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## Emotion-Focused Therapy in the Treatment of Eating Disorders

### ABSTRACT

Emotion-focused therapy is a compelling treatment for the eating disorders and offers a compelling framework for understanding the pathogenesis of emotional difficulties in this population. It is suited to individuals who have difficulty regulating affect (either underregulating or overregulating), and it privileges affect not only as a central determinant of human functioning, but also as a "positive" force, and an important source of wisdom and information to the individual. This makes the approach highly suitable to these individuals who fear emotion so intensely and whose symptoms represent attempts to avoid feeling. Emotion-focused therapy promotes in-session experiencing of emotion with the goal of fostering, with the supportive guidance of the therapist, an acceptance of experienced emotion, a capacity and proficiency in regulating emotion and in self-soothing, and a transformation of destructive or "maladaptive" emotions to more healthy alternatives. Individuals experience renewed hope in the possibility that they may alter and improve their eating disorder by means of working to identify and alter maladaptive emotion schemes, rather than thinking their only recourse is to keep trying harder to change intransigent eating patterns in the absence of a substitute for managing their distress.

The role of affect in the pathogenesis, maintenance, and relapse of eating disorders is unequivocal. "Emotional disturbances" (BRUCH, 1978) have long been recognized as underlying these disorders, and affect has been implicated in triggering eating disorder symptoms (JOHNSON & LARSON, 1982; WILSON & VITOUSEK, 1999). Body image disparagement, or the self-loathing directed toward the body, physical appearance, and weight and shape, is understood as the displacement of negative affect onto the body. Attempting to control and change the body can then be understood as an attempt to render feelings amenable to control and change (KEARNEY-COOKE & STRIEGEL-MOORE, 1997). These individuals present with significant impairment in affective functioning. Alexithymia, or the inability to identify and label accurately affective experience, and emotion-processing deficits, characterize the population (BECKER-STOLL & GERLINGHOFF, 2004; BYDŁOWSKI ET AL., 2005). A central function of the eating disorder can be understood as an attempt to control affect (COCKELL, GELLER, & LINDEN, 2002; TREASURE, SCHMIDT, & TROOP, 2000; VITOUSEK, WATSON, & WILSON, 1998).

Use of the eating disorder to manage affect regulation difficulties may result in either under-regulation or overregulation of affect. Stereotypical clinical presentation, for example, would include the individual with anorexia nervosa who has highly constricted, impoverished, "over-regulated" affect; as well as the individual with bulimia nervosa who may display chaotic and unmodulated affective functioning, and whose symptoms may include other impulsive behaviours in addition to bingeing and purging such as shoplifting, cutting, or substance abuse.

The affect regulation function of the eating disorder is related to a distinctive and pervasive attitude toward emotion among this population. Feelings are intolerable, dangerous, and to be feared, and must be "gotten rid of" or avoided altogether. The eating disorder is a highly effective means of accomplishing this. Starving numbs, bingeing soothes, vomiting provides relief. Attempts at recovery are met with a resurgence of previously avoided feelings that are experienced as being intolerable, the desire to escape them leading to relapse (FEDERICCI, 2004). With the thawing of the emotional self that accompanies increase in weight or decrease in bulimic symptoms, the individual is faced with an onslaught of psychogenic pain that she has no way of managing other than through the eating disorder. The wish for recovery and the logic of knowing what she "should" do are overridden by a desperate sense that "I'd rather die than feel."

## Aetiology

In the emotion-focused theory of development, emotions and the manner in which the self organizes to handle them play a central role in the development and organization of the healthy self, and in the development of psychopathology. The theory postulates the development, primarily in the formative years, of implicit emotional meaning structures (GREENBERG, AUSZRA, & HERMANN, 2007; GREENBERG & WATSON, 2005). The individual is born with an innate capacity for emotional response and experience, and in early interactions these evolve into core emotion schemes. Innate, healthy, adaptive emotions such as fear in response to threat, anger at violation, and sadness at loss, provide crucial information to the individual both in regard to internal experience as well as surroundings. In healthy development, caregivers' responses to these emotional reactions in the developing child validate the emotion and provide coaching both in paying heed to and in handling the array of emotions the individual will experience. Such accurate "processing" of emotions promotes efficacy and resiliency in dealing with future reactions. The individual learns to flee danger, set boundaries, self-soothe, and seek solace in the presence of the soothing other, as appropriate.

If, however, early experience of emotion is met with less optimal, or problematic, responses from caregivers, this will result in the development of core maladaptive emotion schemes, in contrast to healthy and resilient ones. The developing self will organize to cope, both with the

difficult emotion itself and with the inadequacy of the caregiver. A family rule that one must not show anger may result in a core maladaptive emotion scheme by which healthy anger is suppressed. Shaming in response to tears or to reaching out for affection may result in core maladaptive shame, and in a maladaptive emotion scheme by which the individual suppresses the healthy expression of sadness or the spontaneous yearning for communion with another. The self thus organizes around emotional experience to form core maladaptive emotion schemes that function to manage the difficult feelings. Over time, however, the core maladaptive emotion scheme results in increasing difficulties as the individual attempts to navigate emotionally evocative events including developmental challenges such as reaching adolescence, changing schools, or moving house; personal injury such as the loss of a loved one; or trauma such as a sexual assault. The core maladaptive schemes become increasingly inadequate to manage the feelings evoked, and the maladaptive emotions become more difficult to tolerate.

