A Case Study of Emotion-Focused Therapy for Bulimia Nervosa

by

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Abstract

Modern, systematic approaches to case study research have been established. These approaches introduce methodological rigor while retaining the useful aspects of the original psychoanalytic research approach (McLeod, 2010). The primary goal of the current study was to examine emotion-focused therapy (EFT) for bulimia nervosa (BN) through the use of two distinct, yet related case studies employing mixed methods designs. A secondary goal of this research was to situate these case studies within a broader examination of the history and value of case studies in psychotherapy research. This research is laid out in three independent, yet complementary papers represented by Chapters 2, 3, and 4. Chapter 2 is a critical historical review of case study research in psychotherapy. The purpose of this chapter was to further understanding of the role and status of case studies in psychotherapy history and make an argument for the on-going relevance of quality case study research in psychotherapy today. This chapter begins by tracing the history, contributions, and developments of case study research in psychotherapy by linking it to four seminal and representative individuals situated within different theoretical orientations. Factors leading to the demise of the case study and the eventual establishment of systematic approaches to case studies are discussed. Chapter 3 is a mixed methods case study of a young woman with BN and a history of anorexia nervosa treated with EFT. It was written in the style of a pragmatic case study (Fishman, 1999). The main purpose of this study was to explore the session-by-session process and outcome of EFT for BN in this case. Finally, the study in Chapter 4 examined client change from pre- to post-therapy, linking client and therapist perspectives to objective measures of outcome, using the same case of a young woman with BN treated with EFT.

This study combined a case study approach with a mixed methods design and is distinct from the modern case study approaches in psychotherapy as articulated by McLeod (2010). Chapters 3 and 4 are the first known studies examining the individual treatment of BN using EFT. The description of the treatment approach and inclusion of large segments of transcript in Chapter 3 will help practitioners to better understand the unique application of EFT to BN. The outcome-focused study in Chapter 4 provides evidence for the effectiveness of EFT for BN in one particular case. These studies provide examples of mixed methods approaches integrated with case study methodology. Overall, this dissertation explores EFT for BN while also situating these studies within a broader examination of the history and value of case study research in psychotherapy.

Preface

This thesis is an original work by Kendell Banack. The research project, of which this thesis is a part, received research ethics approval from the University of Alberta Research Ethics Board, “A Case Study of Emotion-Focused Therapy for Bulimia Nervosa”, No. 26790, 2012.

Dedication

Dedicated to the five brave women who trusted me with part of their journey.

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To the five women who participated in this study, you have given me much more than I ever gave in return. Your trust in me and your courage to face those things you most feared both humbles me and fills me with gratitude. While the specific stories and experiences each of you shared during therapy may not be directly represented in these pages, they helped to shape the way I conceptualize and execute emotion-focused therapy for bulimia nervosa. This knowledge is woven through the pages of this document and has certainly impacted my work with other clients.

To the two other therapists who were involved in this study, Dr. Michelle Emmerling and Maggie Brennan, I cannot thank you enough for voluntarily meeting with extra clients and taking the time to collect data. It was an honor to join with you for supervision and learn from your unique ways of working with clients.

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To my beautiful daughter Brynn, thank you for your long naps and heart-warming, stress-melting smiles. The appeal of more time to spend with you motivated me to complete this dissertation.

And of course, to Jane, thank you. You know who you are. You do truly know who you are. I am so grateful that I too got to know you.

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CHAPTER 1

INTRODUCTION

In psychotherapy practice and research, the primary focus of study is the case (Fishman, 2005). The case may be an individual, group, organization, or even a community under examination (Fishman, 2005). According to Yin (2009), a case study is "an empirical inquiry that investigates a contemporary phenomenon in depth and within its real life context, especially when the boundaries between phenomenon and context are not clearly evident" (p. 18). Case study inquiry is well suited when there are many variables of interest, multiple sources of evidence, and theoretical propositions guiding data collection and analysis (Yin, 2009). Psychotherapy research, due to the complexity of describing and understanding the processes of client change over time, frequently includes many variables of interest as well as multiple informants such as therapists, clients, and observers. Therefore, because of its complexity, psychotherapy research is often well suited for a case study approach, and perhaps not surprisingly, the case study has been a widely used methodology for sharing psychotherapy practice and research knowledge since the early 1900's (McLeod, 2010).

