The concept of body experience

Body image is a widely used concept in psychiatry, psychology and the social sciences included the Adapted Physical Activity (see Probst & Van de Vliet, 2003). But despite years of research and discussion by clinical researchers, a clear formulation of its meaning does not exist. Under the header of body image, a wide range of phenomena, varying greatly in their specific characteristics, have been described. The terms and meanings vary according to the field from which the concept was approached (see also André, Benavides & Giromini, 2004). Body image has neurological roots (Head, Gerstman: see Kolb, 1975; Shontz, 1969), has been a theme of psychoanalytic thoughts (Reich, 1949; Schilder, 1950), phenomenological (Merleau Ponty, 1962) and other philosophical reflections (Sartre, Spinoza, Kant: see Spicker, 1970), and was the subject of extensive psychological research (Fischer & Cleveland, 1968; Kolb, 1975). In the different orientations, terms are often used without adequate specification of their meaning. The notions partially overlap and different terms are used to denote the same concept. The term body experience has sometimes been used as a category for several different constructs.

This confusion not only reflects what Critchley (1980) called an "intolerable chaos" surrounding the term body image, but also the difficulties in the general understanding of how humans perceive and conceive their body (Van der Velde, 1985). This is probably one of the reasons why there was little progress in defining and understanding the phenomenon. Schilder (1950) introduced the concept of body image which he conceptualized as the picture of our body which we form in our mind. He developed a theory of body image which is closely tied to individual personality, emphasizing in particular the importance of emotions (Shontz, 1990). Originally, body image was treated as a unitary construct (see Body Cathexis, Secord and Jourard, 1953) but during the past decades the research data clearly indicate that body experience has evolved in a more multidimensional construct.

Bielefeld (1986), Cash and Pruzinsky (1990, 1996), Rosen (1996), Thompson (1990, 1996), and Thompson et al. (1999) make a clear distinction in the construct of body image between the definition of body image made by neurological and neuro-psychological researchers (cf. phantom limb phenomenon) and psychoanalysts (cf. body boundary concept) on
the one hand, and the physical appearance definition of body image on the other. The latter is an evaluation of one's body size, weight or any other aspect of the body that determines physical appearance. This physical appearance definition involves perceptual, attitudinal and behavioural features (Cash & Brown, 1987; Garfinkel & Garner, 1982; Rosen, Saltzberg & Srebnik, 1989; Thompson, 1990; Williamson, 1990).

Hence, body image disturbance (Garfinkel & Garner, 1984; Garner & Garfinkel, 1981; Kolb, 1975; Miller, 1991) has been considered a twofold phenomenon comprising a perceptual component as well as a subjective component including affective or cognitive aspects which may operate independently or conjointly. Bielefeld (1986) and Brähler (1986) refer to the neurophysiological aspects and the psychological-phenomenological aspect. The perceptual aspect refers mostly to the degree to which a patient is not able to assess his/her own size accurately or to the degree that exists between the patient's actual body dimensions and the perceived size and shape. Terms as body percept, body image distortion and body size distortion are commonly used in this respect. The second component has been referred to as the degree of unhappiness that patients experience about their body or to facets such as lack of satisfaction, concern, negative cognitive evaluation and anxiety. This aspect is found in terms like body image, body attitude, body concept and body dissatisfaction.

The term "body disparagement" (Ben Tovim, 1995; Slade, 1988) refers to a very intense negative attitude toward the body, a loathing and distaste for the body as an object. More and more the behavioural component is considered as a separate entity. This component focuses on avoidance of situations that cause the individual to experience discomfort related to physical appearance (Cash & Pruzinsky, 1990; Rosen, 1990, 1996; Thompson, 1990). Van der Velde (1985) introduced the term "extraneous body image", i.e. one's mental representation of another's appearance and behaviour. Williamson (1990) described three components: body size distortion (a phenomenon involving the perception of one's current body size or the degree of perceptual accuracy of current body size), preference for thinness (individual's ideal body size or a body size which is used as an ideal standard for judging satisfaction with current body size) and body size dissatisfaction (discrepancy between actual body size estimates and ideal body size estimates).

Heinberg (1996) divided body image disturbance into three major categories: perceptual, developmental, and 'socio-cultural'. The last two focus on a more subjective aspect of body image than the first category. The distinction between developmental and 'socio-cultural' is to some degree artificial because both factors can interact to influence and maintain the body image disturbances. Cortical deficits, adaptive failure and perceptual artefact support the perceptual theory of body image disturbance. The subjective theories can be divided into those with emphasis on developmental factors (cf. puberty and maturational timing, teasing and negative verbal commentary, early sexual abuse or sexualisation) and those with emphasis on socio-cultural factors. Under these socio-cultural factors Heinberg (1996) understands socio-culturally endorsed ideals of thinness and attractiveness, feminist theories, gender role socialization and the influence of mass media. He also included self-ideal discrepancy and social comparison.

It is clear that the idea of body image is a very complex phenomenon, integrating: exteroceptive (mainly visual and tactile) information, perception and interpretation of stimuli from within the body, subjective experiences of bodily functions (affective emotional components) and personal opinion (cognitive constructs) about one's own body. In fact we question the validity of the term "body image" in this respect, because the notion of an image clearly evokes the visual aspect of appearance and as such has been narrowed in eating disorders research to a perceptual question of body size estimation. The term "body experience" seems more appropriate because it refers more to the multidimensional and dynamic aspects than the term body image does. Both in our research operationalisations and therapeutic strategies, we aimed at approaching the major components (physiological, cognitive and affective).
Based on the ideas mentioned above and the proposition of Shavelson et al. (1976) and Fox (1997) concerning the hierarchical model of self-esteem we propose an adapted model.

Between attitude and behaviour is an inconsistency that has to be taken in account. It is worthwhile to consider the view of Fazio (1990). He proposed two different modes by which attitudes can guide behaviour. According to him, 'explicit attitudes' may guide one's behaviour by a deliberate and conscious analysis of the costs and the benefits of that behaviour. Alternatively "implicit attitudes" may guide behaviour in a more spontaneous and affective manner without actively considering the pros and the cons.

This hierarchical model is not in contradiction with a recent suggested tripartite influence model of body image as one theoretical framework for understanding the potential role of multiple influences in the possible development and maintenance of body image (Thompson, Coovert & Stormer, 1999). In this model three influences (peers, parents and media) are thought to have direct effect body image (Keery et al., 2004). A new study of Shroff and Thompson (2006) suggest that peer and media influences are more important than parental influences.
Body experience in eating disorders

• Clinical manifestations of body experience in eating disorders

The disturbance of the body experience is essentially what distinguishes eating disorders from other psychological conditions that occasionally involve eating abnormalities and weight loss (Rosen, 1990). Bruch (1962) was the first to recognize a group of three interrelated "perceptual and conceptual" disturbances in anorexia nervosa: (1) body image disturbances of delusional proportions; (2) disturbance in perception or interoceptive disturbances such as an inability to accurately identify internal sensations such as hunger, satiety or affective states; and (3) an overwhelming sense of personal ineffectiveness. The disturbance in body image of delusional proportions is described as: "the absence of concern about emaciation, even when advanced, and the vigour and stubbornness with which the often gruesome appearance is defended as normal and right and not too thin and as the only possible security against the dreaded fate of becoming illness" (Bruch, 1962).

