Use the Body and Forget the Body: Treating Anorexia Nervosa with Adapted Physical Activity[1]

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ABSTRACT

Anorexia nervosa represents an over-concern with body shape and weight. This article describes seven female patients with severe anorexia nervosa who were given a time-limited program of Adapted Physical Activity (APA). The aim was to investigate how social interaction in activities could move negative attention from the objectified anorectic body to a more profound and subjective experience of one's own body. APA may represent a therapeutic access to anorexia nervosa, as a supplement to psychotherapy.

KEYWORDS

adapted physical activity, anorexia nervosa, body phenomenology, body philosophy, embodiment

FEW SYMPTOMS create stronger reactions in therapists than those of anorexia nervosa, and few require more forbearance and self-questioning. Part of this is the problem of understanding the very nature of the illness. Difficulties in understanding the potential seriousness of the illness, as well as the lack of knowledge and resources for effective treatment, all create a strong need for good descriptions and theoretical models, as well as practical–clinical approaches.

This report attempts to contribute to an evolution of both clinical practice and theory. Our work implicates three fields: body philosophy, clinical psychiatry and adapted physical activity (APA). Each of these fields is comprehensive. As a rule, studies are carried out in only one of them. For this reason, this project is exceptional because we look for an overlapping understanding among the different fields.

The point of departure is one of the crucial psychological phenomena in anorexia: over-concern with body shape and weight. Anorexia presents itself through somatic manifestations such as loss of weight and under-nourishment or malnutrition. But when

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we consider this primarily as a psychic and not a somatic illness, it is because thoughts and feelings about the body and food colonize a large part of the life of the person with anorexia. These psychic qualities are reflected in the diagnostic criteria (DSM-IV; American Psychiatric Association, 1994). Although this preoccupation with the body is so central in anorexia nervosa, in clinical work we experience the lack of good theoretical concepts to understand the subjective experiences of the body. We present such models, based in phenomenological philosophy.

A great number of patients confirm that they have no control over their thoughts and feelings about body shape and weight, and describe them as 'obsessional'. With support from the theories presented, this research project investigates clinically the ways in which adapted use of the body in physical activity can help to reduce this cognitive and emotional over-concern. This may seem paradoxical: that the body is used in order to reduce the preoccupation with the body. We wanted to investigate how the participants experienced interventions within the tradition of Adapted Physical Activity (APA). APA is defined as the integration of special educational science with physical education. The central principle is to adapt the various activities to the performer and not the other way round, as we may find, for example, in traditional physical activity[2] (Sherrill, 1998). Can social interactions in activities and movement move negative attention from the objectified anorectic body to a more profound and subjective experience of one's own body?

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Our aim is to contribute to knowledge about the ways in which form- and context-adapted physical activity may be clinically useful to whom, within a group of patients with anorexia nervosa.

The work is based on a collaboration between the Beitostølen Health Sport Centre (BHSS) in Norway and the Sogn Centre for Child and Adolescent Psychiatry/University of Oslo (SSBU). Patients were recruited from the SSBU and participated in an intervention program at the BHSS. The Health Sport Centre is a rehabilitation center using APA as its main approach in executing its rehabilitation program. This is offered to individuals who have different physical and psychological disabilities.

Earlier research

Looking upon physical activity as a resource for coping with psychic illness has aroused growing interest, and the number of scientific investigations on the subject has increased significantly. Many studies with different methodologies have demonstrated links between participation in physical activity and improved mental health (Fox, 1999; Martinsen, 2000; Paluska & Schwenk, 2000; Weyerer and Kupfer, 1994). However, there is a diagnostic group in which one does not, as a rule, recommend physical activity, namely those with anorexia nervosa. Here, the negative connections have attracted most attention. The reasons for this may seem obvious. In many of these patients compulsive activity is part of their symptomatic behavior (Beumont, Arthur, Russel, & Touyz, 1994). For the anorectic patient with serious malnutrition, the different forms of traditional physical activity will constitute a medical risk. For this reason, a number of therapy programs practice restrictions against physical activity as 'standard treatment'.

In addition, two issues create concern: hard physical activity in itself might induce anorectic symptoms. 'Activity anorexia' has been proposed as an independent illness, very closely related to anorexia nervosa – though with some traits that are different (Epling & Pierce, 1991). So far, the scientific grounds for this type of mechanism seem incomplete and speculative.

Another issue deals with athletes, and particularly top-level athletes, as a high-risk group for the development of eating disorders. The factors, which are considered to contribute to a very high prevalence of anorexia nervosa among performers, are strong focusing on the body, on both aesthetics and performance, as well as on nutrition. There have been corresponding findings with regard to dancers. In predisposed individuals, participation in these environments may function as provoking factors (Sundgot-Borgen, Skårderud, & Rodgers, in press).

We would like to challenge the most restrictive attitudes and practices connected to physical activity in the treatment of anorexia. We have worked exploratively for several years with adapted physical activity in the treatment of anorexia nervosa. There is also now a general tendency in therapeutic milieus to be more open for these ideas and to create graded activity programs. In recent years there have been some publications about the use of body-oriented treatment. However, within traditional APA (Sherrill, 1998) we have found only one earlier study, namely the work of Carraro, Cognolato, and Fiorellini Bernadis (1998) in Italy. Founded on qualitative data collected on 98 patients with eating disorders, they conclude that APA can be usefully integrated into therapy programs for eating disorders. Patients with anorexia nervosa constituted 60% of their material.

