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BODY AND LANGUAGE IN EATING DISORDERS

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In this Seminar we will seek to question the symptoms that descriptive psychiatry classifies as eating disorders – anorexia, bulimia and binge eating disorder – in the perspective of a Lacanian psychoanalytic approach.

The key points of this discussion will be the themes of the body and language in the clinical treatment of anorexia, bulimia and psychogenic obesity.

These contemporary symptoms, which are so widespread in our times, can teach us much about the topic of the next Congress of the World Association of Psychoanalysis on “*The Unconscious and the Speaking Body*”.

The clinical treatment of eating disorders forces us to question the status of the body in its narcissistic image, symbolic structure and functioning as a place that condenses jouissance for the speaking being. Indeed, a negative passion for the mirror, a holophrastic dimension in the functioning of speech and language, and a limitless compulsive jouissance are key factors in this field in contemporary clinical treatment.

0. Thanks

It's a real pleasure to be with you here today in Dublin. I would firstly like to thank ICLO-NLS for inviting me. This meeting is a form of initiation for me on two fronts. Firstly, it's the first time I have given a seminar in Ireland. And secondly, it's the first time I have ever held a seminar in English. Wherever possible, including in Anglophone countries, both in

the United States and in Canada, I have made use of my knowledge of French and Spanish to express myself. Today, the moment has come to take a step forwards in my relationship with your language. For this reason, I would like to apologise straight away for the inaccuracies and errors I will undoubtedly make as I endeavour to express myself in English.

1. Introduction

This difficulty will be slightly alleviated for me by the fact that today I am going to talk about a question that I have now been working on for more than twenty years, both in my institutional work, and in my private practice as a psychoanalyst. The question relates to the field of eating disorders: anorexia, bulimia, obesity, and binge eating disorder. Over the years, I have set out to plumb the depths of this field through articles and books, starting with the indications provided by Lacan and with Jacques-Alain Miller's Lacanian orientation. I have also studied in detail the contributions presented in relation to these questions, not only by the classic figures of psychiatry and clinical psychology in this sphere, but also by colleagues in the Freudian field concerned with these issues. Hardly any of my contributions have been translated into English, but many of my articles and books can be found in French, Spanish and Portuguese, as well, of course, as Italian.

In today's seminar, I will seek to set out my presentation on eating disorders from the perspective of the Lacanian orientation, in light of the topic of the next WAP Congress, which will be held in Rio de Janeiro at the end of April this year: *'The Unconscious and the Speaking Body'*. For this reason, I have chosen to title this seminar *'Body and Language in Eating Disorders'*.

2. From Symptoms of the Unconscious to Symptoms of the Parlêtre

As you all know, in his presentation of the topic of the next WAP Congress, which was published in English in Issue number 12 of *Hurly-Burly*,¹ Jacques-Alain Miller drew attention to a passage that stands at the heart of 21st-century psychoanalysis, as anticipated in Lacan's last lesson. This involved a shift in psychoanalysis, corresponding to a change within contemporary social discourse, from the centrality of truth to the centrality of jouissance. Miller specifies that,

This displacement from truth to jouissance set the measure of what analytic practice is becoming in the era of *parlêtre*.²

For Miller, this shift is the result of a substitution in Lacan, and which marked his attempt to distance himself from Freud from the mid-'70s onward. This involved a substitution, which can be found in the text 'Joyce the Symptom' and in Seminar XXIII, *The Sinthome*, of the psychoanalysis of the unconscious, which was still grounded on the Freudian notion of the unconscious and his first topic, with the psychoanalysis of *parlêtre*, a notion invented and introduced by Lacan in precisely this late stage of his teaching. It was from this moment on, when Lacan let go of Freud's hand and took hold, instead, of that of Joyce – as Miller explains in *Pièces détachées*³ [*Spare Parts*] – so as to be able to consider the role of the real in his analytic experience - that the neologism '*parlêtre*' was invented as a way of establishing the status of the speaking being. On this matter, Miller specifies that:

This metaphor – the substitution of the Lacanian *parlêtre* for the Freudian unconscious – fixes down a scintillation. I propose that we take it as an index of what is changing in psychoanalysis in the twenty-first century, when it has to take into account an *other* symbolic order and an *other* real besides those upon which it was established.⁴

¹ Miller, J.-A., "The Unconscious and the Speaking Body", *Hurly-Burly*, Issue 12, January 2015, pp. 119-132.

² *Ibidem*, p. 132.

³ Miller, J.-A., "Pièces détachées", *La Cause freudienne*, Navarin, Paris 2005, n. 61, p. 148.

⁴ *Ibidem*, p. 126.

This passage becomes clearer, from the clinical perspective, if we consider its implications for the notion of the symptom, and how it changes in the movement from a clinic of the unconscious to one of the parlêtre. It is here, again through Seminar XXIII, that Lacan introduces a notion of the symptom that was to become the title of his Seminar: the sinthome. The progression from a psychoanalysis based on the centrality of the unconscious, structured as a language, to one based on the centrality of the parlêtre implies a movement from the notion of the symptom as metaphor, as an effect of meaning, to the notion of the sinthome as a condensation of jouissance without meaning. This is a condensation of jouissance that is, as such, centred on the body, and presents itself as an “event of the body”. Miller writes that:

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 the parlêtre is an “event of the body”, an emergence of jouissance”.⁵

3. Eating Disorders as Symptoms of the Parlêtre

The primary thesis I wish to propose in this seminar is that eating disorders are not symptoms of the unconscious in the classical, Freudian sense, but rather symptoms of the parlêtre. This is the first time I have formulated this thesis in these terms. I see this as an interesting way to tie in the remarks I have developed over the years in this field with the topic of the forthcoming WAP Congress. The central idea behind this Seminar here in Dublin might thus be understood as an attempt to defend this clinical thesis. To this end, I would like to proceed step by step. I will begin with the outcry that eating disorders provoked, and continue to provoke, as soon as they established themselves as social symptoms.

