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A retrospective account of a former bulimic patient

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Summary

Retrospective interviewing of a former patient by a group of researchers´ could serve as an addendum to the usual psychometric techniques of follow-up research. This article presents a former patient´s retroreport on her negative life and treatment experiences that ultimately were dissolved by a middle range psychoanalytic treatment. The open, extended interview was conducted by a female research psychologist (RH) and two female psychology students.
The narratives about her various treatments convey the impressions that she responded negatively to pronounced, demanding therapeutic attitudes which did not allow her to create her subjective space for correcting developmental fixations. When she experienced a positive therapeutic experience by being offered a patient-oriented psychoanalytic technique she could overcome her deep-seated mistrust and her problems with eating.
This report highlights the potential to learn from our patients´ negative and positive experiences.

Introduction

What if we had as a regular procedure whereby therapists ask their patients to come for follow-up interviews not with him or her, but with a third party? Would the therapist's reputation be at stake or can the credibility of a patient serve as basis for critical discussions? Publications of such reports are rare even among research minded clinicians (Strupp et al., 1969; Strupp 1978; Kächele et al., 1985; Kächele 1981). However, for enthusiastic therapists that are enthusiastic researchers as well, such a procedure could constitute a context of

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discovery that would sharpen the clinical perspective. Instrumentation in psychotherapy research needs reliable and valid psychometric instruments and audio-taped sessions or video-recordings. In our view it may also need the formalized use of a clinically trained perspective. Helen Sargent (1961) pointed this out years ago when she decisively modelled the methodology of the Menninger Psychotherapy Project. Research interviewing, free interviewing by researchers recorded and evaluated by a group could serve as an intermediary between clinicians and the structured techniques of the researchers. This technique has some similarity with the so called Pfeffer-interview - a method introduced by the psychoanalyst Pfeffer in 1959 in order to provide a true psychoanalytic procedure for evaluating the results of psychoanalysis. Pfeffer (1961) gave such a report as a follow-up study of a satisfactory psychoanalysis. The basic idea consists of providing a therapy analogue situation to adequately evaluate the experiences and effects of psychotherapy.

What follows is a report on a special situation, allowing a former patient to retroreport on her life and treatment experiences. The open, extended interview was conducted by a female psychologist with research experience and beginning psychoanalytic training (RH); present during this three hour session were two female psychology students who also were involved in the evaluation of the patient´s report[3]. Before the interview the therapist (HK) only provided basic information on the patient to the research team; after the interview besides his general involvement he made some comments4.

The patient[5]

Two years after her twice a week face-to-face psychoanalytic treatment had been terminated Ms Rosa X2, a 25 year old student of medicine, had been asked by her former therapist (HK) if she were available for a retrospective interview procedure with a research group. She agreed to come to the Centre for Psychotherapy Research in Stuttgart having been treated at

3Whenever the personal pronoun "we" is used it refers to the three members of the research team.
4 All the footnoted commentaries are provided by the treating therapist (HK)
5 Rosa X - the subject of the study - has been informed that this interview has been performed for research purposes. She also gave consent to publish the material.

the Department of Psychotherapy in Ulm. She had no objections to the recording of the interviewing nor to the presence of two students of psychology.

At the time of the first follow-up she is deeply immersed in preparing for her second state examination. She is married to a man of the same age and same social status. He is preparing for his finals in natural science. They share a small flat where they live and work. In her spare time she likes to play the flute, participate in an orchestra, or go to the opera. At the moment these diversions are seldomly enjoyed, this being a strenuous situation. She does not report any symptomatic relapses of her former illness. When she referred to her former disorder, we were struck by her good humour, her vividness and vitality in this particular interview situation. She was open minded, obviously enjoying the session with the female interviewers. We felt free to ask her whatever we wanted to know; she displayed her rich repertoire of non-verbal atonement to those who do not know what it is like to suffer from bulimia nervosa: "Yes, I suffered from severe bulimia and I have gone through quite a few therapies. You want to know more about my life, is this correct, this is what Dr. K. asked me to do. Well, I have reason enough to do him a favour because he really helped me after all".