Vandereycken, Depreitere, and Probst (1987) used a psychomotor program and documented its effect. Kruger and Schofield (1986) and Rice, Hardenberg, and Hornyaak (1989) made use of dance therapy as an intervention for confronting the disturbed body image, which is a diagnostic criterion in anorexia nervosa. Jasper and Maddocks (1992)

reported the use of relaxation techniques and massage. Beumont et al. (1994) suggest a controlled activity program with bending and stretching exercises, training with weights, social exercises and aerobics. Laumer (1997) describes the effect on eating disorders of the physiotherapeutic Feldenkrais-method 'awareness through movement'. Thien, Thomas, Martin, and Birmingham (2000) emphasize that physical activity may promote the therapeutic alliance. These studies indicate that different forms of physical activity may be part of new approaches in work with eating disorders.

The theoretical background

The phenomenology of the body

The body is critical in anorexia nervosa. But the body is not an unambiguous dimension. There are important distinctions between a living and a dead body, between a sick and a healthy body, and between the body as subject and object. Furthermore, there is a social body, a juridical body, a political body, a sexual body, etc.

To paraphrase Ludwig Wittgenstein (1989): 'Can we explain a Beethoven sonata?'. Can we explain a body? Explaining a body implies reducing its ambiguity. Language becomes inadequate. When we speak about the body, it is the spoken-about body, and not the body itself. Language produces metaphors about the body. Our language is in itself part of the body, a physical elongation out into the world. But it is only a part. When we analyze the body, there is always something left that defies analysis; a magical remainder (Duesund, 1995).

Anorexia nervosa is an example of the complex nature of embodiment. We attempt the following description: in the anorectic discourse the body and food are *primary*; for the patients' attention. At the same time, the body is *secondary;* secondary because the anorectic embodiment is a medium. The body is used as an external, concrete tool for promoting the internal life. The body is used in psychological and social maneuvers for the promotion of self-esteem. We can describe this as an instrumentalizing of the body. Anorexia nervosa can be understood as an expression of a psychological defect or flaw, and symptomatic behavior as an attempt at change. A way of describing anorexia nervosa is as 'a disorder of control'. The symptoms can basically be regarded as 'a selfing device' to promote self-development and the sense of self-control (Baerveldt & Voestermans, 1998). In anorexia nervosa manipulating the body may become a tool for gaining psychic, social and spiritual experiences of mastery, clarity, purity and perfection.

The person with anorexia nervosa loses control over the bodily practices that were intended to further the experience of greater control. Focusing on food and the body leads to a limited scope of experience. The intensive body project leads to withdrawal: she or he withdraws in order to demonstrate that they can no longer cope with a complicated existence.

In anorexia nervosa the body is given object status. This object status is part of our culture and becomes clearly evident when we refer to the body as something to be investigated, trained, slimmed, in order to serve other purposes. It may be a matter of aesthetics, or of efficiency and productivity. In this latter perspective, of the body as something objectified, anorexia nervosa can be described as a radical exercise in Cartesian body/thought dualism.

In our search for a conceptual definition of anorectic embodiment, we have been greatly aided by the *body-phenomenological* tradition. The French philosopher Maurice Merleau-Ponty (1907–61) and his main work *Phenomenologie de la perception* (1962) are central in this tradition. Merleau-Ponty belonged to the same intellectual tradition as Heidegger and Sartre. Phenomenology derives its name from the Greek word 'fainomai',

which means 'I show myself'. One should go back to the 'matter itself'. The method attaches great importance to description.

A traditional philosophical problem is the question of how to understand the relationship between perception and consciousness. Heidegger's work *Sein und Zeit* (1927/1978) gave a new impetus by not beginning with consciousness, but with *life-world (Lebenswelt)*. Life-world is our experience of anxiety, worries and everyday tasks. We take our life-world for granted, and we experience it before we reflect on it. Heidegger breaks decisively with the philosophy of consciousness according to Descartes' doctrine on *cogito* and with subject–object-thinking. However, he does not explicitly make the body the subject of his philosophy. Sartre has an extensive philosophy of the body in *Being and Nothingness* (1943/1990), in which he states that consciousness must be described before the body. Merleau-Ponty is one of the few Western thinkers to postulate that our understanding of the world is founded on the body's perception of its surroundings and situations.

To Merleau-Ponty, to be a subject means to be in the world *as body*. Both Heidegger and Merleau-Ponty thematize the alternation between *having* a body and *being bodily*. We both *are* our body and we *have a body*. The body is our primary instrument for understanding. The experience precedes the analysis of the experience. The un-reflected comes prior to the reflection. Experiences are created in a bodily encounter and in reflections about this bodily encounter. The expressing and creating body is the very 'site' for development.

Merleau-Ponty raises objections to Descartes' dualism between body and soul, and the body's split history by introducing *the phenomenal body*. That the body is phenomenal, means that it is experiencing, acting and seeking meaning. 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 in movement is not an objective thing-body, but an experiencing and experienced unity, connected to activity. The body is intentionally seeking out into the world; it is always existential (Duesund, 1995; Skårderud, 1994).

Merleau-Ponty uses the concept of *corps propre*, the *lived body*. In the Cartesian tradition it is the physical characteristics of the phenomena, which are examined. In medicine and in APA this is expressed in disciplines such as anatomy and physiology. 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 German language has corresponding distinctions between *Körper* – the physical body, and *Leib* – the lived body. Cartesian philosophy has its most important roots in *Körper*, while the phenomenological exploration is directed towards the latter (Leder, 1990, 1992).

Merleau-Ponty maintains that the body does not contain an either–or, but a *both*. He calls this *an irreducible ambiguity*. It is both subject and object, with a simultaneous and mutual relationship between these levels. We see and are seen. The body is both subject and object not only in relation to others, but also in relation to itself. The alternating direction is what Madison (1981) and Busch (1999) in their analytical discussion on Merleau-Ponty have called *circularity*. The circular alternation occurs between the body and the life-world in relation to the lived body, the perceived body and other people. But also towards the body itself as an object and a subject.