⁵ Ibid.

I will then seek to define the essential framework within which this categorisation of eating disorders was developed, within the descriptive nosography typical of contemporary psychiatry, which has as its essential reference point the *Diagnostic and Statistical Manual of Mental Disorders* (DSM). After that, I will endeavour to highlight the disparity that separates the descriptive framework in this field from an orientation towards the symptom understood in analytical terms, in the Freudian or Lacanian sense. And finally, I will return to my initial thesis, according to which eating disorders are symptoms not of the unconscious but of the parlêtre, endeavouring to support this on the basis of clinical experience. Developing this thesis will help to reveal the status that the body and language hold in the clinical treatment of eating disorders.

4. *From Black Swans to Epidemic*

Let us begin with some considerations about eating disorders in their status as social symptom. I will begin from an epidemiological and descriptive basis, before then proposing some structural considerations. First of all, it should be noted that the formula ‘eating disorders’ is a recent notion. Its history is closely tied to the developments of the DSM, in particular from its third edition (1981) onward. Here, the empirical-descriptive, self-defined “a-theoretical” approach was introduced, which was closely connected to epidemiology and the testing of the effects of psychotropic drugs, which then came to characterise it. In 2013, as you know, we arrived at the fifth edition of the manual, which introduced some changes both to the organisation of the classifications, and to the specific field of eating disorders, as we shall see later on⁶.

Eating disorders became a historic symptom starting from the point in history at which they began to spread in an epidemic fashion, and when this spread began to be recognised, voiced and questioned within the

⁶ “Feeding and Eating Disorders”, in APA, *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition, American Psychiatric Publishing, Washington DC, London England, 2013, pp. 329-360.

social community, by the media, the scientific community, and the institutions concerned with health and education, particularly in relation to the young population. I have divided the epidemiological development of eating disorders into four periods⁷.

I – *The Black Swan Period*. The first epidemic in the sphere of eating disorders to attract the attention of the media and researchers was that of anorexia nervosa among girls. However, this did not really manifest itself until the second half of the '60s. Before this, cases of anorexia were like black swans: rare cases, in relation to which a real confusion persisted among the medical and scientific community. This confusion surrounded both the causes at stake, and the treatment methods. An epistemological diatribe left everything up in the air as to whether this was a neuroendocrine, nutritional, or psychiatric syndrome – similar, in certain aspects, to the situation that persists to this day in relation to obesity. In '65, the International Symposium in Gottingen on anorexia confirmed for the psychiatric community that anorexia nervosa was to be considered, fundamentally, as a mental illness with significant organic repercussions on the organs, apparatuses and functions of the body involved in the refusal of food by the patient. The two main pioneers of the study and psychodynamic treatment of anorexia nervosa, the American Hilde Bruch and the Italian Mara Selvini Palazzoli, played a key role in sanctioning this epistemological movement towards a psychogenetic approach to anorexia. For this reason, the term 'anorexia' was subsequently combined with the adjective 'nervosa' (mental), to prevent it being confused with a malnutrition condition. In the clinical study of anorexia, the psychogenetic approach was then combined with an important examination of the influence played by the family system and early relations with the caregiver in the formation of anorexia (as with the strong narcissistic component inherent in anorexia, which is characterised, not by chance, by a major alteration in the perception of

⁷ Cosenza D., *Le refus dans l'anorexie*, Presses Universitaires de Rennes, 2014, pp. 37-40.

the subject's body image). However, these considerations had already been in circulation for some time in relation to child obesity, thanks in particular to Hilde Bruch⁸.

II – *The Period of Anorexia among Teenagers in Colleges and Universities.* In the mid-'70s, it became evident both in the United States and in other countries in an advanced stage of capitalist development that anorexia nervosa had become an elective syndrome for many teenagers from the wealthy societies of late capitalism. The social symptom had become firmly entrenched, and anorexia had become a subject of social discourse. This was no longer simply a rare symptom studied by a few specialist doctors in the sector. With its initial stage taking place during puberty, and as a result of its diffusion within developed countries, it immediately seemed to be the female equivalent of the major drug addiction epidemic that had begun to invade the lives of young generations of adolescents in the '60s. Young female students, mostly from good families and medium- and upper-class backgrounds, were afflicted by this syndrome, and remained imprisoned by it for many years. Many studies in the field of ethnopsychiatry have sought to establish anorexia nervosa as an ethnic pathology, based on the model of other syndromes that possess a more exotic character for us. For this reason, even the DSM IV, in its Appendix on culture-bound syndromes, presented anorexia nervosa as a syndrome more characteristic of advanced western societies. In my opinion, following Lacan, what was most decisive in the spread of anorexia nervosa was, more than the ethnical dimension, the reference to societies in an advanced stage of capitalist development. This would explain, for example, why, alongside countries with western languages and cultures (Europe, the United States, Canada, and Australia), Japan has also been affected by anorexia. In other words, in my reading, the epidemic of anorexia, like the so-called new symptoms, occurs in those societies whose dominant discourse involves a rise in jouissance to a

⁸ Bruch, H., *Eating Disorders. Obesity, Anorexia Nervosa, and the Person within*, Basic Books, New York 1973;

social peak, and a decline in the normative function of the symbolic, which is reduced to the pure function of the semblant. This interpretation was taken up by Miller starting from Lacan's *Radiophonie*, in the notion of "hypermodern discourse"⁹.

