

# Eating One's Words, Part I: 'Concretised Metaphors' and Reflective Function in Anorexia Nervosa—An Interview Study

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Anorexia nervosa still qualifies for the designation as an enigma, with an unclear aetiology and a psychopathology poorly understood. A striking clinical feature is the concreteness of symptoms. The concept 'concretised metaphor' refers to instances where there is a psychic equivalence between physical and psychic reality. Emotions are concretised.

**Objective:** To contribute in a more precise language about the body's symbolic role—embodiment in anorexia nervosa.

**Method:** 10 female patients (age 16–35 years) with anorexia nervosa describe in interviews how they conceive mind–body relations in their own lives.

**Results:** Different 'concretised metaphors' are described and categorised, covering a wide range of bodily experiences and corresponding emotions.

**Discussion:** The occurrence of various 'concretised metaphors' in these cases suggests reduced symbolic capacity and impaired reflective function as a core psychopathological trait in anorexia nervosa. This is the first of three companion papers. Part II develops theory on reflective function in anorexia nervosa. Part III presents an outline for psychotherapy for anorexia nervosa.

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## INTRODUCTION

The overall aim of this study is further understanding of the specific psychopathology of anorexia nervosa. A more precise aim is to develop

a more precise language about the body's symbolic role in anorexia nervosa. Anorexia nervosa is a striking example of the complex nature of the human body. It is a basic premise here that the human body also functions as a symbolic tool, as a language to communicate with others and with ourselves about matters beyond corporeality itself. Anorexia nervosa almost always originates from the person's wish and attempt to change. Changing her/his actual body composition is striving to

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change oneself, in psychological, moral, religious, spiritual or social senses.

One key clinical feature in anorexia nervosa is the concreteness of symptoms. The patient presents her/himself with a cognitive and emotional over-concern with bodily qualities, like body shape and weight. Many persons with anorexia nervosa describe this concern as obsessional, and experience the here and now of their bodies as a ruthless reality difficult to escape from. This 'concretism' in anorexia nervosa (Buhl, 2002) is often experienced as an obstacle to recovery. Here it is discussed in relation to 'reflective function'. The term reflective function is well known in developmental psychology and refers to the psychological processes underlying the capacity to make mental representations (Fonagy, 1989).

Central concepts in this presentation are 'embodiment', 'metaphor' and 'concretised metaphor':

### *Embodiment*

The tradition of Western thinking has been sadly negligent in its treatment of the body. During the last decades there has been 'a rediscovery' of the body in many academic disciplines. In such contexts embodiment is a more accurate expression than 'the body', since the academic works are not about the body *per se*. Instead, they are about bodily being-in-the-world, an existential position in which the body is a subjective and intersubjective ground of experience.

A major reference is the French philosopher Maurice Merleau-Ponty (1962). Merleau-Ponty raises objections to Descartes' dualism between body and soul, and the body's split history by introducing the concept of 'corps propre' ('the lived body'). In the Cartesian tradition it is the physical characteristics of the phenomena, which are examined. By using the concept of the lived body Merleau-Ponty attempts to discover deeper meanings in one's experience that one's own body is more than its physical aspects. The body is not a mechanical object responding to the stimuli in its environment. It is in lively interaction and in an ongoing dialogue with the world. The body is experiencing, acting and intentionally seeking out into the world; it is always existential (Duesund & Skårderud, 2003). In this text the emphasis is on one aspect of human embodiment. That is the role of the body in symbolisation, hence the metaphor.

### *Metaphor*

Metaphor is one of the main figures from classic Greek rhetoric. Aristotle (1984) defines the

metaphor in 'poetics' as 'giving something a name that belongs to something else' (p. 1457). The essence of the metaphor is to understand and experience one phenomenon through another phenomenon. The metaphor is a subgroup of symbols. The metaphor is defined as being based on resemblance, a similarity between the phenomenon in the 'source area' and the 'target area' (Lakoff & Johnson, 1999). There is a similarity-in-difference.

