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REDUCING EATING DISORDERS THROUGH EXPERIENTIAL PSYCHOTHERAPY: A CASE STUDY OF ANOREXIA NERVOSA

AMELIORAREA TULBURĂRILOR DE ALIMENTAȚIE PRIN PSIHOTERAPIA EXPERIENȚIALĂ: STUDIU DE CAZ PE ANOREXIA NERVOASĂ

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Annotation: *Over the last decades, the prevalence of eating disorders has increased dramatically. In the current psychiatric nomenclature of the DSM-5 [2], the eating disorders consist of three clearly defined syndromes, i.e. anorexia nervosa, bulimia nervos and binge-eating disorder. The onset of the most clinical cases occurs in adolescence or young adulthood. Data provided by psychiatric practice reveal that eating disorders occur more frequently in women, compared with men. These disorders appear to be multidetermined. Thus, the risk for (or protection against) the development of eating disorders resides in several factors, i.e. genetic, neurohormonal, family, psychological and sociocultural. Negative life events can also play a triggering role. Anorexia nervosa is a debilitating mental disorder with profound biological, psychological and social consequences. Although the overall incidence rate of anorexia nervosa is considerably stable over the past decades, the incidence among adolescents has increased. Different types of psychotherapeutic interventions (e.g., family-based therapy, cognitive-behavioral therapy, dialectical behavior therapy, interpersonal therapy, etc.) are used to treat eating disorders. However, the benefits of experiential techniques (e.g., emotion-focused therapy or gestalt therapy) have been less explored. This paper focuses on a 19-year-old adolescent girl presenting with symptoms of anorexia nervosa. The complaints, results of the initial assessment, goals of the therapeutic sessions, working techniques as well as gains of the intervention based on experiential methods (e.g., the empty chair technique, metapositions, cognitive reframing, etc.) are reviewed. Practical implications are discussed considering the potential of experiential psychotherapy in assisting clients with eating disorders.*

Adnotare: *În ultimele decenii, prevalența tulburărilor de alimentație a crescut dramatic. În nomenclatura psihiatrică actuală prevăzută în DSM-5 [2], tulburările de alimentație includ trei sindroame clar definite, adică anorexia nervoasă, bulimia nervoasă și tulburarea de alimentație excesivă. Debutul cazurilor cu cea mai mare relevanță clinică are loc în adolescență sau la vârsta adultă tânără. Datele furnizate de practica psihiatrică relevă faptul că tulburările de alimentație apar mai frecvent la femei, comparativ cu bărbați. Aceste tulburări par a fi multideterminate. Astfel, riscul pentru (sau protecția împotriva) dezvoltării tulburărilor de alimentație rezidă în mai mulți factori, și anume genetici, neurohormonali, familiali, psihologici și socioculturali. De asemenea, evenimentele de viață negative pot juca un rol declanșator. Anorexia nervoasă este o tulburare mintală debilitantă care are consecințe biologice, psihologice și sociale profunde. Deși, în ultimele decenii, incidența generală a anorexiei nervoase este considerabil stabilă, amploarea în rândul adolescenților a crescut. Diferite tipuri de intervenții psihoterapeutice (de exemplu: terapia de familie, terapia cognitiv-comportamentală, terapia comportamentală dialectică, terapia interpersonală etc.) sunt utilizate pentru a trata tulburările de alimentație. Cu toate acestea, beneficiile tehnicilor experiențiale (de exemplu, terapia centrată pe emoții sau gestalt terapia) au fost mai puțin explorate. Această lucrare își concentrează atenția pe cazul unei adolescente cu vârsta de 19 ani, care prezintă simptome specifice anorexiei nervoase. Sunt trecute în revistă plângerile, rezultatele evaluării inițiale, scopurile*

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ședințelor terapeutice, tehnicile de lucru, precum și beneficiile intervenției bazate pe metode experiențiale (de exemplu: tehnica scaunului gol, metapozițiile, resemnificarea cognitivă etc.). Implicațiile practice sunt discutate avându-se în vedere potențialul psihoterapiei experiențiale în asistarea clienților cu tulburări de alimentație.

