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Psychopathology of anorexia nervosa: a defence from depression. An interpretation according to Massimo Fagioli's Human Birth Theory – two case reports

Psychopatologia jadłowstrętu psychicznego: forma obrony przed depresją. Interpretacja według „teorii ludzkich narodzin" Massima Fagiolego – dwa opisy przypadków

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Abstract

This paper focuses on anorexia nervosa with an emphasis on its onset and treatment, and it particularly addresses two aspects of the disease, which seem completely in contrast with one another – prolonged fasting and recurrent episodes of binge eating/purging behaviour. From a psychopathological viewpoint, these can be considered two symptoms of the same disease, whose psychopathological core is often depression. The anorexic phase is characterised by control of food intake and interpersonal relationships due to a paralysis of affections and mental rigidity, which often provide a schizoid defence against depression and sometimes against fragmentation. In the bulimic phase, a break in this defence reveals violent and uncontrollable affects beneath depression. One possible hypothesis to evaluate would be whether these alternating phases can be overcome if they are interpreted as a false resolution of an intrapsychic conflict as defined by Fagioli's Human Birth Theory, based on a psychic defence reaction that may arise in newborns, and which he termed *annulment pulsion*. If pathogenic factors are present in the first year of life, the annulment pulsion may become pathological and can explain the psychosis in anorexia nervosa patients. This paper presents two clinical cases involving two young women, one suffering from anorexia nervosa purging type with self-induced vomiting complicated by comorbid drug abuse and the other suffering from anorexia nervosa binge eating/purging type and comorbid drug and alcohol abuse. Both were successfully treated with psychodynamic psychotherapy (individual and in groups) based on the interpretation of dreams according to Human Birth Theory, which posits that a dream is a thought expressing itself through images. The patients were treated for 4 and 5 years, respectively. The scores on three standardised tools, Eating Disorder Inventory-3, Symptom Checklist-90-Revised and Toronto Alexithymia Scale, administered before and at the end of treatment, accurately reflected their baseline condition and their clinical improvement. The treatment induced a reduction or resolution of symptoms and a qualitative improvement in the patients' oneiric activity. The encouraging outcomes for these patients support the interpretative hypothesis proposed in this article and the value of the approach based on Human Birth Theory in treating anorexia nervosa. Further work on the subject is clearly warranted.

Keywords: anorexia nervosa, depression, psychodynamic psychotherapy, annulment pulsion, Human Birth Theory

Streszczenie

Niniejsza praca dotyczy jadłowstrętu psychicznego ze szczególnym uwzględnieniem początku zaburzenia i jego leczenia i odnosi się do dwóch aspektów choroby, które wydają się całkowicie sprzeczne – przedłużonego unikania przyjmowania posiłków i nawracających epizodów objadania się/zachowań przeczyszczających. Z psychopatologicznego punktu widzenia można je uznać za dwa objawy tej samej choroby, której psychopatologicznym rdzeniem jest często depresja. Faza jadłowstrętu charakteryzuje się kontrolą w zakresie przyjmowania pokarmu i relacji międzyludzkich, wynikającą z paraliżu uczuć i sztywności psychicznej, które często zapewniają schizoidalną obronę przed depresją, a niekiedy przed fragmentacją. W fazie bulimicznej następuje przerwanie tej obrony, ujawniające gwałtowne i niekontrolowane afekty depresji. Jedną z możliwych do oceny hipotez byłoby założenie, iż te naprzemienne fazy można przezwyciężyć, jeśli zostaną zinterpretowane jako fałszywe rozwiązanie konfliktu wewnątrzpsychicznego, zgodnie z definicją „teorii ludzkich narodzin" Fagiolego, opartej na psychicznej reakcji obronnej, która może wystąpić u noworodków i którą autor określił jako *annulment pulsion*. Jeśli w pierwszym roku życia obecne są czynniki patologiczne, *annulment pulsion* może przyjąć postać patologiczną, a zatem może wyjaśnić występowanie psychozy u pacjentek z jadłowstrętem psychicznym. W pracy przedstawiono dwa przypadki kliniczne młodych kobiet – u jednej z nich stwierdzono jadłowstręt

psychiczny typu przeczyszczającego z prowokowaniem wymiotów i współistniejącym nadużywaniem środków psychoaktywnych, a u drugiej postać jadłowstrętu psychicznego z napadami objadania się i/lub przeczyszczaniem oraz współistniejące nadużywanie środków psychoaktywnych i alkoholu. Obie fazy z powodzeniem leczono metodą psychoterapii psychodynamicznej (indywidualnej i grupowej) opartą na interpretacji snów zgodnie z „teorią ludzkich narodzin", która zakłada, że sen to myśl wyrażana w formie obrazów. Pacjentki były leczone odpowiednio przez 4 i 5 lat. Stan wyjściowy pacjentek i poprawę kliniczną dokładnie odzwierciedlały wyniki uzyskane przed leczeniem i po jego zakończeniu za pomocą trzech wystandaryzowanych narzędzi: Eating Disorder Inventory-3, Symptom Checklist-90-Revised oraz Torontowskiej Skali Aleksytymii (Toronto Alexithymia Scale). W wyniku zastosowanej terapii uzyskano zmniejszenie lub ustąpienie objawów oraz jakościową poprawę aktywności onirycznej. Zachęcające wyniki opisanych pacjentek potwierdzają proponowaną w niniejszej pracy hipotezę interpretacyjną oraz wartość metodyki opartej na „teorii ludzkich narodzin" w leczeniu jadłowstrętu psychicznego. Niezbędne są dalsze badania w tym obszarze.

