time rejected food. The female adolescent experiences a fast rate of change in moods and needs as part of the symptomatology. This change takes place in every girl's relationships (du Bois and Resch 2005). Ettl (2001) describes bulimia as the avoidance of a highly ambivalent object relationship. In this way, the eating behaviour corresponds to the relationship behaviour: in the object relationship eating equates to clinging; vomiting symbolises through the body separation and autonomy.

The onslaught of drives in adolescence severely tests the self-regulatory competence of girls. Winnicott (1956) stressed that in this phase of life fantasies and tendencies appear which are particularly intense and destructive and which adolescents have to cope with and integrate bit by bit. Many adolescents experience such emotional turmoil as traumatic and feel overwhelmed by it. Bulimic symptomatology can help to regulate affect in this regard as it makes it possible to deny feelings that otherwise threaten to overwhelm the ego. The extremely tense adolescent ideal self with high expectations concerning control is faced with an enormous pressure from drives. Adolescents have to learn to regulate their strong sexual and aggressive drives. The bulimic symptomatology always represents an uncontrollable urge; it takes on the quality of a masked outburst of anger and thus from time to time it can make a significant contribution to stabilising the self (Ettl 2001). Moreover, bulimic symptomatology also includes the anger of the adolescent arising out of disappointment with parents, and thus replaces the temper tantrums of childhood. The aggression associated with bulimic symptomatology helps young people in the separation from their parents because at this point they experience food as an object (see below) and can ward off the fear of a loss of love.

A further core developmental task of adolescents, namely that of finally taking possession of their own body, is made more difficult against the background of the adolescent feeling that the body is unpredictable and "bad". Bulimic symptomatology can give adolescents the feeling of being existent and of controlling their bodies with the eating-purging ritual. Bulimic female adolescents describe that when they eat, they feel closely connected to their mother: nevertheless, afterwards they have to vomit without fail in order to separate again. From this ritual, a feeling of autonomy is gained, which can temporarily assist in further development.

The female adolescent's ideal self often holds the firmly established idea of not wanting to become like her mother. The growing physical similarity during pubertal maturation makes it necessary to transform the ideal self so that inner conflicts do not cause excessive tension. In the eating-purging bout, the girl can temporarily defuse the inner conflicts and feel safe and relaxed.

If we assume that bulimic symptomatology primarily represents an attempt to regulate object relationships, then the question of what the nature of the relationship is to the object becomes especially interesting and important. In the following section I would like to take a closer look at two possibilities: food as an object and food as a transitional object.

Food as an object

A positively influenced intensive relationship is built up with an object (food) to evade a feeling of dependency in interpersonal relationships. Clinical work with bulimic adolescents shows that, through bulimic behaviour, various levels of personality (id, ego, superego/ ideal self) and various psychosexual stages of development can be appealed to and activated (i.a. Ettl 2001). Speaking in terms of drive psychology, treating food as an object can be loaded projectively with oral, anal or phallic-genital content. Food as an object has dichotomous object valences. This calls to mind the concept of the good and the bad breast or mother posited by Melanie Klein (1983). Food acts initially as a substitute for the good object that could not be sufficiently internalised by the patient. For this reason, an attempt is made to internalise a stabilising object by executing the action with a substitute object. These substitute objects help to form a triangular mental structure, as the substitute slips in between the subject and the object as a third element. One can also speak of triangulating objects in this respect. Due to their real existence and sensory materiality, they make it possible to partially satisfy needs (attachment, reassurance, safety) and, because of their otherness, they enable non-identity with the object (mother, father), alienation and thus independence towards the object (Burian 2003). In successful mental development, these substitute objects are simply of a temporary nature: should they be retained, this points to a blocking of the developmental process. Experience of triadic relationships with real or intrapsychic objects (e.g. with the father or the psychotherapist) making it possible to regulate closeness and distance to the object (Grieser 2008b) is an important pre-condition for the development of adolescents, and supports the rejection of bulimic symptomatology.