Keywords: *Eating disorders, anorexia nervosa, experiential psychotherapy, case study.*
Cuvinte-cheie: *Tulburări de alimentație, anorexia nervoasă, psihoterapie experiențială, studiu de caz.*

Introduction

Eating disorders are characterized by a persistent impairment in eating habits that results in inappropriate food intake and causes damage to physical health and/or psychosocial functioning [2]. Clinical diagnostic criteria have been established for pica, a rumination disorder, an avoidant/restrictive food intake disorder, anorexia nervosa, bulimia nervosa and binge-eating disorder. Despite some common psychological and behavioural features, these disorders differ substantially in terms of clinical evolution, prognosis and treatment. For this reason, the diagnostic criteria fall into a scheme in which all of the disorders above-mentioned (apart from pica) are mutually exclusive, so that only one diagnosis can be assigned to a clinical episode [2]. Some patients with eating disorders show symptoms similar to those specific to substance use disorders, such as inability to control cravings or compulsive behavioural patterns. This similarity may reflect the involvement of the same neural systems in both types of disorders, including those that regulate self-control of behavioural impulses and reward-related cognition.

Anorexia nervosa: clinical characteristics, prevalence and comorbidities. Mental/nervous anorexia (lat. *anorexia nervosa*) refers to one of the most common eating disorders, which is mostly found in young people and is characterised by a more or less systematic refusal to eat. It rarely begins before puberty or after the age of 40 [*cf.* 2]. This eating spectrum disorder has mainly psychogenic causes. Anorexia *nervosa* covers a voluntarily controlled food restrictive behaviour (most often in an obsessive-compulsive manner), accompanied by weight loss and numerous cognitive, emotional and behavioural problems. Occurring most often in adolescence (in almost all cases among girls), this mental disorder is associated with amenorrhoea (caused by functional disorders of the hypothalamic-pituitary axis), hyperactivity related to eating, physical effort and weight control, changes in personality profile, as well as persistent body image disorders. The evolution and consequences of anorexia nervosa are greatly varied. In young patients there could be atypical elements, such as denial of the fear of obesity. Older patients usually have a longer history of this disease. For this reason, their clinical picture could include a greater variety of enduring disorder symptoms [2].

The fifth edition of *The Diagnostic and Statistical Manual of Mental Disorders* [2] lists the following criteria for diagnosing anorexia nervosa:

A. Restriction of caloric intake relative to requirements, leading to a significantly low body weight in the context of age, sex, developmental trajectory and physical health. *Significantly low weight* is defined as a weight that is less than minimally normal or, for children and adolescents, less than that minimally expected.

B. Intense fear of gaining weight or of becoming fat, or persistent behavior that interferes with weight gain, even though at a significantly low weight.

C. Disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or persistent lack of recognition of the seriousness of the current low body weight.

Anorexic behavior has been described since the 11th century, but the term *mental anorexia* was introduced by H. Huchard in 1883 [*cf.* 8]. Initially, this disorder was associated with hysteria or obsessional neurosis. Later, endocrinologists attributed it to pituitary insufficiency. After World War II, advances in neuroendocrinology better explained the relationship between endocrine disorders

associated with anorexia and psychological problems. Although clinical research findings have sometimes diverged, the definition of the anorexic syndrome is well established [2].

Generally, the onset occurs before the age of 25, when the teenager or young woman justifies her need for dieting to her entourage due to a feeling of being overweight. In some cases, anorexia is associated with bulimic episodes, eating rituals (stereotypies), self-induced vomiting, laxative and/or diuretic use and other atypical behaviours such as systematic thigh perimeter measurement or excessive physical exercise [8]. Sometimes, weight loss can exceed 25% of the initial weight. The characteristic physical appearance is seen in the blurring of the female form and the reduction of visible muscle mass in the limbs. The absence of symptoms associated with common mental disorders explains the difficulty of family or friends to accept the psychological causes that could underlie anorexia and the severity of the disorder. These are often trivialised and regarded as transient. The main marker of anorexic disorder is the patient's unwillingness to recognise their weight loss and neglect of their health. Other symptoms include hydroelectrolytic, metabolic and hormonal disturbances, hypnic disturbances, hypervigilance, repression of sexuality by asserting intellectual preoccupations (as a defensive mechanism), preference for activities that promote body aesthetics, etc. Sometimes (approximately 5% of cases), death could occur through undernutrition accompanied by severe physiological disorders (e.g., cardiac) or suicide [*cf.* 2]. Normalisation of body weight is not evidence of cure. Some individuals with anorexia nervosa recover completely after a single episode, others show a fluctuating evolution with weight gain followed by relapse, and others have a chronic evolution over several years [2]. Relapses of anorexic behaviour are common. In some cases, it is necessary to hospitalize the anorexic patient to restore nutritional balance, treat medical complications and manage health risks. In most cases of anorexia nervosa, remission occurs within five years of the onset of clinical symptoms.

