

## **Re-Reading a Case of Anorexia Nervosa, with a Depressive Basis, Using Contemporary Reichian Analysis**

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### **Abstract**

The present study is a review related to re-reading the analysis of the factors involved in the genesis, evolution and outcome observed in an anorexia nervosa case report. The reassessment was conducted from the perspective of a new global scientific paradigm for scientific evidence, in a specific branch of this methodology, known as “translational research”, which is the application of high methodological-quality evidence, turning it into innovative therapeutic resources, that can make the difference in the management of clinical conditions with low responsiveness to conventional therapeutic resources, as in the case of Anorexia Nervosa, which is the manifestation of a serious eating disorder that may present risks to the patient. Therefore, the scope of the present research is to evaluate the limits and potentiality of individual psychotherapeutic intervention in cases of anorexia nervosa, with a depressive basis, by means of a clinical – analytical reading.

The method for the study was the deep analysis of a clinical case, based on the analytical-therapeutic relationship, on the psycho-bodily activations and their related psycho-pharmacotherapy. These are the three active principles in Contemporary Reichian Analysis, which represents a theoretical-practical reference in an appropriate psychotherapeutic process, as detailed below.

**Keywords:** Eating Disorders; Anorexia Nervosa; Depression; Psychotherapy; Contemporary Reichian Analysis; Analytical Therapeutical Relationship; Psycho Bodily Activations; Psychopharmacotherapy; Evidence-Based Medicine (EBM); Translational Research

### **Introduction**

Evidence-Based Medicine (EBM) is a new global contemporary scientific paradigm, which represents the fullest understanding of biological phenomena and processes that may threaten the lives of individuals, in terms of life expectancy, wellbeing, mental health or quality of life. Therefore, due to the impact of risk factors arising from various causes or biases about the evolution of diseases, it becomes clear that in order to improve the assertiveness of interventions, it is important to bear in mind that Health Sciences are ruled by laws of probability, or deviance, from expected outcomes, among which existential subjective biases are prevalent.

In a context in which uncertainty may prevail, EBM has specific, systematized criteria to assess interventional procedures and make them as assertive as possible. Among these criteria

are more assertive health care resources, either for diagnosis, or for the treatment and prevention of diseases, which must respect the principles of effectiveness (what makes the difference), efficiency (good cost/benefit ratio) and safety (minimal probability margin for adverse events to occur).

Therefore, in the real world, from an EBM perspective, practices tend to get as close as possible to patients’ expectations, as well as rationalizing the use of available resources, which is “Good Clinical Practice”.

It is often recognized, that patients seem to evolve less and less according to the assumptions of the physiopathology of the disease that led them to seek help. Interventions related to health care should, indeed, be unique and personalized and each case should be treated as if it were the only one of its kind. In this

way, the decisions made by the professional, operating within EBM paradigms, as to the appropriate timing and type of intervention, become more assertive.

EBM “translational research” comprises the application of scientific evidence with high methodological quality, turning it into innovative therapeutic resources that can make the difference in the management of clinical conditions showing low responsiveness when treated with conventional therapeutic resources. In this regard, the intervention focused on herein, was planned following EBM methodology and from the perspective of translational research, beginning with a PICOT-question elaboration (Problem/Intervention/ Comparison/Outcome/ Time) used to assess the problem at hand.

### Anorexia Nervosa

Anorexia Nervosa refers to an eating disorder that leads an individual to deeply worry about his/her body weight, having a distorted self-image and a morbid fear of getting fatter. This is a phenomenon that is growing among women (about 10% of the female population is affected) and is characterized as being the psychiatric disorder with the highest mortality rate.

Characteristics of the personality and precursor behaviors related to this disease may include: perfectionism, diet, negative affectivity, depression, impulsivity, anxiety disorders, and worry about environmental pressure to be thin.

From adolescence onwards, anorexia nervosa has a rigorous ideal from the Ego, narcissistic vulnerability, and conflict between dependence and autonomy, together with the rejection of impulses and difficulty in facing them.

S. Freud noted that “anorexia is an eating neurosis in parallel with melancholy: a melancholy that occurs where sexuality has not been developed. The loss of appetite, in sexual terms, is the loss of the libido” (Minuta G- W.Fliess- 1895, 2:29-35).