We sat down and had some coffee. Mrs Rosa X in her light-hearted manner told her story of her life. It would have been exciting to spread out the raw material, the recordings of the the magnitude of words as they poured from her, the moments she made us laugh or the times we could empathize with her, the nightmares she had suffered. Instead of allowing ourselves this poetic deviation we reinstated our scientific demeanour and constructed a sober account of what we had learned from Rosa. The therapist's expert knowledge was banned from this reconstructive account of our intentiously female research group to reappear in some footnotes. We were interested in her view of herself, of herself as a victim and agent of her own development.

Development

Born the fourth child of an upwardly mobile middle class family, she views her parents as being caught in a typical middle class family constellation**.** Her mother gave up her job as a typist in order to become a caretaker and raise the children; the two girls of the family were especially controlled by the mother (i.e. opening their private letters) whereas the two brother somewhat had found ways to better escape the controlling environment. The father had successfully mastered a high school education which was interrupted by the war. He had a hard and slow start in academia, and had to earn his living with no background to support him while studying. This thoroughly influenced his career as "teacher of teachers" - a special post-graduate teaching assignment at the ministry of education of the state. He had strong opinions on how a child should be raised and used to say that one had to be at least once in England, play two instruments, and obtain an academic education. Very soon the child Rosa deeply identified with these life perspectives. When she was six years old, she knew what subject to study, practised two instruments and enjoyed singing alto with a very good voice. But her father seldom expressed gratitude to his devoted daughter. He often yelled that one of his kids was bound to fail. Basically Rosa felt observed, controlled by both her parents, differently except in intensity. Whenever she engaged in something intensely the parents intervened in order to keep her balanced (whatever that meant). Exuberance in a child came from the devil. To Rosa her father's grim face was the source of her strong negative self-perceptions: "Though I am the favourite of my father - I'm sure that - he won't give me a chance, you know, he thinks of me as immature".

There was no information about sexual matters from Rosa´s parents; they were even strict about sexual details in books and journals. The father especially would condemn the slightest interest in this direction. Until she was eighteen Rosa followed his rules strictly, thus desparately reinforcing the feeling of being his favourite child.

Her mother was not available to her; she was overworked most of the time and only wished that the children were good at school and did not do anything wrong. Rosa felt tolerated and made up for it by helping her mother constantly. There were no (girl) friends to whom she

could share her inner feelings. Instead she loved pets; all her life she had them. Her bodily feelings were influenced by her mother's comments. The physical changes in connection with puberty didn't please her at all; but she resented her mother continuously pointing out: "You are too fat!"

As child she had never really cared about weight problems. She was a bit on the heavy side and was not interested in sports; she did fine however except for the effect of the recurring criticisms from her mother. Her menstrual cycle used to be regular except for a time when she lost a considerable amount of weight. At sixteen she decided to loose weight and seriously restrained her diet. She went from 70 to 53 kg within 7 months. It was then that her menstrual cycle became quite irregular. Her wish to see a gynaecologist was interpreted by her father as a way to get a prescription for the pill "to allow indecent behaviour". Since she also showed somatic signs of chronic hunger - constant fatigue, disturbances of circulation etc - her father began intervening, first by direct means: "You don't leave the table until …", then threatening her with hospitalization. Rosa X consented to eat a bit more, but secretly she began vomiting. This remained unknown to her parents for more than two years.

At seventeen she entered her first personal relationship with a boy, with whom she shared the pleasure of composing music. With him she indulged in social closeness without any physical intimacy. In order to escape the parental control she chose to study far from her hometown. In her first term away from home she did things her parents would have never allowed her to do. It was with great pleasure that she told us about the "nasty little things" she had done; small though they were, they conveyed to us the extent of guilt feelings when she, the "most decent child", the most obedient child of these parents, was trying to walk on her own feet.