The 12-month prevalence of anorexia nervosa among young females is approximately 0.4% [*cf.* 2]. Anorexia nervosa is far less common in males than in females. Clinical populations generally reflect approximately a 10:1 female-to-male ratio. Anorexia nervosa can cause various functional limitations that vary from patient to patient depending on other individual circumstances. Some patients remain socially and professionally active, while others become socially isolated and/or stop performing their school or work duties. Other features which can be associated with anorexia nervosa include concerns about eating in public, feelings of personal ineffectiveness, irritability, low self-esteem, negative body image, a strong desire to control one's environment, inflexible thinking, limited social spontaneity, social withdrawal, overly restrained emotional expression, etc. Compared with patients with restricting type, those with binge-eating/purging type score higher on impulsivity and are more likely to abuse alcohol and other psychoactive substances. Frequently, anorexia nervosa is associated with bipolar, depressive or anxiety disorders, as well as with the obsessive-compulsive disorder [*cf.* 2]. Anxiety disorders often appear before the onset of anorexia nervosa. Obsessive-compulsive disorder (OCD) occurs mainly in patients with restrictive anorexia nervosa. Alcohol use disorder and other substance use disorders may also be comorbid with anorexia nervosa, especially among patients diagnosed with the binge-eating/purging type.

Comprehensive treatment of eating disorders requires the attention of professionals oriented in four distinct directions [48], as follows: a) biological aspects, particularly nutritional status to which the harmful consequences of starvation and undernutrition on the one hand and severe obesity on the other are added; b) eating disorder-related behaviours, which include restrictive and ideosyncratic eating patterns, overeating and purging (especially through vomiting, laxative use and compulsive physical exercise); c) thoughts, emotions and attitudes related to eating disorders; these could include distorted self-perceptions, overvalued ideas and self-loathing about body shape and weight, decreased cognitive complexity, increased obsessiveness and perfectionistic thinking that accompany malnutrition, to which increased emotional fragility about nutrition is added, i.e. symptoms of anxiety, depression and sudden changes in affective mood; d) associated

psychopathological and interpersonal problems; it is well known that eating disorders can occur in comorbidity with affective mood disorders, anxiety, obsessive-compulsive disorder, personality disorders, substance use problems, family and interpersonal difficulties, as well as awkward social situations in which an anorexic/bulimic person could face.

Pharmacological and psychological treatment varies according to the gender, age and physiological characteristics of the patient diagnosed with an eating disorder, the stage, severity and chronicity of symptoms, the presence and severity of other comorbid psychiatric/interpersonal medical conditions, and the family and social context, respectively. Professionals in the medical and psychological care of patients suffering from anorexia nervosa, bulimia or other eating disorders recommend initiating treatment by focusing on nutritional rehabilitation. Once this has been addressed, patients are usually more willing to participate in an individual/group psychotherapy programme which, *per se*, can be much more effective.

Eating disorders in adolescence. Even though eating disorders can also occur in adults, they are specific to adolescents. For example, anorexia nervosa is especially common among pubertal girls and bulimia generally occurs in girls in their late teens, having an average age of 18 years [*cf.* 36]. Community and clinical epidemiological studies indicate very large differences between girls and boys in the prevalence of eating disorders, with a ratio of 10/15:1 [14]. This ratio is not especially true for pubertals where the frequency is approximately equal [13].

