

PSYCHIATRY IN THE FLESH

Embodiment of troubled lives. Studies of
anorexia nervosa and eating disorders

Doctoral dissertation

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*To Finn Magnussen,
a mentor and senior who insists
on psychiatry as a humanistic practice*

*But he said to them: Unless I see the nail
marks in his hands and put my finger where the nails were,
and put my hand into his side, I will not believe it.*
The Holy Bible, John 20: 25

I've got you - under my skin.
Cole Porter

And if the body were not the soul, what is the soul?
Walt Whitman

The ego is first and foremost a bodily ego.
Sigmund Freud

It is not enough to say that the mind is embodied; one must say how.
Gerald M. Edelman

*Bodily phenomena are, nevertheless, as meaningful as all other human
expressions, but, like dreams they have to be interpreted.*
Irène Matthis

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 EATING ONE’S WORDS. PART II.
 The embodied mind and reflective function in anorexia nervosa: Theory.

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 EATING ONE’S WORDS. PART III.
 Mentalisation-based psychotherapy for anorexia nervosa. An outline for a treatment and training manual.

Skårderud, F.
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 A qualitative descriptive study.

Skårderud, F., Nygren, P. & Edlund, B.
 ‘BAD BOYS’ BODIES.
 The embodiment of troubled lives. Body image and disordered eating among adolescents in residential childcare institutions.

Duesund, L. & Skårderud, F.
 USE THE BODY, AND FORGET THE BODY.
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2. Skårderud, F. (2007). Eating one's words. Part II. The embodied mind and reflective function in anorexia nervosa. Theory. *European Eating Disorders Review*. In press (published online).
3. Skårderud, F. Eating one's words. Part III. Mentalisation-based psychotherapy for anorexia nervosa. An outline for a treatment and training manual. *European Eating Disorders Review*. In press.
4. Skårderud, F. (2007). Shame and pride in anorexia nervosa. A qualitative descriptive study. *European Eating Disorders Review*, 15 (2), 81-97.
5. Skårderud, F., Nygren, P. & Edlund, B. (2005). 'Bad Boys' Bodies. The embodiment of troubled lives. Body image and disordered eating among adolescents in residential childcare institutions. *Clinical Child Psychology and Psychiatry*, 10 (3), 395-411.
6. Duesund, L. & Skårderud, F. (2003). Use the body and forget the body. Treating anorexia nervosa with adapted physical activity. *Clinical Child Psychology and Psychiatry*, 8 (1), 53-72.

The papers will be referred to by their Arabic numerals.

INTRODUCTION

CASE: THE PLATE OF CONTROL

The overall presentation starts with a clinical vignette, here called ‘the plate of control’. The case refers to a person with the psychiatric disorder anorexia nervosa. Elisabeth is one of the informants in this dissertation. Elisabeth has suffered from anorexia nervosa for almost twenty years, since adolescence. She states, and practices, that she can only accept few items of food.

The idea of mixing different types of food scares me. The sight of too many types of food on my plate, and the idea of them mixed together in my stomach; induce in me a sense of chaos ... I have to have control of my plate to have control in my life... I gradually understood that taking control over food was a way to take control ... over my overwhelming worries, my restlessness, all my anxieties about myself; and simply my need to be somebody.

In spite of its brevity, this clinical illustration supplies us with very interesting and relevant information. The case explicitly elucidates the phenomenon *control*, and she speaks about this within two different experienced realities, an internal and an external. It seems to Elisabeth as though an external order in terms of how she organises a meal by keeping the food elements separate and thus clearly from each other on the plate, might help her to gain access to the internal, emotional experience of being in control of her own life. And correspondingly: A mess on the plate creates an emotional mess. She refers to an emotional uneasiness of restlessness and anxiety, and how she experiences food and ways of eating/not eating as a solution to these problems. It is striking how she speaks about control in different realms, *as being one and the same*.

Her behaviour around food also refers to another personal thematic structure: *Identity*, “simply my need to be somebody”. She implies that the anorectic body practice contributes to the formation of a psychological identity.

Although this clinical vignette is short, it can help us to illustrate phenomena we often observe in persons who qualify for the diagnosis anorexia nervosa (American Psychiatric Association, 1994). It is partly a matter of current psychological themes which are connected to a specific – and here defined as pathological – behaviour around food and body. And partly

it is the very interaction between body and psyche. These are topics which will be elaborated on in different ways in this dissertation.

APPROACHING EATING DISORDERS

This introduction chapter will give a general background on eating disorders and the concept of 'embodiment'. Such background will elucidate the phenomena themselves and the actual relevance of the scientific questions to be studied in this dissertation.

Diagnostic definitions

Eating disorders are here defined in accordance with the criteria in DSM-IV (American Psychiatric Association, 1994). The diagnostic category 'Eating disorders' consists of three diagnostic subcategories, 'anorexia nervosa', 'bulimia nervosa' and 'eating disorders not otherwise specified' (EDNOS). For diagnostic criteria, see Appendix.

The actual emergence of eating disorders

During the last decades eating disorders have changed character from being 'a strange case' to being 'a hot case' (Skårderud & Rosenvinge, 2001). Eating disorders have become increasingly visible.

Clinical and non-clinical contexts

This applies to all levels in health services, as well as to psychiatric outpatient and inpatient contexts. And it also applies to athletics (Sundgot-Borgen, Skårderud & Rodgers, 2003) and to contexts outside the scope of traditional health services, such as child welfare services (Skårderud, Nygren & Edlund, 2005) (Paper 5).

Incidence and prevalence

Greater visibility should not be mistaken for factual prevalence. There are a number of prevalence studies of eating disorders, with great variations in estimates. Low scientific quality in some epidemiological studies may have contributed to exaggerated estimates of prevalence (Skårderud, Rosenvinge & Gøtestam, 2004; Norwegian Board of Health, 2000). There are also critical voices arguing against the suggestion that the prevalence of eating disorders is still on the increase in our own culture group. Fombonne (1995, 1996) refers to indications of a relatively stable incidence of anorexia nervosa during the last 25 years, while there might have been a slight increase in the incidence of bulimia nervosa. Reliable studies

document a prevalence of anorexia between 0.2-0.4 percent. The prevalence of bulimia nervosa is higher, about 1-2 percent (Norwegian Board of Health, 2000). For EDNOS there are estimates of a prevalence between 1.5 and 3.2 percent (Rosenvinge & Sundgot-Borgen, 1999).

Clinical challenges

Due to a heightened awareness among professionals and in the popular media, and also due to the fact that less stigmatisation and greater importance is attached to the right to health care in Western cultures, there will probably be a steadily increasing demand for therapy which will lead to greater visibility of these phenomena. In Norway it has been estimated that only about 30 percent of those with anorexia nervosa and below 6 percent of those with bulimia nervosa are seeking treatments (Norwegian Board of Health, 2000).

New diagnostic categories

Greater visibility in health services and other arenas of eating disorders reveals the complexity and heterogeneity of the phenomena, in the sense that symptoms may seem similar, but people presenting these symptoms are different; in many ways like personal histories, the construction of meaning to symptoms, severity of illness, comorbidity etc. This has been interpreted as a clear indication for a multifactor aetiology. Such complexity has been forwarded by new diagnostic categories. Until the 1970s an eating disorder was synonymous with anorexia nervosa. In 1979 bulimia nervosa was established in the DSM-system as a new diagnostic category. In the fourth version, DSM-IV from 1994, a third category appears, eating disorders not otherwise specified (EDNOS). In an appendix to the definitions of this EDNOS-category the same edition of DSM also proposes the new sub-category 'binge eating disorder'. This refers to binge eating, or overeating, without the purging behaviour known from bulimia nervosa. Hence, cases of obesity and overweight are included in this psychiatric disorder.

Culture-bound syndromes

In the psychiatric panorama eating disorders are described as unique, inasmuch as socio-cultural factors have an exceptionally strong impact on epidemiology, symptoms, development and aetiology (Gordon, 2000, 2001; Barlow & Duran, 1999; Nasser, 1997). The disorders have traditionally been linked with Western and westernising affluent societies, what Brumberg (1988, p.13) has characterised as an illness with "a highly specific social

address”, hence fulfilling the criteria of a ‘culture-bound syndrome’ (Di Nicola, 1990 a). Although, there are newer reports of increasing prevalence and visibility of eating disorders outside the Western hemisphere, particularly being linked to cultures in rapid transitions (Nasser, Katzman & Gordon, 2001).

The enigma of anorexia nervosa

The actual visibility of eating disorders during the very last decades makes demands on the practical organisation of health services and increased competence in terms of effective preventive measures, diagnostics and various forms of therapeutic work, as well as interdisciplinary collaboration. In this context, it is a complicating factor that many health workers regard the work with eating disorders as particularly challenging. This applies especially to the states which are included within the diagnostic category of anorexia nervosa.

A segment of this dissertation deals with a broader range of eating disorders, but in five of six scientific articles the main focus is on anorexia nervosa. When the pioneer in anorexia nervosa Hilde Bruch (1978) presented her popular book ‘The golden cage’, the subheading was ‘The enigma of anorexia nervosa’. The noun enigma refers to a puzzling problem or a riddle. Almost thirty years later, with great efforts in clinical and theoretical research, papers, seminars and conferences, anorexia is still an enigma. A veteran and international expert on eating disorders, the Australian psychiatrist Pierre J.V. Beumont, made the following brief statement shortly before his death (2001): “We have a fairly good understanding of the aetiology and psychopathology of bulimia nervosa. We have only got to the first stage in understanding anorexia nervosa.”

The pathological mechanisms in anorexia are still enigmatic. It can certainly not be taken for granted that everyone agrees that our knowledge of bulimia is good enough. In clinical practice, however, it is very often the states of anorexia which present the greatest challenges; this can cause a great deal of anxiety among experienced therapists, and may contribute to actions the consequences of which may prove harmful.

How can she/he? We still do not have a satisfactory understanding of why somebody risks dying to save themselves. Sometimes the experienced clinicians meet patients where they apprehend or interpret logic behind. Self-starvation is existential, and the symptom is also a restitutorial effort. But with other patients also the experienced perceives – as most people do – the anorectic behaviour and way of psychic functioning as deeply irrational.

Hence, there is confusion, and anorexia nervosa is not satisfactorily understood. But with our personal, professional and contemporary knowledge of what we do not know, with

our understanding of what we do not understand, we still have to meet these persons. We have to deal, talk and negotiate with these children, adolescents and adults fulfilling the criteria for the diagnoses eating disorders and anorexia nervosa. Since some of us are certified as therapists, such encounters are called therapy. The practical, ethical, rhetorical – and consequentially – scientific question is: When is therapy therapeutic?

Some of us are given the formal and legal responses and duties to make decisions on behalf of the patients. These decisions are meant to be for their own best, but very often they are in strong opposition to their own wishes and claims. Many maintain most strongly that our decisions are destructive and deep violations. Sometimes they are right, sometimes they are very wrong. A therapeutic treatment will be effective to the extent that it is able to enhance the patient's psychological, physiological and social capacities without generating too many iatrogenic effects. 'Iatrogenic' etymologically means disorders promoted by the doctor – and is an actual dilemma in the treatment of anorexia.

Few symptoms can create stronger reactions in therapists than anorexia nervosa, and few require more forbearance and self-questioning. Problems of understanding the disorder, the patients' frequent lacking insight into their own illness, as well as their lack of motivation for recovery, their psychological symptoms of under-nourishment and malnutrition, and high mortality (Nielsen, 2001), represent great hazards in terms of harmful effects on the therapeutic alliance. This may be expressed by disrupted therapeutic relations, as well as by overreactions due to intense emotional reactions in the therapists (Garner, 1985; Hamburg & Herzog, 1990). A lack of understanding can lead to a lack of commitment and patience; or worse – to aggression and rejection.

In a special issue on anorexia nervosa in the leading scientific journal *International Journal of Eating Disorders*, Woodside (2005, p. S 41) comments on a series of comprehensive overviews on therapy and therapeutic organisation, that there are "more questions than answers", and that "there are more weaknesses than strengths in our understanding of the treatment of individuals with anorexia nervosa". There is a striking paucity of empirical evidence supporting any method of treatment, leaving "clinicians, patients, and their families in the awkward position of relying on 'best guess' and 'clinical experience' when attempting to choose a treatment for the affected individual."

Hence, there is an obvious need for empirical and theoretical research. Better understandings hopefully constitute a necessary basis for better therapy.

Research methods

Why starve when there is plenty of food? This approach resembles the outsider's lack of generally understanding severe mental disorders. Can a person who has never been psychotic – or anorectic – understand the deeper subjective experiences of these phenomena? Such conditions may appear as enigmatic, given that they are about emotional realities; and that emotions cannot be delimited and concretised in a similar manner as physical phenomena (Gadamer, 2003).

This represents a scientific challenge, due to that objective, seen-from-the-outside descriptions always lose an important part of the experienced realities. There will always be a remainder which is the subjective experience itself. For that reason the most important methodical approach in this dissertation will be qualitative research with emphasis on personal reflections and statements from persons with eating disorders.

Function of mind

More specifically, in eating disorders the relation between body and mind, psyche and soma, can be perceived as confusing. Eating disorders are phenomena which present themselves through behaviour as self-starvation, bingeing and purging practices, abuse of physical exercise and through somatic manifestations such as loss of weight, increased weight and under-nourishment or malnutrition. But when we consider these disorders as primary psychiatric and not as somatic illnesses, it is because we assume a primary psychological dysfunction. Thoughts and feelings about body and food colonize a large part of the lives of persons with eating disorders, demonstrating a 'concretistic' function of mind (Buhl, 2002). A great number of patients describe that they have reduced control over their thoughts and feelings about body shape and food, describing them as 'obsessional', and that they experience the here-and-now of their bodies as a ruthless reality from which it is difficult to escape.

This 'concretism' in anorexia nervosa is often experienced as an obstacle to recovery. But it is also a key to understand psychic reality in anorexia nervosa; how patients are trapped in the concreteness of their symptoms; and mind functions in such a way that emotional and cognitive realities are represented by an emphasis on physical and bodily qualities. This is named, according to different traditions, as 'concretism' (Buhl, 2002), 'concrete attitude' (Miller, 1991), 'psychic equivalence' (Bateman & Fonagy, 2004; Fonagy, Gergely, Jurist & Target, 2002) and 'concretised metaphor' (Enckell, 2002).

Psychological consequences of hunger

The somatic states connected to eating disorders and especially anorectic under-nourishment and malnutrition, will themselves contribute to dysfunctional psychic phenomena, such as emotional instability, low spirits, irritability, apathy, reduced power of concentration and memory, compulsive behaviour and – rituals, bizarre behaviour, and, logically enough, increased preoccupation with food, often with fear of binge eating. This is what we call 'the psychology of hunger' where psychic symptoms are actually seen as secondary to the state of nutrition. In a causality model for eating disorders, the psychology of hunger functions as a 'maintaining factor'. This makes recovery difficult.

DESCRIBING AND INTERPRETING EATING DISORDERS

Further descriptions of anorexia and eating disorders as phenomena will be given below. After the brief introduction above, this is meant as a more comprehensive background for clarifying important aspects of eating disorders. This presentation gives grounds for understanding the research questions elaborated upon in the scientific papers and in the subsequent discussion section in this thesis.

The first part of this background will deal with 'the representing mind'. It will describe the *history of interpretation* of eating disorders, with emphasis on aetiology and meaning ascribed to symptoms. A historical outline describes how these states have been understood and interpreted in different historical and theoretical contexts. The outline is certainly not comprehensive, but it is meant to be an illustration of how symptoms have been ascribed a *symbolic* function, that is to say, that the concrete behaviour and preoccupation with bodily qualities *represent* emotional and cognitive phenomena.

In this connection, updated, current descriptions and interpretations of the psychopathology of eating disorders will be presented. The historical account of interpretation points to the fact that the body has a symbolic mediating role, but the type of meaning content attributed to the body practices, depends on professional, historical and cultural contexts.

The second part of this background will elaborate on the concept 'embodiment', in general and applied on the case of eating disorders. A basic theoretical challenge is simply to develop an applicable and useful conceptual language for the interactions between inner and outer realities. In such an effort the concept of embodiment is introduced.

It is an implicit premise in this dissertation that an understanding of eating disorders implies experiencing the body as far more than 'a thing' – a physical body – and also understanding the human body as experiencing, as intentional and existential (Merleau-Ponty,

1962). Embodiment as a concept not only refers to a state but to a process – better expressed by the verb *embodying* – and conveys as well physical, mental and cultural aspects of bodily experiences, and dialectics between all these realms. In this dissertation embodiment is both actively chosen as a superior theoretical concept, as well it is a intention in the different papers and in the thesis as a whole to enrich the concept with empirical and theoretical material from eating disorders and anorexia nervosa as cases.

THE REPRESENTING MIND: HISTORICAL CONCEPTUALISATIONS OF EATING DISORDERS

The main aim of this section is to demonstrate how eating disordered symptoms through history have been interpreted to function as symbols or representations of inner states. This very rough guide to the history of interpretation of eating disorders, as one has perceived them and still understands them in terms of aetiology and ascribed meaning, refers to different psychological models. I will not here elaborate various somatic explanations that have come and gone. Psychodynamic models are given most space since these have devoted attention to the interactions between body and mind.

Since the rediscovery and naming by Sir William Gull (1874) in England in 1872 and Charles Lasègue (1873/1965) in France as ‘anorexia nervosa’ and ‘anorexie hysterique’ respectively the condition which Richard Morton (1694) had previously described as ‘a nervous consumption’, many physicians have sought to understand the role of emotional and cognitive factors in the pathogenesis of the disorder.

Medical diagnostics is historically a semiotic practice in the sense that symptoms are perceived as signs indicating underlying disorders. In our cultural context, that is to say the Western context, the diagnostic category anorexia nervosa was born in the heyday of another psychiatric phenomenon, namely *hysteria*. In today’s psychiatric diagnostics, one will largely rediscover many of the phenomena which were then described as hysteria in the two main diagnostic categories Somatoform disorders and Dissociative disorders (American Psychiatric Association, 1994). Sigmund Freud and early psychoanalysis contributed to the creation of great narratives about the hysterical symptoms – fainting, convulsions, paralysis, pain, etc. – as meaningful symptoms. Something informs something specific about something else.

Confused sexuality and anti-sexuality

From the very beginning, there have been distinct interpretations of what is symbolised by the disorder. There are a number of descriptions of the psychosexual nature of the disorder, i.e. the sexual, or rather anti-sexual, nature of the symptoms (e.g. Lasègue, 1873; Janet, 1929). The term psychosexual is used to indicate a relating to the mental aspects of sexual phenomena (Fornari & Dancyger, 2003). A great number of authors have interpreted anorexia as expressing a notably female coupling of food and sex. Lasègue described heterosexual anxiety as a component of the hysterical anorexia (Lasègue, 1873/1965). The French psychiatrist Janet (1929) also regarded anorexia nervosa as a hysterical variant due to sexual frustration.

