Clinical Psychology and Psychotherapy
Clin. Psychol. Psychother. **16**, 366–382 (2009)
Published online in Wiley InterScience (www.interscience.wiley.com). **DOI**: 10.1002/cpp.624

Emotion-Focused Therapy in a Case of Anorexia Nervosa

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An emotion-focused approach to the treatment of eating disorders and to case formulation is described in an individual with anorexia nervosa (AN). The basic theory of emotion-focused therapy (EFT), the steps of case formulation and an outline of the tasks and course of treatment of an individual recently hospitalized on an inpatient unit for eating disorders highlight key aspects of the approach. The transformation in this individual, in terms of gaining access to her internal experience, understanding and tolerating her emotions, and working through her core themes of insecure attachment and worthlessness, is described. Weight and scores on self-report measures at the outset of treatment and at 18 months are provided. Copyright © 2009 John Wiley & Sons, Ltd.

Key Practitioner Message:
- Guidelines for treating eating disorders are tenuous and new approaches showing promise must be developed.
- Emotion-focused therapy (EFT) shows promise in the treatment of eating disorders.
- Description of the case shows the application of EFT to anorexia nervosa and illustrates the change in the individual in terms of recognizing and coping with emotional experience.

Keywords: Emotion-Focused Therapy, Eating Disorder Treatment, Anorexia Nervosa

Emotion-focused therapy (EFT) has been proposed as highly suited to the treatment of eating disorders (Dolhanty & Greenberg, 2007). This approach involves processing emotional experience in order to deal with difficulties in affect regulation, which are endemic to this population (Bruch, 1973). The approach is suited to individuals with under- or over-regulated affect, both common in the eating disorders (Wonderlich, Joiner, Keel, & Williamson, 2007). It offers specific techniques for promoting the re-owning and expression of aspects of emotional experience that the eating-disordered individual tends to inhibit (Geller, Cockell, Hewitt, Goldner, & Flett, 2000). It also offers techniques for dealing explicitly and effectively with the harsh internal critical voice, often referred to by these individuals as their 'eating disorder voice' or 'anorexic voice'. It allows the therapy to move beyond the vicious cycle of body image disparagement and displacement, by which negative feelings are displaced onto the body and converted to 'feeling fat' (Kearney-Cooke & Striegel-Moore, 1997). In order to break this cycle, therapist and client work together to identify and process the conditions by which the client's distress is generated and maintained. The approach also allows the therapy to move beyond the tautological trap (Vitousek, Watson, & Wilson, 1998) of viewing the client as 'not ready to change'. Formulation and tasks facilitate the individual's moving forward in the recovery work, to replace the eating disorder as a means of managing affect (Treasure, Schmidt, & Troop, 2000) with more

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adaptive emotional responses. Anorexia nervosa (AN) is among the most difficult to treat of all psychiatric disorders (Halmi et al., 2005). A lack of clear evidence for effective therapies means that guidelines for treatment are tenuous and new approaches showing promise must be developed (Wilson, Grilo, & Vitousek, 2007). A case report of the treatment of an individual with AN using EFT can offer new directions for consideration.

OVERVIEW OF EFT

The EFT theory of development postulates the existence of innate emotions that are shaped and organized through interactions with the environment into basic emotional meaning structures or emotion schemes (Greenberg, 2002; Greenberg & Safran, 1987). The healthy self emerges with a capacity to identify, interpret, heed and be guided by innate, adaptive emotional experience, and to use this capacity to respond creatively and in a novel manner to situations and experiences. Dysfunction is construed as resulting from being caught in rigid patterns of activation of maladaptive emotion schemes that lack flexibility and result in the chronic, enduring experience of psychological pain. In the eating disorders, a lack of, or an impaired, capacity to access, identify and be guided by healthy emotions results in a perception of emotional experience as aversive and overwhelming, and a need for the eating disorder as a means of avoiding 'feeling'.

EFT has as a central goal the working through or processing of these painful emotion schemes, ultimately to transform 'maladaptive' emotions with the activation of healthy innate emotions. Processing emotional experience in the therapy involves increasing awareness of, and expressing, internal emotional experience; working to tolerate and regulate that experience; reflecting on the experience to symbolize and make meaning of it; and transforming it with the activation of healthy adaptive emotion schemes and their associated needs, goals, concerns and action tendencies (Greenberg, 2002; Greenberg & Watson, 2006).

Change in EFT is understood as emerging from this experiential processing, in the form of greater acceptance of the self and of internal experience, as well as a restructuring of maladaptive emotional responses. Acceptance of internal experience refers in particular to an acceptance of, and ability to integrate, previously avoided or disowned experiences or aspects of the self. Self-acceptance entails a shift from a negative evaluation of one's experience and a critical stance towards the self to a more self-accepting stance. Re-owning involves recognizing, understanding and overcoming the avoidance of internal experiences, and with this a reclaiming of the healthy needs and action tendencies associated with that experience. The restructuring of maladaptive emotion schemes occurs through the arousal, regulation and symbolization of emotion, and the pairing of painful, maladaptive emotion experience with primary adaptive emotion.

The formation of a collaborative therapeutic relationship is considered a prerequisite for, and a key ingredient in, case formulation and treatment in EFT. The therapeutic style combines following and guiding the client's experiential process, and emphasizes the importance of both relationship and intervention skills. The therapist is empathically attuned moment by moment and adopts the role of coach in working with the client to establish a focus for the therapy, and guides the client's ways of processing emotional experience while helping to make meaning of that experience. Therapists utilize different forms of empathy, such as understanding, exploration and conjecture, as well as focusing attention on bodily felt meaning, and stimulating and processing emotion using gestalt dialogues and imagery (Goldman, Greenberg & Angus, 2006).

Therapists use the gestalt chair work to facilitate the resolution of certain tasks. Three major types of chair work are used. One is the two-chair dialogue to work with resolving internal splits involving a harsh internal critical voice, such as that described by individuals with eating disorders as their 'anorexic voice' or 'eating disorder voice', that criticizes and berates them, and admonishes them not to eat. Another is the two-chair enactment to overcome self-interruptive splits by which the individual stops or blocks the experiencing or expression of emotion. The other task is the empty-chair dialogue to resolve unfinished business or painful, enduring, unresolved feelings towards a significant other.

CASE FORMULATION IN EFT

The steps of case formulation outlined below amount essentially to the development of a focus in the treatment on that which is most poignant and salient to the individual. With the therapist's guidance, clients focus on their core painful experiences to arrive at a more healthy capacity for tolerating, making sense of and transforming their core maladaptive emotion schemes. Having this focus is a key to unravelling the conditions by which the

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pain is generated and is associated with change in presenting symptoms and a positive outcome (Greenberg & Watson, 2006).

The Steps of Case Formulation

Eight steps have been identified in the process of case formulation (Greenberg & Goldman, 2007):

1. identify the presenting problem;
2. listen to, and explore, the client's narrative about the problem;
3. gather information about the client's attachment and identity histories, and current relationships and concerns;
4. observe and attend to the client's style of processing emotions;
5. identify and respond to the painful aspects of the client's experience;
6. identify markers, and when they arise, suggest tasks appropriate to resolving problematic processes;
7. focus on thematic intrapersonal and interpersonal processes; and
8. attend to the client's moment-by-moment processing to guide interventions within tasks.