Słowa kluczowe: jadłowstręt psychiczny, depresja, psychoterapia psychodynamiczna, *annulment pulsion*, teoria ludzkich narodzin

INTRODUCTION

According to the World Health Organization (WHO) (2021), eating disorders (EDs) commonly emerge during adolescence and young adulthood and are characterised by harmful eating behaviours, such as restricting calories or binge eating, which are detrimental to health. However, it should be stressed that EDs are also responsible for a steep increase in the risk of mortality due to organic damage and medical complications among patients with mental disorders.

The situation raises considerable concern and calls for more effective prevention, including an assessment of patients' childhood for hidden psychological problems, which, in the complex pubertal period, may manifest as EDs.

In the 1960s, EDs were extensively investigated by two psychiatrists, Hilde Bruch (1979, 1962) and Mara Selvini Palazzoli (1974), who looked at body image disturbance in these patients.

Bruch (1962) hypothesised that patients suffering from EDs have difficulty in interpreting stimuli originating from their body and in understanding and defining their own emotions. Selvini Palazzoli (1974) hypothesised that the problematic body perception characterising anorexia nervosa (AN) patients, especially during the dramatic physical changes that take place during puberty, induces a severe intrapsychic conflict that patients try to manage by fasting in an attempt to control and stop the body's physiological growth. Sometimes they are so successful that they put their life at risk.

Selvini Palazzoli interpreted AN as a form of psychosis, a precarious balance between a paranoid-schizoid and a depressive position, based on Melanie Klein's theory.[1]

Starting from this premise, the discussion will involve an interpretation of AN based on the psychosis research by the psychiatrist Massimo Fagioli (2019), which is founded on the identification of a pathological dynamic that he named *annulment pulsion*.

This paper focuses on AN with an emphasis on its onset and treatment, through the report of two clinical cases, which were diagnosed according to DSM-5 (American Psychiatric Association, 2013). Two young women, one with AN purging type (AN-P) with self-induced vomiting complicated by comorbid drug abuse and the other with AN binge eating/purging type (AN-BEP) and comorbid drug and alcohol abuse, were successfully treated with psychodynamic psychotherapy (individual and in groups) based on the interpretation of dreams according to Fagioli's Human Birth Theory (HBT) (Fagioli, 2013, 2019, 2022, 2017, 2011a, 2012, 2011b).

THEORETICAL BACKGROUND

From a psychopathological viewpoint, two aspects of AN, prolonged fasting and recurrent episodes of binge eating/purging behaviour, which appear to be completely in contrast to one another, are two symptoms of the same disease, whose psychopathological nucleus is often depression. The anorexic phase is characterised by control of food intake and interpersonal relationships due to a paralysis of affections and due to mental rigidity, which often provide a schizoid defence (frequently against depression and sometimes also against fragmentation), whereas in the bulimic phase a break in this defence reveals violent and uncontrollable affects such as hatred and anger beneath depression (Costantino, 1992, 1994, 2016, 2008, 2013, 2018, 2010; Costantino et al., 2007, 2017).

It is possible that *the alternation of these phases*, which was noted by Selvini Palazzoli (1974), *might be overcome if it is interpreted as a false resolution of an intrapsychic conflict*, as defined in Fagioli's theory and his discovery of the annulment pulsion.

According to Klein's theory of the maternal object, which was taken up by Selvini Palazzoli, infants experience persecutory anxieties due to the onset of the death instinct, which they project onto the maternal breast. From birth to six months of age the child goes through a paranoid-schizoid position that is the earliest stage of infantile psychological life. Then, if the breastfeeding and the relationship with the mother (or caregiver) are fulfilling, the child will progress through a depressive position (Klein, 1975).

[1] According to Fagioli (2019, p. 56), "Melanie Klein claims that human beings are born with the death instinct and are exposed from birth to the inborn polarity of instincts. The immediate conflict between the life instinct and the death instinct. 'The infant's ego deflects the death instinct partly by projecting it and partly by converting it into aggression. The ego projects that part of itself which contains the death instinct outwards into the breast. […]'".

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Fagioli (2019) proposed a new interpretation of the notion of the death instinct that differs from those of Freud and Klein. As explained below in greater detail, he posited that the death instinct arises at birth as a pulsion, the annulment pulsion, which is the newborn's *psychic defence reaction* against the new hostile environment.

If pathogenic factors are present in the first year of life, the annulment pulsion may become pathological; it can then explain the psychosis of AN patients, in particular their swings between schizoid personality disorder and depression.

According to the theoretical framework conceived and systematised by Fagioli (2019) in 1971, the retina – the only part of the central nervous system that is exposed to the external environment as the foetus comes out of the womb – is stimulated by light at birth, triggering a cascade of events that leads to activation of the respiratory apparatus (Fargnoli and Gatti, 2015; Gatti, 2016). The newborn responds to the new unpleasant environment with the annulment pulsion. Through this non-conscious mental reaction, the newborn's mind makes the harsh external world, the light and itself 'non-existent'.

Although Fagioli claims that a foetus has no mental activity, it does have a biological capability to react to stimuli, which he termed the *capability to react*[2], which forms during pregnancy and matures at 24 weeks of gestation (Gatti, 2016; Gatti et al., 2012). At birth, the capability to react becomes *vitality*, an exclusive human feature that originates from the biological sensitivity developed by the foetus in the final weeks of gestation. After the turmoil of birth, vitality drives the infant to seek restoration of the biological homeostatic wellbeing (warmth and calm) experienced in the womb, this time on a psychological level.

Therefore, simultaneously with the attempt to 'annul' the harsh external environment, through the 'unconscious fantasy of making it disappear' (Fagioli, 2019), the same pulsion, combined with vitality, induces the memory of the sensation on the skin of the amniotic fluid, a caress that the foetus experienced during its intrauterine life. In particular, "the object-relation dynamic with the amniotic fluid is a relation with the object where the existence of the object is realized via the foetus's biological sensibility. At birth, the death instinct as fantasy of the non-existence of the newborn self and of the new-born self in relation with light engenders in the newborn the fantasy of the existence of the intrauterine object as an image of it. *As memory or mnemic trace*" (Fagioli, 2019, p. 68).