In this connection, Merleau-Ponty gives the example that if I take hold of my left arm with my right arm, my right arm will be the subjective, which takes hold, and the left arm will be taken hold of. But when I feel that my left arm is taken hold of, this arm becomes the subjective which experiences the right arm as an object. I take hold and am taken hold of.

Let us return to the anorectic embodiment: can we say that reification, the object-body at the expense of the subjective experience, is so strong that circularity is inhibited? Figuratively speaking, the object-body becomes paralyzed during social and self-imposed disciplinary actions. This embodiment is not open, it closes itself around itself and against the outside world. The person with anorexia nervosa fights bodily needs in a psychological drama. Body-concern is quite literally body-destructive.

The relations between subject and object also become apparent in our clinical experience: even though the body is thus focused upon as a tool, the person with anorexia nervosa may experience 'bad contact' with his/her own body. The body is experienced more via glances, on the weighing scales, in the mirror and via fantasies about being looked at by others, than by *living and feeling* one's own body.

With reference to Merleau-Ponty, there are two situations which damage the existential relation to the life-world, and inhibit 'the intentional arc' (Dreyfus, 2001). It is in the case of illness, and in the strictly rational attention towards the body. The typical anorexia nervosa can be said to represent both illness, which causes the body to stiffen as an object, and a 'rational' disciplining, which is supposed to promote a subjective experience of self-control.

Because we can be objects to ourselves, we can also reflect upon ourselves. The fact that the body is the point of departure for our perception does not therefore mean that we cannot surpass it (Duesund, 1998). The body's circularity is not a closed circle, but it continuously surpasses the body. According to Merleau-Ponty, the body is a unit seeking meaning and surpassing. This takes place through both *reflection* and *action*. These are not separate, but neither do they merge into an absolute entity. It is in *movement* that one comes nearest to a merging. When we are moving, in dance for instance, we can experience an integration of the subjective and the objective. We can sense a feeling of flow and totality. When we are walking, our thoughts are also 'wandering'.

Our investigation deals with movement in APA. Movement is a voyage of discovery inwards towards the body itself, and outwards towards the world and the place in the world where the activity is explored and formed (Duesund, 1995). Movement is given a personal direction by adopting an attitude *to* the world. Merleau-Ponty speaks in this connection about our *being-to-the-world*, instead of *being-in-the-world* (Heidegger). Through movement we place ourselves in an active relation to the world and can 'forget' ourselves by being present attentively. We forget our body, or do not notice it, when we are present in the movement. It is gone from our consciousness and observation. Movement will thus strengthen our ability to be spontaneously and securely present in the world.

According to Merleau-Ponty, the body is related to the world and to itself both as a subject and an object. The living body can never be reduced to be an object only or to a subject only.

The absent body

The aim of choosing and arranging the APA in this project is to examine whether the attention-burdened body can have the possibility through movement to be freed from its oppressive self-observation.

About this presence in the movement we can use the concept of 'self-forgetting'. This concept is of interest for our study. Is the person with anorexia nervosa able, through movement, to give himself/herself less attention or a different form of attention? We would like to give this concept a further meaning by referring to a contemporary author within the same philosophical tradition.

Drew Leder is a physician and philosopher. In his book *The Absent Body* (1990) he

questions how our bodies can be experienced as absent or present. In order to make his points explicit, he defines three body dimensions:

- The Ecstatic Body
- The Recessive Body
- The Dys-appearing Body.

Briefly explained, we experience *from* the body *to* something outside. We project from here to near and far away, and from now to the past and to the future. It is this bodily dynamic force which makes us participate in the world, so that we act, experience, observe, communicate and develop. These transfers make it possible for us to be involved in what our attention is directed at. In this sense we can become 'beside ourselves', *ec-static*.

The Ecstatic Body forgets the own body because it is preoccupied with something else. This forgetting is decisive if we are to be able to live fully in the world. The body is present in an absent way. It is positively absent from our attention.

Leder also writes about another form of absence. With the concept of The Recessive Body he suggests that we also have an embodiment, which is not easily accessible to us, in the form of inner organs and their physiology and functions. Our lungs breathe without our asking them to do so. The intestines relieve themselves without being reminded of it. The organs do so 'of their own accord'.

These different forms of withdrawal can be helpful for our cultural understanding of the body. They can help us to explain the ignoring of the body, as in the numerous reflections on the bodyless mind. The healthy body is alienated in the sense that one does not notice it. The attention can be directed at the world. The sick body is intentionally directed against itself. For the asthmatic, it is not a matter of course that there is breathing. We give little thought to the fact that we can walk, but we think a great deal about it when we have a fractured foot. This is what Leder defines as The Dys-appearing Body. It is painfully present, and the Ecstatic Body's ability for self-forgetfulness becomes inhibited.

It is wrong to equate all types of bodily thematizing and dys-appearance. There are of course many forms of appearance, which are not dys-appearance. We can spruce ourselves up and be happy about the effect. During meditation we carefully observe our breathing. This does not necessarily mean turning it into a problem. These thematizations are voluntary. But the transition from voluntary to involuntary is fluid. The concept of dys-appearance is greatly relevant to our culture's preoccupation with aesthetics and about health and fitness. When we speak of body-focusing, it has mostly to do with how interest turns into problematic dissatisfaction. When focusing on the body and its exterior, it is the flaw and the defect that catch one's attention.

Dys-appearance is a highly relevant concept in connection to the person with anorexia nervosa focusing on the body itself. Strong dissatisfaction with the body is often the departure point for symptomatic behavior, which at times deteriorates into contempt for one's own embodiment.

Using Leder's concepts we formulate: can adapted physical activity help the dys-appearing body of the person with anorexia nervosa to become less dys-appearing, and can it promote self-forgetfulness through movement and joint action?

