

## Eating disorders from a holistic point of view

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### Abstract

Virtually all teenage girls and young women have to some extent an eating disorder and some research has shown to covariate with the intensity of psychosexual developmental disturbances and sexual problems. We suggest simple psychosexual (psychodynamic) explanations for the most common eating disorders like anorexia nervosa, bulimia nervosa, and binge eating disorder and propose the hypothesis that eating disorders can be easily understood as symptoms of the underlying psychosexual developmental disturbances. We relate the symptoms of the eating disorders to three major strategies for repressing sexuality: 1) The dispersion of the flow of sexual energy - from the a) orgasmic potent, genitally mature ("vaginal") state via the b) more immature, masturbatory ("clitoral") state, and further into the c) state of infantile autoerotism ("asexual state"). 2) The dislocation from the genitals to the bodies other organs, especially the digestive and urinary tract organs (the kidney-bladder-urethra) giving the situation where sexual energy is accumulated and subsequently released through the substituting organs. 3) The repression of a) free, natural and joyful sexuality into first b) sadism, and then further into c) masochism. We conclude that the eating disorders easily can be understood as sexual energies living their own life in the non-genital body organs, and we present results from the Research Clinic for Holistic Medicine, Copenhagen, where eating disorders have been treated with accelerated psychosexual development. We included the patients with eating disorders into the protocol for sexual disturbances and found half these patients to be cured in one year and with 20 sessions of clinical holistic therapy.

**Keywords:** Adolescent, eating disorders, integrative medicine, holistic medicine.

### Introduction

Virtually every teenage girl on the western hemisphere – and most women between 12 and 35 years– has an eating disorder to some extent. Working as physicians in general practice we have observed not only a high prevalence of severe eating

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disorders like anorexia (the general loss of appetite or disinterest in food), anorexia nervosa (the intended weight loss by starvation, over-exercise, purging etc.) and bulimia nervosa (the cyclical, recurring pattern of binge eating often followed by guilt, self-recrimination and compensatory behavior such as dieting, over-exercising and purging) (see list of the eating disorders listed in ICD-10 in table 1 (1)), but also a number of milder disorders that less often are put into diagnoses followed by medical treatment, like *binge eating disorder* (uncontrolled bursts of overeating followed by compulsive vomiting), *extreme and obsessive weight control* (often by patients with a normal weight) where the bathroom weight are used several times a day, and *obsessive, neurotic attitudes to food* i.e. a too large importance attributed to avoiding calories, or carbohydrates, or fat, or even the compulsive abandonment of a single food items like white sugar, white bread etc.

Other expressions of this are *extreme exercise-programs* sometimes even encouraged by the physician, and *vanity that converts into a compulsive drive for being as slim as the commercial fashion-models*. The girls often present severely disturbed body images in combination with either an antisocial behavioral pattern with withdrawal and social isolation (antisocial or severely disturbed personality), or a strong dependency on the confirmation of their value as a person from peers and parents (dependent personality type), or a need for constant appraisal of the bodies' sexual value from boys (hypersexual behavior). So the closer we look at the appetite dysregulations, the more they seem deeply connected to psychosexual factors.

Therapists who work with young female patients with eating disorders often notice that there seem to be both a mental (psychoform) and a bodily (somatoform) aspect of the problem. The patient's mind often carries a lot of thoughts and ideas about the vital importance of not getting too fat and ugly, combined with feelings of shame and guilt from not being able to control the eating habits, etc. The patient's body often seems to live its own life. Some times it is compensatory attracted to food, at other times strongly repelled by food, and at other times again not interested in food at all.

Often the phases vary in a cyclic, rather predictable way. In anorexia, food is simply not of

any interest; in anorexia nervosa there is a battle in the patient not to eat in spite of an urge for eating; in bulimia we have the compensatory overeating, and in bulimia nervosa we have the inner conflict between one part of the patient that want to eat and an other that do not. In bingeing the striving is for simply filling the stomach and thereafter emptying it totally again, releasing all tension. The emotional character of the eating disorder has made them difficult to treat with behavioral therapy; it has not been able to treat them successfully with drugs either. So most patients suffer from their eating disorder the first 20 years after early puberty; after that is normally tend to burn out – as to the sexual urge.