A number of factors make an eating disorder in particular a compelling solution to this problem of needing to manage unwanted negative affect. Lack of interoceptive awareness associated with a confusion of internal states of hunger and emotion (BRUCH, 1978) can create a predisposition for dysregulated eating. The eating disorders provide a set of strategies that reinforce an alexithymic style (BECKER-STOLL & GERLINGHOFF, 2004), preserving an unflawed image of perfection by not expressing negative emotions (GELLER, COCKELL, HEWITT, GOLDNER, & FLETT, 2000). Overall, the body becomes a highly effective site for affect management and control (KEARNEY-COOKE & STRIEGEL-MOORE, 1997).

### Overview of the Treatment

There are a number of features that make emotion-focused therapy an appropriate treatment for eating disorders. The overriding goal of this approach is to get beyond secondary emotions such as hopelessness or despair which obscure or protect against primary emotions, and to gain access to core maladaptive emotions such as fear and shame. This is done in order to transform maladaptive emotions and have individuals gain access to and be guided by their innate, healthy, adaptive emotional experience, thereby to alter dysfunctional behaviour patterns and render the eating disorder unnecessary as a means of coping. This is accomplished by processing the presenting maladaptive emotions. These are the painful and seemingly intractable feelings that diminish the self, such as shame, rage, self-loathing, and passive, hopeless despair. "Processing" involves attending to emotion, allowing it, expressing it, symbolizing it through meaning-making, evaluating it vis a vis whether it can be trusted to guide action, and transforming it when appropriate. Processing thus involves heightening awareness of healthy innate emotions and transforming maladaptive ones.

Transforming maladaptive emotion involves in-session activation of maladaptive emotion, processing it, and eventually pairing it with alternative, healthy, adaptive emotion. Only by experiencing the emotion in vivo is it rendered amenable to transformation in this manner (GREENBERG, RICE, & ELLIOT, 1993), making the process-experiential nature of emotion-focused therapy so particularly suited to this population. Simply talking about emotion has the effect of maintaining the distance from the very feelings that the eating-disordered client so desperately seeks to avoid. While giving the semblance of working with feelings, this becomes another avoidance strategy.

Emotion-focused therapy is, further, an "emotion-friendly" approach in that emotion is viewed as innately adaptive, and as a source of important information and wisdom about the self in the world, drawing attention to important cues, providing basic interpretations, and guiding actions. Without access to the adaptive emotions, as in the case of individuals with eating disorders who have shut down emotion or blocked it with secondary or maladaptive emotion, the individual has an impaired capacity for healthy, adaptive functioning and responding to the world. The emotion-friendly stance is another feature that makes this so particularly compelling an approach for this population. It deals directly with the individual's fear of emotion, and with the difficult emotions that she fears. By its very structure it challenges fundamentally her inclination to turn away from emotion, and challenges her belief that emotion is inherently bad. Efforts to reduce affect or distract from it will exacerbate this feared view of emotion, whereas experiencing and processing it, to the point of gaining access to the buried healthy emotions, is corrective experience, giving her evidence that she may in fact be able to experience and tolerate her feelings without the eating disorder.

### Role of the Therapist

The therapist in emotion-focused therapy is considered an "emotion coach," and guides the processing of the emotions, whereby the individual attends to present emotional experience, not only allowing and tolerating it but also exploring and reflecting on it, symbolizing and making sense of it, and evaluating its adaptive or maladaptive nature in terms of whether it leads to adaptive action in the individual's life. In keeping with the process-experiential nature of emotion-focused therapy, the therapist alternately follows and leads the client, in the tradition of client-centered therapy following what is alive and present in the individual's experience, and in the tradition of experiential and gestalt therapy guiding them in how to process that experience to achieve an outcome new and more adaptive than their use of the eating disorder. The goal of process-directive leading is to track the client's process, and also to guide them gently to the next step in that process. This involves urging them ahead of where they are but staying within what is referred to as the "proximal zone of development," that is, a step ahead of where they are but not so far outside the "zone" as to lose them. This activity of the therapist

contributes to the suitability of emotion-focused therapy in treating of eating disorders, as it allows the therapist to avoid the tautological trap (VITOUSEK, WATSON, & WILSON, 1998) of becoming stalemated by the client's lack of readiness to change. By working with the proximal zone of development, emotion-focused therapy allows the therapist to honour the individual's stage of readiness, while yet offering means of moving forward that are tolerable to her and that enhance motivation and capacity for change.

### Emotion Awareness

One of the first tasks in the therapy is to begin to increase the client's awareness of her emotions. Increasing awareness involves focusing on bodily felt feelings, thereby bringing them into awareness and working to identify, label, and express them. It also involves evoking emotion in the session, and then identifying and expressing it. Becoming aware of the emotions experienced in the session becomes an early focus and something that appears to distinguish emotion-focused therapy from other approaches in these clients' eyes. They are so accustomed to ignoring, distracting from, suppressing, escaping, or simply not feeling their feelings, they are frequently struck by the minute attention to emotion expression. When the tears spring to the back of their eyes, they are adept at continuing to talk so that you doubt whether you saw or only imagined the tears. It can be new, sometimes compelling and sometimes disconcerting, for them to have the focus drawn to their emotion in an empathic manner:

Therapist: "The tears are right there kind of pressing at the back of your eyes ... can you say what's happening inside right now?"