In the initial three steps, the therapist uses empathic responding and coaches clients to explore and articulate how their problems fit into their broader life narrative. The therapist is also gathering information about relevant life circumstances, current and historical, in the domains of relationships and identity. Implicit in this also is an assessment of current level of functioning and outside support. This initial phase involves inviting and coaching clients to engage in the tasks of disclosure, exploration and deepening of their experience. In the case of some individuals with eating disorders, there may be blocks at this stage to engaging in these tasks, and attention to the processing style and deficits of the individual will need to occur before a meaningful narrative emerges and is elaborated.

In steps 4–8, the therapist makes process diagnoses and engages the client in processing tasks. A hallmark of EFT is that the attention to moment-by-moment experiencing guides the therapist in making process diagnoses or in assessing clients' functioning and the determinants of their difficulties based on their in-session processing of experiences. These process diagnoses elucidate key aspects of the client's internal processing, facilitate the development of a focus for the therapy and lead to specific interventions.

Step 4, *observe and attend to the client's style of processing emotions*, is a central and critical aspect of the ongoing therapist activity. The therapist assesses processing style, strengths, difficulties and avoidant processes. These include whether clients are emotionally under- or over-regulated, what is the degree of their emotional arousal and the depth and productivity of their emotional processing, and whether they are engaged in conceptual or experiential processing. Therapists read paralinguistic cues, such as vocal quality, and concreteness, specificity and vividness of language. They assess whether the clients have the ability to focus inward and reflect on their internal experiences. Thus, therapists assess the manner and style in which clients present their experience, in addition to its content.

The next step, *identify and respond to the painful aspects of the client's experience*, amounts to 'following the pain'. The therapist listens empathically, and is attuned to verbal and non-verbal cues of pain in the client's narrative and presentation style. As such, the therapist develops a 'pain compass' or an emotional tracking device for following the client's pain. The therapist listens for what is most poignant in clients' experience as they tell their stories, and notes painful life events that they have undergone. The experienced pain is a sign to the therapist of areas that require attention and exploration, while the painful life events provide keys to the origins of core maladaptive emotion schemes that the client may have developed in regard to self and others that generate pain and vulnerability. The therapist also assesses the client's coping skills in managing painful experience, in particular, whether these are avoidant strategies or whether the client is able to attend to feelings, tolerate them and reflect on them.

The sixth step is: *identify markers, and when they arise, suggest tasks appropriate to resolving problematic processes*. Another hallmark of EFT is the attention in the sessions paid to specific therapeutic tasks designed to process experience in such a way as to allow for the reintegration of previously disallowed or muted self-information and experience. Choice of tasks is influenced in part by the therapist's understanding of the painful aspects of the client's experience, and in part through the identification of in-session markers. Markers guide the therapist to initiate particular therapy tasks. Three main markers are conflict splits, self-interruptive splits and unfinished business, and for each, a particular type of chair work is appropriate. Conflict splits occur when a part of the self is critical or

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coercive towards another part of the self, and are processed with a two-chair dialogue. The parts of the self 'speak' to one another, with the goal of ascertaining the impact on the self of the internal critical voice. Self-interruptive splits occur when a part of the self shuts down, blocks or interrupts the self's emotional experience or expression, and are processed with two-chair enactments of the self-interruption. The goal of the enactment is to ascertain the way in which the self blocks the experience, the psychological need to have the experience blocked and the impact on the self of being blocked. Unfinished business involves the expression of unresolved conflict or feeling towards a significant other and is worked through in an empty-chair dialogue. The individual addresses the imagined other in the empty chair to work through the pain of past losses or traumas. Thus, the therapist introduces tasks that will enhance regulation of affect and construction of healthy meaning.

The seventh step consists of *focusing on thematic intrapersonal and interpersonal processes*. Within the work on tasks, the therapist continues to facilitate a focus on those intra- and interpersonal themes that are indicative of the underlying painful issues that appear to impede healthy functioning, such as feelings of insecurity and worthlessness, unresolved anger or separation-individuation issues.

The eighth step is: *attend to the client's moment-by-moment processing to guide interventions within tasks*. Once a task is engaged in, and in general throughout the treatment, the therapists continue to be guided in their interventions by the moment-by-moment style of client processing. Therapists attend to micro-markers such as poignancy, vividness of language, interruptions, deflections, ramblings, rehearsed descriptions, vocal quality and depth of processing. While there is an ongoing attempt to establish a focus on underlying determinants, it is the moment-by-moment processing that continues to guide the therapist in facilitating processing with particular interventions. This guards against perceiving a determinant as stagnant or fixed, and keeps the therapy alive and fresh and 'becoming' in the moment. Thus, markers of dysfunctional schematic processing that interfere with adaptive responding are identified to facilitate intervention and processing.

Overall, then, emotion-focused case formulation involves establishing a focus for the treatment through identifying and articulating the problematic processes underlying and generating symptomatic experience. The focus is derived from the 'process diagnoses' the therapist makes throughout the treatment and reflects that which is most salient in the clients' moment-by-moment experience, maintaining their enduring pain and their symptom presentation.

SUITABILITY OF THE APPROACH TO EATING DISORDERS

The emphasis on processing and overcoming avoidance as a means of managing overwhelming affect makes EFT a compelling treatment for the eating disorders. The prospect, however, of 'going to' previously avoided painful feelings may evoke fear in the individual and trepidation in the clinician new to this approach. It is therefore important to emphasize that the essence of EFT is not simply to arouse affect, but rather to manage it in all of its aspects and to gain mastery over affective experience. Thus, as outlined above, thorough assessment of internal and external resources for managing distress is an important component of case formulation. Risk for suicidality and self-harm are assessed and managed as appropriate. Where risk is present, the work focuses on regulating and tolerating existing feelings, with no attempt to promote further arousal. There also is an emphasis from the outset of treatment on developing a capacity for self-soothing, to cope with feelings that arise in and outside of the session. When the work does involve exploring previously uncharted and potentially distressing emotional experience, the techniques are aimed towards decreasing the sense of being overwhelmed by feelings and ameliorating the urge to manage feelings through eating disorder symptoms or through self-harm. Thus the therapist works as needed with presentations of over-regulation or dysregulation to move towards a mastery of emotional experience. It is necessary, however, that individuals have sufficient cognitive capacity to render them capable of concentration and exploration in the session. While exact weight or body mass index (BMI) at which this is not possible tends to be idiosyncratic to the individual, a lack of any ability at all to concentrate, or to examine experience, would be a contraindication to using EFT.