There are many scientific speculations about biological reasons for the eating disorders - the same way psychiatrists for a hundred years now have speculated in possible biological reasons for mental illnesses; but neither has till this day showed genetic or any other clear scientific evidence for being “hardwired” in the human nature. It is often said that the eating disorders disturb other aspects of the patient's life, including her sexual life, but this is most likely to be the other way round: the eating disorder is a symptom of a deeper psychosexual disturbance.

It is worth to speculate that the problems started with puberty and gradually goes down (“burns out”) during the next 20 years until the 35-year old woman, who statistically have come to know her body and sexuality by getting rid of her eating disorder, or at least of its symptoms. The close association in time and intensity is a strong clue that eating disorders might be causally linked to sexuality.

Psychosomatic and psychosexual research has in accordance with this shown sexuality to be closely linked to the eating disorders. Morgan et al (2) found that anorectics were less likely than bulimics to have engaged in masturbation and also scored lower on a measure of sexual esteem, and both groups exhibited less sexual interest and more negative affect during sex than did a normative sample (2). Abraham et al (3) found that bulimic patients were more likely to experience orgasm with masturbation, were more likely to have experimented with anal intercourse, and were more likely to describe their libido as “above average”, while their controls were more likely to experience orgasm during sexual intercourse (3). Raboch and Faltus (4) found that “primary or

secondary insufficiencies of sexual life were found for 80% of the anorectic patients” (4), while Raboch (5) found that sexual development of patients with anorexia nervosa was accelerated in the initial stages.

Sarol-Kulka et al (6) found in a pilot study that the anorectic patients showed interest in the opposite sex at an earlier age than patients with bulimia; however, the anorectic females, more frequently than bulimic, reported that these interests were never realized. 36% of patients with anorexia and 29% of patients with bulimia had no sexual initiation. When evaluating the negative aspects of their own sexuality, 28% of patients with bulimia and 9% of patients with anorexia reported difficulties in achieving orgasm; 13% of bulimic and 9% of anorectic females reported difficulties in getting aroused, 22% of bulimic and 17% of anorectic females reported fearing the sexual initiation (6).

Handa et al (7) found that 16.3% of patient with eating disorders had been physically abused and Sanci (8) found that childhood sexual abuse happened 2.5 times as often as normal with patients that later developed bulimia; the patients who developed anorexia did not show this association. Although the picture is not at all clear, and even somewhat contradictory, research has shown a strong association between sexuality and eating disorders. In science we must agree that our present understanding of sexuality is messy and unclear in itself that this most likely is the reason for the messy conditions of the research; we actually believe that it is the incomplete understanding of sexuality itself in the mind of the researchers that is the major hindrance for shedding light into this.

As we aim to improve our present state of understanding we have incorporated into this paper a number of classical and modern theories of sexuality and psychosexual development. We believe that this synthesis is of clinical value and have, after working 10 years with holistic sexology in the clinic setting (9-25) developed a holistic sexological cure for the eating disorders that we have tested with success on several patients. We therefore want to present our theoretical understanding to make a basis for further research in clinical holistic medicine both in Denmark and in other countries (this chapter is a part of the Open Source Research Protocol for Clinical Holistic Medicine, that includes all the published strategies for

helping the patients with clinical holistic medicine (CHM) and the obtained results from the clinical practice, to be found at [www.pubmed.gov](http://www.pubmed.gov), search for papers with “clinical holistic medicine” in the title).