The patient soon found company with other students, "a stable company" she insisted. "I felt really good in this group; I joined them in many activities". However nobody in this clique

that remained relatively close throughout her study years, knew about her vomiting. As soon she was alone in her room, she would start binging and vomiting.

We did not try to clarify during this non-reactive interview whether this students´ company represented another variance of the complying-adaptive lifestyle of this patient and if was being transferred to the marital relationship at the end of these years[6]. Although she thought she had satisfying social relationships, her bulimic symptoms continued. Rosa realized that she had difficulties whenever she was in close social situations for more than two hours. She would become nervous and aggressive. She knew that if she would eat something it would calm her down; she couldn't eat at all in the presence of others. She was dimly aware that she began to limit her social ties more and more. If unable to avoid the presence of others, she gorged herself, and vomited afterwards.

Treatments

"After my first term, I knew I wouldn't be able to go on like that". Rosas energy had always has been high, but after the first term she was quite demoralized. Following the advice of her parents she went into a treatment program in the psychosomatic department of her hometown city hospital. "There was plenty of time to think about myself, but even more to think about the others in the group". There was a mixed group of patients, depressives, anorexics, two psychotic patients in a psychodynamic short-term group. She felt left alone with her specific problems and not taken serious by the other 'real' neurotics: "You've only got to stop eating, they told me." After six weeks she felt somewhat better, she had a better understanding about herself, but there were no basic changes in her eating habits, so she thought she'd better continue her studies.

At the end of the second term she was in a poor condition and again was admitted into an inpatient treatment facility. Individual analytic psychotherapy was provided by a female

6 It is true; this attachment style of the patient merits special comments. I am pretty sure that she would have been the only one of the group that would characterize the relationship as intimate as my patient did. One of my implicit goals in treatment were to achieve some mastery of ambiguity and openness in these peer relationships; to make her understand that loyalty in these relationship may be a dangerous thing which could hamper her development again.

therapist. "This lady was just ‘meschugge’. She was smiling constantly even if I was talking about serious and painful experiences. I could have slapped her smiling face. When I asked her to stop smiling, to keep a neutral face, this bitch told me that her smiling was creating such difficulties for me because I never had a mother that provided me with a benevolent positive attitude"[7]: The team conference of the ward decided she was unable to stand individual therapy, reduced her individual sessions from twice weekly to once weekly, and offered her another therapist. After eight weeks she discontinued and opted for a group treatment program again. The male therapist there used very coercive language full of vivid and sexually loaded imagery, when talking to Rosa. She really objected to this; at the same time her vomiting got worse. Before every group session she had to vomit first in order to get through the session. The therapist was convinced that this was because Rosa was repressing her primal drives. After another eight weeks, a painful and heroic time, the patient, Rosa, opted to "repress" the need for therapy and take up her studies again: “I really was looking forward to a normal life even if I only would be able to enjoy bits of it."

This third term again was very distressing; Rosa went through phases of thinking about suicide: "Therapy had been good enough to pull down my walls and demonstrate my weaknesses, but it did not show me any viable alternatives. I was very depressed and desperate. Something had to change or I would soon be a corpse". At the end of this third term Rosa consulted a senior psychoanalyst in the university town. He advised her to join a self-help group; individual therapy would not be helpful in cases of bulimia. Her parents were asking her to do something at least and so she gave herself another six months, a reprieve. She disliked the rituals and strict rules of the self-help group and could not really join the intimate confessional exchanges. After that period she was fed up and turned to passing an intermediate exam. She told us angrily that her father did not show any pride in her excellent exam records, which again resulted in another depressive moods. She decided to give herself a last chance with Dr. K.

7The lessons we could learn about therapists´ interpretations are usually not well received by the profession, true or not - patients´ subjective experience with their therapists is a decisive factor in outcome (see also Kächele et al. 1985).

Treatment with Dr. K.