### *Concretised Metaphor*

'Concretised metaphors' refer to instances where the metaphors are not experienced as indirect expressions showing something thus mediated, but they are experienced as direct and bodily revelations of a concrete reality (Enckell, 2002). There is an immediate equivalence between bodily and emotional experience.

The traditional interest has been in the linguistic metaphor. But in the last decades authors have expanded the model of the metaphor to more than linguistic representations, like memories, feelings and dreams. The philosophers George Lakoff and Mark Johnson (1980, 1999) have been leading figures in terms of changing interpretations of metaphor from being purely a phenomenon in language, a rhetoric or artistic figure of speech, to becoming a model for the general function of mind. In their view, mind is always embodied. They convincingly describe the embodied mind and how sensorimotor experiences constitute the basis for conceptualising. The metaphor is based on the perception of physical realities, like gravitation, sounds, vision, tactility, etc., for example, the depressed person 'feels down' and 'burdened by heavy thoughts'; both examples refer to our experiences of gravitation organising our conceptual system in up-down and light-heavy. The metaphor is pervasive for mental representations, for human understanding, fantasy and reason. The metaphor is basic, but often not conscious.

In this paper it is a basic assumption that the body also functions as the source area for metaphors. Sensorimotor experiences and bodily qualities and sensations, like hunger, size, weight and shape, are physical entities that may also represent non-physical phenomena. This is highly relevant in anorexia nervosa. In 'concretised metaphors' such 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 are difficult to negotiate with. The problem is to distinguish

between the metaphor, and the object or phenomenon which is metaphorised. The 'as if' of the metaphor as a figure is turned into an 'is'.

This study aims to be original in the systematic description and categorisation of different body metaphors, as presented in research interviews with female patients with anorexia nervosa, and in relating these to reflective function. The presentation is divided into three parts. This first of three companion papers presents results from an interview study with patients with anorexia nervosa. Part II (Skårderud, 2007a) brings forth theoretical models about reflective function in anorexia nervosa. Part III presents an outline for psychotherapy for anorexia nervosa (Skårderud, 2007b).

## METHOD

This study is based on qualitative research. The informants are female patients with anorexia nervosa. All of them are recruited from the author's own psychotherapeutic practice. There are two main sources to the data analysed, due to the wish to increase research quality through methodological triangulation.

- Research interviews with patients in active treatment for anorexia nervosa. All interviews were done by the author. The interviews followed a manual for semi-structured interviewing.
- Transcripts from therapy sessions with the same patients.

An additional source is medical data and process notes from their medical notes. Such data were not actively used in the analysis. They contribute with a wider context for interpretations, but may also represent a bias. The study was approved by the Medical Ethical Committee.

### *Participants*

Ten female patients participated in this study. They were between 16 and 35 years. A necessary criterion for inclusion in the study was the fulfilment of the diagnostic criteria for anorexia nervosa according to DSM-IV (American Psychiatric Association, 1994). 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. BMI is calculated from body weight divided by square of the height. BMI

less than 19 is defined as underweight. Nine of ten had their symptom debut and had also been diagnosed before they were 18 years old. The tenth patient started with her anorexia at the age of 19 years. The patients had been diagnosed for anorexia nervosa from 5 months to 19 years, median 5.4 years.

At the point of time for data collection all the informants, hereafter called patients, were in active treatment with the author. The context for the treatment was a private psychotherapeutic practice with public funding. Some of the patients had additional therapy contacts, from a psychomotoric physiotherapist or music therapist. All of them had been treated by the author for more than 6 months. In this context treatment means individual psychotherapy, with a session every week or every second week. The psychotherapeutic approach is mainly based on psychodynamic models, with considerable integrations with elements from cognitive and psychoeducative traditions.