K. Abraham commented that the melancholic person’s sadistic drive seems to tend to annihilation, devouring the object of love. Psychoanalytical studies from Evelyne and Jean Kestenberg and Simone Decobert see a structure with elements of perversion in the anorexic person: the pleasure of being unsatisfied in cultivating situations of emptiness and hunger.

The stance of contemporary Reichian analysis shifts analytical etiopathogenesis of compulsive eating disorders (CEDs) along the arrow of the evolutive phylo-ontogenetic time, placing it in the suffering Self’s primary object relationship, originating from the primary intrauterine orality of the deep umbilical area, the 6th bodily level, and the mouth, which is the 2nd bodily level. Moreover, from a psychodynamic perspective, there is a secondary narcissistic defense which is peripherally marked on the 3rd bodily level, neck which is very rigid and almost armor-plated.

Considering the basis of our liquid modernity, which features accelerated, rarefied relationships, strengthens the hypothesis for another etiopathogenic factor of anorexia: the social scene. The Family Superego has been replaced by a social media superego, which appears to be persecutory and excluding, thus making primary objectal relationships vulnerable, guiding us towards even more exaggerated immersion in the great oral area. Currently, there is increasing use of atypical antipsychotic and antidepressant drugs.

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What are we asking for today? Are we seeking to fill the emptiness in our affective relationships? Do we want more structure and less oral liquidity, so that we can bear our accelerated rhythms? Or is it both of these?

Fundamentally, those drugs must be used to facilitate psychotherapeutic contact, reducing symptomatology and taking it beyond the limits of the oral character trait!

### Methodology

Contemporary Reichian Analysis (CRA) provides a highly-coherent epistemological reading which is informed by the Theory of Complexity (entropy/negentropy) and general systems theory and examines relationships and the interdependence between the parts making up the whole. CRA thought derives from both a circular and a linear approach, considering both partial and whole, both bi-dimensionally and three-dimensionally.

CRA includes bodily intelligence as an extraordinary trait in a three-dimensional vision of the person: providing a proper, precise, psycho-bodily grammar-system, it proposes a clinical-analytical and bodily re-reading of psychopathology and the unconscious, opening up the pre-subjective and inter-bodily dimensions within the realm of the therapeutic setting.

CRA uses a differentiated diagnosis that permits a personalized therapeutic project to be drawn up. It observes the “how” of the thinking and of the verbal language, the bodily language and the character of the relationship, as well as the evolutive time and the patterns of traits that are deposited in the “drawers of time” during the whole history of a person.

The CRA model combines psychotherapy, psychopharmacology, neuroscience, psychoanalysis and corporeity while maintaining dialogue with other approaches. CRA starts from the observation of the phenomena of life, their causes and their sequence in time. CRA introduces the phylo-ontogenetic arrow of time with the marks imprinted by the object relationships experienced during the evolutive steps on the peripheral levels of the body, that will later make up the relational styles, but that will also create epigenetic imprints and neurotransmitter imprints in the cerebral nuclei during the stratification of the brain. The CRA model, including the imprinted signs of the biological and biographical history of a person, considers that the body first receives impressions in an ontogenetic-bottom-up direction and afterwards, achieves bottom up-top-down circularity during the development of the formation of the mind. Informed by the internal evolutive world, the body emerges on the negentropic arrow of time.

In fact, life begins, ontogenetically, from conception and develops until cerebral maturity, following an ascending, evolutive, negentropic direction. Our upright stance, which is a result of the phylogeny that unites the three-dimensionality of space-time, has permitted deep stereoscopic observation of our surroundings.

Therefore, the bottom up / top-down circularity is taken into consideration in the diagnosis and in the therapeutic project directed to that specific person. The clinical symptoms will then be evaluated as well as the biological-biographical history that has been marked on them by the relational bodily levels. The relational style of the character traits, which have been marked

by the implicit requests of the person's evolutive stages, would also be evaluated.

The aim of directing the therapeutic project is to develop a more accurate, personalized diagnosis, including the bodily and relational levels, which transmit information about the central nervous system from the periphery through the cortico-spinal tract. By enhancing clinical-analytical-bodily vision, it is possible to establish a "geometric" etiopathogenic location for eating disorders, psychosomatic diseases and affective disorders. In the therapeutic setting, the beginning of this journey was in the first 500 days of the primary object relationship, in which, as A. Damasio said, we go from "the I Object to the I Subject".