Clinicians and scientists have subsequently continued this kind of discourse and described how anorexia often followed in the wake of menarche and breast development (Bruch, 1978; Crisp, 1980; Meyer, 1971), that the girl with anorexia often had difficulties coping with heterosexual relationships (Crisp, 1967; Selvini-Palazzoli, 1974), and that the condition ultimately represented an arrest of the body on the road to sexual maturity and adult life (Crisp, 1967; Frick & Schindler, 1972; Muller & Beck, 1973). The anorectic condition is a physiological and psychological clinging to infancy. Hence, anorexia has been interpreted as anti-sexuality. Correspondingly, in adult women, anorexia has been explained as sexual anxiety or an expression of sexual conflicts (Covert, Kinder & Thompson, 1989).

Psychoanalytic interpretations

The emphasis given to psychosexual aspects in anorexia is to a certain extent due to psychoanalysis. In classical psychoanalysis, the most central life energy, 'libido', was sexuality, and psychic disorders were viewed in the light of internal and external conflicts around sexuality. The early psychoanalytic understanding of anorexia nervosa or hysterical anorexia made use of Freud's (1923/1975) 'drive-conflict' of the mind. This type of model perceives the root of psychopathology as an intrapsychic *conflict* between biological aims seeking discharge and culturally influenced constraints against this discharge. There is an assumption of the relative intactness of the mind, as opposed to psychopathological models proposing *deficits* in structure. Symptoms represent symbolic expressions of sexual and/or aggressive aims and defences against these aims (Goodsitt, 1997).

Freud himself did not write very much about anorexia and eating problems. Very early in his career, in 1883, he and Josef Breuer met the patient Nina R. Her anorectic symptoms and vomiting were perceived as part of her extensive hysterical symptomatology (Freud

1893/1990). In a letter from 1895, Freud wrote (Freud, 1885/1975, p. 200): “The famous *anorexia nervosa* of young girls seems to me (on careful observation) to be a melancholy where sexuality is undeveloped. The patient asserted that she had not eaten, simply because she had *no appetite*, and for no other reason. Loss of appetite – in sexual terms, loss of libido.” In the early 1900s he included *anorexia nervosa* within the developmental framework of fixated unconscious conflicts relating to oral sadistic fears, regressive wishes and primitive fantasies (Fornari & Dancyger, 2003).

Later, in the middle of the twentieth century, a psychoanalytic position interpreted anorectic denial as sexual anxiety and as a defence against sexual fantasies, with fear of oral impregnation as underlying the illness (Waller, Kaufman & Deutsch, 1940; Berlin et al., 1951). Although these clinicians regarded *anorexia nervosa* as a paradigm of psychosomatic disorders, they employed a psychogenic, linear model of causality that closely resembled Freud’s conception of hysteria. Like hysterical conversion symptoms, the abnormal eating behaviour of *anorexia* was given primary symbolic meaning and considered amenable to interpretation; conflict over unconscious oral impregnation fantasies was believed to be expressed through avoidance of food, or alternatively through periodic gratification of the fantasy by binge eating, generating guilt and anxiety (Taylor, Bagby & Parker, 1997).

Anorexia nervosa interpreted as a hormonal dysfunction

After the first texts, interpreting self-starvation psychologically and psychoanalytically, had appeared, there was published surprisingly little literature about *anorexia* in the first half of the last century. This can partly be explained by a lack of diagnostic competence. In 1914, the German pathologist Morris Simmond launched his descriptions about loss of weight possibly having an explanation in hormonal failure as function of injuries to the brain’s pituitary gland. A number of cases of *anorexia nervosa* were obviously misinterpreted as ‘Simmonds disease’ (Skårderud, 1994). *Anorexia nervosa* was then rediscovered in the second half of the last century. The psychoanalysts Hilde Bruch and Mara Selvini Palazzoli contributed largely to this rediscovery. And both opposed to earlier understandings of *anorexia* as a variant of hysteria.

Hilde Bruch: Interoceptive confusion and self deficits

The classical psychoanalytic approach to *anorexia nervosa* – with emphasis on instinctual drives, unresolved oral conflicts and motivational interpretations of the symptoms – was not particularly successful (Taylor, Bagby & Parker, 1997). A major critic of this theoretical

conception and psychotherapeutic approach was Hilde Bruch (1973, 1982/83). She is considered as one of the modern pioneers of eating disorders; perhaps *the* pioneer. Noting that treatment results from traditional insight-oriented psychotherapy were rather poor, Bruch concluded that the classical psychoanalytic formulations of anorexia nervosa were based mainly on atypical cases suffering from conversion hysteria. Her conclusions were subsequently supported by Garfinkel et al. (1983), who used psychometric tests to document differences between patients with anorexia and patients with conversion disorders. The latter showed fewer pervasive psychological deficits, and they appeared better able to use fantasy and to respond to insight-oriented psychotherapy.

Bruch regarded (1982/83, 1985) the psychopathology of primary anorexia as different from the Freudian understanding of psychoneurosis, and more akin to what we today would describe as narcissistic, borderline and schizoid personality disorders. It was her opinion that the core problem lies in a deficient sense of self and involves a wide range of deficits in conceptual developments, body image and awareness, and individuation (Taylor, Bagby & Parker, 1997).

Hilde Bruch (1962) observed that anorexic patients manifest difficulties in accurately perceiving or interpreting stimuli arising in their bodies, such as hunger and satiety, and also fatigue and weakness as the physiological signs of malnutrition. In addition, she observed that patients with anorexia experience their emotions in a bewildering way and are often unable to describe them. Such disconnections between physiological and subjective feeling components of emotion are commonly termed as *alexithymia*. The concept originates from Greek and literally means ‘no-words-for-feelings’.

Alexithymia as a construct is developed based on clinical observations of patients with classical psychosomatic disorders. It has been defined as greatly reduced or absent symbolic thinking and inhibited fantasy, preventing internal attitudes, feelings and wishes from being revealed (Sifneos et al., 1977). The alexithymic may readily speak about being nervous, sad or angry, but when he or she is asked to be more explicit about these feelings, it becomes difficult: “Don’t know,” or “can’t find the right words”. One will often have difficulties localising affects in the body. Many will also have difficulties in differentiating between various types of ordinary affects when invited to make a comparison. According to the descriptions of Sifneos and colleagues (1977), the alexithymic may have short, violent outbursts of affect without being able to explain or connect them to relevant feelings. The eyes may be full of tears, but one does not feel any specific sadness. One’s body movements may be stiff and rigid, one talks with only few gestures, and one’s intonation is often flat and

barely reveals any feeling. There is rich empirical evidence for the association between alexithymia and eating disorders in general, and not only for anorexia nervosa. For a review of the scientific literature, see Taylor, Bagby and Parker (1997).

The lack of awareness of inner experiences and failure to rely on feelings, thoughts, and bodily sensations to guide behaviour, may contribute to an overwhelming sense of *ineffectiveness* and an overall lack of awareness of living one's own life (Bruch, 1962, 1973). The clinical picture presented is the patient's effort to compensate for these underlying deficits. Bruch (1973, p. 24) defines anorexia nervosa as a "struggle for control, for a sense of identity, competence and effectiveness". Bruch also contributed to a broadened and updated version of the conception of anorexia as anti-sexuality, by introducing 'maturity fear' as one of the possible symbolic messages of anorexia nervosa (1973). The psychological immaturity of the person leads to a fear of the tasks, responsibilities, duties and challenges fantasised to oneself in an adult version.

Bruch (1973) advanced a developmental model to explain the psychological deficits in eating disordered patients. In her opinion, 'interoceptive confusion', as described above, is a consequence of consistently poor attunement between the innate needs of the child and the responses of the caregivers in the environment. The misinterpretation of the non-verbal presymbolic communications of the infant, and the parents' "direct mislabelling of a child's feeling state, such as that he *must* be hungry (or cold, or tired), regardless of the child's own experience ... (leads) a child to mistrust the legitimacy of his own feelings and experiences" (p. 62). In the terminology of contemporary developmental psychology and psychoanalysis, this could be described as 'incongruent mirroring' (Gergely & Watson, 1996).

For Bruch the person with anorexia is therefore *one who does not know*, because he/she is a *person who has not learned to distinguish*. The relationship between experience and category has not been established in a valid manner. Experiences with the body are 'mis-categorised', and for Bruch this is understood as a *cognitive* and *perceptual* disorder. There is, however, a close connection between experience and existence. When the child or patient do not know *what* they feel and need, they are close to experiencing loss of own reality. The child does not *know*, and can be close to what is called impaired reality testing. It is a generally accepted tradition to understand anorexia as a non-psychotic disorder, but some of the ideas a person can have, such as the belief that one can become fat by merely being in the same room where butter has been used for frying, do represent a severe distortion in reality perception. According to Melamed, Mester, Margolin and Kalian (2003, p. 622), "it is

professionally appropriate to establish that anorexia nervosa, in certain life-threatening situations, is a psychotic illness.”

Mara Selvini Palazzoli: Helplessness of the ego

The other “mother” of eating disorders, the Italian psychiatrist and psychoanalyst Mara Selvini Palazzoli (1971, 1974) arrived independently at a similar formulation; that the main issues underlying anorexia nervosa stem from a *helplessness of the ego* rather than from instinctual conflicts. Hence, she refers to what later, in a classical text by the Norwegian psychoanalyst Killingmo (1989), has been named as deficits rather than conflicts. She also emphasises the lack of identity and sense of personal effectiveness, as well as incapacity to recognise and distinguish different kinds of feeling states, impulses and wishes. And also in her theoretical model, poor attunement leads to “an attitude of mistrust towards the body, its stimuli and its needs” (1971, p. 209). Selvini Palazzoli agrees with Bruch that psychotherapists must avoid giving motivational interpretations to eating disorder patients, as this may merely repeat earlier experiences of insensitivity and be experienced as ‘invasion’.

Selvini Palazzoli (1974) writes within a psychoanalytic ‘object relations’ model. The symptoms in this tradition can still be regarded as relatively distinct symbols, but now as symbols of a distorted self and distorted object relations, particularly of mother as the object. According to Selvini, self-starvation is the female adolescent’s attempt to end the feminisation of her body, and thus to minimize the confused, ambivalent identification with her mother.

In both models, drive–conflict and object relations, symbols are understood in a fairly precise and delimited form. The models give an impression of knowing what the symptom actually indicates in terms of underlying psychodynamics. From this angle, they may seem little open for complexity and alternative explanations. Symbols are perceived as distinct representations in the same way as a wedding ring is perceived as a symbol of marriage.

Self esteem and self pathologies

What is a possible position today for phenomenological descriptions and theoretical understandings of eating disorders, and specifically anorexia nervosa? How do we now, fruitful for understanding and therapy, conceive the anorexic ‘shell’, the denial and isolation?

Searching the psychological literature for texts about persons with eating disorders, more specifically texts describing anorectic and pre-anorectic personalities, we come across many conceptual variations over Bruch’s (1973) theme of ‘lack of sense of self’ and ‘low self-esteem’. A central figure outside the psychodynamic tradition, and a pioneer in the

development of Cognitive behavioural therapy (CBT) and Interpersonal therapy (IPT) for eating disorders, the British psychiatrist and professor Chris Fairburn and colleagues (1997, 1998, 1999) presents empirical research on the association between eating disordered symptoms and extensive 'negative self-evaluation'. And from a wide range of perspectives and traditions, great emphasis is placed on self-conscious emotions (Lewis, 2000), like shame and inferiority (Crisp, 1980; Lerner, 1986; Strober, 1991; Vitousek & Ewald, 1993; Goodsitt, 1997).

Thus, eating disorders and anorexia nervosa can be understood as an expression of a psychological deficit or flaw; and symptomatic behaviour can – partly – be understood as an attempt to change. Baerveldt & Voestermans (1998) describe anorexia nervosa as a 'selfing device'. The author Geist (1989), writing within the tradition of self psychology, 'fourth generation psychoanalysis' based on Hein Kohut's writings (1971, 1977, 1984), makes explicitly use of the broad concept 'self pathology'.

The behaviour is a problem, but also a compensation as already proposed by Bruch (1973). One of her patients described: "Anorexia is a way of bringing order to one's universe, and attempt to freeze time and relationships" (Bruch, 1988, p. xvi).

The cognitive tradition

The American psychologist Kelly Vitousek (formerly also writing under the name of Kelly Bemis) has been an important supplier of premises within the cognitive theoretical tradition and the cognitive-behavioural therapeutic tradition within eating disorders. Vitousek and Ewald (1993) describe that "anorexia nervosa is fundamentally both a cognitive disorder and a disorder of the self. After the psychopathological process has been initiated, the lives of anorexics are progressively dominated by a central, overdetermined idea about one aspect of the self: that the self's worth is represented in – or at least delimited by – the weight and shape of the body" (p. 221).

The symptoms are a sign that something is wrong, but also that one seeks to compensate or rectify what is wrong. One searches for a solution. But the solution becomes the problem. Vitousek and Ewald (1993, p. 221) write that "cognitive models for eating disorders differ from cognitive models of other disorders in several important respects. (...) Perhaps the most obvious and significant of these is the prominence of material on the *motivation* for, and *function* of, symptomatic behaviour. Cognitive theories of psychopathology usually disavow dynamic notions of motivated symptomatology, emphasizing instead the *automaticity* of the information-processing errors that derive from

lawfully and unintentionally acquired schemas". However, cognitive theories for eating disorders have tended to stress the motivated, functional aspects of anorexic beliefs and behaviours, to at least as great an extent as the psychodynamic theories of the eating disorders, "which they most closely resemble" (Vitousek and Ewald, 1993, p. 222).

Interestingly, the enigmatic nature of eating disorders and anorexia nervosa apparently helps to bring about a rapprochement between different theoretical traditions.

In the same text, Vitousek and Ewald contribute with phenomenological categories for self deficit and self pathology, which are specifically related to anorexia nervosa. They create a three-part categorisation of self pathology in anorexia, and this is based on the double presumption that anorexia represents a deficit in the psychological self, and that the symptoms serve adaptive functions. The categories are respectively:

'Unworthy self'

This category consists of aspects of the self-like low self-esteem, feelings of helplessness and ineffectiveness, poorly developed sense of identity, tendency to seek external verification, extreme sensitivity to criticism, and conflicts over autonomy and dependence. The anorectic condition can be seen as an expression of, and/or a compensation for these psychological qualities.

'Perfectible self'

This category consists of aspects of the self-like perfectionism, grandiosity, ascetism and an either-or cognitive style. The anorectic condition can be seen as an expression of, and/or a compensation for these psychological qualities.

'Overwhelmed self'

This category consists of aspects of the self-like preference for simplicity, preference for certainty, tendency to retreat from complex social environments and avoidance of strong affect. The anorectic condition can be seen as an expression of, and/or a compensation for these psychological qualities.

These distinctions between respectively 'unworthy self', 'perfectible self' and 'overwhelmed self', conduce to useful and clarifying phenomenological descriptions within the same diagnostic category.

Vitousek and Ewald (1993, p. 221) write that “once formed, the dominant anorexic idea gives rise to subsidiary beliefs and behaviours, *characteristic information-processing errors*, and starvation-induced physiological changes, which all serve to maintain and reinforce the underlying premise”. Unfortunately, this reference contributes very little to elaborate descriptions of what these ‘characteristic information-processing errors’ actually represent. The emphasis is on describing the phenotypes of the disorder, and less on exploring impairments of the psychological functions as such. In that respect, the psychodynamic traditions are more oriented towards developing theories about mechanisms behind self deficits and impairment of symbolic capacity.

Self-regulation and affect regulation

Several experts in the field of eating disorders have formulated that abnormal eating behaviours and associated symptomatology are seen as attempts to re-establish a form of self-regulation of unpleasant emotional states and other aspects of self. Many contemporary psychodynamic models have a special perspective on eating disorders as a disturbance in self-regulation and affect regulation. In Grotstein’s (1986, 1987) conceptualisation, an impairment of the capacity to process and regulate emotions represent the *primary* regulatory disturbance. This impairment may reflect a constitutional, inherited deficit or may be acquired through defective bonding in an inadequate nurturing environment (Grotstein, 1986; Taylor, Bagby & Parker, 1997). Grotstein (1986) suggests that the symptoms offer “a makeshift ‘floor’ under, or container around, a fragmenting self to protect it from disintegrating catastrophe” (p.104).

Goodsitt (1997) writes from a self-psychological perspective, and also proposes that patients with eating disorders have severe deficits in self-organisation and self-regulation, and are subject to profound states of over-stimulation and tension. The absence of reliable internal self-regulation causes the anorexic to feel inadequate, ineffective, and out of control; as already described by Hilde Bruch. Persons with anorexia may feel excessively influenced and exploited because they are deficient in self-regulatory structure and are therefore dependent upon others for their well-being. In Goodsitt’s view, persons with eating disorders “attempt to drown out these anguished feelings by frantic self-stimulatory activities. This is the common denominator to such behaviours as starvation, bingeing, vomiting and hyperactivity. The symptoms are misguided attempts to organize affects and internal states meaningfully” (p. 59).

Affects are primary in our lives. They are already there in the maternity ward. But they continue to develop in the *interaffective* encounters between the child and the care persons.

Affects are exchanged, modulated and integrated, they are thematised and tolerated, or not thematised and not tolerated in the attachment bonds. Contemporary psychoanalytic traditions, such as self psychology (Stolorow, Atwood & Brandchaft, 1987), Daniel Stern's latest development of psychodynamic concepts based on empirical studies of infants (1985/2000) and Fonagy and Target's (1996, 1997) model on 'mentalisation' (see later in this chapter), all put an emphasis on the central role of the affects, not only in adjustment of affect states, but more fundamentally in the unfolding of a sense of self and agency, and in the construction of the psychological self.

An integrated self experience is expressed through a certain capacity to synthesise conflicting emotions. The eating disordered patients often present themselves via their lacking capacity to synthesise, that is to say, through both their affective and cognitive either-or, all-or-nothing and black-or-white. Monsen (1997) describes that such a synthesising capacity may develop when the parents tolerate all, and not only some, feelings in the child. "Tolerating the whole child" over time establishes the child's own tolerance and modulation of affective reactions. "This kind of tolerance facilitates moreover the use of feelings as self-signals. In a favourable development, feelings will be conceived as signals for an altered self-state, in contrast to a disturbed self development where an activation of feelings may act as a warning sign of imminent disorganisation and fragmentation (p.134)".

Non-tolerated feelings are repressed or encapsulated as acting out. Activation of such feelings is rapidly experienced as shame and self-contempt. Lack of shared experiences can contribute to shame since one's own emotional needs can be felt to be unacceptable. The anorectic fantasy about not needing anything can be interpreted as a grandiose compensation for such a feeling of shame; just like the contempt which parents, friends and therapists at times may experience as emanating from the anorexic, can be interpreted as a protection against self-contempt.