Risk factors for eating disorders among pubertals and adolescents include biological variables as well as psychological, family and socio-cultural dimensions. Biological factors highlighted in numerous studies refer to: a) genetic influences [43, 47]; b) disorders in neurotransmitter systems such as serotonin [26, 45]; c) metabolic problems [3, 12].

Psychological and family risk factors include a very wide range of variables related to: a) differences between girls and boys in adapting to puberty-specific demands, such as changes in physical appearance and hormonal changes [31, 41]; b) the negative image and dissatisfaction that some adolescents, especially girls, have with their own bodies [28, 33]; c) unhealthy dieting patterns [12, 20]; d) involvement in activities that emphasize weight control and/or physical appearance [4, 15]; e) differences between girls and boys in their reactions to the onset/escalation of eating disorder specific symptoms [36]; f) the presence of eating disorders particularly among mothers [1]; g) poor levels of intrafamilial communication and lack of parental affection [6, 34, 42]; h) excessive criticism from parents [30]; i) problems with adolescent autonomy and identity [23, 27, 34]; j) lack of family cohesion [38].

Socio-cultural factors that can contribute to the onset of eating disorders in adolescents include: a) media influences on the standard of the female figure and the physical demands associated with masculinity [3, 32, 40]; b) expectations of the opposite sex regarding gender roles, which fuel the "superwoman myth" [39, 41]; c) racial [7, 29] or ethnic [19, 25] background.

Materials and methods of research

Psychotherapy is an applied branch that developed at the confluence of psychology, psychopathology and psychiatry. Initially, this theoretical and practical field was conceived as a means of therapeutic intervention (complementary to pharmacological treatment) addressed to patients with mental illness in psychiatric clinics [24]. During the 20th century, psychotherapy has evolved significantly through the development of intervention methodologies, the training of specialised professionals, the application of psychotherapeutic techniques in the successful treatment of some mental disorders (e.g. anxiety-related disorders, depression, obsessive-compulsive disorder, etc.) and, perhaps most importantly, the extension of psychotherapy outside psychiatric services. Currently, an important direction in the progress of psychotherapy is its use in mental health as a means of self-awareness, personal optimisation and overcoming adverse life or relational circumstances [21,24].

In the field of psychotherapy, numerous currents have emerged which have nonetheless many points of convergence. The ultimate target of the various psychotherapeutic approaches is to activate and enrich the personal resources of the clients in order to adapt more effectively and integrate satisfactorily into their life space. The humanistic-experiential orientation was outlined during the last half of the 20th century as a reaction to psychoanalysis and behavioural theories [24]. Classical psychoanalysis considered the human individual to be implacably determined by instincts and unconscious intrapsychic conflicts. Behaviouralist theories transformed the human being into an "automatic entity" that can be programmed and controlled. The humanist-experiential approach is based on a profoundly refreshing conception of the human nature. Experientialists value the premise that psychological and psychosomatic pathology reflects the influences of negative life experiences that block the "positive forces" of the human individual's personality, promoting health and well-being. In order to unlock these forces, and implicitly attenuate pathology, a psychotherapeutic context based on empathy, unconditional acceptance of the patient, the congruence and use of specific therapeutic procedures must be ensured [44].

Experiential psychotherapy considers the human individual as an active entity with latent potential that can be capitalized on [35]. The purpose of humanistic-experiential psychotherapeutic approaches is to maximise awareness of the self and to reach a superior level through which the individual acquires a clearer awareness of his or her own inner universe, external environment and spiritual dimension of human existence. Existentialists and transpersonalists emphasise self-determination, creativity, spontaneity, authenticity as well the integration of body, mind and spirit into a unified whole [5].

In a review of 86 studies, R. Elliott [10] reports a consistent body of empirical evidence according to experiential approaches that are effective at helping people make lasting change over time. Clients who choose humanistic-experiential psychotherapies show more change than those in no therapy at all. Other studies have shown the effectiveness of humanistic-experiential psychotherapeutic approaches (e.g. drama therapy, art therapy, emotion-focused narrative therapy, etc.) in improving symptoms specific to anorexia nervosa [22], anxiety [46], bulimia [9, 22], depression [11, 17, 37], post-traumatic stress disorder [16], Cluster B (e.g., borderline or histrionic)/C (e.g., avoidant personality disorder) personality disorders [18], psychotic disorders [11], etc.