A qualitative study

This is an explorative study based on a qualitative method of research, which includes interviews and observations. The verbalized personal experiences of the participants

form the basis for the investigation. The qualitative approach gives room for an elaboration of arguments and theory. The study generates hypotheses, and can form the basis for subsequent quantitative approaches.

Participants

Seven female patients participated in this study. All fulfilled the criteria for anorexia nervosa according to DSM-IV. They had had their diagnosis for the last two to five years. The youngest patient was 14 years old, the oldest 19. Body mass index (BMI) varied from 13.8 to 16.9. BMI is calculated on the basis of the individual's weight (kg) divided by height (m) squared. WHO defines a BMI less than 19.0 as underweight.

The seven patients were recruited from the Centre for Child and Adolescent Psychiatry. At the time of the intervention this was a national third-line institution. This means that the patients had first been treated in local or regional health services. Owing to a lack of therapeutic progress, they were referred to this national center and admitted. They were therefore very serious cases of anorexia nervosa. There was also an eighth participant, but she is excluded here because she had bulimia as her main diagnosis. Two patients came from the outpatient unit for eating disorders, and the five remaining came from a specialized inpatient unit. The two from the outpatient unit had a therapeutic relationship with one of the authors (FS).

In addition to interviews and observations, the patients were given a medical examination at the beginning and end of their stay. Their weight was checked weekly. On admission and on discharge they filled in screening instruments for eating disorders and their attitudes to their own bodies: Eating Disorders Inventory, Children's Version (EDI-2 C) and Body Attitudes Test (BAT).

Intervention

The scope of the intervention was limited by a time schedule, an in-patient stay of two weeks at the Beitostølen Health Sport Centre. The patients with eating disorders were registered as ordinary patients and integrated with the other patients who had a broad range of diagnoses.

Beitostølen Health Sport Centre is situated 240 km from Oslo, at the entrance to the Jotunheimen mountain region. The health sport centre was among the first rehabilitation centres in the world to evolve adapted physical activity. The staff work in interdisciplinary teams composed of physiotherapists, sport instructors/riding instructors. These have regular meetings in an extended team with the doctor, nurse, psychologist, social worker and the leader of leisure activities, in which the contents of the programs and experiences obtained from the sessions are discussed. The goals for this adaptation have physical, psychic and social aspects. An important objective here is social integration.

Children and adolescents are generally accompanied by escorts, often their parents. In this particular case, we used the staff from the adolescent psychiatric clinic as escorts. This was partly to ensure continuity in the ongoing treatment of the patients, and partly to prevent negative effects due to sudden changes in the life- and treatment situation, for example changed routines for meals and activities. In addition, we saw this as a possible mutual learning process. The staff at the psychiatric clinic wanted to learn more about APA. The staff at the BHSC would acquire better knowledge about this patient group.

Activities

What distinguishes APA from a number of other fitness activities is the fact that one adapts the activity to the performer, and not the other way round. The interdisciplinary

teams organized the activities. The arrangements of the activities were based on reflections upon the special nature of people with eating disorders and the special nature of APA. When choosing and adapting the activities, one tried to make sure that they would not contain competitive elements. Furthermore, the activities should offer challenges, but resemble *training* as little as possible, they should emphasize the social aspect and contribute to relaxation and experiences of nature.

Ideally, the activities should open up contextual experiences with people and animals, nature, sounds and smells. The staff were instructed to avoid making comments about looks and weight. In order that the activities should generate good experiences, it was important that the patients themselves were able to voice their opinions about the activities, set their own limits for what they did and did not wish. This was as important as the activity itself, and presupposed a good dialogue between the instructor and patient. In the course of the intervention, the activities were constantly individually adapted to each participant. The aim was to create a positive body feeling during the course of the activity, a feeling which ideally should help to develop a more positive body image and thereby an improved self-image.

The patients in the project were in activity for 3–4 hours a day. Each participant had her own timetable. Care was taken to achieve an optimal balance between rest and activity. The participants in the project were included in groups of persons with different functional handicaps.

Indoors, there were adapted activities in a shallow swimming pool with a constant temperature of 37ºC, on a climbing wall, and in the relaxation and activity rooms. The sessions at the swimming pool consisted of playful and social activities such as ball games, the use of floating equipment as well as relaxation exercises to music. Distance swimming was not of current interest. On the climbing wall, participants were introduced to climbing with a top-rope and to security techniques. The focus was especially on safety and security, and on learning to have confidence in the person who secures the climber. Relaxation was integrated into all the activities, but was also practiced in a special relaxation program, with emphasis on hold/let-go techniques and weight- and warmth sensations. In the activity room, participants carried out balancing exercises with balls and other apparatus, as well as coordination exercises and sensory/motor exercises. Ball games emphasized collaboration in the groups without the traditional element of competition.

Outdoor activities included skiing, riding and outdoor life. The skiing trips should not be too demanding physically and participants were encouraged to take it easy and wait for each other. These were social and experiential outings. Alpine sports included traditional downhill skiing in a skiing resort. The riding activities encouraged contact with horses and collaboration with them. The client should enjoy riding, being in contact with nature and the environment. Riding took place on a riding ground and with excursions into the local environment. Basic exercises and safety routines were practiced in order to create a sense of security, mastery and motivation. All participants had their own assistant. Outdoor life also included staying overnight in a Lapp lavvo. Also included in the program was rowing and paddling, walk-orienteering, looking at pits and observing seasonal changes, as well as instruction on animal life and the geography of the mountain wilds.

Interviews

Interviews were carried out by one of the authors (LD). Each patient was interviewed twice, on arrival and on departure.

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

- expectations regarding the stay at the BHSS;
- previous experiences with sport and athletics;
- experience of one's own body;
- body ideals;
- situations in which one's preoccupation with the body is particularly extensive;
- interests and social life.

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

- which situations and activities had which effects on the preoccupation with the body;
- social interplay;
- experiences of mastery and failure.