Food as a transitional object

Food can also take on the character of a transitional object. The transitional object has the function of conveying at least part of the perceptions to the child that are actually associated to needs that are currently not being satisfied. In this way, the transitional object represents continuity of perception, which makes it possible for the child to deal with arousal and not be overwhelmed by it (Winnicott 1956). The transitional object thus represents a bridge between the mental frame of reference and an external reality that no longer corresponds to this. The lack of symbolic capacities in bulimic adolescents due to bad internal representations of the mother (Krueger 1988, Williams 1997) leads to the use of food as a transitional object, which can link the inner and outer worlds. In this area of transitional space and objects described by Winnicott as being "between the thumb and the teddy bear, between oral eroticism and true object relationship" (Winnicott 1953, p.89), the bulimic adolescent is able to use food to separate herself from the mother. Food as a transitional object represents something: that is to say, it is a part-symbol that stands for another object and at the same time requires its own specific presence in order to fulfil its function (i.a. Hirsch 2000). Krueger states that "these individuals because of their concrete, non-symbolic mode of operation, are not able to move to an external non-bodily transitional object. They seem instead to struggle to create a transitional object which is external, concrete and specific. The effectiveness of the object is fleeting, however, and can remain no more fixed in emotional consciousness than the defective internal images of body, self or other" (1988, pp. 61–62).

Bulimic adolescents in psychotherapy

Adolescents have to deal with developmental tasks that are diverse and complex. At the same time, critical situations and phase-specific crises that revolve around the core issues of separation from parents arise time and again, taking possession of their own body and their relationship to their peers. Many adolescents develop noticeable styles of behaviour that are only temporary and report on seemingly pathological thoughts and feelings. For most adolescents, however, these are phenomena that are specific to a phase and disappear into the background again as the accompanying issues are

worked through over the course of adolescence. Nevertheless, some adolescents develop psychic disturbances which continue into adulthood.

The vitality and enormous strengths of adolescence make psychoanalytical work with adolescents an exciting undertaking, as it repeatedly presents the psychotherapist with new challenges. If we manage to develop a dialogue with them, we discover that our adolescent patients quickly grasp an understanding of psychodynamic interdependencies and the use of interpretations that relate to their symptomatology, and that they are able to implement the knowledge they gain from the psychotherapy sessions very well. Moreover, adolescents usually find it easy to cast their psychotherapist as the good object and to "use" her for their further development.

Blos (1979) describes adolescence as the second individuation process, which is marked by the high vulnerability of personality organisation. Difficulties and crises, which lead to adolescents demanding therapeutic assistance, are related to unresolved dependencies and infantile attachments. As a consequence of the specific character of adolescence, the classic therapy technique has to be adapted. Golombek and Garfinkel (1983) stress the necessity of therapists having to remain consistent towards adolescents, as well as having to identify realities and to establish limits. Moreover, a willingness to share some of the thoughts, ideas and standards of the adolescents is important, as in this way it is acknowledging their need for identification.

Frequently, adolescents do not want to address the issue of their feelings with the therapist. At times the psychotherapist is experienced as a dangerous object that wants to gain access to the adolescent's inner life (Müller-Pozzi 1980). Therefore in psychotherapy with adolescents it is a matter of functioning as a good object and offering conditions that allow an inter-subjective space to develop, creating a venue for their difficult, unmentionable experiences in order to cope with them. Bion (1962) referred to the relieving function of containment, the emotional containing of archaic feelings that is carried out by the person on whom these feelings are projected. In psychotherapeutic work with adolescents, containment plays an important role.

In the section that follows I would like to illustrate these observations by presenting four casuistic examples.

The two drawings were created in collaboration with Claudia Ginocchio, Zurich.