Analyzing Bruch's work, two disturbed aspects can be distinguished. The first is "perceptual" and refers to the degree to which the patient is not able to assess her size accurately. The most perplexing abnormality is the patient's apparent inability to recognize how thin she has become (Garfinkel & Garner, 1982). Bruch (1973) refers to this phenomenon as disturbed size awareness. In some cases the overestimation seems to be restricted to particular parts of the body (stomach or thighs). These patients will acknowledge that, in general, they appear emaciated, but that further dieting is a necessary sacrifice to eliminate their protruding stomach.

The second aspect of body image disturbance, according to Bruch, involves cognitive and affective components without any obvious sign of perceptual mediators. This refers to some patients who assess their physical dimensions accurately, but react to their bodies with extreme forms of disparagement or occasionally aggrandizement (Garfinkel & Garner, 1982), or an extraordinary loathing for all or parts of their body. Anorectic girls are haunted by the fear of ugliness and are forever concerned with their appearance, while denying the abnormalities of their starved bodies. In essence, patients with eating disorders tend to perceive themselves as unrealistically big or fat and as being grossly out of proportion at certain body regions (hips, stomach). They are proud of their emaciated bodies and consider them as ideal. The disturbed body experience is often expressed as a rejection of the body, a refusal to grow up (Lafeber, 1971).

Since Bruch's (1962) description of perceptual and conceptual disturbances in anorexia nervosa, a substantial amount of literature on body image disturbances in eating disorders has been published. This should be viewed, however, against the background of a massive increase in the literature concerning eating disorders over the last 20 years.

In the eating disorder pathology, body image disturbance is a central theme. The experience and significance of body weight and shape are distorted. Persons suffering from an eating disorder evaluate their body structure, their size or certain body parts in an unrealistic way. Even when clearly underweight, some experience their appearance as normal or even too fat. The discrepancy between the way they see themselves and the way they see others is striking: in most cases, they can give a pretty accurate estimate of another patient's body size while they do not realize they themselves look the same or even worse!

Furthermore, they have wrong ideas about the consequences of eating on their body structure. After a meal they feel their stomach is 'bulging' or their belly is 'swelling'. Most patients with eating disorders nourish a very negative attitude towards their own bodies and their physical appearance in general. They are constantly watching their body, criticising it relentlessly or fighting it. Others avoid seeing themselves (naked) and often hide in loose clothing. Generally they are dissatisfied with certain body parts (usually their belly, thighs or bottom). But this dissatisfaction can also apply to body parts that are not related to weight (wide hips, short height, short legs and narrow shoulders). This dissatisfaction however, does
not lessen with weight loss. Their attitude can be compared to that of people suffering from 'imagined ugliness' or body dysmorphic disorder, who repeatedly undergo plastic surgery. A minority of patients with anorexia seems to be proud with their emaciated looks (which they seem to show in an almost 'exhibitionistic' manner), but for most of them the weight loss doesn't increase their satisfaction at all. Independent from their low weight, they continue experiencing themselves as too fat. Along with frequent weighing or mirror inspections, some develop their own standards, such as 'my ribs must show' or 'the inner part of my thighs shouldn't touch when I am standing'.

Patients suffering from an eating disorder lack confidence in their own body; they experience it as something annoying and they don't feel 'at home' in their body. They dislike being touched and have trouble with physical closeness in general. This feeling of alienation can resemble depersonalisation (or a form of dissociation), similar to what occurs following physical or sexual abuse. In their self experience, the way they think others think about them often plays an important role. And they generally anticipate a negative opinion. It is as if they looked at themselves through the eyes of someone very critical. In this way, the opinion they have about themselves is constantly subject to conflicting points of view: 'how do I see myself' (the internal lens), 'how do others see me' (the external lens), 'how do I really look' (the unbiased or neutral lens) and 'how would I like to look' (the ideal lens). The more the four lenses diverge, the more problematic the self perception is. The core problem resides in the absence of self esteem and the negative self perception, which is expressed in the negative body image. The translation of 'discord with one's self' into 'discord with one's body' is highly culturally defined.

This disturbed body experience has become a central theme in the conceptualization of eating disorders. Although some investigators, notably Hsu and Sobkiewicz (1991), contend that body image disturbance should not be a required for the diagnosis of anorexia nervosa and bulimia nervosa, clinically it usually is a prominent symptom, and, therefore, became the central topic of our research project.

After discussing the clinical manifestations of body experience, the causes of these disturbances and the importance of body experience to the maintenance of the other symptoms of eating disorders are briefly examined.

Body experience in eating disorders is a multidimensional problem that includes perceptual, attitudinal and behavioural features. Not all persons with eating disorders, however, suffer from each of these different types of body experience disturbances. There are several possible explanations for it, such as cultural standards for beauty, learning within the family, disturbances in development of self-identity and effectiveness, disturbances in psychosexual development and deficits in self-esteem for the development of a negative body experience in women with eating disorders (Rosen, 1990; Heinberg, 1996).

These findings differ in such way that it is impossible to put them in a particular theory but they do fit in a combined biopsychosocial model (Garner & Garfinkel, 1981; Vandereycken, 1989). In fact there is no evidence about the origin of a negative body experience in eating disorders. Vandereycken and Meermann (1984) believe that the multidimensional and developmental approaches are the only models that are in a position to illuminate the complex pathogenesis of anorexia nervosa in any detail at all. The biopsychosocial model consists of the possible relationship between various predisposing, precipitating and perpetuating factors. In this model social, psychic and biological stressors (such as interpersonal separation or loss, sexual conflicts, heightened achievement demands or distressing pubertal shape changes,...) are the precipitating factors. The influence of culture, family, personality and
physical condition should be predisposing factors.

It could be hypothesized that many persons possess the individual, familiar or cultural antecedents and that these become pathogenic within the context of stressors which initiate, dieting, weight loss and pursuit of thinness. The distorted and negative body experience, disturbed social interactions, changed self-experience and physiological deviations would be perpetuating factors. The problem of the chronology of body experience disturbance and other psychological variables is not clear at the moment. This makes it difficult to draw meaningful distinctions between premorbid characteristics and those who might arise as a consequence of body experience disorders.

Fairburn (1988) and Garner (1986) have asserted that body image disturbances also play a role in the development of other characteristics of eating disorders. The extreme eating abnormalities and weight control in these disorders are secondary to the over-concern with weight and shape. Rosen (1990) concludes that there is consistent evidence that negative body experience predicts severity of eating and dieting pathology and does so to a greater extent than other psychological variables. Another study (Spoor et al., 2005) found that in the eating disordered group appearance orientation was positively associated with internal body awareness. Eating disorders symptoms were negatively related to the awareness of bodily signals. No significant associations were found in the general sample of women. These results indicate that in eating disordered individuals preoccupation with the body and eating disordered behaviours are not negatively associated with hunger, but with awareness of their bodily signals as well.