Interaction in the interview situation

All interviews were taped. Patients were free to stop the tape-recorder at any time if there was something they did not wish to reply to, if they needed a break or wanted to change their answer. However, no one made use of this offer. They appeared to be very eager to communicate their experiences about the interventions and to state independent opinions. They considered it important to use the interview to make statements about the program. The reason they gave for this was that they wished to help others with similar eating disorders.

The interview was planned in advance to last 30–60 minutes. This was the case for the initial interview, while the final interview lasted 45–75 minutes. The interviews went smoothly, and the patients were extremely verbal. They were obviously used to talking about themselves and their own situations. New experiences from the intervention were also reflected upon.

Observation

Observation of each participant was carried out by instructors and companions, and recorded in written reports. The observations were written on separate observation schemes. These formed supplements to the interviews as a basis for the analysis. The observations concentrated on social interplay and staying power in the activities.

Analysis

As a computerized support for the qualitative text analysis of the transcribed interviews and the observation reports we used the data program Textbase BETA (Sommerlund, 2001).

Text analysis was carried out in three steps: first, we undertook a so-called *condensation of meaning* (Kvale, 1996), implying a rough analysis of the topics from the interviews and observations. With the help of the data program for text analysis different units of meaning were marked, and condensed by the authors into briefer statements. The next step in the analysis consisted of structuring by *categorizing the different units of meaning.* Finally, we undertook a *joint categorization*. This involved placing together all the parts in the interviews and observation reports which can come under the heading of a joint category. Two of the main categories were a priori. They were based in fundamental research questions. These categories were 'Forgetting the body' (The Ecstatic Body) and 'Body Reminder' (The Dys-appearing Body). These analytic categories were formulated on the basis of hypotheses which indicate that some forms of activities and social contexts may reduce the attention directed towards the body, while other forms may increase it. Other main categories and subcategories were developed during the process of analysing

the texts. Two such main categories are 'Phases in the illness' and 'Social fellowship'. As shown later, subcategories were created under these main categories.

Validity

To validate is to convince the critical reader that the research results are direct and probable consequences of the research process itself, and not more or less random statements. It is a matter of credibility. Validation comes to rest on the quality of craftsmanship in research.

Hence, to validate is *to make good descriptions* of the consecutive steps in the research progress. The reader should be given good enough background to consider the relative credibility for alternative knowledge claims (Polkinghorne, 1983). To validate is to give an account of procedures, inclusion criteria, contexts and concepts, etc.

In this study, we want to underscore some more specific techniques to improve the validity of the results. *To validate is to check*. During each interview, the method of interviewing was to stop after some of the answers, to repeat, confirm and clarify, and to probe deeper into presented topics. This corresponds to what Kvale (1996) calls 'communicative validity', or 'member checks' (Denzin & Lincoln, 2000). Patients were invited to go back over their statements and make changes where one presumed possible misunderstandings. To some extent, we also discussed the observations with the staff, who collected these data.

To validate is to triangulate. That is, to approach the same material from different methodological angles. To collect our data we used both interviews and observation. The two text materials, interviews and observations, worked as complimentary sources. This triangulation was designed to strengthen the credibility of our analysis.

We were two researchers working on this study. *To validate is to systematically use different modes of cooperation*. In the categorization process we structured two phases. First, we worked separately, developing proposals for main and subcategories. Then we met, worked jointly, and through dialogue agreed upon the final categories and a common understanding of our interpretations.

Concepts do not exist in a vacuum. They are contextual, and an important part of the context is theory. *To validate is to theorize.* An important part of this study has been to be very explicit about some of the theoretical background for operational concepts and our research hypothesis.

Results

Interview on arrival

Our interviews at the arrival serve the purpose as background information; important for our analysis of the post-intervention interviews.

Expectations regarding the stay The expectations varied. Some looked upon participation in the project as a possibility of practicing and burning calories. Others hoped to find relaxation and a break from everyday life, and several others wished to challenge themselves socially and experience nature and the outdoor life. Some also wanted to help others suffering from the same illness by taking part in the study.

Previous experiences with sport and athletics None of the participants had a background of elite sports. All said they were pleased to participate in physical activity, but also that physical activity was a reminder of the possibility of losing weight and burning calories. Hence, before the intervention there was an ambiguous attitude towards physical activity.

Situations in which preoccupation with the body is particularly extensive The patients described stress connected to their preoccupation with the body. They pointed to several types of situations, such as being together with people of the same age, especially at school when they had gym (which some were excused from), during breaks, in the lunch hour and generally at meals.

Interests and social life Several patients described how being a person with anorexia nervosa had contributed to a solitary life with few or no friends. This was particularly the case for those who had been ill the longest.

After the intervention: Interviews and observations

There were no significant changes for the group in relation to body weight and the screening instruments EDI-2C and BAT. This was only to be expected, as two weeks is a very short time for observation.

The qualitative findings are discussed in four main categories:

- forgetting the body;
- body reminder;
- phases in the illness;
- social context.

Findings linked to the question of whether APA can help to reduce the negative attention towards the body itself among individuals suffering from anorexia nervosa are discussed according to Merleau-Ponty's and Leder's body philosophy.

Forgetting the body (The Ecstatic Body) All patients pointed to riding as a suitable activity for changing focus,

> *Sophie*: I forget my eating problems when I am sitting on a horse. Then I only concentrate on that. I noticed this already on the first trip. Oh! I forgot everything. It was lovely.
>
> *Anna*: When I am riding I don't need to use so much of myself. One does use oneself, but in a different way. In some way it is not *you* who is using *you*. It is the horse which makes you move . . . It was a terrific experience to gallop, it was really fun to do it . . . I got a bit of a kick out of it. Saw the other horses running in front of me at quite a speed . . . Well, a kind of feeling of freedom.
>
> *Hilde*: When I am riding and sitting on the horse . . . then I can't run about so much because I'm actually sitting there. I think that is all right. It is peaceful and so I can avoid doing so many other things. In the beginning, I was mostly concerned with what I looked like up there on the horse. Gradually I got more concerned with how the horse was doing.
>
> *Susan*: I'm afraid of gaining weight and I feel that I have to move all the time. I can never calm down. I stand and trip. It is only while riding that my thoughts go away. Then I don't have to do so many other things. Even though I don't like the smell, I still ride every day.