III – The Period of Bulimia and Overeating. The '80s and '90s were characterised by rise in bulimia, which was also formulated in specific descriptive terms in '79 by Gerald Russell, and introduced as a separate condition in the third edition of the DSM. Over time, pure forms of anorexia, restrictors, proved more marginal, giving way to forms of anorexia whose development included stages of bulimia. This is the period of anorexia-bulimia, in which the refusal of food alternates with moments of blowout, followed by a constant, corresponding practice of evacuating the substances ingested in the human body. Purging methods can vary: they include, for instance, vomiting, the use of laxatives, or frenetic exercise. What matters in bulimia, driven by an anorexic ideal, is that the end result, between substances ingested and substances evacuated, be at least zero. This can be verified through the subject's weight, on the basis of the measurement given on the scales after any food substances ingested have been purged. In these forms, hyper control in anorexia coexists and alternates with bulimic excess, in a devastating oscillation.

At the same time, the effects of economic globalisation and the development of new technologies applied to mass communication enabled anorexia and bulimia to spread well beyond the rigid barriers of social classes, and beyond the confines of advanced capitalist countries. Even in developing countries, especially in large cities, the phenomenon assumed an epidemiological consistency. In the section on eating disorders, the DSM IV introduced the Binge Eating Disorder as a framework within eating disorders not otherwise specified, that is, which

⁹ Miller, J.-A., "Une fantaisie", *Mental*, 15, février 2005, pp. 9-27.

cannot be related to anorexia and bulimia. This is one step away from what the fifth edition of the DSM sanctioned in 2013: Binge Eating Disorder as an autonomous syndrome, distinct from anorexia and bulimia. In the field of eating disorders, this syndrome displays a clear-cut prevalence of the compulsive dimension over the narcissistic one.

IV – The Beginning of the 21st Century: Mass Obesity and Virtual Communities. The fourth stage that I wish to highlight in this brief history of the epidemiology of eating disorders is the one in which we are now fully immersed, the 21st century. This stage is characterised by a number of dominant trend lines.

First of all, there is the progressive prevalence of overeating disorders over undereating. As I was saying earlier, Binge Eating Disorder was established as a veritable psychiatric syndrome in the DSM V. It is characterised by periodic bingeing crises, without successive purging practices. The condition is characterised by a lack of control, ego-dystonia and reactive depression, and often acts as a precursor in the development of true obesity, understood as a nutritional pathology denoted by a Body Mass Index higher than the statistic norm. The question of the aetiology of obesity remains entirely unresolved, and the debate in the psychiatric field on this matter is also still up in the air. Nonetheless, when we are confronted with forms of obesity that cannot be clearly explained through organic factors, we believe the question of psychic causality is yet to be articulated. This question already presents a challenge for various kinds of medicine and therapy (from clinical nutrition, to psychotherapies, and bariatric surgery), given that nothing seems to render therapy quite as powerless as obesity. At the same time, the WHO has described obesity as “the new pandemic of the 21st century”. Far from a marginal matter, then, this is an absolutely emblematic syndrome, paradigmatic of our times.

Secondly, given the stability of the ratio between women and men that develop anorexia or bulimia – out of ten cases, one is male and nine

female – we are witnessing earlier onsets than in previous periods, as well as frequent relapses in adulthood, coinciding with moments of crisis. In this regard, the picture presented by binge eating and obesity nonetheless differs considerably from that of anorexia and bulimia: these are not markedly female syndromes, and, for the most part, are not treated in puberty, but often later on in adulthood, as an already well-installed symptom in the patient's life.

One further, characteristic aspect of the contemporary development of eating disorders concerns the appearance, from the beginning of the new millennium, of virtual communities distinguished by an identification with the symptoms of anorexia and bulimia. Unlike many sites that are geared at the treatment of anorexia and bulimia, offering mutual support mechanisms to help individuals overcome the condition, most websites put forward a form of propaganda in favour of anorexia and bulimia, which are deified as incarnations of an alternative, fundamentalist lifestyle. In the face of this new phenomenon, a wide debate has been initiated not only in the scientific community, but also in the larger political community, since, in all intents and purposes; this is a social phenomenon with disturbing implications, which can no longer be restricted to the clinical field.

5. Limitations of the Sociological and Psychosocial Approach

Let us turn now from the social dimension at stake in eating disorders to the clinical one. It is important to draw a distinction between the two levels, and not to reduce the singular manifestation of anorexia or bulimia in a patient to the characteristics of their social context. We in fact hold it as true, following Lacan, that the subject is constituted in the field of the Other. But it is also true that this process of constitution follows a particular itinerary for each individual subject, which can never be reduced to a pure, linear determinism. Psychoanalysis, since Freud, has highlighted this principle of over-determination of the symptom, which releases it from all linear determinism, be it biological-genetic or social.

As such, there is no doubt that the hypermodern social discourse favours the epidemic spread of symptoms that are not organised Oedipally, and are not governed by the symbolic function of the limit. In this context, in a famous book, Richard Gordon once explained the movement from the social symptom of hysteria to that of anorexia-bulimia, from an ethnopsychiatryc perspective¹⁰, as an effect of the movement from the disciplinary regime of Victorian-style classic capitalism, to contemporary capitalism, which overturns the taboo surrounding sexuality, and subjects this, too, to the system of goods and the social circuit of free consumption. However, even if the operation of social discourse can account for the spread of a social symptom, it is never enough to explain why a certain symptom takes hold in a subject's life. Here, all sociological and psychosocial approaches find their limit when faced with the results of clinical experience. Indeed, in this field the analytical principle of the case by case, one by one approach must apply.