Despite the long history of case studies within psychotherapy, the approach has been out of favour within the field for over 50 years. This is partly linked to the evidence-based treatment movement in psychotherapy and partly to criticisms directed towards traditional case study research in psychotherapy. The evidence-based treatment movement began as an effort on the part of governmental, insurance, and professional bodies to identify specific psychotherapy treatments as effective for specific disorders (Elliott, 1998). The goal was to guide clinical intervention as well as establish the

effectiveness of psychological treatment more generally. The evidence-based treatment movement has been controversial for a number of reasons, one of which is related to the list of criteria used to identify evidence-based treatments. Task forces within the United States, United Kingdom, and elsewhere have emphasized the use of randomized control trials (RCTs) to establish evidence-based treatments (Chambless & Ollendick, 2001). The appeal of RCTs to policy bodies can be linked to the rigorous methodological strategies inherent in the design, such as random assignment and control groups, and the subsequent confidence that comes when making claims of causation and generalization. Due to the evidence-based treatment movement, RCTs became the gold standard of psychotherapy outcome research by the 1990's (Barkham, Hardy, & Mellor-Clark, 2010; Chambless & Ollendick, 2001). As a by-product of this movement, other research designs in psychotherapy, including the case study, became largely ignored.

A number of criticisms directed towards case study methodology in psychotherapy also contributed to their decline. These criticisms began to be clearly articulated in the 1960's and continued through to the 1990's (see Bolgar, 1965; Dukes, 1965; Eysenck, 1987; Leitenberg, 1973; Shapiro, 1961; Spence, 1986, 1994). One of the most criticized aspects of case study methodology was the possibility of researcher bias. Traditional case studies such as those conducted by Freud (see Breuer & Freud, 1895/1957) were often constructed from memory with no objective measures of outcome or descriptions of treatment procedures to support conclusions (McLeod, 2010). Without checks and balances in place, the overlooking of contradictory evidence or even intentional selective reporting was possible. Readers began to doubt the general validity of case study research in psychotherapy. A byproduct of these criticisms of case study

methodology and the movement towards RCTs has been researcher and practitioner hesitancy to engage in case study research due to the belief that it is intrinsically unscientific. For this reason, case studies have nearly vanished from peer-reviewed research literature in psychotherapy (Leitenberg, 1973; McLeod, 2002).

Much has been lost in the process of moving from methodological pluralism in psychotherapy research to a body of literature dominated by large scale RCTs (Fishman, 1999). Case studies offer an accessible and interesting form of research for practitioners to read, a flexible and feasible means of recording and reporting innovations in practice, and a method for integrating training and practice for both psychologists and students (McLeod, 2010). Furthermore, methodologically rigorous approaches to case study research in psychotherapy, which have proper checks and balances in place to minimize researcher bias, have been introduced (see McLeod, 2010; Fishman, 1999; Elliott, 2002; Stiles, 2007; and Etherington, 2000). Fishman (2005), a prominent proponent of case study research in psychotherapy, has argued that now is the time to re-establish the case study as an acceptable method of applied research.

General Description of the Study

This dissertation is situated at a time in the development of psychotherapy when an argument for case study research is necessary and relevant. The primary goal of the current study is to test and illustrate the use of emotion-focused therapy (EFT) for bulimia nervosa (BN) through the use of two distinct, yet related case studies employing mixed methods designs. The secondary goal is to situate these case studies within a broader examination of the history and value of case studies in psychotherapy research.