And shame and self-contempt come clearly to the fore in persons with bulimia, with food orgies and purification as anxiety- and tension reducing activities in those with high impulsiveness, mood swings and poor capacity to regulate tensions. Kaye and colleagues (1986) found that 50 percent of the patients who overate, experienced anxiety-and tension reduction during overeating, and 67 percent experienced the same after overeating.

Reflective function and mentalisation

The historically rather newly developed theoretical and empirical constructs 'reflective function' and 'mentalisation' are relevant in the conceptualisation of anorexia nervosa and

eating disorders. The term reflective function refers to the psychological processes underlying the capacity to mentalise, a concept which has been described in both the psychoanalytic (Fonagy, 1991) and cognitive psychology literatures (Morton & Frith, 1995). Reflective function, referred to in developmental psychology, “is the developmental acquisition that permits children to respond not only to another person’s behaviour, but to the children’s *conception* of other’s beliefs, feelings, attitudes, desires, hopes, knowledge, imagination, pretence, deceit, intentions, plans, and so on. Reflective function, or mentalization, enables children to ‘read’ other people’s minds. By doing this, children make people’s behaviour *meaningful* and predictable. Their early experiences with other people enable them to build up and organize multiple sets of self-other representations. As they learn to understand other people’s behaviour better, they become able flexibly to activate the representation(s) from these multiple sets that are best suited to respond to particular interpersonal transactions” (Fonagy, Gergely, Jurist & Target, 2002, p. 24-25).

In the context of this dissertation reflective function and mentalising are used as rather synonymous concepts. These and derived concepts will be central in three of the scientific papers inherent in this dissertation, both used conceptually in the interpretation of verbatim statements from patients with anorexia, in linking such interpretations with applicable theoretical models, and not at least in using such empirical and theoretical material as guidance for proposing therapeutic approaches (Papers 1, 2 and 3) (Skårderud, 2007 a, b, in press).

The two main concepts reflective function and mentalisation involve both a self-reflective and an interpersonal component that ideally provides the individual with a well-developed capacity to distinguish inner from outer reality, pretend from ‘real’ modes of functioning, and intrapersonal mental and emotional processes from interpersonal communications. “This ability arguably underlies the capacities for affect regulation, impulse control, self-monitoring, and the experience of self-agency – the building blocks of the organization of the self” (Fonagy, Gergely, Jurist & Target, 2002, p. 25). Mentalisation is intrinsically linked to the development of the self, to its gradually elaborated inner organisation, and to its participation in human society, a network of human relationships with other beings who share this unique capacity. As documented by the British tradition with Peter Fonagy and colleagues, insecurity in attachment relationships and limitation in mentalising skills are linked. Applied on eating disorders; when mentalisation is impaired, and when psychic reality is poorly integrated, the body may take on an excessively central role for the continuity of the sense of self.

Summary of this section

Let us summarise central features in the history of interpretation which are connected to eating disorders in general and to anorexia in particular. The summary emphasises historical notions about ‘the representing mind’, about symbolisation as a mediator between outer and inner realities, and between body and mind; and about what is represented.

In early psychological and particularly psychoanalytic models of anorexia nervosa, symptoms were interpreted as messengers referring to specific psychological realities. In psychoanalytic models as drive–conflict and object relations, symbols are understood in a fairly precise and delimited form. The models give an impression of knowing what the symptom actually indicates in terms of underlying psychodynamics. The self-psychological tradition is an example of a change in the understanding of the mind’s symbolic function. This tradition is one example among several of modern psychoanalytic understandings where symptoms may still convey symbolic meaning, but their invocation derives more from an emergent need to drown out painful self-states. When we now speak of the mind’s symbolic function, *it is with far more emphasis on mental representation as processes and capacities, than on the meaning of symptoms and signs*. This represents an increasing interest in ‘the *how* of representation’ – impaired symbolic capacities – at the expense of ‘the *what* of representation’ – literal interpretations of meanings of symptoms and pathology. Self deficits are expressed with impairment of one’s own sense of cohesion, vitality, self-soothing, sense of well-being and security, tension regulation and self-esteem regulation. Symptoms are viewed as restorative, as attempts to restore cohesion, vitality and self-regulation (Goodsitt, 1997).

There is a contemporary trend describing and understanding eating disorders as a disorder of regulation. Not least does this open up for an integration of different explanatory and descriptive models in medicine and psychology. Advances in developmental psychology, affect theory, neurobiology, infant development research, trauma research, new concepts of personality development, and current concepts in psychoanalysis, have all contributed to the evolution of a new and distinct entity, that of self-regulation in general and of affect regulation in particular. In addition to individuals with acquired deficits in affect regulation, however, there are individuals with inherited deficits in their neurobiological functions that may predispose them to affective dysregulation. Acquired and/or inherited deficits may be involved in the genesis of the problems of emotion regulation underlying the eating disorders. And eating disordered symptoms express and/or are restorative to such dysregulation; and many of the symptoms are presented as bodily behaviour (Taylor, Bagby & Parker, 1997).

Themes and discussions presented here will be further developed in depth in the scientific studies 'Eating one's words I, II and III' (Papers 1, 2 and 3), and briefly discussed in 'Bad boys' bodies' (Paper 5). 'Shame and pride in anorexia nervosa' (Paper 4) (Skårderud, 2007 c) deals particularly with the role of shame and pride in patients' descriptions of own affective lives.

EMBODIMENT

In this section I will focus on one particular element in the alleged matrix of the development of eating disorders: The roles of the human body. This part of the presentation of backgrounds for the scientific questions to be raised, investigated and discussed in this dissertation, introduces the theoretical construct 'embodiment'. The intention of applying such a term is to open up for wider perspectives on the many possible roles of the human body in mental life and psychopathology. Moving from 'body' to 'embodiment' underscores processes more than states, and moves beyond the physical qualities of the human body. The concept has important origins in philosophy and social sciences. In the last few decades, the prominence of the body in popular culture has generated intense academic interest and activity, and fields from across the disciplinary spectrum have turned their attention to the body as a central concern of social theory (Reischer & Koo, 2004). Seeking to overturn a naturalistic approach to the body as biological given, this broad literature has redefined the body as a sociocultural and historical phenomenon (e.g. Bourdieu, 1977; Elias, 1978; Foucault, 1979; Goffman, 1968).

The use of the concept embodiment in the context of this dissertation is a statement about the usefulness of expanding the perspective beyond traditional medical models, and to let different scientific disciplines and discourses meet and fertilise each other. But embodiment is a most wide concept, and has to be concretized with reference to different theoretical discourses and experiential domains, e.g. like neuroscience, developmental psychology and socio-cultural interaction.

The reductionism of models about the human body

In the field of eating disorders, which focus so strongly on bodily appearances and practices, it is striking and strange that so few theoretical models for what a human body is, does and can convey, have been evolved. In the existing psychological models for pathology, such as

current cognitive and psychodynamic models, there has been little explicit elaboration on this type of thematic structure. And, to the extent that it has been touched upon, one intuits a subtext of a basically Cartesian attitude. In such models there is an implicit and fundamental distinction between body and mind, like in the concept ‘psychosomatic’. A literal understanding of psycho-somatic disorders is that something inner – mental phenomena – express themselves as something outer – physical and pathological phenomena. This also indicates a causal chain, from inside to outside. Such classic conceptualisation nurtures on the dualism, and it is relevant to ask if such a concept actually is any helpful in the understanding of clinically and theoretically challenging phenomena like eating disorders.

Is it possible to avoid such kinds of reductionism? First, we need to remind ourselves that models exist in language. The models about interactions between the human physical and psychical are metaphors. As metaphors they nurture on simple experience. And we experience a dualism between consciousness and physical experience. We know that we think, but we do not necessarily experience that thinking has a physical quality. When thinking, we do not have a clear notion about the electrical and chemical signals which are the physical basis for thinking. In such cases, body is experienced as absent (Leder, 1990). And on the other hand, we feel physical pain when hurt. With our minds we try to endure physical pain. In such cases the body is present in a painful and problematic way.

The psychoanalyst Iréne Matthis (2000, 2005) reminds us of the metaphorical quality of models about the human body. She states that we should “not think of the ‘whereabouts’ of such a proposed interaction as the location of a definite place, for example in the brain. We should rather regard it as a way of speaking, since we are actually talking about processes and functions probably taking place all over the body. Nor should we think of such an interaction as a cause-effect mechanism, where a physical process causes a psychical phenomenon, or vice versa. For such an interaction we have no other proof than our conscious experience. Because of this experience we often *talk about* interactions between the physical and the psychical. There is nothing wrong with this linguistic usage, but we should not forget that it is only a way of speaking and not a proposition about a cause-effect relationship” (2000, p. 220).

The existential body

We will most certain never be able to include the whole spectrum of psychical and physical interactions within any one description, because of the way our consciousness, on which the

descriptive mode is based, dichotomises natural phenomena. The concept embodiment, although wide, represents an effort to oppose against classical dualism and to integrate. Embodiment refers to a philosophical position with great emphasis on the body as a psychological, cultural and historical phenomenon, as well as a biological and material one. By emphasising the existential nature of human bodily experiences, thus indicating scepticism regarding the tendency to objectify the body, it therefore follows that studies under the rubric of embodiment are not about the body per se. They are about personal, psychological and cultural experiences as these can be understood from the standpoint of bodily being-in-the-world (Csordas, 1999).

We are living in the world as embodied individuals, and our bodies will always contribute with new experiences. Whenever we are referring to an individual's body, that body is always responded to in a series of particularised contexts and local fashions (Weiss, 1999). The danger of viewing the body as a singular entity is that we may lose sight of the fact that the body is never isolated in its activity, but always already engaged with the world. The expression 'the body' is problematic insofar as it implies a discrete phenomenon that is capable of being investigated apart from other aspects of our existence to which it is intrinsically related. The use of the definite article also suggests that the body is itself a neutral phenomenon, unaffected by its own biography, family of origin, close relations, gender, race, age and changing capabilities of the body. The move from one expression to another – from the body to embodiment – “corresponds directly to a shift from viewing the body as a nongendered, prediscursive phenomenon that plays a central role in perception, cognition, action and nature, to a *way* of living or inhabiting the world through one's acculturated body” (Weiss & Fern Haber 1999, p. xiv).

Theoretical approaches to embodiment

Where a descriptive approach might leave us at a loss, when we try to accommodate a holistic model of body-mind, a theoretical line of discourse might bring us further. Embodiment has historically been approached from different theoretical discourses. An actual problem is that human embodiment is such a complex and rich phenomenon that the concept necessarily becomes wide, and with many possible interpretations. Some of the theoretically discursive approaches will very briefly be mentioned here; mainly to elucidate how the concept embodiment may refer to manifold aspects of mind-body.

Body and affect

One feasible discursive way to open up the classical reductionism of body-mind and psychesoma to a more holistic view, in an up-to-date scientific context, is to bring forth recent scientific descriptions of human affects. Human affects are both psyche and soma. Already Sigmund Freud described the affect as something lying on the frontier between the mental and the somatic, and the study of them necessarily had to be an embodied pursuit (1915). During the last decades there has been a rich interdisciplinary development about affects, in general and related to psychopathology. An example of such an interdisciplinary collaboration is the field of ‘neuro-psychoanalysis’, linking up psychological and psychoanalytical concepts with recent developments in sciences like neurology, neurosciences and evolutionary biology (Damasio, 1994, 1999; Panksepp, 1998; Schore, 1994; Solms, 1996, 1997 a,b).

Some affective reactions are taken for granted, like hunger or thirst. Other affects are sadness, anger, pride, shame, guilt, disgust and embarrassment. Affects often reveal themselves via bodily signs, like facial expresses, although it is our wish and intention not to reveal them. Affects are experienced as feelings, and at the same time as bodily experiences. Matthis (2000, p. 217) defines affects as “all those embodied processes that, when they reach consciousness, can be perceived as on the one hand as feelings and on the other as emotionally charged physical concomitants. These may be perceived as, for example, burning in the skin, a racing heart or shortness of breath; bodily sign that we readily interpret as the expression of an emotion”.

Within such a context, Irene Matthis (2000) quotes the very late Freud (1940), immediately before he died, about that the data to be worked with in psychotherapy, and states herself that “the data which we are to work on must be drawn from *an embodied agent*, not a disembodied consciousness” (p. 219). Matthis introduces the concept of an ‘affective matrix’. From the neuroscientific studies cited above (Damasio, 1994, 1999; Panksepp, 1998) we know that affective processes certainly connect to and influence not only the specific neuronal tracts and centres related to emotions and feelings (e.g. in the brain stem, hypothalamus and basal forebrain), but several other areas in the brain that affect the bodily functions.

Matthis refers to Mark Solms (1996, p. 495): “So the psychic and the somatic manifestations of affect are simply *two ways of representing the same underlying thing ...* This simple fact explains why *affect is both an essentially subjective state and something which is inextricably connected with the body.*” Affects have two perceptual sides, almost like

a coin: one is related to the psychological aspect of feelings and emotions *per se*, the other to the bodily expressions of what we take to be affect-equivalents.

The agentic body: Body philosophy and body phenomenology

One of the philosophical pioneers in challenging the dualism, and challenging conscious mind's superiority over the 'low' body is Friedrich Nietzsche (1844-1900). He describes how physical experiences always come first, and represent the 'place' for reason, experience and creativity. For Nietzsche consciousness is an aspect of bodily functions (Skårderud, 1994 a). Such a trail, emphasising mind as embodied, is further developed almost a century later by the French philosopher Maurice Merleau-Ponty (1907-61). The concept of embodiment today is heavily influenced by the 'body-phenomenological tradition', derived from Merleau-Ponty and his main work 'Phénoménologie de la perception' (1962).

Merleau-Ponty is one of the few Western thinkers who postulates that our understanding of the world is founded on the body's perception of its surroundings and situations. To be a subject, means to be in the world *as body*. In this ontological position the human body is in lively interaction and in an ongoing dialogue with the world. For Merleau-Ponty the body is not a mechanical object responding to the stimuli in its environment. The body is experiencing, acting and seeking meaning.

Within social sciences, two primary theoretical orientations toward the body have emerged: The body as 'symbol' and the body as 'agent'. Merleau-Ponty is a prominent representative of 'the agentic body'. He states that "the body is our general medium for having a world" (1962, p. 146). He points to the human body as a fundamental aspect of the acting self, thus seeking to transcend the dichotomy of the self as subject versus body as object in order to draw attention to the often overlooked role of the body in social action (Comaroff & Comaroff, 1992). The self is ultimately an embodied self, and the symbolic capacities of material bodies can thus be 'employed' by this self so embodied as one way to act on the world. That is, bodies are not only constitutive of subjectivity, but also mediate the relationship between persons and the world.

With reference to Merleau-Ponty, there are two situations which damage the existentially open relation to the life-world. It is in the case of illness, and in the strictly rational attention towards the body. The typical anorexia could be said to represent both: Illness which causes the body 'to stiffen' as an object, and 'rational' bodily practises which are supposed to promote a subjective experience of psychological well-being, mastery and

self-control. Body-phenomenological reflections on embodied experience, how his theories may be applied on eating disorders and anorexia nervosa, and also function as a background for clinical intervention, is more fully described in one of the scientific papers in this dissertation, 'Use the body, and forget the body' (Paper 6) (Duesund & Skårderud, 2003).

Embodied mind: Body as source for metaphorical function

Embodiment is also a key concept, as Merleau-Ponty is a central reference, in the works of the philosophers George Lakoff and Mark Johnson (1980, 1999). In their view mind is always embodied. Physical realities, like gravitation, sounds, vision, tactility etc. functions as a physically perceived source area for the development of bodily metaphors, which again are pervasive in the building concepts, mental representations, fantasy and reason. The effort of Johnson and Lakoff is "putting the body back into the mind" (Johnson, 1987; Lakoff & Johnson, 1999). Mind is always and inevitably embodied, based on bodily perception and sensorimotor experiences. The bodily-based metaphor is basic, but often not conscious.

Lakoff and Johnson are cognitive philosophers, and do not operate with theories about psychopathology. In clinical examples of psychopathology we may experience that bodily metaphors do not function mainly as *representations* capable of containing an experience, but as *presentations* which are experienced as concrete facts here-and-now and difficult to negotiate with (Enckell, 2002). The 'as if' of the metaphor as a figure is turned into an 'is'. Such phenomena will be developed further in the three companion articles 'Eating one's words I, II and III' (Papers 1, 2 and 3), respectively dealing with empirically based descriptions, theory and consequences for psychotherapy. They will also be illustrated in the article 'Shame and pride in anorexia nervosa' (Paper 4).

The symbolic body

The science of anthropology, including the sub-speciality of medical anthropology, has been a pioneer in enriching the understanding of the ambiguous functions of the human body. According to the classic scholar Claude Lévi-Strauss anthropology is "the science of the concrete" (1960). The scientific field is food, bodily fluids, bodily decorations, rituals et cetera. The 'symbolic body' is central in this tradition. Symbolic meaning arises from these concrete phenomena. The human body is concrete and defined, but also endlessly rich as 'text' (Ricoeur, 1977).

Mary Douglas, in her groundbreaking work 'Natural symbols' (1970, p. vii), was among the first to articulate the symbolic significance of the body. Douglas argues that "there is a strong tendency to replicate the social situation in symbolic form by drawing richly on bodily symbols in every possible dimension". In the symbolic way of thinking the human body is inevitably both-and, both concrete and symbol. Body symbols or body metaphors are fundamental in human experience of meaning, in the sense that metaphors are defined as resemblance, a similarity-in-difference. The 'analogy' is central in transporting meaning from a concrete to a symbolic realm, and vice versa. The body metaphors are often direct analogies to what they express. In anthropological literature there are rich descriptions of how bodily metaphors are 'mimic' (Solheim, 1998; Douglas, 1966). They copy their reference. Concrete behaviours are lifted above the concrete reality into wider meanings, based on resemblance. There is a likeness between something and something else, i.e. controlling appetite resembles controlling life, pure food may associate with purity of mind and spirit. To quote another anthropologic scholar, Gregory Bateson (1972), they are "metaphors that are meant", in the sense that they are experienced as 'real'. Inspirations from body-symbolic traditions will explicitly and implicitly be a reference in the scientific papers in this dissertation.

Summary of this section

In the understanding of interactions between body and mind in the case of eating disorders and anorexia nervosa we need to admit great shortcomings. The construct of embodiment is deliberately applied as a key concept in this dissertation, and briefly introduced here, with the hope that it can contribute as a mind-opener for the diversity and complexity of how the human body interacts with mental processes. Hopefully it might liberate us from explanatory narrow-mindedness.

The application of embodiment is a reminder of the human body as far more than physicality. And with some of its conceptual roots in the social sciences, embodiment may demonstrate to be useful when we aspire to understand better the strong influences of culture on as well prevalence as phenotypes of eating disorders.

SUMMARY

The aim of this introduction has been to present historical and theoretical concepts, empirical data and phenomenological descriptions in order to clarify the premises for how eating disorders and anorexia are understood and interpreted by the author; as the starting point for research questions and application of research methods in the studies constituting this

dissertation. The main and more detailed research objectives and research issues will be presented in the next chapter.