FORMULATION AND TREATMENT IN A CASE OF AN

The individual in this case is a 24-year-old woman with AN of the restricting type (AN-R) who had

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recently discharged herself, against medical advice, from a hospital inpatient eating disorders unit. She had gained 30 lbs in the hospital, going from a BMI of 10 to 16. Onset of AN had occurred at age 15 years, and she had maintained a BMI of 11 or under for much of the 9 years of her illness outside of hospitalizations. The treatment described here is up to the 18-month mark in weekly outpatient individual psychotherapy. This time frame is consistent with guidelines suggesting required length of psychotherapy for AN will be 1–2 years (Wilson et al., 2007). The client was also followed by a physician experienced with eating disorders throughout the treatment and saw a dietitian as needed. Prior to the onset of treatment, she signed a release agreeing to the use of her clinical material for training and publication purposes. Consent for the submission of this case report was also re-established, and her approval of the manuscript was sought.

Initial Steps

The initial steps of identifying the presenting problem, listening to and exploring the client's narrative, and gathering information about the client's current and historical relationships and attachment and identity concerns can be a challenge in treating AN. The presenting problem is likely to be related to body image disparagement and distortion, and associated distress. Narrative and history may be constricted and minimalist. This client tells her history in a detached, storytelling fashion:

> C: *Even at seven years old I wanted to have a flat stomach and to be thin. My friends and I would weigh ourselves, and they would be like, 'Hooray, I'm up to 63 lbs,' like they were happy they went up, and I would be like, 'Hooray, I'm still down at 50.'*

She provides details of her history with little or no insight, and with little emotion. She reports that she had 'OCD' and 'separation anxiety' as a child. She describes her family having been significantly stressed by the AN, but improved with her recent weight gain. The therapist notes a potential interpersonal theme in her report that she fears they will finally become angry and 'burned out' at having to accommodate her illness if she returns to her AN. She reports having one sibling who lives at home, and a boyfriend who also lives with her in the family home.

Step 4: Observe and Attend to the Client's Style of Processing Emotions

This client's presentation from the outset is indicative of an impoverished capacity for attending to internal experience. She responds to probes about internal experience and feeling by referring to weight, food and body image. The therapist has the goal of coaching her in attending to, and making sense of, her feelings, that the idiosyncratic nature of her specific difficulties can become more accessible to her. From this early stage, the therapist therefore begins to draw the client's attention to her internal experience and have her attempt to label and express her feelings:

> C: *I think I look extremely fat. I'm embarrassed by it. I don't think I can keep eating. I just feel totally disgusted.*
>
> T: *Yeah . . . that must make it really hard to eat. And if you start to restrict, what happens as the weight starts to fall off? Do you feel better?*
>
> C: *I never see myself as skinny. Except when I was at my lowest, I did see certain parts of myself as skinny. But now when I look at pictures of myself when I was at my lowest, I can see that I was skinny. But now I just look so much bigger than that. And it just totally disgusts me. And I don't know why but I find being disgustingly skinny attractive. I know that's not right, like that's messed up.*
>
> T: *But nevertheless, that's how you feel.*

The therapist notes that questions regarding feelings are interpreted and answered in terms of weight and how 'skinny' she feels rather than how she feels emotionally.

Step 5: Identify and Respond to the Painful Aspects of the Client's Experience

There is a need to modify the steps of EFT to fit this population. With the extreme degree of over-regulation of affect in some individuals with AN, signs of pain are subtle and may not be recognized as pain by the client, so following the pain compass is difficult. Markers such as slight, even miniscule, shifts in facial expression must be used to explore her internal emotional experience. Empathic conjecture can be used as well as exploratory questions about her experience to help guide her despite the paucity of internal reference points

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for feeling and experience. Reflecting markers that the therapist hypothesizes are signs of inner experience, or empathically imagining what it might be like to have that experience, are valuable tools for the therapist to use. In this way, the individual begins gradually to build an array of signs for recognizing, and labels for identifying, her inner experience.

Continuing with the vignette from above, the therapist begins to reflect the aspects of the client's experience that appear to be causing her pain:

T: *So as you say this . . . I see you kind of searching to try to find words to describe what it was like when you were restricting. It was as though your life was getting narrower and narrower, like being on a little island that was shrinking. What's that like? At the time do you feel miserable, or do you feel shut down, or do you feel elated because you like the feeling so much? Or how does it go?*

C: *I feel more confident about my body. But I don't really have any other feelings.*

The therapist stores this observation and begins to hypothesize that a function of the AN is to render her without feelings. The therapist continues; note that the therapist's tone of voice is very gentle, not challenging or confrontational:

T: *I'm thinking how you really wanted to come to this therapy, right? So try to tell me what it is that made you want to come.*

C: *I want to find a way to let go of why I need to be so thin.*

T: *M-hm. . . . and what do you picture as you say that? 'I want to find a way to let go of needing to be so thin.' Do you picture . . . some sort of a release? Is it like some sort of prison? Or . . . ?*

C: *Yeah, it's kind of like . . . then I'd be free.*

T: *M-hm. . . . To do what? What is it that you want?*

C: *To live and not be stressed out about every single thing I put in my mouth. And not always be focused on my body.*

Very subtle, almost imperceptible, changes in the client's facial tone and expression, along with this slightly more focused response, offer the therapist an opportunity to begin to reflect on her internal difficulties.

T: *This looks hard. You tell it like a story, but this looks incredibly hard. (empathic conjecture)*

C: *(Nods)*

T: *It's hard even to think about continuing to eat to maintain this. Is it fear . . . are you scared?*

C: *I'm scared my weight's going to go up.*

T: *What scares you about that? (experiential inquiry)*

C: *That I'll look even fatter.*

T: *And then . . . ? Do you ever keep following it to see what it would mean?*

C: *Well, I feel I have nothing to give right now. And being thin is acceptable. If I'm fat I'm just taking up space.*

The therapist notes and stores the statement, *I have nothing to give*, as a marker of self-critical processes and as indicating a core intrapersonal theme of worthlessness.

T: *M-hm. So again, this looks hard. It looks like something stirs behind your eyes. And that it's really hard . . . that you're really stuck. You have this idea that you want to be free, but right now all it would mean would be to be fat.*

C: *Yeah. And I feel myself slowly slipping since I left the hospital. I choose lower calorie items.*

T: *And this is what you've said happens, right? You start to relapse.*

C: *But this is the first time that I went into treatment voluntarily. The other times I was a kid and they put me in and force-fed me.*

Thus, when the therapist follows and validates the painful aspects of weight gain, the client asserts her own investment in her current efforts to recover.

T: *So after it would be: Get me out of here, and then lose the weight as fast as I can.*

C: *Yeah, it was awful. I would dump the food into my clothes, disconnect the feeding tube and get it into my sheets, hide my water and get dehydrated.*

At this point, she launches into a discussion of the exact calories of foods. The therapist is alerted to this style of moving into food, weight and body

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image talk when feelings are discussed, hypothesizing that these issues may be a form of interrupting, blocking or distracting from feelings. Even from this early stage, the therapist gently directs the client back to the issue, using the uncharacteristic energy the client showed when she described her anorexic behaviours:

T: *So you're a pro. As you talk about this you're animated and so into it. Like, you knew how to work the system, hide the food, lower the calories. But now it's different because this time you wanted treatment. You wanted to be free.*

Step 6: Identify Markers, and When They Arise, Suggest Tasks Appropriate to Resolving Problematic Processing

Once there is initial alliance formation and the therapist has begun to attend to the client's style of processing and presentation of painful experiences, the therapist identifies markers and initiates tasks to resolve problematic processes related to painful core experiences. Three of the primary markers for tasks are self-criticism, self-interruption or blocking of feelings, and unfinished business with a significant other.