**Table 1. The 2007 ICD-10 list of eating disorders and sexual disorders. Notice the similarities**

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(F50.) Eating disorders
(F50.0) Anorexia nervosa
(F50.1) Atypical anorexia nervosa
(F50.2) Bulimia nervosa
(F50.3) Atypical bulimia nervosa
(F50.4) Overeating associated with other psychological disturbances
(F50.5) Vomiting associated with other psychological disturbances
(F50.8) Other eating disorders
(F50.9) Eating disorder, unspecified
(F52.) Sexual dysfunction, not caused by organic disorder or disease
(F52.0) Lack or loss of sexual desire
(F52.1) Sexual aversion and lack of sexual enjoyment
(F52.2) Failure of genital response
(F52.3) Orgasmic dysfunction
(F52.4) Premature ejaculation
(F52.5) Nonorganic vaginismus
(F52.6) Nonorganic dyspareunia
(F52.7) Excessive sexual drive
(F52.8) Other sexual dysfunction, not caused by organic disorder or disease
(F52.9) Unspecified sexual dysfunction, not caused by organic disorder or disease

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### *Oral sexuality, sexual repression and eating disorders*

The Freudian concept of oral sexuality is little understood by contemporary physicians and psychiatrists (26), but Freud’s concept was acknowledged by the whole tradition of psychoanalysts and psychodynamic researchers and therapists from the last century including Jung (27) and Reich (28,29).

## Case Study

### *Female patient 36 years old*

The patient tells her story about an eating disorder (bulimia nervosa) starting when she was 16 years, a little before she became sexually active. She had this condition until recently – first when she was 30 years old did she have spontaneous remission from it - in spite of many years of cognitive psychotherapy. She was first treated on an individual basis at the University Hospital Psychiatric Clinic; then she came in a bulimia psychotherapy group for 18 month, when she was 20-21 years old, followed by 6 years in individual psychotherapy with a female experienced psychologist. The focus of the therapy was getting control over the eating habits. She reported that she always had big problems with desire, getting sexually aroused, and getting satisfactory orgasm, and she complains about a life-long history of unsatisfactory sexual relationships. She explained that her bingeing was motivated primarily of the extremely relaxed and happy feelings she got after filling her stomach completely until it almost busted, and then immediately after emptying again completely by vomiting. The process itself was not really emotionally rewarding, neither the eating part of it nor the vomiting part, but the total bodily relaxation was what she was really after. Only after she learned how to relax and go with “the flow in life”, letting go of controlling everything, did the eating disorder leave her. It seemed that the therapy was unproductive, because it aimed at helping the patient getting control, not at helping the patient to learn to let go of the control.

Freud believed that sexuality during the child’s psychosexual development traveled from the mouth to the anus (and bladder), until it reached its final destination in the genitals. Reich had a somewhat different understanding, as he believed that the sexually healthy little girl had genital sexuality, and only when she was denied her “genital rights” i.e. by being punished for masturbation, would she repress her sexuality away from the genitals and into the other organs. Freud also had the idea of sexual development from infantile autoerotism into the more mature masturbatory, clitoral sexual competency, before the girl finally reach genital maturity and able to have

sexual intercourse. Reich believed that whenever sexuality became repressed it was kept by the body-  
amour and the muscles of the body. So when sexuality was repressed, it moved into the tensions of the body, and thus out of reach and use for the patient (28). Today we know in theory three ways for sexuality to become repressed – three neurotic strategies for getting rid of a sexuality that cannot be contained in the patient’s childhood environment:

- *Repression of sexual energy by destroying the sexual ray of energy:* from the genital state (orgasmic potency) to “infantile autoerotism” (lack of orgasmic potency).  
The first is the repression of the sexual energy, from flowing freely through the genitals allowing the person so engage in sexual intercourse, to the more restricted masturbatory state, where the sexual energy still can be used for pleasure raising a sexual circle, but only within the person herself, into the still more futile and useless state of infantile autoerotism, where sexual energy cannot any longer form a beam of energy and flow, but only hang as a cloud of sexual energy (a sexual quality or “odor”), just barely allowing the observer to identify the gender of the person. The infantile autoerotism is the typical sexual state of the schizophrenic patient; in psychodynamic theory the lack of sexual interest in the world from this state is one of the suggested reason for autism.
- *Repression of sexual energy by displacement from the genital to other organs – sexualisation of the digestive system.* When sexuality cannot be accepted by the girl’s parents it can still survive by being transformed into emotional charge associated with eating, defecation and urination. The mouth, intestines, anus and bladder can, as observed already by Freud carry enormities of charge of sexual energy. The reader that doubts this might recall Gräfenberg study from 1950 where he quite surprisingly documented the very important role of the urethra in many women’s sexuality (30). This means that the sexual energies in many ways