"My former roommate in the hospital told me about him[8]. I insisted on an initial interview with him. He reminded me of my forcefulness later in treatment saying that I had put a revolver to his head to make clear that he had to treat me[9]. This time, however, treatment became something like an intimate talk with someone you can trust and you can talk to. I felt accepted and well understood". Treatment took place mostly twice a week, sometimes three times a week, for fifty-minute sessions, in a face to face situation[10]. Rosa X conveyed to us that it took her quite a time before she figured out what it was to be the patient, to overcome her uncertainty as to what she was expected to do[11]. "I could never really believe that I could talk all the time and still enjoy his benevolence". She was told that as a patient she would have rights and duties. She knew her rights, but what constituted her duties remained unclear, opaque to her. She continuously mobilized her well-developed sense of mistrust, but never found any real cause. So it really took her time until she could confide in him.

The topics of treatment, as she remembers, were firstly around her childhood and her relationship to her parents. Later on it focused much more on the actual events of her present situation, with her colleagues from the study classes. "It was then that I realized the first time how much my actual working capacity was disturbed. Then I started get anxious when facing a session; I lost my speech during the session, I forgot what I wanted to talk about. I felt dizzy, numb, trembling. In other situations I would have reacted aggressively, hitting the table with my fists, but here I felt helpless, I was not in control of the situation". The

8 In fact the roommate had given three names to the patient; the first one, a female psychoanalyst immediately signalled to her on the phone that there would be no chance for a treatment soon. Dr. K was the next on this list. There was no personal information about him besides that he worked in the university department.

9 During the initial interview I realized that up to now this patient never had what I would consider "a real treat" for her severe condition; in my notes written immediately after the session I decided that the patient suffers from a bulimia nervosa (axis 1), a hysterical personality (axis 2) with quite a few schizoid features as defensive operations acquired during adolescence

10 Twice a week sessions face to face of two and a half years´duration. Formally this may be called a middle frequent psychoanalytic therapy in line with Thomä & Kächele (1987).

11 At first we had to focus on her being the most decent child as a repetitive relationship theme (Luborsky & Crits-Christoph 1990)

therapist conveyed to her that she was free to say nothing as well, without being criticized, as he was neither father nor mother. This helped her a lot, she said, and she began to be silent for longer periods without feeling guilty. Looking back she now resumes the idea that she always had the feeling of being observed. Then in treatment she had realized that she herself was highly interested in keeping control over everything and that she had a deep-seated need to keep things in perspective. She therefore always renounced the therapist's suggestion to use the couch. Lying 'naked' there, she would have had the feeling of being observed and attacked from behind. Sitting face to face was at least some kind of a protected situation. Lying on the couch also would entail staring at the walls, but the walls don't answer her aggressions; how would she have had a chance to dissolve them thereby. Sitting face to face would give her the feeling that her aggressions could be handled by mutual control. Still, from time to time, she urgently felt the need to stand up and walk to the window to distance herself from the situation. In all these two and a half years during therapy she could never do it; if she had done it, it would have been a way of being unmasked. We wondered about that, but Rosa X didn't´ t tell us more about it. It somehow expressed the idea that to do nothing was as intolerable to her as to be controlled all the time.

Therefore to her the most important result of that therapy with Dr K. was the strengthened feeling, not only of being tolerated, but also to have rights and to be loveable. With regards to her parents, she is still very sad, as they still do not understand her. But now she has learnt to delineate herself. She still remembers when she discovered the right to be angry with them for the very first time. That was also the first time that she could weep in a session: "I couldn't eat a thing for a few days after that experience".