### *Data Collection*

The patients were thoroughly informed, verbally and in text, about the aims of the study, and their therapist's dual role as clinician and researcher. The research interview was presented as separated from the therapeutic context. The patients signed a written declaration of consent. Both verbally and in text there was great emphasis on that all participation in the study was voluntary, and that absence from participation would have no negative consequences. But it is of course difficult to assess how much liberty the patients actually experienced. One patient of the eleven said no to the invitation to participate. She feared that recorded sessions, interviews or transcripts could get in wrong hands. Due to a limited number of patients fulfilling the criteria for anorexia nervosa in the psychotherapeutic practice, the data collection lasted for 2 years.

### *Research interviews*

The interviews were semi-structured. 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, for the better or worse.
- How the eating disorder impinges on your life, negative or positive aspects.

- The interaction between emotions and cognitions and body shape, weight and food.

In a semi-structured interview the written guide is not used slavishly. The interview may follow different themes that appear in the dialogue. In the practical accomplishment, emphasis, in the interview sessions, was put on clarifying, repeating, confirming and diving deeper into the answers. Such a practice corresponds to what Kvale (1996) describes as 'communicative validity' or 'member checks' (Denzin & Lincoln, 2000). These are methods to improve the validity. The interviewing lasted for approximately 1 hour.

#### *Therapy sessions*

Four consecutive therapy sessions were recorded. This was done before the interviews, in a time span of up to 3 months before the research interviews. Four consecutive sessions were chosen partly because this gives more data, but also to reduce the possible impact of experiencing the recording as a stressor. The patients may behave differently/be more shy or timid when recording is introduced. A recorder is not usually used in sessions. Interviews and therapy sessions were transcribed by one assistant in Word text format.

#### *Reflections on Method*

In a discussion on the method used in the present study it is inevitable to look into the dual role as therapist and researcher.

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, 1994). In combining both, one must serve two masters. This can lead to ethical problems that must be addressed in every material instance. In the opinion of the author, no serious ethical objections were experienced in this case concerning the dual role of researcher/therapist. The nature of the 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 twofold contexts may be seen as partial aspects of a common context of inquiry and

introspection. It is also essential to repeat the fact that the researcher/therapist has more comprehensive background information about the patients, and that this may influence the interpretations.

The fact that the therapist accomplishes research interviews with his own psychotherapy patients must be viewed as an intersubjective co-construction of meaning. This particular task should be seen as a part of the dialogical process, in which research and therapy cannot distinctly be separated. 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. And that the patients' answers in the research context are also a communication to the therapist. This may contribute to circular 'proofs'. And one may critically state that anorectic patients are a 'risk group', being compliant with the interviewer. The group as such is described as other-directed, sensitive to and dependent on others needs and views (Buhl, 1990).

#### *Analysis*

A computer programme, NVivo, was used for the qualitative text analyses (Gibbs, 2002). With reference to the main research questions in this paper, the text analysis was carried out in five consecutive steps:

1. First, all statements involving food and/or body were marked. The computer program is based on making so-called '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.
2. Second, 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, that is 'an empty stomach gives me a sense of being strong'. Hence, statements about food and/or body without such emotional-cognitive valuation were eliminated. In practical analytical work the context of investigation of such linkages were two to three consecutive paragraphs in the transcripts. The selected parts could vary from very brief statements to coherent narratives.
3. 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, that is 'controlling my appetite gives me a feeling of control in other areas of my life'.

4. 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.
5. Finally these categories were organised in a hierarchy, in relation to superior common categories.

In the analyses, the interviews and transcribed therapy sessions were originally treated as separate data sources. The same process of analysing, as described above, was carried out for both sets. But in the finishing phase the main categories were integrated. It is the author's view that the two text materials did not differ markedly in content, but more in form. This can easily be controlled by the extracted texts and nodes created in the different text sources in the data program. In the transcribed texts from the therapy sessions, categories were developed from more fragmented and abrupt statements, while the texts from the interviews gave more coherent narratives and arguments.