can be preserved, but disguised, as sexual emotions connected to non-sexual organs; the joy associated with the later is obviously often much easier to accept for the parents: The little girls is cute when she eats; she is even cute when she goes to the bathroom, but she is definitely naughty and not-so-cute when she plays with her own genitals. So the displacement of sexual energies turns her, if she is raised in a sex-negative environment, into a socially acceptable person. If we compare the eating disorders with the sexual disorders, it is quite interesting to see how parallel these two lists are (see table 1). Of course this psychodynamic understanding of body and sexuality might seem rather incomprehensible, if you are unwilling to acknowledge sexual energies as the fundamental vital energies in the human being, as did Freud, Jung, Reich, and so many of the other great psychologists and physicians of the last century. But if you can follow this scheme of thinking, then you can also examine your female patient presenting an eating disorder for a deeper layer of psychosexual developmental disturbances, that could be corrected, and by doing so you can help the young woman not only to get rid of her eating disorder, but also of other more existentially important problems related to a poorly developed sexuality.

- *Repression of sexual energy by degeneration into sadism and masochism.* A third way sexuality could be repressed is as sadism and masochism. The idea that sexual repression leads to masochism, which is perhaps most strongly and clearly expressed by Reich in his book "Character Analysis" (29), is that sexuality basically calls for meeting with the opposite sex, in an active, aggressive way. Sexual aggression is thus the most natural thing with both sexes, although the expression of male and female sexual aggression is very different, the male aggression often looking like sexual violation and harassment, while the female aggression often is looking more like seduction and "hooking". When sexual aggression becomes

blocked, i.e. when the girl is told not to be so sexually challenging to the boys in the way she dresses and acts, or when she is sexually neglected of the father and other boys and men who she is depending on interacting with for her psychosexual development, her sexuality first turns into evil sexual intent (i.e. sexually torturing the boys by rejecting them or slating or intimidating them); the logic in this is that sexuality still exists, because it breaks through the barrier using force (which is sadism). If sadism is also repressed, the flow of sexual energy is turned inwards, instead of outwards (which is masochism). So masochism is basically sadism turned inwards towards self. If the reader wonders how sadism is created from sexual energy turned evil, we refer to our explanation of evilness in general in the Life Mission Theory (31-39). This theory explains how and why all intents seem to turn evil, when they cannot be realized by the little child (36).

## **Sexual theories for anorexia nervosa, bulimia nervosa and binge eating disorders**

### *Anorexia nervosa*

The basic pattern of anorexia nervosa seems to be the lack of desire and the lack of self-acceptance and acceptance of body and sexuality. The girl often presents severe problems related to her personality; her mind is often not fully developed compared to other girls her age, her sexuality is often less active, unless she uses this as a kind of activity that uses calories i.e. instrumentally and not for the sexual pleasure; spiritually she is often not able to give and receive love, and she often also has a poorly developed self (see (40) for a systematic way to analyze the personality disturbances). So it might be a little simplistic to point to the patients psychosexual development as the fundamental cause of the eating disorders, but according to psychosomatic theory the problems related to the lack of development of her personality is actually also likely to be caused by her

more fundamental problems related to her psychosexual development.

So we do not find it hard to see how anorexia nervosa relates to repressed sexuality; the patient's sexuality is often repressed in several ways: obviously there is often the regression toward the infantile autoerotism; then there is the translocation of sexuality from her genitals to her digestive system (and often also bladder-urethra); and finally there is often a strong component of masochism leading to self-destruction. If the reason for starvation really is masochism, and it often looks so, there is a hidden sexual pleasure in the self-destruction that is stronger than any pain you can inflict on the patient during the most rigorous scheme of behavioral therapy. Actually any scheme that represses the masochistic sexual energy is likely to deprive the female masochistic patient even the last remaining joy and meaning of life. This is likely to be the reason why behaviors coercive therapy, which is still in use in psychiatry, most often is strongly contra-productive.