THE AIMS OF THIS STUDY

The main research aims of this dissertation are to contribute to:

- Better descriptions and understandings of the specific psychopathology of eating disorders, with particular emphasis on function of mind and psychological characteristics; and with particular emphasis on anorexia nervosa.
- To develop a more precise language about the human body's manifold roles in eating disorders. Such descriptions are subordinated under the theoretical concept embodiment. This is a wide and rich concept with emphasis on the body as a psychological, cultural and historical phenomenon, as well as a biological and material one. The aim is to further the understanding of the nature of eating disorders and anorexia nervosa, as well as more general understandings of body-mind interactions.
- Finally, use empirical findings combined with theoretical models in the systematic development of tailored therapeutic methods and techniques.

The study is based on six scientific articles. Five are about anorexia nervosa, while the sixth investigates body image disturbances and pathological body practices in an adolescent at-risk population. Each of the scientific papers have their own specified research questions and aims, all contributing to and defining more precisely the main research aims. Three of these six papers, 'Eating one's words I, II and III' (Papers 1, 2 and 3) are subordinated under a main category 'Reflective function and mentalisation in anorexia nervosa'.

REFLECTIVE FUNCTION AND MENTALISATION IN ANOREXIA NERVOSA.

PAPERS 1 – 3

The aim is to study function of mind in anorexia nervosa. There is particular emphasis on the mediating role of the human body in making mental representations. This section consists of three companion articles. Each of the three articles in the series can stand alone, with separate aims, topics and discussions. But in the context of this dissertation they should be read as a unity, as three parts of one study. Part I presents empirical data. Part II links these data and the interpretations of them systematically to relevant theories. Part III discusses findings from the

two first parts and uses them as a scientific basis for proposing therapeutic approaches designed for anorexia nervosa.

Paper 1

Eating one's words. Part I. 'Concretised metaphors' and reflective function in anorexia nervosa. An interview study.

The research aim is to elucidate function of mind in anorexia nervosa. The specific aim is to provide better understandings of the anorectic persons' psychological functioning, with emphasis on the interactions between mind and body, and between internal and external realities. The study also includes an investigation of the ascribed meanings, with reference to psychological, relational and/or existential contexts, of anorectic symptoms, as described by the patients themselves.

Paper 2

Eating one's words. Part II. The embodied mind and reflective function in anorexia nervosa. Theory.

The main purpose of this article is to develop a theoretical frame to explain and comprehend the empirical findings in Part I. In this Part II the main emphasis is on theoretical models describing compromised reflective function and mentalisation, as defined in Part I, and relating this to anorexia nervosa.

Paper 3

Eating one's words. Part III. Mentalisation-based psychotherapy for anorexia nervosa. An outline for a treatment and training manual.

This third article in the series of companion articles serves as the discussion section of Part I and II. The main aims of this Part III, is, firstly, to discuss how impaired mentalisation represents limitations for therapeutic and psychotherapeutic work with anorexia nervosa. And secondly, how an outline for psychotherapeutic enterprise with persons with anorexia nervosa can be developed, based on the principle that therapy should be tailored based on the psychological specificities of the psychopathology of the respective disorders. The aim of the paper is to propose psychotherapeutic goals, stances and techniques.

OTHER STUDIES. PAPERS 4 – 6

Paper 4

Shame and pride in anorexia nervosa. A qualitative descriptive study.

This study aims to further the understandings of embodiment in anorexia nervosa and deepen the descriptions of specific psychopathological processes proposed in the studies described above, by in detail describe and categorise the role of shame in this disorder. The more specific aim is to describe and categorise types and subtypes of shame, and their interactions with symptoms and meanings in anorexia nervosa.

Paper 5

“Bad boys” bodies. The embodiment of troubled lives. Body image and disordered eating among adolescents in residential childcare institutions.

The research aim is to describe patterns of pathological eating behaviour, dysfunctional body focusing and psychological symptoms in a sample of childcare residents compared with a non-clinical sample. There is a particular interest in eating disorders, body image disorders and related phenomena in wider gender and cultural contexts, e.g. males and immigrants.

Paper 6

Use the body, and forget the body. Treating anorexia nervosa with adapted physical activity.

The main research question is whether social interactions in activities and movement can move negative attention from the objectivated anorectic body to a more profound and subjective experience of one’s own body?

To sum up, the studies described in these separate scientific articles all contribute to the main research aims in this dissertation, by investigating and discussing different aspects of psychological function, psychopathology and therapy, with the main aim both to broaden and deepen the understandings of eating disorders and anorexia nervosa.

METHOD AND MATERIAL

This chapter will present and discuss the use of scientific methods in the thesis. The main focus will be an extensive use of qualitative research methods. In three of the six scientific papers (Papers 1, 4 and 6) qualitative research is the principal methodological approach. In the Papers 1, 4 and 6 there are discussions about the applied qualitative methods. These will partly be repeated here and partly extended.

First a general background for the use of qualitative research methods: Such scientific inquiry is founded on long and solid epistemological traditions, but it is rather new as a field in medicine. Qualitative research has during the last five decades established itself in the social sciences, and slowly in psychology and psychiatry as disciplines placed both in natural sciences (e.g. genes and biology of the brain), social sciences (e.g. social relations) and humanistic sciences (e.g. language, linguistics and philosophical positions on consciousness and perceptions of reality). And qualitative psychotherapy research represents its own discipline, expanding classic concepts of what is 'evidence-based medicine' (Skårderud, 2003 a).

Until recently, the field of qualitative methods was fragmented into different disciplines and traditions, often with communication gaps across the interpretative communities. "With an absence of common literature, procedures, and criteria, interviewers have to a large extent had to rely on their individual creativity" (Kvale, 1996, p. 9). This state of affairs has now changed with the increasing number of books, journals and conferences in this field. Cross-disciplinary works have been published (Creswell, 2007; Denzin & Lincoln, 2000; Flick, 2002 a,b; Kvale 1996, 2004). With the new literature, a common knowledge base is available for methodological and theoretical development.

The recently developed base of common knowledge in qualitative methods seems to be self-recruiting. It not only brings practical and theoretical guidelines for the accomplishment of studies, therefore recruiting researchers, but also contributes to research communities' self-confidence on behalf of these methods; as practitioners of 'good research'. Also technical reasons might be suggested for the current application of qualitative methods. Both developments of small portable tape recorders and computer programs facilitating qualitative analyses of transcribed interviews, have contributed.

Sophistication in qualitative inquiry is unevenly distributed in the scientific disciplines. What may be conceived as old news and common wisdom in anthropology may

be unknown or considered as unscientific in psychiatry. In parts of the medical and psychological society we still experience 1) a limited knowledge about qualitative research, and 2) a scepticism, and even resistance, concerning the scientific validity and quality. These two phenomena probably tend to be connected. But, it is a general impression that more medical and psychiatric journals stimulate the submission of scientific papers based on qualitative research methods.

Eating disorders and anorexia nervosa is a scientific field with an obvious request for both qualitative and quantitative methodological approaches. As a type of psychopathology it is based both in biology and culture. When dealing with the enigmas of psychiatric disorders, I have found the qualitative approach appropriate; searching the subjective experiences of patients as a ground for conceptual and theoretical development. This could later be a basis for the development of new research questions and instruments to be used in quantitative research designs.

The essential question in this section of the dissertation is: What about the quality of these qualitative studies? In scientific papers and dissertations methodological issues are often discussed in the Discussion section. Self-critical discussions on method are a fundamental aspect of qualitative inquiry. The researchers' explicit reflections on their research as a part of the process of knowledge production are at the very hearth of qualitative validation (Flick, 2002 a). Hence, The discussion on method is placed in this section, where method and material are presented. That gives the possibly of at the same time presenting and critically discussing applied methods.

OVERVIEW OF SAMPLES IN THE SCIENTIFIC ARTICLES

Paper 1

Eating one's words. Part I. 'Concretised metaphors' and reflective function in anorexia nervosa. An interview study.

Paper 1 reports from an interview study with ten female patients with the diagnosis anorexia nervosa. They were between 16 and 35 years at the time of the interview. Seven of ten had suffered from the restrictive subtype of anorexia (ANR), where the main symptom is restriction of food. The remaining three corresponded to the bulimic subtype (ANB), with episodes of bingeing behaviour. Body Mass Index (BMI) at the time of interview varied in a range from 10.8 to 17.2, median 16.2. Body Mass Index is $\text{weight}/\text{height}^2$. BMI less than 19 is defined by WHO as underweight. Nine of ten had their symptom debut, and had also been diagnosed before they were 18 years old. The tenth patient became anorectic 19 years old.

The patients had had the diagnosis anorexia nervosa from five months to 19 years, median 5.4 years. At the time of the interview all the informants were patients in the author's psychotherapeutic practice. The patients were diagnosed by me according to DSM-IV criteria (American Psychiatric Association, 1994). They presented a variety of comorbid states, like anxiety, depression and obsessive-compulsive disorder. None were psychotic. It is of particular relevance in this study to report comorbidity concerning Personality disorders. One anorectic informant was also diagnosed as Borderline personality disorder, one Avoidant personality disorder and one Personality disorder not otherwise specified. The informants were recruited consecutively from the authors' private practice.

Paper 4

Shame and pride in anorexia nervosa. A qualitative descriptive study.

Paper 4 is a related interview study with thirteen female patients with the diagnosis anorexia nervosa. Ten of the thirteen are identical to the persons interviewed in Paper 1. Hence, different characteristics are only slightly different, compared with information above from Paper 1. The informants were between the ages of 16 and 39 at the time of the interview. Eight of the thirteen patients had suffered from the restrictive subtype of anorexia (ANR), the main symptom being restriction of food. The remaining five corresponded to the bulimic subtype (ANB), with episodes of bingeing behaviour. Body Mass Index (BMI) at time of the interview varied in an interval from 10.8 to 17.6. Eleven had their symptom debut, and had also been diagnosed before they were 18 years old. One patient started with her anorexia at the age of 19. The last one experienced the onset of illness when she was 32, after a severe psychological trauma. The median was 6.4 years for the time they had had their diagnosis. At the time of the interview all the informants were patients in the author's psychotherapeutic practice. Concerning comorbidity of personality disorders, the situation was the same as reported in the sample above, in Paper 1. The three informants, who were recruited in addition to the study reported in Paper 1, did not fulfil criteria for Personality disorders. As above, the informants were recruited consecutively from the authors' private practice.

Paper 5

'Bad boys'' bodies. The embodiment of troubled lives. Body image and disordered eating among adolescents in residential childcare institutions.

This paper reports from a quantitative research study comparing a sample of childcare residents with a non-clinical group. The procedure for recruiting

Childcare residents

This study deals with the total population of adolescent clients above the age of 14 in residential childcare institutions in the municipality of Oslo, the capital of Norway. In the sample 36 (59%) were boys and 25 (41%) girls. The mean age was 16.2 years (SD 1.7) (range 14-21). Split on gender, the mean age was 16.6 years (SD 1.7) for girls and 16.1 years (SD 1.9) for boys. 64% had a Norwegian ethnic background, while 36% were defined as first- or second-generation immigrants.

Non-clinical sample

The comparison group consisted of 196 respondents, all above the age of 14, of which 78 were boys and 118 girls. The mean age of the non-clinical group was 15.5 years (SD 1.1), respectively 15.4 years (SD 1.1) for girls and 15.5 years (SD 1.9) for boys. This sample was chosen because they had already been investigated as a 'normal' reference with EDI-C.

Paper 6Use the body, and forget the body. Treating anorexia nervosa with adapted physical activity.

Seven female patients participated in this study. All of them fulfilled the criteria for anorexia nervosa according to DSM-IV. They had had their diagnosis for the last two to five years. The youngest patient was 14 years old, the oldest 19. Body Mass Index (BMI) varied from 13.8 to 16.9¹. None of these seven are identical with the patients used as informants in the other sub-studies. The seven patients were recruited from the Centre for Child and Adolescent Psychiatry. At the time of the intervention this was a national third-line institution. This means that the patients had first been treated in local (first line) or regional (second line) health services. Due to a lack of therapeutic progress, they were referred to this national centre and admitted. They were considered as serious cases of anorexia. There was also an eighth participant, but she was excluded from the report because she had bulimia as her main diagnosis. Two patients came from the outpatient unit for eating disorders, and the five remaining came from the specialized inpatient unit. The two from the outpatient unit were engaged in a therapeutic relationship with me, the author; the others not.

¹ The use of BMI as a reference is not a good parameter in adolescents, due to the individual variations in growth.

OVERVIEW OF RESEARCH METHODS IN THE SCIENTIFIC ARTICLES

Three of the six papers (Papers 1, 4 and 6) are based on the use of qualitative research methods with verbal material generated by semi-structured interviews as the main data sets. To some extent this method was supported by supplementary data, i.e. medical journals. Combination of data collection corresponds to the methodological concept 'data triangulation' (Denzin, 1989; Flick, 2002 a). Triangulation is an approach to increase the quality of research, i.e. to validate.

Paper 1

Eating one's words. Part I.

Analyses were performed on the basis of transcribed texts from research interviews. All procedures were conducted in accordance with the Helsinki declaration. The patients were informed about the content and purposes both in writing and orally. This was also the case before the interviews referred to in Paper 4 and Paper 6. In the interviews referred to in Papers 1 and 4 I was the sole interviewer, and also the therapist for these patients. Due to ethical reasons time was spent on underscoring for these patients that an eventual refusal to participate would not have any negative consequences for the treatment. And this was repeated several times, also in the beginning of the interview.

This interview study was based on the use of semi-structured interview guides. The guide was produced in such detailed way that it can be used by other interviewers. The interview guide included a few predefined issues. In the information given to the patients in advance, the following themes were presented:

- The history of your eating disorder with your own words. Attributions: Your ideas why you have got such a problem.
- Important turning points, to the better or worse.
- How the eating disorder inflicts on your life, negative or positive aspects.
- The interaction between emotions and cognitions and body shape, weight and food.

The guide also had more detailed proposed questions to be asked, but there was also an instruction that the guide should not be followed slavishly. The order and contexts in which these issues were entered into the conversation were often determined by the informants' natural developments of their stories. Issues not touched upon spontaneously by the interviewee, were brought up by the interviewer at the end of the conversation. In this way,

the interview guide worked more as a checklist of issues, than as a list of questions structuring the course of the conversation. Verbal data were not only produced by semi-structured interviews, but also by transcripts from four consecutive therapy sessions. That is an example of data triangulation. Denzin (1989) distinguishes four types of triangulation, where one form is 'data triangulation'. This refers to the use of different data sources, which should be distinguished from the use of different methods for producing data.

Based on the results in this interview study, Papers 2 and 3 function as extended discussions of the results, respectively as a theoretical discussion and as an outline for clinical application.

Paper 4

Shame and pride in anorexia nervosa. A qualitative descriptive study.

The design of this study is based on same principles as the study described above and presented in Paper 1. Different statements from the patients were categorised and interpreted as types and subtypes of shame and pride. In this study transcripts from therapy sessions were not employed as a data source. The descriptions above concerning the research interview is close to identical with procedures in the study presented in Paper 4. But in written and oral information in beforehand, and in the interview guide, there was a far greater emphasis on the topic of shame.

Paper 5

"Bad boys" bodies. The embodiment of troubled lives. Body image and disordered eating among adolescents in residential childcare institutions.

The childcare residents and the non-clinical comparison group completed the self-report questionnaire Eating Disorders Inventory – Child version (EDI-C). The childcare residents also completed an extended questionnaire, including questions regarding the use of Anabolic-Androgenic Steroids. These data were analysed statistically. Concerning the complete design of the study, see note². As a part of the procedure there were also arranged preparatory

² This study was designed and accomplished as a combination of quantitative and qualitative research methods. Five of the adolescents with highest scores on symptom scales on the self-report questionnaire EDI-C were selected for semi-structured qualitative interviews. But Paper 5 does not include the analyses of these transcribed interviews. These will be presented elsewhere (Nygren & Skårderud, manuscript).

information meetings for staff, discussing practical, logistical as well as ethical aspects of the research work.

Paper 6

Use the body, and forget the body. Treating anorexia nervosa with adapted physical activity.

Also in this qualitative interview study a considerable amount of time was spent to inform both patients and staff about the study and the physical activities to be assessed; and on ethical issues, i.e. the possibility of any time to say no to participation without any negative consequences for the patient and the treatment. All interviews were taped. The patients were particularly informed about being free to stop the tape-recorder at any time if there was something they did not wish to reply to, if they needed a break or wanted to change their answer. The interviews were carried out by one of the authors (LD). Each patient was interviewed twice, on arrival and on departure to Beitostølen Health Sport Center (BHSS).

The interview guide for the first interview was focused on the following topics:

- Expectations regarding the stay at the BHSS.
- Previous experiences with sport and athletics.
- Experience of one's own body.
- Body ideals.
- Situations where one's preoccupation with the body is particularly extensive.
- Interests and social life.

The interview guide for the final interview centered on experiences from the stay. These included:

- Which situations and activities had which effects on the preoccupation with the body.
- Social interplay.
- Experiences of mastery and failure.

To enhance the scientific quality the design of this study was based on data triangulation, theory triangulation and also what Denzin (1989) and (Flick, 2002 a) describes as

‘investigator triangulation’³. This refers to that different observers or interviewers are employed to enrich the analyses and also to detect or minimise biases resulting from the researcher’s person. Actually it also includes ‘methodological triangulation’. Data triangulation refers to data both from interviews and from written reports from instructors/observers. The main material is transcribed verbal data from two sets of semi-structured interviews with the female adolescent patients, at the beginning of the intervention and immediately after the intervention. This was an intervention study investigating experiences of applying Adapted physical activity for a group of patients with anorexia. The instructors accomplishing these activities also functioned as observers, recording their observations in written reports on separate observation schemes. Investigator triangulation refers to how interviews were accomplished by one of the researchers (LD), categorisation and interpretations were first done separately by the two authors (LD and FS), then compared and coordinated.

ETHICAL ISSUES

With reference to Paper 5 a possible ethical issue in research of this kind is to expose persons to questionnaires about vulnerable and controversial topics, like body image, negative self-evaluation and psychiatric symptoms. A more specific ethical dilemma may arise out of the research design applied in Papers 1, 4 and 6 (regarding two patients), where the informants at the same time were patients in the researcher’s psychotherapeutic practice. The dual role as patient and informants, respectively as therapist and researcher, may represent the risk of some patients being afraid of denying taking part in the study. They may have feared negative consequences of saying no about participation to their therapist, who they to various extents may have felt dependent upon; or experienced mixed feelings towards. The way of addressing such ethical issues are partly described above, and the dual role of therapist and researcher will be further discussed later in this chapter.

