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ORIGINAL ARTICLE

Eating disorders, substance use disorders and multiple symptoms: three clinical vignettes

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Abstract

Abstract During the longitudinal study of three patients, referred to services at 3, 13, 15 years for eating disorders, reduced food intake and anorexia nervosa, other symptoms appeared depending on difficult development, relational and personality problems. The patients showed the interweaving of symptoms at different times: they were dealing with modified developmental needs and contexts, included new possibilities of attachment that might produce different internal organizations. These changes required different treatments. Anorexia started early in life for these girls, but presented different steps of organization. We wanted to start finding some aspects of a staging model to map the course of ED, because many patients arrived later in life, reported untreated early symptoms, actually personality traits. Mapping the evolution, could allow to take care of patients at the very early stage of problems when few symptoms are present, and better patients' evolution might be possible.
Level of evidence Level V opinions of respected authorities based on clinical experience.

Keywords Eating disorder · Compulsive obsessional disorder · Substance use disorder · Depressive disorder · Personality disorder

Introduction

Our purpose is twofold:

1. To explore the relationships between anorexia nervosa, substance use disorder and/or symptoms present in other diagnosis of DSM V [1];
2. To start proposing one possible way of understanding the alternation of different symptoms during development, in order to identify relevant behavioral endophenotypes for eating disorders as some researchers [2, 3] are doing to day with epidemiological studies, but trying to better understand the internal dynamics.

Clinicians have growing concern about the utility of the diagnostic evaluation in psychiatry because the procedures categorize symptoms appearing only in the full expression of the illness when already consolidated. The treatments geared towards earlier forms of the illness might facilitate better recoveries and the understanding of the core of the complicated multiple symptoms that we find at different times like obsessional, compulsive, perfectionist, manic-depressive symptoms together with different kinds of personality disorders.

Considering the dramatic social and cultural changes in the last 50 years, and the resulting change in eating and substance abuse disorder [4], a great debate has started and continues to this day, regarding how to frame the various manifestations and eventually unify them, in order to intervene adequately and have comparable protocols.

At the beginning of Italian specific services, based on Law n. 162, 26th of June 1990, the sociogenesis of addiction is identified as the most important pathogenic factor.

The availability of drugs on the market and the difficult juvenile conditions were at the center of the investigations.

5 years later, psychogenesis is considered very important, as well as the recognition of possible genetic influence on the disorder.

Beginning in the 1980s an American Psychiatric Association committee, in charge of creating a classification system for children 0–3 years old [5], proposes that the second axis

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should consist in a relational axis and that this axis should be considered prognostic for personality organization.

As a result, the concept is established and fully developed, wherein the psychopathology is always relational, and not due only to the child and in the child [6–9]. Meanwhile Rizzolatti and his school [10] discover mirror neurons and their functions as the basis of understanding the others' intention and its own, through movement, and their importance in interpersonal connections, intersubjectivity and human empathy.

The focus for treatment gradually shifts from the subject to the relationship between the context and the subject, even in the classifications: the International Classification of Functioning [11] is developed, replacing the handicap classification of chronicity, wherein the context in which any individual who is healthy or with problems, is classified and adapted and the subject's participation [12] with the environment and his/her quality of life is classified, regardless to the personal physical or psychic problem.

Preventing and taking care must therefore depend more and more on the study of relationships between the subject and the environment.

In ED, two aspects characterize subjects who have more difficulties with abstinence or accepting an adequate weight and/or their self body image:

1. *The chronic aspect* often with the frequent presence of depression or manic traits, obsessional symptoms, behavior or personality disorders and various expressions of psychosis, exacerbated in different moments of life. These clinical conditions have brought to dual diagnosis [13]
2. *The craving real and actual* (always present in patients referring to services), in an enslaved bond to a given substance or to food refusal in AN, binge eating or bulimic intake, reproducing a compulsive need.

But only a part of ED and substance use disorders are referred to services, because many people are able to keep a job or continue their studies and never get to services. The first epidemiological studies gave the same results for subjects taken and not taken care by services.

Social tolerance regarding alcohol, drug, gambling abuse, eating disorders produce different possibilities of recovery or surviving all the same when the context sustains the affected persons, giving them the possibility of a future, even in very difficult psychological situations.

Many dependent subjects seek assistance for different reasons: sometimes they arrive too late: they refuse professional help, sometimes they drop out and perhaps they return later, after many years, depending on the bonds or the relationships that permitted them to go forward without specialized help, even possibly for decades.