Case study 1 – Food in bulimic symptomatology as a transitional object within the framework of separation

Tina was 17 years old when I first met her. Her mother is Spanish, her father Swiss. She grew up in Spain. She started psychotherapy on the advice of her mother due to her bulimia symptoms. Tina reported that these started shortly after she moved to be with her father – her parents separated when she was three years old. Tina described a very close relationship with her mother without any limitations and a strong lack of trust in her father who had left her mother. As early as the first sessions, we interpreted the bulimic symptomatology as an attempt to establish closeness to her mother and at the same time to prove to herself and others that she could be without her mother. Tina expressed the fact that the bulimic symptomatology would probably improve if she were to return to her mother in Spain but that she definitely did not want to do that, she had to make it "alone". In this session, we spoke of her excessive demands of wanting to complete her various developmental stages without any dependence whatsoever. The bulimia gave Tina the feeling at times of being able to meet her own emotional needs: she impressively described how the draw of bulimia increases daily and she loses herself more and more frequently in her bingeing/vomiting attacks. As a first step, recognition of her desire for security and closeness led to Tina addressing her desires for a relationship with her father. This was asking too

much of the latter and it became clear to Tina that she would like to find a different lifestyle and living arrangements. As she finally moved into shared accommodation, she found a piece of "mother country" again in the warm contact with her flatmates, which had a positive effect on her psychological well-being. The intensive use of psychotherapeutic space to understand and regulate her emotions, working on the early ideal self as well as an increasing separation from her parents, led to her abandoning the bulimic symptomatology within a year and, through career decisions, to a further definition of her own identity.

Case study 2 – Bulimic symptomatology as an uncontrollable drive, as a masked outburst of anger

This 15-year-old girl was sent for psychotherapy by her general practitioner due to her bulimic eating disorder. In our first talk, Maria described a difficult family situation with an alcoholic father and a mother who withdrew from any type of communication. This related above all to difficult, emotionally-charged issues. Maria was full of anger, towards her mother in particular, but as the adapted older daughter she had not found a means of expressing it. For her mother's sake she wanted and had to be the sensible, steadfast daughter: she was afraid of her father, which is why she avoided any arguments with him. Given this back--ground, she started to "binge" until her stomach nearly burst. By vomiting she managed in some way to satisfy this drive. Her aggressive feelings became less intense through this and so she managed to continue to "play" her role in the family. Maria worded her experience thus: "I put all my anger against my family into bingeing." In therapy, we worked extensively on this function of the symptomatology and we sought solutions to her difficult family situation. The young girl came for psychotherapy treatment for a year. The experience of an understanding object during this period as well as guidance with respect to specific handling of her negative emotions enabled her to better regulate her aggressive feelings. During family therapy, which took place in parallel with the individual therapy, the parents of the young girl managed to achieve a joint effort for their daughter and were able to relieve the girl in part from her "parentification" (Boszormenyi-Nagy and Spark 1981).

Case study 3 – Bulimic symptomatology as an attempt to differentiate from the mother: The bad object or how not to be like the mother

"I feel as repulsive as a hippopotamus lying in mud. I have let myself go, just like my mother always did. It is a terrifying thought that I could be like her …"

The 16-year-old was referred by her general practitioner for her pronounced bulimia symptoms. I met a shy, pleasant girl, who appeared to have no connection to her emotional life. In the initial sessions I experienced mainly pleasantries and her descriptions gave me the image of a perfect world. I was repeatedly forced to ask her about the "hateful reality" (problems of standard of schoolwork, a lack of relationships with peers, huge conflicts with her mother) and about her symptoms of bulimia. When doing so, Helene gave me the feeling of being intrusive and of stalking her. In my counter-transference I further experienced a nearly unbearable feeling of emptiness that I actively filled with questions. Over the course of the first year of therapy Helene gradually found a language for her diffuse feelings and her physical sensations.