### *Bulimia nervosa*

Bulimia is in many practical ways the opposite of anorexia, but it still contains from a psychodynamic view many of the same basic elements of repressed sexuality. The shift from the genitals to the digestive organs (and often also bladder-urethra) is the same; the repression of vital sexuality and orgasmic potency into the masturbatory, clitoral state is the same, although the bulimic patient often is less repressed than the anorectic; and the masochistic quality of the bulimic behavior is often rather obvious. But in bulimia the fundamental drive is preserved. The patient wants to eat; when the patient tells about the strength of the urge it carries the same feel as the other basic biological urges, making it highly likely to be an expression of a hidden sexual urge. If this is the case, it is clear that it is uncontrollable by the girl or young woman. The power of sexuality is stronger than the power of the mind; it cannot be controlled by direct repression; it can only be handled by intelligent negotiation.

So if this is the case, the bulimic patient must learn to acknowledge her compensatory drive for eating as an expression of her sexuality; and her

neurotic sexuality must be developed to enable it to shift back and inhabit once again her pelvis, genitals - and become a natural sexuality.

### *Binge eating disorder*

This disorder is a less serious disorder that seldom leads to medical attention, as we find it in girls and young women with almost normal psychopathology. In many ways this disorder is the clearest expression of sexuality taken to the digestive system. Instead of filling her vagina she is filling her stomach; and instead of releasing the tension in an orgasm, she releases it through vomiting. Many of these patients seem to have their sexuality repressed to the clitoral level being able to masturbate, but not to have full orgasm during coitus (loss of orgasmic potency).

The masochistic component is often lacking, but it can be there also. The simplest way to understand this is the patient masturbating through her digestive system, the same way other women masturbate by filling the vagina and emptying it again; we have noticed the habit of some of these patients to fill their anus and rectum with objects or large amount of water, and releasing this again for sexual pleasure or for reasons of "purification". This is obviously the same sexual dynamics taking directly to the intestines. The same way the urine can be held back and finally released as a masturbatory practice of some of these often sexually innovative patients.

The bulimic and the bingeing patients are often sexually active also; not all their sexual energy is channeled to the digestive organs, making the situation a little more complex. It is like a diverted river, where more or less water is running in a parallel river.

The cure is to help the patient lead all the water, all the flow of sexuality, back into the main river. First when the patient own all her sexual energy and is able to use it maturely genitally for satisfying sex with a partner, will her eating disorder – the symptoms of her disturbed sexuality – finally be cured.

## Sexological treatment of eating disorders

In treating the eating disorders as sexological disturbances it is important to go directly to the patient's sexuality; this means that the therapist and the patient should agree completely that her sexuality and personality as a whole is much more important than her eating disorder. Of course, if the patient is dying from starvation or excessive overweight there might be practical problems in using such a strategy; it is important to remember that all problems start as small problems and only if they remain unsolved for a very long time turn into huge, even mortal situations. So this approach is wisely used as soon as the symptoms of the eating disorder appears, not when the girl or young woman has lost so much weight that she is unable to concentrate on anything and close to dying.

The aim of the holistic sexological therapy is the development of the patient's whole personality through rehabilitation of her sexuality – her genital character – with an often-used expression by Reich (28,29).

Holistic Medicine is nothing but the classical, European medicine going back to Hippocrates; this is the beginning of modern medicine, which we know rather well from uniquely well-preserved sources called the Corpus Hippocraticum (41). We have in recent years tried to develop holistic medicine into a modern, scientifically based system of clinical medicine, where patients are cured mostly without drugs and surgery. The theory and practice of clinical holistic medicine has been described in a number of books (42-45) and experimental cures for many illnesses and disorders including cancer and schizophrenia have already been presented in a series of papers (46-75). The sense of coherence seems to be a core concept in the understanding of holistic healing (76-81).

