

Eating One's Words: Part III. Mentalisation-Based Psychotherapy for Anorexia Nervosa—An Outline for a Treatment and Training Manual

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This paper presents a new outline for psychotherapy with persons with anorexia nervosa. 'Model on mentalisation' is the intellectual and empirical framework for this contribution. Mentalisation is defined as the ability to understand feelings, cognitions, intentions and meaning in oneself and in others. The capacity to understand oneself and others is a key determinant of self-organisation and affect regulation, and is acquired in early attachment relationships. Impaired mentalisation is documented and described as a central psychopathological feature in anorexia nervosa. Psychotherapeutic enterprise with individuals with compromised mentalising capacity should be an activity that is specifically focused on the rehabilitation of this function, with special emphasis on how the body is representing mental states. The paper describes psychotherapeutic goals, stances and techniques. It is intended that this outline will be further developed into manuals as a basis for therapy, training and research. Copyright © 2007 John Wiley & Sons, Ltd and Eating Disorders Association.

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INTRODUCTION

The aim of this paper is to propose an outline for psychotherapeutic approaches to anorexia nervosa, and to introduce a 'model on mentalisation' (Allen & Fonagy, 2006) as an intellectual framework for

developing therapeutic techniques for this disorder. There is a general agreement that working with anorexia nervosa may be challenging. Ambivalence about recovery is a central feature. Patients with anorexia rarely seek treatment on their own initiative (Rosenvinge & Kuhlefeldt-Klusmeier, 2000), the motivation to change is low and/or unstable (Geller, Williams, & Srikameswaran, 2001), approximately one-half of the patients drop out of treatment (Vandereycken and Pierloot, 1983) and in a review Fairburn (2005) states that treatment

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outcome is generally poor. Despite research efforts there is a striking paucity of empirical evidence supporting any method of treatment for anorexia nervosa (Woodside, 2005).

This is the third and final part of three companion papers, 'Eating one's words I, II and III'. The series aims at furthering the understanding of the specific psychopathology of anorexia nervosa, based on research (Part I, Skårderud, 2007a), apply and develop relevant theory (Part II, Skårderud, 2007b) and outline psychotherapy on this empirical and theoretical basis (Part III). The recommendations for therapy follow the principle that psychotherapeutic interventions should be tailored directly to psychopathological processes.

Part I reports from an interview study based on qualitative research methods. The study demonstrates how bodily sensations and qualities like hunger, size, weight and shape are physical entities that represent mental states. The overall finding is the isomorphism between inner and outer reality, mind and body. The patients demonstrate a closeness, a more or less immediate connection between physical and psychological realities; for example restrictive control of food represents psychological self-control. The 'as if' of mental representation is turned into an 'is'. Most persons with anorexia nervosa experience this corporeality as an obsessional and ruthless reality which is difficult to escape from. This concretisation of mental life is interpreted as impaired 'reflective function' and 'mentalisation', and is proposed as a central psychopathological feature in anorexia nervosa.

'Reflective function' is the broader concept and refers to the psychological processes underlying the capacity to make mental representations. This concept has been described both in the psychoanalytic (Fonagy, 1989, 1991) and cognitive (e.g. Morton & Frith, 1995) psychology literatures. 'Mentalisation' is an aspect of reflective function, and can be defined as 'keeping one's own state, desires, and goals in mind as one addresses one's own experience, and keeping another's state, desires, and goals in mind as one interprets his or her behaviour' (Coates, 2006 p. xv).

Part II develops further theoretical concepts to discuss the empirical findings and to describe impairment of reflective function in anorexia nervosa. 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, the patients are forced to experience

the self from without. Anorexia nervosa is described as a disorder of self- and affect regulation, and the concretistic symptoms essentially serve the function of maintaining the cohesion and stability of a tenuous sense of self.

The idea that severe eating disorders are essentially self disorders has emerged gradually as clinicians and researchers have recognised the need to revise earlier conceptual models because of serious limitations in their ability to explain the clinical features of the eating disorders and to devise effective therapies (Taylor, Bagby and Parker, 1997). Already the pioneer in eating disorders, Bruch (1962) stated 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.

Finally, this Part III, building on research results and theory in the preceding texts, and on clinical experience, deals exclusively with the psychotherapy of anorexia. The first section of the paper describes the 'model on mentalisation'. The second section applies these conceptual tools to describe more precisely the difficulties, limitations and hindrances to psychotherapy with anorexia nervosa. And, based on these descriptions, the third section will outline some basic approaches and goals in therapy. *Psychotherapeutic enterprise with individuals with compromised mentalising capacity should be an activity that is specifically focused on the rehabilitation of this function.* In the history of interpreting anorexia there are numerous descriptions of the possible symbolic meanings of symptoms. This text will try to move interest from the 'what is symbolised' to 'how symbolised', from interpretation of *meaning* to enhancement of *function*.

A MENTALISING THEORETICAL AND THERAPEUTIC PERSPECTIVE

Mentalisation

The concept *mentalisation* originates from French psychoanalysis (Lecours & Bouchard, 1997; Luquet, 1987; Marty, 1990) in the late 1960s, but diversified in the early 1990s when Baron-Cohen (1995), Frith and Frith (2003) and others applied it to neurobiological based deficits in autism and schizophrenia, and, concomitantly, Fonagy, Target and colleagues (Fonagy & Target, 1996, 1997; Fonagy, Gergely, Jurist, & Target, 2002) applied it to developmental psychopathology in the context of attachment

relationships gone awry. This text leans on works in the latter tradition (Allen & Fonagy, 2006). Anthony Bateman has together with Peter Fonagy been a pioneer in translating theoretical principles into therapeutic principles (Bateman & Fonagy, 2004). The scientific and clinical staffs at The Menninger Clinic in Texas, USA, are also important contributors, with Jon G. Allen (Allen, 2001, 2003, 2006) as a prominent professional.

The model is based on developmental psychology and contemporary psychoanalysis, and, not least, with a strong ambition to integrate recent developments in neuroscience. The model also includes revised versions of 'attachment theory'. Originally Bowlby (1969) described the human biological urge to search for a secure base of attachments for survival and development. Attachment is seen as an innate biological instinct to ensure protections and reproduction through physical proximity to caregiver. Attachment is a context for the development of the social brain. Basic polarities for attachment theory are approach—avoidance, security—insecurity, attachment—loss (Holmes, 2001).

