Center for Open Access in Science ▪ https://www.centerprode.com/ojpr.html
Open Journal for Psychological Research, 2022, *6*(1), 1-6.
ISSN (Online) 2560-5372 ▪ https://doi.org/10.32591/coas.ojpr.0601.01001h

The psychotherapeutic approach in Orthorexia: A Case study

Tsvetelina Slavchova Hadzhieva

South-West University"Neofit Rilski", Faculty of Philosophy, Blagoevgrad, BULGARIA

Received: 11 December 2022 ▪ Revised: 27 February 2022 ▪ Accepted: 4 April 2022

Abstract

The article aims to describe and outline the potential possibility for the implementation of orthorexia neurosis as a consequence of the inappropriate dietary pattern of nutrition, which is expressed in people in food navigation, who are established earlier and obsess daily about Orthorexia. A case study is presented, which eloquently shows that Orthorexia can affect people, regardless of age. An attempt has been made to emphasize this by compulsively following atypical eating habits changing the personal pattern of introduction, where the main focus is on food.

Keywords: eating disorders, Orthorexia, eating habits.

Eating disorders are characterized by abnormal eating navigations, insufficient or excessive food intake, and compensatory behavior (American Psychiatric Association, 2000). Their contradiction is associated with danger to the emotional individual's health and functional functioning (Stice & Shaw, 2004).

Many studies in this area have shown that one in six girls between the ages of 15 and 18 resort to a strictly reducing diet that deprives the body of vital macro and micronutrients (Smithers et al., 2000).

From a clinical point of view, eating disorders are divided into three main types:

(a) Anorexia nervosa: disorders occurring with excessive control and limited food intake;

(b) Bulimia nervosa: overeating, followed by compensatory cleansing, abuse of laxatives, and heavy physical activity;

(c) Unspecified eating disorders. Orthorexia Nervosa falls into this category.

Eating disorders are classified as psychiatric illnesses, where the risk of mortality is 12 times higher than all other psychiatric illnesses. The most characteristic and distinctive for them is that patients are highly obsessed with food, its nutritional value and mainly classify it as "allowed" and "forbidden." Food obsession engages all the attention and thought process of people suffering from eating disorders, immersed only in the idea of hunger, which in any way try to suppress (anorexia) or under its influence lose control over the amount of food consumed (bulimia and hyperphagia). In both eating disorders, patients experience an obsessive fear of gaining weight. As in the former, restrictive nutrition, based on the strong will control imposed by the affected person in bulimia. This control is often missed and overwhelmed by "wolf hunger" attacks, followed by induced vomiting (Martín-Murcia et al., 2011).

Correspondence: Tsvetelina Slavchova Hadzhieva, South-West University"Neofit Rilski", Faculty of Philosophy, Blagoevgrad, BULGARIA. E-mail: ceti_hadjieva@swu.bg.

Studies have found that eating disorders are among the most severe factors affecting the quality of life of sufferers and the most common cause of death from somatic complications or suicide compared to other psychiatric illnesses (Arcelus et al., 2011).

In the last decade, the Bulgarian public has become more closely acquainted with the issue of eating disorders, including Orthorexia, where many authors in this field support the opinion that orthorexia neurosis is still an eating disorder. However, it lacks the same clinical character as in anorexia nervosa and bulimia nervosa (Markov, Markov, Vodenicharova & Baikova, 2016; Markov, Markov, Baikova & Petrova, 2011; Hadzhieva, 2019).

The term "orthorexia neurosis" comes from the Greek "orthos" – correctly and "orexis" – appetite. Orthorexic symptoms are expressed in a pathological, irrational pursuit of healthy eating, use only of healthy food, and guilt and anxiety in a "mistake" in the diet. The term was introduced by Dr. Stephen Bratman (1997), who strongly emphasizes pathological attachment to dietary theories, obsession with unreasonable diets, and inability to eat spontaneously, where the mating instinct is suppressed and silenced in favor of "reasonable signals for a healthy diet." The author, who has gone through Orthorexia, believes that people suffering from Orthorexia most often have obsessive personality traits. They devote much of their time thinking about healthy food, planning its purchase, preparation, and consumption. It is characteristic of them that they have a sense of superiority over their lifestyle and eating habits. The very process of dieting leads to euphoria, and mistakes cause a feeling of solid guilt and inferiority (Bratman, 1997).

A study on orthorexic eating habits found that 11.76% of orthorexics suffered malnutrition, and 26.5% of the total number sought to reduce their body weight. The researcher emphasizes that although the craving for healthy food is not a mental disorder when this aspiration is accompanied by overvalued ideas, physical dysfunctions, and social isolation, it can now be defined as a pathological condition (Shanwal & Dasgupta, 2014).

Here it is important to note that Orthorexia can progress to anorexia and bulimia. In some cases, recovering from anorexia and bulimia develop Orthorexia due to uncontrolled, compulsive eating habits (Bratman & Knight, 2000).

With the case described in this article, we want to visualize the development and course of Orthorexia to prove the real and serious threat as an eating disorder that carries the potential of the eating disorders already diagnosed in DSM-V.