[2] "In Human Birth Theory Fagioli asserted that the embryo and the foetus are biological existences without psychic activity. In spite of that, during the last months of gestation the foetus is presumed to develop what Fagioli named a prepsychic 'libidic capability', specifically caused by its cutaneous contact with the amniotic liquid. Fagioli claimed that this 'libidinal' experience could leave traces which may be 'stored' at a subcortical level. […] According to Massimo Fagioli at birth, this prepsychic libidinal storage, through the activation of the somatosensory cortex, becomes a mental content, a memory of homeostatic sensations that constitutes a first indefinite 'image' of itself" (Atzori, 2019, p. 351).

This first psychic dimension enables the newborn to realise the existence of herself or himself and of herself or himself in relation to the object – "the intuition-hope that the breast exists" (Fagioli, 2019, p. 71) – and to develop a natural tendency to seek relationships with other human beings. This memory of the earlier sensation is generated by *the capability to imagine*[3] and gives rise to an early, vague, internal image that will develop and evolve in the first few months of life through the relationship with the mother.

Fagioli views the capability to imagine, which is a non-conscious thinking activity, as the earliest mental activity. In his first work, *Death Instinct and Knowledge* (2019), which introduces HBT, he referred to this complex dynamic as *disappearance fantasy*.

As noted above, the infant's capability to imagine should develop through the relationship with the mother. If breastfeeding has been fulfilling, that is, the mother has responded with affectivity not only to the infant's physiological needs but also to her or his psychological requirements, the child should develop the internal image that originates at birth. According to Fagioli (Ricerca sulla verità della nascita umana, 2016, pp. 269–270), at 8–10 months of age such a child placed in front of a mirror can then recognise herself or himself. However, how can this be explained if the child has never seen herself or himself before? Such knowledge cannot derive from a conscious figure seen previously (infants cannot see as well as older children or adults), but rather stems from the realisation of her or his internal image. While she or he is looking at herself or himself in the mirror, the child recreates her or his identity of birth and begins to become self-aware.

Thus, Fagioli overcomes the body-mind Cartesian dualism and proposes that the mind and body are fused from birth and that the mind is originally healthy, not fragmented as posited by several researchers. Notably, Klein (1975) herself hypothesised the infant as having an unintegrated Self. However, if the caregiver's failure to respond suitably to the infant's requirements and need for affection induces the annulment pulsion, this fusion may be lost and result in fragmentation of the psychic Self. If the relationship with the caregiver is disappointing, at weaning the infant will leave the breast by acting an annulment pulsion against it and the relationship with it: this becomes the main cause of the inner void and lack of vitality (Fagioli, 2019; Maccari et al., 2017).

According to HBT, the annulment pulsion may arise in infants as a psychic defence reaction directed against the disappointing relationship with a non-responsive caregiver.

Fagioli (2019, p. 79) claims that the death instinct leads to the loss of the external object and that "infants realize themselves as destructive, having caused the non-existence

[3] Fagioli (2019, p. 72) described fantasy as "the expression of the death instinct which, at birth, as it is a fantasy of the non-existence of the external world, makes the foetus's intrauterine condition – oneself being in relation with the object – existent as a mnemic trace (the capability to imagine)".

of the other and, at the same time, the annulment of themselves as psychic beings".

Moreover, "given the annulment pulsion-fantasy of their self in a current situation, infants have no possibilities of finding in themselves a self that is endowed with the libidinal possibilities of a relation with the object. In other words, there is complete psychic blindness, in the sense of the impossibility of having an object-relation, of seeing-perceiving the qualities of the object" (Fagioli, 2019, p. 79).

This pulsional dynamic, which can lead to the loss of the unconscious representation of the other and of oneself in relation to the other, has the potential to affect the development of the child's mind, which, according to HBT, is healthy at birth.

The two clinical cases described below lend support to this theoretical construct and to the notion that EDs, particularly AN, may originate in the first few months of life. An early problematic relationship with a non-affective caregiver may predispose the child to premorbid personality disorders which at the time of the pubertal crisis may then induce an ED. This crisis is above all a physiological crisis involving physical changes that begin to arise around 12 years of age. It is a difficult phase and, unless it is resolved, it can lead to severe psychopathology such as AN. Selvini Palazzoli (1974) had already realised that breastfeeding not associated with an interpersonal resonance of positive experiences might be a key problem for AN patients. Her intuition can be taken further in the light of HBT: an infant developing its vitality and internal image through the relationship with a responsive caregiver becomes increasingly independent, whereas a non-responsive caregiver can induce disappointment that gradually results in the loss of vitality and affectivity.

According to this theoretical framework, damage to the internal image of the body and the person as defined in Fagioli's HBT – induced by repeated disappointing childhood experiences – can result in a body image disturbance (Costantino, 1992, 1994, 2008), which is the leading cause of EDs and which may lead to an altered perception of one's own body. (For the hypothesis that damage to one's internal image may affect the healthy development of one's body image, see: Costantino, 1994.)

A child's body image begins to develop in the early postnatal period through the relationship with the mother, which should confirm the fusion of body and mind that exists at birth. In contrast, a fraught relationship may result in a split between the psychological and the somatic parts of the Self and in a confusion between biological and emotional disturbances (Atzori, 2019; Bruch, 1979, 1962), which may in turn disrupt the processing of sensory information and affect the ability to recognise and understand one's own emotions: both are common features of EDs.[4]

In ED patients, particularly those with AN, psychodynamic psychotherapy based on HBT aims to repair, reconstruct and recreate that first essential relationship, helping the patient recover the affection, sensitivity, receptivity, vitality, and trust in others that were lost in the first months or years of life.