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. It posits that a sense of self develops from observing oneself being perceived by others as thinking or feeling. By internalising perceptions made by others about him—or herself, the infant learns that its mind does not mirror the world; its mind interprets the world. This capacity is referred to as mentalisation, meaning the capacity to know that one has an agentive mind and to recognise the presence and importance of mental states in others (Gunderson, 2004). Secure attachment promotes mentalising capacity, while insecure attachment and trauma can undermine it.

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. And the works of Fonagy and collaborators also show that this mentalising capacity provides a critical link in the transmission of attachment security across generations. Mothers and fathers who scored high on this dimension tended to have children who were secure. 'Insight is

not only good for you but it is even better for your children' (Coates, 2006 p. xvi–xvii).

In summary, mentalisation has been empirically linked to important findings in development, both in neuroscience and clinical psychology; in the understanding of psychopathology; and in the conceptualisation of treatment efficacy both in children and adults. 'What we have here is something of a conceptual revolution, one that is still underway' (Coates, 2006 p. xvii).

The concept may for some appear to have a dehumanising and technical ring to it, and should be humanised. We must keep in mind that the mental states perceived and the processes of perception are suffused with emotion; hence, mentalising is a form of emotional knowing (Allen, 2006). Mentalising is the normal ability to ascribe intentions and meaning to human behaviour, to understand 'unwritten rules', and shapes our understanding of others and ourselves. Hence, it is central to human communication and relationships. It can be described as being able to see oneself from the outside and other persons from the inside. There is an ethical aspect to this: The better one understands other people's behaviour, the harder it becomes to treat a person as a thing.

Mentalisation is about 'mind-mindedness', having mind in mind. Related concepts are 'empathy', 'emotional intelligence', 'psychological mindedness', 'metacognition', 'insight', 'observing ego', 'mindfulness', 'interpretation' and 'reflection'. Mentalising involves both a self-reflective and an interpersonal component that ideally provides the individual with a well-developed capacity to distinguish inner from outer reality, physical experience from mind and intrapersonal mental and emotional processes from interpersonal communications. Hence, the anorectic concretisation of emotional life can be described as one of more possible presentations of impaired mentalisation.

Mentalisation means to be able to understand one's misunderstandings. Impaired mentalisation may cause confusion and misunderstandings, acting on false assumptions. Being misunderstood is highly aversive. It may generate powerful emotions that result in coercion, withdrawal, hostility, over-protectiveness or rejection—and symptom increase (Bateman & Fonagy, 2004). The psychiatric patient with impaired mentalisation, for example a person with anorexia, will often experience the vicious circle: Impaired mentalisation creates misunderstandings and ruptures in relations, and an insecure world becomes even more insecure. Such stress, fear and affective arousal will further impair

the mentalising capacity. And, hence, the anorectic withdrawal and way of behaving may appear as an island of control and predictability.

Mentalisation-Based Therapy for Borderline Personality Disorder

The scientific tradition on mentalisation aspires to develop a new intellectual framework for psychotherapy (Fonagy, 2006a). Based on developmental studies of psychopathology, the ambition is to identify psychological and neural mechanisms underlying disturbance, and, consequently, employ therapeutic techniques specifically designed to address a developmental dysfunction.

Psychotherapy provides an opportunity for intensive practice in mentalising. The therapeutic relationship is an attachment bond, and one important aspect of psychotherapy is that it activates attachment systems. An effective psychotherapeutic relationship is the best analogue of a secure base in attachment that fosters mentalising. 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, such as occur in transference enactments.

So far, the main work has been done with borderline personality disorder. A mentalisation-based format for psychotherapy for borderline personality disorder, MBT, was developed and manualised, and has been shown to be effective in a randomised controlled clinical trial (Bateman & Fonagy, 1999). In that study, MBT was provided in a day-hospital setting for 18 months and was contrasted with usual psychiatric care. MBT showed effective results in diminishing hospitalisations, medication usage and suicidal and self-injurious behaviours. In addition, it also showed significant benefits in symptoms of depression and anxiety, and in social and interpersonal function. Particularly impressive was that patients continued to improve during an 18-month period of follow up (Bateman & Fonagy, 2001; Gunderson, 2004).

In advocating mentalisation-based treatment there is no claim of innovation. 'On the contrary, mentalisation-based treatment is the least novel therapeutic approach imaginable; it addresses the bedrock capacity to apprehend mind as such. . . . Nonetheless, fostering the capacity to mentalise might be our most profound therapeutic endeavour: cultivating a fully functioning mind is a high aspiration indeed' (Allen & Fonagy, 2006 p. xix).

Most psychotherapies probably promote mentalising capacities. The activity of mentalising is the core of psychotherapy, as it is of childrearing and ethics. It underpins clinical understanding, the therapeutic relationship and therapeutic change. And it is an old assumption that much of the effectiveness of different forms of psychotherapy may be due to those features that are common rather than those that distinguish them from each other (Frank, 1961). *But, the specific aspect of mentalisation-based therapy is the systematic focus on the enhancement of mentalising itself. In that sense, mentalisation can function as a superior concept guiding clinical work, and with the emphasis on both cognitive and emotional processes bridge psycho-educative, cognitive and psychoanalytical techniques.* But different from traditional cognitive therapy working with own thoughts, the mentalising approach also focuses on the feelings and thoughts of others.

A mentalising approach can be seen as simplifying the basic steps in psychotherapeutic encounters, either in individual, group or marital and family treatment contexts; not at least in milieu therapy. Promoting a mentalising attitude means an inquisitive, playful, curious and open-minded style in dialogues, with a focus on minding the mind. A mentalising attitude focuses on promoting the *attentiveness* to the activity of mentalising. And Allen (2006) proposes that the better term is *mentalising*, and not *mentalisation*, emphasising the activity.

Minding Anorexia Nervosa

Today, there is no correspondingly well-developed mentalisation-based model for psychotherapy for anorexia nervosa. And a model for the psychopathology and therapy for borderline personality disorder cannot, of course, be directly applied to other kinds of disorders. But as there are important differences, there are also striking similarities in the modes of experiencing psychic reality in borderline personality disorder and eating disorders. And there is also a documented comorbidity of these two disorders (Rosenvinge, Martinussen, & Østensen, 2000; Skodol, Oldham, Hyler, Kellman, Doidge, & Davies, 1993).