A possible ethical dilemma in the study presented in Paper 6 might have been that adapted physical activity represents increased activity compared with the hospital setting they all were in before the intervention described in the study. And without the patient being able

³ In Denzin’s (1989) terminology this refers to different methodological approaches. In addition to semi-structured interviews, the research protocol included medical and laboratory examinations and self-report questionnaires Eating Disorders Inventory – Child version (EDI-C) and Body Attitudes Test (BAT). But analyses of these results are not included in the paper.

or willing to compensate increased use of energy with increased intake of food, such research intervention may contribute to weight loss, and thereby deteriorated medical state. Weight was followed on a regular weekly base before, during and after the intervention, and there were none significant weight changes connected to the intervention. But the result could have been different. A practical way to deal with such challenges was negotiations with the patients about the necessity of moderate changes in their daily amounts of food.

THE QUALITY OF QUALITATIVE RESEARCH

In the studies presented in this dissertation conversations, in the sense of research interviews and transcribed therapy sessions, are at the centre of the qualitative research methods (Fog, 2004). And ‘hermeneutics’ represent a philosophical basis for the inquiry. Hermeneutics refers to the process of interpretation, and originates in a scientific context from interpretation of texts. The aspiration is to seek meaning, deeper than the ones that immediately appear. From a hermeneutical understanding, the interpretation of meaning is the central theme, and the “concepts of *conversation* and *text* are pivotal” (Kvale, 1996, p. 38). The interpretation of meaning is characterised by a ‘hermeneutical circle’. The understanding of a text takes place through a process in which the meaning of the separate parts is determined by the global meaning of the text.

In the actual context of this dissertation: The research interviews and the therapy sessions are conversations about the human life world, with the oral discourse transformed into texts to be interpreted. To quote Kvale (1996, p. 46): “Hermeneutics is then doubly relevant to interview research, first by elucidating the dialogue producing the interview texts to be interpreted, and then by clarifying the subsequent process of interpreting the interview texts produced, which may again be conceived as a dialogue or a conversation with a text.” Firstly, the dialogic practice in the interviewing and therapy sessions with the elaboration of themes, with patients being invited to describe, reflect upon and interpret their own personal realities, represents a hermeneutical practice. Secondly, there are the analyses of the transcribed texts. Such analyses deal with how these texts are to be understood and interpreted, and in this case categorised and organised in clusters. There are striking similarities between hermeneutics in social sciences and humanities and psychotherapeutic practices with emphasis on the co-development of meaning and understanding. Such perspectives are relevant for this study with the researcher also being a therapist.

Verification

Hermeneutic approaches have historically had an uneasy relationship with the natural scientific approaches. It has not been accepted as ‘real research’. For some, considerations of qualitative research prompt thoughts of relativism and loosely established truths. A charge is often made that there is no way to establish the validity or truth value of scientific claims or observations in qualitative work (Jessor, 1996). It is in the context of such tensions one saw the development of ‘a third road’ of inquiry – qualitative research. This has meant the systematic development of methods and techniques.

Verification of knowledge is in quantitative research commonly discussed in relation to the concepts of ‘generalizability’, ‘reliability’ and ‘validity’. This trinity is not immediately transferable to qualitative research, given epistemological differences between the approaches. But gradually develops a scientific literature reformulating these concepts within the contexts of qualitative inquiry (Fog, 2004; Flick, 2002 a; Kvale, 1989, 1996; Eisner & Peshkin, 1999).

Based on such literature my way of translating a concept like validity into the practice of qualitative inquiry is that validation rests on the quality of craftsmanship in research. This approach represents a de-mystification of the concept of validity, bringing it back from philosophical abstraction down to everyday practice. *To validate is to convince the critical reader that the research results are direct and probable consequences of the research process itself, and not more or less random statements.* It is a matter of credibility. Done in proper ways such research is time-consuming and often difficult.

The quality of craftsmanship has to be secured in all steps of the research process. Kvale (1996) describes seven steps: Thematising – Designing – Interviewing – Transcribing – Analysing – Verifying – Reporting. To validate is to make good descriptions of the consecutive steps in the research progress. The consecutive paragraphs will describe and discuss procedures and present strength and weaknesses, pros and cons, related to some of these steps.

Thematising and designing

The application of a scientific method is secondary to the research questions. The *why* and *what* is prior to the *how*. The author has long experience in clinical work with eating disorders and particularly anorexia nervosa. This experience has contributed to the conviction that research and clinical literature insufficiently explain the specific psychopathology and with particular reference to the bodily concretisation of mental life in eating disorders. A basic

assumption was the metaphorical relation between body and mind. The basic aim of this research has been to develop better *descriptions* referring to these phenomena, based on eating disordered patients' subjective experiences. The design was founded on a 'patient-as-expert-perspective', where the patient was regarded as an expert on her own experience. Assuming that there is a difference between perception, feeling, and thinking, and the use of language, the aim was to provide descriptions as close to the informant's subjective experience as possible. The aim has been to contribute with *relevant* knowledge on a descriptive and conceptual level for further empirical research and further development of theory, not necessary knowledge that is representative on a statistical level. For that purpose a phenomenological, descriptive, and qualitative study design with elements of Grounded theory (Strauss & Corbin, 1998) applied on a limited number of informants was considered as beneficial. In the initial phase of thematising and designing the research approach was not strictly linked to any specific theory, although the researcher is biased in the sense of being trained as a psychiatrist and psychotherapist, with emphasis on 'internal realities' and the dynamics of psyche.

The overall design was set up not to test explicit hypotheses, but to be explorative. The study presented in Paper 6 represents an exception. In this case a theoretical and philosophical model was applied on a clinical material, actually to explore whether a clinical intervention introducing social interactions in activities and movement could move negative attention from the objectivated anorectic body to a more profound and subjective experience of one's own body?

Sample size

In the three different interview studies the number of informants are respectively ten (Paper 1), thirteen (Paper 4) and seven (Paper 6). A common critique of qualitative research is the limited number of interviewees. Such a critique may be relevant in the sense that one aspires to be representative. One needs to be aware of the risk of extrapolating observed phenomena in a very limited clinical group to be pervasive for the whole clinical population fulfilling the criteria for the same diagnosis. The selected group may be skewed or in some sense atypical.

From a strictly scientific position, the results from analyses can only be referred to as saying something about these samples, and nobody else. Bigger samples could have enriched the picture. Strauss & Corbin (1998) have developed a model for deciding sample size based on criteria for 'data saturation'. New informants in interview studies should be included until three subsequent interviews have been conducted without essential new information being

added. Such an approach was not used in this dissertation. It might have been desirable, although there is some uncertainty about how to estimate what is actually 'essential new information'. In this dissertation such procedures were not followed due to practical reasons. The actual samples were based on patients available. The informants were recruited from two settings, respectively the author's private practice with a restricted number of persons to ask (Paper 1 and 4), and the last sample (Paper 6) were the actual patients at a specialised inpatient eating disorders unit at a specific time; where the two last recruited from the outpatient service at the same institution. Another practical aspect is that a large sample represents a huge load or work. Kvale (1996) warns against the '1 000-page question'. Many transcribed pages may represent such a load of work that it undermines the depth and thoroughness of the analyses.

On the other hand, the criticism for using a limited number of informants may not be that relevant for much qualitative inquiry and for this dissertation. Criteria for quality in quantitative research should not uncritically be adopted on qualitative research. The ambition is to search for relevant, new knowledge. Such knowledge may be valid without necessarily being representative for a larger group or a population. The question of generalizability could be investigated in later steps preferably with quantitative methods. A case study design with $n = 1$ could also contribute significantly to knowledge. And an 'atypical' informant may contribute more than a 'typical' informant. A main objective here is to elucidate the richness of phenomena as such. (And the complex phenomenon of embodiment in anorexia nervosa may represent an extreme case that helps us to understand general aspects of human embodiment in non-clinical populations.) In qualitative research a sample of interview subjects may not have been chosen at random, but by criteria as typicality of extremeness. This was the case when we selected five adolescents for qualitative interviews in our project with childcare residents. As described in Note 1 these analyses are not reported in Paper 5.

Interviewing and data collection

In Paper 1 verbal data were not only produced by semi-structured interviews, but also by transcripts from four consecutive therapy sessions. After transcribing, statements from both scientific interviews and therapy sessions were categorised. And then they were interpreted with reference to theoretical and empirical constructs referring to reflective function. Based on the results in this interview study, Papers 2 and 3 function as extended discussions of the results, respectively as a theoretical discussion and as an outline for clinical application.

The three companion articles as a unity (Papers 1, 2 and 3) not only apply data triangulation, but also what Denzin (1989) denotes as ‘theory triangulation’. Theory triangulation refers to approach “data with multiple perspectives and hypotheses in mind ... Various theoretical points of view could be placed side by side to assess their utility and power” (pp. 239-240). Particularly in Paper 2 the results presented in Paper 1 are discussed within different theoretical contexts.

Various modes of checking have been suggested as a validation technique by writers on qualitative research (Kvale, 1989, 1996, 2004). In the interviews performed by my co-researcher (Paper 6) and myself (Papers 1 and 4) we adapted a stance of checking. The method of interviewing was to stop up after some of the answers, to repeat, confirm and clarify, and to go deeper into presented topics. This corresponds to what Kvale (1996) calls ‘communicative validity’ or ‘member checks’ (Denzin & Lincoln, 2000). The patients were invited to go back to their statements and make changes where one presumed possible misunderstandings. The interviews were performed in a way so that we tried to stimulate the patients’ own elaboration of the topics, helping them in non-instructive ways to find own formulations and to try to elucidate their perspectives by examples.

In such ways there was a very close resemblance between the approach in interviewing as a researcher and in my own dialoguing as a therapist. This is a probable background for not finding important differences in the materials respectively from research interviews and transcribed therapy sessions in Paper 1. In the analyses the interviews and transcribed therapy sessions were originally treated as separate data sources. The same process of analysing, as described detailed in Paper 1, was carried out for both sets. But in the finishing phase the main categories were integrated. The two text materials did not differ markedly in content, more in form. This can easily be controlled by the extracted texts and ‘nodes’ created in the different text sources in the data program. The slight differences in form refers to that the transcribed texts from the therapy sessions were more fragmented, while the texts from the interviews gave more coherent narratives addressing the research questions.

Analysing and verifying

All interviews and the consecutive therapy sessions were transcribed verbatim. As a support for the qualitative text analysis we/I have used data programs for text analysis. In the study presented in Paper 6 we used Textbase BETA (Sommerlund, 2001), and in the studies presented in Papers 1 and 4 I used NVivo (Gibbs, 2002).

Pros and cons of bias

In these two studies on reflective function and shame, Papers 1 and 2, I was the one and only to code and analyze. An argument *against* such a procedure, coding own material, may be that the researcher/therapist is biased. Hence, a coder not that involved with the informants and the interview procedures could see with ‘fresher’ eyes. And the researcher particularly interested in the topics to be investigated may also be biased in the sense of being oversensitive for these topics.

An argument *supporting* such a procedure is that the researcher/therapist is biased. I am biased in the sense that I have memories from the interviews, also including non-verbal information, affective states etc. This may open up for richer interpretations. And I am biased in the sense that I do know the patients well, also with the possibility of stimulating the researcher’s sensitivity to information. An additional source is also medical data and process notes from their medical journals. Such data were not actively used in the analysis. But they also represent a bias by contributing with a wider context for interpretations.

In qualitative research, bias, the researchers’ cultural, personal and professional pre-conceptions, should not necessary be eliminated or minimised. But it should be reflected upon and expressed; as being tried here (Malterud, 1996). And the concept of ‘reliability’ from quantitative research is not necessarily relevant in similar ways in qualitative inquiry. As the discussion above may indicate, the ambition of two or more coders’ reliability could represent an obstacle to rich and in-depth analyses.

In the study reported in Paper 6 we chose a slightly different approach, since we were two researchers to analyse and code the texts. The two of us compared and discussed our respective codes and interpretations, discussing differences and consensus. Hence, in this case communication is a part of the validation process. This also corresponds to Kvale’s (1996) ‘communicative validity’.

Computerized support in validation

The computerized support enhances overview and practical order in complex materials. And the data programs facilitate validation procedures. This can be illustrated with an example from the analyses of material presented in Paper 1. The research aim was to bring forth descriptions of concretization of emotional life in anorexia life; the closeness between bodily experiences and emotional life. After repeated readings of each interview, each text was explored by thematic coding (Fraser, 1999). Firstly, all statements involving food and/or body were marked. The computer program is based on making ‘nodes’. This part of the analysis

selected excerpts from the text with reference to two basic nodes, 'food' and 'body'. That includes all kinds of mentioning of these topics. The next step was a further selection of all of these statements that made a connection between food and/or body and descriptions of emotions or cognitions, i.e. "an empty stomach gives me a sense of being strong". The third step in the analysis was a further selection of those of the statements which contained direct descriptions or indications of a similarity between the emotional-cognitive state and a sensorimotor experience, i.e. "controlling my appetite gives me a feeling of control in other areas of my life". A fourth step was to categorise such body metaphors; to arrange the different units of meaning into categories. New nodes were created consecutively in the analytical work, defining different forms of body metaphors. Finally these categories were organised in hierarchy, in relation to superior common categories.

Hence, this way of analysing is based on a 'bottom up principle'. All the developed constructs were then validated by testing each of them against the original text. This confirmatory process followed the 'top down principle'. In this process, the higher order categories were applied on each full text excerpt that had been a part of constructing them. The purpose of this procedure of 'translating back' was to control that the generated construct definitions fitted with the original text and to detect needs for adjustments or supplements. A result of this process was the recognition of possible overlaps between categories. The same or very similar statements could contribute to more of the categories. It can be difficult to distinguish between some of the categories; like between the 'Emptiness' and 'Purity' or between 'Control' and 'Protection', see Paper 1. Hence, the constructs are not reciprocally expelling, but rather different punctuations of the anorectic experience.

The analyses of shame affects in Paper 4 also followed the same 'bottom up principle'. It is interesting from a methodological perspective that the scope of the investigation was expanded during the analyzing process. The research aim was originally to investigate shame. But some patients also presented statements that could be categorised as "opposite to shame". In addition to negative, shameful experiences more of them also described positive experiences related to being a person with anorexia nervosa. Their anorectic symptoms and behaviour made them proud. Hence, to contribute to a richer picture of such self-evaluation the research scope was expanded to also include pride.

Theory as validation

According to Denzin (1989) another way of validation is to theorize. Concepts and interpretations do not exist in vacuum. They are contextual, and an essential part of the

context will often be theory. In this dissertation the most explicit example of theorizing as validation is the process of linking empirically based constructs with theoretical models as reported in Paper 2. Although one will always be biased to some extent by overt or covert theoretical concepts, the basic approach was to openly search relevant theories to further develop the empirically developed constructs. Concretely, this was done by searching in data bases, e.g. using ‘embodiment’, ‘body metaphor’ as key words. And it was done in conversations with professionals and researchers working in different disciplines, inside and outside the discourses of eating disorders, medicine and psychiatry. This is expressed explicitly in Paper 2 referring to theoretical concepts from different traditions as cognitive science on embodied mind and psychoanalysis. In Paper 6 theory is used in a different way. The use of body-phenomenological philosophy in that study 6 is an illustration of how a body-phenomenological philosophical position was fundamental for operational concepts, research hypothesis and intervention.

Dual role as therapist and researcher

Self-criticism is a part of validation, trying to falsify one’s own work and search for possible invalidity of findings. In this final section of the presentation and discussion of applied methods, I will deal with my dual role as therapist and researcher. It is of particular methodological interest that respectively the ten informants in Paper 1, the thirteen informants in Paper 4 and two of the informants in Paper 6 were recruited from the author’s psychotherapeutic practice.

There are certain basic differences between the roles of clinician and researcher. For the researcher, the goal is the generation of knowledge. For the psychotherapist, the patient’s therapeutic improvement is the goal (Fog, 2004). In combining both, one must serve two masters. This might raise dilemmas of ethical and scientific character. These must be addressed in every material instance. In the discussion about the dual role as therapist and researcher in this dissertation there are possible pros and cons, weaknesses and strengths; due to biases in both parts, interviewer and interviewed. I did not see any ethical or scientific objections so strong that they were decisive for not performing this research with such methods. Anyhow, the first lines will be about ‘cons’:

Cons

Psychotherapy can be described as an intersubjective co-construction of meaning. As a critique with reference to scientific validity one must be willing to accept that the patients

have, in varying degrees, assimilated terms, expressions, fragments or entire modes of reasoning that form part of the therapist's/researcher's preconceptions. When the therapist accomplishes research interviews with his own psychotherapy patients, there is already a dialogical process going on; where research and therapy cannot distinctly be separated. This may contribute to circular 'proofs'. And the patients' answers in the research context may also be conscious of less conscious communication to the therapist, referring to issues outside the scientific context. One may critically state that anorectic patients are a 'risk group', often described as being 'over-compliant' in relationships. This may be aggravated in a therapeutic context where the patient may feel dependent upon or grateful to the therapist. A patient-therapist relationship is far from a symmetrical relationship, and therefore includes the issue of power. The group as such, persons with anorexia nervosa, is described as outer-directed, sensitive to and dependent on other's needs and views (Buhl, 1990).

And, also contributing to scientific invalidity, there is the possibility that the patient-therapist relationship is not well-functioning at the actual time. This may represent negative or complex affects on both sides. Hostility or a sense of inferiority may inhibit the patient's free elaboration on issues presented in the research interview; or acting out in the interview setting. Or, a difficult emotional climate at the time of interviewing may influence the researcher's freedom, openness and curiosity in the role as interviewer.

Pros

The following lines will be about 'pros'. It is my statement that the nature of the research task is such that it is compatible with therapeutic aims: The patient's improved self-understanding and articulation of her own situation. In fact, a change of the context for the dialogue may itself be advantageous for the therapeutic process. The research practice takes its place in a context – an ongoing therapeutic relationship – which is basically oriented towards increased self-understanding and insight. In that manner, the two different contexts may be seen as partial aspects of a common context of inquiry and introspection. Contexts contribute to constructions of meaning. Some of the patients referred to the role of being an informant as different from the role of patient, pointing to the feeling of being estimated as a person with *important and valuable* life experiences. And the patients'/informants' experiences of two rather related, but not identical contexts for dialogue and inquiry may stimulate experience of differences and eventually stimulate self-reflection, being able to see oneself in different roles.

And within the practical context of psychotherapy I consequently spent some time in the first or one of the first sessions immediately after the research interview to discuss the experience of being in a different role in relation to me, and me being in a different role towards them. The motivation for this was threefold: 1) On an ethical basis to check that this had not been a negative experience. 2) On a scientific basis discuss their experience of being in such a role, and being able/not able to express themselves in satisfactory ways, and 3) on a therapeutic basis to stimulate self-reflections about oneself operating in different roles and realms.

An established patient-therapist relationship, if experienced as safe enough by the patient, may be a particularly good context for the patient to relax and try to develop true subjective versions. And the experienced therapist knowing the patient will probably be aware of such traits in the patient's behaviour. In this way the dual role may contribute to the validity of research.