6. From disorder to Symptom

Turning now from the psychosocial field to the clinical one, the issue of the mode of classification proposed by the descriptive psychiatry of the DSM needs to be addressed. Beyond any variations, however important, introduced in the passage from one version of the Manual to the next over the past 35 years, it is important to highlight the points that prevent the reduction of such a classification to an analytically-oriented clinical approach¹¹. I will now summarise these in three points:

I – Deficit/solution. First of all, while the DSM presents the very notion of a disorder in terms of a behavioural deviation compared to a statistically calculated norm, for example a deviation in the subject's eating habits, the analytical approach conceives of the institution of anorexia or bulimia in terms of the creation of a solution for the subject, however precarious

¹⁰ Gordon, R., *Anorexia and Bulimia. Anatomy of a Social Epidemic*, Basil Blackwell Ltd, London 1990.

¹¹ On this point, Loose R., "If it is broke why not fit it?", *LACUNAE. Journal for Lacanian Psychoanalysis*, volume IV (issue 1), 2014, pp. 113-121.

or pathological this might prove. This is a solution to a more radical problem that the subject cannot tackle in any other way.

II – Universal/singular. The notion of the disorder, like that of illness, refers to a universal idea of the subject's condition, based on the model of biomedical sciences. The psychoanalytical approach, by contrast, suggests that anorexia, bulimia and binge eating disorder represent symptomatic solutions whose keystone is to be found in the singularity of the subject in question. The key question we need to pose when confronted with this symptom is, on each occasion: what function does this symptom have for the subject? What purpose does it serve for them within the structure of jouissance? What problems does this symptom respond to for the subject, in their relationship with the Other? The classificatory descriptive approach of the DSM does not offer a programmatic response to these questions, putting the subjective dimension involved in the disorder to one side. However, in clinical work with these patients, it is difficult to achieve lasting effects of change without dealing with the level of subjective implication involved in the symptom. It is essential to address this level, because individual subjects do not develop eating disorders via the same paths or for the same reasons, even if they can seem identical from the perspective of descriptive nosography.

III – Transference factor. The descriptive diagnosis of the DSM takes place outside of transference, excluding from its diagnosis that which is in fact the central factor in psychoanalytical diagnosis: transference. Indeed, it is not so much on the basis of the regular repetition of an organised series of behaviours deviating from a standard norm that we conduct diagnoses. This is typical of a descriptive diagnosis, in line with the DSM, as well as psychotherapeutic approaches that are more consistent with this approach, such as cognitive-behavioural therapies. By contrast, psychoanalytic diagnoses are based on how the patient engages with the transference relationship, and the extent to which this reiterates his or

her unconscious mode of relating to the Other and the circuit of jouissance. For this reason, it seems more fruitful to propose the Freudian approach of the symptom in the field of anorexia, bulimia and binge eating too, than the neo-Kraepelinian disorder-based approach.

7. From Symptom to refusal of the Other

However, in the clinical treatment of so-called eating disorders, we cannot help but note a difference that is encountered repeatedly in patients concerned, compared to the analytical symptom revealed by Freud. To return to what we were saying before, Freudian symptoms, in line with neurotic ones, are symptoms of the unconscious. These symptoms transmit a message, a meaning that emerges from between the lines of what is said, beyond the conscious intention of the speaker. These symptoms have a meaning for the speaker; they convey some unconscious, enigmatic signification. The neurotic subject who undergoes analytical treatment wants to know this enigmatic signification; they cannot live without seeking to identify it.

The so-called contemporary symptoms, among which we can certainly count eating disorders, as well as drug addictions, present themselves as symptoms disconnected from the unconscious. To use the expression employed by Lacan in relation to Joyce, we are dealing with subjects who, for the most part, are “unsubscribed from the unconscious”. These symptoms do not convey any meaning for the subject affected by them. They do not carry any unconscious message. They do not function on the basis of a principle grounded on metaphor, on the reference to an elsewhere, but rather establish themselves in the life of the subject as condensations of jouissance anchored on the exercise of a number of regularly reiterated practices. The subject does not resist such practices. Instead, in an ego-syntonic relationship with the symptom, they do not experience it as an illness but rather as a style of living; not as a problem, but as a solution.

Even in those symptoms in which no truly ego-dystonic relationship can be detected, such as bulimia and binge eating disorder, the subject's experience is still dominated by a suffering that is not transformed into an enigma. This is in fact what occurs with classic neurotic symptoms, such as in hysteria or obsessive neurosis. Understanding the meaning of their symptom, which is consistently repeated, preventing the subject's desire from being satisfied, stands at the very core of the need of the neurotic patient in analysis. The new symptoms, by contrast, are divested of the value of an enigma. These are symptoms lacking in any enigma, disconnected from the unconscious, and thus without meaning. For this reason, they are also immune to transference, associated with weak demand, and hostile to medical or psychotherapeutic treatment, analytical treatment even more so. To take up the formula coined by Miller in '97, in his Seminar *L'autre qui n'existe pas et ses comités d'éthique*, such symptoms incarnate a substantial refusal of the Other¹².

8. *A Symptom that Covers the Structure*

One particularly striking aspect in the clinical treatment of contemporary symptoms, and certainly that of eating disorders, is diagnostic opacity. I am clearly not referring to the descriptive diagnosis of anorexia, bulimia or binge eating, which does not present great difficulties of formulation. I am referring, rather, to structural diagnosis: the diagnosis that enables us to also gain an adequate understanding of the patient's unusual relationship with food substances. It has been repeatedly stressed that when we encounter such patients, for example during the initial sessions, it is generally speaking rare to be able to identify any elements that would enable us to clearly lean in the direction of an open psychosis, for instance. There are of course some cases in which anorexia develops in an openly paranoid subject, for example in the classic delusion of being poisoned, or more recently, as stressed by Dewambrechies La Sagna, of

¹² Miller J.-A., Laurent E., *El Otro que no existe y sus comités de ética* (1996-1997), Paidós, Buenos Aires, 2005, pp. 373-379.