## RESULTS

In analysing the texts there are numerous statements that illustrate symbolisation via the body. Here they are conceptualised as body metaphors, where bodily qualities and behaviour represents emotional, social or moral phenomena. Many of the patients' statements illustrate the very concrete and direct character of many of the body metaphors. It is striking how such statements point to a basic and close relationship between emotion and physical body, a more or less 'immediate translation'. In these body metaphors there is a striking closeness, a direct analogy and primary relation between emotions and different sensorimotor experiences. Emotional experiences are organised and felt, based on different domains of physical life. Emotions are concretised.

Categories from the analyses will be presented. The final categorisation ended up with two main categories. A distinction was made between specific and compound body metaphors. Specific body metaphors refer mainly to one domain of the sensorimotor experience. They are more 'local'. They are presented here, referring to their different domains of physical experience. Compound body

metaphors may be based on some or more of the specific metaphors. They are more 'global', being less distinct concerning the sensorimotor domain or physical experience. It can be difficult to distinguish between some of the categories. Hence, they are not reciprocally expelling, but rather different punctuations of the anorectic experience. The different categories are presented by text examples from the transcripts. In the presentation of results there is no reference to the frequency of the different categories, considered not to be the topic of this study. The topic of the study is to elucidate the phenomena.

### Specific Metaphors

In the superior category 'specific' body metaphors listed in Table 1 will be described. These sub-categories are not meant to be complete. Interviews with more patients with anorexia nervosa would increase the number of examples.

#### Emptiness/fullness

Fear of eating and of gaining weight is a key feature in anorexia nervosa. But statements also underscore the metaphorical connections between eating as an act of filling oneself and emotions of being overwhelmed. 'Too much' is not only about the physical amount of food, but also about the problem of handling difficult emotions and cognitions. The feeling of too much induces the urge for emptying.

*Sol: I am so confused. It is simply too much for me. I have to reduce. I am completely filled up. In some way or another I do have to empty myself. (She refers to her frequent vomiting and misuse of large doses of laxatives.)*

*Hanna: Some days ago I should have had a meeting with my boss. I was anxious about this. Then I decided to vomit. I couldn't stand having the lunch in my stomach. I cannot have anything in my*

Table 1. Specific body metaphors

Emptiness/fullness
Purity
Spatiality
Heaviness/lightness
Solidity
Removal

*stomach, because then I cannot concentrate. I need to be empty to feel alert.*

Both cases illustrate the immediate metaphorical connections between the physical act of emptying the stomach and bowels, and clarifying one's mind.

### *Purity*

This category is close to the former. But there are significant differences. Purity has connotations to asceticism and spirituality, often relevant in anorexia nervosa. Pure food refers to low fat and low calories. But some of the patients also describe purity as few items of food, served separately and not blended. This serves to keep an overview and certainty of what one takes in. The purity and certainty on the plate refers to the longing to simplify one's life.

*Emily: My anorexia was there when everything else seemed unpredictable, excessive, in a frantic state. Its austerity, its plain, straightforward and concrete nature infused the unsure with something safe—it served as a channel to something more basic, minimalist, uncluttered, pure.*

This statement compounds purity with reduction—'minimalist'—making the anxious and emotionally overwhelmed Emily getting in contact with some 'basic' experiences.

*Sol: I became so pure, I hadn't sullied myself with food, conversation with others, or dirt on my body.*

Sol speaks about the period in adolescence when her anorectic symptoms started, how she isolated and devoted herself to this condition. In this statement, in one single sentence, purity is connected to three different realms; physical dirt, food and relations to others. This category demonstrates a metaphorical link between a physical experience of purity and simplicity and an emotional and relational reality.

### *Spatiality*

This category is about the concrete sensations of oneself filling space, meaning size, and the metaphorical links to the feelings of being allowed to 'take space' emotionally and in relations.