A case study: results and considerations

The case study we are presenting in what follows has been suggestively named *Food that does not feed me!*

Case description. Georgiana is a 19-year-old teenager, a 12th grade student at a high school in Iași. She came to therapy following the recommendation of her family doctor and some specialized clinical consultations. The appearance of amenorrhoea, decreased appetite and obvious weight loss led the specialist in nutritional diseases to diagnose her with anorexia nervosa.

The client had an obvious bodily frailty, with below average weight and height for her age group. Observing Goergiana's movements and posture in our first meeting allowed us to notice a certain stiffness in her neck and nape area, a peculiarity which led us to hypothesize a high level of anxiety. Between the sofa and the chair, Georgiana chose to sit on the chair. She refused to hang her coat on the hanger, preferring to keep it on her lap, probably to create a barrier. She clung tightly with both hands onto her coat in a kind of self-hugging. This behaviour could be explained through a strategy Georgiana chose to cope with the unfamiliar situation. Probably, the novelty of the event i.e. the first meeting with the psychotherapist was associated with emotional insecurity (anxiety), the client's solution being to build protective shields.

The discussion with Georgiana revealed the following accusations: a) she usually ate once a day; on some days, she did not eat anything; b) she had difficulties at school (which she considered a school failure) due both to her refusal to attend certain classes and to her disinterest in learning in

general; c) she had a negative self-image (self-deprecation); we noted her rejection of her own body scheme (e.g., *I am dry, flat, shapeless and unattractive!*), as well as the abundance of critical terms (negative adjectives) in Georgiana's self-description; d) she had an almost permanent feeling of tiredness; d) she was not "in the mood" for self-care, going out, friends, school.

Family relationships. Georgiana did not bring up for discussion her relationship with her parents. She lived with her father. Her mother had died three years previously, when Georgiana was 16. Her father was mostly away because he had entrepreneurial activities that involved a lot of travelling. Georgiana was not fond of talking much about her mother (*She died and that's all*!). Her relationship with her father, when he was at home, consisted of poor communication only about things that needed to be bought or domestic choires. The father was not aware of Georgiana's poor results in school (*I only tell him that everything is OK and he leaves me alone*!). The only other person she consulted and trusted was her family doctor, namely a close friend of Georgiana's late mother.

Failing school. The client remembers that in her early years at school, she used to be top of the class (*Until the 9th grade, I only got first prize*). Georgiana's mother was closely involved in her school work because she had always wanted her daughter to be top of her class, not to embarrass her. For this reason, Georgiana felt a lot of pressure from her mother (*My mother never cared if I wanted it as much as she did or if I enjoyed learning and spending most of my time dealing with school!*). Moreover, in order to motivate Georgiana to learn, her mother resorted to harsh methods such as excessive criticism, humiliation (often in front of other people), beating her with a wooden spoon or a belt from her trousers, and other such measures which (as Georgiana stated) *made me feel like someone who had done something very bad for which I deserved to be blamed all the time.*

Traumatic experiences. Georgiana's initial interview clearly revealed her mother's death and the alienating relationship they had. Georgiana's mother had discovered her terminal lung cancer. From the moment she learned about her diagnosis, she only lived three more months. Even in this very short period of time, she acted cold and dictatorial with Georgiana *(My mother was only interested to know if I had eaten and what had gone on at school. This hurt me the most and made me think that I was worthless to my parents!).*

The aim of therapeutic intervention. The purposes of the initial interview were: a) to reveal the client's life history; b) to identify the core psychological trauma; c) to agree on the overall goal of the therapy sessions. After the anamnesis interview, it became clear that the objective of the next sessions would not be, as Georgiana had initially stated (*To eat better!*), but to explore her feelings about the loss of her mother and the relationship she had with her.

The relevant content of sessions. First session. In this first session, Georgiana expressed concern that she could not remember any happy memory with her mother. She was convinced there might have been some, but she could not think of any, and what scared her the most was that she could not cry when she thought of her mother. In this context, it was considered appropriate to use an exercise to help Georgiana express her emotions. The client was asked to draw a tear.