We will consider three stories, recording the changes in their symptoms as well as in their relationships with their families and the context during many years.

Clinical methodology is as follows:

1. When the patient arrives, we make an intervention program trying to consider his/her comprehensive personality, the relational context and the developmental evolution, with the possible traumas and the resilience.
2. The changes that food and drugs intake, as well as symptoms and psychic organization, alternated within the same individual. We try to understand how changes in the network at a specific moment, oblige excessive alcohol consumption, drugs use, gambling or induce a dangerous abstinence from eating food, binge eating or bulimia.

Lisa: evolution of a case of reduced food intake (or anorexia?) with a serious obsessive symptomatology in a 2-year-old child and pathological family bonds

Lisa is sent to the University clinical psychology service by her pediatrician, who is worried because the relationship between the 24-month little girl and her mother does not seem to evolve.

Lisa arrived at home after 4 months hospitalization in intensive neonatal therapy (TIN), because she was born preterm (24 weeks G.A.), but not small for date. The mother thinks about her, all the time, and is unable to resume her work activity, which she is otherwise interested in, because she is afraid that neither the child's grandmother nor the babysitter are able to take care of Lisa's needs.

The parents state that the girl continues to wake up repeatedly every night. Completely uninterested in food, which is milk given by bottle or spoon, blended colored food, or a piece of bread given to her by hand. Faced with repeated offerings from the adults, she seems to "like" something that she then refuses in a drastic manner after having taken one or two mouthfuls at the most.

The mother is in a continuous state of alert: in order to make the child accept some food, she creates little games which become rituals necessary for the child to eat and which exclude the father, who would be otherwise interested in participating.

Lisa is very curious about objects and people around her: she moves and walks with agility, speaks with a very competent language for her age, although not necessarily responding immediately to questions but recovering the conversation some minutes later.

The hospitalizations she will have the next years, are never due to her weight but to the violent drops in her

immune defenses, so that a simple flu or otitis, easily becomes pneumonia or purulent otitis with high fevers and consequent dehydration problems.

It is easy to think to psychosomatic sicknesses. Does she deserve a dual diagnosis [14] or these are symptoms of the same growing problem at this age?

In the joint psychotherapy [15] with her and her mother, and also with her father when possible, we work on the relationship with video feedback, recorded with S. McDonough's interaction help technique [16].

A year later, during a therapy session at the hour in which the girl usually eats, we arrange for her to eat a plain pizza, her preferred food.

We wish to understand how much of the problem is due to the eating ritual, in order to understand if it is the mother (or whoever is acting on her behalf) who is completely at the girl's service, and how much is due to the presence of food itself. The child is becoming more and more a "dictator" and seems to manifest a personality disorder [17, 18]. The most disturbing symptom shows up in the tyrannical interaction with her mother when she is supposed to eat, and in most situations also with all the people who take care of her.

Can we already use the world AN? or we better call her behavior, poor food intake? We have lots of classifications [19–21] for children in difficult relationship with food in the first years of life, but sure we do not have all the symptoms required in DSM V, in order to call it AN [22].

But, is this the beginning of a future AN? Obsessional symptoms, research of power, control of attachment and distance from parents: in this specific situation also the countertransference is very similar to the one elicited by young girls with AN, opposition, obsessional difficulties in touching food, trying always to do what she wants, but we cannot judge the fundamental relationship with her own body image [23] that we will see only a few years later.

The girl devours with her eyes and smells deeply the pizza. The ritual is very complex. Even with the express desire shown through mimicry and gestures, L. does not touch the pizza. She approaches her father. In the mean time the mother begins to list all the reasons why Lisa will not eat: hated tomatoes, too hot and warm, too many people around, the pizza that is not cut the way she is used to, because L. does not touch any food with her hands. We ask the parents to go out because L. might want to demonstrate what she can do on her own.

The mother gives strange excuses to Lisa in order to explain why she is leaving and L. reacts very weakly, pretending to hold on to her dress and, immediately after her mother leaves. Lisa starts eating the entire pizza by herself, taking the pieces which were cut by the pizza maker, with her hands. She does not seem to notice that she has stained her fingers, something that seemed impossible for the mother, and appears to be very satisfied with her actions, completed in an entirely adequate amount of time.

The message appears to be very clear and we verbalize it when the parents return: we insist that the girl should attend a nursery school. The mother decides she should attend the nursery close to her parents' house, she will return to work at a local store, so that she could pick her up from the nursery school in a brief amount of time "just in case".