It is my conviction that the dual role was particularly beneficial for scientific quality when the topic was personal shame; and actually increased the validity of the research process. Generally in shame research there is an ethical and practical issue connected to face-to-face interviews about shame. Shame is usually connected to concealment and silence. The shameful does not want to speak about one's own shame. The ethical dilemma in this type of face-to-face interviewing is that it may induce shame in already shame-prone individuals. The practical problem, on a methodological level, is that shame in the academic interview context with strangers decreases the likelihood of aspects of shame being divulged. There is research evidence that respondents may feel uneasy when responding to questions about shame (Andrews, 1998). Because an established patient-therapist relationship presumably represents a safer environment for the patient, being interviewed by one's therapist may improve research validity and also reduce stress in the interview situation.

In his paper "The psychoanalytic interview as qualitative research", Kvale (1999) draws attention to extensive parallels between qualitative research and the psychoanalytic interview, such as knowledge production through interpersonal relations, a focus on psychopathological phenomena, generalizations from case studies, and validation through communication. The psychoanalytical interview comes in important aspects close to conceptions of knowledge developed within existential and hermeneutical philosophies and epistemological traditions emphasising 'subjective truths' and co-construction of narratives. Kvale underscores the influence of the interpersonal interaction of the interview situation. This concerns the importance of extensive knowledge of the research participants and their

life situation over longer periods of time for making sound bias for interpretations and for critically validating interpretations of the participants' statements. One thing is to know the patient. An additional probable advantage is knowledge about the kind of psychopathology involved.

Skills as psychotherapist also mean to be experienced and educated in interviewing groups with different problems. Practically all psychiatric problems affect in a negative way relationships and the capacity of free interpersonal communication. My personal bias as an interview researcher, interviewing patients with anorexia nervosa and eating disorders, is more than twenty years with psychotherapeutic enterprise with this diagnostic group. This may mean many blind spots, in the sense that internalised theoretical and working models select information, with the tendency to self-confirmation.

On the other hand, clinical experience and a fair knowledge of scientific and clinical literature on this particular diagnostic group may mean an increased awareness of possible obstacles and pitfalls in interpersonal communication. E.g. the therapeutically trained interviewer knows about the probability of alexithymic traits – 'no words for feelings' – in eating disorders; or the tendency to 'over-compliance'. This knowledge may be expressed in an interview stance regulating one's activity, patiently helping the patient to elaborate descriptions, guide the use of concrete in stead of abstract concepts, work with examples, use curiosity in a supportive and playful mode and spend necessary time elaborating. In practical terms it may mean 'not accepting' the first response, but then to go to new questions.

In a therapeutic context this may simply be called therapeutic, in the sense of stimulating minding minds and minding bodies – one's own and others. In a research context this could lead to richer material, and may be named validation.

SUMMARY OF MAIN RESULTS PAPERS 1 – 6

REFLECTIVE FUNCTION AND MENTALISATION IN ANOREXIA NERVOSA. PAPERS 1 – 3

Paper 1

Eating one's words. Part I. 'Concretised metaphors' and reflective function in anorexia nervosa. An interview study.

The specific research aim of this interview study with ten female patients with anorexia nervosa was to provide better understandings of the anorectic persons' psychological functioning, with emphasis on the interactions between mind and body, and between internal and external realities. The many quotations from patients demonstrate immediate connections between physical and psychological realities. Different 'concretised metaphors' were described and categorised, covering a wide range of bodily experiences and corresponding emotions. The occurrence of various 'concretised metaphors' in these cases proposes reduced symbolic capacity and impaired reflective function as a core psychopathological trait in anorexia nervosa. To understand the specific psychopathology of anorexia nervosa one should not only look for the possible meaning of anorectic behaviour, but for reflective function itself; the compromised capacity of making mental representations.

The transcripts from the interviews demonstrate a possible two-way direction in the metaphoric process. Bodily experiences induce emotional and cognitive experiences, like the feeling of hunger may induce satisfaction. But emotions may also induce bodily sensations, like the urge to bodily purification in complex social situations, or the feeling of bodily expansion in stressful situations.

The many different categories of body metaphors demonstrate a 'polysemic' character of embodiment in anorexia nervosa. 'Polysemi' means that the sign refers to more meanings. A symptom can mediate different meanings, even contradictory, also for one and the same patient. This demonstrates an ambiguous nature in body symbolic in these cases of anorexia nervosa. There is no closed and unequivocal relationship between symptom and meaning.

Paper 2

Eating one's words. Part II. The embodied mind and reflective function in anorexia nervosa.

Theory.

The main purpose of this article was to develop a theoretical frame to explain and comprehend the empirical findings in Part I. Anorexia nervosa as a psychiatric disorder presents itself through concreteness of symptoms. Emotions are experienced as a corporeality here-and-now. In anorexia nervosa there is a striking closeness between emotions and different bodily experiences. This is interpreted as impaired 'reflective function', referring to the capacity to make mental representations, and is proposed as a central psychopathological feature. In this Part II the main emphasis is on psychodynamic models describing compromised reflective function and impaired mentalisation, and on relating these to the phenomenology of anorexia nervosa. The psychodynamic concepts 'concretised metaphors' and 'psychic equivalence' are discussed as useful tools to better understand such compromised symbolic capacity. Psychotherapy in anorexia nervosa can be described as a relational process where concretised metaphors will be developed into genuine linguistic ones. Psychotherapy with individuals who demonstrate compromised reflective function should be focused on helping them patients build this interpretive capacity. One way of conceptualising the psychotherapeutic enterprise in anorexia nervosa is as an activity that is specifically focused on the rehabilitation of this function.

Paper 3

Eating one's words. Part III. Mentalisation-based psychotherapy for anorexia nervosa. An outline for a treatment and training manual.

This third article in the series of companion articles presents more extensively the theoretical and clinical concept mentalisation, and discusses how impaired mentalisation represents limitations for therapeutic and psychotherapeutic work with anorexia nervosa. An outline for psychotherapeutic enterprise with persons with anorexia nervosa is presented, based on empirical and theoretical material from the two preceding papers in this series. The outline is based on the principle that therapy should be tailored based on the psychological specificities of the psychopathology of the respective disorders. The paper proposes psychotherapeutic goals, stances and techniques.

OTHER STUDIES. PAPERS 4 – 6**Paper 4**Shame and pride in anorexia nervosa. A qualitative descriptive study.

Based on statements from thirteen female patients with anorexia nervosa ‘globalised internal shame’, different subtypes of ‘focal shame’, and different subtypes of ‘pride’ were categorised. Shame is described both as cause and consequence in relation to symptoms in anorexia nervosa. Descriptions of interactions between eating disorders and negative feelings of shame were described and categorised as a shame-shame cycle. Shame may lead to more shame. This is described as factors maintaining and possibly aggravating the illness, a self-perpetuating cycle. Descriptions of interactions between eating disorders and positive feelings, which in this study were limited to being defined as a sense of pride, were described and categorised as a shame-pride cycle. This is described as emotional conditions under which the illness is maintained and which possibly leads to insufficient, weak or unstable motivations of patients to become well. The paper concludes with the statement that the use of shame, as well as pride, as concepts in regard to anorexia nervosa, and including these emotions in functional analyses with reference to motivational issues and possible aggravation and maintenance of the disorder, may improve our understanding of the nature of anorexia nervosa, as well as being a guideline for therapists.

Paper 5“Bad boys”” bodies. The embodiment of troubled lives. Body image and disordered eating among adolescents in residential childcare institutions.

The aim of this study was to describe patterns of pathological eating behaviour, dysfunctional body focusing and psychological symptoms in a sample of childcare residents compared with a non-clinical sample. The study investigated a population with more or less well defined risk factors in their personal histories. There was a particular interest in males and immigrants. Main findings were high scores on EDI-C symptom scales for boys in the childcare resident group; few differences between girls in the two samples; and high frequency of having used Anabolic-Androgenic Stereoids among boys in childcare.

Boys in the childcare sample scored significantly higher on eight of eleven scales in the EDI-C questionnaire, compared with boys in the non-clinical sample. The gender differences on the symptom scales in the non-clinical sample, where girls scored higher than boys, were expected with reference to the research literature. But such differences were not found in the group of childcare residents. Here the boys approached the levels of girls. There

were interestingly few differences between childcare girls and girls in the non-clinical sample. Based on the knowledge about risk factors for eating disorders and dysfunctional body preoccupation, such as trauma, neglect and other psychiatric symptoms, one would expect higher symptomatic levels in the childcare group.

In regression analysis the psychological subscale Ineffectiveness (I) was an important predictor for EDI-C symptom scales for both boys and girls in the childcare sample. With one exception, the subscale Perfectionism (P) for boys, ethnicity was not a variable associated with significant difference within the childcare group.

Body image problems among boys have hitherto been given little attention. In conclusion, the paper calls for increased efforts in describing and detecting pathological cognitions, emotions and behaviour concerning the body in males in general and, more specifically, in high-risk male groups, such as childcare residents.

Paper 6

Use the body, and forget the body. Treating anorexia nervosa with adapted physical activity.

The research questions in this explorative study were: In which ways, in which forms and contexts may adapted physical activity be clinically useful to whom within the group of anorexia nervosa patients? Can social interactions in activities and movement move negative attention from the objectivated anorectic body to a more profound and subjective experience of one's own body? The activities, which reduced the patients' negative attention towards their bodies, were focused on relations to others, they were non-competing and not predictable. The activities, which provoked negative bodily attention were those of the opposite, individually based, focusing on results and predictable. The paper concludes with the need for further research on different forms of physical activities, in different contexts, as a supplement of psychotherapeutic enterprises. Physical activity is existential and has several aspects including non-physical.

DISCUSSION

The main research aims of this dissertation, as described, were to contribute to:

- Better descriptions and understandings of the specific psychopathology of eating disorders, with particular emphasis on function of mind and psychological characteristics; and with particular emphasis on anorexia nervosa.
- To develop a more precise language about the human body's manifold roles in eating disorders. Such descriptions are subordinated under the theoretical concept embodiment. This is a wide and rich concept with emphasis on the body as a psychological, cultural and historical phenomenon, as well as a biological and material one. The aim is to further the understanding of the nature of eating disorders and anorexia nervosa, as well as more general understandings of body-mind interactions.
- Finally, use empirical findings combined with theoretical models in the systematic development of therapeutic methods and techniques.

This discussion section will try to elucidate how these main research questions have been answered. The three main aims, as quoted above, will be discussed separately in three sections; although the different phenomena are closely related.

REFLECTIVE FUNCTION AND MEANING

This first section of the joint discussion of all papers will comment on the following main research aim:

- Better descriptions and understandings of the specific psychopathology of eating disorders, with particular emphasis on function of mind and psychological characteristics; and with particular emphasis on anorexia nervosa.

The papers in the thesis most explicitly addressing this research question, Papers 1 – 4, deal with anorexia nervosa, and, therefore, the comments here in this section will mainly refer to these papers and mainly to anorexia nervosa.

There is a wide agreement that the psychopathology of anorexia is not satisfactorily understood. Operating explanatory paradigms have obvious limitations. Cognitive therapy traditions experience the shortcomings of describing this specific psychopathology as an expression of dysfunctional cognitions. Systemic approaches lack scientific basis for hypotheses saying that particular family patterns are linked to the development of the disorder. Psychodynamic traditions may impress by metaphors describing the meanings of symptoms, but such metaphors are constructions in language and their validity may be questioned. And the neuropsychological inquiry into anorexia nervosa is still in its birth phase. Collier and Treasure (2004, p. 363) write that “little is known about this aetiology, particularly its biological components, and this is severely hampering the development of new treatments”. An evolutionary approach, based on the idea that behaviour in some way is beneficial for survival, concludes with anorexia nervosa as “an evolutionary puzzle” (Gatward, 2007).

Self disorders

Given the pervasive character of the concretisation of mental life, clearly demonstrated in the empirically based Paper 1, *it is proposed that impaired reflective function is core to the psychopathology of anorexia nervosa*. More than that, when one wants to illustrate forms of impaired reflective function in a model of mind, anorexia is an exemplary case. Just because of the explicit bodily concretisation of emotional life, anorexia most precisely illustrates modes of experiencing psychic reality. Descriptions from the empirical field of anorexia nervosa and eating disorders can enrich the general understanding of reflective functioning. It is a basic assumption here that the mental experiential world is a representational structure, and that the function of the mind is to produce and elaborate representations. Concerning the psychopathology of anorexia, based on empirical results in this dissertation, one may formulate the realms of representation radically simplistic: There is the *how* of representation, and there is the *what* of representation.

A main contribution here is to focus on *how*. Such an emphasis supports the description of anorexia nervosa as ‘self disorders’; i.e. representing dysfunctions in self-organisation and self- and affect regulation (Grotstein, 1986, 1987). Defining anorexia nervosa in this way stimulates the search for common traits with other forms of severe

psychopathology. The reference to common traits in psychological functioning in anorexia nervosa and other 'self disorders', like personality disorders, stimulates *transdiagnostic* thinking. Today, there is a risk of isolation and short-sightedness in professional milieus working with anorexia nervosa and severe eating disorders.

Reflective function

The *how* of representation

Being aware of methodological limitations, the categorised statements from ten female patients with anorexia nervosa strongly refer to a particular form of psychological functioning. These anorectic discourses demonstrate how, in the sense of immediate connections between physical and psychological realities. Feelings are experienced as feelings, but also as bodily and sensory correlates. And the sensitive focus on bodily qualities and experiences induce emotional reactions.

The statements from the patients do not function mainly as metaphorical representations capable of containing an experience, but as presentations which are experienced as concrete facts here-and-now and difficult to negotiate with. The representational quality of the more abstract meaning of the metaphor is lost and it becomes an immediate concrete presentation. This concretisation of mental life is proposed as a central psychopathological feature in anorexia nervosa. A proposal for a distinction between pathological and non-pathological ways of functioning is the level of freedom in the metaphorical processes. Persons with anorexia nervosa themselves often experience their preoccupation with food, calories, weight and size as a pervasive obsession.

Such impaired functions may be named in many different ways. In this dissertation such phenomenological descriptions of impairment are strategically linked to the concepts *reflective function* and *mentalisation* (Allen, 2003, 2006; Allen & Fonagy, 2006). This choice of concepts is strategic in the sense that it links this work on anorexia and eating disorders with the current and important development of 'model on mentalisation'. Mentalisation represents a conceptual shift in understanding psychopathology and approaching psychotherapy. As a concept it originates from psychoanalytic traditions, as described in Paper 3. But it is original in the sense of 'updating' psychodynamic traditions into the contemporary scientific climate. In the context of this dissertation, by actively linking own research with the mentalisation tradition, the intention is to lift understandings of anorexia and eating disorders and the therapeutic ways to approach them, to another conceptual and scientific level. *Linking phenomenological descriptions of anorexia nervosa with the scientific tradition on*

mentalisation aspires to develop a new intellectual framework for the psychopathological models of and psychotherapy for anorexia nervosa; and later for other severe forms of eating disorders.

The mentalisation model is based on developmental psychology and contemporary psychoanalysis, and, not at least, with a strong ambition to integrate recent developments in neuroscience (Fonagy, 2006). The model also includes revised versions of ‘attachment theory’ (Bowlby, 1969, 1988), and how attachment may be linked to affect regulation. Attachment is a context for the development of the social brain. On the basis of empirical observations and theoretical elaboration, Fonagy and Target developed (1996, 1997) the argument that the capacity to understand interpersonal behaviour in terms of mental states is a key determinant of self-organisation and affect regulation, and that it is acquired in the context of early attachment relationships. Secure attachment promotes mentalising capacity, while insecure attachment and trauma can undermine. Today this body of thought is reliably anchored in empirical studies of great robustness, demonstrating attachment patterns as a predictor for mental health, the connections between secure/insecure attachment and mentalisation, and the role of mentalisation in regulating affects and negotiating relationships (Battle et al., 2002; Beeghl & Cicchetto, 1994; Fonagy, 1989, 2006 a,b; Fonagy, Gergely, Jurist & Target, 2002; Holmes, 2001). Zachrisson and Skårderud (submitted) review the scientific literature on attachment patterns, based on the use of ‘Adult Attachment Interview’.

Mentalisation capacity is basic, and impairment may contribute to the development of a number of mental disorders such as anxiety and depression (Allen, Fonagy & Bateman, in press; Allen, Bleiberg & Haslam-Hopwood, 2003). Given the generality of the definition of mentalisation, most mental disorders will inevitably involve some difficulties with mentalisation. In fact we can conceive of most mental disorder as the mind misinterpreting its own experience of itself, thus ultimately a disorder of mentalisation (Bateman, Fonagy & Allen, in press). However there is a key issue here - not whether a mental disorder can be re-described in terms of the functioning of mentalisation – *but rather whether the dysfunction of mentalisation is core to the disorder and/or a focus on mentalisation is heuristically valid, i.e. provides an appropriate domain for therapeutic intervention.*

So far, it is borderline personality disorder that has received the most attention in relation to mentalising. A fragile mentalising capacity vulnerable to social and interpersonal interaction is considered a core feature of the disorder (Bateman & Fonagy, 2004, 2006; Fonagy, 2006 b). This is not an insignificant proposal because, if correct, a borderline patient’s problems in mentalising or maintaining a mentalising capacity will impact directly

on his/hers response to treatment - if a treatment is to be successful it should have mentalisation as its focus or at the very least stimulate development of mentalising as an epiphenomenon. It is only for borderline personality disorders that clear empirical support with randomised controlled trials exists (Bateman & Fonagy, 1999; 2001; Gunderson, 2004). Although other studies, for example investigating mentalising as a core technique in family therapy and in adolescence (Fearon et al., 2006), and replication of the original studies in borderline personality disorder by an independent group are underway.

Mentalising theory is today being applied to a number of disorders, e.g. post traumatic stress disorder (Allen, 2001) and depression (Allen, Bleiberg, & Haslam-Hopwood, 2003). And this thesis is seen as a contribution to the expansion of the mentalisation model into the clinical realities of anorexia and eating disorders. The empirically based hypothesis in this thesis is that impaired mentalisation is a precise description of core psychopathological traits in anorexia nervosa. This is also supported by a study from Cassel Hospital in United Kingdom (Fonagy, Leigh, Steele, Steele et al., 1996). 82 non-psychotic psychiatric patients were grouped according to Axis I diagnoses depression, anxiety, substance use and eating disorders; and Axis II diagnoses borderline personality disorder, antisocial or paranoid disorder, other personality disorders, and no Axis II. The eating disordered patients scored lowest on reflective function, in the paper described as 'Reflective self', together with the patients diagnosed as borderline personality disorders. It should be mentioned that in this sample seventy-two percent of the sample had a definite Axis II diagnosis, where forty-four percent of the sample met DSM diagnostic criteria for Borderline personality disorder.

'Reflective-functioning manual' (Fonagy, Target, Steele & Steele, 1998) is developed to measure reflective function/mentalisation based on the 'Adult Attachment Interview, AAI' (George, Kaplan & Main, 1966). The scale is based on Main's (1991) seminal chapter on metacognitive monitoring and single versus multiple models on attachment. The scale asserts the clarity of an individual's representation of the mental states of others as well as of their own mental states.