contamination¹³. Such patients refuse to eat because they are tormented by the certainty that their food has been poisoned or contaminated. The refusal of food is, in this case, clearly a persecutory defence characterised by an invasive, threatening *jouissance* coming from the Other. Another classic version of this case is anorexia predicated on a religious delusion. In this case, food is identified with an object of demonic temptation from which subjects must distance themselves as far as possible in order to draw closer to the purity of God. The historic phenomenon of the ascetic fasting of medieval female saints cannot, of course, be reduced to a simple chapter in the history of psychopathology. As has been suggested by some Italian colleagues that have studied the phenomenon in depth, especially in relation to the work of Saint Teresa of Avila – Erminia Macola¹⁴ and Giuliana Kantzà¹⁵, in particular – the position of the mystic, in which the renunciation of bodily values is played out in a dialectic relationship with a transcendence towards God, must not be confused with the lay and nihilist cult of the thin body characteristic of contemporary anorexia. It is nonetheless true that in some cases the line between anorexia and the ecstatic experience and religious delusion is a thin one.

Most patients suffering from eating disorders present none of the fundamental phenomena (hallucinations, delusions) that can be clearly associated with psychosis in its classic forms.

On the other hand, the same could be said for neurosis. It is rare for such subjects' speech to display clear elements that testify to a subjective division, a questioning of their own symptom as something enigmatic. For the most part, their relationship with their symptom, when not openly loved as in the early stages of anorexia or drug addiction, is instead governed by the model of illness understood in a medical sense:

¹³ Dewambrechies La Sagna C., "L'anorexie vraie de la jeune fille", *La Cause freudienne*, 63, juin 2006, p. 57-60.

¹⁴ Macola E., *Il castello interiore. Il percorso soggettivo nell'esperienza mistica di Giovanni della Croce e Teresa d'Avila*, Edizioni Biblioteca dell'immagine, Pordenone 1987

¹⁵ Kantzà G., *Teresa tra angoscia e godimento*, Milano, Mimesis 2015.

something which has afflicted them from a certain point in time, which is repeated irresistibly, but in connection with which they have neither any involvement, nor any subjective responsibility.

We should not deduce, however, that there is no neurotic use of these symptoms. Hysterical anorexia clearly does exist, as stressed by Lacan in his Seminars from the latter half of the '50s – Seminars IV¹⁶ and V – and in his text from '58, *'The Direction of the Treatment'*¹⁷. Equally, there is such a thing as neurotic bulimia, and, more generally, a neurotic functioning of the subject's uncontrolled, excessive relationship with food. It is essential to identify and distinguish these from the more typical forms of anorexia nervosa, bulimia and obesity, by identifying certain features that can be detected in the former but not in the latter:

- a) A clear metaphorical function as a message being transmitted through the eating symptom and directed at a receiver who is able to recognise it in its metaphorical significance as an appeal, responding to the call for love (father, mother, parents, teacher, boyfriend, instructor...);
- b) A phallic inscription of the body of the subject which, however precarious, enables them to function in the dialectic of the sexes through their own body as a cause of desire, phallicising thinness itself;
- c) A sensitivity towards the enigma on the part of the subject and a desire to know, which is an essential passion for the hysterical female subject, and which we find intact, on the condition that it is roused from the state of symptomatic torpor, in the neurotic forms of eating disorders.

As has been stressed by Dewambrechies La Sagna, the territory in which anorexia nervosa is to be found with the greatest specificity can be

¹⁶ Lacan J., *Le Séminaire. Livre IV. La relation d'objet*, 1956-1957, Paris, Seuil 1994, p. 199.

¹⁷ Lacan J., "La direction de la cure et les principes de son pouvoir" (1958), *Écrits*, Seuil, Paris 1966, pp. 598-602, 608.

identified via a method of exclusion, by distinguishing it from cases of open psychosis with anorexic symptoms, and from hysterical-neurotic forms. I propose taking the same approach to forms of bulimia and binge eating, which involve an excessive consumption of food. In my opinion, however, this does not imply that we must see anorexia nervosa as a structure apart, as Dewambrechies La Sagna would appear to uphold. Rather, I believe that within the vast territory of eating disorders, as distinct from open psychoses and forms of neurosis, one must begin to recognise the discreet signs of ordinary psychosis, as expressed by the title of the next NLS Congress here in Dublin. This is an idea that I developed in my doctoral thesis at Paris VIII, which was published last year in France with the title *Le refus dans l'anorexie*¹⁸.

My contribution today is thus intended as a reflection on the role of the body and language in eating disorders, in the lead up both to the WAP Congress in Rio on *The Unconscious and the Speaking Body*, and the NLS Congress in Dublin on discreet signs in ordinary psychoses.

9. Two Off-Topic Areas: Food and the Mirror

I will seek to structure my remarks on the body and language in eating disorders around three thematic coordinates: the subject's relationship with the drive, image, and speech. These three coordinates reflect the three registers of subjective experience proposed by Lacan: the Real, the Imaginary, and the Symbolic. I am placing them in this order for a didactic purpose, because this structure reflects, sufficiently faithfully, the order in which the symptomatic aspects presented in the clinical treatment of eating disorders appear. In reality, though, at the structural level, these axes should be considered together in their synchronic, logical connection, testing the tightness and form of the link between them on a case by case basis.

¹⁸ Cosenza D., *Le refus dans l'anorexie*, cit., pp. 163-167.

I – Eating Disorders as Pathologies of Orality: the Refusal and the Object ‘Nothing’

Let us begin by considering eating disorders from the perspective of the drive. First of all, they could be defined in terms of pathologies of orality. This is the most obvious way of framing them, which justifies to a certain extent the classification between the eating disorders of anorexia, bulimia, and binge eating disorder. The eating function and the subject's relationship with food prove highly disturbed. This aspect strikes one immediately in these patients, who might appear on the surface not to be particularly problematic. When they enter into the sphere of their relationship with food, as with the mirror and their body image, such patients find themselves confronted with two black holes. They are absorbed by out-of-the-ordinary practices and thoughts. In relation to anorexia nervosa, Dewambrechies describes these two dimensions of experience as two outside discourse areas.