In the first meeting we had with the parents, they told us how they chose their own home: exactly halfway between both parents' homes. With this nursery arrangement, the child would pass the entire day in the mother's parents' house area.

At the nursery the meals, which she refuses completely for 2 months, are gradually introduced, and then pacts are made: she eats only food prepared at home by her mother in containers which the little girl observes carefully.

The next progress involves the school preparing food only with products taken by the mother: later, when L. is reassured that her teachers and schoolmates love her, she begins to have lunch with the other children, eating almost the same things as everybody else but seated at another table and finally... eating at the big table, where she helps another little girl who refuses to eat her food.

It is through food that distance and bonds are established. But at least twice a year, the whole system becomes completely erratic because of her autoimmunity problems: she has to be hospitalized and the mother has to stay with her 24 h a day. Maybe Lisa tries to obtain now what she lost because of her long hospitalization in TIN: at this moment she likes food, she does not have problems about her body image, she has just learned that she can control the presence and distance with her parents through her way of handling food intake. She is very self-conscious and extremely obsessional in school duties.

The repeated hospitalizations do not allow the mother to achieve at taking some clear distance from her daughter. The father tries to help in every manner but he also becomes involved in her eating rituals, with the same capriciousness.

She is acutely intelligent in every activity, with a good degree of socialization: in fact she is a leader in the class, and when a classmate opposes her, she retreats to a corner angrily and can even get to the point of hitting if she believes she is not being treated fairly.

The obsessive framework, with the continuous search for a personal order in her own clothes and things, controlling her parents, her grandparents, her teachers and classmates accompanies the anorexic controlling behavior with food: she maintains an adequate weight in spite of being thin, until in group therapy (which she participates in, with much pleasure), a "prince charming" appears at 8 years in her group.

She is as seductive as she can be, proposing games and performances at the end of which she is always the princess, dressed up and full of necklaces, etc. In the mean time the national enrollment process obligates the parents to send her to school in the town where they also live in and where the mother finds a new job.

When Lisa leaves the maternal area, in order to be in the family area, the entire family system is modified, allowing the mother, for the first time, to declare how much she wishes to change the relationship with Lisa because now (that the girl is better) she feels enslaved by her child's exaggerated authority which not even the father is able to keep under control.

During the reawakening of her love for "the prince", some new aspects of anorexia which had never manifested appear: this time she does not want to continue going to her dancing lessons, where she excels, "because her thin legs and her very flat belly are growing too fat". Because of the precocious puberty and difficulties in accepting her body image, that appears, she must be careful with everything she eats, absent reason in the preceding period in which her interlocutor was the food as such, not as an agent of her shape. Now the dysmorphophobic aspects are prevalent and we realize that this change is connected also with her parents living finally in the area they had chosen for their couple and their child, after multiple sessions of Scenotest.

In this new stage of her development, some aspects of anorexia nervosa appear and then disappear, depending on the varying situations and on the relationship with the mother, which changes continuously. We observe alternating frameworks, in which the obsessive aspects prevail, wherein there are still the well-known immunological failures which require hospitalization, in which she recovers the 24 h mother's presence. As soon as she is discharged from hospital, she asks for full autonomy.

When she starts school, close to her home, she attempts to retrace her steps: food prepared at home, then food from home cooked at school, ands so on. The mother finally begins to be less afraid of Lisa's vindictiveness and accepts running the risk of her not eating. Lisa feels more free, but continues to be very controlling.

The mother returns without her, after 2 years to ask for help, because "she cannot take it anymore" also if Lisa is very successful in everything and eats normally.

At this moment there is a big change, without relapses for the moment with respect to anorexia, but certainly with important traits of a personality disorder which is showing up more and more. It is still difficult, however, to make a prognosis, but we think she has now the forces to go better and her mother starts handling better the relationship with her.

With the benefit of hindsight, it seems that the most fruitful intervention has been the continuous work on the relationships with the people who took care of her in the family, at school and in the psychotherapeutic groups.

The pediatrician's early referral which allowed for an intervention in the difficult mother–daughter–father relationship with the noteworthy effort to change the family interactions was anyway fundamental in the partially good evolution of anorexia.

We have presented the evolution of this case in detail because it is our impression that in every eating disorder, the problem of the organization of an eventual psycho-pathologic personality is present in different ways.

The anorexic aspects probably partially depending on genetics, are finally determined by the bonds and the attachments with the different contexts and the need of perfect sharing the distance between the parents' native spaces in order to choose the right home for the couple and the child.