When Leder (1990) uses the concept of The Ecstatic Body, he alludes to the body being absent from attention. This is based on what Merleau-Ponty calls our body phenomenological *being-to-the world*. The body is directed beyond itself. We experience through our senses. From our physical point of departure, a perceptual world emerges which

thrusts the object body into the background. It is this bodily intentional force, which enables us to take part in the world. Merleau-Ponty states that the contrast of subject–object comes to light in the reflection, but draws back in the experience. One of the patients offers a direct comment which corresponds to Merleau-Ponty's statement about surpassing the objectified body:

> *Anna*: It is so unbelievably good to sit there and feel it. You are using your body even though it is not your own decision. It is the rhythm of the horse which decides that you are there, sort of. I feel that I am on the inside of myself, because as a rule I feel myself to be on the outside.

When she finds it 'unbelievably good to sit there and feel', it emerges from the context of the interview that she does not feel her 'anorectic corporeity', but senses her own body in a different and more open way. Within the body-phenomenological tradition, anorexia nervosa can be described as a closing up in relation to life-world. The anorectic body's over-preoccupation with surface, weight and calories, inhibits the contact between the body and the life-world. When the body is objectified through dys-appearance, we lose the basis for openness. The ideal-typical anorectic does not know the world through her body, because she/he does not know/feel the body herself/himself.

We would like to remind the reader of Merleau-Ponty's concept of *circularity*, the ideally open exchange between subject and object, inwards in the body and outwards towards the world. Riding can be interpreted as an activity that reopens this circularity. In movement we can experience an integration between the subjective and the objective.

> *Anna*: . . . because as a rule I feel myself to be on the outside. When I am riding, I am on the inside. Then I can just be, and be me.

She experiences being in contact with herself and her body. She experiences herself as being identical with her own body. The body does not separate her from herself or from the world, but unites her with both. The circularity follows the movement out into the world. It both opens and extends the body, in the same way as it also opens and extends the understanding of itself in the world.

Because riding, in particular, seems to contribute to these experiences of 'self-forgetfulness', we can assume several possible explanations.

Relation The horse is a living creature, not a machine, and an object for care and consideration. Attention is moved from oneself towards the relation horse/rider and beyond. It is a situation for two, in which the horse also represents the initiative and the movement.

> *Hilde*: In the beginning I was mostly concerned with what I looked like up there on the horse. Gradually I got more concerned with how the horse was doing.

Absence of competition The way in which riding was organized, as a slow and experience-oriented activity, gave very little room for competitive comparisons and achievements.

Absence of training

> *Anna*: Among the activities up here, riding has been the most positive one. It is not a kind of endurance training. You feel that you can cope with things you wouldn't have believed you could, and all without thinking 'now I've been clever because I ran so and so far'. It has nothing to do with being clever.

Unpredictability Riding is an activity which is very little controlled by rules or based on patterns. The movements in the landscape cause in themselves a transfer of perspective towards nature, and contribute to the experience of fellowship among the riders.

> *Susan*: I think it is easier to be under compulsion if I don't also have an experience, that is to say, if it is only a matter of doing this or that. It is much better when I have been out riding or skiing, because I then get an experience of nature as well.

Other activities too contributed to a shift in attention. Ball games, for example, and the outdoor life, paddling, indoor climbing, downhill skiing, dance and relaxation exercises in the swimming pool. However, the responses were not as unambiguous as they had been to riding.

> *Anna*: I get peace from my obsessional thoughts during ball games. There is no one better than the other here and we are having quite a lot of fun. One gets a little extra energy. I feel the same when I am dancing.
>
> *Susan*: I feel my competitive spirit awakening when I go skiing with others. So I went on a trip by myself. At first I thought I would be strong and active. But then I managed to take it easy, and the weather was beautiful. I sort of enjoyed it. It felt rather similar to when I was climbing. There was music then. I was able to enjoy it without thinking about metabolism or competition.
>
> *Elizabeth*: It was fun carrying on with activities and to feel that there were none of these demands for achievement. This has been absolutely wonderful. It has been fun doing it. I have not felt any pressure to achieve from the staff.

The reports written by the observers correspond mostly to statements made by the patients. Both groups emphasize the types of activities that do not have a quality of *training*. Repetitive training and exercises increase the risk of an excessive focus on calorie burning. The activities which gave the best results concerning a shift of attention were those in which the emphasis was on the *game* itself and on its attendant *social interplay*. The spontaneous, accidental and collective aspects became crucial in preference to rational, purposeful and individual ones. For example, a number of patients stressed the element of discovery and exploration in the ball games, and in other playful activities such as balancing exercises with a skateboard and cones. The *unpredictable* were emphasized as a significant factor. The activity is discovered as one goes along, and reduces negative self-attention.

Body reminder (The Dys-appearing Body) We would like to emphasize the negative experiences. These came to light when the activities failed to have the desired effect of limiting the anorectic body-attention.

> *Anna*: This has been rather annoying . . . When we were supposed to play something, it was sort of boring . . . it didn't pick up speed, and the result was that I didn't manage to completely forget these ideas about training. Because when there are constant pauses, it can't go at all smoothly. Then all I think of is that I will soon have to run. Now I have to be in activity, now I have to do this or that.