Distancing herself now a little bit from these memories, Rosa X tells us that she continued to write a diary during the treatment. Her reasoning was that she wanted to understand her change better if hopefully any change would occur[12]. Summarizing the changes that have taken place, she states that still there is no way to communicate with her father about her

[12] Diary writing by patients happens quite often, but it has not been made objective of systematic studies.

problems. He still insists that she offers herself as the helpless child that she no longer feels to be. So the lack of mutual acknowledgement leads to a clear differentiation. Her mother seems to be in a better situation now that the other children have left the house[13]: She now sides with her mother and supports her when tense situations arise with her father; she becomes the much needed for consultant of her mother[14]. She herself has given up quarrelling with her parents on serious issues. She does not believe that a change in these old petrified patterns can happen as her father especially is not interested in that kind of change at all[15]. However Rosa X feels a greatly enhanced capacity to handle aggressive issues. Confronting her parents with her plan to marry was a particularly noteworthy instance. She feels that she can be quite outspoken with her husband. She really thinks her newly gained openness is an enrichment of their relationship, though sometimes the husband feels her to be too direct.

Rosa X thinks of herself as 'cured'. "My life doesn't circle around eating anymore". From time to time she might get an attack of hunger: to her (now) this is a good signal that she wishes for something she cannot get and supplements for it by food. She thinks she is fairly well in control though vomiting takes places from time to time - how often we simply forgot to ask - but she herself describes it as a tool that she would like to keep. She thinks it is more important that she keeps control of situations and that she can identify their meanings etc. There would be no sense in pushing herself into more than that; it only would lead into another neurosis.

"When I was young, my ideal was that of a slender woman like my older sister who passed as a typical woman[16]. Now I think I am pretty independent from society's ideals." More

13 It is very remarkable how systematically the relationships to the sisters and brothers are left out in this "reconstruction" the patient seduces her interviewers into.

14 It is well known that our patients like to play the doctor game with their family partners in aggressive identification with their therapists. The true amount of it is unknown yet

15 A few unavoidable phone-calls with that father (as being the paying parent) made the therapist a partisan of that opinion.

16 It is not surprising that Rosa X chose the same study topic as the older sister. Likewise the development of the older sister played a significant role in the treatment. The sister also married without consent of the parents and got pregnant without father´s consent and "survived"

important than slenderness she holds a stabile circulation and a good capacity to concentrate. For her future she would hope for children, fulfilment in the family und motherhood. This would be more important than professional success. Only her hobby, practicing music, should not be sacrificed, for nothing.

Our team, looking back onto this vivid description of Rosa X's history and present-state self-examination, was puzzled by the apparent lack of sexual matters. Here and there a little word like "if there would have been the proper one within the clique, then I would have made him my friend" (whatever that meant). She remembered herself saying to Dr. K in the 2nd session, when he asked her about sexual issues, that there were no problems at all. "I already knew then that when I use such a strong language something is rotten in the state of Denmark". According to her report it took her two full years to address the topic of sexuality. In the third year of her treatment it seemed to be so thoroughly dealt with that, for the first time in her life, she could entertain full sexual intercourse[17]. By the way, the man involved was not part of the clique that had stabilized her over the study years.

Some additional psychometrics

Self-reports on past and present mental events are notoriously dubious (Nisbett & Wilson 1977). It was obvious to the research team that the patient was exaggerating her state of health. Being a researcher implies being critical; and so we felt we should have some standardized measuring. The patient was very cooperative; she had been treated well and she wanted us to treat us well. So she did. She not only spent an afternoon reporting her story with us listening and recording, but she also rejoiced our hearts by filling out lots of questionnaires. We offered her the whole selection of instruments available to us, but to keep interest in this story we single out just a few of the results. We used the Anorexia Nervosa Inventory (ANIS, Fichter and Keeser, 1980) and the Eating Attitude Test (EAT, Garner &

17 It is remarkable that the report of the research group places the sexual question at the end of this report. It tinges the descriptions in a special way, the hysteric´s special way of not communicating to her mother what she unconsciously was up to with the father. Reading the report I was reminded how "wild", how unconsciously seductive, she appeared for the initial interview.

Garfinkel 1982) to cover the symptomatology, the Freiburger Personality-Inventory (FPI Fahrenberg et al. 1970) to cover trait personality factors and the Giessen-Test (GT, Beckmann & Richter 1972) to cover interpersonal personality dimensions. For the GT we experimented with an unusual instruction, asking the patient to fill out one version "as you would have done it before treatment" and one version "as you feel now ".