In its psychotherapeutic evolution, CRA compares, considers and includes the most recent, significant neuroscientific findings offered by the research of A. Damasio, V. Gallese, G. Bateson, F. Varela, H. Maturana, E. Tiezzi, S. Porges and E. Kandel, among others.

### Clinical-Analytical Case

Isabella is 38 years old, 1.55 m. tall, and weighs 37 kg. Our objective is to identify the "when", the "where" and the "how" of Isabella's imprinted signs, on her evolutive arrow of time, and her relational patterns that have led her to the expression of anorexia nervosa as a depressive equivalent.

Isabella recognises that she needs to process the ending of her relationship with her ex-boyfriend, when she lost 10 kg. In the anamnesis, she reported that her first anorexia crisis happened when she was 14, the second crisis when she was 29, and she is seeking therapy for her third crisis. She was born to her parents by natural birth following an unplanned pregnancy, but she was not breastfed. She reported that, from pregnancy onwards, her relationship with her mother has never been good. Isabella said that her mother was desperate when she heard she was pregnant. Isabella always describes her mother as being an unbalanced, bad person.

The perinatal period represents a critical time frame when environmental experiences can cause long-term consequences on the nervous system and on the behavior, stress and allostatic load (stress) with incidence on the prefrontal cortex, hippocampus or amygdala.

Functional neuroimaging studies have shown an increase in volume in major cases of depression and maternal anxiety disorders.

In fact, in women affected by depression during the third trimester of pregnancy, Oberland et al. observed a higher degree of methylation of the promoter and exon 1F in relation to the NR3C1 glucocorticoid receptor in their neonates.

Similar results were confirmed by McGowen et al. who studied the expression of the gene NR3C1 in neurons in the hippocampus of a person that was a victim of sexual abuse as a child and later committed suicide.

Allan N. Schore states that the left brain is the one that thinks and ratiocinates, it is highly verbal and analytical, it is not developed before the second year of life and, therefore, has little participation in primary relationships.

The first, critical, period of development of the right side of the brain starts during the third trimester of pregnancy (or even earlier?) and continues until the second year of life. The development of the right side of the brain is fundamental for emotional safety because the right side is molded by the relationships with the environment during infancy.

According to Allan N. Schore, a particularly significant relationship, such as the therapeutic relationship, is inherent to the experience of attachment that is able to activate circuits on the right side of the brain, causing a series of changes to affectivity and emotional expression. This is a factor that can influence mutations in epigenetic processes.

SM Stahl compares the therapeutic relationship to psychopharmaceuticals, claiming it can represent a neurobiological probe that is able to induce epigenetic changes in the cerebral circuits and could be considered to be "epigenetic-medication".

Isabella's mother, who was a Jehovah's Witness, was very aggressive, reactive and abusive to her 4 children. Isabella is the third of four siblings and she has two older sisters and one younger brother.

The parents, who are Argentinian, were married for eight years. After the parents separated, the mother started a new relationship with another partner, and Isabella chose to live with her father, from eight to eleven years of age.

When Isabella was eleven years old, her father found a new partner and she returned to her mother's home. She lived there from eleven to nineteen years of age. Her father, a very intelligent man who is successful in his profession, had an executive position and travelled frequently at the time. Although he was very affectionate with his children, he didn't express it bodily.

When Isabella was around twelve or thirteen years of age, she was accused by her mother of seduction and complicity in the abuse she suffered from her stepfather. She was so shocked by her mother's interpretation and the lack of maternal protection that she went to hide under her bed in her bedroom and stayed there for two whole days.

Isabella did not love her body and did not accept herself - she thought she was ugly.

When her two older sisters left her mother's home Isabella was fourteen, which was when her first crisis of anorexia with a depressive basis occurred. Her mother did not "see" her and did not notice what had happened. After a couple of years, the younger brother also left home to join his sisters. Isabella was the last one to leave her mother's home, returning to her father's home when she was nineteen, where her father and his partner welcomed her.

Isabella remembers that she has always been criticized by her mother. The mother used to say that she was ugly and used to hit her, predicting that Isabella would never do anything good or useful.