*Else: I am a hopeless person, not worth loving. Everything I do is stupid. I should not have been born, and very often I do think that I do not deserve to live. I cannot stand myself, I cannot stand more of myself than this (referring to her actual body size*

*with her hands). If I grow bigger, it will be unbearable.*

*Ingrid: It is difficult enough as it is. How big can I be? It is not about fat, it is about how much of me? How can I stand it if it becomes even more of me?*

Again, through the two cases, it is demonstrated how there is close and immediate relationship between a physical experience, and an emotional and relational analogue; with low self-esteem and negative self-evaluation linked to the sense of not being worthy taking up space.

### *Heaviness/lightness*

The patients' statements confirm how weight phobia is a key feature in anorexia. But they also show how the experience of weight goes beyond the pure physical experience. Some of the patients refer to a correspondence between the physical experience of weight and heaviness, and negative feelings of being burdened. Lightness is a relief, both a physical experience and an emotional state of relief.

*Christina: I dream of being so light that I can float in the air. Then I can move down the main street among the people, one meter above the ground, and I will feel that all my worries are gone, lifted off my shoulders.*

*Karen: I feel sad. And when I am sad, I feel burdened and heavy. . . and then comes the urge to lose weight.*

The last statement shows how a physical sensation follows an emotional reaction; emotions are concretised within a realm where she is obsessively worried.

### *Solidity*

The physical contact with one's body, experiencing the hardness of the skeleton and/or trained muscles, is underscored as important, bringing experiences of predictability and reducing anxiety.

*Hanna: Nobody can be trusted. Not my parents, not therapists, neither my friends. I am disappointed all the time. And then I get scared. I know it sounds crazy, but when I get scared, I really need some fixed points in my life. I need to feel my skeleton. I want physical contact with my bones. My bones are to be trusted. There have been times when I have*

*gained weight. That has been extremely difficult; I have not been able to sense my firmness.*

*Maria: When I don't have access (to bones and skeleton), when there is something between what I feel when I touch myself and my inside, then I get scared. I don't like it. Things are blurred.*

...

*I want to be hard. I will be hard as rock. Then I become more distinct to myself. If there are days without exercise, I sense that I am inert and terrible, and I lose control.*

*Emily: When my anorexia came, it concealed my soft, open vulnerability. It defined the blurry edges of my being with clear, hard straight lines; no diffuse, wandering self, no doubts about what I was, where I started and ended, I became fixed and unfluctuating.*

In all three cases the physical contact with the body's solidity corresponds with the experience of overview and certainty.

### Removal

This category is constituted of examples of how reducing body weight and body tissue metaphorically signifies to take something negative away. Getting slender relates to changing identity, taking something away and to open the possibility of reconstructing a new self, for 'a new start'.

*Hanna: When I was in hospital, admitted because of my extremely low weight, I remembered thinking that this is good. The old, chaotic, unhappy me is gone, and this is a new opportunity. Now I am down to bedrock. And this time I will be another person.*

*Else: I felt guilty all the time... People behaved far better towards me than towards my... friends. I had got too much of too many good things. I was rich, and they were poor. And I had not deserved it. By not eating, I think I tried to be another person, by peeling off my outer parts.*

Removing body tissue is equated with removing negative emotions and cognitions. These two cases demonstrate how issues of identity and psycho-

logical self are bodily concretised in anorexia nervosa.

To sum up, specific body metaphors are named so because they so directly refer to one domain of physical experience relating to an emotional and cognitive experience. This specificity makes clear the equivalent relation between emotion/cognition and sensorimotor experience/behaviour. It is worth emphasising that these quotations demonstrate that the drive for thinness in anorexia nervosa represents far more than reducing weight as such. They refer to a rich diversity of meanings of self-starvation, again based in a variety of bodily experiences, for example purity, spatiality and solidity. And it is to be repeated, as shown, that one patient can contribute to more of these categories.

### Compound Metaphors

In compound body metaphors, different and more domains of sensorimotor experience may interact with the experienced feelings. It is still the 'direct translation' from emotion and situation to bodily experience, but different functions of the body may take part in these symbolic processes. The categories that will be presented here are 'Vulnerability/protection', 'Control' and 'Self-worth' Table 2.