Self-Criticism

From early on, the therapist notes markers for two-chair dialogues to resolve internal conflict splits and begins to prepare the client for this work by drawing her attention to her 'critical voice'. In this client the 'voice' is incessant and extremely harsh, telling her, for example, that she deserves nothing and should be beaten and left to die. By the third session, the therapist identifies a marker of self-criticism and initiates a two-chair dialogue. The marker is a comment in which she states that she is a traitor for eating food. The therapist introduces the chair work as a tool for becoming aware of the impact of this internal 'critic':

T: *So come over here (to the 'critic's' chair) and let's try to see how it goes. Can you picture yourself in this other chair (the 'experiencing self' chair) and tell her what you were just saying: 'You're such a traitor. . . .' (activating the critic)*

C: *Well, I always think: You're being such a traitor. What kind of anorexic eats pizza? Like, I had pizza last night.*

T: *She can't answer so can we make it into a statement? Can you tell her what kind of anorexic she is? You're a lousy anorexic.*

C: *Yeah. No anorexic eats pizza. Then I feel like I look so fat. I tell myself. . . .*

T: *Can you tell her?*

C: *You look so fat, and you're eating this fattening food, and you're going to get even fatter.*

T: *And what do you think of her for that?*

C: *That she's disgusting. . . .*

T: *Tell her . . . you disgust me.*

C: *You're disgusting. You disgust me. And you shouldn't be eating.*

T: *You shouldn't be eating anything. You're going to get fatter.*

C: *You're going to get fatter. You're going to gain weight. You're no kind of anorexic.*

T: *Right. And the goal is to be anorexic, so you're on the wrong track. Is that right?*

C: *Nods.*

The therapist switches her to the 'experiencing' chair.

T: *Now it's like pushing the replay button. Here you are trying to eat, and you hear her telling you how disgusting you are that you are eating. What's it like to hear that?*

C: *Bad, and makes it hard to eat.*

T: *Yeah . . . I'll bet it does. And on your face . . . it looks distressing.*

C: *Nods.*

T: *Can you try to start to put words to it? (guiding to symbolize emotion in words)*

C: *When you tell me this I feel like a traitor and like I don't deserve anything and that I'm a bad person and that I'm not good at anything so I have no right to eat. The only thing I was good at was being anorexic, and now I'm not good at that anymore.*

The therapist then draws her attention to the fact that this is the 'critic' speaking and switches her back to the critic chair. They repeat the sequence. The therapist then switches her back to the experiencing chair:

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T: *What happens?*

C: *Then I usually struggle through the meal.*

T: *M-hm . . . and what happens right now when she says all this? What's it like to be spoken to this way?*

C: *I feel like crap, and I shouldn't be eating and I am disgusting.*

T: *So the first thing that happens is you agree with her. So can you tell her what it's like to have to agree with her? What's it like that she convinces you of all these bad things about yourself? I don't know, but it looks painful.*

C: *It's painful and upsetting and I feel like I have no worth, and that I'm not good at anything anymore.*

T: *So when you talk to me this way, it hurts. (therapist focuses on the pain)*

C: *Nods.*

T: *And it sounds like it makes it so hard to keep going. It makes it so hard to put every bite. . . . (empathic conjecture)*

C: *It makes it so hard to put anything into my mouth. Nothing is safe for me.*

T: *Right. Can you tell her what you need from her if you're going to keep eating?*

C: *I need you to be quiet and let me try and live, because before you were killing me.*

T: *And what's it like to tell her this, that I need you to be quiet and let me try this?*

C: *It's scary and sad.*

T: *Yes.*

C: *But I want her to be quiet.*

T: *Right. Can you tell her the sad part?*

C: *Sad because I guess I'm going to miss you.*

T: *And scary because . . . ?*

C: *I don't know what's going to happen.*

Thus by attending to the 'anorexic voice' and exploring its impact on her, she is able to begin to assert her healthy needs and stand up to this part of herself. This vignette also illustrates the way that two-chair work can be productive even in the early stages of therapy for AN when there is little 'feeling', as emotions are shut down or numbed and not yet accessible. In time, the chair work will be more evocative of feelings, and also the client's agency in the 'anorexic voice', and the function of the voice in protecting her from painful feelings will become evident.

Unfinished Business and Self-Interruption

Important themes related to the client's relationship with her mother arise in the therapy. She describes a close relationship where she felt overprotected as a child, yet neglected in the context of difficulties with her sibling's health and behaviour. She is firm in her denial of any need to process feelings related to her mother, and in particular, has a rule that she must not express anger, disappointment or any 'negative' feeling towards her mother, even in her mother's absence. When these feelings do arise, she blocks them as in the example below. This example also illustrates how markers for the type of chair work are fluid and move productively among self-critical splits, self-interruptions and unfinished business:

C: *You're so fat, that's the real problem. Maybe if you weren't so fat we wouldn't have this problem.*

The therapist facilitates processing the interruption:

T: *Yeah, so quit talking about your mom and. . . . Tell her what she should do instead.*

C: *You need to just shut up and deal with how fat you look.*

T: *And how should she deal?*

C: *Well, see the one way is lose weight, but that's not the way I want to deal with it.*

T: *But that would be the easy route to go.*

C: *Yeah, that's the easiest way.*

T: *Shut up, and stop eating.*

C: *Yeah.*

T: *Exactly.*

Switch.

T: *So what's it like when she does this . . . Stop this nonsense, this family stuff.*

C: *Part of me agrees, and then part of me says, well, no, obviously my family has something to do with it. And I need to figure it out.*

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T: *Yeah. But it's so scary, right? (empathic conjecture)*

C: *Nods.*

T: *It's so scary to think. . . .*

C: *Anything bad about them.*

T: *M-hm. And one thing you said last time is if you hurt your mom, you could lose her, right?*

C: *Nods. Pained look on face.*

T: *M-hm.*

C: *Like I'm afraid she could have a nervous breakdown.*

The therapist now moves into the unfinished business:

T: *Can you tell her this? (gesturing to other chair, i.e., to put mother there) I'm afraid if I . . . really pursue this. . . .*

C: *I'm afraid if I really pursue this that you're going to have a nervous breakdown. I feel you're going to leave me and have nothing to do with me. And I just can't bear for that to happen.*

T: *Right. . . . M-hm . . . The very thought of it is just so painful, right? I feel like I don't exist without you. . . . (empathic conjecture)*

C: *Nods.*

T: *M-hm . . . m-hm . . . What's happening?*

C: *I don't know . . . I always think I hope I die before my mom.*

T: *Tell her this. I even hope I die before you, 'cause I can't bear to live without you.*

C: *I hope I die before you because I can't bear to live without you and not have you by my side.*

T: *And this is an old feeling, right? You know this so well, since you were little. . . .*

C: *Nods. Painful expression on face intensifies.*

T: *So what's happening?*

C: *I just feel so bad, I feel like I've trapped my mom. And I don't think she should feel that way. I feel like she probably feels. . . . (client again interrupts her own pain in relation to her mother with guilt over having 'trapped' her. The therapist notes this as a marker and initiates processing the interruption.)*

T: *Can you come here and do that?*

Switch.