The empathic tone of the therapist combined with this persistent drawing of attention to signs of experienced affect set the agenda for exploring affect as an overriding therapeutic goal.

This early consciousness-raising around emotion involves attending to and allowing any emotion experienced, in an accepting attitude of "this is where you are right now." As therapy progresses, and the goal becomes one of transforming maladaptive emotion, there is an attempt to have the client work productively with emotions in order to facilitate the emotional change associated with a positive treatment outcome. The goal is to work toward having clients be mindfully aware of the painful emotion evoked, in that they have the emotion (rather than the emotion "having them"), own it, recognize their agency in it, and be willing to work with the emotion (GREENBERG, AUSZRA, & HERRMANN, 2007). Productive emotion-processing also involves working with emotion that feels "fresh" rather than "stuck," and that is relevant to an important therapeutic theme.

An important task in the emotion awareness work is also to differentiate between primary, secondary, and instrumental emotions, and adaptive versus maladaptive emotions. Primary emo-

tions are the first, spontaneous responses to a situation or event, such as fear at threat. Secondary emotions occur in response to primary emotions, often if the primary emotion was somehow unacceptable, and often with the effect of obfuscating the primary emotion. The secondary emotions are often the ones to be expressed first in the therapy, and must be accepted in order to form an alliance, and eventually to move beyond them to the important primary emotions. Instrumental emotions are those that have been learned and reinforced through interpersonal gain, such as attention for tears, and these must also be accepted and processed in order to move beyond them to core primary emotions.

## Empathy

Empathy is not only a precondition to therapeutic change, but an active ingredient of emotion-focused therapy. The therapeutic relationship and the empathic presence of the therapist are the foundation for the processing and transforming of painful emotion. Through the steps of raising awareness of emotion, attending to it, and fostering an attitude of allowing its experience and expression, the therapist's empathic attunement to and reflection of the moment-by-moment markers of affective experience in the client enhance awareness and foster acceptance. This is critical, for example, in the effort to process emotion with an individual with anorexia nervosa who feels empty and devoid of any feeling, and displays only the faintest sign of emotion. The following illustrates the simple but vital task of empathic exploration of these faint glimmers of emotional experience:

Therapist: "What is that like?" (to have an internal dialogue at mealtime telling her she does not deserve food.)

Client: "It makes it hard to eat."

Therapist: (very gently) "It makes it hard to eat and ... I don't know, but it looks painful."

Client: "It *is* painful."

This simple therapist exploratory response is important as it begins the process of encouraging the client to attend to, acknowledge, and symbolize feelings, thereby overcoming the distraction from internal experience that is a central process of avoidance in this population.

At another point the therapist makes the avoidance of emotion more explicit in the ongoing emotion education of the client:

Therapist: "You say you feel nothing, yet your face shows something...your face is very good at registering feelings even when you aren't aware of them, and we can use that to help you find out how you feel. I can reflect back to you what I see, and then we can explore that and check out if it fits with what might be going on inside of you."

The manner and tone of this intervention is one of warmth and concern, not a lecturing tone. Note that, as stated above, this vignette is with a very emotionally "numb" individual, for exam-

ple as may occur with low weight, and is an illustration of one of the ways in which the steps of emotion-focused therapy must be adapted, in this case slowed down, in the early stages of therapy with the extremely alexithymic eating-disordered client.

These vignettes also introduce another specific empathy task in emotion-focused therapy, that of empathic conjecture. Empathic conjecture is a technique for leading the client within the proximal zone of development. The therapist uses their own felt sense of the moment and of the experience, along with their empathy, defined here as the "imaginative entry into the experience of the other," to conjecture as to where to lead the current processing. Such conjecture can have an evocative function where a straightforward reflection may not, and can result in moving the processing forward.

### Working with Splits

An important component of emotion-focused therapy is working with different aspects or parts of the self that appear to be split or in conflict with each other, or in which one part has a previously unarticulated negative impact on the self experience. There are three main types of splits. One is working with an internal "critic" or critical voice. Another is working with self-interruptive processes such as shutting down feeling or blocking emotional experience. The third is working on "unfinished business" with a significant other that has become a part of the self's own inner dialogue. The therapist will structure the processing of these splits using "chair work," described below. The work with splits has a number of important functions in the therapy. One is evoking emotion, to render it accessible to processing and transformation. The individual will almost invariably be unaware of the impact on the self of an internal dialogue that is familiar and habitual, but when the different sides of the split are listened to from the standpoint of different chairs, they become fresh, alive, and emotionally evocative. It is harder to ignore and allow to carry on an intensely critical inner voice when awareness of the pain it occasions is raised in awareness.

Another important function of working with splits is to have the individual discover her agency in the creation of her internal experience. She so often feels the victim of her emotions, whether the passive victim of hopelessness and despair, or the angry victim of the cruelty or neglect of others. This attributing one's pain to forces not within one's control has a defeating and "stuck" quality to it. Working with splits highlights the agency not only of felt emotion but of self-interruption or the process of blocking one's feelings. As the split is processed, another function of this work with splits emerges, and that is the identification of needs arising out of the emotional experience, having these needs validated, and feeling deserving of them. These functions will be highlighted in the course of illustrating the three types of chair work below.