In the 35th therapy session, we manage to speak about the connection between her bulimic symptomatology and her identifications or counter-identifications with her mother:

The patient is slightly late today, she looks bloated. She glances at me searchingly and asks how I am. In response to my enquiry she states that sometimes she thinks about how I'm able to do it when I have to listen to the problems of other people the whole day long. I say that she probably asks herself how I cope with it

all, how I "digest" it to a certain extent. She nods and states that all these stories must somehow stay with me, I must have to take them home with me. I say that she is having a lot of thoughts because of me today and ask whether there is a particular reason for this. She denies this and says that she simply feels guilty when she thinks that she too is bothering me with her "little problem". I am surprised at this description of her state of mind and tell her so. Over the rest of the conversation, Helene puts into words that her own thoughts and feelings are worthless and not worth talking about, and that she is surprised that I am always interested and listen attentively although she reports the same thing every time. In response to my comment that she is unable to imagine that what is inside her could be good, she is quiet for a long time (at that moment I feel uncertain and question whether this interpretation is inappropriate, am afraid of having asked "too much" of her). Then she tells me that it was particularly bad at the weekend with her eating and her body, she felt especially fat and ugly. When she looks at herself in the mirror, she sees a revolting, bloated person that she wants nothing to do with. It is so difficult having this feeling. She only feels better once everything is out, when she feels that her stomach really is empty.
I make a reference here to my earlier interpretation that everything that is inside is bad and therefore has to be put out, in particular if through this she is anywhere near her mother whom she describes as "fat" and repulsive and who is constantly talking. Helene agrees and adds that her mother is also someone who is completely unable to control her feelings. She then depicts several situations and describes how she was constantly ashamed for her mother before. Exactly how she must be ashamed of herself now for her bulimic behaviour, I say. That is crazy, Helene says, she has never looked at it like that before: the more she has tried to be different than her mother, the more like her she is somehow.

Case study 4 – Bulimic symptomatology on taking possession of the body

The 15-year-old girl appeared distinctly autonomous and independent. She was brought in by her parents for assessment due to problems with the standard of her schoolwork. In our sessions it quickly became obvious that she was primarily worried about her bulimia, for she had read in the media that you can even die from it. She described herself as someone who is fairly unsusceptible and who does not "whinge" but can take it. In the first phase of psychotherapy we dealt intensively with various conflicts with friends and colleagues. On the one hand, Melanie took validation of her perception from me, yet on the other she could accept criticism from me regarding her part in the conflicts. She identified with me as the good mother object that did not rival her (unlike her real mother whom I met at the start of the psychotherapy treatment during a family talk), but who reflected her and accompanied her sympathetically in her final taking possession of her body. Melanie, who is an extremely pretty girl, experienced her adolescent body as a foreign object, as a "bad, uncontrollable object" (Streeck-Fischer 1997). Over the course of the psychotherapy, we managed gradually to understand that firstly through the symptomatology she can be reassured of her own body and experience the (apparent) control of her body or food positively. This feeling stabilised her identity and strengthened her feeling of being autonomous. In the second year of treatment (the bulimic symptomatology has not existed for several months now) Melanie reported vague physical fears. She experienced these as a flood, as "something that comes from outside and inundates me, that I can do nothing against, which simply washes over me and gives me a feeling of helplessness." This loss of control was a traumatic experience for Melanie, and at times she reverted to her bulimic symptomatology. Following this, in psychotherapy the girl dealt intensively with the demands of school and her future goals. As she has since become very successful with regards to her achievements, she has found her self-esteem to have been strengthened in this area, which has had a positive influence on her adolescent development.

Concluding remarks

Bulimic symptomatology can take on important functions for female adolescents and help them to regulate affect and to stabilise their self-image. The apparent control of the body or food in bulimia temporarily supports the adolescent development of identity. Bulimia can be seen as an attempt to control the fusion and separation fears that re-occur in adolescence. In order to fulfil the developmental tasks of differentiation and separation from the preoedipal mother, female adolescents with bulimic symptomatology use food as an object. They give in to the regressive draw not

to their mother but to food. This occurs to a certain extent under their own control and helps to give them a temporary feeling of autonomy. In this respect, bulimia has a regression-controlling function. For the development of girls, who temporarily develop bulimic symptomatology during adolescence, the core question is whether they subsequently find other forms of coping with the various developmental tasks and the associated affect requirements in a manner suitable for the ego, or whether they have to continue resorting to other forms of acting out (eating, indiscriminate sexuality, addictive substances). At this point, the psychotherapeutic treatment of adolescents may help to prevent more severe psychopathological developments.

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