Overall, this dissertation explores EFT for BN while illustrating the usefulness and limitations of a systematic case study approach in psychotherapy research.

This work is laid out in three independent, yet complementary papers represented by Chapters 2, 3, and 4. Chapter 2 is a critical historical review of case study research in psychotherapy. The purpose of this chapter is to further understanding of the role and status of case studies in psychotherapy history and make an argument for the on-going relevance of quality case study research in psychotherapy today. Chapter 2 both traces some of the history and enunciates some of the key ideas and principles of case study research by anchoring it to four key individuals in the history of psychology and psychotherapy: Sigmund Freud from within psychoanalysis, Burrhus Frederic Skinner within behaviourism, Carl Rogers within person-centered therapy, and Aaron Beck within cognitive therapy. Each of these individuals made significant contributions to applied psychology using case studies as a tool to communicate and proliferate knowledge. Furthermore, these individuals conducted case studies in methodologically innovative ways thereby creating the opportunity for future researchers to draw on and expand from case study methods specific to psychotherapy research.

After tracing the history of case study development through the contributions of these four individuals, factors contributing to the demise of the case study in psychotherapy will be linked to two key movements: the birth of RCTs as the gold standard of psychotherapy research and a number of criticisms directed towards case study methodology in psychotherapy. The response of proponents of case study research in psychotherapy will also be explored. This response led to the development of five modern, methodologically rigorous approaches to case study research within

psychotherapy as articulated by McLeod (2010): pragmatic case studies (Fishman, 1999), n of 1 time-series case studies, the hermeneutic single case efficacy design (Elliott, 2002), theory-building case studies (Stiles, 2007), and narrative case study research (Etherington, 2000). A sixth method for the creation of flexible, yet systematic case study research is proposed from within the modern mixed methods movement. Chapter 2 concludes with an argument for the on-going relevance of quality case study research in psychotherapy. Overall, Chapter 2 partially addresses the dearth of research on the history of case studies in psychotherapy. It makes a unique contribution by furthering understanding of the role of case studies in psychotherapy history as well as today.

Chapters 3 and 4 each offer a distinct study drawn from the same case of EFT for BN. The collective purpose of these two chapters is to illustrate the use of EFT for BN, and a secondary goal is to provide evidence for the usefulness and limitations of a systematic case study approach in psychotherapy. Chapter 3 presents an in-depth case of a young woman with BN and a history of anorexia nervosa treated with EFT. It is written in the style of a pragmatic case study (Fishman, 1999). The main purpose of Chapter 3 is to explore the session-by-session process and outcome of EFT for BN in this case. A convergent parallel mixed methods design guided data collection and analysis (Creswell & Plano Clark, 2011). The design was selected to promote a more comprehensive understanding of a complex research topic **(**Creswell & Plano Clark, 2011). In accordance with the convergent parallel mixed methods design, both qualitative and quantitative data were collected concurrently and analyzed separately.

The study in Chapter 3 was guided by the following research questions:

- Qualitative question: How can the content and process of EFT for BN, including session-by-session client change, be described and interpreted in this particular case?
- Quantitative questions: To what extent do psychological and behavioural symptoms of BN change from session to session? To what extent do client reports of the working alliance change from session to session?
- Mixed methods question: What results emerge about client change in therapy when combining client reports about what was most helpful in each session to weekly behavioural and psychological symptom change and ratings of the working alliance in this particular case?

The qualitative data collected in Chapter 3 included transcripts of therapy sessions, weekly feedback forms from the client reporting what was helpful in the session, and therapist session notes. Transcripts of therapy sessions were analyzed using interpretive description (Thorne, 2008) as a guiding framework and techniques drawn from McLeod's (2000) paper outlining a qualitative strategy for analyzing psychotherapy transcripts. Qualitative data was used to gain insight into the content and process of EFT for BN.