Recent studies in functional neuroanatomy raise the veil over a new approach of body image research. Uher et al. (2005) found that processing of female body shapes engages a distributed neural network parts of which are underactive in women with eating disorders. The considerable variability in subjective emotional reaction to body shapes in patients with eating disorders is associated with differential activity in the prefrontal cortex. A study of Beato-Fernandez and colleagues (2005) shows that the exposure of the own body image provoke different patterns of change in regional cerebral blood flows in Bulimia Nervosa compared to Anorexia Nervosa and to a control group. A Japanese study suggests that women tend to perceive distorted images of their own bodies by complex cognitive processing of emotion, whereas men tend to perceive distorted images of their own bodies by object visual processing and spatial visual processing. (Kurosaki, Shirao, Yamashita, Okamoto, Yamawaki, 2005). These recent studies show that neuro-biological research will be more and more important in the body image field.

- **Body experience criteria in the diagnosis of eating disorders**

  Anorexia Nervosa (AN) is characterized by a refusal to maintain a minimally normal body weight. Bulimia Nervosa (BN) is characterized by repeated episodes of binge eating followed by inappropriate compensatory behaviours such as self-induced vomiting, misuse of laxatives (or other medications), fasting, or excessive exercise. A distorted attitude towards one's own body shape and weight is an essential feature of both disorders. The diagnostic criteria according to DSM-IV (American Psychiatric Association, 1994) concerning the negative body experience are found in table 1.

### Table 1: DSM-IV criteria for anorexia nervosa and bulimia nervosa concerning the negative body experience.

<table>
<thead>
<tr>
<th>Anorexia nervosa</th>
<th>Bulimia nervosa</th>
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<tr>
<td>1. Intense fear of gaining weight or becoming fat, even though underweight.</td>
<td>1. Recurrent inappropriate compensatory behavior in order to prevent weight gain, such as self-induced vomiting; misuse of laxatives, diuretics, enemas or other medications, fasting, or excessive exercise.</td>
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<tr>
<td>2. Disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or denial of the seriousness of the current low body weight.</td>
<td>2. Self-evaluation is unduly influenced by body shape and weight.</td>
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</table>
Changing the way AN patients experience their bodies should be considered a priority in the treatment of this disorder. According to Bruch (1962), a realistic self-concept and the acceptance of the body are necessary for recovery. Inbody and Ellis (1985) as well as Vandereycken, Depreitere and Probst (1987) claimed that one of the causes for the failure of some methods of treatment lies in the neglect of these aspects of therapy. Other authors (Button, Fransella & Slade, 1977; Cash & Brown, 1987; Crisp & Kalucy, 1974; Garner, Garfinkel & Bonato, 1987; Halmi, Goldberg & Cunningham, 1977; Rosen, 1990; Thompson, 1990) pointed to the negative prognostic value of a distorted body experience.

The literature on AN shows a conspicuous lack in information on specific therapies which focus on the distorted body experience. In this article we want to review therapeutic interventions that specifically focus on improving the body experience of AN-patients.

The literature on AN shows a conspicuous lack in information on specific therapies which focus on the distorted body experience. In this article we want to review therapeutic interventions that specifically focus on improving the body experience of AN-patients.

PS: Since the vast majority of eating disordered patients are women and our study is focused on female patients only, we will speak only about "she" and "her".

The measurement of the negative body experience

In the last two decades, several attempts have been presented to objectively assess body experience in eating disorders, ranging from questionnaires to semi-experimental methods (Table 2). According to Cardone and Olson (1973), the body experience can be assessed in three ways: with projective or affective methods, with questionnaires or self-reporting scales, or with so-called objective semi-experimental procedures (perceptual methods).

The problem with projective techniques, such as Strober's sophistication of body concept (1981), is that they rely on a theoretical construct to make inferences about the body experience. The self-reporting questionnaires are quite popular. The subject is asked to fill in a questionnaire by responding to items on the basis of his self-knowledge. Responses about body experience provide factual knowledge; i.e. information about his own behavior and experiences, about earlier inferences based on facts and judgment of others. Two advantages of this method are that it is based on how the subject responds and expresses himself, and second that researchers do no need to interpret the subject's behavior. On the other hand, the subject may not know himself sufficiently well to give a truthful response, or the subject may consciously select responses in function of their social desirability. Moreover, just as in other research based on questionnaires we should be in a position to assume that the subjects are motivated to provide the (often intimate) information. That is the reason why the reliability of such an instrument is sometimes questionable due to the patient's test attitude towards her own body. The problem with perceptual assessment is that it overemphasizes the visual aspects while neglecting the affective and cognitive components of one's body experience. In spite of these considerations we think that by employing the interview method, different questionnaires and a perceptual method we can get a global picture of the body experience of the patients. In addition, it is advisable to use a number of methods on the subject's attitude towards her own body in combination with a number of questionnaires on general psychological complaints.

The video distortion method

One of the most commonly used operationalizations of body experience is the estimation of one's own body size. In recent years, we have built up a considerable experience with body size estimation (BSE) using the video distortion method on a life-size screen (whole body procedure). Subjects have to adjust the previously distorted image of themselves on the screen until it corresponds to: what they think they really look like (cognitive response), what they feel they look like (affective response) and what they wish to look like (optative response). Finally the have to estimate the real dimensions of a neutral object (neutral response). The videotaped images can be distorted in two ways: from narrow to wide and vice versa. This new method was shown to have a high reliability (Probst et al., 1992; Probst et al., 1995a) and may be considered as the most "natural" of all existing methods to estimate one's own body size.
sizes, because the subjects are confronted with their life-size image as if they are looking in a mirror. The general finding of this study is that eating disorder patients and normal control subjects show no significant differences in accuracy of body size estimation (Probst, 1997; Probst et al., 1995b, 1998a,b).

### Table 2: Review of the assessment methods of body experience.

<table>
<thead>
<tr>
<th>Assessment of body experience</th>
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<tbody>
<tr>
<td><strong>Interview</strong></td>
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<tr>
<td>Structured interview</td>
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<tr>
<td>Unstructured interview</td>
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<tr>
<td><strong>Projective techniques</strong></td>
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<tr>
<td>Draw a Person test</td>
</tr>
<tr>
<td><strong>Questionnaires</strong></td>
</tr>
<tr>
<td>Rating scales</td>
</tr>
<tr>
<td>Graphical scales</td>
</tr>
<tr>
<td>Numerical scales</td>
</tr>
<tr>
<td>Unidimensional</td>
</tr>
<tr>
<td>Multidimensional</td>
</tr>
<tr>
<td>Hierarchical</td>
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<tr>
<td>Semantic differential</td>
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<tr>
<td>Checklists</td>
</tr>
<tr>
<td><strong>Perceptual techniques</strong></td>
</tr>
<tr>
<td>Linear techniques (BPM)</td>
</tr>
<tr>
<td>Paper and pencil techniques</td>
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<tr>
<td>Technique with movable marks</td>
</tr>
<tr>
<td>Configuration techniques</td>
</tr>
<tr>
<td>Preference of physical appearance</td>
</tr>
<tr>
<td>Paper and pencil techniques</td>
</tr>
<tr>
<td>Silhouettes body image cards</td>
</tr>
<tr>
<td>Distortion techniques</td>
</tr>
<tr>
<td>Mirror distortion</td>
</tr>
<tr>
<td>Photo distortion</td>
</tr>
<tr>
<td>Videodistortion</td>
</tr>
<tr>
<td>Direct method</td>
</tr>
<tr>
<td>small image</td>
</tr>
<tr>
<td>life size images</td>
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<tr>
<td>Indirect method</td>
</tr>
<tr>
<td>Computer methods</td>
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<tr>
<td>Body image assessment software</td>
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</tbody>
</table>

_WBM = whole body method, BPM = body part method_
Questionnaires

Beside the videodistortion method (see also Smeets, 1995) different self-reporting questionnaires are used. There are a large number of questionnaire measures that assess a generic aspect of body experience.