## Self-Critical Splits

The work with self-critical splits is an aspect of emotion-focused therapy highly suited to work with eating disorders for a number of reasons. One is simply the extremely self-critical nature of the internal "dialogue" of these individuals. Another is that it allows an immediate and effective inroad into the vicious cycle of body image disparagement that is so often resistant to shifting to any more meaning-based therapy talk. (Clinicians familiar with this population will have heard many times that there is nothing else – she is just fat, and that is the problem.) Not only does it allow a road in, but it is one that is acceptable to the client, because it does not try to sway her away from body image discussion. It embraces it. Fortunately, it leads efficiently to other aspects of feeling and meaning. Finally, the two-chair dialogue is particularly compelling in therapy with these individuals because many are already aware of an internal critic which they refer to as their "anorexic voice." This "voice" sets rules, demands compliance, and berates the self for breaching injunctions. Pursuit of thinness is seen as the only means of feeling better. The individual caught in this cycle becomes fiercely self-critical and denigrates herself for being fat and for being unable to achieve her goal of sufficient weight loss.

"Structuring" a split, that is, by placing the "agent" of the feeling in one chair, and allowing the self to experience and respond to the agent in the other, has an extraordinary effect of "unsticking" the therapy. A simplistic example of structuring a split in this manner is the one below of body image disparagement:

Client: "I'll walk by a window and see myself and just think how fat I am."

Therapist: "Come over here." (Switch chairs.) "Be the part that tells you you're fat. Picture yourself in the chair and tell her: 'You're fat.'"

Client: "You're fat."

Therapist: "What's the tone when you hear it in your head?"

Client: "Oh, it's nasty."

Therapist: "Use it now..." (with disgust) "You're fat."

Client: "Yeah, you're fat and disgusting and you make me sick."

Therapist: "Come over here." (Switch.) "Tell her what it's like to be talked to like that."

Client: "It hurts."

Therapist: "Yeah, it hurts. What do you need from her?"

Client: "I need her to stop."

Therapist: "Can you tell her?"

Client: (strengthened) "I need you to stop always criticizing me."

Here, recognizing herself as the agent of the contempt rather than just its victim, and experiencing the feelings of shame that this produces, is a crucial first step in split work (see Greenberg & Watson, 2005; Elliott, Watson, Goldman, & Greenberg, 2004). To recognize and accept the agency in the creation of a feeling or state is to render it amenable to change. This



is to be distinguished from an attitude of "blaming" the client for her difficulties. This is not "you are doing this to yourself and could stop if you wished," but rather an attitude of awe in the face of the organism's capacity to induce a feeling state, and curiosity and motivation in seeking to unravel the psychological function served by the agent, the pathogenesis of the need for such a function, and the healthy need of the "experiencing self" in the face of the agent.

The "two-chair dialogue" can also initiate an evocative process in which the emotional impact of negative self-talk comes alive in the session. Putting the "anorexic voice" in the chair allows the individual to hear this internal critical voice in a new and emotionally alive way. The processing of the emotions evoked can have a powerful effect in softening the harsh critic and altering the internal dialogue of body self-loathing.

Client: "I'm fat and I just can't stand how I look."

(Introduce chair work.)

Therapist: (gently) "Tell her she's fat."

Client: "You're fat" (tone is flat, not "into it" yet).

Therapist: "Tell her again—you're so fat" (introducing felt sense of disgust into tone).

Client: (tone of disgust) "You're so fat. You're disgusting."

Therapist: "You disgust me" (making it more personal from the critic—not just you are disgusting, but you disgust me).

Client: "You disgust me. You're so fat, I can't stand you. You're fat and lazy and stupid."

Therapist: "You're just useless" (summarizing and emphasizing felt sense of fat/lazy/stupid as next step in proximal zone).

Client: "You're useless. No one can stand to be around you."

Therapist: "No one loves you, you're so fat" (next step in proximal zone).

Client: (emphatically, continuing without pause, as though therapist's last line were her own) "Not even your own parents love you."

Therapist: (gently) "Not even your own parents love you."

(Client begins to cry. Switch chairs.)

When the therapist probed the experience of receiving this harsh criticism ("What's it like to have her talk to you like that?"), the client's initial response was "She's right." With further processing, she was able to tell the critic that it hurt her and made her feel "beaten down." By accessing adaptive feelings at this stage she was then able to stand up to the critic, and tell her that she needed her to be her friend and walk beside her, supporting her. She was also able to recognize the source of the critical voice as being that of her mother, who had been verbally and physically abusive. What was striking was that until this introduction of chair work, this client did frequently express emotion, but of a circular and helpless nature, concluding that she was helpless to change because she was fat. It was the first time that she was able to see and experience something underlying the body image despair.

The example above of the client agreeing with the critic occurs very frequently, and it can take longer and more processing to have the "experiencing self" stand up to the critic. More often it will initially go as follows:

Client: "Yeah, you're fat and disgusting and you make me sick."

Therapist: "Come over here." (Switch.) "Tell her what it's like to be talked to like that."

Client: "I agree with her. She's right."

This is an opportunity to work on raising emotion awareness by coaching her to reflect on her inner experience.

