DUBLIN BUSINESS SCHOOL

AN EXPLORATION INTO THE PSYCHOTHERAPEUTIC TREATMENT OF ORTHOREXIA NERVOSA FROM A FEMININE PERSPECTIVE

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ABSTRACT

The aim of this dissertation is not only to investigate the presenting symptoms of the condition known as orthorexia nervosa (ON). It also seeks to understand the underlying structures that may be sustaining this form of disordered eating. To date the relationship between obsessive–compulsive disorder and orthorexia nervosa has not been sufficiently examined. Through a psychoanalytic lens, the author looks at how the creation of the obsessional structure could be used to explore and understand new eating disorders. The research examines how a psychodynamic perspective could be used to treat this clientele. Furthermore, the dissertation will consider the social discourse surrounding eating disorders and how a feminine approach can be used to bridge the gap, between psyche and soma in the quest for wholeness.

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CHAPTER 1: INTRODUCTION

Orthorexia nervosa (ON) is a term coined by a holistic practitioner named Steve Bratman (1997) in an article that he wrote for the *Yoga Journal*. In short, it is defined as a compulsion to eat 'right', or to eat the right foods in pursuit of perfect health (Bratman and Knight, 2000). This term came about to describe some of the behaviours that were becoming apparent to him in his clinical practice, such as, the desire to adhere to strict principles around food and what is deemed to be healthful (Bratman and Knight, 2000). In other words, it is an obsessional quest for nutritional perfection. McGregor (2017) suggests that ON is more than just a desire to eat healthily, and that the person with ON may display obsessional behaviours akin to obsessive-compulsive disorder (OCD). Unlike other eating disorders such as anorexia nervosa or bulimia, it is not engaged with in an effort to control weight as many sufferers are considered to be a healthy weight.

This concept began to stir the interest of the medical world, and it was in Europe that research first began to emerge. In an attempt to create a diagnostic criterion Donini, Marsili, Graziani, Imbriale and Cannella (2004) devised a questionnaire, called the ORTO-15 questionnaire. Dunn and Bratman (2016) explored the diagnostic criteria further and showed varying rates of orthorexia in the general population. Orthorexia was considered for inclusion in the latest Diagnostic and Statistical Manual (DSM-V, 2013), however this failed due to lack of sufficient research (Brytek-Matera, 2012). Defining criteria, although important, as a step towards measuring prevalence, and establishing a clinical diagnostic criterion, is not the purpose of this inquiry. Medically speaking orthorexia is not a recognised eating disorder, however, it can

be understood in a medical sense as "something that has afflicted them from a certain point in time, which is repeated irresistibly, but in connection with which they have neither any involvement, not any subjective responsibility" (Cosenza, 2016).

In chapter one, the author will discuss the underlying structure of orthorexia. Pollack and Forbush (2013) suggest that an OCD co-morbidity with ON may exist. Whelan (2008) explores the relationship between eating disorders, perfectionism and OCD. Orthorexics often wish to control their environment, and often display obsessive-compulsive behaviours when it comes to the sourcing and preparation of food. This becomes the norm and may not be recognised as a form of disordered eating. It becomes "second nature – almost natural and invisible" (Orbach, 2009, p. 3).

Chapter two seeks to explore how the body plays a part in the expression of symptoms. The orthorexic appears to be trying to connect the body and the mind via a control mechanism. The ability to control her body through precise planning may be seen as a distraction from experiencing painful emotions. A temporary relief ensues from the engagement with the orthorexic behaviours. The concepts of psychodynamic psychotherapy in response to self-harm as posited by Motz & Welldon, (2002) may be applied to orthorexia as it aims to "highlight the elements of secrecy, risk taking, guilt and ritual" (p.185).

Furthermore, the social discourse and the quest for wholeness will be explored in Chapter three. Attempting to change the symptoms without addressing the underlying causes is a form indeed a therapy doomed to fail. Current treatments for ON focus mainly on psychoeducation, Cognitive Behavioural Therapy (CBT), and psychotropic medications. To date, there have been no studies of treatment effectiveness for orthorexia (Hay, 2013; Koven & Abry, 2015).The

objective is to move beyond diagnostic criteria towards a deeper understanding of what the symptom means and move towards the development of a psychotherapeutic approach for ON as a distinct eating disorder. Hanganu-Bresch (2018) suggests that "while there is not an official DSM diagnosis yet, orthorexia is at a minimum a symptom of a cultural pathology, a neoliberal disease emerging from the proliferation of 'clean eating' discourses, and a technology-of-the-self gone awry". We are all human and to apply these diagnostic categories can be used "in the service of distancing the more distressing elements of the human condition from ourselves" (Sullivan, 1989, p.192).