We already find this conception of anorexia as a pathology of orality in Freud, for whom the problem assumes two forms. The first moves in the direction of hysteria, and is hinted at in *Three Essays on the Theory of Sexuality*, where Freud draws a connection between anorexia and the hysterical disgust at the base of the refusal of food. In this context of neurosis, the subject's relationship with food is ambivalent; they essentially refuse the object of their desire. The situation is the same with food as it is with sexuality: refusing it, as Lacan teaches us in his commentary on the dream of Freud's beautiful woman butcher, becomes a hysterical means of keeping the desire for it alive. The second solution proposed by Freud moves in the direction of melancholia, as suggested in Draft G of *Mourning and Melancholia*. Here, at the base of the refusal of food stands a lack of any libidinal investment towards the external object, and the entire libido is condensed in the body of the subject. In this context, the refusal of food corresponds more to a mode of jouissance that is entirely condensed in the body, which is without loss, and

absolute. It is for this reason that, for Freud, the mourning process is impossible in melancholia; the object has never been lost. These two alternative directions enable us, as early as Freud, to articulate the bases of a differential clinic of anorexia and eating disorders.

Karl Abraham contributed more than any other direct disciple of Freud to the elaboration of a discussion on the role of the drive in eating disorders. In his text from 1916 on the earliest stage of the libido, anorexia nervosa and nervous hunger are situated, in line with drug addictions and alcoholism, at the level of the earliest fixation of the drive at the oral or cannibalistic stage¹⁹. Subjects that develop these pathologies have not experienced the loss of the first object of satisfaction, have not been able to incorporate the oedipal law, and reproduce the relationship with the primary object through their object-substance of jouissance. They tend to experience failure in the sphere of sexuality and desire, and find much more satisfaction in their symptom than in the jouissance available in life with a sexual partner. For his part, as early as his 1938 text *Family Complexes in the Formation of the Individual*, Lacan conceives of anorexia as an experience of weaning, locating a refusal to wean (*refus du sevrage*) at the root of anorexia nervosa (but also of drug addictions and gastric neuroses). Here, Lacan makes use for the first time of one of the keywords that he will subsequently continue to employ in his interpretation of anorexia nervosa: 'refusal'²⁰.

Lacan introduces the second keyword twenty years later, again in his analysis of anorexia nervosa. This word is 'nothing'. Particularly in anorexia, this responds to the enigma that surrounds the question of which object constitutes the cause in anorexia nervosa. Phenomenology already informs us that this is not an object in the world, one which is visible or representable. Rather, it is clearly an invisible, non-

¹⁹ Abraham K., "Esquisse d'une théorie de la libido basée sur la psychanalyse des troubles mentaux" (1916), *Œuvres Complètes II*, Payot, Paris 1977.

²⁰ Lacan J., "Les complexes familiaux dans la formation de l'individu" (1938), *Autres écrits*, Seuil, Paris 2001, pp. 31-32.

representable object, as indeed all objects at the root of desire are, which Lacan calls 'objects little-a'. Anorexia highlights the importance of not confusing the object of desire, which is in front of us, a phenomenal object of the world, with the object that causes desire, which is, so to speak, behind us, at our shoulders, as explained in his Seminar X on anxiety. This confusion is more likely to occur with food in bulimia or binge eating, drugs in cases of drug addiction, and alcoholism with alcoholics, but is less likely in anorexia.

Lacan introduces 'nothing' as an object cause of anorexia nervosa, debunking a common belief and clear phenomenal fact: that the anorexic patient does not eat. Lacan writes, instead, that: the anorexic subject eats the object 'nothing'²¹. At first, for Lacan, this 'nothing' had an eminently symbolic value and was closely connected with hysteria: it represented that elsewhere that could not be reduced to an object, and which was never fully attainable in experience, because it had been lost from the start, and stands at the very base of the life of desire. However, the further Lacan advances in his elaboration, introducing the centrality of the real in the analytical experience, the more he reformulates the notion of 'nothing', transforming it from a pure signifier into an object cause, and introducing it into the series of object little-a's. Lacan thus describes anorexia more clearly as an affirmative action, as a practice that produces an affirmative jouissance through the refusal of food²². This thesis is consistent with clinical experience, which reveals a euphoria and tone of humour in anorexic patients which is strengthened narcissistically the more capable they are of keeping the oral drive under control. The traits of ego-syntony and hyperactivity are both present in anorexia nervosa, all the more so when the patient succeeds in adhering to their own superego ideal of rigid control of the oral drive through a refusal of food. This thesis has been borne out by certain studies in the field of neuroscience: the

²¹ Lacan J., "La direction de la cure", cit., p. 199.

²² Cosenza D., "Anorexie", WAP, Scilicet. *Les objets a dans l'expérience psychanalytique*, École de la Cause Freudienne, Paris 2008, pp. 29.31.

repeated refusal of food generates an increase in endorphins in the organism, the effects of which include euphoria and a heightened note of humour in the patient. The protracted refusal of food thus produces an effect of *jouissance* in the body. This is a very particular effect of *jouissance*, which differs from the *plus-de-jouir* effect that characterises the loss of discursive *jouissance* typical of the neurotic subject. In anorexia, the *jouissance* of ‘nothing’ constitutes an unlimited, infinite *jouissance*, which dispossesses the subject, casting them astray. For this reason, subjects suffering from acute anorexia move towards death without realising it, pulled along by this mode of absolute *jouissance*. As such, the anorexic *jouissance* of the ‘nothing’ differs from that driven by partial objects of the drive, which are lost objects that return at certain junctures of the subject’s experience. The ‘nothing’ object of anorexia, as proposed by our Argentine colleague Nieves Soria, is not removed from the body²³. Rather, it remains encysted in the body. The anorexic subject does not yield her object to the Other. As Augustin Ménard writes, the anorexic subject refuses above all to eat the signifier²⁴, that is, to accept the loss of *jouissance* brought about by the symbolic inscription of her body into the field of the Other. This, too, renders the object difficult to locate, and the distinction drawn by Lacan between the object ‘nothing’ and the oral object illustrates, at least, that these are two distinct objects that cannot be reduced to one another.