C: *(as mother) You've made it so I can't do anything, I have to be with you all the time, I can't live my life 'cause otherwise you'll do something drastic and I feel like I have no choice but to stay with you.*

Acknowledging her fear of harming her mother is a key step in identifying themes of separation-individuation and unresolved anger. Processing these themes will eventually set her on the road to differentiating from her mother and setting boundaries by accessing the anger that helps to transform her fear.

Step 7: Focus On Thematic Intra- and Interpersonal Processes

Work on the tasks and, in particular, the significant time spent in the therapy on processing blocks against speaking about her mother, with the accompanying sense of being lost without her, highlight the major intrapersonal and interpersonal themes that became the focus of the therapy. Both the intrapersonal and the interpersonal themes that emerged in the therapy were related to issues of attachment, separation-individuation and identity formation. Specifically, there appeared to be an insecure attachment with her mother and an associated failure to achieve the milestones of separation and individuation. This left her with core feelings of being unworthy and with an injunction against expressing her sadness and anger at what she missed in their relationship, for fear that it would rupture the insecure bond with her mother.

As the therapy progresses, continuing to attend to the pain in her moment-by-moment processing and focusing on her core sense of worthlessness allows her to begin to find ways to self-soothe and access an inner resilience. Note that in the face of body image and weight talk, the therapist alternates following and exploring the body image distress itself with attending to markers and expressions of underlying pain. This allows the profound distress of 'feeling fat' to evolve into the sadness of yearning for her mother, and from there into the anger at her mother that the client has forbidden herself from acknowledging or expressing:

C: *(very dejected) I feel crappy. I gained 0.2 kg. I know it doesn't sound like a lot, but it is to me,*

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and if I keep gaining that much . . . I feel like I'm just about ready to give up.

T: *So it's just feeling totally uphill right now . . . it's really hard, you're just dragging yourself through it. It's hard to see why to keep going. What would it be like just to stop everything and go back? (empathic exploration)*

C: *I don't know . . . part of me thinks it would be comforting. But I'd probably lose a lot of the stuff I have now. . . .*

T: *Like . . . ?*

C: *Like being able to go places and stuff like that. But sometimes it just doesn't seem worth it.*

T: *No, I'm sure it doesn't.*

C: *Sometimes in the back of my head I think I'd rather be skinny and stuck laying in a hospital bed than be fat and walking around. I know that's like my eating disorder talking. . . .*

T: *But right now it feels real, right? And what is it that's on your face . . . you look so distressed . . . if we imagine the eating disorder would be a relief, can you get at what it would be a relief from? What's pressing these tears . . . ? (empathic exploration)*

C: *(Begins to cry) I don't know . . . I feel so fat . . . when I look in the mirror all I see is fat. And that really upsets me . . . I feel like I look like I'm at a healthy weight.*

T: *And can you say what's distressing about that?*

C: *(Crying intensifies) It looks horrible to me.*

T: *Can you get at what pushes these tears?*

C: *I've just been working so hard. . . .*

T: *You have been working so hard. . . . (empathic reflection)*

C: *And it feels like my weight's going up and it's not supposed to be.*

T: *Like somehow it's betraying you or . . . What does it mean when it goes up? That it's going to keep going, or . . . ? (empathic exploration)*

C: *Yeah. I feel like it's going to keep going. Like, I already feel fat enough as it is.*

T: *And if it keeps going . . . ?*

C: *That's just unacceptable. And I know if it keeps going I'm just going to cut back.*

T: *M-hm. Like, as you try to tell me this . . . what's it like to be inside you as you try to tell me this. When you feel fat, what does it feel like? For some people it's dirty, or it's defeated. . . . (empathic conjecture)*

C: *Well, I feel unacceptable, gross, shameful. . . .*

T: *M-hm. Shameful . . . like sort of exposed? (empathic exploration)*

C: *Like I'm embarrassed.*

T: *Of . . . ?*

C: *How I look. I feel like it looks like I don't care about my body.*

T: *So it must so hard. What would be the thing that would keep you going? The price is so high . . . to have to feel so awful. . . . (empathic exploration)*

C: *I don't know. I feel like I just want to curl up into a ball and be left alone.*

T: *And would that be almost like comfort? Like an escape? If you could just curl up . . . would it almost be soothing? (empathic exploration)*

C: *I think soothing and comforting. Curling up in a ball in a corner and just wasting away finally.*

T: *And so the wasting away part is somehow comforting. I picture kind of the opposite . . . somebody there to pat you or stroke you and to say . . . you're holding on for dear life. (crying intensifies) So what brings the tears with that . . . with the image of receiving comfort? (empathic exploration)*

C: *I don't know . . . I guess I'd like . . . to curl up in my mom's arms . . . but. . . .*

T: *So if you could breathe and let the tears come a little bit. They seem so important . . . like, that's the wish, right? Somehow to be held and comforted by her, right? (empathic exploration)*

C: *Nods.*

T: *And that's such a kind of painfully sweet image, right? (empathic exploration)*

C: *Nods. Crying intensifies.*

T: *It looks like it's like a lump in your throat that you try to hold back. M-hm. What would it be like to just let yourself breathe a little bit, and say what brings those tears? How that would be so nice. . . . (empathic exploration)*

C: *I don't know . . . I don't feel I deserve for my mom to. . . .*

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T: *So you hold it back . . . you can't just wish it without those other voices coming in. It's like it's so hard just to . . . it's like it almost pushes at the surface, doesn't it, that yearning . . . it looks like really hard work just not to let yourself wish it. . . . What's going on right now? (empathic exploration)*

C: *I don't know, just my body feels so gross. I feel so fat and gross. I just feel so disgusting.*

The intensity of longing for her mother is interrupted by the shame and distress of feeling fat, highlighting the effectiveness of body image distress as a means of escaping affect.