It could be argued that orthorexia does not discriminate between the genders as much as other eating disorders such as anorexia nervosa or bulimia nervosa and as such, eating disorders have been viewed as typically female issues in the Western World. Although we cannot ignore the role of gender in the treatment of eating disorders (Striegel-Moore, Rosselli, Perrin, DeBar, Wilson, May and Kraemer, 2009), this paper will move beyond gender into the archetypal meaning of masculine and feminine.

The addition of the feminine as another layer in this complex manifestation may prove fruitful in the discussion and treatment of this pathology (Sullivan, 1989). In summary, there is certainly room for further research particularly into what the individual's symptom tells us about the underlying structure and how it may be addressed in the psychotherapeutic encounter, namely from a feminine perspective.

CHAPTER 2: THE CREATION OF AN OBSESSIONAL STRUCTURE

> *"It is often shameful to acknowledge psychic injuries since they affect one's sense of identity at a much deeper level" (Sullivan, 1989, p. 151).*

Introduction

This chapter will explore what compels one person to face into their suffering, whereas another individual will be content to know as little as possible and opt instead to discharge inner conflicts through obsessional behaviours or symptoms. This chapter will briefly explore the application of both drive and object relations theory and the clinical implications of this in an attempt to understand the underlying structure of the orthorexic. Although we must note at this point that the "finding of obsessional symptoms does not necessarily justify the diagnosis of obsessional neurosis" (Miller, 1997).

A recurring theme in the literature is the relationship between the so-called obsessional symptoms and the underlying obsessional structure (neurosis). In the neurosis there is a conflict, and a splitting of psychical activities into some that are admissible to consciousness and others that are unconscious (Freud, 1913). Freud (1905) also suggests that during the complex process of sexual development, 'fixation points' develop, in other words the sexual development is thwarted and to which a regression may take place if difficulties are encountered later in life. Where the patient "is obliged to repeat the repressed material as a contemporary experience instead of, as the physician would prefer to see, remembering it as something belonging to the past" (Freud,1920).

Cosenza (2016) views eating disorders from the perspective of drive theory and defines them in terms of "pathologies of orality". From a Lacanian perspective, it has been common practice for some time to approach the clinical treatment of eating disorders from the perspective of "holophrasic rather than of the metaphor". (Cosenza, 2016) suggests that they cannot be explained in the Freudian sense as originating in the oedipal complex. Instead, we are looking at autoerotism of the anal-sadistic kind, and before any object-choice is made, and which creates only self-satisfaction (jouissance[1]).

Thus, Cosenza (2016) compares the so-called contemporary symptoms amongst which we can certainly include orthorexia "as symptoms disconnected from the unconscious". They are signifying[2] and "establish themselves in the life of the subject as condensations of jouissance anchored on the exercise of a number of regularly reiterated practices" (Cosenza, 2016). The subject does not resist these practices for, they have an ego-syntonic[3] relationship with the symptom and this is why as Cosenza (2016) suggests "they do not experience it as an illness but rather as a as style of living; not as a problem, but as a solution".

[1] Jouissance moves beyond Freud's concept of the drive as found in the pleasure principle. Lacan first developed his concept of an opposition between *jouissance* and the pleasure principle in his Seminar "The Ethics of Psychoanalysis" (1959-1960). Lacan considered that "there is a *jouissance* beyond the pleasure principle" linked to the partial drive; a *jouissance* which compels the subject to constantly attempt to transgress the prohibitions imposed on his enjoyment, to go beyond the pleasure principle as posited by Freud (1920).

[2] "This means that all obsessional behaviour, and moreover even hysterical, if we say that it is structured like a language, I would say that this does not mean that beyond the articulated language which is called discourse, it is something which, taking all the acts of the subject, would have this sort of equivalence to language which exists in what is called a gesture, because a gesture is not simply a well-defined movement, the gesture is signifying"(Lacan, Book V, 1957-58 p. 354).

[3] In psychoanalysis, ego-syntonic refers to the behaviors, values, and feelings that are in harmony with or acceptable to the needs and goals of the ego, or consistent with one's ideal self-image.