A. H. (the name only initials) is 53 years old, lives in a big city, and has two children. She shares in her family; great importance has always been given to food-high-calorie, varied in the past and present. Due to her high professional commitment, A. H. failed to pay enough attention to her children, which is why the food there often served as praise, reward, consolation, celebration, as a means of isolation, peace, compensation. For this reason, the lack of attention to her children, she uses food as an emotional and physical substitute to excuse the absence, lack of awareness, and commitment to family life.

A. H. began to follow a diet about five years ago due to conscious guilt towards the unhealthy eating habits of her children. He began to read various materials related to healthy eating, becoming a follower for a short time of various nutritionists, following their dietary prescriptions. He constantly talks to the people around him about the new things he reads every day on social networks, accepting them without criticism. He often changes his views on the health benefits of a particular food. Obsessive thoughts about food occupy her almost constantly. Her new eating habits lead to permanent mental engagement and activity in exercising her healthy diet.

She often allows herself to teach others how to eat on her initiative to emphasize that she already has a more conscious diet than before. She feels a certain superiority over others who still "do not know how to eat properly," according to her.

During the consultation process, the high degree of guilt he felt towards his overweight children became apparent. For a long time, she was accused of being in this physical condition precisely because she was not well enough acquainted with food and the process of eating and because A. H. did not have enough parental presence, which she compensated with food. Feelings of guilt began to diminish when she realized that she was already eating a different diet, where she did not buy harmful high-calorie food as a prerequisite for her family members to consume it.

It is impressive that any information you read about nutrition and diet is considered an absolute truth that is not questioned or criticized. There is inconsistency and a sudden change in dietary preferences.

Her compulsive craving for healthy foods is related to the desire for possible weight loss and the fear of disease. Health as a value is her motivating factor for following a healthy eating pattern and her attempt to "exonerate" herself for the bad eating habits she had before.

Of particular interest to us was the question of the sharp change in food preferences of A. H. – from high-calorie food intake to a highly restrictive diet and how exactly this quick change affects her health. Reports frequent sudden mood swings, heightened sensitivity, irritability, irritability.

1. Methodology of work

She set the beginning of the therapeutic work by keeping a nutritional protocol; A. H. had to reflect each meal type, quantity, degree of hunger, and satisfaction with the diet. From reading these daily protocols, we found that her diet was inadequate (alimentary), despite her claim that she was feeling well.

Then we drew her attention to the need for a complete and varied diet, including all micro and macronutrients. Physical and mental disorders that occur with prolonged restrictive feeding were discussed.

Eating disorders in A. H. are a consequence of the lack of adequate knowledge about nutrition and the exposed feeling of guilt for the developed unhealthy habits in his family and the desire to imitate, established by the new dietary trends in society. The case of A. H. turned out to be the unlocking and supporting factor for her eating disorder.

As a consequence of dietary nutrition, these physiological conditions have often led AN to attacks of "wolf hunger" as a counter-regulatory response of the body. Therefore, it was necessary to apply the method of behavioral therapy to replace the established negative eating habits with more appropriate ones. Cognitive-behavioral therapy is a method that causes cognitive change-modification in the thinking and belief system of the individual to cause lasting emotional and behavioral change (Bek, 2018). In this way, AN's dysfunctional thinking (influencing her mood and behavior) undertook a change, evaluating her thinking more realistically and adaptively, improving her emotional state and behavior. As a result, her somatic complaints diminished, as did her guilt.

Her eating behavior changed when she gradually began to incorporate the foods she had excluded from her diet. In contrast, the pursuit of healthy eating was maintained, but not to such a compulsive degree. In the course of psychological counseling, I realized the need and importance of proper nutrition. About guilt, she accepted the fact that at that time, she did not have the necessary awareness of food and nutrition in general and appreciated the current reality that she was now much more informed and able to maintain genuinely healthy eating habits. This therapy helped A. H. transform his "automatic" negative thoughts by identifying, evaluating, and responding to his unrealistic and maladaptive thinking.

In the positive approach created by Peseshkian, the idea of connecting and illuminating recognized and underdeveloped human abilities is advocated, and in the psychological symptom, he relies on the personality's ability to compensate for what he does not yet know about himself and does not know how to use. This method develops the psychodynamics of conflicts and clarifies the psychological content of the problem.

Positive psychodynamic psychotherapy considers four main areas in which a person invests his life energy (body; activity; contact; future, fantasy). With harmonious and satisfying functioning, one feels "happy" in one's balance model. In the case of solid conflict dynamics, transformations in the balance model are usually provoked. Positive interpretation and clarification of the psychological content expand the individual's perceptions of his current difficulties (in Dimitrova, 2015).

Through situational encouragement, as part of the method of positive psychotherapy, AN was able to make sense of and process guilt as a prerequisite for changing her eating behavior in the present. The positive interpretation assured her that she already had the necessary knowledge to lead a better lifestyle.

2. Discussion

The way of eating is determined by various factors that determine the direction of behavior. The eating behavior of dieticians defines their diet as atypical because it is oriented towards restrictive nutrition, which involves reducing the quantity and quality of food. If continued for a long time, this disturbed diet creates conditions for the development of an eating disorder (anorexia, bulimia, Orthorexia).