T. – *What does a tear look like?*

G. - *Small, thin!*

T. – *What makes it be like that?*

G. - *...who cares!*

Any attempt to develop the exercise received no response from Georgiana. Moreover, a certain discomfort of the client expressed by body agitation, verbal and paraverbal attitude, respectively was noticed. Georgiana had difficulties in expressing her own emotions probably because she was not used to it and had not been encouraged to do so. For this reason, the discussion was oriented towards topics such as what emotions are, what they mean, how important they are and how they help us in everyday life.

Second session. Within the first few minutes of arriving in our practice, Georgiana wanted to talk about a dream she had had a few days after the previous meeting

G. - *I happened to be walking around the city, in my own neighborhood, and what puzzled me was that even though it was broad daylight, there was nobody on the street. I was alone. It was a strange feeling that I can't describe. Then, I heard some kind of noise. I say 'a kind of' because it wasn't the usual city noises, it was the noise made by various animals. I told myself then in my mind that something had happened to the fence at the zoo and probably all the animals had escaped. I didn't know what to do! I simply froze and remained paralyzed on the spot, somewhere in the middle of the street. And I was waiting for them to appear, I didn't know from which direction, I just knew that they would appear. What animals would come, how would they react, what I should do?... all these questions were running through my head, but I couldn't move, I was paralyzed. After a few moments, I saw some rather large lions coming towards me. I was very scared, but I couldn't move from where I was standing. They came near me, sniffed me, or what lions do, and continued their way past me. Then, the tigers came, like big, fierce cats. I could sense danger. Then, the elephants came. I was afraid they would run me over, they were huge, I felt overwhelmed by how big they were, but they didn't run me over. The monkeys made a lot of noise, but they were playful, like naughty children. The dogs waddled around my feet very lovingly, and the cats almost climbed on my feet, they had a lot of nerve. Many birds were flying above me. They were happy to be out of their cage. Towards the end of the dream, I was getting used to all those animals around me. I felt like those birds, free! What do you think this dream means?*

T. – *Rightly so, what does this dream mean to you?*

Georgiana was asked to describe what each animal represented to her (symbolically). At some point, Georgiana realised that she could relate them to emotions, e.g. lion-fear, tiger-panic, monkey-happiness, elephant-worry, dog-love, cat-bravery, birds-feelings of freedom, unwinding.

G. - *So the message in my dream was for me to understand that if no animal did anything bad to me, then my emotions 'won't eat me either?!'. Then, I can let them go!*

T. – *How do you fell now?*

G. - *Releaved, I fell like I escaped!*

Third session. In this session, Georgiana arrived very upset and angry. The cause of this emotional state was her flat neighbour who visited regularly and brought her food.

G. – *I don't need her food. Why does she care about me?!*

T. - *I see you're very upset with your neighbour for bringing you food?*

G. - *Yes, veeeery!*

T. – *When else did it happen for you to be this upset?*

G. - *Aaaah, almost all the time when my mother lived.*

T. – *All the time...?!*

G. – *Yes, she was suffocating me with her food! She didn't know anything else about me, except to scold me and feed me. Beating and feeding. I felt she didn't care about me anyway and I didn't understand why she bothered to feed me, I didn't mean anything to her anyway!*

T. – *I notice you're furious at your mother!*

G. – *Very furious!*

Following the discussion above, the empty chair technique was used to help Georgiana express her anger at her mother's behaviour. For the first time, Georgiana cried.

Fourth session. In this session, Georgiana recalled the discussion she had with her father about her mother. She wanted to know more about her and so she had worked up the courage to ask her father. She learned that her grandmother, i.e. her mother's mother, whom she had never met (because her grandmother had died when Georgiana's mother was very young), had been a very cold woman. Georgiana also learned that her mother had lived alone in a boarding school in the city since the age of 10. They had no relatives in the city, and her grandmother had wanted to send her to a better school than the one in their village. Georgiana's mother often had to make do for days with food from the canteen, which was not tasty at all. She would eat there until she would receive the package with

homemade food that her grandmother would send her. From what her father told her, Georgiana understood that her mother had suffered many deprivations as a child, including hunger. Moreover, she was used to her grandmother's 'absence' from home, as she was more absent emotionally.