Desire and the root of obsession

In the earliest stages of psychic life, every infant responds to what its mother wishes for it (MacDougall, 1989, p. 272). The behavioural strategies that the obsessional employs are an attempt to find a point of identification of what might constitute the desired object for the mother. This concept will be looked at further in Chapter three as we will see that psychotherapy can provide the adequate environment to allow the appropriate regression to our needs "to that infantile level where the split between the true and false selves begin to entrench" (Sullivan 1989, p. 68). The right therapeutic environment allows a person to create a sense of security in themselves though the transitional space and to transpose this into their outer world (Sullivan, 1989, p. 82).

For the obsessional, they do not accept that desire in fact means lack[4]. Desire is relational and becomes a form of dialogue (Orbach, 2009, p. 137). For the orthorexic, instead of living in the present they dream about what they could be, or more importantly should be. "This gap between reality and dream is often filled by the obsession" (Woodman, 1982, p. 25). When the orthorexic finds it hard to exist in the interval between signifiers[5] this becomes unbearable and the symptom becomes a way to defer (through jouissance) in what Cosenza (2016) refers to eating pathologies as "temporal interval pathologies".

[4] 'What must be maintained for the obsessional is the distance from his desire, and not the distance from the object' (Lacan, Book V 1957 – 1958, p. 349).

[5]The signifier is the constitutive unit of the symbolic order because it is integrally related with the concept of structure. The single condition which characterizes something as a signifier, for Lacan, is that it is inscribed in a system in which it takes on value purely by virtue of its difference from the other elements in the system.

Object relations and orthorexia

Fairbairn's (1952) largely unfinished object relations model can be applied to the understanding of the obsessional personality. It begins with an exploration into how specific childhood events that are seen as "intolerable to the child can trigger the splitting defence that isolates (via repression) the frustrating aspects of the object along with the part of the child's ego that relates only to that 'part-object'. This process ultimately leads to the child becoming fixated on the 'neglectful object" (Celani, 2007). These split off part-self and part-object structures are too disruptive to remain conscious yet remain repressed and perpetuate themselves through repetition compulsions and through the transference as seen in adult obsessional pathologies such as orthorexia. A defence structure of this kind allows the subject to avoid "affective flooding" (MacDougall, 1989, p.155) and offers an escape from the Other in the form of compulsive acts. Orthorexic rituals and behaviours become the 'transitional theatre' and often tend to give the appearance of normality, in which mental pain and conflict are split off and ejected from consciousness so that they must seek a solution elsewhere (MacDougall, 1989, p. 65).

Addiction to perfection: an imperfect solution

'Each fresh repetition seems to strengthen the mastery they are in search of' (Freud, 1920).

The thesis elucidates that the orthorexic's behaviour is a way to keep the anal-sadistic drive under control. In a contradictory fashion, the obsessional represses this "climatic jouissance that no living being can bear, and at the same time provides a kind of substitute by recapitulating

the tendencies of the repressed on the level of the signifier" (Miller, 1997).[6] Lacan also seems to suggest that the obsessional structure is sustained by the fact that death is a solution to unresolved conflicts (the conflict with the symbolic father). 'As the slave waits for the death of the master, he works' (Leader, 1992).

Death doesn't exist in time, at some point in the future or past, for the obsessional. However, neither is it in the frame. More precisely, death is the frame itself, the very process of freezing something in a frame. "What he does is to *mark time?"* (Leclaire, 1956). This is why social media platforms like Instagram are so attractive to obsessionals as they are in fact 'freeze frames' of other people's lives in particular pictures about food, diet and health – a never ending quest for wholeness. The influence of media – particularly social media on the obsessional may mean that they look to a figure such as a famous actor or singer. The rise of the 'influencer' in social media circles is a topical example of such figures. This attempt to find an object that could be the object of desire.

In a Freudian sense, the repeated behaviours, rituals and fixed ideas about 'eating the right food' that the orthorexic engages, manifests as a last resort "to avoid fantasised punishment for infantile longings" (MacDougall, 1989, p. 50). The othorexic is "enslaved to their routine"

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[6] "It is in this contradiction that the obsessional subject is constantly caught, and this indeed as you know is what constantly preoccupies him precisely to maintain the Other, to maintain the subsistence of the Other with respect to all these language formulations with which he more than anyone else is preoccupied, and which are precisely established here to sustain the Other who is perpetually in danger of collapsing, of succumbing under the demand for death; this Other who is nevertheless the essential condition for his maintenance of himself as subject. He could not even subsist as a subject if this Other as such were effectively cancelled out" (Lacan, Book 5, 1957-58 p.363).