Mentalisation is operationalised for scientific research as 'reflective function'. 'Reflective-functioning manual' (Fonagy, Target, Steele, & Steele, 1998) is developed to measure reflective function based on the 'Adult Attachment Interview, AAI' (Main & Goldwyn, 1995). In a study from Cassel Hospital in the United Kingdom 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, anti-social or paranoid disorder, other personality disorders and no Axis II. The eating disordered patients scored lowest on reflective function together with the patients diagnosed as borderline personality disorders (Fonagy et al., 1996).

Not least to promote therapists' beliefs in their own competence, it is appropriate to deconstruct parts of the myth that anorexia nervosa is such a particular phenomenon. From the perspective of supervision and training, it is important to help therapists to learn about the particularities connected to this disorder. Such specific competence is relevant in itself, but just as important is that competence may function as a door-opener to the demystification of the disorder. When one understands what is special, it is easier to recognise what is common. And recognising common aspects may enhance professional self-confidence. Anorexia nervosa is still an enigma, but it is important to deconstruct the myth of anorexia as extremely difficult to comprehend and treat. The reference to common traits in psychological functioning in anorexia nervosa and, for example borderline personality disorder, to think *transdiagnostically*, may contribute to openness, interest and curiosity. Today, there is a risk of isolation of professional milieus working with anorexia nervosa.

Mentalising may serve a function as one amongst other theoretical and empirical concepts constituting a base for tailored therapeutic activity. But it is important to emphasise that, with respect to the psychopathology of anorexia nervosa, the tradition of mentalising is far from satisfactorily elaborated. Not least, this refers to the need to develop models concerning *embodiment*; 'the embodied mind' and 'the minded body'. There are many dimensions of human embodiment, but here it applies specifically to the role of the body in the development of mind, both in normal development and in different psychopathologies.

Let us redefine: Maybe the case of anorexia nervosa and eating disorders may represent the phenomenological ground for such elaboration. A person with anorexia will most often be a person with difficulties in interpreting and regulating their own affects, in interpreting other peoples emotions, but not least in perceiving and interpreting their own corporeality. Bruch (1962) observed that anorexic patients manifest difficulties in accurately perceiving or cognitively interpreting stimuli arising

in their bodies, such as hunger and satiety, and also fatigue and weakness as the physiological signs of malnutrition. The person with anorexia can be a person who is obsessively preoccupied with bodily qualities and sensations most of the 24 hours of the day, and at the same time has distorted experiences of their own physical body. Hence, anorexia nervosa can be described as embodiment gone awry, therefore elucidating developmental processes, and as such contributing to widening the scope of the mentalising-model.

The challenge for the therapist is to become a better mentaliser. This challenge increases when mentalising non-mentalising and impaired mentalising. But one can also redefine this, and state that psychopathology itself, as in anorexia nervosa, may help us in this effort. Psychopathology compromises mentalising, and scientific knowledge develops descriptions that can guide the psychotherapeutic approach and focus.

It is stated here that more of the basic principles applied in the treatment model for borderline personality disorder are utterly relevant for working with anorexia nervosa; since they refer to the fundamental capacity of mentalising as such. But further developments are also necessary. Hence, anorexia nervosa can contribute to widening the scope of mentalisation-based treatment and psychotherapy.

LIMITATIONS TO THERAPY

It is a main thesis in this paper that the described central aspects of the psychopathology of anorexia nervosa are not adequately understood and taken account of in many therapeutic encounters. In practical terms this means insufficient assessments or over-estimating the patients' mentalising capacities. The patient's intellectual skills may confuse therapists.

Therapeutic Alliance

Uncertain motivation for recovery is a relevant topic for many patients and health workers may lack motivation to work with them. Few symptoms can create stronger reactions in therapists than anorexia nervosa and few require more forbearance.

After approximately a half century of psychotherapy research, one of the most consistent findings is that the quality of the therapeutic alliance is the most robust predictor of treatment success. This finding has been evident across a wide range of

treatment modalities. A related finding is that poor outcome cases show greater evidence of negative interpersonal process, that is hostile and complex interactions between therapist and patient than good outcome cases (Safran & Muran, 2000). It has also been shown that 'patient factors' such as motivation make the greatest contribution to the therapeutic alliance (Horvath & Symonds, 1991). Many clinicians find it difficult to establish healthy working alliances with their patients with anorexia nervosa. Let us address this problem from two perspectives, 'theirs' and 'ours'. The dual perspective is: how to understand patients, and how to understand therapists' negative reactions.

Patient factors

Anorexia nervosa often represents great therapeutic challenges, not least due to the impaired mentalisation and more precisely the concretisation of emotional life.

Patients' lack of insight into illness. One limitation in therapy is the patient's lack of insight into their own illness. The body functions metaphorically (Skårderud, 2007a, 2007b), but this symbolic communication via the body is not experienced as metaphors by the anorectic patients, but rather as concrete reality. It is the bodily reality here-and-now, a harsh reality difficult to escape for the patient. Representations become presentations.

Restorative function of symptoms. Another limitation in therapeutic processes is the possible restorative function of symptoms. The symptoms are destructive, but at the same time they may function for self-cohesion and affect regulation; and therefore may be subjectively experienced as constructive. This contributes to unstable or absent motivation for recovery. The patient may seem to be trapped in the concreteness of mind-body representation, and this may help us to realise why he or she may be so difficult to engage in therapeutic relations.

Alexithymia. Impaired mentalisation in anorexia nervosa will often be expressed, or rather not expressed, as incapacity to give verbal accounts of one's inner states. Bruch (1962) 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'. And the concrete way of functioning mentally may represent paucity or absence of verbal accompaniment, often contributing to frustrating and non-productive silences in the therapeutic situation.

Pseudo-compliance. Patients with anorexia are described as 'outer-directed' (Buhl, 2002), in the sense that low self-esteem induces a high sensitivity for attention, tokens of esteem, praise and comparison and great interest in compensating low self-esteem through performances, achievements, skills—and a sensitivity and a drive for satisfying other peoples' needs (Skårderud, 2007c). This may be expressed in high compliance towards people—and therapists. 'The clever child' also tends to aspire to be 'the clever patient'. Using a Winnicottian term, the 'false self' is at work (Winnicott, 1975).