Following an exercise based on the meta-positioning technique, Georgiana understood that, for her mother, food was a form of expressing the fact that you care about someone, that you care for them and that you love them. When Georgiana came out of the role, she thanked her mother in a letter for the food she had received from her and communicated to her that she now understood why she had behaved this way. This led to a resemnification of Georgiana's relationship with food. If, until the role-play, food was for her a reminder that her mother did not love her, but only fed her (to survive), after doing the exercises, Georgiana understood that, for her mother, food was a form of manifesting the love she had for her daughter. Therefore, food symbolised her mother's language of love. She did not know how else to express her love.

G. - *So, my mother loved me!!!* (Georgiana burst out in tears).

Fifth and sixth sessions. During these sessions, Georgiana had a better physical appearance and her emotional tone was marked by a state of cheerfulness. She came dressed in "cheerful" colours and wore discreet make-up. The client asked to talk about school. She received support in coming up with a schedule for catching up on school subjects she had missed due to the decline in her interest in learning.

Seventh session. This session coincided with the fact that, at the end of the previous week, Georgiana's father had asked her to visit her mother's grave together. Georgiana confessed that she was not "comfortable" to do this (*When I discovered what kind of person she actually was, was I to lose her again?).* For this reason, it was deemed appropriate to initiate a mourning process. It began with a role play together with Georgiana. The dialogue between Georgiana and her mother focused on the following contents: a) the mother told Georgiana how she had tried to do her best as a mother; b) Georgiana told her mother how she had felt as her daughter; Georgiana was stimulated to express all the feelings (both negative and positive) she had towards her mother; thus, feelings of confusion, abandonment, disinterest, guilt (*I wished for you to die sooner!*), rejection, abuse, lack of love, hatred; the positive feelings associated with the relationship with her mother's mother were of love, care, protection; c) Georgiana was asked to say what she had learned from her mother; one of the client's answers, suggestive of the objectives and course of therapy, was *From my mother, I learned that love can also be expressed through food* (in this context, the idea that food equals love was emphasized); d) Georgiana thanked her mother; e) at the end of the exercise for going through the mourning process, Georgiana said goodbye to her mother through a symbolic hug.

Eighth and ninth sessions. Georgiana continued to come to therapy for two more sessions, after which she left to study at university in another city. During these sessions, the achievements Georgiana had had in the last period were highlighted. The client's physical and psychological transformation was appreciated and encouraged. Georgiana said: *It seems like my life is just beginning! I really want to nourish myself with what's best in it.* The resemnification of the symbolism related to food is also seen in Georgiana's discourse who no longer associated food with her mother's abuse (*My mother loved me, but she didn't learn how to show it to me!*).

Conclusions

In the case study that is the object of this paper, the core trauma that can be related to Georgiana's eating problems is the loss of a significant emotional relationship. In the case subjected to analysis, this relationship (which is based on the primary need for attachment of any human being) is incongruent with a maternal figure. From a therapeutic point of view, the sessions focused on accompanying and stimulating Georgiana to explore and express, as authentically as possible, her own feelings about her relationship with her mother and her mother's death.

Georgiana's personal history exemplifies the key importance of early life relationships with parents, especially with the mother. From birth, the child finds him/herself in a relationship with his/her mother that is based on one of the fundamental psychological necessities for lifelong individual health and positive development and demand. For the child, food satisfies the basic need for affection; at the same time, food is the object of a demand for love from the mother. The child demands to be fed and loved and, at the same time, the loving mother also demands for the child to receive the food she prepares for him/her.

In cases of anorexia nervosa, the symbolic value of food takes on a reversed connotation, i.e. "food that does not nourish". The anorexic child/adolescent may end up "refusing" their mother's food, the latter providing this food more to unconsciously compensate for her own inability to love. The task of experiential psychotherapeutic approaches (e.g. active listening, resemnification, empty chair technique, metaphor technique, meta-positions, etc.) are used precisely to resemnify the symbolism of food not only as a support for survival but also as a "form of love".

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