METHODS

We present two patients diagnosed with AN according to DSM-5 (American Psychiatric Association, 2013), who underwent psychodynamic psychotherapy based on the interpretation of dreams according to HBT, which posits that a dream is a thought expressing itself through images. The first patient was a 25-year-old unmarried Italian woman with a degree who was an osteopath; she suffered from extreme AN-P with recurrent self-induced vomiting complicated by comorbid drug abuse. The second patient was a 35-year-old Italian woman with a high-school diploma; she was employed, had separated from her husband and suffered from extreme AN-BEP complicated by comorbid drug and alcohol abuse.

They were treated in private practice for 4 and 5 years, respectively. Before the start of psychotherapy and at the end of treatment they were evaluated with three psychological tools: the Eating Disorder Inventory-3 (EDI-3), the Symptom Checklist-90-Revised (SCL-90-R) and the Toronto Alexithymia Scale (TAS-20).

Treatment began with weekly 50-minute individual sessions. A weekly group psychotherapy session of 2.5 hours was added a year later. It is common practice for patients joining group psychotherapy to continue attending their individual sessions, at least initially, to prevent drop-out (Burlingame et al., 2013).

This article proposes dream analysis as a diagnostic method where the patients' oneiric images reflect their pathological thoughts and dynamics: through their dreams, they tell the therapist the feelings (e.g. negative affects, hate, anger, anguish) they experience in everyday life due to their mental condition – for instance, dreams of injuries and deep scars may represent severe mental suffering.[5]

Iannaco et al. (2015, p. 72) proposed a categorical distinction between sane and pathological and its application to dreams. In their view, dreams interpreted according to HBT provide valuable access to the unconscious as well as a sort of "x-ray of the patient's mental health condition"; dreams can point to the type of disorder from which the patient suffers and its severity; and they can help monitor the internal changes the patient experiences during therapy, since, in this period, the content of dreams undergoes considerable changes.

The unconscious relationship with the psychotherapist, based on transference, allows the patient to process negative experiences, particularly those of early childhood.

The psychotherapist needs to be highly sensitive and attuned to oneiric communication. The psychotherapist's

[4] For an in-depth analysis of the alteration of interoceptive awareness in ED patients, see: Bischoff-Grethe et al., 2018; Gaetano, 2018; Mervin et al., 2010.

[5] For further detailed studies on psychodynamic psychotherapy with dream interpretation according to HBT, see: Homberg et al., 2015; Iannaco et al., 2015, respectively.

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goal is to restore the patient's affective dimension, which has shrunk or disappeared due to repeated annulments, by establishing a sound relationship with them and interpreting their dreams. The important function of interpreting/frustrating the annulment pulsion to recreate what was made to disappear is discussed in detail below.

Training in this therapeutic approach also plays a key role in therapeutic success (Costantino et al., 2022).

This paper describes how the psychopathological factors of AN – a schizoid disorder with the risk of disintegration of the Self in the first patient and severe depression in the second – were treated by the approach outlined above and how the patients responded to a therapy based on the interpretation of the non-conscious psychological dynamic underlying their mental disease.

Since AN may originate in the first few months of life, the patients' relationship with their caregivers at that critical time was also assessed through clinical interviews and by analysing their non-conscious communication.

The favourable outcomes of these two patients and their scores on the psychological evaluation tools suggested that clinical recovery from AN should be accompanied by 'oneiric recovery'.

CASE REPORT 1

An extremely thin 25-year-old woman (P.) came to the office. During the clinical interview she appeared alert, calm and detached. She said that a few weeks earlier she had been in hospital for severe malnutrition.

From her family history, she was the youngest of five children. P. had been told by her mother that in the early breastfeeding period she used to cry very often; her mother was so tired that she gave P. tranquilising psychotropic drugs.

P. began to worry about her weight when she was only 8 years old. One time at school she had tried to refuse to undress for a physical examination, because she was ashamed of her body. Her height was then 1.39 m, she weighed 30 kg and her body mass index (BMI) was 15. Since then she had become obsessed with her weight and although she was underweight, she began dieting, exercising and leading an overactive lifestyle. At 11 years, her height was 1.55 m, but she still weighed 30 kg and her BMI was 12.

She had had her first period at 14 years, but it soon stopped. At 15 years, she began to self-induce vomiting and to ingest laxatives to lose weight (EDI-3, Symptom Checklist, SC). At 18 years her mother died of an incurable disease and she experienced a painful separation. After that, she began to use marijuana and cocaine.

When P. presented in the practice, she weighed 36 kg (height 1.65 m; BMI 13.8) and used to induce self-vomiting as soon as she finished eating. In the worst periods this happened up to seven times a week (EDI-3 SC). She also exercised six times a week for two hours to control her weight and took fluoxetine 60 mg a day (EDI-3 SC). On clinical examination she was thin to the point of emaciation. Accordingly, her health was precarious, and she still had amenorrhoea. She had taken her degree and was working as an osteopath.

Before beginning psychotherapy, the clinical interview was integrated with the EDI-3, SCL-90-R and TAS-20. The ED composite risk (EDCR) score of the EDI-3 indicated a severe and uncommon clinical picture (95th percentile) with severe drive for thinness (DT = 99th percentile), bulimia (B = 86th percentile) and body dissatisfaction (BD = 95th percentile). Her general psychological maladjustment composite (GPMC) score (94th percentile) reflected a high clinical risk and a significant level of anguish resulting from a wide range of psychological constructs like low self-esteem (LSE = 82nd percentile), personal alienation (PA = 75th percentile), interpersonal insecurity (II = 87th percentile), interpersonal alienation (IA = 96th percentile), interoceptive deficits (ID = 96th percentile), emotional dysregulation (ED = 96th percentile), perfectionism (P = 63rd percentile), asceticism (A = 97th percentile) and maturity fears (MF = 85th percentile).