Quantitative data collected in Chapter 3 included session-by-session client reports of binge eating and purging, emotion regulation capacities, and the quality of the relationship between client and therapist. Data was analyzed using visual and effect size analysis (Busk & Serlin, 1992; Morgan & Morgan, 2009). Quantitative data was used to understand the client's experience of the therapeutic relationship as well as the extent to which psychological and behavioural symptoms of BN changed from session to session.

Parallel mixed data analysis (Teddlie & Tashakkori, 2009) was the guiding framework for data integration. After analyzing each data strand separately, client reports about what was most helpful in each session were arranged chronologically alongside quantitative client reports of symptom change and the working alliance in an integrated data display (Onwuegbuzie & Combs, 2010). The most helpful event in each session as identified by the client was emphasized and client symptom change was used to provide a context for understanding the possible significance of these events. Weekly reports of the working alliance were used to better understand the role of the working alliance in change. Meta-inferences about client change and events that may have precipitated change are drawn.

Using the same case of a young woman with BN treated with EFT, the main purpose of Chapter 4 is to examine client change from pre- to post-therapy. The case study in Chapter 4 is unique in that it does not fit within one of the five genres of case studies in psychotherapy as articulated by McLeod (2010), but was systematically designed using modern mixed methods approaches. A convergent parallel mixed methods design was followed (Creswell & Plano Clark, 2011). The design allowed for the analysis of similarities and differences between quantitative measures of change and qualitative client and therapist perspectives of change from pre- to post-therapy. It was chosen to promote a more comprehensive understanding of the topic given the complexity of the research problem (Creswell & Plano Clark, 2011).

The study in Chapter 4 was guided by the following research questions:

- Qualitative question: How does the client understand change from pre- to post-therapy and to what does she attribute change?

- Quantitative question: To what extent do psychological and behavioural symptoms of BN change from pre- to post-therapy?
- Mixed methods questions: To what extent do the client's interpretation of change and quantitative indicators of symptom change converge or diverge? To what extent does the therapist's interpretation of symptom change converge or diverge with qualitative and quantitative client reports of symptom change?

Qualitative data included client pre- and post-therapy interviews and a post-therapy interview with the therapist. This data was used to explore how the client and therapist understood client change from pre- to post-therapy. A primarily deductive thematic analysis guided by the types of behavioural and psychological changes expected from therapy was used for qualitative analysis (Creswell & Plano Clark, 2011; Lincoln & Guba, 1985). Quantitative data included several measures of behavioural and psychological symptoms of eating disorders. It was analyzed using effect-size analysis (Busk & Serlin, 1992). Quantitative data promoted an understanding of the extent to which psychological and behavioural symptoms changed from pre- to post-therapy and also in follow-up.

To explore the extent to which qualitative and quantitative findings converged or diverged, parallel mixed analysis was used (Teddlie & Tashakkori, 2009). After analyzing each data strand independently, a side-by-side comparison for merged data analysis (Creswell & Plano Clark, 2011) allowed for the comparison of client symptom change on a variety of measures represented by effect sizes to the client's perspective of symptom change. Equal weight was given to qualitative and quantitative data. Findings

from the therapist's interview aided in the interpretation of combined qualitative and quantitative data from the client.

Chapters 3 and 4 are the only known empirical studies of EFT for the individual treatment of BN. Furthermore, they have been situated within a convergent parallel mixed methods design. Using a formal mixed method design is an example of introducing a more methodologically rigorous framework to the case study approach. The uniqueness and methodological innovation of the studies in Chapters 3 and 4 places them in a position to make important contributions to psychotherapy theory, research, and practice.

In summary, Chapter 2 offers a critical historical review of case studies in psychotherapy, and Chapters 3 and 4 illustrate a new and promising treatment approach for BN. Taken together, they represent an argument for the on-going relevance of quality case study research in psychotherapy. In the remainder of this introduction, the ethical issues and procedures that were relevant for sound case study research in this case as well as the logistics of playing the role of both the therapist and researcher for this dissertation will be discussed.