One of the most widely used is the Body Dissatisfaction subscale of the Eating Disorder Inventory (Garner et al., 1983). This instrument (9 items) uses a 6-point scale to measure satisfaction with different body site (hips, shape, buttocks, thighs, stomach). The Eating Disorder Inventory (EDI; Garner et al., 1983) is a well known questionnaire aimed at assessing the psychological characteristics of AN and BN. It comprised three subscales assessing attitudes and behavior concerning eating, weight and shape (Drive for Thinness, Bulima, Body Dissatisfaction) and five subscales tapping more general organizing constructs of psychological traits clinically relevant to eating disorders : Ineffectiveness, Interioceptive Awareness, Perfectionism, Maturity Fears and Interpersonal Distrust.

The Body Attitude Test (BAT, Van Coppenolle et al, 1990; Probst et al., 1995a, 1997; Probst, 2000a,b) is a more recent self report questionnaire developed for patients suffering from eating disorders. This questionnaire consists of 20 items and is scored on a 6-point scale (0-5; never-always; except item 4 and 9 who are negatively keyed items) (See appendix). The maximum score is 100 and the lower the score the more 'normal' the response pattern. The higher the score the more disturbed the body experience. Repeated analyses yielded a stable four factor structure: negative appreciation of body size, lack of familiarity with one's own body, general body dissatisfaction and a rest factor. Repeated tests in different subgroups have shown the Body Attitude Test to be reliable and valid, as well as easy and practical. The test is translated and validated in different languages.

The Semantic Differential (Osgood, Suci & Tannebaum, 1957) is a general technique, among other things, and can be used to assess attitudes in terms of bipolar adjectives. The subject is asked to score a number of concepts on a 7-point scale. This is an attitude scale in which score 1 represents the most negative attitude, score 4 a neutral attitude and score 7 the most positive attitude towards a concept (p.e. my body; my ideal body; my body right now;...). Each scale consists of two diametrically opposed attitudes (fat/thin; beautiful/ugly; attractive/repulsive; uncomfortable/comfortable; powerful/weak; inactive/active; small/large;...).

The Body Shape Questionnaire (BSQ, Cooper et al, 1987) is designed to evaluate the preoccupation with body shape and feelings of being overweight (34 items). It clearly differentiates between BN patients and women who are not suffering from eating disorders.

The Ben-Tovim Walker Body Attitude Questionnaire (BAQ, Ben-Tovim et al, 1991; see also Probst, 2000a,b) is a 44-item self report questionnaire whose subscales encompass six distinct aspects of body experience: feelings of overall fatness, self disparagement, strength, salience of weight, feelings of attractiveness and consciousness of lower body fat. The BAQ has been developed which assesses a broad range of attitudes which women hold towards their bodies.

Recent research shows that there are significant differences in the conceptual underpinnings of the available measures. Researchers seldom present any arguments for selecting one measure instead of another. The abundance of different related and unrelated measurements with or without conceptual underpinnings can lead to potential weaknesses, eminent obstacles and interpretational perils. In the next future the challenge for researchers of body image lies in the successful transformation of past mistakes. Before starting a research project researchers have to answer four crucial aspects regarding the measurement of body image:

• to elucidate the distinctions between the various constructs of domain of body image;
• to discuss the issues surrounding the distinctions between categorical and dimensional measures;
to examine the implications of developing measures that are tailored to assess;
• to consider the advantage and disadvantage of employing an inductive as opposed to a deductive strategy in devising a measurement model for the study of body image (Thompson, 2004).

Psychomotor therapy / body-oriented therapy in eating disorders

• General information: Definition - Evolution

Psychomotor therapy comprises all forms of psychotherapy which centre on the body to improve psychic functioning. In this approach patients are faced with primarily nonverbal experiences, which can be verbally discussed later or elsewhere in treatment. This form of treatment is usually connected to existing psychotherapeutic schools of thought (behaviour, cognitive, or psychodynamic therapy). We are not considering other nonverbal treatments like art therapy, gestalt therapy, or psychodrama. Even though they use nonverbal methods of expression, they are not directly centred on body experience. Psychomotor therapy has been applied to eating disorder patients under different names: body image groups (Kaplan, Kerr & Maddocks, 1992; Jasper & Maddocks, 1992), body image therapy (Garner & Garfinkel, 1981; Miller, 1991; Wooley & Kearney-Cooke, 1986), body movement therapy (Roth, 1986), dance movement therapy (Krueger & Schofield, 1986; Rice, Hardenberg & Hornyak, 1989; Stanton-Jones, 1992), physiotherapy (Davison, 1988; Hare, 1986), psychomotor therapy (Vandereycken, Depreitere & Probst, 1987, Probst, 2001).

These therapies cannot clearly be distinguished. They often overlap in their goals and techniques, and are usually considered an addition to verbal psychotherapy. The difference lies in the specific methods, techniques, and goals. Psychomotor therapy (PMT) often makes use of movement exercises, sports and games, relaxation techniques, and bodily exploration and expression. Movement exercises consist of gymnastics and physical fitness (e.g. running, throwing, pulling and pushing), rhythmic movement (e.g. dancing and related forms), movement in water, style bound forms (e.g. equilibrium gymnastics, circuit training), and self-defense exercises (e.g. judo, wrestling). Relaxation techniques can be used in different forms (e.g. yoga, autogenic training, breathing techniques, massage). Sports and games are categorized in individual and group-related play forms. Bodily exploration and expression consist of exercises enhancing personal growth (e.g. sensory awareness, self-confrontation techniques with video camera or mirror, concentration exercises) on the one hand, and exercises to develop social skills and positive interaction on the other (e.g. nonverbal expression, trust exercises).

• General aspects of body-oriented therapies (BOT)

Even though Bruch pointed to a disturbed body image as an essential aspect of AN patients as early as 1962, very few publications concerning methods of BOT appeared between 1960 and 1980. It was not until 1975 that more concrete treatment programs for AN patients were developed (Agras & Kraemer, 1984). Only in the last decade a growing interest for the incorporation of body experience in treatment programs was formulated. The approach evolved from a physiotherapeutic method (Ziemer & Ross, 1970) to a more integrated, mainly nonverbal psychotherapy in which the body plays a central role as an instrument and target of treatment (Vandereycken et al., 1987). Cultural differences between Anglo-Saxon and Roman countries, and between Western Europe and North America, tied to the liberalization of how the body is viewed, explain the possible differences in the approach to BOT.