The alternation between obsessive symptoms in order to control everybody and her own social strength, shares with anorexia the nutritional refusal-restriction when exactly every feeding ritual is not completed: at 2 years it is difficult to understand what is prevailing: OCD or food refusal as well as the distance with her mother. Only later, at 8 years, when the development allows her to fall in love with the Prince, she will show the worry for her too fat legs in a new play of intersubjectivity of extreme importance.

But it is fascinating that at this moment the mother declares and acts in consequence, in order to break the important bonds they have together and this probably has been possible because of the long therapeutic work. But this is one kind of organization. We need to take into consideration also with adults and adolescents who employ food or drugs to balance their attachment problems, and their painful needs of loneliness and depression in order to understand the interweaving of symptoms.

Depending on the time of the development of the disease, the gender, and the enormous power of the context and the bonds involved, it is difficult to think of a single protocol [24] in which psychotherapeutic work is still necessary with the subject's main relationships and with the mentalization of the very meaning and use of the food symptom.

Maria: anorexia at 14 years of age; at 30, alcoholism and gifts

Maria was referred for anorexia at age 14. From a lower-middle class family, she has an older brother. There is a chronic conflict between the parents composed of lies and deceit: they are all held together by hatred and unresolved economic disputes with the mother's relatives.

After several years of anorexia with hospitalizations, during which she is very good at deceiving the staff about the food she consumes, highlights the increasingly frequent

behavioral problems: petty theft, lies, and indiscriminate use of all the drugs which she could steal, without ever entering into the criteria which could define her as an addict.

As an adult she is an alcoholic and a victim of domestic violence from the young man whom she ends up marrying, who comes from one of the most problematic families of the area.

She is reported to the social services at her child's birth for the presence of alcohol in her breast milk, and then for assisted violence. One of her typical traits is a constant mode of giving gifts, and after a few months requesting them back, either with the caretakers as well as with acquaintances and friends, in a strange display of alternating manic and depressive moments.

The eating disorders have remained in the background, in an overall behavioral disorder, within an atypical antisocial personality disorder with an unresolved trauma, and with heavy manic-depressive cycles. Despite the great efforts of the social services, we are faced with a teenager, Maria, who comes to the service with a family that offers a model of life with perverse aspects and little or no support capacity. We can attribute a meaning of rejection and attempt to leave the family group to her severe anorexia, anyhow the service cannot collaborate with the parents, who are too busy with their own problems, in order to modify the bonds with the daughter. It is possible that Maria has witnessed violence between her parents repeatedly, and that she has suffered even physical mistreatment, and there has certainly been a severe problem of neglect.

The presence of unresolved traumas which we tend to find in the case histories of addicts, anorexics, alcoholics and PDs, with a variety of very well-known consequences, based on the difficulty of involvement due to a profound contempt of one's self and/or one's own body.

Compared to Lisa, who receives an excess of attention, Maria lives in neglect, a victim of assisted violence and, with an enormous effort, attempts to exit from her environment through anorexia, with her husband and child, but the family bonds seem impossible to overcome, despite the efforts of the social workers, who give her support, help her create a network and look after her on several occasions. She does not seem to be able to be resilient, probably due to repeated trauma, during her upbringing and the difficulty in showing the resilience that allowed her to hope to be able to stop drug assumption, having a child.

The cumulated traumas, from genetics to the lack of a possible network, the refusal of a community due to a complete distrust in the possibility of being helped, suggest a rather unfortunate future for this woman. This prognosis unfortunately, will fulfill itself, despite her relatively early referral to services, and despite the great commitment of the whole social network. Maria faces a lot of cumulated problems that appear with different symptoms and also with moments of remissions: she has more then a dual diagnosis and also her transition to parenthood looks so difficult that her child will have to face a transgenerational difficult heritage. Once more, no matter how soon Maria has been referred to services, the difficult original network does not facilitate her and she employs drugs to defend herself from the pain of food restriction. The deception about her difficult marriage that reproduces the well-known assisted violence between her parents, but now directly addressed on her at the presence of her child takes her away some hope. The other big deception because she was unable to stop drugs for the sake of her child, makes her feel that the only possible future for her is to try to survive as she can.

Most of the patients with such a heavy family background, during the last century in Italy, would not arrive to clinical services lost in the big unaffordable group of social problems. This is one of the reasons why meta-analyses often produce very contradictory results and continuously the team of DSM is trying to find new definitions for classifications that will allow to have a clear understanding of the different kinds of ED and of their longitudinal development.

Denise: "My illness is visible to everybody."