A second crisis of anorexia with depressive basis occurred when Isabella was 29, with the end of another affective relationship.

When she arrived at therapy, she thought she was “a disgusting person who has nothing to offer to anyone”.

She stated the only reason she would not take her own life was that she didn't want her father to suffer because he didn't deserve to.

As for her professional life, she is very competent, she has a high-ranking position and leads a team. She doesn't know the language of relationships, and therefore she doesn't know how to talk about anything but work.

### Observations

The symptoms linked to Isabella's eating disorder give us clues about the relationships that were established during her primary orality, at the time of her inter-bodily and pre-subjective communication with her mother.

In Isabella's case, the anorexia has also had an important emotional function to maintain dominance over the capacity to "distance", alternating it with a deficient oral phase caused by the lack of maternal nursing and "blocking" the neck as a form of narcissistic defense.

Her implicit request was related to exclusion and abandonment issues.

She was not breastfed, her mirror-neurons didn't mirror maternal inclusive smiles, much less her mother's warmth. Isabella didn't grow up in a sufficiently-good maternal field to acquire a firm-enough basis for good resilience.

Primary inclusion and acceptance are born from the signs transmitted by the mother's bodily language (mirror-neuron, contact and presence) during the stages of the primary object relationship.

Isabella reports abandonment and a lack of care from her mother. She complains of "not being seen" by her mother, and that neither she nor her needs were noticed, not even during her crisis with anorexia. On the contrary, she received violent responses, abuse and threats, and had no safe place to relax. In order to survive, she had to be in a constant state of alarm and prepared for escape.

She tells of an event she experienced when she was six years of age, when she did not want to eat and her mother rubbed the dish in her face.

The “how” of Isabella's relationship with her world in intra-uterine and oro-labial time is very stressful. It is the time of initial dialogue with partial eyes, mother-uterus and mother-breast; such imprinted signs are very evident in the historical narrative of her relationships, even the later ones.

The “how” we communicate with our world, which is to say our relational style, is a “condition sine qua non” of life.

Communication is the basis for the interactions that feed relationships.

Isabella sought psychotherapeutic treatment because of the difficulties she had in communicating with her colleagues at work, but she also had difficulties in her affective relationships with men.

In her therapy sections, she has always repeated that she would never be able to live in a loving relationship, carrying the maternal emotional past that accused her of being incapable, ugly and imperfect. In fact, Isabella expressed a contemptible, distorted self-image, which is typical in those suffering from anorexia and depression.

### Treatment and Outcome

Isabella's analytical-therapeutic treatment started with a careful anamnesis of the ontogenetic relationships in her biological and biographical history, which was necessary in order to identify the most appropriate project for the therapeutic setting. The “position” and the “how” of the analyst had to be examined and individualized, so that the relationship between Isabella and the analyst-therapist was appropriate to handle the issues of exclusion and emotional emptiness effectively. In this way, the analyst could deal with her distorted body image and low psycho-emotional esteem.

In the therapeutic setting, the analyst made herself "present" and made contact, using her eyes as an affective mirror, being inclusive and smiling. Being aware of the inter-bodily and pre-subjective dialogues that were significant for the patient, the analyst used them as a careful guideline from which to seek her own resonating bodily levels for the counter-transference of traits to make the therapeutic project effective.

Isabella had suffered a relational pattern of exclusion, being left with a bitter taste by her primary intrauterine relationship and experiencing postpartum deficiency in visual, epidermic and gustatory neuron-mirroring. In the absence of those references, Isabella had had affective emptiness and had, at the same time, denied her own needs, manifesting omnipotent behavior and a narcissist attitude for survival.

From the analytical point of view, the issue relating to exclusion was evident in her intrauterine and oro-labial experiences during her primary biological relationship with her mother.

Myelination of the Ventral-Vagal Circuit occurs during the last three months of intrauterine life and continues into post-partum. This circuit regulates safety, danger and affective communication with the world, through neuron-mirrors, eye and skin contact, milk and prosody. According to S. Porges, neuroception contains information about everything that happens during this stage of development: sensations, emotions, intonation, posture and body language.