This clinical profile was confirmed by the SCL-90-R scale scores: somatisation (T = 82), obsessive-compulsive (T = 73), interpersonal sensitivity (T = 74), depression (T = 79), anxiety (T = 79), hostility (T = 80), phobic anxiety (T = 66), paranoid ideation (T = 67) and psychoticism (T = 77). Her global severity index (GSI) score (T = 81) indicated severe psychological distress.

Her TAS-20 score exceeded the cut-off (alexithymia positive = 64).

She began individual psychodynamic psychotherapy. A month later, P. reported that she had dreamed that she had been walking along the beach with a young man, when a huge wave of dark water and fire suddenly engulfed them. Her first dream suggested that P. had a major problem with her sexuality: since fire destroys everything, dreaming of it may represent anxiety in relation to the experience of libido. Notably, Fagioli (2019, p. 40) reported a case of a schizophrenic patient who consistently dreamed about fire: "He masturbated whilst having oral fantasies of destroying the part-object breast (he was living alone with his mother), thereby making orality, the matrix of the object-relation, too destructive to experience. He would 'Always dream of fires', meaning the libido = a fire that destroys".

Realising and accepting adult sexuality requires a healthy relationship with one's body and body image; in contrast, P.'s severely disturbed body perception involved viewing herself as overweight although she was very thin. Her oneiric images, where parts of her body were often broken or wounded, were in line with the assumption of an impaired internal image of the body, which probably had a negative influence on her body perception, the main obstacle to living one's sexuality. Atzori (2019) has stressed the need for additional work into the psychological factors that may underpin the impaired sensory consciousness of the Self, where the internal image of the body and of the person lacks a solid mental representation, making the relationship between the

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psychological and the somatic parts of the Self prone to psychopathological breakdown.

P.'s baseline EDI-3 ID score (96th percentile) indicated an inability to recognise and respond properly to her emotions, her SCL-90-R S score (T = 75) reflected an altered perception of body signals, whereas her elevated TAS-20 score (64) pointed to alexithymia.

AN patients do not perceive their body properly. The sensory awareness of their Self is altered due to the impaired internal image of their body, which according to HBT goes back to the foetus's memory of skin contact with the amniotic fluid. Fagioli hypothesised that a weakening of that memory, resulting in diminished intrapsychic and physical sensitivity due to the annulment pulsion[6] (Atzori, 2019; Fagioli, 2015, unpublished raw data), may hamper one's perception of the body and the development of accurate body maps through inter-human relationships during growth.

Clearly, disturbed body perception is highly dangerous: AN patients fail to realise the potentially fatal nature of the organic condition induced by their extreme weight loss and continue to try to lose weight despite being very thin.

Getting P. to gain weight was a challenge, since each kilogram deeply distressed her and risked inducing the disintegration of the Self, because her 'thin figure' acted as a container for her destructuring anxiety.

Therefore, P. experienced an alternation between a false sense of wellbeing when she succeeded in losing weight – thus realising a schizoid dimension – and severe mental distress when the needle on the scale went up: it was a daily struggle with death.

It became clear that P. oscillated between a schizoid attitude with lack of affectivity, when she 'annulled' her intrapsychic conflict by fasting and losing weight, and a deep anguish with the risk of fragmentation as soon as she gained weight and lost control over her eating habits.

After a year it was decided to add group psychotherapy to her treatment, to enable her to have affective and emotional relationships with other patients and to help her face and address her problems in a protected group setting.

One day P. received a present from the group: a colourful painting by a famous female painter, who was very close to the group. After that important event P. came to the group session with a bright expression and reported she had had a pleasant dream. In it, a teddy bear was handing out gifts – she had taken all of them and was very happy. She also dreamed that, while sunbathing, she had noticed she was very tanned but had several scars on her arms.

In therapy it was suggested that the teddy bear in this dream might represent P.'s affective dimension, restored as a result of treatment. A year later, after she began group psychotherapy, her fatuous dimension receded, and her affective dimension was beginning to emerge (the teddy bear). Having achieved a new receptivity, she could now accept all 'those beautiful gifts', i.e. interest and affection, but also the psychotherapist's interpretations of her dreams, which were healing the 'wounds' of her internal image as the oneiric image of the scars in her arms seemed to symbolise.

However, when she reached 43 kg, P. was unable to accept the weight gain; she had a severe relapse and lost 7 kg.

Several months after this serious crisis she described this dream and began to process her depression.

She was walking with her mother up a well-marked uphill mountain path, when her mother asked her: "Why didn't you tell me that your depression was so serious?". In the dream, P. did not answer, but she felt relieved that she was no longer alone and had finally understood what route she should follow.

P.'s dream revealed the severe depression the little girl had endured in becoming anorexic. The interpretation suggested was that the mother represented the psychotherapist, and that the uphill path was her psychotherapeutic work, which made her feel safe and confident. After strengthening her psychic Self and the relationship with the psychotherapist and the group, P. could now address her severe depression by taking 'the uphill mountain path', without risking the disintegration of her Self. The first improvement was the passage from a schizoid dimension, where affections were completely absent, to the depression which she felt when she gained weight. However, now P. was capable of bearing, processing, and overcoming it.

After 4 years of treatment, P. dreamed that she had a 4-year-old girl whom she was sure she would never bathe in cold water again.

P.'s dream represented herself and the duration of her psychotherapy. It was also possible that, through the recreation of that first fundamental relationship (child/patient – mother/psychotherapist), she had finally recovered her memory of the sensation of the amniotic fluid experienced as a foetus, hence her intrapsychic and physical sensitivity (Atzori, 2019; Fagioli, 2015, unpublished raw data): in her dream she was sure 'she would never again bathe her little girl in cold water'. Her EDI-3 ID score fell from the 96th to the 22nd percentile, her SCL-90-R S score decreased from T = 82 to T = 76 and her TAS-20 score declined from 64 to 31, appearing to confirm the hypothesis of a renewed sensory consciousness of her Self.