### Control

'Control' and 'self-control' are often referred to as central psychological topics in anorexia nervosa (Surgenor, Horn, Plumridge, & Hudson, 2002). The anorectic person, who has a feeling of not controlling her life, uses the control of appetite as a tool for an increased sense of control. There is a clear connection between the concrete eating as a source area and psychological control as a target area in the metaphorical process.

*Emily: My anorexia is the mask I wear to hide my gooey, amorphous, swirling insides from seeping out... In its absence, I feel I am being propelled along forces outside myself, out of control, merging*

Table 2. Compound body metaphors

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Control
Vulnerability/protection
Self-worth

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*into other roads without the time to react in an appropriate way. It helps me slow down and take a look around before I proceed. Through my eating disorder I have learned how I can avoid steep, crumbling roads, dark passages, and unknown territory that bring with it an array of surprises . . .*

*The questions that haunted me, the fluxes of life, and the inexplicable desires were harnessed when my anorexia and I were working together in our lofty pursuit of some unabashed true me. It was guidance, or faint whispers of it, as an alternative to the unfamiliar course I was travelling along without brakes, road signs, and power steering.*

...

*I think my anorexia helped to restore some order and direction to my life, and return to something more wholesome when my environment seemed overwhelming with endless choices. It assisted me in having not to choose. It was like a static, uncluttered refuge within me.*

*Elisabeth: I can't take any more changes. I need to control my life. I want the state of things to remain constant over time, so that existence is as predictable as possible . . . When, in my anorexic condition, I keep to a rigid food regime that maintains my weight at a very low level; it contributes to creating the security and stability, the sense of control, in my existence that I've never had.*

*Sol: My anorexia and I, together we had full control. It made me almost invulnerable. Other people? Who were they? Ignorant, superficial, boring people who did understand absolutely nothing. For us their way of living was worthless, we had something much bigger, better and more true. . . This not eating . . . was simply enormous. At last I'd found a way of bringing order to a world that had been nothing but chaos.*

*Helena: When I got the message that T, whom I loved so much, had committed suicide, the first thing I did was to go on the scale. I was losing the grip, and I felt my body expanding. I needed to do*

*something about that. . . that was the time when I got worse.*

The transcripts from the interviews also demonstrate the possibility of a two-way direction in the metaphoric process. Bodily experiences induce emotional and cognitive experiences, like controlling appetite may induce satisfaction. But emotions may also induce bodily sensations, as illustrated by Helena in the last statement.

#### *Vulnerability/protection*

Many of the patients' descriptions of their eating disorder refer to its role as a kind of protection. The anorexia is described as a reaction to a sense of vulnerability and of being unprotected, an 'openness' in body and relations. An emotional and relational openness induces a physical 'closing' of the mouth and the body.

*Helena: Now I must get well! I cannot stand this any longer. My anorexia has destroyed almost ten years of my life. But I am so afraid of the last kilos. I know I must, and that I shall. But I lose my nerve.*

*Why? Well, I think it is because I then will give away a kind of protection. When people see me today, they see that I am weak and vulnerable. When I have normal weight, they won't think anymore that I am weak. They will think I am strong, and they will attack me and put heavy demands on me. I am not sure that I am ready enough.*

*Sol: I well remember when I became sick, the world was difficult, it was full of perhapses; perhaps Mum and Dad were going to divorce, perhaps we were moving . . . and I was just supposed to stand there and be too little to understand anything. Everything was just DOUBLE. At the same time everything gradually became chaos; nothing fitted; things weren't the way I saw them, they said. I found the world difficult, but that wasn't right, they said. When I got anorectic, I felt safer. I had a mission. I could do things again. It protected me, understood me from top to toe from the very beginning. That was incredibly lovely.*

The protective nature of the anorectic syndrome becomes explicit through these statements. Majority of the patients also comment on the feeling of protection related to 'boundaries'. The eating

disorder is described as a strategy for instituting boundaries, and boundaries are experienced as positive and protective.