Client: "Yeah, you're fat and disgusting and you make me sick."

Therapist: "Come over here." (Switch.) "Tell her what it's like to be talked to like that."

Client: "I agree with her. She's right."

Therapist: "M-hm ... so your first reaction is to agree with her. That's kind of a thinking reaction. I wonder what it would be like to try to tell her what it's like inside, what it feels like, to have to agree with her when she speaks to you this way."

This would be a point when even the stuck, entrenched, body image difficulty can begin to show signs of opening, because the next response will be so idiosyncratic. It will also be a sign of the degree of psychological investment the individual has in not moving past body image or self-criticism to the feared primary emotions, as some individuals will begin to shift with just this suggestion to look beyond the "agreeing," while others will stick tenaciously. Of course, how they respond will set the course for the next step.

Client: "It makes me feel small and defeated and like there's no point."

Therapist: "Kind of like...when you talk to me like that, it makes me feel hopeless."

Client: "Yeah...hopeless." (secondary emotion)

Therapist: "And it makes it harder to keep going with my recovery, if there's no point."

Client: "Yeah! And hard to eat! How am I supposed to put food in my mouth when she keeps telling me it's making me fat? I mean, I know it is, but I don't need to be reminded all the time."

Therapist: "So it's kind of like ... 'You're making it harder ...'"

Client: "Yeah."

Therapist: "Can you tell her?"

Client: "You're making it harder."

Therapist: "Tell her more."

Client: "You're making it harder to eat and it's hard enough already."

Therapist: "And how do you feel towards her as you tell her this?"

Client: "I'm frustrated!"

Therapist: "Yeah, you sound a bit angry."

Client: "I am."

Therapist: "Tell her."

Client: "I'm angry at you." (primary adaptive emotion)

Therapist: "Tell her what you need from her."

Client: "I just need you just to back off and give me a chance. Let me try this."

### Self-Interruptive Splits

One of the key variants of split work is when feeling is blocked or shut down. In various ways, in the course of these tasks, it becomes apparent that the individual blocks or interrupts her own emotional processes. The work then becomes making this interruption explicit, and again looking at the impact on the self of this process of disallowing painful emotion.

The goal in processing "blocks" or self-interruptive splits is to get at the agency, the manner, and ultimately the psychological function of shutting down feelings. This has the purpose of converting "I just don't feel anything" or "I can't feel" to "I stop myself from feeling in the following way for the following reasons." We start, in other words, not with challenging the block or trying to remove it, but by emphasizing it and making it deliberate.

It is important, then, that while ultimately the goal is to effect change by means of processing and transforming emotion, working with splits and blocking is fruitful and productive even in the early stages of therapy when many individuals with eating disorders, especially anorexia nervosa, will not "feel" any emotions. In fact, another important tenet of emotion-focused therapy, drawn from its origins in gestalt therapy, is to "change to become what you are, not what you are not," and this applies to the individual who "has no feelings" or feels "nothing" or "numb." She can become discouraged and believe that she is failing at the task and that she "should" feel something. It is important in using emotion-focused therapy with this population to be ready for this, and to work productively and in a way that avoids having her feel inadequate for having no feelings. For example, with these individuals, asking how they are feeling in an open-ended way can induce this sensation of "not feeling anything." One way to address this is taking a stance that assumes that "nothing" is a valid option.

Therapist: "So what's happening ... it looks like you just shut down."

Client: "Yeah—I feel nothing."

Therapist: "Right, good ... nothing is something. Is it like numb, or shut down, or kind of neutral?"

Client: "Kind of numb."

Therapist: "Aha ... so it's amazing ... this ability to just turn off what you might be feeling. I wonder if we can figure out how that happens. Come over here. (Switch.) Can you make her go numb?"

Client: "I don't know. It just kind of happens. Like: 'Don't feel!'"

Therapist: "M-hm ... Don't feel because if you do ...?"

Client: "If you do, it will hurt too much and you won't be able to handle it."

This begins to get at another aspect of the anorexic voice or critic, in that while it is harsh, with further processing it almost invariably turns out to be "motivated" by a wish to protect her.

Client: "If you feel, it will hurt too much and you won't be able to handle it."

Therapist: "Aha ... so I'm just looking out for your own good. It will hurt too much."

Client: "Yeah ... you don't want to go there. You know how that feels, and it will feel awful!"

This protective quality of the critic is one of the things that will begin to work towards a softening of the critic, paradoxically by having the experiencing self soften when she makes contact with the protective quality of the critic.

Client: "If you feel, it will hurt too much and you won't be able to handle it."

Therapist: "Aha ... so I'm just looking out for your own good. It will hurt too much."

Client: "Yeah...you don't want to go there. You know how that feels, and it will feel awful!"

Therapist: (Switch to the "experiencing" chair) "Tell her what happens when she keeps stopping you from feeling."

Client: "I see that you're just trying to stop me from being hurt, but it's not working. I end up feeling worse. I need you to let me have my feelings. I can handle it. Or at least I want to try."

Another way to work with her feeling that she is not doing the therapy right is to structure it into a self-critical split:

Therapist: "Come over here. Tell her: 'You can't even feel!'"

Client: "Yeah, you're lousy at this, you can't even get doing therapy right!"