In Isabella's case, she had lived in dysfunctional states. Her body had defended itself by means of sympatheticotonia, with evident, chronic contraction in her neck, which was the location of her rigid Superego, which had little flexibility and allowed few relational exchanges.

Isabella had not learned how to exchange, nor how to receive or to give. In her relationships, she had not achieved intimacy, with herself or with anybody else.

Her bodily expression lacked contact and presence. Her gaze was not bright, but, rather, it was hard and cold. She was extremely rational, with herself and with the world.

In the cognitive realm, she was very intelligent and bright, but in the affective realm she was weak and very alarmed.



At the time of her separation from the paternal field, which represented the little affectivity she had received up to then in her life-story, and her return to the arid maternal field, Isabella fell back into depression and into the anorexic mindset expressing that depression.

The analyst worked with all those emotional issues and helped Isabella, little by little, to elaborate and repair her neurovegetative dystonia, balancing her vagal-sympathetic system and lowering her reactivity and her disorganization. She was cared for and nurtured with tenderness and sensitivity by the analyst-therapist, whose goal was to help Isabella alter her platform of insecurity and mistrust in her relationships with the Other than Self.

The presence, the contact, the tenderness, the respect for the needs and for the rhythms of the Other that were proposed by the analyst were the fundamental ingredients for the deconstruction and reconstruction of a platform that is now, functionally, more effective and sustainable for Isabella.

The analyst-therapist offered her inclusive eyes and appropriate counter-transference, from the precise diagnosis and relational "how" chosen at the beginning of the treatment, thus creating a true, trustworthy, affective relationship between her and her patient. Isabella received the benefit that was necessary for the evolution of her self-esteem and confidence, leading her to learn how to receive, how to exchange and, therefore, how to communicate better in the relational world.

Isabella has achieved intimacy and self-confidence through the feminine position of her analyst that expressed a "sufficiently-good mother" who included her with tenderness, honesty and clarity.

Isabella has strengthened her defensive assertiveness, finding a safe place for herself, without abuse, and she has improved her interaction with the world, building a strong affective link with the analyst who represents a trusted point of reference, even today, after treatment has concluded.

The therapeutic setting represented ideal, fertile ground for exchange, being a little biosphere, like a living system that is complex and evolving, bringing positive outcomes thanks to an appropriate, respectful relationship through which to take evolutive steps and find a sustainable rhythm thanks to a careful, accurate diagnosis. The analyst was able to deal with the deficient development phase and its associated dysfunctional bodily levels that had been marked in the intercorporeal, pre-subjective time of the patient's life-story.

Bodily activations are phylo-ontogenetic movements and they can represent epigenetic medicine within the therapeutic relationship. They are the outcome of a structural coupling arising from careful use of the language of character traits. Some bodily activations were used by the analyst.

The selection of these corporeal activations took into consideration the diagnosis, as did the selection of the most appropriate character trait for counter-transference in this case. Both of these choices were informed and directed by the person's biological and biographical history, as well as by the implicit and explicit requests expressed by Isabella in the Therapeutic Setting. It was very important to bring "serotonin" to Isabella's

Primary Object Relationship, in her early biological-biographical stages.

Some of the corporeal activations used in the above-described case included:

- 1 – Converging on a flash-light, towards a fixed point;
- 2 – Returning your gaze towards your own nasal pyramid from the fixed point of a flash-light,
- 3 – Repeating these same activations without using the flash light, looking to a fixed point on the ceiling above the couch and returning to the nasal pyramid.

The "how" of the "right distance", of the smiling eyes, of the warm, inclusive prosody of the analyst-therapist added to the convergence of Isabella's gaze towards the fixed point of light, and its return to her own nasal pyramid, are the able to balance serotonin and dopamine levels, so as to become able to separate and to functionally identify oneself in the analytical time of the previously-deficient primary object relationship, just as it had been in Isabella's case.

In a psychoanalytical reading, it is possible to identify issues associated with exclusion/inclusion, dyadic relationships, interdependence and autonomy and first separation-individuation.

### Conclusion

The Evidence Based Medicine approach affirms that "when revisiting any field of human knowledge from the perspective of scientific evidence, a level of knowledge can be reached that was beyond older, conventional scientific methods based purely on cartesian logic". That represents exactly what has been observed in the present report, and provides the opportunity for significant developments through further qualitative clinical research.