II – Pathologies of the Image

What has been said in relation to the object ‘nothing’ also has repercussions for the subject’s relationship with their own body image. As is well-known, particularly in anorexia nervosa, one of the more disturbed dimensions of the patient’s experience is their altered relationship with their own body image. This is not to be understood simply as an alienating relationship with this image. Experiencing an alienating

²³ Soria N., *Psicoanálisis de la anorexia y bulimia*, Buenos Aires, Tres Haches 2000, p. 120.

²⁴ Ménard A., “Structure signifiante de l’anorexie mentale”, *Actes ECF*, mai 1989, p. 16-20.

relationship with one's own body image is not, after all, such a strange occurrence. This forms part of the experience of the neurotic subject. As Lacan teaches us in his mirror stage, the price that the child pays in order to obtain a unitary Gestalt of his own body in the mirror is a loss of jouissance. Something essential of his being does not appear in the mirror, and is not returned by the reflected image. This is the real, which cannot be reduced to self-representation. For this reason, every time the neurotic subject experiences a crisis, one variant of this crisis is a calling into question of his own image, an identity crisis. Often, this is reflected in a modification of the image at the phenomenal level: moving home, changing the colour of one's walls, getting a new hair-cut, etc. ...

In anorexia nervosa, as well as in bulimia, we witness something more radical. The relationship with the mirror presents a dual movement that cannot be reduced to the dialectic of alienation and separation. Psychiatry has long noted the presence, particularly in anorexia, of a dysmorphic perception of the body image on the part of the patient. In such patients' daily lives, this altered perception of the body image translates into a failure to perceive the extreme thinness of their body. Instead, they consistently perceive something in excess, excess fat to be eliminated. For those around her, the anorexic subject's experience in front of the mirror thus reveals itself as a perceptive experience that has lost contact with reality. For the patient, however, this experience is repeated on each occasion as a painful encounter with their own image. This is an unhealthy experience in which the Other, with the mirror as its narcissistic metaphor, says no, without fail. At the same time, the anorexic patient cannot help but punctually show up for this appointment with the mirror. It is stronger than she is. But what does the anorexic subject encounter each time she punctually places herself in front of the mirror? What she encounters goes beyond the image. She encounters the judging gaze of the Other: in the judging gaze in the mirror, she comes face to face with the refusal of the Other. This refusal cannot be reduced

to the judgement inherent in the judging gaze of an omnipotent mother, undivided by castration. This is the refusal of the Other as an encounter between the anorexic subject and her own gaze, which is not separated, as such, from that of the primordial Other. Thus, following the reference axis of the image as a symptomatic question of anorexia, we can grasp, beyond the narcissistic covering, the libidinal nucleus that sustains it, connected to the gaze as an object not lost by the subject, but which returns to the real each time the anorexic subject is in front of the mirror. The fact that this is an object that is not lost in anorexia nervosa is illustrated by the fact that the gaze presents itself in the experience of the patient as a judgement without appeal, as a pure incarnation of the Superego, which tends towards infinitisation. Every time, there is something in excess to be eliminated in the body. In essence, what this movement in anorexia aims at is to extinguish desire from the body, to destroy the disruptive, *Unheimlich* [uncanny] element from the body image, to kill it at its root.

III – From Body Image to the Body of the Image

Those Lacanian authors who have dealt most extensively with eating disorders, in particular anorexia and bulimia, have interpreted the issue of the anorexic subject's body image by reducing it to a problematic stage in the subject at the crossroads with the mirror stage. It is indeed no coincidence that the symptom erupts above all during puberty, when the body is transformed, *drives return to animating the body and to being strong*, directing desire at a sexual partner. The act of transitioning from the partner of childhood, which coincides with the primary maternal object, to a sexual partner outside of the family, proves an impracticable passage for many of these patients. The eating disorder most often takes hold at this critical juncture, when, as Stevens has posited, adolescence fails in its task of becoming a symptom of puberty for the subject.

It is striking that, despite having accorded considerable attention to anorexia nervosa in particular, Lacan did not tackle the problem it raised in light of his theory of the mirror stage, as numerous Lacanian analysts working in this field did in fact proceed to do. I would propose, though, that one might identify an element of rigour in this omission on Lacan's part. While many researchers of anorexia from the '60s sought the key to anorexia in the narcissistic disorder and in an altered relationship with body image, Lacan focused on the invisible core of anorexia: what he calls the object 'nothing', as the driving force behind anorexic refusal. We might propose, picking up on a recent intuition by Miquel Bassols²⁵, drawn from the poet Lizama Lima that, from the Lacanian perspective, what matters most in the issue of the image in anorexia is not body image and the altered perception that takes place compared with the reality principle. Rather, the problem is to be found at the level of the body of the image. What fails in anorexia is the signifying treatment of the body, which gives rise to a functioning of the imaginary register and a body image which does not follow the logic of the signifier, the laws of metaphor and of metonymy: the laws of the unconscious, which are essential for the 'phallicization' of the body and for it to function in the dialectic of desire. In anorexia, the image does not function as a signifier, but rather as a rigid, frozen, a-dialectic sign. For this reason, too, anorexia does not present itself as a symptom of the unconscious, but rather as a symptom of the parlêtre. It is a writing of the body not constructed on the logic of the signifier, but rather on the letter of jouissance.