The work then is to process being told that. There is always a way to go next. For example, in this scenario, when she gets down on herself for not being able to have feelings about being down on herself, one of the possible outcomes is getting perspective on how it is always the "critic" that is talking, and how the "experiencing self" gets no say.

Client: "Yeah, you're lousy at this, you can't even get doing therapy right!"

Therapist: (switch) "So she even tells you you're lousy at this. Tell her what that's like."

Client: "She's right. I screw up everything."

Therapist: (pointing to "critic" chair) "That sounds like this side talking. She kind of takes over both chairs."

Client: "She does!"

Therapist: "And what does she tell you?"

Client: "Shut up, first of all! And you'll do things *my way*."

This vignette is also an illustration of a number of qualities of the "anorexic voice." One is that it functions both as critic and as self-interrupter or blocker of feelings. Another is that it is not only exceedingly harsh, but has a pride and confidence not seen in the self-critics in this work with other populations, such as with depressed individuals. This is consistent with the ego-syntonic nature of anorexia nervosa. The anorexic critical voice takes over and does not let her speak. Individuals with eating disorders have long been describing their "anorexic voice" in this way. They will refer to their anorexia as not letting them do or think something. Structuring the two-chair dialogue is a very effective way of getting at the agency, the impact, and the function of this harsh internal critic. In keeping with another tenet of emotion-focused therapy, this "makes the automatic deliberate." This battle is going on in her head anyway. Many times in the past have we told such clients, "Try not to listen to that voice," or "Try to distract from it." But there is power in giving the anorexic voice its say, and having the individual describe its impact, and, ultimately, see her own agency and motivation in the anorexia. In the above vignette, after the client had been frustrated by her lack of feeling, and then was struck by the idea that the anorexia took over both chairs and was so domineering, she came alive in the session as she described the anorexic voice's role. She found this very helpful, and informed the therapist that although she had tried to describe the anorexia to others before, this was the first time that anyone had ever actually "met" her and witnessed the way she spoke to the client.

### Unfinished Business

In unfinished business, the technique used is referred to as "empty chair" work, in which the individual speaks "to" a significant other in the empty chair, evoking, and then processing, the painful, unresolved feelings towards the other. The unfinished business work can help in understanding the developmental issues related to the eating disorder. As she addresses a significant other in the empty chair, the individual can express the emotions felt at the pain of early losses or failures, and in so doing arrive at a new understanding of her difficulties. It may become apparent that it was unsafe to express emotion because there were negative consequences if she did. Perhaps the adults in charge of her care themselves were unable to regulate their emotions, or relied on her as the child to "take care" of the adults' emotional needs. Abuse or neglect could also have deprived her of the opportunity for healthy processing of emotions, making her feel confused, ashamed, or disgusted in connection with certain emotional states. She may therefore have shut out or buried the experience of primary core emotions, and replaced them with the "secondary" maladaptive emotions of self-loathing or contempt for the self. Processing the emotions evoked when addressing the other in the chair can have a powerful impact. This new experience of allowing and expressing the emotional pain of early relationships in the empathic presence of the therapist fosters a new capacity for self-regulation and self-soothing.

Markers inevitably occur for moving from the two-chair dialogue with the inner critic to unfinished business with the empty chair. Accessing the tone and manner of the inner critic is often evocative of a past relationship in which the negative feelings toward the self may have originated, and as such will lead to unfinished business work. For example, the tone will take on a distinctively parental tone or flavour. This may be in the form of an admonishing or authoritative tone, or in the case of one client, the critic would address her as "sweetie," more suggestive of a parent's voice than one's own critic. In this case, the critic voice was not so harsh or indicative of severe self-loathing, but rather more invalidating and exasperated with the self:

Client: (in the critic chair): "Look, you've been doing this for 20 years now, you're 35 years old, this is ridiculous."

Therapist: "Kind of like ... 'Get over it!'"

Client: "Exactly, I mean, come on. Look, sweetie, I know you think this is a big deal, but it's just not that big a deal."

Therapist: "M-hm ... and do you know whose voice that is?"

Client: (resigned) "Yeah, I guess it's my mother's. That's exactly what she did. No matter how I tried to tell her that I was not doing well, she would always tell me how someone somewhere else in the world was worse off."

Therapist: (moving into unfinished business work with the mother) "Can you tell her what that was like?"

Client: "Well, I always ended up feeling guilty, and like my troubles weren't real or important."

Therapist: "Tell her how you feel towards her when you say that."

Client: "I guess I feel angry. Like, what did I have to do to get you to see that I was not okay? I just got sicker and sicker. (anger in voice increasing) And if I had a daughter and I found laxatives in her room, I would *not* just say 'That's not very smart.' That's just not helpful."

In this case, the client had been very reluctant to speak about her mother. She felt she should take responsibility for her eating disorder, and not blame others. She also said that although her mother had made mistakes, she had done her best, and furthermore that now they had a very good relationship and that she did not wish to jeopardize that. Even though the mother would not actually be present in the chair work, she felt that it would change the relationship in her own mind, and that when they were together, this would change the dynamic. By ending up coming to the work with the mother in this way, through identifying her mother's voice in her own critic's voice, she was able to proceed with it, and work through the issues. When her mother came to town for a visit sometime after, the client informed the therapist that the visit had gone very well. She reported that her mother had asked how the therapy was going, and she said in her droll way that she had answered: "Well, I do a lot of talking to chairs," indicating that her fears of destroying the relationship with her mother by processing the difficult feelings and memories, including her anger and resentment, had not come to fruition. In fact,

she felt freed from the underlying resentment that she had felt towards her for years. The unfinished business work with her mother also paved the way for, in her case, the more crucial work around her father, which she then proceeded to do, while earlier this work was absolutely off-limits.