After this dream and 4 years into psychotherapy, P. was reassessed. The attenuation of her ED symptoms was reflected in the reduction in her EDI-3 scores. The EDCR score fell from the 95th to the 64th percentile, which indicated an intermediate clinical risk of ED; DT decreased from the 99th to the 61st percentile and BD from the 95th to the 77th percentile; B disappeared (B = 00). The psychological scores also fell: LSE from the 82nd to the 35th percentile, II from the 82nd to the 37th percentile, ID from the 96th to the 22nd

[6] Fagioli's hypothesis of a progressive loss of the memory of the intrauterine experience with a consequent decrease of intrapsychic and physical sensitivity due to the annulment pulsion dynamic (Fagioli, 2015, unpublished raw data) has been further explored and operationalised by Atzori who focused on the role that these psychic factors could play in sensation seeking. This constitutes the starting point of a research that is still in progress. See: Atzori, 2019.

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percentile, ED from the 96th to the 35th percentile, P from the 63rd to the 37th percentile, A from the 97th to the 31st percentile and MF from the 85th to the 53rd percentile. As a result, the GPMC score fell from the 94th to the 27th percentile, indicating an intermediate level of severity.

Symptom attenuation and improved clinical picture were confirmed by the reduction in the SCL-90-R scale scores: somatisation fell from T = 82 to T = 76, obsessive-compulsive from T = 73 to T = 62, interpersonal sensitivity from T = 74 to T = 57, depression from T = 79 to T = 62, anxiety from T = 79 to T = 64, hostility from T = 80 to T = 52, phobic anxiety from T = 66 to T = 59, paranoid ideation from T = 67 to T = 53 and psychoticism from T = 77 to T = 57. The GSI score declined from T = 81 to T = 64, reflecting a general moderate level of psychological distress.

The new TAS-20 score was below the cut-off (alexithymia negative = 31).

After 4 years, P.'s psychotherapeutic treatment is not over, but she is improving and has stopped taking drugs and fluoxetine. Recently her period has returned, marking another important step towards recovery from AN, and she has finally accepted that she must gain weight. Today, she is gaining weight and has reached 42.7 kg (height 1.65 m; BMI 16.1). A recent evaluation with bioelectrical impedance analysis showed a clear improvement. She no longer risks death, although she is still suffering from severe malnutrition.

Altogether, the positive effects of psychotherapy and her clinical improvement were confirmed both by her dreams, which reflected a transformation of her oneiric activity, and by her EDI-3, SCL-90-R and TAS-20 scores at four years.

CASE REPORT 2

D. was 35 years old when she presented at the office. She looked very smart and was apparently calm, but as soon as she began to speak, it was clear that she was in fact anxious and in severe discomfort and that her apparently carefree attitude may have been hiding a deep depression. She was educated to high-school level and worked as a shop assistant.

During the clinical interview, she said that she had barely eaten ever since she was a child and that she had obsessive thoughts about food: she felt it was dangerous and perhaps poisoned, so she began to check it carefully. D. said that when she was a child her parents used to quarrel. She witnessed episodes of domestic violence, which upset her so much that she often went to sleep hoping never to wake up again. She had her first period at 12 years and felt ashamed. She became anorexic and rapidly lost weight; she also began to suffer from binge eating crises. She sometimes injured herself to the point of bleeding.

Her relationships with men had always been negative, based on masochism and a passive attitude that made her miserable. She married at 26 years, but the marriage failed. After the separation, her anorexic crises worsened. She lost 20 kg and ended up weighing 30 kg (height 1.53 m). Meanwhile her menses stopped. She began to abuse alcohol and became a cocaine user.

The alternating anorexic and bulimic phases represented two types of her relationship with food. During eating binges, she devoured her food raw and frozen; she would eat in a detached, emotionless manner for hours. Eventually her condition required her to lie motionless in bed for long periods of time. Binges were sometimes followed by strict dieting, which took a severe physical and mental toll. D. often experienced suicidal thoughts due to her distress and the suffering caused by her condition and she thought she could not be cured.

When she came to the office, she was thin to the point of emaciation (weight 30 kg; BMI 13) and had amenorrhea (EDI-3 SC). To lose weight, she took laxatives 5–6 times a week and exercised 7 days a week for 2 hours (EDI-3 SC). She had binge eating episodes at least 3 times a month, and up to 3 times a week during the worst periods (EDI-3 SC). These episodes were often preceded by sexual intercourse and drinking. However, she was aware of her illness and wished to get better. For AN patients, this is an essential step towards recovery; sadly, however, they usually see a specialist after the disease has already severely affected their body, and sometimes even after they have been admitted to hospital.

Before beginning treatment, the clinical interview was integrated with EDI-3, SCL-90-R and TAS-20. The EDCR score indicated an extremely serious clinical profile (99th percentile). In particular, the ED specific scale scores – DT (99th percentile), B (99th percentile) and BD (99th percentile) – reflected a high level of disease severity. The psychological scale scores indicated that D. felt inadequate and constantly insecure (LSE = 99th percentile), she experienced a deep emotional emptiness (PA = 99th percentile), felt uncomfortable in social and personal relationships (IA = 99th percentile), was unable to express (II = 99th percentile) and to recognise her emotions (ID = 99th percentile), she was extremely impulsive with a tendency towards self-destructive behaviour (ED = 98th percentile), she had perfectionist tendencies (P = 98th percentile), a high level of self-restraint and self-discipline (A = 99th percentile), and found it difficult to assume adult responsibilities (MF = 99th percentile). Her GPMC score (94th percentile) indicated a high level of psychopathology.