As far as the symptomatic improvement was concerned, the psychometric instruments demonstrated quite a satisfactory change with some hits on a quite modest level of remaining symptomatology. The conservative measurement of personality change by the FPI registered that on the scales "psychosomatic disturbances", "depressivity", "sociability" "extraversion" and "masculinity" Mrs Rosa X resided within the middle norm range of her age group. She exhibited lesser degrees on the scales "irritability" and "striving for dominance". Relatively high degrees were on the scales "aggressivity", "composure" and "openness". There was some degree of inconsistency, some ambivalence as Mrs Rosa X still displayed a somewhat immature emotional disposition, however, exhibited quite a bit of self-reliance as well. Summarizing, the FPI portrait supported the clinical impression of a fairly healthy young adult person.

In order to increase the objectivity we asked a fourth colleague (RP) to evaluate the results of the pre-post forced comparison on the Giessen-Test. He had neither seen the patient nor knew him any other test results. What follows are his solitary insights in the dynamics of change of this patient:

> "The profile of change documents the partially drastic shifts that exist between the state as it were at the beginning (seen from now) compared to the state at the follow-up. The then extremely negative social role identity, which implicitly points to narcissistic deficiencies, has been replaced by a very positive social resonance. The potential for social competence that was already initially sufficiently available to her has considerably increased, now expresses a high degree of phallic-narcissistic potency. Initially, strong tendencies to retentively and even schizoid regulated object relations have now given way to open, trustful relationship capacities. The affective core has shifted from a depressive pattern to a modulated in-between way of colouring her experiences. Drive control does not exhibit any change and remains in a middle range. The same applies for social adaptation. Summary: at the follow-up the profile on the Giessen-test displays an ideal of how a patient should look like after successful therapy".

Intriguing as this all may be in her final statements Mrs Rosa X underscored that she was still busy with working through all the many things she had gone through. She still is impressed

what therapy turned "upside down" and there still were things she did not want to face. Therefore she would not think of having any further therapy just now: "Still, life would go on, wouldn't´ it!"

Conclusions

Writing up the abundant material was more strenuous than the research group had imagined. The whole enterprise had been conceptualized as an exercise in methodology in order to find out new ways of handling complex clinical data. One could well ask: how many times must a man or a woman look at a video recording to really grasp meaning behind words? For clinically less-trained researchers it remains a hard job to grasp the notion of unconscious meanings so we have largely refrained from making far-reaching conjectures. However we feel that Rosa X´s way of telling her story makes sense without inferring too many far-reaching concepts. It points to the overwhelming importance of ongoing family interactions, especially during early and late adolescence, for the development of a disturbance like bulimia nervosa, whatever the early confliction constellations might have been (Lidz 1992). We also feel it useful to focus on systematic investigations in the heartland of the clinicians, to replicate the complex clinical judgment within a formal research design in order to understand better development and change processes in clinical syndromes. We feel that our description of this patient's development and therapeutic experiences has more intersubjective validity than the therapist's claim as three participant observers can testify to this report[18].

Coda

Another research psychologist conducted a second follow-up six years after termination who had ample experience in the use of a by now standard follow-up instrument - the LIFE interview (Gitzinger et al. 1997). This time the objective was to probe the utility of a long-

[18] Meanwhile this group-based methodology for retrospective evaluations has been implemented by a large scale study of the German Psychoanalytic Association (Leuzinger-Bohleber et al. 2003).

term evaluative perspective couched within the frame of a large scale multi centre study on eating disorder (Kächele et al. 2001).

Ten years later, the therapist himself conducted a third telephone follow-up. The patient had given birth to two children and says she now leads a satisfying family life. The therapy was so important to her that she twice visited him in Ulm, apparently to get some reassurance that he would not mind her preference of motherhood over her anticipated career as a doctor. With regard to her bulimia, she said: “you know, it is only recently that my mind has cleaned itself from these thoughts!”

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