The field of eating disorders can enrich the mentalisation tradition by introducing clinical and theoretical descriptions of embodiment. The complexity of functions of the human body is scarcely elaborated in this tradition. Mentalisation is about minding oneself and other. The descriptions are most often restricted to minding minds. Eating disorders should be comprehended as a clinical field to learn from. Concretisation of emotional life also means that inner life is concretely expressed, i.e. acted out externally. A mentalising approach, in this case, should be expanded to also represent a focus on minding bodies. Hilde

Bruch (1973) stated that the core problem in anorexia was a deficient sense of self and involved a wide range of deficits, manifested as difficulties in accurately perceiving or interpreting stimuli arising in their bodies, *both of physical and emotional character*.

To develop the concept of impaired mentalisation on anorexia and eating disorders, more research is necessary. E.g. comparative studies between borderline personality disorders and anorexia nervosa may be useful, both in developing deeper understandings of the respective psychopathologies, and also in targeting therapy. In the future conceptualisation of mentalisation, one might apply a more specific focus on aspects of mentalisation. A typical borderline patient is described as a weak mentaliser in relation to other people. In contrast, an anorectic person may appear as one who actually has the capacity of ‘reading’ other people. Such an assumption may be wrong, in the sense that one may confuse good minding of others’ minds with being oversensitive to the judgement of others. Or, some persons with anorexia actually may be fairly good mentalisers concerning others, but demonstrate impaired functions particularly in minding one’s own mind and minding one’s body. Hence, investigating aspects or domains of mentalisation might be a relevant design for looking for similarities and dissimilarities within and between diagnostic groups.

There is a well-known comorbidity of eating disorders and personality disorders (Rosenvinge, Martinussen & Østensen, 2000). Respectively three of ten (Paper 1) and three of thirteen (Paper 4) informants qualified for an Axis II diagnosis in my studies. Such facts of comorbidity call for the research interest in comparing anorexia nervosa and severe eating disorders with different diagnostic groups of personality disorders, as described above, actively looking for similarities and dissimilarities. Concerning similarities, one should also be aware of the risk of overlap, of actually describing the same phenomena in the same persons only described with different diagnostic tools.

In sum, to specify future research aims in anorexia nervosa this disorder may be described as a specific form of personality disorders, emphasising dysfunctions in reflective function and self- and affect regulations. The focus of the research could be the particular specificities compared to other diagnostic groups and phenomenological presentations.

Meaning

The *what* of representation

Medical practice is historically in the very centre of the scientific discipline semiotics, i.e. interpreting symptoms as meaningful signs of physiological and psychological states. A key

finding in Paper 1 is how the anorectic patients themselves ascribe numerous possible meanings to anorectic behaviour and symptoms. The semiotic figure ‘polysemy’ is introduced to describe this. Polysemy means that a sign – like a symptom – refers to more meanings (Ricoeur, 1976; Johnson, 1987). The many different categories of body metaphors described, refer to the polysemic character of embodiment in anorexia nervosa. Some of the patients contribute to more of the categories.

In the history of anorexia nervosa there are numerous examples of descriptions of possible meanings of symbolisation via the slender body. The anorectic denial has been read in many different ways, both with reference to spirituality, religion, psychology; and in the contexts context of interpersonal relations, family and culture. My research indicates that there is no closed and unequivocal relationship between symptom and meaning. This is symbolically more open. Such results are also supported by new research, applying qualitative approaches to detect anorectic patients’ own attribution of meaning to their symptoms and behaviour (Nordbø et al., 2006). The described anorectic discourses in my thesis demonstrate that denial of food may have many different, and also opposing, meanings at the same time. The anorectic behaviour represents a psychological crisis, a kind of poverty in mastering, but still the anorectic body is rich in a semiotic sense. On a general level, the results call for attention for the dependency of personal, familial and cultural contexts when one tries to conceive meanings and functions of anorectic symptoms. One should be aware to the overt risks of reductionism if one states to know what anorexia ‘is about’ on a general level.

Shame and pride

Paper 4 demonstrates the pervasive role of negative shame affects in a sample of females with anorexia nervosa. Many clinicians and researchers will support the statement that shame is a central phenomenon in eating disorders (Burney & Irwin, 2000; Cook, 1994, 1996; Goss & Gilbert, 2002; Sanftner & Crowther, 1998). In order to define shame it can be described as a multifaceted experience with different components and mechanisms. It has been conceptualised in terms of (Gilbert, 1998, 2002; Tangney, 1996): Emotions, as a primary affect of its own, or as a composite of other emotions such as anxiety, anger or self-disgust. Cognitive aspects, seeing oneself or being seen by others as inferior, inadequate or flawed. Bodily components, like blushing. Behaviours and actions, e.g. concealing, hiding, running away and withdrawing. Interpersonal relationships, as the relationship between the shamed and the shamer.

The extensive descriptions presented in Paper 4 of shame feelings – and also some descriptions of pride – related to anorectic symptoms and behaviour, refer both to *what* (content) and *how* (reflective function).

Concerning *what*, described content of emotions and cognitions and meaning, the patients report strong global and focal negative shame more or less directly related to anorectic behaviour and symptoms. They refer to shame related to feelings and cognitions, to achievement failures, bodily functions and appearances (body shame), self-control, self-destructiveness, sexual abuse and simply the shame of having an eating disorder. As research results these categories enrich the phenomenological picture of possible appearances of negative self-evaluation in anorexia nervosa. From a critical perspective, demonstrating the presence of shame is not original in the sense that the way shame is used in this thesis probably will be more or less synonymous with other concepts to define self-evaluation, self esteem etc. (see e.g. Fairburn et al., 1999; Vitousek & Ewald, 1993). Closely related phenomena are described with different nomenclature.

Yet, the concept of shame is deliberately chosen in this research. Although ‘low self-esteem’ is usually seen as the common denominator across disordered eating and eating disordered patients (Fairburn et al., 1997, 1998, 1999), the concept itself has been criticised for being too vague and disorder non-specific (Robson, 1988). The concept of internalised shame (Gilbert, 1998) has been proposed as more powerful both in its association with psychopathology and as a theoretical construct (Cook, 1996). Compared with self-esteem, shame has been previously defined as a more severe perception that one has attributes that others will find unattractive and be a cause for rejection and attack (Gilbert, 1998; Gilbert & Thompson, 2002). The greater the severity with which these feelings are experienced, the more one can anticipate that they will have behavioural consequences. On such basis it is claimed in Paper 4 that ‘body shame’ is a better concept than ‘body dissatisfaction’ in the work with eating disorders, especially as a disposing and releasing factor for behaviour in terms of food and change of body form. ‘Body dissatisfaction’ is about to become a problematic and disorder non-specific concept, since it is so widespread among Western women that it has become a norm (Rodin, Silberstein & Striegel-Moore, 1984).

Descriptions of interactions between eating disorder and feelings of shame, described as a shame-shame cycle, are a contribution to the understanding of factors maintaining and possibly aggravating the illness, a self-perpetuating cycle. Shame can lead to more shame. In such ways anorexia nervosa fit Kaufman’s (1989) descriptions of ‘shame-based syndromes. These are syndromes where shame is considered as both as a cause and an effect. Descriptions of interactions between eating disorders and positive feelings, which in this study are limited to being defined as a sense of pride, and described as a shame-pride cycle, will promote an understanding of the

conditions under which the illness is maintained and which lead to insufficient, weak or unstable motivations of patients to become well. Descriptions of the type presented in Paper 4 and briefly repeated here, support the interest in performing functional analyses of anorexia nervosa. These are analyses emphasising the negative and positive functions of the symptoms in the lives of patients (see e.g. Serpell, Treasure, Teasdale & Sullivan, 1999; Skårderud, 1994 b). Describing the role of shame and pride in functional analyses contributes to more disorder-specific descriptions. There are few psychiatric illnesses where destructive symptoms can to such an extent contribute to positive experiences. Other forms of illness where this may be the case, are self-mutilation and variants of substance abuse. Comparative studies should be encouraged.

Concerning *how*, in the sense of indications of reflective function, the patients describe how shame is enacted, or embodied, in practices like self-starvation and physical self-mutilation. The statements from the patients not only demonstrate examples of general and focal shame, like body shame, but they clearly demonstrate ‘embodied shame’ in the sense that bodily behaviour concretely expresses basic shame emotions. E.g., this is demonstrated as an isomorphism between shame feelings and wanting to punish oneself in a physical way. A person may injure herself physically to create a sense of unity between inner and outer experiences. She feels emotionally destroyed, and she physically destroys herself. Shame is concretised. This supports the conclusions in Paper 1 and further developed in Papers 2 and 3 concerning impaired mentalisation. The isomorphism between inner and outer realities is in the model on mentalisation described as ‘psychic equivalence’ (Fonagy, Gergely, Jurist & Target, 2002). And the shameful self may be experienced as the shameful body. An emotional state is equated with physical tissue. When a patient may be confronted with a mirror-image of this shameful body, her feeling of shame may increase. The study of shame and pride strongly supports the notion of anorexia as a self disorder, in the sense of impaired mentalising capacities and self- and affect dysregulation.

Summary

To summarise this section: It is my statement that research presented in this dissertation can contribute to a paradigmatic shift, in the sense that the results put greater emphasis on *functions* of mind; reflective function and the capacity of mentalising more than meaning. Meaning is highly relevant, but this research also demonstrates its ambiguous, ‘liquid’ or ‘local’ character, being dependent on a variety of contexts. Linking the here described phenomenology of anorexia nervosa with the empirical and theoretical model on

mentalisation, including integration with revised attachment theory and neuropsychology, will represent a new conceptual framework for these disorders

EMBODIMENT AND EATING DISORDERS

This second section of the joint discussion of all papers will comment on the following main research aim:

- To develop a more precise language about the human body's manifold roles in eating disorders. Such descriptions are subordinated under the theoretical concept embodiment. This is a wide and rich concept with emphasis on the body as a psychological, cultural and historical phenomenon, as well as a biological and material one. The aim is to further the understanding of the nature of eating disorders and anorexia nervosa, as well as more general understandings of body-mind interactions.

Already in 1895, in his unpublished 'Project for a scientific psychology', Sigmund Freud had attempted an outline of the neurological foundation of our psychic makeup, but the anatomical explanation was limited by the scientific state of the art. Disillusioned, he abandoned the neurological pursuit. He never retreated, however, from the belief that neurology would one day confirm his thinking on the functioning of the mind (Oppenheim, 2005). With recent advances in biotechnology, like PET scans and functional MRI, we have gained some more knowledge. Scientists like Allan N. Schore (1994), Mark Solms (1996, 1997 a,b), Jaak Panksepp (1998) and Antonio Damasio (1994, 1999) is today developing the discipline of 'neuro-psychoanalysis' with integrative models of body and mind, affect and brain, and hence, on an empirical base seriously challenging the Cartesian notion of a body – mind split. Affects are expressed *both* as physical and psychical.

To be more precise with reference to this dissertation: Embodiment as a concept embraces an enormous complexity of possible interactions. And a more advanced understanding would not at least demand future victories of psychobiology, neuropsychology and neuroanatomy. At this moment, when describing embodiment in eating disorders, we have to deal with rather coarse models. It is important to remember that they are models and working metaphors. Anyhow, we can try to make our descriptions more precise. This has already been attempted when applying the concept embodiment in stead of 'the body' in our

conceptualisation about the possible roles of the human body in eating disorders. The strength of this concept is its wideness and openness, including non-physical experiences. It includes as well the ‘embodied mind’ as the ‘minded body’ and the ‘acculturated body’. The weakness of this concept is its wideness and openness, with a manifold of possible meanings derived from different scientific discourses, from anthropology and philosophy to anatomy.

Well aware of the conceptual limitations, the descriptions of embodiment in eating disorders will be divided in three, based on the results and discussion in the studies. These are three different ways to punctuate embodiment. They respectively refer to ‘Modes of psychic reality’, ‘The body in movement’ and ‘The embodiment of culture’.

Modes of psychic reality

This part of the discussion will continue the descriptions above about reflective function and eating disorders. As stated many times in the dissertation, a basic trait of eating disorders is the concretisation of inner life. This is itself an illustration of embodiment. When psychic reality is poorly integrated, the body may take on an excessively central role for the continuity of the sense of self, literally being a body of evidence. “Not being able to feel themselves from within, they are forced to experience the self from without. This may become critical in adolescence, when changes in body shape and function signify a far greater change in identity for these individuals than for those whose psychological self-representation is developmentally more advanced” (Fonagy, Gergely, Jurist & Target, 2002, p. 405). With this quote the authors explicitly refer to anorexia nervosa. A disciplinary reference for such descriptions of embodiment is developmental psychology; it is about how the representational self is developed in man.

As a summary of the studies, different aspects of clinical phenomena in anorexia nervosa and eating disorders will be integrated with reference to three modes of experiencing psychic reality, as described in model on mentalisation (Fonagy, Gergely, Jurist and Target, 2002); and presented most extensively in Paper 3. These are descriptive models, and the modes described here, psychic equivalence, pretend mode and teleological stance, may all be actively functioning in one person at the same time. They are not distinct categories, being reciprocally exclusive. It is a central statement in this thesis that such integration of anorectic phenomenology with theoretical constructs from mentalisation model is mostly beneficial for the understanding of the specific psychopathology of anorexia nervosa. This will be elucidated by discussing the concept of ‘body image distortion’, see below. It is also

beneficial for the understanding of obstacles in therapy; and for tailoring therapy for these disorders.

Psychic equivalence

‘Psychic equivalence’ as a construct means equating the internal with the external world, and refers precisely to the empirical findings described in Paper I, and also illustrated by quotations from the patients in Paper 4 on shame and shame-based behaviour. Psychic equivalence refers to a mind-world isomorphism. Already Freud made distinctions between ‘thing-representations’ and ‘word-representations’ (Ricoeur, 1970; Wilden, 1972). The first ones are *analogue* symbols; connected to their reference through a direct, sensory connection. Word-representations, on the other hand, the signs in verbal language are more random. They are based on conventions, on what we have chosen as meanings. There is no inner, ‘necessary’ connection between the symbol and reference. The verbal language is based on *digital* communication (Solheim, 1998; Wilden, 1972). Hence, psychic equivalence equates thing-representations.

The construct ‘psychic equivalence’ applied on the phenomenology of anorexia nervosa

‘Psychic equivalence’ in eating disorders is about carnal thoughts and emotions. An understanding of the phenomenon may be of utmost importance for the therapist, being aware of that one may experience a frustrating difficulty to engage the patient and establish a fruitful working alliance. The patients’ fear of not being in psychological control can lead to controlling behaviour, like checking, double-checking and including controlling the therapist. A general feeling of distrust might be expressed as distrust towards food, but also towards the therapist. And in therapeutic interactions one must be prepared for that this mode of functioning represents a focus on physical and bodily aspects, often more than on emotional ones.

Teleological stance

‘Teleological stance’ is a highly relevant and useful concept to name clinical phenomena in anorexia and eating disorders. Teleological stance refers to a developmental level where expectations concerning agency of the self and the agency of the other are formulated in terms restricted to the physical world (Gergely, 2001; Fonagy, Gergely, Jurist & Target, 2002). There

is a focus on understanding actions in terms of their physical as opposed to mental outcomes; “I don’t believe before I see it”.

The construct ‘teleological stance’ applied on the phenomenology of anorexia nervosa

“I don’t believe before I see it on my body”. In anorexia nervosa and eating disorders people want to change, i.e. with reference to self-esteem and social acceptance, and such changes are sought to be fulfilled by physically changing their bodies. Teleological stance is also relevant to understand therapeutic relationships in particular, like battles about agreements, appointments, contracts, time, money and attention. Patients may have problems accepting anything other than a modification in the realm of the physical as a true index of the intentions of the other. If the therapist really cares, he or she is expected to show this benign disposition and motivations to helpful in concrete manners; like availability on the telephone, extra sessions at weekends and acts ‘beyond routine’ and ‘beyond rules’.

Pretend mode

In a clinical perspective this refers to dissociation between internal state and outside world. In psychotherapeutic work, words with reference to inner states are commonly used with the expectation that these will have a real impact on the patient. But while the patient is in ‘pretend mode’, the words may be understood, but do not have such real impact. Ideas do not form a satisfactory bridge between inner and outer reality, and affects do not accompany thoughts.

The construct ‘pretend mode’ applied on the phenomenology of anorexia nervosa

A clinical feature, not at least in anorexia nervosa, may be feelings of emptiness, meaninglessness and dissociation in the wake of trauma. In the therapeutic relationship this may lead to endless inconsequential talk of thoughts and feelings. The dialogues may appear as relevant, given the topics of emotions and thoughts, but with minor effects. Pretend mode as a concept is a useful tool to widen the understanding of ineffective therapy.

I will expand the conceptualisation of pretend mode in the mentalisation tradition (Fonagy, Gergely, Jurist & Target, 2002) to also include that many patients with eating disorders not only are confused with relation to their own feelings, but also concerning bodily sensations. Hilde Bruch (1973) collected these experiences in the concept ‘interoceptive confusion’. Similar phenomena are operationalised in the questionnaire Eating Disorders Inventory in the psychological subscale ‘Interoceptive Awareness’. The Child version of this

instrument is applied in the study in Paper 5 (Garner, 1991). For the childcare boys the ratings of the psychological subscale Interoceptive Awareness (IA) is significantly higher than in the non-clinical sample.

Body image disturbance

The ‘body-image disturbance’ in anorexia and eating disorders; that the patient may experience oneself to be big or fat when slender and emaciated, is not yet satisfactorily explained in research literature. The understanding of patients wrongly perceiving their bodies, can be helped by a combination of the presented three modes of reality. It is a clinical experience, and described in literature (Farrell, Lee & Shafran, 2005), that body image disturbance is contextually dependent on affective state; most prominent when there is negative affective arousal. In affective arousal, losing control over emotions, the person may actually experience how she expands, gets bigger. This refers to psychic equivalence. What exists inside is also experienced outside. In addition, actually not being able to precisely perceive one’s own physical body may be a bodily expression of pretend mode, as an experience of ‘not being in contact with’ one’s body.

The statement here is that there is a parallel situation in the way of experiencing/not experiencing bodily states and experiencing/not experiencing emotional states. Neither the pretend mode nor psychic equivalence has the full quality of internal reality. *Pretend mode is too unreal, while psychic equivalence is too real*, and combined they may represent the psychological matrix for the patient’s confused experience of one’s body, here described as body image disturbance.

The body in movement

In Paper 6 embodiment in anorexia nervosa is approached from a different phenomenal and theoretical perspective. If we apply the body-phenomenological model presented in Paper 6, based on the works of Merleau-Ponty (1962), on eating disorders, then this type of medical phenomena can be described as a radical objectifying of the human body. This represents a closing down of the existential and experiencing openness towards life-world. Focusing on food and body leads to a limited scope of experience, and the intensive body project usually represents a withdrawal of attention from outer and social realities.