This vignette and case highlights a number of aspects of the course of emotion-focused therapy with eating-disordered clients. One is that they are very often, we could almost say universally, fiercely protective of their mothers. Even a hint of putting the mother in the chair to tell her how they feel implies a criticism. Because of the techniques and philosophy already mentioned of meeting the client where they are at, the therapist simply works with this.

Therapist: (in empty chair work with the mother) "Can you tell her how that felt?"

Client: (blocks) e.g., "It wasn't her fault" or "It wasn't that bad" or "No, I couldn't tell her that."

Therapist: "Right, come over here." (Switch; the unfinished business work now moves into processing the self-interruption, or the blocking of the feelings toward the mother.) "Tell yourself not to get angry at your mother."

Client: "Yeah, that's easy, don't get angry at your mother."

Therapist: "Tell her why not?"

Client: "You'll hurt her."

Therapist: "Aha ... and if you hurt her ..."

Client: "Well, for one thing, she may not put up with you anymore. She has hung in there through all of this, she doesn't deserve that."

Therapist: (picking up on the part about the mother may not put up with her rather than the mother not deserving it) "So if you get angry at her, you could lose her."

Client: "Yeah, you could. And that would be horrible"

With experience and education on the nature of emotion and on the way that unprocessed painful emotions lead to psychopathology and processing them leads to a reduction in psychopathology, clients learn first hand that "feeling bad leads to feeling good," i.e., that processing the painful and difficult feelings actually clears the way for the spontaneous occurrence of more positive feelings and memories.

This vignette also introduces an important concept in working towards identifying the core maladaptive emotions that need to be processed for change to occur. While it is essential to follow the client in search of the idiosyncratic pathogenesis of the eating disorder and associated difficulties, core developmental themes tend to cluster around issues of attachment or identity. Difficulties in these arenas tend to be associated with the emotions of fear and shame, respectively. Failures in the area of attachment are associated with fears of abandonment, while identity issues are associated with feelings of shame. These are interrelated and certainly one or both can be present for any given individual. It is often also the case that the presenting



theme appears to be related to an attachment issue (in that there is a fear that love will be withdrawn if she behaves in a certain way, shows negative emotion such as anger, or is otherwise not "perfect") but that turns out to be more fundamentally a shame-based problem. In fact, it is striking to us the degree that shame is pervasive in these individuals with eating disorders. Even if both attachment and shame are present, it is essential to differentiate these in order to work through their core maladaptive emotion schemes.

Two-chair critical dialogue and empty chair work can begin to unravel and direct the therapy toward the core maladaptive emotion scheme. The parents of a very chaotic young woman with severe bulimia nervosa reported accepting that she was "insecurely attached," but being puzzled by this, as they were a stable family and both parents had always loved her and been demonstrative with their love. Chair work revealed that she had had an "explosive" temperament almost from infancy, while their other children were of a more passive temperament. In their frustration, and without guidance in how to deal with the intensity of her anger, they were highly critical of her, which in the chair she was able to say made her feel that she was bad inside, like a bad seed, and that she had deep shame about this. Working with the empty chair, she was able to express her anger at their inability to find her in her rage as a young girl, and coach her in how to manage the intensity of her feelings. She had no fear, past or present, that they would leave her or give up on her. The shame is related to identity issues in that, seeing oneself reflected as bad in the other's eyes, the self is shamed. The shame and identity issue can also arise from messages that invalidate feelings, in that the self learns that "my feelings are not okay therefore I am not okay." This would apply to the case of a young woman who was taught that expression of anger was not acceptable, and who would be separated from the family until she could show more socially appropriate feelings. Attachment issues did arise in that she formed an idea that they would not love her if she were angry or not perfect, but there was no core fear of abandonment. There was shame that who she was was not okay. We highlight this as an example of the way that the processing of emotions in this therapy can unravel the often mysterious pathogenesis of an eating disorder in the context of an overall loving home life. The failure to process the emotions in response to difficulties, rather than the nature or severity of the difficulties themselves, appears to be what is important in the development of psychopathology (WARD & GOWERS, 2003). Identifying shame in this population is critical in creating pathways toward recovery, and processing shame is a central task in emotion-focused therapy.