Direct versus indirect approach

The importance of body experience within the therapeutic framework depends on the theoretical views on AN. Vandereycken, Probst and Meermann (1988) distinguish two basic views. One group of clinicians considers the disturbed body image as a secondary symptom, caused by another factor. These therapists aim essentially at treating the underweight, the family problems, or the intrapsychic problems, while considering the distorted body image as a
subordinate phenomenon. When the primary cause is solved, the body image is assumed to spontaneously normalize. The second group of clinicians considers the distorted body image as a primary and essential aspect, which requires specific therapeutic intervention. One group of therapists merely utilizes verbal means, usually cognitive therapy (Fairburn & Cooper, 1989; Freedman, 1990 & 2002; Garner & Bemis, 1982; Rosen, 1990). Another group of therapists states that the body should be seen as a specific point of impact. They endorse the use of psychomotor therapy that is usually part of a multidimensional treatment model, in which verbal psychotherapy also plays an important role.

Multidimensional therapeutic model

We already agreed with the fact that body experience is a multidimensional phenomenon. It seems obvious then that only a multidimensional approach would be capable of focusing on the complexity of the body experience of anorectic patients. Integrated in a multidimensional treatment, the psychomotor therapy serves the specific purpose of influencing the body experience. However, it is not only the purpose of the PMT. In group psychotherapy, for instance, the patients are able to develop insight in the meaning and role of their bodies through more verbal techniques. In art therapy, they express their feelings about their bodies in paintings and drawings, with clay and collages. In the sexual education group (Van Vreckem & Vandereycken, 1994), the patients receive information, and they discuss their feelings of the body as an expression of the sexual identity. A flexible approach is necessary when trying to integrate a great variety of treatment models and when attending to the specific problems of each individual. It is possible, after all, that different strategies are necessary for different categories of patients.

Individual versus group therapy

Until 1985 PMT was most often a form of individual therapy, after which the interest shifted to group therapies. Vandereycken and Meermann (1984) state that this approach combines the advantages of self-confrontation with those of group confrontation. In the group approach, the patients may experience the fellow participant's support and the possibility to learn from interpersonal interactions (Jasper & Maddocks, 1992). In group PMT, denial or minimization of problems can be managed much easier. Most of the exercises in PMT have more impact when performed in group, mainly because of the feedback and the confrontation of the fellow participants (Schlundt & Johnson, 1990; Inbody & Ellis; Yellowlees, 1988; Van Deusen, 1993).

• Cornerstones for a psychomotor therapy in eating disorders

From the specific conduct pattern of eating disorders, Vandereycken, Depreitere, and Probst (1987) suggest three possible starting points: the distorted body experience, the hyperactivity, and the fear to lose self-control. These three features are typical of many anorexia nervosa patients and play a central part in their pattern of behaviour.

Disturbed body image

The distorted self-image or the weak and negative self concept are aspects of the anorexia nervosa syndrome, frequently described in the literature (Garfinkel & Garner, 1982). The body is, on the one hand, experienced as thoroughly negative, and appears on the other hand as if it were split off from the essential personality. The anorexia nervosa patient conceives herself as much too fat, in spite of her emaciation. Her body is either an object of menace or a passive, insensible burden she has to drag along all the time. Selvini-Palazolli (1974) described the negation of the body as follows: the anorexia nervosa patient fights the greatest struggle with her own body, the female body, which at the height of her illness seems to her a reprehensible and even repulsive "object". To an anorexia nervosa patient the body is at the same time bad and fascinating. It dominates the patient, because it forces her to eat. Since she cannot get rid of the body, she struggles to keep it under control (the "master" has to become a "slave"). As a result the perception and awareness of internal stimuli are prevented or distorted. The patient does know how much food her body needs; she no longer has a normal sensation of hunger, satiety, and
even fatigue. Many patients with anorexia nervosa appear to act in a state of depersonalization which makes their bodies seem "wooden". At the same time there is a frequent denial, repression or avoidance of sexual feelings. Appetite, functional pleasure and sexual desire are obstinately fought. Afraid of bodily pleasure and sexual desire, they are unaware that both stress and malnutrition vitiate sexual arousal.

**Hyperactivity**

A striking feature of anorexia nervosa that is described as a secondary symptom among patients with anorexia and bulimia nervosa, is the paradoxical constant restlessness or urge to move (Bruch, 1973; Casper, 2006; Epling & Pierce, 1996; Kron, Katz, Gorzynski & Weiner, 1978; Mond et al., 2006; Vandereycken, 1978). This hyperactivity is frequently observed in eating disorders, is substantially larger than in a clinically population, and may be seemingly appropriate (riding a bicycle, walking, swimming, etc.) or meaningless (e.g. pacing a room). Rather than using movement in a functional way as a means of relaxation and enjoyment, anorexics become prey to a kind of impersonal, ego-dystonic urge to move. A number of bio-psychological mechanisms have been proposed to clarify the role of hyperactivity in eating disorders. A first and obvious explanation is that physical activity is simply an effective method of caloric expenditure and appetite suppression fulfilling the desire to lose weight. There is abundant evidence that obsessive-compulsive behaviour plays an important role in hyperactivity and has become a ritualized, stereotype obsessive-compulsive behaviour. A third explanation is that hyperactivity may play an important role in affect-regulation (Probst, 2003; Vansteelandt et al., 2004). In bulimia nervosa and binge eating disorder, passivity and a lack of exercise are described.

**Fear of loss of self-mastery**

Anorexics are driven to acquire an absolute mastery over their body by controlling their internal and external environment on the physical level (weight, food intake, hunger, tiredness) and on the psychological level (perfectionism, asceticism). They transmute their fear of loss of such mastery into the unbarring fear of becoming fat, even while weight loss continues. With each bite of food they assume that their bodies will become disgustingly big. Patients who moreover suffer from bulimia, regularly experience a complete loss of control over their eating behavior; the more obstinately they want to fast, the stronger their urge to eat. Their attempts to keep everything in their lives, especially their physical functioning, under control points to the essence of their problem: a paralyzing sense of helplessness, an embodied inability to live. It becomes obvious that anorexia nervosa is a pseudo problem-solving behavior that in fact perpetuates the problem (Vandereycken & Meermann, 1984).

- **Objectives of psychomotor (body-oriented) therapy**

Rosen (1990) suggests the multidimensional aspect of the body experience (perception, attitude, behavior) as the focus for BOT. According to Wooley and co-workers (Wooley & Wooley, 1985; Wooley & Kearney-Cooke, 1986), the changes during puberty, the influence of earlier sexual experiences, and the relation of the body experience of mother and daughter are the three components which influence the body experience of patients most, and should therefore be explored. From the specific conduct pattern of eating disorders, Vandereycken, Depreitere, and Probst (1987) suggest four specific objectives for body-oriented therapy.

**Rebuilding a realistic self image**

A crucial condition for recovery is the development of a more realistic and positive body experience. This means that the patients should be made aware of their deteriorating physical condition. The patients should also be prepared for their changing body during weight restoration and the accompanying feelings and needs. The next step consists of accepting these changes which result in a physically mature body. It is obvious that attention needs to be given to earlier negative experiences. Changing these into a positive body experience is an extra step. In some cases even the reconstruction of the
Development of the body experience can be important (Kearney-Cooke, 1988). In any case, AN patients have more need to develop a healthy look on their bodies than to develop a more cultural influenced image (Van Deusen, 1993). Their wrong attitudes regarding body size and weight, and their eating conduct should be reversed.