From the therapist's perspective this may be conceived as *pseudo-compliance*. Actually, there is no working alliance, but mainly an ambiguous form of politeness; saying 'yes', meaning both 'yes' and 'no'.

Self- and affect regulation. Patients with anorexia often present themselves via their lacking capacity to *tolerate, modulate* or *synthesise affects*, expressed both through their affective and cognitive either-or, all-or-nothing. In clinical terms therapists may experience oscillations between restrictive silence and outburst of both positive and negative affects; for example excitement, enthusiasm, fear, rage and shame.

Physiology and psychology of hunger. In addition, as therapists we are often confronted with *physiological* symptoms of under-nourishment and malnutrition, like tiredness and exhaustion. And there are the *psychological* symptoms of malnutrition. The somatic states will in themselves often contribute to dysfunctional psychic phenomena, such as emotional instability, low spirits, irritability, apathy, reduced power of concentration and memory, compulsive behaviour and rituals and, logically enough, increased preoccupation with food rituals, often with fear of binge eating. This is what we call 'the psychology of hunger', where psychic symptoms are 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.

Impaired mentalising—by age. And, not least, treating anorexia nervosa often means working with adolescents; immature by definition and

whose mentalising capacities are not yet fully developed.

Therapist factors

A possible negative contribution to therapeutic enterprises does not concern the patients, but the therapists; and our difficulties with being able to understand the very nature of these disorders. A lack of understanding can lead to a lack of commitment and patience, to moralising statements and coercive behaviour; or worse—provoked to aggression and rejection. And this may be reinforced by self-starvation inducing clinicians' rational fear of somatic complications and death. Anorexia nervosa is a psychiatric disorder with a rather high mortality rate (Nielsen, 2001). But rational fear does not necessarily lead to rational reactions. Filled with such frustrations, therapists may elicit potentially treatment-destructive interventions.

Therapists' lack of insight into illness. Some therapists seem to be more prepared to endure aggressive outbursts, verbal attacks, acting-out and overtly destructive behaviour, for example from persons diagnosed with borderline personality disorder, better than the silence, isolation and restriction of the anorectic.

The excluded therapist. Health workers experiencing rejection is well-known in clinical work with anorexia nervosa; and enduring rejection is difficult. The anorectic person's withdrawal into the 'realm of the concrete' is perceived also as a withdrawal from relationships and as an exclusion of the clinician. The shame-based denial by the patient, claiming not to be worthy of any help or anything good (Skårderud, 2007c), may similarly be experienced as a provoking disruption of attachment.

Therapeutic freedom. The drama of soma, threat of death and the anorectic 'no' restricts the therapist's freedom of movement. Anorectic behaviour is *utterly seductive* in the way it directs attention and focus from emotions and the person's subjective experiences to physical entities like gram, kilo and calories. In this way anorexia nervosa is 'contagious'. And it may be contagious in the sense that clinicians in the therapeutic relationships reproduce patients' rejective style of attachment, with high risks for drop-outs and disrupted therapeutic relations.

Therapists' impaired mentalising. The concept of mentalisation is relevant not only to describe patients, but also their helpers. The capacity of mentalisation is contextual; it is far from an either-or capacity. In some situations we all mentalise badly, in the sense of being able to understand the others' position. Mentalisation is reduced in situations of affective arousal and in intensive attachment relations, like threat of separation, relieving attachment traumas. Hence, impaired mentalisation is contextual. And the severely ill anorectic patient may also in some contexts appear to be a good mentaliser. Therefore, she or he confuses us.

And when confused, the therapist may feel frustrated and provoked, and mentalising is impaired.

To sum up, the very nature of the psychopathology of anorexia nervosa, here called 'patient factors', and clinicians being intellectually and emotionally challenged by these disorders, here called 'therapist factors', together represent great hazards in terms of harmful effects on the therapeutic alliance.

Impaired mentalisation and psychic modes of reality. In the following paragraphs there will follow elaborations of the hindrances and complications already described, with conceptual reference to the model on mentalising. It is a basic premise in psychodynamic therapy that there are related processes coming into being between the infant and caregivers, and later between patient and therapist. Former and actual relationships are reciprocal metaphors, and the Greek *meta-phoros* is etymologically very close to Freud's original German concept of *transference*, *Übertragung* (Enckell, 2002). History becomes a model to understand the contemporary, and the contemporary becomes a model to understand history. And where therapeutic alliances are established, where new attachment bonds are formed and activate former bonds, new possibilities for development and change appear. Half a century ago Alexander (1952) established the concept of 'corrective emotional experience'.

The outline of therapy presented here is in this manner theoretically founded in models of developmental psychology. In the further presentation there will be an emphasis, with explicit reference to the tradition of mentalising, on psychic modes of reality that can be experienced and described in anorexia nervosa. There will also be an emphasis on corporealities; how different modes of realities involve bodily experiences. The presentation will be illustrated with clinical examples, demonstrating

both psychological function and how this may be expressed in therapeutic relations.

Psychic equivalence

Psychic equivalence as a construct means equating the internal with the external world (Fonagy, 2006b; Fonagy et al., 2002), and refers precisely to the empirical findings described in the first paper in this series of three (Skårderud, 2007a). *Psychic equivalence covers one central aspect of the phenomenological essence of embodiment in severe anorexia nervosa*. Psychic equivalence refers to an interesting, but problematic mind–world isomorphism. What exists in the mind must exist in the external world, and what exists out there must invariably also exist in the mind.

Possible clinical expressions relevant for treatment. Psychic equivalence in anorexia nervosa is about carnal thoughts and emotions. Part I presents a number of examples of equivalence between body and mind in anorexia nervosa, and the process of equating goes both ways: What is thought and felt, is also perceived as physical reality. And bodily perceptions represent emotional realities. The patient experiencing lack of control in her life, can also have an experience of bodily expansion, getting bigger and fatter. Hence, psychic equivalence is relevant for the understanding of the 'body image disturbance' in anorexia nervosa. It is a clinical experience, not yet satisfactorily described in research literature, that body image disturbance is contextually dependent on affective state; most prominent when there is negative affective arousal. The 'as if' of the representational mind is turned to an 'is'.

Part I gives examples of how the anorectic patients ascribe numerous possible meanings to symptoms. Hence, there is richness in what being symbolised, but poverty in how to symbolise. The psychic pain for the patient is that he or she is trapped in this harsh corporeality here-and-now; and does not satisfactorily mentalise how his or her body functions as a metaphorical source for emotional life, and vice versa.