T: *M-hm . . . What are you seeing?*

C: *I don't know, I just feel so . . . I feel so ashamed of myself 'cause I've like gained all this weight. I feel like I don't look skinny.*

T: *And I wonder what that says about you . . . could you stick with that . . . ? If in your mind you don't look skinny, there's something so shameful about that. . . .*

C: *I guess 'cause I feel . . . I've been like that for nine years. . . .*

T: *For sure . . . and it almost looks linked to this other thing that you're so not used to . . . this wish to be held by your mom. And that seems so hard to tolerate. That's a normal thing to wish for. And it's somehow a sad hard thing that happens with coming out of your anorexia and coming alive. And the hurt is just so piercing.*

The therapist thus follows the body image distress when it resurfaces while gently guiding the client to return to the connection between it and the pain of longing for her mother. This sets the client on the track to exploring the profound loneliness that she has often alluded to:

C: *(renewed crying) I feel so alone right now.*

T: *Yeah, that's what it looks like.*

C: *I feel like so far away from everyone.*

T: *Yeah.*

C: *And like part of me wants just to be like alone, but then. . . .*

T: *Then you're lonely, right? (empathic exploration)*

C: *I don't know, I don't even know how I feel anymore.*

T: *It looks like part of you knows 'cause part of you makes tears, right? Part of you feels sad and lonely and scared. . . . (empathic conjecture)*

C: *(Crying intensifies) And gross and ashamed of how fat I've become. And I'm ashamed of the fact that I'm still eating. And I don't know why I feel so alone.*

T: *But you do, right? You just feel impossibly alone. M-hm. It's awful. Where do you turn? You just want somebody to reach you somehow. It looks so hard even to do this . . . like as if you just wish you could stop the tears. (empathic conjecture)*

C: *I just feel like such a failure in all aspects. Like I feel like a failure to my eating disorder and I feel like a failure to my mom and everyone else because I feel like I'm almost ready to give up and then I feel like I'm betraying my mom but I feel like such a failure to my eating disorder and I just feel like a failure as a daughter.*

T: *You're so caught between these . . . if you keep going like you're going, you fail your eating disorder, but if you go back, you fail your mom. And I imagine that to feel this bad and to know that if you go back to the eating disorder it would numb this stuff would be such a strong pull.*

C: *I just feel so confused. I feel like I'm constantly being tortured by my mind. And I don't know what I did that was so bad to feel like this.*

So here, the desire for comfort was the first sign of self-soothing, and with *I don't know what I did that was so bad* was the first sign of resilience and of increased standing up for the self in the face of the anorexia.

T: *That's right.*

C: *I feel like somehow I deserve it. And it might be easier to take if I knew what I did. (slight resentment in tone)*

T: *Right. So there's still that sense of deserving to feel this awful. But on the other hand there's this: I can't see what I did that was so bad. It really doesn't make sense, does it?*

C: *I read a study last week that said that anorexia is partly in your genes but that it takes something*

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to trigger it, and they listed the things. And I read them and . . . well, not all of them, but a lot of them were going on when I got sick. Through the week I just thought back . . . I had moved the year before, and changed schools . . . I had a rough time making friends at first. Then I was in dancing and cheerleading.

This is the first acknowledgement that the AN occurred in a context outside of her control. The session then led to one of the first occasions when she expresses annoyance at something her parents had done, and without significant self-interruption, she begins to express that she is disappointed that they do not recognize how hard she is trying.

Parallel to her elaborating, accepting and processing the idea that her family life played some role in her AN, the client expanded her repertoire in terms of how she processed her emotion. She moved from storytelling and using body image to distract from painful feelings to an ability to tolerate and identify her internal experience and express her feelings, and then to begin to assert her needs. In the context of these, she engaged as well in a process of maturing in terms of her attachment style, her independence and her assertiveness. This development first emerged explicitly in the context of her starting to experience her feelings about her 'lost youth', when she finds herself resentful and regretful about all that she has lost through the anorexia:

C: *The last couple of days I've been crying myself to sleep, which is so unusual because usually I feel like crying but the tears won't come out. And I thought I'd feel better if I cried. But I think I've decided I liked it better when I couldn't cry.*

T: *Of course . . . in some ways it's so much easier, because you can't feel it if you can't cry. Whereas this sounds like just agony. (empathic conjecture)*

C: *I just feel like giving up. I've ruined the best part of my life. So there's no point . . . Like, I'm too old now to go out and party and like. . . .*

T: *Do the things you should've done, you mean. . . .*

C: *Yeah. I got my eating disorder when I just turned 15, and before that, I was just so focused on doing everything perfect. If I was told not to do something, I didn't do it.*

T: *So you never got to be a teenager. And in some ways from what you've told me, you never got to be much of a kid either. You were always obeying and striving and . . . this is a terrible loss if you kind of wake up . . . m-hm, even right now you could just cry and cry. . . . (empathic understanding and refocusing attention to client feelings in the moment as they show on her face)*

C: *(Crying. Nods.) I think of that, and I think: Why can't I just be normal? But then I look in the mirror and I'm like, I look so fat. . . .*

T: *And it's so unfair, you just don't get to . . . have a . . . (client increases crying) . . . m-hm. . . .*

C: *I just . . . I feel like no one really understands me. (Here the client is saying this in a different style than she would have earlier in the therapy. It does not have a helpless or a complaint tone, but is emphatic despite the tears. She gestures with her hand to emphasize the words, as though it is frustrating as well as distressing.) Like, I know my mom understands me a lot, but I just feel . . . I don't know, I feel alone.*

T: *Yeah, nobody really gets it, right? There's so much pulling you . . . m-hm . . . like if you wake up from this numbness, there's so much loss to face, and so much grief, and this alone feeling. Everybody else thinks okay, you're doing it, keep going, you're doing great, but you're like: You have no idea what torture this is. (empathic understanding)*

C: *(Tearfully) And like . . . everything is just so hard. (This is what would be considered productive emotional experiencing, because she is 'having the emotion rather than the emotion having her'. She is regulated, able to express, and she is engaged in listening and reflecting with the therapist on the meaning of it.) And . . . it's like . . . I'm doing it all for nothing because . . . the fun times are over.*

T: *That's right, like you've lost the chance. (empathic understanding)*

C: *I'm 24 and I'll be 25 at the end of the year.*

T: *That was supposed to be when the carefree part was so supposed to happen, right? (empathic understanding)*

C: *Yeah. I just feel like now I should be doing mature things or something. Not that I don't want to be doing mature things, but. . . .*

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T: *No, I see, it's like now all of a sudden you're supposed to start into the responsibility part, and you missed the irresponsible part. (empathic understanding)*

C: *I like being responsible, but I also wish that sometimes I could just go carefree and. . . .*

T: *Of course. You never got to do it.*

C: *(Still crying and reflective) And get pissed drunk and . . . I won't even drink alcohol because I'm too afraid of the calories. And besides, who am I going to get drunk with . . . myself? (tone of resentment enters again)*

T: *Not appealing.*

C: *No.*

T: *So it must be like . . . what are you getting better for? Right? If it's just going from the burden of illness to the burden of adult responsibility. With no breather in between. (empathic understanding)*

C: *And . . . I don't know . . . I feel like I want to be responsible but . . . I guess I just wish I could've been a kid.*

T: *Yeah.*

C: *And now it's over. (crying intensifies) I mean, when I was a kid I was an adult.*

T: *Exactly. All that responsibility, right? M-hm . . . It's like so many years of what you missed. It seems like all that's in store for you now is just having to face up to all that you missed. (empathic understanding)*

C: *And on top of that I just can't get past how fat I feel and how fat I look.*

T: *M-hm. And what does that feel like?*

C: *I just want it to go away.*

T: *Yeah.*

C: *And . . . I just feel like . . . I was just a waste. (crying intensifies)*

T: *And there's something so sad about that, right? You've always told yourself you're a waste of space, but now you see this sadness in it. . . . (empathic conjecture)*