This clinical picture was also confirmed by her SCL-90-R scale scores, which indicated a high level of symptom severity: somatisation (T = 67), obsessive-compulsive (T = 82), interpersonal sensitivity (T = 108), depression (T = 89), anxiety (T = 102), hostility (T = 49), phobic anxiety (T = 138), paranoid ideation (T = 74), and psychoticism (T = 113). As a result, her GSI score (T = 98) indicated severe psychological distress. In addition, the TAS-20 score exceeded the cut-off value: alexithymia positive = 81.

It was suggested that D. begin individual psychotherapy to be followed by group psychotherapy. After some sessions, D. felt much better and described two dreams. In her first

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dream, she was looking at herself in the mirror, but did not recognise her face. In the second, she had a doll with fixed eyes.

D.'s first oneiric image of failing to recognise herself in the mirror indicated an impairment of her internal image, as noted in the theoretical background, which was replaced by an 'anorexic figure', an ethereal, asexual and only physical figure (Costantino, 1992, 1994, 2016, 2008). This is a well-known and common symptom of a psychotic crisis. It is essential for patients to recreate their own internal image of birth through psychotherapy: it is a healing process based on the non-conscious relationship with the therapist, who must interpret patients' annulment and all their destructive unconscious dimensions.

The second oneiric image, i.e. the doll with fixed eyes, which represented D. as a child, confirmed the serious damage to her psychic Self. She had fixed eyes due a lack of vitality: she had lost her gaze, she was like a doll.

A year into therapy her state of mind improved and she appeared ready for group psychotherapy. The early period was difficult, but she adjusted and tried to build and maintain positive relationships with group members. She gradually became happier as she felt more supported and connected. Nevertheless, she occasionally relapsed into abnormal behaviours and was unable to be in steady relationships.

After 2 years and a year after she began group psychotherapy, D.'s dreams began to change. In one she dreamed she had a baby girl, but she was too small for her age.

The little child in the dream represented D.'s internal image. However, her small size for her age reflected the persistence of her underlying idea of an abnormal birth unlike other people. That unconscious thought may have been the core of her depression.

Unlike in the case of P., D.'s severe depression underlying her AN could be addressed and treated directly.

Before the start of psychotherapy, her EDI-3 LSE score (99th percentile) and her SCL-90-R D score (T = 89) indicated an extremely serious depression. Throughout her psychotherapy, D. was asked to focus on her poor self-esteem. Then, one day she achieved her ambitions; she began working as a chef in her family's restaurant and her attitude changed. The restaurant became a success, gratifying her and boosting her confidence.

After 4 years, D. described another dream in which she asked her gynaecologist to have her period again.

This dream was an important step towards recovery. After that dream her period returned.

Five years into psychotherapy, D. was re-assessed. The EDI-3 scores indicated that she had overcome her ED: the reduction of the EDCR composite score from the 99th to the 1st percentile suggested that D. no longer had problems with eating or body weight; in particular, DFT, B and BD fell from the 99th to the 0 percentile. As regards the psychological scale scores, the symptoms had diminished or disappeared: LSE, PA, II and A fell from the 99th percentile to 0, ED fell from the 98th percentile to 0, IA from the 99th to the 6th percentile, P from the 98th to the 84th percentile and MF from the 99th to the 32nd percentile. As a result, the GPMC score fell from the 94th to the 7th percentile (low clinical risk).

A significant alleviation of her symptoms was also confirmed by the SCL-90-R results: somatisation decreased from T = 67 to T = 38, obsessive-compulsive from T = 82 to T = 38, interpersonal sensitivity from T = 108 to T = 40, depression from T = 89 to T = 43, anxiety from T = 102 to T = 40, hostility from T = 49 to T = 46, phobic anxiety from T = 74 to T = 44, paranoid ideation from T = 74 to T = 47 and psychoticism from T = 113 to T = 43. As a result, her GSI score decreased from T = 98, severe psychological distress, to T = 39, absence of high-risk clinical features.

The TAS-20 score fell from T = 81 (above the cut-off) to T = 19 (absence of alexithymia).

Five years into psychotherapy, D. is no longer depressed, she has had no more compulsive eating and bulimic crises and has attained a normal body weight (height 1.53 m; weight 48 kg; BMI 20). She stopped drinking and using psychoactive substances. She has also begun to have regular sexual activity and an affective life. D. is now a sensitive, confident and accomplished woman who is capable of positive human relationships.

The beneficial effects of psychotherapy were confirmed by a completely transformed unconscious dimension and by normal EDI-3, SCL-90-R and TAS-20 scores at the end of treatment. In particular, her EDI-3 LSE score fell from the 99th to the 0 percentile and the SCL-90-R D score from T = 89 to T = 43.

DISCUSSION

The first patient had very severe AN-P, where depression seemed to be absent. When P. came to the office, she was in poor physical condition and she was not aware that her life was at risk.

Individual psychotherapy was critical in the early stage of treatment, since it enabled P. to build a trusting relationship with the psychotherapist, which then gave her the confidence to deal with the anguish she experienced as soon as she gained some weight. Weight control is a well-known defence mechanism generated by depression in AN patients, although some may also develop destructuring anxiety. This phase is very difficult, because patients who gain weight are at high risk of dropping out of treatment. Through the affective relationship established with the therapist, P. was able to address her pulsional activity, namely the pulsion to annul her physical body, which was the cause of her inner void and loss of vitality. All sessions involved the interpretation of the annulment pulsion. The next time P. appeared to be calm and wore an empty smile that masked the lack of affectivity related to the annulment of the affective dynamic with her therapist, which in turn concealed the annulment of the psychotherapist and a continuous annulment of her physical condition, which was close to collapse.

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This phase of the relationship with the therapist involved a constant battle, where the annulment of the therapeutic relationship and the affective dynamic with the therapist equalled a death sentence for the patient. P. was again experiencing the dynamic that had marked the relationship with her mother.