(Woodman, 1982, p. 29). To the point that they are locked into a complex system and it becomes a fear of living an unrestricted life and to break free of the ‘addiction to perfection’.

Summary

This chapter examined the underlying psychical structure of orthorexia from Freudian to Lacan, drive theory and object relations. A common theme in eating disorders is the striving for perfection and ‘righteousness’ within this framework the orthorexic is "working so hard to create their own perfection that we forget that we are human beings" (Woodman, 1982, p. 10). Therefore, the obsessional needs the ‘possibility of death’ it is not necessarily death itself but the perpetual motion of life that the obsessional can use to ‘freeze time’ so in obsession, ‘death’ does not mean death, it means freeze-framing. What must be maintained for the obsessional is the distance from her desire, and not the distance from the object.

CHAPTER 3: THE BODY AND OTHOREXIA NERVOSA

'The body is made not born' (Orbach, 2009, p. 139).

Introduction

From a feminine perspective, there is a cultural construction of femininity, which may leave women in western societies more vulnerable to developing some degree of disordered eating behaviour (Motz & Welldon, 2002, p. 212). Maine (2008) and Holmes (2016) look beyond the medical model of eating disorders and view the symptoms through a feminist framework by exploring how feminist approaches may be integrated into the treatment approach for orthorexia nervosa.

Treatments for eating disorders often avoid any emphasis on the developmental aspects of the disorder, or motives for the choice of the body as the forum for the expression of self-control (Motz and Welldon, 2002, p. 210). Instead, it may be the case that the "ego has ceased to identify with either body or mind" (Woodman, 1982, p. 75). Often the body is used as a tool through which aspects of the symptom serve as a means to resolve inner conflicts (Chlebowski & Gregory, 2009). Therefore, in the words of Orbach (2009), "our struggle is to recorporealise our bodies so that they become a place we live from rather than an aspiration always needing to be achieved" (p. 145).

Orthorexia: as an act of subjugation

Whether described under male or female terms, an orthorexic longs to mask a deep underlying fear of embodiment. Orbach (2009) and Woodman (1982) explore the idea of the trans-generational concept of embodiment. Orbach (2009, p. 10) suggests, "every aspect of our body sense embodies something about our mother's own physicality" (Orbach, 2009, p. 41). Woodman (1982) echoes this sentiment "the child personifies the mother's disappointment less in her child than in herself, the child grows up attempting to justify its very existence, which psychically it has never been granted" (p.17). As we have seen in the discussion in chapter one, the individual begins to equate their body with the bad maternal object. A paradox emerges, and we see an individual with an obsession with health yet also often experiencing such a self-loathing or what (Spelman, 1988, p. 98) termed "somatophobia" or body loathing.

Sands (2003) attempts to conceptualise the clinical relevance of this 'bodily subjugation' and discusses the different ways that both men and women use to manage psychic pain that arises when their needs are constantly unmet and focuses on the body as a means "to subjugate the need for and dependence on a chronically unattuned and unresponsive Other". The orthorexics behaviours are therefore attempts to self-regulate feelings of "shame, helplessness and rage" (Sands, 2003). A paradox emerges, whereby on the one hand when difficult feelings and emotions are displaced into the body the individual can "maintain that she emotionally needs nothing from anyone else, she remains locked in an omnipotent, closed system proudly invested in her own self-sufficiency rather than in other people" (Sands, 2003).

It is often the case that patients with eating disorders seek to control the body as a way to gain control over other areas of their lives, and they often fear close relationships that make them feel out of control, messy or 'too much'' as they don't have the capacity to 'regulate intense

affect'(Sands, 2003). (Sands, 2003) posits, "they put into body what cannot be put into mind" and that this "cuts across diagnostic categories".

Eating disorders as a form of self-harm

Motz and Welldon, (2002) discuss the inverted violence against the body as displayed in eating disorders such as anorexia nervosa. It could be argued that the same can be applied to orthorexia, albeit the violence is not always visible. Instead of self-harming in the physical sense, the individual harms themselves through restriction, obsessive thoughts about food and eating, what they can and cannot eat and avoiding situations and social gathering involving food and eating.