*Elisabeth: A buffer against the cruelty in the world; that is what my anorexia represents. It makes me unique; I cannot be confused with other people. I have a distinct outline towards the rest of the world.*

*Maria: I was not able to limit myself; I did not know where I started and where I ended. That is why I did like this: (She describes with her whole body how she diminished herself). Like from a grape to a raisin.*

*Sol: . . . in an otherwise limitless world, I was sure of my limit. In a world of empty stomachs and laxatives after the bouts of vomiting, I was certain, that boundary was quite certain, and the others had no choice, they had to respect the limit I laid down.*

These statements do, in various ways, illustrate problems of identity in anorexia, striving to achieve a more distinct experience of oneself and making psychological distinctions between inside and outside, self and others. Majority of the statements comment relations as potentially invading and damaging. The 'anorectic no' represents an existential and psychological closing towards such threats.

#### *Self-worth*

Many of the patients describe food not as a natural good, but as a reward. This may be surprising for some; they describe that they like food. The problem is that it is a luxury they cannot indulge in. Food is a benefit related to performance and efficacy, something one has to work hard for really to deserve.

*Else: This has been a bad day. I am a lazy person, I have done nothing extra. I don't feel I deserve to eat anything today.*

Again, there is a demonstration of the immediate connection, in the sense of the close analogy between the physical realm of eating and psychological realities. This category also, again, clearly demonstrates the central role of self-esteem and negative self-evaluation in anorexia nervosa. This category covers the feeling of not deserving something good, concretely expressed in food.

To sum up, these compound body metaphors are more 'global' than the specific 'local' ones, and

referring to emotional and cognitive experiences often referred to as central in anorexia nervosa, to mention a few, the sense of vulnerability and a threatened and overburdened self, experiences of lack of control in different realms of life, and low self-esteem inducing the feeling of not deserving. The compound body metaphors can be based on a combination of more specific body metaphors, that is the sense of control can refer to an empty stomach, a firm and solid body, being thin and a feeling of purity. But what is considered as the main finding in this main category of body metaphors, and similar to specific metaphors, is the immediate relation between emotion/cognition and sensorimotor experience/behaviour.

## DISCUSSION

In this discussion section the emphasis will be on the interactions between body and mind as presented above in the categorised statements from patients with severe anorexia nervosa. A limitation to the study is the limited number of interviewees. One should particularly be aware of the risk of extrapolating observed phenomena in a very limited clinical group to the whole clinical population fulfilling the criteria for the same diagnosis. The selected group in this study may be skewed or in some senses atypical.

To conclude the results:

- The categorised statements refer to a particular form of psychological functioning. The many quotations from patients in this text demonstrate the immediate connections between physical and psychological realities; the concretised feelings here-and-now.
- The transcripts from the interviews demonstrate the possibility of a 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 refer to the 'polysemic' character of embodiment in anorexia nervosa. Polysemi means that the sign refers to more meanings (Ricoeur, 1976; Johnson, 1987). Some of the patients contribute to more of the categories. They may contribute to different

specific metaphors and also to more of the compounds metaphors. 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. This is more open. The patients' statements demonstrate that denial of food may have many different, and also opposing, meanings at the same time. For the person with anorexia, a slender or emaciated body may simultaneously signify both strength (control) and weakness/vulnerability (hence, searching for experiences of protection). The anorectic behaviour represents a psychological crisis, a kind of poverty in mastering, but still the anorectic body is rich in a semiotic sense.

### **Reflective Function**

The human body is unavoidably metaphorical. We all ascribe a metaphorical meaning to the body that goes beyond the purely physical. This is neither mystical nor incomprehensible. But it is regularly hidden, being an everyday experience. It is so 'close' that it is difficult to see.