Curbing hyperactivity, impulses, and tensions

In terms of learning theory one could say that physical activity may be a good reinforcer. Appropriate physical activity connected with a certain degree of weight gain, may be handled efficiently in a behaviour therapy program. It is desirable to curb hyperactivity and restlessness - characteristic for many anorectic patients - into a more controlled form of movement, where the patient is allowed to move intensively but within certain limits determined by the therapist. Learning how to limit physical activity through rest and relaxation is important. Sustaining a good physical condition can be an extra goal.

Developing social skills

AN patients must learn how to communicate with their bodies, this means how to use body language. This includes expressing feelings and irritations toward others. Their lack of assertiveness and low self esteem are often noticed during social interaction.

Learning how to enjoy the body

When patients have more or less accepted their bodies, this means how to use body language. This includes expressing feelings and irritations toward others. Their lack of assertiveness and low self esteem are often noticed during social interaction.

Therapeutic techniques

There are several ways to accomplish these objectives. From the wide array of possibilities, ranging from focusing on self-confrontation to self-perception (Vandereycken, Probst, & Van Bellinghen, 1992), one chooses the techniques which seem most effective in influencing the distorted body experience of AN patients (Vandereycken, Probst, & Meermann, 1988). No activities are intrinsically therapeutic. The exercises are not only goals in themselves; they are just a means by which to attain the desired goals. Even though group BOT is usually used, the therapist must work in an individual way. Certain exercises can be used to achieve different goals. It is important to present the patient with a safe and structured framework, where everyone knows the rules and where the therapist is sufficiently informative about the therapeutic setting. We have to keep in mind that BOT can be very confronting for some AN patients who have been in constant struggle with their bodies for several years.

Table 3: The elements of a body oriented therapy in eating disorders.

<table>
<thead>
<tr>
<th>Impression or body perception</th>
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<tr>
<td>Expression or revealing inner experiences</td>
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<tr>
<td>Communication or body in interaction</td>
</tr>
<tr>
<td>Exertion or bodily performance</td>
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<tr>
<td>Sensation or bodily pleasure</td>
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Relaxation and breathing exercises

(Andersen, 1985; Crisp et al., 1985; Giles, 1985; Kaslow & Eicher, 1988; Kerr, 1990; Krueger & Schofield, 1986; Martin, 1985; Roth, 1986; Vandereycken et al., 1987). Most widely used are Jacobson's progressive relaxation method and autogenic training by Schultz. Alexander's eutony (Gelb, 1987) and yoga (Giles, 1985, Daubenmier, 2005) are used occasionally. Biofeedback is also mentioned as an aid (McKee & Kiffer, 1982, Zerbe, 1993). Respiratory exercises - especially those aimed at a lowering respiration frequency, amplifying abdominal respiration, and lengthening expiration - are often included in relaxation training. The objective is not just to regulate respiration, it also facilitates learning how to sense one's own body.

Massage (Jasper & Maddocks, 1992; Mc Farland & Baker-Bauman 1990; Vandereycken et al., 1987). In treating AN-patients, the following forms of massage are used: relaxing
and/or activating massage of back and legs, and passive mobilization of the limbs. The most commonly used techniques are patting, subtle touching, and kneading. The passive mobilization consists of letting limbs and head move passively, while a partner mobilizes the joints; it aims at relaxation and awareness of the body. Field et al (1998) found that bulimic patients benefit from massage.

Role playing (Garfinkel & Garner, 1982; Giles, 1985; Hudgins, 1989; Kaplan et al., 1992; Kerr, 1990; Martin, 1985; Vandereycken et al., 1987). The main emphasis is not on drama techniques, but rather on deepening the emotional experiences through participation, contact, interaction, and nonverbal communication. Besides psychologically resolving earlier conflicts, present and future problems can be enacted. Role playing can also act on a behavioural level. Two specific forms are applied here: doubling and role reversal. "Doubling" is a technique in which the therapist or another member of the group will sit next to the patient and imitate her nonverbal posture. This enhances cognitive, affective and motivational awareness (Hudgins, 1989; Hudgins & Kiesler, 1984). "I am the boss" is a similar exercise, in which two patients are instructed to show each other that they are dominating the other through expression, posture, gestures, and movement. In "role reversal", the patient impersonates a real or imaginary person to increase awareness of the self. This technique helps to test the perception of the self and others on accuracy, to distinguish one's boundaries, and to practice new behaviours in a safe environment. Expressing relations within the family or within the group of patients through "body sculpture" can be useful for analyzing complex interpersonal relations.

Physical activities, sports and games (Andersen, 1985; Crisp et al., 1985; Eckert & Labeck, 1985; Garfinkel & Garner, 1982; Giles, 1985; Kaplan et al., 1992; Kaslow & Eicher, 1988; Kerr, 1990; Martin, 1985; Rice et al., 1989; Tokumura et al., 2003; Vandereycken et al., 1987; Wooley & Wooley, 1985; Ziemer & Ross, 1970). Physical activities like fitness training (Beumont et al., 1994), aerobics and callanetics (Kennedy et al., 1992), sports (swimming, volleyball, wrestling, horseback riding), and gymnastics are used in treating AN-patients. Controlled progressive movement programs are usually employed here. Beumont et al. (1994) suggest the following activities for the fitness training of AN-patients: non-aerobic activities, stretching, flexibility, posture improvement, weight training, and exercises requesting social support. We use a program to be executed twice a week, consisting of warming-up, power training, and relaxation. It is not clear whether, as Kennedy et al. (1992) state, these activities also improve weight repartition. Thiem et al. (2000) found that the incorporation of a graded exercise program may increase compliance with treatment but it did not reduce the short-term rate of gain of body fat or BMI.

Dance and creative movement (Garfinkel & Garner, 1982; Giles, 1985; Jasper & Maddocks, 1992; Kaslow & Eicher, 1988; Kearney-Cooke, 1988; Kerr, 1990; Mc Farland, 1990; Rice et al., 1989; Vandereycken et al., 1987; Vandereycken & Meermann, 1984; Wooley & Wooley, 1985). This includes all dance and movement forms which focus on expression through the body: rhythmic exercises, dance (including primitive dancing and folk dancing), aerobics, free movement expression, improvisation, and pantomime. In these dance and movement forms, the patients can express feeling experiences like sadness, joy, security, shame, aggression, dependence, shyness, etc. Patients are encouraged to use their body as a means of expression, even when most of them do not feel comfortable with their body.

Sensory awareness training (Giles, 1985; Kaslow & Eicher, 1988; Krueger & Schofield, 1986; Vandereycken et al., 1987). These exercises aim at discovering the body through the senses in a non-threatening way. Being conscious of internal sensations has a direct effect on the ability to recognize feelings. It is also the step to perceiving a mutual relation between bodily sensations and feelings. Peripheral concentration exercises focus attention on relatively neutral objects through auditory and visual observation. In this way, the attention is on the stimuli without being affectively immersed. Body boundary exploration concentrates on tactile awareness of the difference between one's body and the outside world. "Body scanning" ("trip around the
"body") is a tactile exercise to explore the external manifestations of the body through touching and feeling of the body boundaries. Internal sensory exploration focuses on breathing, heartbeat, feeling of hunger, and fatigue. During a "trip into the body" the patient is asked to visually imagine making a trip inside her body.