What is interesting about orthorexia is that it is not a communicative disorder per se. Nor is it a physically violent form of self-harm in the sense that it may be easy for the individual to 'hide' such behaviours more easily than say a person who cuts themselves or starves themselves to the point of death as seen in extreme cases of anorexia nervosa. Motz and Welldon (2002) describe self-harm as "a hopeful one, indicating a desire to return to the world and restore the capacity to feel, not least by finding a symbolic method of communicating distress" (p.175).

Arguably, orthorexia is a manifestation of something gone awry in the individual's psychical world. "The desire to self-harm can be so powerful that it mirrors a compulsion" (Motz and Welldon, 2002). These theoreticians suggest that self- harm "reflects the way that women communicate their experiences and assert control over their private spheres of influence, their own bodies" (ibid, p. 155). The adoption of ritual provides distance, for without the ritual "what will protect her from the terrors of life she essentially rejects" (Woodman, 1982, p. 49).

Body, language and eating disorders

As we have seen earlier, the orthorexic derives some form of enjoyment from their behaviour. Cosenza (2016) expounds that language poses a problem for those with eating disorders, particularly in relation to the metaphoric function of language. He suggests, "speech appears to be deprived of metaphoric significance". It becomes a form of impersonal speech. Could this be considered a form of alexithymia[7]? Whereby from a clinical perspective, the individual "experiences a sense of impermeability, a sort of desensitization caused by the symptom, which prevents them from either recognising or expressing their own emotions" (Cosenza, 2016). It is the opening up of the subject's unconscious using speech and language amongst other things that can resonate and effect change in the individual (Cosenza, 2016).

Additionally, Woodman (1980) explains that 20th Century woman have been living in a male-oriented culture which has kept them unconscious of their own feminine principle. So much so that we are seeing how "their unconscious femininity rebels and manifests in some somatic form" (Woodman, 1980, p. 10). Therefore, she believes that it is through the body that we can most immediately access the problem. Cosenza (2016) advocates that eating disorders are not symptoms of the unconscious in the classical Freudian sense, but rather symptoms of the "parlêtre"[8], more structured like a language in the vein of Lacan, which implies that the symptom

[7] Alexithymia is a personality construct characterized by the subclinical inability to identify and describe emotions in the self. The core characteristics of alexithymia are marked dysfunction in emotional awareness, social attachment, and interpersonal relating.

[8] Lacan introduces parlêtre as a new word for the unconscious wrought from parle and être. “As you know, the symptom as a formation of the unconscious structured as a language is a metaphor, it is an effect of meaning, induced by the substitution of one signifier for another. On the other hand, the sinthome of a parlêtre is an ‘event of the body’, an emergence of jouissance. Moreover, there is nothing to say that the body in question is your body. You can be ‘another body’s symptom" Jacques Alain Miller- the Unconscious and the Speaking Body (2014).

is more metaphorical as opposed to "a condensation of jouissance without meaning" (Cosenza, 2016). In other words, a form of jouissance that centres on the body and presents itself as an "event of the body" (Cosenza, 2016).

Summary

The body cannot be ignored in the treatment of eating disorders and care must be taken to acknowledge the behaviours associated with orthorexia and how such behaviours ultimately fail to achieve what the patient unconsciously desires. As we will see in the next chapter, it is through conscious acceptance of the repeated behaviour; via the therapeutic alliance and that is brought to the fore and forms the basis of psychodynamic treatment.

CHAPTER 4: THE QUEST FOR WHOLENESS -A FEMININE APPROACH

Orthorexia: a social construction

It is important to note the function that the obsessional behaviour serves in relation to the person's individual psychological history and social context. The pervasive nature of media creates a culture in which "improving the way the body looks and functions is seen as a crucial personal responsibility" (Orbach, 2009, p. 136). Denial of the psyche is deeply ingrained in our culture. It is no surprise that Orthorexia appears as a form of 'transitional theatre' or as a way of splitting off mental pain so that it may be resolved elsewhere (MacDougall, 1989, p. 65). It may be the case that "all is visible to the outside world of the lifelong struggle to survive psychically is the impenetrable armour plating against any representation of emotional arousal or physic pain" (MacDougall, 1989, p. 123). In orthorexics this is disguised as 'preoccupation, health concern or moral endeavour, almost everyone has a rhetoric about trying to do right by their body which reveals a concern that the body is not all right as it is' (Orbach, 2009, p. 73). In addition, failure to do this may "signify shame, failure or a rejection of the values that we are presumed to aspire to" (Orbach, 2009, p. 11).