The statements presented in this study illustrate instances where the metaphors are not experienced as indirect expressions showing something thus mediated, but they are experienced as direct and bodily revelations of a concrete, often ruthless, reality. These 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 are difficult to negotiate with. The 'as-if' quality of the more abstract meaning of the metaphor is lost and it becomes an immediate concrete experience. This suggests impairment of the reflective function of the mind.

Such impairments in reflective function in anorexia nervosa have been described in terms of 'concretism' (Buhl, 2002), 'concrete attitude' (Miller, 1991), 'psychic equivalence' (Bateman & Fonagy, 2004; Fonagy, Gergely, Jurist, & Target, 2002) and 'concretised metaphor' (Enckell, 2002). These are different namings of basically similar phenomena. Within the context of this study, with emphasis on metaphorical processes, the concept of concretised metaphor is used. This is due to the fact that this concept has been thoroughly developed in a psychoanalytic context, linked to theory as well as clinical cases; hence being more than a pure description. In a review of literature, mainly

psychoanalytic, Enckell (2002) refers to such and similar concretised body metaphors as a reduction of the capacity to use functioning metaphors; a collapse of the symbolic room between the body and emotion/cognition. Through bodily sensations, the internal as well as the external world is given form.

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. Typically, the anorectic patient has unfortunately little conscious awareness of the metaphoric connections between her/his concrete symptoms and the underlying emotions and sense of self. *The anorectic problem is not that thinking is metaphorical but rather that she/he is possessed by these interactions of body and mind. The patient is 'used by' rather than using them critically in his/her thinking and acting.*

There is an agreement among many authors that such phenomena represent a regression or an insufficient development of symbolic capacity (Enckell, 2002). Campbell and Enckell (2002), among others, propose that concretised metaphors can be viewed as restitutive efforts. The concrete presentation can be seen as a reaction to a threat of inner fragmentation, and an attempt to maintain a cohesive mental configuration, albeit a concrete one. Different forms of stress may threaten the integrity of the self, and through concretisation these persons attempt to bolster their sense of self by trying to strengthen the experience of being grounded in their own bodies. Hence, the concretisation of metaphorical processing described here points to a vulnerable or distorted self-organisation in anorexia nervosa. This will be further developed in Part II of this study.

### **The Polysemic Body**

The results demonstrate that there is no unambiguous or closed relationship between food denial in anorexia nervosa and metaphorical content. In the history of anorexia nervosa, there are numerous examples of descriptions of possible meanings of symbolisation via the slender body. From the very beginning, since the diagnosis anorexia nervosa was made by Gull in England in 1872 and hysterical anorexia by Lasègue in France in 1873, there have been interpretations of the sexual, or rather anti-sexual, nature of the symptoms (Lasègue, 1873/1965). Psychoanalysis has without doubt been

influential in such an emphasis. Freud described anorexia nervosa as 'a melancholy where there is undeveloped sexuality' (1885, p. 200).

Reviewing literature from the last decades, the anorexic denial and isolation have been read in many different ways, both with reference to spirituality, religion, psychology; and in the contexts context of interpersonal relations, family and culture. It is the statement of the author that such interpretations are random, based on a limited number of clinical cases, and primarily theory- and ideology-driven from therapists and authors. The different symbolic readings of the anorectic body as text demonstrate the importance of cultural, theoretical and ideological contexts.

## CONCLUSION

The main topic of this interview study is the bodily concreteness of symptoms in anorexia nervosa. To understand the specific pathology of this disorder one should not look only for the possible metaphorical meaning of the anorectic behaviour, but for reflective function itself—the compromised capacity of making mental representations; of metaphorisation. It is necessary to search not only for *what* is symbolised, but also for *how* symbolised. 'Concretised metaphors' is a fruitful concept for describing such phenomena. It emphasises the deficit in reflective function and the acting-out nature of symptoms, and brings us closer to the specific pathology of this disorder. It may help us to realise why anorexia may be difficult to understand, and that the patient may be difficult to engage, because she or he is trapped in the concreteness of body symbolism.

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