**Self-perception and body perception** (Barabasz, 1987; Biggs et al., 1980; Giles, 1985; Gottheil et al., 1969; Jasper & Maddocks, 1992; Kaslow & Eicher, 1988; Krueger & Schofield, 1986; Rice et al., 1989; Schlund & Johnson, 1990; Vandereycken et al., 1987; Wooley & Wooley, 1985). Concerned here are exercises aimed at amplifying awareness of one's own body in its external appearance. Mirror exercises and video feedback are assumed to have different effects (Fischer, 1986). These exercises are based on exteroception, the opposite of sensory awareness which is based on interoception of the body (Probst, 2005; Delinsky & Wilson, 2006).

Even though AN patients usually avoid mirrors, they are taught to handle a mirror correctly, to look at it, alone or with others. According to Krueger and Schofield (1986), the mirror should help in forming a more stable integrated mental representation of the body. Norris (1984) reported that mirror confrontation influences a patient's ability to estimate one's own body size.

The positive effects of video confrontation and video-feedback on self-evaluation have been proved (Fischer, 1986), but it can also have unwanted negative effects (Dowrick & Biggs, 1983). Hence when using video, the therapist must carefully select patients and inform them prior to the session. Video recordings do not just inform about external appearance, but also about nonverbal expression. The video images can be watched during the recording (immediate feedback) or afterwards. A standardized form of video confrontation seems therapeutically very useful (Yager, Rudnick & Metzer, 1981; Fernandez & Vandereycken, 1994; Leichner & Kasma, 1989; Probst et al., 1990, 1997; Sala et al., 1993; Vandereycken & Meermann, 1984). Patients, usually dressed in bathing suit, are filmed at the beginning of the treatment and at fixed time intervals in a standardized line up. Afterwards, the recordings are watched by the patients (possibly in the company of fellow patients during group BOT) and they are asked to discuss their feelings and reactions while watching the video (see infra). Badura and Steinnmeyer (1984) state that the watching other patient's recordings (hetero confrontation) is just as important as self-confrontation. The research method of body size estimation through video distortion - where patients correct a distorted videotaped image of themselves (Probst et al., 1992) - could possibly help in developing a positive self image (cfr. supra). Similar is the exercise of drawing one's own body, life size, and then comparing it with the correct measurements. Wooley and Roll's test (1991), in which body parts on a standard figure are coloured according to their significance, can be viewed as a similar form of self-confrontation.

**Guided imagery.** Hutchinson (1985) and Kearney-Cooke (1988) described these exercises with patients suffering from eating disorders. In her imagination, a patient is led to make-belief situations, aiming to summon sensory and affective material, including special body experiences. We can thus discover negatively laden body parts. This negativity of certain body parts can also be discovered when the patient is asked to write a letter to her own body or a certain part of her body, including an answer to the negativity (Jasper & Maddock, 1992).

- **Therapeutic procedures in the body oriented therapy**

For more than 20 years the University Psychiatric Centre - K.U.Leuven, campus Kortenberg (Belgium) has specialized in the inpatient treatment of eating disorders. After a phase of trial and error, the treatment program is now firmly established as a multimodal intensive group approach. We are working with two groups of 9 patients suffering from bulimia or anorexia nervosa. Almost all our patients have been treated before unsuccessfully. This negative selection explains the necessity of an intensive and long (4-6 months) treatment in a specialized unit. Our treatment program is based on four major components: 1. a highly structured behavioural contract regarding weight and eating (Vandereycken, 1987 & 1989); 2. Intensive and
confrontational group therapy (Vanderlinden & Vandereycken, 1988); 3. Active participation of the patients's family (Vandereycken, Kog, Vanderlinden, 1989); 4. Emphasis upon altering the distorted body experience as describe in this chapter.

In our body-oriented approach a number of basic principles are followed:

♦ Offering a secure and well structured framework in which everybody knows the rules, and where the therapist constantly provides information about who, what, why and how. We should indeed bear in mind that in body oriented therapy patients are intensely confronted with their problems, because they have often fought and hated their body for years. It is therefore important that patients are well informed and that they are aware of the objectives of the different exercises. It may be important for example to explain the functioning of the respiratory system during breathing exercises.

♦ The link between the exercise and its goals must be clear to the patient. An example may clarify this: Patient A has great problems with body contact, patient B with relaxing. When the therapist proposes back massage of B by A, patient A knows she will be confronted with body contact and patient B with the problem of relaxation. In the subsequent discussion the experiences of both patients can be a talking point which can be enriching for the other members of the group. Also previous positive or negative experiences with body contact can be discussed.

♦ During discussions, also in the body oriented therapy sessions, patients are constantly invited to express their feelings which arise during the exercises. When the inhibition to do so is insurmountable, they are asked to further deal with them in the group psychotherapy. The fact that the fellow patients of the group witness this is a guarantee that it will happen. The underlying message of all exercises and discussions is self respect, which will enable the patients to build up love for their own body. For this purpose it is important that during BOT the patients get aware that beside the outward appearance there are other personal potentials and values that are at least equally important in life. The therapist's role will consist in bringing home to them that gaining weight is not synonymous with feeling fat or puffy, but with health attractiveness and expressivity, in 'living as they may never have experienced it'.

♦ The constant offer of body oriented situations, together with direct and constant self confrontation through video, mirrors and discussion among group members, as well as presenting the same situation twice during the treatment with an interval of several weeks or a few months, enables the patients to discover their changing attitude towards the exercises. The visual feedback intensifies the kinaesthetic sensations by providing a new perspective on the body. The discussions show what patients themselves think about the changing appearance of their body.

♦ Whenever possible the exercises are designed so that the patients can also try them out outside the therapy sessions, on their own or with a partner. This is possible for breathing exercises, relaxation training and mirror exercises.

• Efficacy of body oriented therapy

The question of whether or not BOT is effective has so far only been answered from a clinical rather than from a scientific point of view. Investigating the results is especially difficult when BOT is integrated in a multidimensional approach. Besides that, varying aspects of the body experience can be changed or distorted. Including these aspects in research is very difficult and requires a multimethod approach. In the earliest studies (Button, 1986; Button et al., 1977; Crisp & Kalucy, 1974; Garfinkel, 1981; Slade & Russell, 1973), the influence of treatment on the body experience is investigated by means of a perception test (body size estimation) of questionable methodological value. Considering the opinion of the patients themselves, certain recent studies (Köpp & Jacoby, 1993; Probst, Vandereycken & Van Coppenolle, 1994; Probst, 1997, 2005) pointed out that a multidisciplinary approach, with a specific place for BOT, has a positive influence.
on body experience. A follow-up shows that compared to the scores at admission, the total sample of eating disorder patients reported significantly fewer signs of body dissatisfaction one year later (Probst, 1997).