For the therapist the mode of psychic equivalence may contribute to confusion: inner states are concretely presented in a bodily way. Common psychological states are low self-esteem, insecurity and confused identity, affect dysregulation and ambivalence. These may concretely be lived out as ambiguous and contradictory messages, and literally confusing us. The patient in inner conflict with herself, plays out these conflicts. Here are some

examples, all referring to one or more of the patients interviewed in Part I:

She tries to be somebody by becoming nobody. She is the one who is most hardworking to be clever and most ill. She is very interested in food, but does not eat it. She tries to improve her self-esteem by destroying herself. She sacrifices herself to save herself. She behaves like a small child, and as a mother for her parents. She is the self-obliterating child governing the whole family. She is the most obedient protesting most violently. She is conforming and different. She longs for help, and despises her helpers.

Psychic equivalence may for the therapist represent a frustrating difficulty to engage the patient and establish a fruitful working alliance. The patient's 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 is expressed as distrust towards scales, amounts of food but also the trustworthiness of the therapist. Insecure identity generates the patient's tendency to compare themselves with others, concerning concrete achievements and bodily qualities. The therapist working with anorexia and eating disorders should be aware that one's own body is being assessed and judged; and this may impair therapeutic relationships, particularly in initial phases. Hence, the therapeutic relationship and interchange, and other relationships, are also concretised and psychologically equated.

Teleological stance

'Teleological stance' is introduced as a concept to deepen the understanding of such physicalisation of life and relationships. As a child normally develops, it gradually acquires an understanding of five increasingly complex levels of *agency of the self*: physical, social, teleological, intentional and representational (Fonagy et al., 2002; Gergely, 2001). Teleological stance refers to a developmental level where expectations concerning agency of the self and the agency of the other are present, but these are formulated in terms restricted to the physical world. 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'. Patients have problems accepting anything other than a modification in the realm of the physical as a true index of the intentions of the other.

Possible clinical expressions relevant for treatment. In the world of psychiatric disorders anorexia nervosa and eating disorders represent a special case, in the sense that in the biographies of the patients one can find an initial active wish for change. The persons want to change themselves, in self-esteem and social acceptance, and such changes are sought to be fulfilled by physically changing their bodies. Hence, teleological stance may be a useful concept to describe and understand the concretisation of ambitions for self-improvement in anorexia nervosa.

Teleological stance is also relevant to understanding relationships in general, and therapeutic relationships in particular, like battles about agreements, appointments, contracts, time, money and attention. If the therapist really cares, he or she is expected to show this benign disposition and motivations to be helpful in concrete manners; like availability on the telephone, extra sessions at weekends, physical touching, holding and acts 'beyond rules'. Hence, this may contribute to violations of therapeutic boundaries (Bateman & Fonagy, 2004).

Pretend mode In a developmental perspective 'pretend' represents for the child an alternative mode of experiencing reality. It is a decoupling of internal from external reality (Fonagy, 2006b; Fonagy et al., 2002). Actually the child is playing and 'playing with reality' (Winnicott, 1971). In a clinical perspective with adolescents and adults 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 on the part of the therapist 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. As Bateman and Fonagy (2004) write about therapy with borderline patients: "Therapy' can go on for weeks, months, sometimes even years, in the pretend mode of psychic reality, where internal states are discussed at length, sometimes with excessive detail and complexity yet no progress is made, and no real understanding is experienced' (p. 70). Ideas do not form a satisfactory bridge between inner and outer reality and affects do not accompany thoughts.

Possible clinical expressions relevant for treatment. A clinical feature, not at least in anorexia nervosa, may be feelings of emptiness, meaninglessness and dissociation in the wake of trauma. In the thera-

peutic relationship this may lead to endless inconsequential talk of thoughts and feelings, and will be experienced as tiresome by the therapist. The dialogues may appear as relevant, given the topics of emotions and thoughts, but with minor effects. This represents *pseudo-mentalising*. Pretend mode as a concept is a useful tool to widen the understanding of ineffective therapy. The alexithymic patient may lack words for inner life, while the patient in pretend mode has words, but they are not yet their own.

The described outer-directedness, with the patient trying to interpret and satisfy other people's needs (Buhl, 2002), may lead to *hyper-mentalising*. The combination of pseudo- and hyper-mentalising may contribute even more to the confusion described above.

Pretend mode—as 'not being in contact with'—may also be relevant if furthering the understanding of the nature of body image distortion in anorexia nervosa. One of the patients interviewed in Part I, Maria, spoke of her body. When underweight she described a satisfactory firmness of her body above the waist. 'Then I become more distinct to myself'. But she did have a radically different experience with her thighs and legs, particularly thighs. She used words like numb, fatty, liquid and without borders. And when she was scared or stressed, she felt this even worse; 'it is as they live their own lives, beyond my control, and sometimes they are in the other part of the room'.

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 have the full quality of internal reality. *Pretend mode is too unreal, while psychic equivalence is too real*. In normal development the child integrates these two modes to arrive at a reflective mode, or mentalisation, in which thoughts and feelings can be experienced *as* representations. 'Inner and outer reality are seen as linked, but separate, and no longer have to be either equated or dissociated from each other' (Bateman & Fonagy, 2004 p. 70).

THERAPY

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 effects are hopefully reduced if intensity and therapeutic

approach is carefully titrated to patient capacities (Bateman & Fonagy, 2006). Based on what is presented in Parts I and II and about obstacles to and possible complications in therapy, this section will outline some very basic goals and tasks in psychotherapy to further such titration in the work with anorexia nervosa. The text will not deal with organisational aspects of treatment services.

A fundamental assumption is 'entering the concrete'; to point to the expediency of entering the phenomenological world presented by the patient; an acceptance and understanding of the patients' way of mental functioning. The psychoanalyst Josephs (1989) writes that 'an alternative to getting the patient to enter the realm of the symbolic (the therapist's world), is the therapist instead entering the realm of the concrete (the patient's world). After all, the patient is usually looking for an ally' (p. 495).

Therapeutic Alliance

This is a vital insight for building healthy therapeutic alliances. A necessary primary focus is the establishment of a working relationship between patient and therapist; given the robust scientific knowledge about the predictive value for good outcome of the therapeutic alliance and given the frequent difficulties with establishing such in work with anorexia nervosa.