Anna's words are representative of a number of other patients. They stressed boredom which keeps the focus on one's own body. This was linked to extremely low intensity, too much exercising and to demands for skills which are too low in regard to the patients' competence and their desire for challenges. The activities feel 'empty' and the head feels 'filled up'.

Practicing and being involved in activity is not the same. Practicing or drilling has a mechanical aspect, especially in the initial stage. Even though practicing in itself may not be physically exhausting, it may – by virtue of being practice – contribute to a negative body focus. This applied to various forms of circular and balancing exercises. The boredom was described as having been lessened by the fact that the activities were carried out in pairs or in a group. Entering into a fellowship inspires one to forget the body.

Two weeks must be regarded as a short time for intervention, and yet there is an indication of a process in some of the answers. Sophie comments on the relaxation exercises:

> *Sophie*: It takes some time before the need for control loses its grip on me. Gradually it felt really good.

This is also confirmed by the observations. The experiences of the relaxing exercises changed somewhat over time. The girls seemed to improve in relaxing.

The use of physical activity is both complicated and, at worst, risky for patient groups that have exaggerated physical activity as their symptomatic behavior. Even though the intention is to create forms of activity other than the obsessional behavior and the slimming behavior, there is still a risk of alternative activities also being incorporated in the anorectic psychology.

> *Anna*: I have thrown up once during these weeks. Not more than that. But I feel somehow that training has taken its place. So it gets a bit obsessional. It turns out that if I have been so and so active one day, then I can't be less active the next day.

Several activities can be a temptation for achievement and calorie burning. Even though the pool activities took place in therapeutically heated water, the very presence of the adjacent swimming pool shifted the attention towards training and competition. The cross-country skiing trips would trigger the idea of going fast. But also here both patients and observers underline a process. In the course of the intervention the aspect of experience came to the fore, and the training aspect receded into the background.

One of the patients made interesting comments on the context of the activities.

> *Anna*: When I am riding, I can feel that I am totally in the situation. But as soon as we enter the paddock, it becomes boring, and then painful thoughts come streaming in.

The trips out into the countryside represent a freedom from everyday life. The return to the paddock is also a return to habit; and also to a therapeutic rationality in which the girls are expected to produce medical and psychological improvement.

Phases in the illness

Some of the replies commented on the fact that the experiences of the interventions depended on the stage of the illness. The two patients who were oldest and had been ill longest were worried about the youngest ones with the shortest history of illness. When one has been ill for a short time, one's insight into the illness and motivation for change are usually limited. The invitation to the activities may primarily represent yet another chance of burning calories. It was reported that two girls had sneaked into the swimming pool for extra swimming in the evening.

> *Anna*: If I had been here right from the beginning when I fell ill, it is absolutely certain that I would have gone in for training and for loosing weight. Because at

> that time I greatly admired people who were thin and looked slightly ill. I don't do that any longer. At the beginning – at least that is how I felt – almost the only thing you think about is stopping eating. . . . Actually I believe that it is important that one has come a little under way in the treatment before arriving here. It depends where exactly one is in the process. Like Hilde and I, we are pretty much at the same stage and manage to motivate each other quite well.

Social fellowship

Social interplay was a central criterion for the organization of the activities. In the final interviews the informers point repeatedly to the significance of the social context of the activities. The other patients were physically handicapped individuals between 18 and 60 years, with a variety of diagnoses. Contact between these individuals and the anorectic patients had a great impact on how the activities were experienced. We categorize these findings into two areas:

- fellowship in activity;
- to see oneself in relation to others.

Fellowship in activity There is ample clinical and scientific documentation for the assumption that anorexia nervosa is often connected to difficulties in finding good words to express one's emotional life. This may interfere with one's social interaction. This certainly applies to psychotherapeutic treatment in which verbal skills are expected. In addition, there are other forms of social difficulties. Low self-esteem, shame, being highly sensitive about what others may think about one, and a poor ability to set limits, which may contribute to a fear of intimacy.

We were given descriptions, particularly from the observation reports, of how social interaction can be facilitated by the physical activities. One interacts and communicates about 'something' instead of being expected to say something about oneself. Working together in the activities may mean social protection and security. Contact is established non-verbally and indirectly, through play, games and the tools which are being used, and precisely this may encourage verbal dialogue. The player does not put herself across as an anorectic, but as a partner. In this way one can achieve a different role as the customary one in the therapeutic context.

The body can promote its ecstatic ability through the learning of skills (e.g. riding) and by using instruments or tools (e.g. skis). But even more radical are the encounters with 'the others', says Merleau-Ponty. Through experience my body and the other's body become two sides of the same phenomenon, although there is always a distance between the two. Each person experiences him/herself and the other from one's own specific perspective. It is precisely this distance which enables us to supplement each other's perspective, to enter into a fellowship and extend our life-world.

The anorexia nervosa patients also meet with the other patients in the social environment outside the activity program. They tell us about taking the initiative to make contact, and about responding to the other's initiative.

> *Sophie*: Everyone is fairly open here. This makes people make contact with you. I feel that the other patients respected me as the person I am and that has been a wonderful feeling. I have learned to be together with people. I have been given the chance to show that I am a person.

Seeing oneself in relation to others Several of the patients describe how seeing the functional disabilities of others made them see their own illness in a different perspective.

Maria: Many of those who are here cannot get well. But I can.

Karen: Training with patients with other handicaps has been interesting. To see how they cope with things . . . I think they are unbelievably good at making the best of things and finding solutions.

Elizabeth: Where the body is concerned, I have found out that if one is a little overweight, or without a leg, then one can still have a very good time. Have a little joy and be happy with oneself. I suppose I have known this before, but I have not seen it at close quarters. This has probably been rather important for me to help me continue working with myself.