Behaviours as established in the context of orthorexia may be acted out in the transference, for example Motz and Welldon (2002) suggest that "the transference relationships created by the unconscious needs of these patients rather than being seen as obstacles to treatment were used to develop an understanding of the patient's internal world" (p. 172 &186). "Misguidedly she (the therapist) might applaud her patient's attempts at health or self-regulation" (Orbach, 2009 p. 75). The quest for wholeness suggests that we are not removing the defenses or

behaviours that may have served as a coping mechanism for the individual, instead we look towards an approach that explores the what and why of the control aspect whilst respecting the value of the symptom for the individual.

There is no doubt that hypermodern social discourse favours the epidemic spread of symptoms that are not organized Oedipally (Cosenza, 2016). Like Cosenza's (2016) view of anorexia, so-called new disorders, namely orthorexia "occur in societies whose dominant discourse involves a rise in jouissance to a social peak, and a decline in the normative function of the symbolic". This may be understood from male, as well as female perspectives as 'this distorted evaluation may be fruitfully understood as resting on the basic split in our worldview that denigrates the feminine principle and idealizes the masculine' (Sullivan, 1989, p. 36).

The loss of the feminine archetype

Women are more likely than men to develop eating disorders (Sands, 2003). The same cannot be said of the development of pathological eating behaviours like orthorexia nervosa (Oberle et al., 2017). Sullivan (1989) suggests that "as psychotherapists our central task involves mending psychic splits and restoring inner wholeness; we especially need to include both sides of the psyche, the feminine and the masculine, in our approach to our work" (p.16). Feminine and masculine are not used to refer to gender but to the "energetic patterns of being, both of which are present in all people at all times" Sullivan, 1989, p.13).

Building upon object relations theory in our society we treat the Other as an object outside ourselves, something to better, to dominate, to control and therefore, this dualism breeds disorder. The division of good and bad needs to be bridged by trusting the mystery of

manifestation of one of the teachings of the feminine journey (Sullivan, 1989, p.159). By bridging and integrating the gap between 'good self and 'bad self' objects, Motz and Welldon, (2002) agree that "the function of therapy will be to articulate these thoughts reducing the need for splitting off good and bad feelings and acting out" (p. 158). Overall, therapy for orthorexia could also be informed by looking deeper than the presenting behaviour, in a non-judgmental way, to find less destructive ways of resolving distress and emotions as Woodman (1980) "consciousness will not always solve the problem, but it may make the suffering meaningful" (p.7).

The quest for wholeness: the therapeutic alliance

Sullivan (1989) suggests a more balanced approach to the therapeutic work, with a feminine approach focusing on being rather than doing in other words "the goal oriented, rational, perfectionist, masculine principle has to be balanced by the feminine" (Woodman, 1982, p. 13). Sullivan (1989, p. 21) summarises the difference between the masculine and the feminine archetypes as 'doing versus being'. The masculine archetype is associated with doing; to forge ahead it demands perfection, control and domination, which are often prized qualities in our modern society (Woodman, 1982, p. 156). For the orthorexic who thrives on doing the right thing, simply being can be difficult as for them, it "sounds like a euphemism for nothingness or ceasing to exist" (Woodman, 1982, p. 84). This fear and resistance must also be respected as it can often mask deep-rooted fear that resonates deep into the psyche of the orthorexic. There is no one size fits all therapeutic approach for ON.

As discussed in Chapter one, the symptoms become a response to unmet infantile longings. Effective therapy may arise by acceptance from both therapist and client that a cure is not the goal. Sullivan (1989) suggests that the process of therapy needs to be viewed as a kind of death and rebirth. In that, the patient descends into the unconscious, and this regression may feel like death, followed by a renewal and rebirth that supports a new way of living. Wholeness may come from taking responsibility for the shadow by differentiating herself from the Mother (Woodman, 1982, p.37). Woodman (1982) particularly writes about the anorexic, "if the feminine identity has been truly born, then it can accept death in precisely the same way it can accept its own life" (p. 99). Through awareness comes choice, and by refusing to be a "mere player on the world's stage" (MacDougall, 1989, p. 128) they overcome the drama of obsessional neurosis. "Completeness or wholeness is the most a human being can hope for" (Woodman, 1982, p. 51).