Denise, 15 years old, goes to the center for ED at the public hospital, accompanied by her mother and she is taken to the emergency room, for asthenia, insomnia and depression.

For a week she eats only three fruits per day. When she goes back home, she attends an artistic institute. For 2 years, she sees a young man with whom she has a good relationship that, however, ends because there is "always a quarrel" because she is tired and he is ill at ease. At school she behaves like a perfectionist.

At 18, back to the hospital she states that now she is not very well and she has noticed that this causes people to pay more attention to her. Thinking about food has become a continuous obsession.

The family is composed of the father who is frequently away from home because of work, her housewife mother, and her 8-year-old brother.

The mother assumes that it all started with the constipation that the patient has presented since she was a small child.

The mother's father and aunt are bipolar.

Denise's mother had married and moved away from her family at 18, and she returned after a serious financial downturn in the family business, to which Denise's father contributed to "save".

Denise is depressed, asthenic, anhedonic. Seriously underweight, and bradycardic, she loses 10 kg in the previous 3 months due to food restriction and physical hyperactivity.

She begins a daily semi-residential treatment without improvement.

The father is abroad and after some days the mother, anxious and agitated, reports, with a very confusing narrative, that Denise, at 12, had suffered physical and psychological abuse from a foreign classmate who was 3 years older than her.

The parents got to know about this accident, 1 year later and reacted, but the school and the entire town argued against the family, stating that Denise provoked him with her beauty and naiveté.

During her hospitalization she is proposed an artificial nutritional treatment with a nasal gastric probe, which Denise refused and asked to be dismissed.

She is dismissed after another 4 weeks of hospital treatment. She is unable to follow the food plan, with very serious dysfunctional thoughts regarding her weight and body image: "I cannot find reasons to eat and be well." At home she quarrels constantly with her mother because she does not want her help; and she avoids contact with her father, who has returned home.

In the following weeks she loses 3 kg., becomes very depressed (despite the pharmacological treatment with antidepressants first and anti-psychotics afterwards), she is hospitalized at the psychiatric service, and starting enteral nutrition with naso-gastric tube. During her hospitalization at the psychiatric service from Monday to Friday, Denise frequents the ED Day Hospital for meal assistance and other psychosocial activities. After 4 weeks of treatment she is very scared. "I do not want to go back to being the Denise from before." She is afraid of being marginalized and judged. "Here I am protected, I am protected in my illness." But she demonstrates an intense fear of gaining weight. She is discharged from the psychiatric service after 6 weeks of treatment, and continues to attend the ED Day Hospital treatment, where she organizes her assisted studies for her graduation exams.

Despite the difficulties, she faces her graduation exams and she passes her exams while her weight stabilizes at 45 kg.

She intends to suspend her treatment: she has a very low awareness of herself.

She does not want to do anything but she wants to deal with the situation: she cannot bear the semi-residential hospitalization, expressing her fear of "continuing to get fat", attending the day hospital, and she stops her treatment without telling her father.

Denise goes abroad for her holiday during which she mostly feeds herself irregularly, with alternating lack of control and restrictions and, with her friends, she experiences uninhibited sexual behavior.

When she returns, still very focused on food, she seems to identify herself with the role of a sick person. "I cannot look for a job while I'm like this." She has mood swings and goes to the Day Hospital 2 days a week. She feels well enough. She goes out with her friends every evening. Her uninhibited sexual behavior increases, including impulsive promiscuous behavior, frequently being with various young men intimately, including at discotheques, where she behaves promiscuously with strangers. She eats compulsively daily. She abuses alcohol and uses cannabis, gaining weight, up to 53 kg.

The following month she begins work as a bartender. She continues to eat compulsively, uses drugs and has promiscuous sexual behavior which she attempts to control but is unable to. She weighs 60 kg.

Denise's parents are aware of her behavior and they declare themselves impotent to intervene in any way. The mother describes the situation very emotionally, while the father participates very little.

A month later the parents report that Denise has an episode of confusion, walking on foot to a pajama party which is about 20 km. away, and when they find her on the road she is very aggressive and only the father is able to stop her.

The mother, very anguished, asks for hospitalization in a protected structure, demonstrating her anguish because of what has happened, and is completely incapable of managing her rapport with her daughter.

On this occasion, after the psychiatric hospitalization, an assessment of the situation is established, through SCID II and a borderline personality disorder with depression emerges, and with MMPI II: "She appears rigid, unadoptable, mistrustful, attached to her own opinions. In interpersonal relationships she tends to seek confirmation and emotional gratification through the development of somatic manifestations; this is accompanied with a tendency to live more on a level of her own inner fantasies rather than on a level of real relationships."