We are not in this paper going to repeat all the practical tools and details, but the interested physician is encouraged to start just by talking with the patient about her personal history and present problems and after obtaining the trust of the patient continuing this therapeutic work by using therapeutic touch, i.e. massage of the whole body. The combination of the conversational therapy and the bodywork has been

used for millennia to rid the patients of repressed emotions hidden in the body or related to the body and sexuality in the patient's mind. The basic idea in the therapy is to work against the patient's emotional resistance, to bring all difficult emotions up to the surface of consciousness, but first a variety of emotions will show in the therapy, often sorrow, anxiety, anger, helplessness, hopelessness or despair. After the emotional layer an even more intense layer of emotions connected to the sexual aspects of the body and its energies, including the genitals and pelvic area will appear.

The holistic sexological bodywork is normally *not* including the patient's genitals, as many patients can be helped without this degree of intimacy. If the patient is not sufficiently helped there are a number of small and large sexological tools to be used, like *acceptance through touch* (11) and *vaginal physiotherapy* (14,15), which are relative small tools and much smaller procedures than the standard pelvic examination, and larger tools like the expanded *holistic pelvic examination* (13), going all the way up to direct sexual stimulation of the patient in a radical and provocative technique developed 50 years ago by sexologist like Hoch and Reich called the *sexological examination* (82-92).

The fundamental strategy of therapy is to take the patient back in time, to allow her to confront the emotional and sexual problems of her early life, childhood, and even fetal life if necessary, that she could not solve at that time. The patient will get well again the reverse order of her getting ill – this is the law of Hering (93). The patients will heal her whole existence, not only a part – that is the salutogenic principle (94-95). The patient will come back into the old traumas, when she is exposed, in a symbolic form, for the traumatic events and energies that once created her wounds – that is the famous principle of similarity going all the way back to the ideas of Hippocrates; and finally she will heal when she got the resources needed at the time of the trauma, and is so confident with the therapist that she is able to receive them.

The eating disorders can easily be understood as sexual energies living their own life in the parallel body organs related to digestions, and we present our experience from the Research Clinic for Holistic Medicine that the eating disorders easily can be treated, if therapist and patient can agree that

sexuality, not the eating disorder, is the focus of the therapy. In our project we have observed that virtually all young female patients to some degree have an eating disorder; we understand these as symptoms of psychosexual developmental disturbances and we therefore successfully included the patients with eating disorders into the protocol for sexual disturbances [9]. We found that about half the patients was cured, not only for their sexual problems, but also systematically from their eating disorders, in one year and with 20 sessions of clinical holistic therapy. In general we found that independently of the type of problem about half the patients were cured, and the more direct the patient's sexuality was approached in the therapy, the more efficient it was (9,15,96).

## **Ethical issues**

Holistic therapy and holistic sexology should be made according to the ethical standard of the International Society for Holistic Health (97) and the laws of the country you reside in. It will be difficult for physicians not familiar with contemporary holistic medicine or the works of Freud, Jung, Reich, Lowen, Rosen and others (26-29,98,99), to understand the full clinical rationality in interpreting the eating disorders as psychosexual disturbances. It will also be difficult for psychiatrists that normally do not touch their patients at all, to understand the therapeutic value of therapeutic touch. And when it comes to using the manual sexological tools, many physicians who are not sexologists, might find these tools too intimate and too directly sexual. In our clinic we have until now used the small manual sexological tools, and only rarely the holistic pelvic exam. Direct sexual stimulation of the female patients seems to be necessary in primary anorgasmia and similar sexual disorders, but we have not, in spite of the indication, found it correct to use these tools in our clinic, but have referred the patients in need of such therapy to the sexologists using these methods.