Ethics in Case Study Research

The Canadian Code of Ethics for Psychologists provides guidelines for both psychotherapy and research (Truscott & Crook, 2004). In addition to abiding by the Canadian Code of Ethics for Psychologists, this study was conducted in adherence to the Government of Canada's *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans 2nd Edition* (CIHR, NSERC, SSHRC, 1998) as well as all other legislation and regulations both provincially and federally. These guidelines were

followed throughout the study, keeping in mind the basic ethical and moral principles of autonomy, non-maleficence, beneficence, justice, and fidelity. In addition, approval for the study was obtained from the University of Alberta's Research Ethics Board prior to commencement.

Case study research demands extra attention to ethical issues due to the specificity of examination of the client's life and the complex relationships between client, therapist-researcher, and supervisor (McLeod, 2010). In recognition of the unique ethical demands of case study research, this section addresses three pertinent ethical issues: negotiating consent, confidentiality, and the impact of pairing research with therapy on the client.

Negotiating Consent

Obtaining informed consent for participation in case study research is challenging. This is because it is difficult for clients to understand the scope of case study research prior to providing consent and also due to lack of researcher consensus regarding how to best obtain consent (Gavey & Braun, 1997). To address these challenges, process consent (Grafanaki, 1996) rather than traditional informed consent was used for this study. Process consent, in this case, involved obtaining written, informed consent prior to the commencement of therapy and research and then verbal consent intermittently throughout therapy. Furthermore, at therapy termination, an audio and video recording release was obtained from the client. This served as a reminder to the client that recordings of her past therapy sessions would be used for research purposes and also provided the additional opportunity to formally refuse the release of recordings at a time when she more fully understood the scope of the research. Finally, a draft of the case report was provided to the client. She was invited to provide feedback on the report

and specifically asked to pay attention to particularly identifying information. After feedback from the client was received and modifications made as necessary, written assent was obtained for the release of the report. Process consent conducted in this way is considered an ethically sound procedure for case study research (McLeod, 2010).

Another method used to promote true consent to research participation was providing alternative contact information to the client in the case she had a question or concern and felt uncomfortable approaching the therapist. For example, a colleague negotiated initial consent with the client. Furthermore, contact information for two other members of the research team as well as two clinical supervisors was provided to the client prior to the commencement of therapy. Contact information for a supervisor was provided once again during the process of obtaining a release for audio and video material as well as during the process of obtaining final assent for the case report. Providing alternative contact information to the client was a strategy used to promote true consent.

Confidentiality

Maintaining client confidentiality requires extra effort in case study research. Standard procedures such as sharing the limits of confidentiality, storing data securely, and using information only for research purposes were followed. Even so, due to the large amount of personal information gathered and reported, additional procedures are required to safeguard a client's identity in case study research. Two primary strategies were used to protect the client's identity in this case.

First, details that did not alter the context of the study in significant ways were disguised. Guidelines for authors from the Journal of Pragmatic Case Studies in

Psychology (2007) suggested changing a client's age by a few years, ethnic origin from one geographic area to another similar area, occupation, and religion. In addition to these strategies, a pseudonym was used (McLeod, 2010) and certain peripheral facts about her family were changed to protect the identity of her family. Changing facts in these ways helped to protect client confidentiality while not compromising the clinical utility of the case.

The second strategy used to maintain confidentiality was closely linked to the informed consent procedure. In reading the case report during the process of obtaining final assent for release, the client was encouraged to pay attention to particularly sensitive, possibly identifying information. This information was discussed and changed or deleted as necessary. In addition, a letter was sought from a colleague in the same geographical area indicating that the information as written was unlikely to reveal the client's identity. These procedures were recommended in McLeod (2010).

Impact on the Client

Some clients describe case study research as enhancing their therapy experience (Marshall et al., 2001; Stone & Elliott, 2011). Research questionnaires and interviews require clients to reflect on their experience and this has the potential to further promote client growth. Furthermore, therapists who conduct case study research typically spend extra time preparing for and reflecting on the therapy and this too is likely advantageous for the client (McLeod, 2010).