10. *Speech That Does Not Resonate*

Having discussed the anorexic subject's relationship with the oral drive and the image, let us now turn to the relationship between the anorexia subject and speech. Compared with the first two aspects, this point has undoubtedly received the least attention in discussions within the

²⁵ Bassols M., "The image body and the speaking body", in www.wapol.org, Xth Congress of WAP, The Theme, Orientation Texts.

scientific community concerned with eating disorders. Yet it is a central point, and psychoanalysis, particularly Lacanian psychoanalysis, is to be thanked for having highlighted it as such. I would propose, based on clinical experience, that this trait does not concern solely anorexia, but bulimia and binge eating disorder too; that is, the entire spectrum of eating disorders. We touched upon this earlier, when I suggested that the anorexic subject – but also in bulimia and binge eating – poses a problem in relation to the metaphoric function of language. This problem affects the function of speech, conditioning its use. This can be seen from the earliest sessions with such patients. Their speech appears to be deprived of metaphoric significance. It is an empty, often stereotyped, impersonal speech. It is rare to find that disparity, which is present in the speech of the neurotic subject, between the dimension of the enunciated and that of the enunciation itself. Nor can we detect, or at least only very rarely, the delusional construction or hallucinatory formulation typical of open psychoses.

In some areas of research in the medical-psychiatric field, this aspect has been examined in light of the paradigm of alexithymia. According to this paradigm, there are pathologies that directly afflict the body, including anorexia and obesity, in which the patient experiences a sense of impermeability, a sort of desensitisation caused by the symptom, which prevents them from either recognising or expressing their own emotions. This is a sort of sensorial freezing, which also affects the subject's relationship with their own speech. Another, more recent approach, associated with the latest developments in the theory of attachment, places the emphasis, instead, on a deprivation at the level of such patients' meta-cognitive capacities, that is, in the difficulty they experience in thinking their own thoughts. This is very evident in the hyper-concretism of thought that is so apparent in psychogenic obesity, where the metaphoric significance of language and its inscription in a determined discursive context are lost in the subject's speech. This is the

resonance effect within the structure of speech, connected to the metaphorical functioning of language, which is lacking in these subjects. For this reason, we have long posited that, in the clinical treatment of eating disorders, such patients present a closure of the unconscious. It is in fact precisely the opening up of the subject to their unconscious dimension that allows for the effect of resonance typical of the speech structure. In the daily lives of speaking beings, the evocative, metaphorical dimension of speech – upon which the art of poetry constructs itself, through writing – like the formations of the unconscious (dreams, slips of the tongue, symptoms, etc.), is guided by a reference to an elsewhere, to another place, the supposed repository of their meaning.

11. From Metaphor to Holophrase

Within our field, it has thus been common practice for some time now to approach the clinical treatment of eating disorders from the perspective of holophrasis rather than of the metaphor. The concept of holophrasis is a notion that Lacan gleaned from linguistics, and which he distinguishes from the use of metaphor. Holophrasis is introduced, in particular, in Seminar XI, to offer a linguistic grounding for the structural position of three clinical frames that cannot be reduced to the logic of the metaphor: psychosis, mental debility, and the psychosomatic phenomenon. First of all, this means that these frames cannot be explained in Oedipal terms or through a clinical approach based on the paternal metaphor and the Name of the Father, which underpins the field of neurosis. In the clinical approach founded on the metaphor, the subject is constituted in the interval between two signifiers (S1 – S2), which return to us the minimal signifying battery in the chain in operation. It is precisely this dimension of the interval between signifiers, the site of lack and constitution of the subject, which is omitted in the clinical approach of holophrasis. The holophrastic structure in fact constitutes a monolithic condensation of signifiers that do not form a chain among themselves, but which

agglutinate, repeating themselves unvaryingly, off-topic, in the form of S1s not attached to any S2s. Going beyond those cases in which we can detect a clear hysterical-neurotic structure, it has for some time been more common within our field to consider eating disorders from the point of view of the clinical approach of holophrasis than that of the phallus and the paternal metaphor. This does not necessarily mean that we are dealing with cases of psychosis, that is, with unmodifiable *structural holophrases*. Rather, in a significant number of cases we are confronted, to use a formula by Carlo Viganò, with *positional holophrases*²⁶, connected to the pervasiveness of the symptom, which can be altered with treatment.

In fact, one need only consider what happens in moments of crisis in bulimia or binge eating to clearly perceive the implications, for the subject, of this inability to exist in the interval between signifiers. Often, bulimic crises and binge eating episodes occur when the subject is faced with empty time, a period of waiting, or an unforeseen event that changes their plans for the day. The impossibility of experiencing this temporal interval²⁷, of coping with the deferral of a meeting or someone's absence, drives the subject to binge and to lose control. Oral jouissance imposes itself upon the subject, defenceless, and the reference to the symbolic Other disappears. But it is the subject himself or herself that disappears in the midst of this experience of jouissance, which presents clear analogies with the experience of the drug addict in a moment of crisis. In this sense, we might also understand eating pathologies as temporal interval pathologies. In these pathologies, the logical experience of the time for comprehending, like the symbolic space in the process of working through mourning, proves impracticable for the subject. In this sense, eating disorders serve to compensate for the failure in the

²⁶ Viganò C., "Sinthomo e transfert nell'anoressia", *La Psicoanalisi, L'anoressica e l'inconscio*, n. 50, luglio-dicembre 2011.

²⁷ Cosenza D., "Silence and the Voice in Anorexia Nervosa", *European Journal of Psychoanalysis, Feminine Pathologies*, Volume II, N.1-2, January-December 2015, pp. 93-100.

subject's symbolic constitution, providing him or her with a solution that offers a treatment for this failure.