Even in this situation the mother emphasizes the eating disorder and the precocious psychosomatic difficulties, different from those demonstrated by Lisa. The very precocious eating disorders are typical also in borderline personality, which allows thinking to a common beginning of the different pathologies that are present in this woman.

In almost all eating disorders, we find a small child's body who requests special attention/care which the parents remember. Very often the maternal mental functioning has been during the first years of child's life the so-called operative thought that prevents the child from feeling his/her real affective needs, even while following each medical indication with absolute precision. In this situation the use of substances is part of the habits and traditions of those who work in bars or those who frequent discotheques, often linked as an anesthetic against shameful suffering and anxiety such as what happened to Denise, who needs to use the substances to be in a place where the use is habitual and where no particular search needs to be made.

It is interesting that even the promiscuous sexual habits are initiated with friends, a support for giving herself permission to use her body in a manner differentiated from situations of great control, which she had studied for many years, and from which she derived her own behavior.

There is also another particularly interesting element, and not only in this situation.

Many addicted subjects display anhedonia, and alexitimia and the flash obtained by drugs rather than the sensations produced by the excessive ingestion or abstaining from ingesting food, represent the only possibilities that these subjects have to experience emotions that are strong enough to be remembered and avoid uncontrollable suffering. The hope to experience pleasure in every day life, without serious dependencies, thus becomes one of the necessary tasks in the psychotherapeutic treatments with these patients.

Her diet improves when she is alone. She has a tendency to restrict herself, but she does not fast, have bulimic crises or have any induced vomiting.

Despite the general framework being satisfactory, there are still significant obsessive thoughts about body image and weight, with tolerable fatigue at the moment.

The relationship with her new boyfriend continues positively.

She is somewhat stressed about the preparation of her school examinations despite having discontinued her therapy and the drug use that had diminished the pain of fasting in the past.

She has been able to manage moments of distress without resorting to agitation (vomiting, self-hurting), despite the temptations.

She has difficulty accepting herself at her current weight, and she is unable to like herself in her own body. Only at this point it is possible to work psychotherapeutically about the problem of the changes in her body and her vital and relational situations.

The amenorrhea, which has ceased for months, has given way to a spaniomenorrhea, which evokes, for the first time, the possibility of having children.

His particularly painful case history about repeated treatment in group therapy and hospitalizations begins with eating difficulties for which the family had requested aid from social services. Subsequently, even the use of the drugs that are given to Denise, especially those that help her not to suffer from hunger which she obligates herself in order to remedy her own unacceptable increasing body weight, comes to a good end, predictable from the beginning, only partially, because of the family's involvement and of the heavy intergenerational heritage.

Conclusions

From these few examples, but mostly from the many cases which we have seen over time, beyond the specificity of each type of dependence and personality, it seems to us that the therapeutic plan should depend on the psychological organization of the person who uses one or another resource in different moments of their own existence, and that the choices at every moment will have an influence on a future in which all of the equilibriums will be put into question repeatedly.

The reported cases constitute the most complexes situations where a family background, the actual situation, and the difficult early story of ED was very important. In all the situations, the development has induced the change of needs and of the individual possibilities of facing realities in different ways that anyhow require a change of interventions absolutely different, mostly centered on body needs, and/or in relational treatments and personal help. The rather rigid protocols that some centers apply without taking care of the different situations can be the only possible intervention in front of very very meager young persons, but maybe the transgenerations need a very attentive study of what the person can reach alone. Maria, who lives in a very difficult context, wants to find in a son a par of release of all this tension that obliges her to employ drugs in order to accept life, and in a way deals with reality problems with a contact with reality that for Denise with a family apparently more attentive to her, is unbearable and she gets into total confusion.

Our life today seems to have so many varieties of situations, that it looks more and more difficult to find patients whom we can help through protocols, but we have at every moment to review how the needs and the wishes are changed. It is true that we can find perfectionism, obsessive–compulsive personality disorders and obsessive compulsive disorder, [25, 26] find, but the basic reason can be so different like it is in Lisa and Denise that interventions can be fundamentally a help to relationship, or a massive change of the context, or a protection all life long, like for Maria and her desired son. We are far from seeing some clear psychic organizations.

Compliance with ethical standards

Conflict of interest The authors declare that they have no conflict of interest.

Ethical approval All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards.

Informed consent Informed consent was obtained from all individual participants included in the study.

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