The annulment pulsion is the psychotic core that needs to be overcome, because it makes the patient feel all-powerful and appear serene because of the disappearance of the image of the relationship: image and content of the relationship. The annulment pulsion makes the dynamic of the previous session disappear: there is no area from which it is removed, it simply is not there.

Thus, the annulment pulsion does not destroy the external object; the object is made non-existent by the person in the oneiric representation, producing emptiness and a mental absence that can lead to mental fragmentation. According to Atzori (2015, p. 164), the consequence of repeated annulments is an affective impoverishment that can ultimately result in the person's "complete dehumanisation".

An observation P. made after the end of a relationship with a man was particularly significant. She admitted she was glad he had left the place where they had been living together, because now she would be able to eat as little as she wanted. She ostensibly had no emotional reaction.

Throughout the first phase of psychotherapy, this challenge was addressed by interpreting and frustrating her annulment, the pulsional reality that leads to loss of affectivity and the disappearance of pain.

P. had been told that as an infant, during breastfeeding, she used to cry often and that her mother, who was psychologically and emotionally absent, managed her crying with sedatives. Little P.'s reaction to her distress was to make her mother, the breast and the content of the breast disappear. The annulment of a human relationship blocks out the pain and results in emptiness and loss of vitality and with them the loss of the possibility of finding a 'good object' with which a secure attachment might be developed.

During the first stage of psychotherapy, as she addressed her pulsional activity within the psychotherapeutic relationship, P. found again the sensitivity she had lost and mentally recovered it.

Notably, her relationship with the psychotherapy group showed increasing affectivity/sensitivity. Today, P. is a sensitive woman who has a sound relationship with a man.

The case of D. was different, because here the need to address depression was immediately clear.

Indeed, the severe depression that underlay D.'s anorexic phase had violent effects during her binge eating crises, which were very distressing and required her to lie in bed for hours. She often had suicidal thoughts.

As D. spoke about herself, it was clear that she had been trying to heal herself by making her body feel emotions by having sexual intercourse, as if physical stimulation could free her from the deep distress caused by depression and her inner void. In her case, loss of vitality was due to multiple sexual relationships that involved no emotion and caused a brief pleasure that was followed by an even greater sense of emptiness. Essentially, relationships that were based on seeking physical sensation were unable to fill the void that was related to a psychological problem; on the contrary, the repeated disappointments further contributed to her distress, feeling of emptiness and depression. In his important psychiatry text *Death Instinct and Knowledge*, Fagioli (2019) describes the case of a patient with symptoms quite similar to those of D. This woman constantly battled against extremely severe depressive crises that she partly resolved by eating and having sex.[7]

An important dream pointing to the cause of D.'s depression was the one involving a baby girl who was too small for her age. As noted above, this dream represented the realisation of a recovered internal image, although the baby girl image was extremely small. It may be hypothesised that D.'s depression laid in this very image that was small, too small, the small size suggesting that D. was less than other people. The image reflected the thought that lay behind it: self-devaluation. Indeed, D. had not achieved her own identity: she had dropped out of university and worked in the family business, where she was not considered a bright girl. D.'s physical relationships with men had no affective content and masked the annulment of her human reality and her identity. Yet, these were the goals she needed to achieve and strengthen to overcome her depression.

Addressing her problem required a major effort that involved interpreting and combating this vicious circle: disappointing relationships, a growing sense of emptiness, a lack of self-confidence and a worsening depression induced by repeated symptoms, which masked her annulment with respect to other people.

The repeated interpretations of the annulment on which some of her relationships were based led D. to achieve a separation from her pathological relationships. This was her first major achievement: rejection of pathological relationships.

In psychotherapy, if it is still possible to find a solution through a strong therapeutic relationship, a possible cure is already underway and opens new prospects for finding more meaningful human relationships.

Through the psychotherapeutic relationship D. began to feel more self-confident. Joining group psychotherapy strengthened her vitality, reduced the number of relationships based on introjective identification, and led to improved social relationships. Besides learning to establish valuable relationships, D. also learned to work better and as she sought to improve this aspect her identity also grew.

[7] "A patient came to me when she was having a full-blown psychotic crisis. She was eating excessively and putting on a lot of weight, which was having a devastating effect on her. She had sex frequently, with no qualms, having one-night stands, even going as far as asking strangers for lifts she did not need just to have sexual intercourse, no matter how quick. She soon made me comprehend that she was continuously fighting against terrible depressive crises, which she managed to control to some extent by eating and having sexual intercourse" (Fagioli, 2019, pp. 125–126).

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CONCLUSION

The reduction or resolution of ED symptoms in both patients, their discontinuation of drugs and the qualitative improvement of their oneiric activity, which were reflected in their psychological scores, seem to support the value of treating AN with psychodynamic psychotherapy based on Fagioli's HBT.

These encouraging results also seem to confirm the hypothesis that, from a psychopathological viewpoint, prolonged fasting and recurrent episodes of binge eating/purging behaviour are two aspects of the same mental disease, whose psychopathological core is often depression and sometimes fragmentation.

Given the need for a multidisciplinary approach, the favourable outcomes in these patients highlight the key contribution of the 'therapeutic alliance', a non-specific therapeutic factor, to the treatment of EDs, as recently stressed by Monteleone et al. (2019), who also called for greater efforts in the study of evidence-based therapies and their application in the treatment of these disorders.

One limitation of the study is that it is impossible to compare the interpretation of AN as a 'defence' from depression (or fragmentation), which is based on Selvini Palazzoli's intuition and taken further through HBT, with other hypotheses in the literature.

Further work on the subject is clearly needed. An analysis of a larger number of case studies with additional single and comparative cases can help replicate the present clinical observations and increase the validity of this study.

Conflict of interest

The author does not report any financial or personal connections with other persons or organisations, which might negatively affect the content of this publication and/or claim to have rights thereto.

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