Anna: When I found out how far down in the dumps many have been, some have been paralyzed from the neck downwards, and now they can run and manage to talk – it is quite impressive. It makes me realize that in a way they have quite a lot of joy of life. And some of the blind ones . . . when I see how they manage; that they manage to get around when they can't see. It has really impressed me.

The participants in this study were divided in their opinions as to whether there should be one or several patients with anorexia nervosa in the project simultaneously. Half of them thought that as regards activities and eating, being alone would limit the chance to compete with and compare oneself to others. The other half thought that being in a group would enable them to support each other in the work of getting well.

Discussion

In this article, we have described a phenomenological approach to the psychiatric category of anorexia nervosa. Instead of indulging in etiological speculations of a psychological, biological or cultural nature, we have placed emphasis on the appearance of the illness. The core in this appearance is that the life-world becomes restricted via an overfocusing on weight, food and the body's ornamentation. A characteristic trait of anorexia nervosa is that, over time, the illness destroys social relations. The illness represents an overheated and antisocial relationship with oneself. It has been our basic premise that shifting attention from the body and food represents an existential opportunity. But, of course, the most important clinical issue is to what extent this can also represent an improvement. May APA be a part of the therapeutic approach to anorexia nervosa? Does there exist a hitherto mostly unused therapeutic access to anorexia nervosa as a supplement to psychotherapy?

We attempt to argue briefly for a 'yes' from a philosophical position. We put forward the argument that 'self-forgetfulness' is of value. This is, of course, not unequivocal. There are many ways of forgetting oneself which ought not to be linked to health, medical recovery or psychological growth. Chemical intoxication can contribute to one particular form of self-forgetfulness. One can do physical training on such an intense level that one 'is dead beat'. Patients who injure themselves with blows or cuts – not an unknown additional symptom in eating disorders – may discover that physical pain helps them to 'forget' their psychic pain. And in psychotherapeutic terminology 'forgetfulness' does not readily sound like a therapeutic tool, where the aim is self-reflection and insight.

When we speak of self-forgetfulness, we refer to what in Merleau-Ponty's thinking represents a de-objectification of the relation to oneself; a reopening of the existential relation, and a transfer of the body 'in the third person singular' to 'the lived body'. Those who live entirely in the world of objects, according to the French philosopher, live an 'unsuccessful existence'. By using movement and action in these opening assignments,

we discover the potential interplay with psychotherapy. According to Merleau-Ponty, the body is a unit seeking meaning and surpassing. Language is not a 'thing', but it may be experienced as one in an objectified state. Language is also movement, and an action. Our development takes place when we move within real situations and relations, in which sensing and action are the grounds for promoting perception and language. Perception is not a way of getting to know about something, but it is part of the process through which the world is brought to light. Words are not originally an object in the world, but a behavior, that is to say, they are an expansion of our bodily relationship to the world. Language is basically metaphorical, and the primary metaphors originate from the bodily experiences (Lakoff & Johnson, 1999). Only later are we able to construct abstract, i.e. apparently body-free languages. Self-forgetfulness, Leder's ecstasy, can open us up to emotions and new cognition and thus promote language. The body is the fundament for *communicating* with or without words. In psychotherapy, we base ourselves on both a healing relationship and a healing language. The person with anorexia nervosa may experience that she/he lacks both a language, which is good enough, and courage to enter into relationships. In adapted physical activity, the physical and social movement can contribute to the relational and the linguistic movement.

Conclusion

The question of whether it is not only philosophically, but also empirically valid, that APA is a useful tool in the treatment of anorexia nervosa is one which will have to be verified through further research. Additional qualitative studies are required to further additional knowledge about the shape and context of the activity. This will lay the foundation for future quantitative studies with standardized goals for change and criteria for improvement, and with a design in which control groups are included. Medical control and medical criteria need to be included as an integral part. The types of activities, which are medically unjustifiable for the thinnest and somatically poorest, will also have to be chartered. We see an especially interesting and crucial challenge in developing criteria for indication and contraindication for the use of APA connected to a differentiation of patients, particularly to phases in the anorectic illness. It may be difficult to avoid patients abusing the activities for calorie burning shortly after they have fallen ill. But with a case history stretching over several years, there are greater possibilities of good collaboration, because there is generally a fuller recognition of the illness. This again will stimulate the development of good phenomenological descriptions of the characteristic phases and forms of anorexia nervosa.

We want to stimulate interest in learning more about, and promoting the courage to practice, APA for this patient group; within the context of good quality, secure medical practice. A grounded use of physical activity and bodily approaches may be beneficial for the therapeutic relationship (Thien et al., 2000). A limitation of our study is that we did not systematically ask about actual and potential consequences for the patient–therapist relationship. Patients with anorexia nervosa are very often met with restrictions. From our interviews we obtained indications about the usefulness of a 'yes' instead of a 'no'. To be allowed some type of activity may also be an experience of being given something, hopefully furthering confidence and working alliances.

APA can be stimulated by integrating body-philosophy. Such traditions of thinking can give a broader understanding of activity as being more than mechanical mastery. We also hope that our results from one diagnostic group, anorexia nervosa, can stimulate related research for other groups with 'dys-appearing bodies'.

The aim of this project was to investigate how social interactions in activities could

move negative attention from the objectified anorectic body to a more profound and subjective experience of one's own body. The activities, which reduced negative attention towards their bodies, were focused on relations with others, they were non-competing and not predictable. The activities, which provoked negative bodily attention were those that were the opposite, individually based, focusing on results and predictable. Based on such results, future research should investigate what types of activities, in which contexts, are advantageous for whom; and to what extent such a shift of attention, 'self-forgetting', also implies health.

Physical activity is existential and has several aspects including non-physical.

Notes

1. This study is a common project by the authors, each contributing equally. They are given in alphabetical order.
2. With traditional physical activity we mean physical activity that is based on training and inspires competition.

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