There is a growing body of neurological evidence for the importance of secure attachment for mentalising capacity (Slade, Belsky, Aber, & Phelps, 1999; van Ijzendoorn, Moran, Belsky, Pederson, Bakermans-Kranenburg, & Kneppers, 2000). Insecurity, affective arousal and attachment traumas impair mentalisation, while a secure base represents open-mindedness. Activating attachment systems is facilitating change. What is the therapeutic alliance if not an attachment bond? Hence, a working alliance can in itself be considered as beneficial for enhancing mentalisation. And the other way round: serious relational ruptures may for the patient function as being (re)traumatised.

The presented model of psychopathology represents an intellectual basis for the development of the therapeutic alliance. A theoretical model of psychopathology is always as a simplification, using a set of conceptual metaphors. A model can be most helpful to organise the confusing phenomenology presented by the patients, as described above. And, hence, it can help us to better understand and tolerate such confusing appearances. A model of mentalisation when working with anor-

exia nervosa can be helpful for the therapist as a buffer against affect arousal. The therapist's mentalising the patient's impaired mentalisation may make it easier to empathise with the patient, like the patient, and enhance his or hers 'negative capability', that is the capacity to tolerate and doubt and to 'stay with' the material (Holmes, 2001).¹

'Psychic equivalence' as a construct is most helpful to deconstruct confusion. The same goes for 'concretised metaphor', extensively presented in Parts I and II, referring to the same phenomena with other terms (Enckell, 2002). Bodily sensations and qualities metaphorically represent mental states. The anorectic body can be 'read' as a text (Ricoeur, 1977). The equation of inner and outer reality makes it possible to decipher symptoms and bodily behaviour as distinct expressions of emotional states. The problem is, and what we often do not see, is that it is too distinct. Bodily practices of anorexia can be read as statements of both problems and solutions, of 'pros' and 'cons' (Serpell, Treasure, Teasdale, & Sullivan, 1999). The anorectic body may refer to loss of control, vulnerability, distrust, sense of ineffectiveness and being overwhelmed by affects and contradictory demands. And they refer to attempted solutions, as strategies for control, protection, reduction, effectiveness, purity and radical simplification.

Confusion can be unravelled by reducing the complex to the simple, but confusion can also be created by reducing complexity into something that is too simple, that is body-mind isomorphism. Confusing bodily practices in anorexia nervosa can be read as confusion itself is the message. What therapists need to see, is that the confused state is not ours, but the patient's. These disorders communicate distinctly about being indistinct; they speak precisely about the patients' sense of vagueness, insecurity, ambivalence, paralysing ambiguity and affective dysregulation. The patient's body and behaviour may be interpreted as messages about being emotionally malnourished. They do not have what they need to feel safe. And the body 'talks' about that dilemma.

Mentalising the patient, and being able to see beyond bodily practices and symptoms, most often reveal the anorectic person's anxiety, fear and an incapacity to handle one's own affects. It is a wrong assertion to see the patient as 'strong' with a firm will. Symptoms are driven not by strength, but by a

¹ The term 'negative capability' stems originally from the poet Keats, referring to his prescription for approaching poetry (Holmes, 2001).

sense of weakness, fright and despair. Hence, the therapeutic focus on securing, assuring and making safe is important. The patient's fear and anxiety is concretised as fear about food, weight, etc., and the therapist's genuine interest in even details may be reassuring and beneficial for the working alliance. One shows interest in what engages the patient most, although using this to bridge the concrete preoccupancies with affects. And since fear most often is a key feature, demonstrating one's knowledge about eating disorders as such, may be comforting. Mentalising the patient's impaired mentalising capacity also reveals that recovery most probably will demand time. Hence, patience and slow progress is necessary when working with persons who are severely ill with anorexia. Therapeutic impatience will often be harmful for the alliance.

The eventual teleological function of anorexic patients requires the therapist to ensure that they do what they say they will do. Motivation of others is judged by outcome. Promises must be kept within the agreed time. Whilst a neurotic patient may accept that a therapist has forgotten something and accept an apology or the offer of an alternative explanation, the teleologically functioning patient may believe that the therapist has forgotten because he or she does not like the patient or wants to punish her or him (Bateman & Fonagy, 2004). The apparently small error may be conceived as a serious violation.

Mentalisation-Based Treatment of Anorexia Nervosa

Introducing a mentalisation-based treatment approach to anorexia nervosa means that the main priority is not content, but *function*. The main aim of psychotherapy with anorexia nervosa is not primarily to achieve specific 'insights' into oneself or one's past, however interesting or intellectually satisfying these may be, but rather to develop the function for minding oneself and others; and to distinguish between bodily sensations and mental representations; to identify feelings, thoughts and impulses, for example put them into words; and in general assist the capacity of symbolising,

The possible meanings of symptoms in anorexia may be many, not one and only (Nordbø, Espeset, Gulliksen, Skårderud, & Holte, 2006). Of course, the investigation of meaning is highly relevant and important in the specific therapeutic relationship. But, it is the investigation as such, the *activity*, the curiosity, wondering and explorative mood which are in focus. Content is important, but there is a basic focus

on the process of mind-mindedness itself. The further presentation leans partly on some of the guidelines described by Bateman and Fonagy in their manual 'Psychotherapy for borderline personality disorder' (2004). But these are also expanded with therapeutic approaches more specific to anorexia nervosa.

A Mentalising Stance

A main goal of psychotherapy is to enhance mentalising. Bateman and Fonagy (2004) define 'the mentalising stance' as an ability on the therapist's part to question continually what mental states both within the patient and within themselves can explain what is happening. This represents an inquisitive stance, exploring triggers for feelings, identifying small changes in mental states, highlighting patient's and therapist's differences in perceptions of the same events, bringing awareness to the intricacies of the relationship between action and meaning and placing affect into a causal chain of concurrent mental experience, etc.

Here-and-now

This refers to working with current mental states. The main focus should be on the present state and how it remains influenced by events of the past rather than on the past itself. Past experiences are of course utterly relevant, but they need to be emotionally linked to the present situation, bridging narratives and affects.

Marked Mirroring

Staying mentally close with the patient is akin to the caregiver's mirroring response, providing the infant with feedback on his or her emotional state to enable developmental progress. 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—marking' (Bateman & Fonagy, 2004 p. 210). 'Marked mirroring'—first to mirror the patients emotional state, and then to intentionally mark a discrepancy, compels patient and therapist to examine their internal states further. The difference makes a difference.