When it comes to teenagers below 18 years old, we have chosen to wait with the manual sexological treatment until they could sign up for these treatments themselves as adults legally responsible for their own treatment. For patients below 18 years we have often used the normal pelvic examination as basis for a

conversation about sexuality and related issues, and we have found the pelvic examination to be as therapeutic as it is unpleasant and even experienced as "very painful" by 15% of the teenagers (100). We know from several studies that patients with a history of sexual abuse very often react very negative emotionally to the pelvic examination (101); the penetration of the vagina with the speculum and other instruments, or just even the fingers, often gives strong associations to - and memories of the sexual abuse, and according to the principle of similarity this can - and should - be used therapeutically to help the female patient to heal her old wound on body and soul from the sexual abuse (18-20).

## **Discussion**

The observation of the psychoform and somatoform dissociation of the patient will naturally lead to an intent to heal the patient by reconnecting mentally and bodily to the patient. As we are sexual beings, and as a disturbed sexuality has so many symptoms and is followed by so many complications of all kinds, we cannot afford to be a-sexual and to keep all discussion of the patient problems in the a-sexual realm, if we truly want to help the patient.

For almost 100 years psychotherapy and psychiatry have disagreed about the importance of sexuality in mental diseases; this disagreement continues when it comes to the eating disorders. We cannot here settle this old discussion today; just inform the interested reader about the theories and the tools for healing also the patient with an eating disorder. When you have worked for some years in the holistic clinic, as we have now with more than 500 patients, and seen how the dynamics of masochism, sexual repression into autoerotism, and sexual shifts from the genitals to the other organs of the body like the digestive organs (from mouth to anus) and the whole urinary tract (kidney-bladder-urethra) can be easily reversed and often followed by the radical improvement not only of the patient's sexuality, but also of quality of life, physical and mental health, and level of social, sexual and working ability, you will also come to believe in the old psychodynamic theories of Freud and his students. We found it often helpful to teach the patients about quality of life



theory (102-105) and quality of life philosophy (106-113).

The sexological approach in the treatment of physical, mental, and existential problems are not new; the traditional holistic medicine of old Greece did exactly that. We have become quite alienated to simple conversational therapy and bodywork during the last five decades, where biomedicine and drugs have become the answer to every problem of the patient, but with biomedicine we have not be able to help all patients and today every second citizen in modern society is a chronic patient, even in countries like Denmark where biomedicine and health service are absolutely free. So we have to conclude that biomedicine is not going to help all patients and biomedicine is not likely to help teenagers and young women with eating disorders – especially not if the psychodynamic hypothesis presented in this chapter is likely to be true. The most fundamental problem with the sexual approach is that is has proven very difficult to understand the true nature of sexual energy in scientific terms, and that the whole field of human development is theoretically extremely farfetched (114-126). To simplify everything it is important to recall that the essence of relating is being able to say I-Thou. In therapy the courage to love your patient is what in the end will heal you patient and release the patient from disease/pathology (127).

## Conclusions

Virtually all teenage girls and young woman have an eating disorder to some degree. We have suggested simple sexual explanations for the most common eating disorders like anorexia nervosa, bulimia nervosa and binge eating disorder. We have suggested that these disorders could easily be understood as symptoms of psychosexual developmental disturbances. We have analyzed the symptoms in relation to three major ways that patients use to repress their sexuality as children: 1) The dispersion of sexual energy from the genitally mature to the immature masturbatory (clitoral) state, and further into the state of infantile autoerotism, 2) the dislocation from the genitals to the other organs especially the digestive organs and the bladder-urethra, giving a situation where sexual energy is

accumulated and released though substituting organs and 3) the repression of free, natural and joyful sexuality into first sadism, and then further into masochism.

The eating disorders can easily be understood as sexual energies living their own life in the parallel body organs related to digestions and we present our experience from the Research Clinic for Holistic Medicine that the eating disorders can be treated, if therapist and patient can agree that sexuality, not the eating disorder, is the focus of the therapy. In our project we have included patients with eating disorders into the protocol for sexual disturbances, and we have found about half the patients to be cured in one year and with 20 sessions of clinical holistic therapy, independent of the problem the patient initially presented with (9,128-132).

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