A still more subtle example of the importance of uncovering core maladaptive shame is the case of an elite athlete with anorexia nervosa. Reports of family life were consistently that her parents were kind and loving and that this was not where her anorexia had originated. It was difficult, from all appearances, to see any reason that this should not be the case. In her harsh self-criticism, she would attribute her troubles to her own difficult and perfectionistic tempera-

ment, which had emerged at a certain point in mid-childhood. She would report that "if anything, they were too nice," in that they would never see fault in her. Two chair dialogues processing the way her harsh anorexic voice would criticize her performance revealed her tendency to warn herself that "if you don't stay vigilant all the time, then you may slip up, and worse still, you may not know that you are slipping up, but others will see it, and you will look ridiculous." The feeling evoked was shame. In exploring further, she revealed that in the first school she attended, she was considered gifted in her area, and felt special and admired. When she moved to a school of other children in the same field, she sensed that, not only was she not special, but that she must appear ridiculous to have thought herself so. It became her mission never to let that happen again, and she began a rigorous course of relentless hard work and self-criticism, to be sure that she would always catch herself in fault before others caught her. Her "alliance" with the anorexic voice in the two-chair dialogue was based on her gratitude to that part of her for the "tough love" that she believed spared her from further ridicule and shame. The task in the empty chair work became one of expressing her anger to her parents for not having protected her, and having exposed her to shame, by allowing her to go into the world with an inflated view of herself.

An example of a case of anorexia nervosa in which the core pathogenic emotion was fear of abandonment was a young woman who was much loved and cherished by both parents, and who also presented as puzzled as to the cause of her severe anorexia. Empty chair work revealed a mix of anger at her mother with fear of expressing it for fear of losing her. This young woman also became adept at speaking her self-interruptions, which would essentially take the form of "don't listen to the therapist, because if you recover, your mother will leave." It came out that the onset of the anorexia at the age of 12 coincided with her inadvertently learning information from an argument between her parents that made her believe that her mother was going to die or leave. She recalled distinctly beginning to do things that she believed would ensure that that would not happen. The empty chair work became about expressing her anger at her parents for allowing their arguments to affect the whole family and her well-being, and about finding it in her to function as a young adult independent of their relationship.

The unfinished business work tends to be the work that is most emotionally evocative with these eating-disordered individuals. This is in keeping with the extreme contempt in which they hold themselves, that it can be difficult for them to feel emotional in response to their critic's harsh words. But the unfinished business work can succeed in evoking emotion even in the most blocked among them. An individual whose mother had left her when she was 12 years old is a case in point. This was an extremely symptomatic individual who had tried many therapies, and who used humour and a delightful personality to disguise deep despair and loneliness, and who described herself as loathe to feel anything, and incapable of crying.

Therapist: "Tell her what it's like as she walks away."  
Client: (in a sad, childlike voice) "I don't know what I'm going to do. Try and be better."  
Therapist: "How?"  
Client: "Be thinner ... I don't know."  
Therapist: "I'll do anything."  
Client: "Yeah."  
Therapist: "Tell her how this feels."  
Client: "I hate her."  
Therapist: "Tell her."  
Client: "I do, I hate you ... her ..." (begins to cry) "What are you doing? What's wrong with me?"  
Therapist: "So it makes me feel like there must be something wrong with me for you to walk away like this."  
Client: "I just don't understand." (to therapist:) "It's funny, I feel like I'm a child"  
Therapist: "Be the child. What do you say?"  
Client: "I want to throw a temper tantrum."  
Therapist: "So throw a temper tantrum."  
Client: (laughing through tears) "No, I'm not going to."  
Therapist: "Try to do some version of it ... I hate you."  
Client: "Yeah, I can't say it but that."  
Therapist: "Try to say some version of it ... 'How dare you?'"  
Client: (tears increased to barely able to speak) "What are you doing? Come back."  
Therapist: "Come back."  
Client: (continuing crying) "Why are you leaving me?"  
Therapist: (softly) "Yeah."  
Client: "I don't know what I did."  
Therapist: "Right. It's like it's my fault."  
Client: "It had to be."  
Therapist: "It had to be."  
Client: "It wasn't my fault, but ..."  
Therapist: "What's happening?"  
Client: "I just pictured my mom sitting there, and I felt guilty."  
Therapist: "Aha ... come over here." (switch) "Be your mom and make her feel guilty."  
Client: "She'd start crying. And she'd say 'It wasn't your fault. I never stopped loving you. I had to leave. There was no other way. It was for the good of the family. I'm sorry that I made you feel that way and I don't know how to stop it.'"

Self-critical work had never moved her to feel her feelings or to be able to cry in sadness, so great was her self-loathing and contempt for herself. But the image in the empty chair of her

mother walking away from her when she was a child had the evocative quality that allowed her to start to consider its impact on her. She began to see this as something that if left unprocessed would continue to leave her vulnerable to her severe eating disorder symptoms.

## Conclusion

The eating-disordered individual presents with an impaired capacity to identify, interpret, heed, and act upon an inherent emotion-information guidance system. Without this essential capacity to have mastery over internal experience, she is denied a significant source of efficacy in navigating her emotional, interpersonal, and cognitive world. In the absence of the capacity to tolerate, regulate, and be guided by the important information and wisdom in healthy and innate emotional responses, she finds affective experience aversive and overwhelming. The eating disorder serves the function of helping her to regulate her affective experience. With the growing recognition of this central function of the eating disorder, there is a growing interest in developing treatments that will deal explicitly with affect. The extreme avoidance of feelings and the intensity of the fear of being shamed or overwhelmed by them, have made emotion-focused therapy an appropriate and fruitful approach to treating this population. In the context of the therapeutic alliance, eating-disordered clients with overregulated or underregulated emotion can progress toward healthy emotional processing and expression, and can achieve an accompanying reduction or cessation of their eating disorder symptoms.

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