Active Approach

Hence, this represents an active approach, actively using language to ask, comment and propose

alternative views. But it is important to stress that this is based in a *not-knowing position*. Ideas are ideas, 'thinking out loud', with the intention of increasing the ecology of possible views. They are not interpretations, as in classical psychoanalysis.

An active approach deliberately relates to the alexithymia often experienced as a significant clinical trait in persons with anorexia, see above. For the patient experiencing feelings of sadness and emptiness such activity may represent vitality. But of course, the level of activity must be adapted to the function of the patients. It is a frequent experience in successful psychotherapy with anorexia nervosa that it is useful, or rather necessary, for the therapist 'to lean forward' in initial phases, while one gradually gives more of the initiative to the patient.

Regulating the activity and intensity of attachment relationship is a key challenge. For the outer-directed patient, non-responsiveness may be experienced as threatening; feeling responsible for the wellbeing of the therapist. For the shameful patient silence may stimulate negative shame feelings. Hence, therapeutic activity can be relieving. On the other hand, too much activity on the therapist's behalf may be experienced as invading and threatening.

Minding the Functions of Symptoms

As described above, the patients with anorexia nervosa most regularly experience both the 'pros' and 'cons' of symptoms, experiencing the anorectic way of living as both a problem and a solution. A mentalising approach to anorexia stimulates the open investigation of different functions and meanings of symptoms. Such an approach, opening up for the dialogue not at least about the possible positive aspects of the disorder, may be experienced as liberating for the patient. The therapist marks that it is allowed to present ambivalences, doubts, hesitations and resistance. Creating such an atmosphere of open inquiry is most often beneficial for the therapeutic alliance, not at least because the therapist demonstrates that he or she is one who understands the complexity of the disorder.

Such a therapeutic approach is based on the therapist's role as an expert, from a *knowing position*. But the way of investigating is done with the inquisitive stance, from a *not-knowing position*.

Psycho-Education

A mentalisation-based approach to anorexia nervosa bridges psychotherapy and psycho-education,

altering between being an expert in the sense of factual knowledge and an expert in the sense of open inquiry, between knowing and not-knowing. For patients the competent therapist sharing his or her knowledge about different aspects of the disorder, including the model of psychopathology, will hopefully be experienced as an interested and trustworthy person. The utility of psycho-education can in general be partially explained by the idea that information and understanding gives the patients the opportunity to move from the traditional role of passively accepting treatment to becoming active agents in the treatment process (Corey, 2000; Haslam-Hopwood, Allen, Stein, & Bleiberg, 2006).

Negotiating Non-Negotiables

A particular challenge of working with anorexia nervosa is the inevitability of non-negotiables in the treatment. The major non-negotiable is that the patient has to eat more and more healthily simply to survive. Many iatrogenic effects are consequences of too harsh and authoritarian ways of presenting such basic non-negotiables, and introducing more non-negotiables than necessary (Geller & Srikaneswaran, 2006) that is, why should not patients be allowed some sort of physical activities, as long as these activities are adapted to the nutritional and somatic situation? (Duesund & Skårderud, 2003). Moralistic and threatening approaches will often produce fear, protest and a war-like situation, and reduce therapeutic possibilities.

The non-negotiables need to be redefined: they are also an excellent opportunity to demonstrate the mentalising ambition to understand different and opposite views, and to *negotiate non-negotiables*. Much may have been achieved if the patient is moved from a 'no' to any weight gain to accepting a minimal increase over months. The latter represents a 'yes', although a small one. From that position it may be possible to negotiate the frames and limits. How to deal with non-negotiables is at the very heart of treating anorexia, and must be given careful consideration. For the therapist this represents a key situation to demonstrate *both firmness and flexibility*, not *either-or*. Again there is the striking similarity with parents' relation to children.

Stimulating Affective Consciousness

There is a gap between the primary affective experience and its symbolic representation. A mentalisation-based psychotherapy actively tries to bridge gaps. Technically, this means an active

focus on experienced affects, and to elaborate these both in details and contextually.

The point of departure may be a concrete situation, for example the patient's increased vomiting combined with a stressful situation during recent days. A spectrum of mentalising interventions regarding affective states may be like this: (1) a supportive and emphatic approach is basic in the series of interventions. (2) The affect is identified not only by the behaviour; there will be simple and systematic clarifying and naming of feelings. (3) Then one explores the contexts of the emotions; that is the current emotional and interpersonal context. (4) And so forth, widening the exploration context to broader interpersonal contexts, as recurrent themes in the patient's life and (5) eventually explore the actual emotions in the patient-therapist context, that is mentalising the transference. With impaired mentalisation, transference is experienced as real, accurate and current and needs to be accepted as such in the treatment, and not as a displacement and repetition of the past.

Bateman and Fonagy (2006) emphasise that non-mentalising interpretations should be used with care. Interpretations, in the classical psychoanalytical sense, may be too advanced, referring to concrete mode of functioning; being without any positive effect. Or they may be experienced negatively. As Bruch (1985) stated: 'To these patients, 'receiving interpretations' ... represents in a painful way a re-experience of being told what to feel and think, confirming their sense of inadequacy and thus interfering with the development of a true self-awareness and trust in their own psychological abilities' (p. 14). The patient may respond with pseudo-compliance, the hallmark of the anorectic functioning, or, if threatened enough, may simply bolt from treatment.

Minding the Body

The focus on the patient minding their own body is also of specific relevance to psychotherapy with anorexia nervosa. The concept 'body' is demonstrably inadequate. It 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. We may lose sight of the fact that the body is never isolated in its activity, but always already engaged with the world. Hence, we make a shift from 'body' to 'embodiment', where the embodiment refers to an anti-Cartesian and existential position in which the body is the subjective source or intersubjective

ground of experience; 'a way of living or inhabiting the world through one's acculturated body' (Weiss & Fern Haber, 1999, p. xiv). 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).