C: *And everything is getting so hard. My family think it's so all good and fine, but it's not. Like, it's still so hard. Everything I eat is still so hard.*

She then moved into a phase where she began to do the things that she believed she should have done in her 'youth'. For example, she took a course, began to shop for clothes and accepted her mother buying her things, and began to socialize, and on occasion, drank alcohol. She went on a small vacation on her own. A significant part of the therapy then involved her gradual and painful decision to end the relationship with her boyfriend, whom she discovered was better able to support her in her eating disorder than when her 'personality' came out. Difficult as it was for her to do this, it was not as risky as examining her relationship with her mother, and working through the relationship with the boyfriend was like the testing ground for that with her mother. Her profound fear with both was that if she stood up to them or challenged them, or in the case of the boyfriend, if she left him, she would end up utterly alone and devastated. She began to date, and entered a serious relationship with a more appropriate partner, and after this point she began in earnest to experience feelings of anger and rebellion, albeit within very 'reasonable' bounds, in the relationship with her parents and in particular with her mother.

A pivotal session in this phase of the therapy involved her first expression of anger towards her mother for pushing her too hard in her recovery:

C: *I guess finding a way to move away from my house is really scary. I still don't want to cut the wire. I'm still afraid that I'm just going to lose them if I spend more time with my boyfriend. And I don't want to do that. I feel it's like I either have my boyfriend or my family, I can't have them both. And I don't want that to be.*

T: *So can we just explore that for a minute? Can we find out what you kind of mean by that . . . that you can have one or the other.*

C: *I don't know, I guess I'm spending a lot of time with my boyfriend, and without my parents, and I'm afraid they're going to move on without me. (becomes tearful)*

T: *So can you say what the distress is . . . 'cause that was your biggest fear.*

C: *I guess I'm just afraid because they mean so much to me. (crying intensifies) I feel like . . . I know I'm trying to get better, but I'm not better enough to not have my family.*

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T: *Right . . . that somehow when you get better you're not going to have your family . . . And of course that would be devastating.*

C: *It's like I'm like stuck because if I go backwards, I'm afraid they'd just be like: We've had enough of your crap, and they'd leave. Then I'd be even more alone, 'cause if I go backwards I'm obviously going to lose my boyfriend, too. And if I go forward. . . .*

T: *You have to lose them.*

C: *And I still struggle with so many things, and I'm afraid they're going to think everything's just easy, and it's not.*

T: *And what would be hard about that . . . you'd stop getting the support?*

C: *Yeah, and I feel like they're like the only people that understand fully. And if they think I'm all better then they don't understand either.*

Initiate chair work:

T: *Can you put both your parents here? And tell them this: I'm afraid that if you think I'm all better. . . .*

C: *I'm afraid if you think I'm all better you're going to stop supporting me, and it's like . . . (crying intensifies) you guys are the only ones that really understand me. I mean, I know I'm trying to move forward. But I'm not better. I'm better than I was . . . and I know when I'm with my boyfriend, I'm trying to be normal. But I'm still not fully normal. And I guess if you guys think I am, then I have to pretend, and I can't talk about my struggles. . . .*

T: *Right. And tell them what that will be like: If I can't talk to you about my struggles. . . .*

C: *I guess if I can't talk to you about my struggles I don't know as though I'll be able to keep moving forward, 'cause I won't have anyone.*

T: *Right. And it will be so lonely, right? So it feels like you're telling them: so I need. . . . What do you need from them?*

C: *(Still crying) I guess I need you guys to stick with me and. . . .*

T: *Right . . . let me still talk about the hard parts, and not just be well with you.*

C: *Yeah. (crying intensifies)*

T: *Can you tell them what's bringing the tears with this?*

C: *I guess I'm just afraid they're going to be disappointed or just be like, if you can pretend to be better with your boyfriend, why can't you pretend to be better with us?*

She reports that her mother had been critical of her continuing with one of her 'anorexic' rituals in her food preparation. Note below that the client experiences both anger and sadness towards her mother. It is essential for the client to differentiate these, and experience and express each. In earlier sessions there would have been explicit discussion of this differentiation. Here, having already done this work, the therapist can guide her in each more implicitly by identifying each feeling as it resonates most poignantly.

Switch.

T: *Let's just try this out. Be your mom. Tell her it's stupid.*

C: *(As mother, and in an annoyed tone) It's so stupid that you're using your own dishes. It's such an inconvenience.*

T: *It's an inconvenience and . . . what's the message? . . . you should be over it?*

C: *I guess it's kind of like: You should be over it, it doesn't make a difference anyways, and I mean . . . part of me is like: it might not make a difference. . . .*

Therapist switches her as she begins to speak in her own voice:

C: *It might not make a difference but I'm still not convinced, and it's still just more comfortable for me, and how can you say that (voice begins to crack) when I've made so many changes? (Although her voice cracks as though in sadness, the 'how can you?' is frequently a marker for resentment, and here also has a petulant tone.)*

T: *That's it . . . I think that's the thing. So what is it that you are saying to her? I think it's almost that: I resent you saying it. (guiding toward the felt resentment)*

C: *Yeah, I guess so.*

T: *Can you say that?*

C: *I resent you saying that when I've made so many other changes, and if it doesn't make a*

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difference like you say it doesn't then why is it such a big deal? Like, I've been doing so many other things. This is something small that I'm not working on right now, but I'm working on so many other big things, how does this compare?

T: *It doesn't compare.*

C: *It doesn't compare. Would you rather me focus on that and not be going out and stuff, 'cause I'm working on that.*

The resentment in her tone is increasing. The therapist next urges her towards being specific in what she is expressing:

T: *So I think you're getting at this gut sense of what you're feeling toward her: So, don't push me, or what is it? I'm already moving at a break-neck pace, don't push me any faster, or . . . ?*

C: *Yeah, I guess I feel like: I'm sorry to disappoint you, but I'm going as fast as I can, I'm doing as much as I can. (Tone is not 'sorry,' but assertive and angry.)*

T: *So you don't sound sorry right now, you sound a little bit angry. Like: I feel like you're acting disappointed, and I resent it.*

C: *Yeah, I feel like you're acting disappointed and I'm mad. I feel like it's not fair that you be disappointed over this one little thing.*

T: *Right. It's not fair. Can you tell her what you need?*

C: *I need you to be supportive and look at the bigger things that I'm doing. (assertive need)*

T: *Right. And not to lose sight, and not to jump out of the short term, I'm not there yet.*

C: *Yeah, I guess it's like: I may be doing more normal things now but I'm not completely better, I'm still struggling with so many things. And I guess I feel like when she says that. . . .*

T: *Can you tell her: When you say that. . . .*

C: *When you say that, it's like, you're just another person who doesn't understand anymore. (crying intensifies. After expressing the anger, the sadness becomes more palpable and clear, and the therapist coaches her in the direction of expressing the fear of losing her mother.)*

T: *And that is your worst nightmare. Can you tell her: that was one of my worst fears of recovery. . . .*

C: *And that was one of my worst fears of recovery. That you're just like everyone else who doesn't understand. (crying more. This has deepened the sadness and sense of loss, and also serves as a marker for switching chairs, when a feeling has been amplified.)*

Switch.