Mind is inevitably embodied, cf. the works of Lakoff and Johnson (1980, 1999). The clinical case of eating disorders strikingly demonstrates that also body is minded, in the sense

that physical qualities convey symbolic meaning. Such object status of bodily qualities is part of our culture and becomes clearly evident when we refer to the body as something to be investigated, trained, slimmed, in order to serve other purposes. The anorectic patient is 'stuck' in this objectification. The explorative investigation presented in Paper 6 is original in the sense that it demonstrated that the body in movement could move negative attention from the objectivated anorectic body to a more profound and subjective experience of one's own body. The activities, which reduced negative attention towards their bodies, were focused on relations to others, they were non-competing and not predictable. Not at least, this is a theoretical and empirical incitement for conceptualising treatment programs and organising treatment facilities. This is also a reminder of the richness of embodiment. There is not 'the body', but 'many bodies'. Physical activity is existential and has several aspects including non-physical.

The embodiment of culture

Anorexia nervosa and eating disorders are described as 'culture-bound syndromes' (Di Nicola, 1990 a). Cultural factors have an exceptionally strong impact on epidemiology, symptoms, development and aetiology (Gordon, 2001; Barlow & Duran, 1999; Nasser, 1997). The studies in the dissertation contribute with empirical material relevant for reflections on embodiment of culture in eating disorders.

Pathoplasticity of eating disorders

The different ascribed meanings of anorectic symptoms and behaviour, the polysemy discussed above, opens up for the importance of contexts. Meanings always depend on contexts, and the polysemy of anorectic embodiment open up for the impact of different cultures.

A simplistic model may be like this: A common and core feature of the specific psychopathology is the impaired reflective function. On this matrix different culturally based systems of meanings may be formative for the phenomenological presentation of the disorder. Such a model helps us to understand the *changeability* of both symptoms and meanings of symptoms in time, space and culture. Changeability not only refers to perceiving, understanding and interpreting the disorders differently in different contexts, but also to how the disorders themselves are in the process of change. This is robustly documented by clinical descriptions from different historical, geographical and cultural contexts (Skårderud,

submitted). Such changes are referred to as the *pathoplasticity* of symptoms in eating disorders (Skårderud & Nasser, 2007).

One way of illustrating pathoplasticity is ‘fat phobia’ in anorexia nervosa. ‘Intense fear of gaining weight or becoming fat’ is a part of diagnostic criteria for making the diagnosis in accordance with DSM-IV (American Psychiatric Association, 1994). Historical studies offer a unique opportunity for studying alterations of the role of fat phobia in anorexia nervosa. In descriptions of self-induced hunger throughout the centuries, fat phobia has in the clinical descriptions been a non-existent phenomenon until the second half of the twentieth century. When Gull established the modern diagnosis of anorexia in England in 1872, and Lasègue in France in 1873, there was no mention of fat phobia (Lee, 2001).

In Gull’s epoch we can speak of ‘the Victorian anorectic’ (Skårderud, 1991): Romanticism idealised the spirit rather than the body. Denial of the body’s needs, and idolising paleness and weakness was interpreted as fragile spirituality, with the anorectic poet Lord Byron as one of the romantic heroes. At the end of the nineteenth century, the thin body does not only become a status symbol for *spiritual* purity, but also a *social* status symbol for the middle class woman who is unsuited for productive work on the farm or in industry.

Today the motivation to lose weight rests to a far lesser degree on religious or spiritual beliefs, even though this can certainly not be totally excluded. A more current attribution is now personal *psychology*. Body practices are ideally meant to lead to increased self-esteem. And reduction of fat, both in food and as body tissue, is a rather newly created symbolic representative of mastery.

A great number of recent epidemiological studies, case and hospital reports undermine the statement that eating disorders are syndromes rooted in the Western world (Prince, 1983; Schwartz, 1985). It is documented in reports that the eating disorders are increasingly emerging in the rest of the world. This applies to all continents (Nasser, 1997; Nasser, Katzman & Gordon, 2001). However, the patients can appear to be atypical in terms of the traditional Western descriptions. During the last few years there has been a significant increase in incidence in China. In a study from 1991, Lee (1991) describes sixteen Chinese anorexia patients in Hong Kong. And he points out that several of these Asian patients do not present fat-phobia. In a later work, Lee (2001) continues to elaborate the discourse around fat phobia, and poses the rhetorical question in the title: “Fat phobia in anorexia nervosa: Whose obsession is it?” His answer is that this obsessive fear of fat and being fat it is the obsession of the West, and that fat phobia as an essential diagnostic criterion is an expression of ethnocentrism. Lee (2001) also reminds us that there are several Western reports, from several

European countries, Canada and the USA, where fat phobia is absent in anorexia patients. In a survey of the epidemiology of eating disorders, Patton and Szmukler (1995) maintain that the emphasis on fat phobia as a central diagnostic criterion will lead to a lack of identification of cases of anorexia nervosa in wider cultural and geographical contexts.

Another possible and troublesome illustration of pathoplasticity and cultural impact on the phenomenological expressions of eating disorders are the both clinical and scientific descriptions of an increasing combination of traditional symptoms of eating disorders and bodily self-harm and self-inflicted pain, like cutting and burning (Favazza, 1996). Treatment of eating disorders today often presents therapists to the additional challenge of such pathological and often provoking behaviour.

And the results in Paper 5 also contribute in the same direction in order to demonstrate the need to amplify our perspective. Not only do boys present surprisingly high scores on the symptom scales in the questionnaire Eating Disorders Inventory – Child version (EDI-C), but their scores also indicated chaotic ways of eating, bingeing and dieting. Qualitative interviews with a sample of five high-scoring childcare adolescents, both boys and girls, confirmed the impression of chaotic patterns⁴. High scores on symptom scales do not necessarily qualify for diagnosis. Hence, also in our own cultural contexts we should gain competence in detecting more than the traditional forms of eating disorders, including atypical and sub-clinical forms; ‘impure’ and ‘chaotic’ forms of pathology in addition to the ‘pure forms. And that goes particularly for boys and men. In both sexes we should as well look for other phenomenological expressions of psychological discomfort with the body (Skårderud, 2007 d). Epidemiology reminds us of the fact that the most typical forms of eating disorders are the ‘atypical’ ones – the EDNOS category.

Culture-reactive syndromes

Anorexia nervosa and eating disorders reflect tensions between cultures and individuals at risk. But cultures are not stable. Rather the opposite; in discussing interactions between possible and probable cultural risk factors for the development of eating disorders the instability of cultures itself, as an unstable context for the construction of secure bonds and safe identity, is proposed to be important (Di Nicola, 1990 b; Skårderud, 2001).

⁴ As described in the chapter Method and material, the results from the qualitative interviews are not reported in Paper 5, but will be presented elsewhere (Nygren & Skårderud, manuscript).

Our own Western culture can be described as in rapid transition. Referring to modern societies Nasser (1997) and Nasser and Di Nicola (2001) suggest redefining eating disorders as ‘culture chaos syndromes’, with precise reference to the way in which rapid societal transitions create vague frameworks for identity formation. And Di Nicola (1990 b) proposes that in cultures with rapid socio-cultural changes it is more precise to speak of anorexia nervosa as ‘a culture-reactive syndrome’ instead of ‘a culture-bound syndrome’. Culture-bound syndromes refer to more or less stable traits in cultures, while culture-reactive syndromes put main emphasis on cultural instability; on the modernisation process itself as a risk factor for the development of pathology. Such a development of the original concept helps us to better understandings of this form of eating disorders within our own cultural contexts, of cases in societies undergoing rapid socio-economic change outside Western cultures, as well as migrants experiencing cultural change (Skårderud, submitted).

‘Cultural equivalence’

Although there is robust epidemiological documentation *that* there are connections between eating disorders, anorexia and culture, the research literature presents very few theoretical contributions about the *how* and *what* of cultural impact.

Again, let me turn to the construct psychic equivalence. It is tempting to speculate that this description of isomorphism between internal and external realities gives an indication of specific culturally conveyed psychological dilemmas in different contexts. When cultural impact is at debate, it is equally tempting to reformulate the concept psychic equivalence to ‘cultural equivalence’. Concretisation in the sense of psychic equivalence may also be extended to embodied messages about cultural contexts. Anorectic search for control may refer to a sense of loss of control not only in a personal, inter-personal but also in a cultural context. Anorexia as a search for self-control and a mode of self-construction refers to cultural challenges about construction of identity. In Paper 5 we discuss the possible connections between chaotic eating patterns in a high risk population with their experiences of chaotic environments. Such ideas are far more developed both empirically and theoretically in Skårderud (submitted).

THERAPY

This third section of the joint discussion of all papers will comment on the following main research aim:

- Finally, use empirical findings combined with theoretical models in the systematic development of therapeutic methods and techniques.

An outline for a therapeutic manual

The effective treatment of anorexia nervosa and severe eating disorders experiences obstacles. We often describe the anorectic patient as one with limited insight into one's illness. In the case for anorexia there is also the clinicians' and the researches' limited insight into these illnesses. Our difficulties as clinicians to understand the very nature of these disorders may lead to a lack of commitment and patience and coercive behaviour. A part of the clinical reality of anorexia nervosa in health services today is the risk for iatrogenic damage. With reference to paper 4, profound shame can complicate the therapeutic processes by challenging its very foundation: Dialogue and the therapeutic relationship itself as health promoting. One of the central behavioural expressions of shame is silence. Shame represents withdrawal in a context where aim and method are candour and intimacy. Understanding the role of shame in therapeutic relationships can be useful for enabling therapists to persevere, by gaining an understanding of the behaviour which may be experienced as a rejection.

Paper 3 presents a rather systematic attempt to outline some central principals, approaches and issues in a psychotherapeutic enterprise for anorexia nervosa. Patients who suffer from anorexia are heterogeneous in terms of background, clinical features, comorbidity and personality functioning, but it was a premise in developing some basic therapeutic principles, that impaired reflective function were a prominent trait in the psychopathology. This outline also includes research experiences from Paper 6, using adapted physical activity as a supplement to psychotherapeutic treatment. In fact it is described as more than a supplement. In itself adapted physical activity can be beneficial, as it also may be harmful. But physical experiences in different forms and contexts – as adapted physical activity, physiotherapy, yoga etc. – may also be an experiential background to be dealt with in therapy. How does one feel one's own body?

Paper 3 is, as described, based on the assumption that impaired reflective function is a core trait of the psychopathology of anorexia nervosa, and that this provides an appropriate domain for therapeutic intervention. The centrality of such traits represents reasonable grounds to believe in the efficacy of a mentalisation-based therapeutic approach. Hence, Paper 3 is original in the sense of making an outline for a mentalisation-based to approach to anorexia

nervosa. Psychotherapy provides an opportunity for intensive practice in mentalising. The therapeutic relation is an attachment bond, and one important aspect of psychotherapy is that it activates attachment systems (Fonagy & Bateman, 2006). An effective psychotherapeutic relationship is a good analogue of a secure base in attachment that fosters mentalising (Holmes, 2001). Not only does psychotherapy entail mentalising in the sense of exploring thoughts, feelings, hopes, wishes, dreams, and the like, but also psychotherapy provides the opportunity to experience and learn from failures in mentalising, which frequently occur in therapy with anorexia and severe eating disorders.

This dissertation proposes the systematic elaboration of manuals for the psychotherapeutic enterprise with anorexia. Based on the principle on stimulating mentalising capacity, this can be seen as a further development of the pioneering work of Hilde Bruch. Based on her descriptions of the psychological function in eating disorders, she also reformulated psychotherapy, both attitude and technique. In her view (1962, p. 194), “*giving insight to these patients through psychoanalytical interpretations was not only useless but reinforced a basic defect in their personality structure, namely the incapacity to know what they themselves felt, since it has always been the mother who ‘knew’ how they felt*”. She advocated a psychotherapeutic approach aimed at increasing these patients’ awareness of the feelings and impulses that originate in themselves and which they can learn to recognise (Bruch, 1962; Taylor, Bagby & Parker, 1997).

Stimulating mentalisation is neither a panacea for improvement, nor exclusive for a mentalisation-based therapeutic approach. Most forms of psychotherapy stimulate mentalising capacity. And today there are interesting related trends in other forms of novel treatment approaches for anorexia and eating disorders. E.g. Tchanturia and colleagues in London base interventions in cognitive therapy for anorexia on neuropsychological research proposing disturbed emotional and informational processing (Southgate, Tchanturia & Treasure, 2005; Tchanturia, Campbell, Morris & Treasure, 2005). A weakness in the typical neuropsychological profile involves low mental flexibility and set shifting skills. Treatment is targeted on increasing mental flexibility. In newer recommendations for cognitive therapy for bulimia nervosa and binge eating, there is a general increased focus on affects, affect regulation, mood intolerance and ‘mindfulness’ (Mitchell, Agras & Wonderlich, 2007; Williams, 2007). There is an interesting convergence in the therapeutic field of eating disorders, meeting around affects and mind-mindedness. But a difference is that a mentalisation-based approach also focuses on the minds of others, including the mind of the

therapist. And in the technical adaptations described in Paper 3, there is also a far more systematic focus on minding the body.

And as a tradition originating in psychoanalytic treatment there is an explicit focus on the therapeutic bond as an attachment bond. Attachment systems are activated. In practical terms this means that there is a focus on the therapeutic relation itself as a tool for corrective emotional experiences. The therapist intentionally titrates intensity and affect attunement. The task of the therapist “is to represent accurately the feeling state of the patient and its accompanying internal representations. In addition, the therapist must be able to distinguish between his own experiences and those of the patient, and be able to demonstrate this distinction to the patient” (Bateman & Fonagy, 2004, p. 210). This is called ‘marked mirroring’, and refers to first to mirror the patients emotional state, and then to intentionally mark a discrepancy. This intentionally compels patient and therapist to examine their internal states further.

Paper 4 demonstrates the pervasive nature of shame affects in the group of informants. This is relevant for the psychotherapeutic enterprises. The therapeutic relationship as an attachment bond may activate shameful feelings. The fact that shame is activated by virtue of the therapeutic context itself also means that this can be a suitable room for providing it with a language in the dialogue. But, therapeutic relationships can also be shame-provoking. Awareness of a potential re-traumatisation in the therapeutic situation should be crucial. Hence, this calls for strict demands on tactfulness, good manners and patience, ethics and therapeutic technique. As therapists, an enriched understanding of the role of shame in anorexia nervosa may activate our awareness of our own feeling of shame, in the sense of ‘a positive sense of shame’ (Skårderud, 2003 b). The inquisitive and non-directive stance in a mentalisation-based approach, and the sensitive focus on the therapeutic relation itself, will hopefully be helpful for reducing shame. Such an approach also focuses on the therapists’ openness on mistakes and failures in the therapeutic relationship (Bateman & Fonagy, 2006), with the therapists functioning as role models for open inquiry.

The rationale for the outline in Paper 3 is the hypothesis that it is beneficial for improvement to specifically focus on the stimulation and rehabilitation of mentalisation. That has not yet been proven scientifically. For example, mentalising problems have been described in schizophrenia (Frith, 2004), but that is not the same as a mentalising-based intervention being ultimately useful as a treatment method itself. The same applies to conditions such as autism in which patients have been shown to suffer more or less complete mind-blindness

(Baron-Cohen, Tager-Flusberg, & Cohen, 2000). Whether a specific focus on mentalising provides an appropriate focus for interventions is to be investigated.

FUTURE RESEARCH

Reflective function and mentalisation

- More qualitative research studies to develop the specificity of reflective function in eating disorders, and compared with other diagnostic groups.
- The systematic investigation of reflective function and mentalisation in anorexia nervosa, e.g. applying 'The Reflective-Function Manual' (Fonagy, Target, Steele & Steele, 1998) measuring reflective function based on the 'Adult Attachment Interview, AAI' (Main & Goldwyn, 1995).
 - o Comparative studies with other forms of eating disorders, with a focus on aspects of mentalisation.
 - o Comparative studies with other forms of psychiatric disorders, e.g. borderline personality disorder, with a focus on aspects of mentalisation.
 - o Comparative studies of male and female persons with eating disorders and related forms of body image disturbances and pathological body practices. This refers to the results in Paper 5, the quantitative study on adolescent childcare residents.
- Model on mentalisation includes a developmental perspective on affect regulation, proposing both inborn genetically disposing factors and that the healthy mentalising capacity also originates in the context of secure attachment relationships. Zachrisson and Skårderud (submitted) review the scientific literature on attachment patterns, based on the use of 'Adult Attachment Interview'. This calls for more focused studies, and with a more specific intent to study connections with affect regulation and mentalising capacity.
- Model on mentalisation includes a specific focus on neuropsychology. Neuropsychological findings in eating disorders are somewhat inconsistent (Tchanturia, Campbell, Morris & Treasure, 2005). This may be because studies have used a broad range of tests on relatively small, heterogeneous clinical groups, thus limiting the detection of subtle neuropsychological differences in these patients.

Therefore, adoption of a more focused, hypothesis-driven approach is proposed. A feasible way is to design studies based on collaboration with scientist working with neuropsychological detection of mentalising capacity in other diagnostic groups. Anyhow, this would be beyond the actual competence of this author.

Embodiment

- Interdisciplinary dialogues with social and human sciences can contribute with the intention to develop theoretical models to conceptualise the human body and human embodiment.
- Increased research efforts in describing and detecting pathological cognitions, emotions and attitudes concerning the body in males generally, and more specifically in high-risk male groups. That refers both to epidemiological studies and qualitative research on male experiences.

Therapy

- To further develop the outlines for therapeutic enterprise into real manuals as basis for
 - o Therapy
 - o Clinical training
 - o Scientific research as a basis for evidence based practice.

CONCLUSIONS

To conclude, central in this thesis has been to:

- Demonstrate impaired reflective function in a sample of patients with anorexia nervosa.
- Combine such empirical findings with theoretical models, proposing impaired reflective function to be a core psychopathological trait; and on this basis again develop theory more specific for anorexia nervosa and eating disorders.
- Let such empirical and theoretical models guide therapeutic approaches.
- Focus on the relevance of the affect of shame in anorexia, and how the pervasive role of shame supports the notion of anorexia nervosa as a 'self disorder', in the sense of impaired reflective function and affect regulation.
- Document and describe pathological eating behaviours and negative body image in a sample of male childcare residents; moving attention to male experiences.
- Reporting from an explorative study using adapted physical activity on a group of hospitalised adolescent girls with anorexia nervosa, aiming to move attention away from negative body focus; and recommending adapted and medically secured forms of physical activity as a part of treatment.
- Linking the phenomenology of anorexia nervosa and eating disorders, as described in the sub-studies in the dissertation, with epidemiological research and theoretical concepts to further the understanding of the strong impact of culture on eating disorders.

The dissertation has aspired to contribute to a new intellectual framework for understanding eating disorders, with main emphasis on particular anorexia nervosa.

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