When the transference is working, two individuals are effectively mingling with each other at the level of the soul (Sullivan, 1989), this element of the relationship is vital as it represents "an expression of the devalued feminine principle" (p. 41). By embodying the patient's original objects, the therapist can offer the client a container within which he/she can experience herself the transference (Sullivan, 1989, p. 59). Motz and Welldon (2002) also describe how the therapeutic relationship can offer a woman an 'experience of containment' that perhaps was missing from early childhood attachment with a caregiver. It is this process that allow for the integration of the disavowed parts as part of the journey or quest to wholeness (Sands, 2003).

Cosenza (2016) highlights that these so-called new symptoms "are immune to transference". Also "the eating disordered individuals vehement denial of need for the Other makes it much more difficult for her to form a developmental and self-object transference- that is a transference in which the therapist is experienced as the longed-for Other" (Sands, 2003). For these reasons, it may be important to approach the treatment of eating disorders at the subjective level of the symptom, as individuals do not develop eating disorders for the same reasons even if the symptom manifestations are similar. There is usually enough objectivity to allow the therapist to function however, "at some very profound level, the two individuals in the therapeutic situation are merged" (Sullivan, 1989, p.195).

Summary

The goal for the therapeutic alliance invites the therapist to assist the client towards self-actualisation and understanding of the self. Similar to the approach to anorexia taken by Motz and Welldon (2002), difficult relationships are often re-enacted within the transference relationship between the therapist and client therefore a therapeutic approach that can offer a sense of containment so that these earlier difficulties can be uncovered and worked through may be preferred (p.211).

CHAPTER 5: CONCLUSION

Looking at orthorexia from a purely behavioural or medical perspective will ultimately limit our understanding of it as such. Short-term therapies, such as CBT, have been criticised for ignoring the underlying issues that serve to perpetuate the eating disorder (Zerbe, 2015). The efficacy of CBT for eating disorders is mixed (Hays, 2013; Holmes, 2016). For this reason, mainstream therapeutic approaches such as CBT may prove disastrous in the treatment of orthorexia as they often overlook the symbolic meaning of the symptom and ignore the fact that therapeutic 'success' must encompass human failure – limitations, death and inadequacies (Sullivan,1989, p. 42).

Thapaliya (2017) explores current criticism for the use of psychodynamic psychotherapies in treating OCD compared to behavioural approaches such as CBT. However, this is an area open for further research particularly from an individual if not feminine perspective (Kay, Gabbard, & Greist, 1996). Delving into the symbolic meaning of the symptom, is the crux of the psychodynamic understanding (Zerbe, 1995) and (Zerbe, 2001). In addition, Chlebowski and Gregory (2009) present cases that illustrate how "a psychodynamic approach may enrich clinical understanding and optimise treatment (of OCD)". Therefore, it could be considered that subgroups such as orthorexia may benefit from a psychodynamic conceptualization of treatment.

In relation to self-harm, the meaning of the symptom needs to be understood, as it usually signifies much more than a desire to conform to an accepted notion of attractiveness or status. In the case of orthorexia, we are not looking at deliberate self-harm e.g. cutting, but more so at the

rigid structure that stems from the restrictive and obsessive behaviours apparent with orthorexia. Woodman (1982) explores how living a virtuous lifestyle may not in fact be living at all and that "by filling in the gap between psyche and soma, we may find a way to recognise our distortion, experience it, and trust that we may not need to change it through incessant obsessive behaviours as are demonstrated in the orthorexia" (p.61). As we have seen for the orthorexic it is "often easier to be *better* than you are, than to be who you are" (ibid, p. 61).

Further exploration into the psychodynamic treatment of how emerging eating disorders such as ON can be addressed from a feminine perspective may open up an interesting field of research into this little understood disorder. This enquiry advocates a feminine perspective as an approach that is worth delving into further in the treatment of both genders. During psychodynamic therapy, the individual is in a position to explore their psyche in a way that fits them as an individual and as Sullivan (1989, p. 18) suggests, it may prove useful to embrace the dynamic side of the feminine principle, that is to embrace play and playfulness in the creative process. Sullivan (1989) suggests that if we can "cherish the patient in all his gory messiness, perhaps he/she too, will find some way to love his dreadfully imperfect self. Perhaps he will find a way –not to perfection or cure, for perfection is incompatible with life, but to wholeness" (p. 86). It is hoped that by further research into psychodynamic options for eating disorders that therein lies an effective approach for individuals suffering from ON.

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