T: *Be your mom, and see what happens in this chair when she hears what it's like and what you need.*

C: *I don't know . . . part of me says she'd be like: Well, it's been long enough. But part of me thinks she would be like: I'm sorry, I didn't realize.*

T: *So let's follow one of the parts. Which part feels more prominent, it's been long enough or I'm sorry? (Again, it is crucial to differentiate between two feelings, and one way to do so if unclear is to ask which she feels more.)*

C: *They're sort of both equal. I guess my gut feeling is my mom would be more like, I'm sorry I didn't realize.*

T: *Yeah. So can you try saying that?*

C: *Yeah, there's been so much going on, I just kind of got caught up with dealing with so much. . . .*

T: *Is it kind of like: And I thought you were kind of okay? So I can carry on and do these other things?*

C: *I guess I kind of think she'd be more like: I was just doing too many things, and I was just . . . you were an easy target just to . . . get some of my anger out. And I'm sorry, I didn't mean it.*

T: *And how does the sorry feel? Is it like realizing, or is it blowing her off, or . . . ?*

Once again, the therapist notes two opposing tendencies, one is the tendency to have the mother soften and apologize, and the other is this idea that the client is an 'easy target', so the therapist probes for differentiation. This is an example where following the client's processing guides to the salient underlying meaning and need, as it seemed that the sadness was the predominant emotion. But in fact this client found sadness more acceptable than anger, and premature 'softening' and apologizing on the part of the mother could further disallow her anger. Often, once the anger begins, it is necessary to process it numerous times before a sense of

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'being heard' and validated leads to an ability to 'forgive' or 'let it go'.

> C: *I think she's probably sort of realizing 'cause . . . I do know my mom is dealing with a lot, and . . . I also know (voice begins to crack) I'm always an easier target. . . . (The client thus starts with a kind of defence of her mother, she is 'dealing with a lot,' but is able to stick with the feelings around being an easy target. Once again, the first marker of feeling is her voice cracking as though in sadness, but she is able to access her resentment.)*

Switch.

> T: *Can you tell her this?*
>
> C: *I guess it's like: I'm always an easier target because I don't really yell back at you guys.*
>
> T: *Right. And tell them what this has been like.*
>
> C: *I don't know, it's just like, I'm just in the way, and the only thing I'm good for is to get anger out and to shout at and then push out of the way.*
>
> T: *Because there's always going to be some more pressing crisis.*
>
> C: *(Crying intensifies) I guess it's like, unless I'm dying it doesn't matter.*
>
> T: *Right. That's the thing. M-hm. So when I got my eating disorder, and got really deathly ill, I got what I needed. And now that I'm. . . .*
>
> C: *Not dying anymore. . . .*
>
> T: *And in fact, showing signs of moving on . . . it's like, well, that's done.*
>
> C: *Yeah. It's like, we can yell at her again for no reason at all. Or stupid reasons.*
>
> T: *Right. So what's it like to tell her this?*
>
> C: *I guess it hurts. And it makes me feel alone and misunderstood.*
>
> T: *M-hm. Right. And I would be angry if I were you. (empathic conjecture)*
>
> C: *I guess I feel kind of used.*
>
> T: *Yeah.*
>
> C: *I guess I feel like, I'm working on so many things, when something is a comfort, why not keep doing it for a while?*

Although she expresses some guilt at expressing her anger, she is able to recognize that she has to deal with these feelings if she is to keep moving forward:

> C: *I guess I need to make it feel like I'm not going to lose my family.*

Over the next sessions, anger becomes more of a focal issue. While she is disconcerted about the fact that she is now sometimes 'grumpy' or 'snappy' with others in her life, the therapist and she share a joke about it that in her ongoing developmental catch-up, she is now in the 'teenager' phase, when anger and rebellion are essential to healthy development. They work on strategies to handle these feelings in her life, and to have her needs met, as well as processing the feelings using chair work. She is able to tell her parents in the chair that she needs them to let her live her own life, a significant change from begging them not to leave her. She also comes to understand that the issue is not to blame her parents, as she feared would happen, but rather to allow her to go through the developmental task of separating and differentiating herself from her mother and, in particular, to be able to express her anger to her mother without fear of losing her.

Step 8: Attend to the Client's Moment-By-Moment Processing to Guide Interventions Within Tasks.

Throughout the therapy, the therapist's attention to the client's processing facilitates the transformation of maladaptive emotion schemes that generate core pain. The client came to recognize that processing difficult feelings led her to feel better and allowed her to experience other positive emotions.

> C: *These are like pain tears. I've had rage tears—like at the hospital when I was a kid and they made me eat. But this is different.*
>
> T: *And how is it to leave it here when you've been crying like this?*
>
> C: *Behind my eyes usually feels like a headache 'cause it's all welled up. But this feels like a release.*

As the therapy progresses, she reports that she occasionally finds herself laughing spontaneously at something in her life, and initially this causes her intense guilt. The therapist guides her to process these occasions of happy feelings just as they would process the painful ones. As the therapy progresses further, she becomes spontaneous in her ability to

DOI: 10.1002/cpp

take pleasure in her life and is able to laugh in a carefree manner that conveys joy. She also begins to consider going the 'next step' of gaining more weight to become fully weight-restored.

At 18 months, this client had maintained all of the weight she had gained in hospital. She also showed improvements on self-report measures of mood and emotional awareness. On the interoceptive awareness subscale of the Eating Disorder Inventory (Garner & Olmsted, 1984), her pretreatment score (8) fell within the range for AN, while her score at 18 months (3) was within the normal range for college students. Her total score on the Toronto Alexithymia Scale (Bagby, Parker, & Taylor, 1994) was reduced from 54 (intermediate) to 49 (non-alexithymic), and, in particular, on the subscale of difficulty identifying feelings, her score was reduced from 21 to 16, the latter within the range of non-patient norms. Her depression, as measured by the Beck Depression Inventory (Beck & Steer, 1987), was reduced from 35 (severely depressed) to 22 (moderately depressed).

CONCLUSION

EFT in this case of AN illustrates the application of EFT to individuals with eating disorders. The approach provides specific techniques and therapy tasks to decrease alexithymia and increase awareness of internal experience, to decrease the harshness of the internal critic or 'anorexic voice', and to enhance resilience and develop a capacity for self-soothing. The tasks ultimately facilitate the transformation of the maladaptive emotion schemes that have generated the chronic enduring pain, and the rigid and maladaptive mode of responding to the world and to internal experience that have maintained the eating disorder. In this case, both the client's maladaptive shame and fear are transformed by accessing the sadness of her grief and her assertive anger. Such transformation, along with the acquisition of a new capacity for managing and tolerating internal experience, leads to the development of a sense of mastery, agency and efficacy in navigating her world, and facilitate a relinquishing of the eating disorder as a means of managing affective experience.

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DOI: 10.1002/cpp