**E. Kandel stated:** "Words modify synapses and this has psychotherapeutic validity in the world of Science".

**G. Ferri states:** "Words modify synapses, but the "how" words are expressed also modifies synapses, and appropriate bodily activations also modify synapses."

### Glossary:

**Evolutive Stage:** One of a number of periods, from conception onwards, during an individual's ontogenetic evolution, representing "when" a significant event occurs and is marked on a person's psychobiological unity. This is a biological stage in evolutive development in a person's life, during which the history of the person's relationships with relational objects are imprinted and recorded on specific areas of the body.

**Relational Bodily Level:** The specific location in the body "where" imprinting's and signs are marked by object relationships during the evolutive stages; they are the entrances, or portals, leading to the central nervous system, receiving and conveying information;

**Relational Object:** S. Freud's concept referring to interactions with objects (which can be "partial" or "whole" objects) to satisfy the impulses (drives) during a person's biopsychic bodily development;

**The Object Relationship:** This describes "how" a person interacts with his/her world from a psychoanalytical perspective. There is an oral object relationship and, for example, there

could be a psychoanalytical diagnosis of a melancholic object relationship;

**The Primary object relationship:** The period of time of the biological relationship with the mother that has two specific parts: the intrauterine stage, lasting nine months, and the oro-labial stage, lasting approximately six months;

**Character:** Etymologically character means "incised mark" and it is imprinted by the biological-biographical history of a person. Thus, it comes to represent a person's specific way of being and his/her style of relationship with himself/herself, with the Other and with the world. It can be a mechanism used for narcissistic protection, preservation and or adaptation;

**A Character Trait:** A trait arises from a series of relational patterns imprinted over time by dialogues with the unconscious. Each of us has a set of traits that reveal our relational styles when communicating with another person and or with the world;

**The "How":** The pattern of the relational style of the character traits;

**The "When":** The specific evolutive stage of ontogenetic development;

**The "Where":** The relational bodily levels, or peripheral afferents;

**Internal time:** This is the time, or time-line, of the emotions, feelings and sentiments, It is evolutive, and negentropically upward;

**External time -** The linear, objective time of a person from birth in which the individual is born, develops, matures, ages and dies. It is the time of thought, of seeing and considering. It is involutive and entropically downward;

**The Phylo-ontogenetic, evolutive arrow of time -** The whole life of a person from conception onwards. The whole period of a person's life is observed: the relationships and the time of the formation of the relational patterns, as well as the body, the brain and the thoughts.

By considering the time from conception onwards, we can explore the biological and biographical depth of the upward, negentropic evolution of the human being as a complex living system. We can read and order the person's ontogenesis, also in terms of character, in the mind to body direction;

**Bodily Activation** – A sequence of appropriate phylo-ontogenetic movements for one or more of the seven bodily levels that can reach the cortical-spinal areas through the peripheral afferent pathways. By reaching the central areas, it can connect the depths with the surface, connect implicit memory with explicit memory. It is like a fractal elevator that can repair trauma by adding new imprinted marks and permitting new patterns, by forming new neural circuits and by stimulating and balancing the neurotransmitters;

**Living Systems** – Systems functioning, and interacting, as or like a set of living organisms, ranging from unicellular organisms to individuals, organizations, planetary bodies or, even, the whole universe;

**A Biosphere** – A three-dimensional space in which the entropic

arrow of time can be reversed. The planet's biosphere, or the psycho-analytical setting, for example;

**Entropy** – According to Carnot's 2nd law of thermodynamics on dispersion, closed, isolated systems always move from higher order down towards greater disorder, or entropy, in an irreversible process.

**Negentropy** – From the biological perspective, as Darwin affirmed, the living universe evolves upwardly from disorder to order, towards higher states and greater complexity. Our lives, for example, begin inside the uterus, which is, itself, a partial relational object, and we evolve towards adulthood, becoming Subjects or "whole objects";

**Dissipative Structures** – Phenomena creating order far from thermodynamic balance, such as those that may arise in chaos theory. According to Ilya Prigogine, in these cases determinism and unpredictability co-exist;

**A Fractal** – A complex, repetitive, never-ending pattern across different orders of magnitude. These are frequently found in nature;

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