Anorectic embodiment has several different aspects. One aspect refers to culture. Culture, in the sense of common and normative reflection, whether it be in the form of religion, philosophy, moral, biological science or the aesthetics of contemporary consumer culture, objectifies the human body. Flesh is symbolically loaded; like being thin may symbolise control and psychological strength in our affluent, contemporary Western culture (Skårderud & Nasser, 2007). The body is metaphorised in the sense that physical qualities metaphorically represent non-physical qualities. This object status is part of our culture and becomes clearly evident when we refer to the body as something to be investigated in, trained, slimmed, in order to serve other purposes. Collective norms and ideals about good and bad, beautiful and ugly, adapted by the individual, and in particular the insecure, sensitise the human body in a psychological sense.

In anorexia this is complicated by a second aspect; the immediate and analogous connection between inner and outer reality. Physical qualities refer to social and emotional qualities, and vice versa; and for the person with anorexia there may be a non-negotiable link here-and-now between fat and weak (psychic equivalence). A third aspect is the possible dissociative experience of one's bodily sensations (pretend mode). Bruch (1962) described patients' difficulties in accurately perceiving or interpreting stimuli arising in their bodies.

Hence, anorectic embodiment is a complex and possibly confusing picture. At the same time there may be a culturally driven unduly negative focus on exterior, combined with incapacity of making distance to this dissatisfaction, and at the same time experiencing impaired awareness of one's bodily sensations. The body is emotionally and cognitively experienced more via glances, on the weighing scales, in the mirror, measuring circumferences of limbs, counting skin folds on the stomach and via fantasies about being looked at by others, than by *feeling* one's own 'lived body' (Merleau-Ponty, 1962). *Anorectic corporeality may at the same time be experiencing one's body as too real and too unreal—and too disgusting.*

Mentalising the body means to stimulate the patient to investigate concretely the experiences with body and food, and connect them with emotional, cognitive and relational experiences, with the aim to transfer them into a language reflecting upon them *both as physical reality and as metaphor*. The patient is 'lost in translation'—or 'lost in representation'. A patient may be desperately afraid of fat, and she is also generally afraid; of what? Can these experiences of fright be linked?

This refers specifically to the concepts psychic equivalence and concretised metaphors. In the perspective of therapeutic alliance, this is to meet the patient where the patient is. In clinical work with anorexia nervosa one learns how the feelings are bound up with concrete experiences. The dialogues about emotions can be experienced by the therapist as non-committal, empty and exhausting. But the dialogues dealing with the non-negotiables of treatment, like proposals of increased food intake and weight increase, can become very emotional. This may be seen as a limitation for psychotherapeutic work, but also as a possibility. Meeting the patient in the concrete is also a possibility for reaching out and thus bringing emotional experiences into the dialogue.

The aim of psychotherapy is enhanced mentalisation, and in this context this refers to separating body from body, that is sensation from representation, flesh from affect. This represents a *de-concretisation*, opening up the closed psychological experience of equivalence of realities. In the language of body metaphors, psychotherapy is *re-metaphorisation* (Carveth, 1984); an exercise in becoming conscious and self-critical in our employment of the metaphors we live—and eat—by.

It is important to stress that the use of concretised metaphors as a concept refers to the absence of conscious language about the metaphorical function of bodily qualities. Hence, they are categorically different from linguistic metaphors, since language is lifting the experience above the physical realm. This is important to stress, since 'metaphor' is a popular concept in some schools of psychotherapy. Bateman and Fonagy (2004) warn against the extensive use of metaphors in therapy, although referring to borderline personality disorder. Linguistic metaphors presuppose an ability to use mental representations, and 'rather than heightening the underlying meaning of the discourse, use of metaphor is more likely to induce bewilderment and incomprehension' (p. 213).

In practical terms, 'entering the concrete' can have several practical meanings. Imagine this scene:

Under the therapist's couch one can see the weighing scale. Let this be a statement for reflection and discussion: It may be useful that the therapist is also the person who is responsible for the regular weighing and actively taking part in monitoring the eating programme. This is usually a very challenging situation for the patient, and therefore a suitable arena for the therapist to demonstrate his/her empathic presence.

Psychotherapy will be helped by concomitant physiotherapy, programmes for activity, bodily awareness or body psychotherapy. Duesund and Skårderud (2003) describe the possible benefits of adapted physical activity as a supplement to the psychotherapeutic dialogues. Social interaction in activities can move negative attention from the objectivated anorectic body to a more profound and subjective experience of one's own body. This is intentionally using the body—like movement, social interactions, physical and psychological challenges (the lived body)—with the intention to 'forget the body' (the anorectic objectified body). Forget in this context actually means turning attention from the anorectic objectified body towards the lived body. Thien, Thomas, Martin, and Birmingham (2000) also describe how a grounded use of physical activity and bodily approaches may be beneficial to the therapeutic relationship. This points to unutilised possibilities in psychotherapeutic enterprises collaborating with traditions such as physiotherapy, body-oriented psychotherapy and adapted physical activity (Duesund & Skårderud, 2003).

Experiences from different kinds of activities and different perceptions of one's body in different contexts are an utmost relevant topic in the mentalising psychotherapeutic dialogue.

Repairing Ruptures in Therapeutic Alliance

The hindrances in psychotherapy with anorexia nervosa are described above. In psychotherapy research a consensus is emerging around two related issues: That strains in the alliance are inevitable, and that one of the most important therapeutic skills consists of dealing therapeutically with this type of negative process and repairing ruptures in the therapeutic alliance (Safran & Muran, 2000). In this context this may mean to investigate common and in detail misunderstandings, different views and possible alternative views and behaviours with regard to concrete events.

CONCLUSION

Patients who suffer from anorexia are heterogeneous in terms of background, clinical features, comorbidity and personality functioning, but it is stated here that impaired reflective function most often, in severe cases, is central in the psychopathology. Of course, psychotherapy has to be reinvented in every new case. But it is possible to define some basic principles. The aim of this paper has been to outline such principles, with specific reference to described deficits in reflective function. Linking up to a current tradition this is described as mentalisation-based treatment.

All therapy requires mentalising, while mentalisation-based treatment and psychotherapy entails explicit attention to mentalising in the therapeutic process—both in individual, groups and family contexts (Allen & Fonagy, 2006). The future challenge will be to further qualitative and quantitative research on the psychopathology in anorexia nervosa and eating disorders; and to develop outlines into treatment manuals as basis for therapy, training and scientific research. Introducing a mentalisation-based approach for anorexia nervosa is not least meant to be helpful to reduce iatrogenic effects. Mentalising—holding mind in mind—is a key challenge for both therapists and patients.

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