The question however is how - besides the subjective therapeutic understanding - one can check if the BOT interventions are indeed of any use for the patient's problems. How and when does one know that the body oriented therapy has had an influence on the instinctive relation as well as on the uncontrolled physical activity? How and when does one know that the psychomotor activities proposed sustain the patient's development? How and when does one know that BOT provides support in learning how to cope with problems? How and when does one know that the BOT or psychomotor therapy (PMT) has had an influence on the patient's problems? Answering these crucial questions is not a simple task.

The patients' subjective remarks can give an indication. Upon discharge patients say or write:

♦ 'I just want to add that psychomotor therapy has helped me a lot.'
♦ 'I want to thank the psychomotor therapist for his help. He taught me a lot. He often had to exhort me, but he made me look at myself in a different manner.'
♦ 'I think psychomotor therapy was not always fun. The tasks were always difficult, but I learned a lot by executing them.'
♦ 'It doesn't affect me having to say goodbye. Through psychomotor therapy the psychomotor therapist made me feel more confident and now I dare a lot more. I thank him for his patience and the interest he showed in me.'
♦ 'For me psychomotor therapy was often a difficult and confronting therapy, but it did help me a lot to get where I am now...'.
♦ 'I have the feeling that the psychomotor therapy helped me on the way of a complete acceptance of myself... Sometimes the nature of the tasks we had to carry out surprised me but afterwards I always thought I had learned a lot.'
♦ 'I find it difficult to linger over myself. But psychomotor therapy helped me in this. I feel I can be less resistant to change.'
♦ 'The psychomotor therapy was not the easiest therapy for me but the psychomotor therapist helped me through it. There were even moments when I could enjoy it. My body is no longer a necessary evil but a team-mate I have to take into account...'.

All the above is familiar to many psychomotor therapists. Of course such remarks need to be interpreted scrupulously. After all, what is the value of these kinds of remarks? How durable are they? They were written down upon discharge and are perhaps influenced by the 'hello-good-bye effect'. After all they are addressed to the therapist and expressed in the presence of the therapist. But such remarks, completed with one's own observations and observations and remarks by other team-members, tell something about the turn taken as well as about the value of psychomotor therapy for certain patients.

At least a final remark with respect to the changes in body experience after treatment has to be made. When we compare our results one year after admission with the data of normal subjects, we see that eating disorder patients still have a more negative body experience. But can one expect body experience to change so quickly and is it realistic to expect "normalization" anyway? How many eating disorder patients will not retain a special relationship to their bodies throughout their lives?
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Die Körpererfahrung bei Essstörungen: Forschung und Therapie

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Abstract


L'expérience corporelle dans les troubles de l'alimentation : recherche et thérapie

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Abstract

La thérapie psychomotrice peut, à certains égards, être interprétée comme une partie de l’activité physique adaptée pour les personnes souffrant de troubles mentaux. En Belgique et aux Pays-Bas, l’expression « thérapie psychomotrice » est utilisée pour désigner la thérapie axée sur le corps et la thérapie par l’exercice ou le mouvement. L’activité physique et l’expérience corporelle sont les piliers de la thérapie psychomotrice. L’expérience corporelle (schéma corporel) est un concept largement utilisé qui est très complexe à opérationnaliser. Les troubles du schéma corporel sont également très difficiles à traiter. Depuis le développement des troubles de l’alimentation, avec leur expérience corporelle spécifique, dans les années soixante, une attention sans cesse croissante a été accordée au concept, à l’évaluation et à la thérapie de l’expérience corporelle.

Aujourd’hui, un modèle hiérarchique de l’expérience corporelle avec un aspect perceptuel, affectif, cognitif et comportemental, est proposé. La mesure de l’expérience corporelle a évolué au cours de la dernière décennie. Aujourd’hui, il existe une grande variété de méthodes projectives, déclarées par l’individu et perceptuelles visant à évaluer l’expérience corporelle de manière plus objective. La thérapie psychomotrice (appelée parfois thérapie par le schéma corporel ou axée sur le corps) est l’une des possibilités d’influencer le schéma corporel négatif. L’intégration de la thérapie psychomotrice est maintenant considérée comme un aspect essentiel du traitement. Aujourd’hui, ce qu’on appelle « thérapie psychomotrice » occupe une position de plus en plus importante dans la plupart des traitements multidimensionnels des patients souffrant de troubles de l’alimentation. La littérature sur la thérapie psychomotrice recèle un large éventail d’idées, d’interventions et de suggestions destinées à influencer cette expérience corporelle négative. Du point de vue du modèle de conduite spécifique des troubles de l’alimentation, trois piliers de la thérapie psychomotrice sont proposés : les troubles du schéma corporel, l’hyperactivité et la crainte de perdre sa maîtrise de soi. Il existe plusieurs manières d’accomplir ces objectifs et un large éventail de possibilités d’influencer les troubles de l’expérience corporelle. étant donné que les exercices ne constituent pas un objectif en eux-mêmes, l’accent est mis sur les procédures thérapeutiques. La fin de l’ouvrage répond à la question de savoir si la thérapie psychomotrice est efficace ou non. Vu que la thérapie
psychomotrice est intégrée dans une approche multidimensionnelle, il demeure difficile de prouver sa valeur ajoutée. Toutefois, différentes recherches générales et spécifiques ont révélé que la thérapie psychomotrice a eu une influence positive sur l’expérience corporelle. Les remarques subjectives des patients confirment ces rapports scientifiques.
The Body Experience in Eating Disorders: Research & Therapy

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Abstract

Psychomotor therapy can in some regards be interpreted as part of Adapted Physical Activity in the domain of people suffering from mental disorders. In Belgium and the Netherlands the term psychomotor therapy is used for body oriented or body image therapy and exercise or movement therapy. In psychomotor therapy physical activity and body experience are the cornerstones. Body experience (image) is a widely used concept that is very complex to operationalise. Body image disorders are also very difficult to treat. Since the development of eating disorders, with their specific body experience, in the sixties more and more attention is paid concerning the concept, the assessment and the therapy of body experience.

To date a hierarchical model of body experience with perceptual, affective, cognitive and behavioural aspect is suggested. The measurement of body experience evolved the last decade. To date, there is a wide variety of projective, self report and perceptual methods to assess the body experience in a more objective way. Psychomotor therapy (sometimes called body image or body oriented therapy) is one of the possibilities to influence the negative body image. The integration of psychomotor therapy is now considered as an essential aspect of the treatment. To day the so called "psychomotor therapy" is achieving an increasingly important position in most of multidimensional treatments of eating disorders patients. The literature on psychomotor therapy shows a wide array of ideas, interventions and suggestions to influence this negative body experience. From the specific conduct pattern of eating disorders three cornerstones for psychomotor therapy are suggested: the disturbed body image, the hyperactivity and the fear of loss of self-mastery. There are several ways to accomplish these objectives and there is a wide array of possibilities to influence the distorted body experience. Because the exercises are not a goal of themselves attention is paid on the therapeutic procedures. At the end the question of whether or not psychomotor therapy is effective has been answered. Because psychomotor therapy is integrated in a multidimensional approach it remains difficult to prove its added value. However different general and specific research pointed out that psychomotor therapy has a positive influence on body experience. The patients’ subjective remarks confirm these scientific reports.