In presenting the present case, we have attempted to explain some of the predisposing, triggering, and supporting factors in the development of Orthorexia. For the orthorexic behavior of A. H., insufficient knowledge about nutrition and overexposed guilt turns out to be the key factors. With the help of the psychotherapeutic methods and techniques described above, he restored his regular diet and processed his guilt. She shifted her focus from food and responsibility to more rational thoughts, replacing "automatic" negative thoughts, eliminating their destructive effect on her personality. Eating disorders create several consequences that upset the psycho-physiological balance in the body. Psychotherapeutic work should be aimed primarily at restoring eating behavior while looking for the cause (symptom) and applying methods to overcome it to provide practical corrective support and return to everyday life.

A. H. restored her regular diet by assessing her transition through different eating styles as a necessary life experience to establish a more fulfilling lifestyle. He ventilates his negative emotions through the awareness of guilt as a resource for dealing with it.

Acknowledgements

This research did not receive any specific grant from funding agencies in the public commercial, or not-for-profit sectors.

The author declares no competing interests.

References

American Psychiatric Association (2000). *Diagnostic and statistical manual of mental disorders* (4th ed. — text revision). Washington, DC: Author.

Arcelus, M., Wales, A., & Nelson, S. (2011). Mortality rates in patients with anorexia nervosa and other eating disorders. A meta-analysis of 36 studies. *Arch Gen Psychiatry*, *68*(7), 724-731.

Arusoĝlu, G., Kabakçi, E., Köksal, G., & Kutluay Merdol, T. (2008). Orthorexia nervosa and adaptation of ORTO-11 into Turkish. *Turk Psikiyatri Derg*, *19*(3), 283-291.

Bek, D. (2018). *Kognitivno-povedencheska terapia: osnovite i otvad tqh* [Cognitive-behavioral therapy: the basics and beyond]. Sofia: Iztok-zapad.

Bratman, S., & Knight, D. (2000). *Health food junkies: Orthorexia nervosa: overcoming the obsession with healthful eating*. New York: Broadway Books.

Bratman, S. (1997). Original essay on Orthorexia. *Yoga Journal* [updated 2010 June 2].

Brytek-Matera, A. (2012). Orthorexia Nervosa – an eating disorder, obsessive-compulsive disorder, or disturbed eating habit. *Archives of Psychiatry and psychotherapy*, *1*(1), 55-60.

Dimitrova, S. (2015). *Psihoterapiq za deteto i negovite roditeli* [Psychotherapy for the child and his parents]. Sofia: Printekst OOD.

Hadzhieva, Ts. (2019*). Psiho-socialni aspekti na hraneneo i hranitelnite razstroistva* [Psychosocial aspects of nutrition and eating disorders]. Blagoevgrad: RA „Perun dizain“

Kembal-MacBraid, N. (2016). *GAPS. Sindrom na hranosmilatelnata sistema i psihikata* [GAPS. Digestive system and psyche syndrome]. I.Z.: Kibea.

Kuntz, U., & Hilert, A. (2001). *Narusheniq na hraneneto: prichini, siptomi, terapiq* [Eating disorders: causes, symptoms, therapy]. Sofia: LIK.

Markov, P., Markov, D., Bajkova, D., & Petrova, I. (2011). *Zdraven risk ot restriktivni modeli na hranene pri jeni v predfertilna i fertilna vazras*t [Health risk of restrictive eating patterns in women in prefertile and fertile ages]. *Sb. XXVIII Scientific and Technological Session*, 202-6.

Markov, P., Markov, D., Vodenicharova, A., & Baikova, D. (2016). Socialni epigenetichni modulatori na model na hranene [Social epigenetic modulators of the feeding pattern]. *Social Medicine*, *1*(1), 18-20.

Martín-Murcia, F., Cangas Díaz, A. J., & Pardo Gonzalez, L. (2011). A case study of anorexia nervosa and obsessive personality disorder using third-generation behavioral therapies. *Clinical Case Studies*, *10*(3), 198-209.

Shanwal, V. K., & Dasgupta, P. (2014). Emotional intelligence: A management tool for orthorexia Nervosa. *Indian Journal of Health & Wellbeing*, *5*(6).

Smithers, G., Gregory, J. R., Bates, C. J., Prentice, A., Jackson, L. V., & Wenlock, R. (2000). The National Diet and Nutrition Survey: Young people aged 4-18 years. *Nutrition Bulletin*, *25*(2), 105-111.

Stice, E., & Shaw, H. (2004). Eating disorder prevention programs: A meta-analytic review. *Psychological Bulletin*, *130*(2), 206.

Vandereycken, W. (2011). Media hype, diagnostic fad, or genuine disorder? Professionals' opinions about night eating syndrome, Orthorexia, muscle dysmorphia, and emetophobia. *Eat Disord*, *19*(2), 145-155. www.orthorexia.com/?page_id=6.

Zamora, C et al. (2005). Ortorexia nerviosa. Un nuevo trastorno de la conducta alimentaria? *Actas Esp Psiquiatr*, *33*(1), 66-68.


C O A S