Other clients find aspects of case study research unhelpful (Stone & Elliott, 2011). For example, recording sessions can make it difficult for some clients to be open, and in addition, some find it challenging to complete questionnaires after an emotive session

(Stone & Elliott, 2011). To offset research intrusion on the therapy process, questions regarding the research were encouraged at any point, and clients were assured that the research protocol was secondary to their best interests (Grafanaki, 1996; McLeod, 2010).

Another potential negative impact on the client in this case included the impact of reading the case reports (McLeod, 2010). Despite the potential long-term benefit of reading case reports (Sommer, 2003), potential harm was avoided using three strategies as suggested by McLeod (2010). First, case reports were written with great care. When writing reports, the client was imagined as the audience. Second, a personal cover letter was sent with the case report to prepare the client for the read. Third, the client had the option to meet with an auditor to debrief after reading the report.

Managing the Roles of Therapist and Researcher

For this study, the therapist was also the researcher. This brought forth unique aspects of case study research such as making decisions regarding self representation in writing, managing research intrusion during the therapy process, and moving back and forth from distance to closeness during data analysis. These aspects will be explored below.

The question of self-representation in Chapters 3 and 4 was challenging to answer. There are examples of therapists' referring to themselves in the third person when writing case reports. This proved to be inherently difficult, and therefore, when writing the case studies in Chapters 3 and 4, the first person was used. For ease of writing, the first person will also be used for the remainder of this section.

For me, writing in the third person felt like a misrepresentation of the data. By not acknowledging myself as a co-constructor of the therapy process, I felt dishonest to

myself, to the client with whom I had worked so closely, and to the reader. When I began to write in the first person, I noticed a heightened sense of vulnerability in a piece of work where I already felt exposed. In this heightened vulnerability, I came to appreciate the vulnerability of the client who entrusted me with this piece of work, her work, where she bravely bared her soul and trusted me as a guide during her therapy journey. It seemed only fair that I too would experience a sense of vulnerability in the creation of these case studies, and perhaps this, in the slightest way, may minimize the power differential between myself as the therapist-researcher and the client in this case. In writing in the first person, I acknowledge my role as a co-constructor of the therapy and research process.

Managing research intrusion during therapy also required sensitivity and attention. Most trainees experience anxiety when their work is monitored for research purposes (Moran, 2011). Data gathered after therapy sessions as well as before and after therapy can feel like an evaluation of personal therapeutic skills. Furthermore, detailed analysis of therapy transcripts clearly reveals the therapist's character, technique selection, timing, and execution, and case formulation skills. In this case, there was also the added pressure of generating a workable piece of therapy that could be represented in my own dissertation. I noticed this pressure early in my involvement with this dissertation research project.

Several strategies proved helpful for managing research intrusion on my own therapy process. First, I used journaling before and after sessions as a way to process my own anxieties related to therapy (Creswell, 2007). This helped me to process self-doubt and fears of not doing something "right". Second, EFT is inherently focused on the

moment-by-moment processing of the client. When in the therapy room, I naturally felt drawn into my client's experience and this made it easy to focus on her moment-by-moment needs. Third, bi-weekly supervision alleviated research intrusion. It provided an opportunity to receive support in case conceptualize, reassurance for pursued session work, suggestions for future directions, as well as processing research intrusion.

A final and integral strategy for minimizing research intrusion was the involvement of other clients and therapists in the research project. For ethical and logistical reasons, five participants were invited to participate in the study and three therapists, including myself, were assigned to these five participants. Having the opportunity to base my dissertation on the therapy experience of any one of these five individuals, as well as the opportunity to select a client who had worked with a different therapist, dramatically eased the pressure on myself to excel in every session with every client. In the end, given the opportunity to maximize on my own insider perspective, I chose to base this dissertation on my own work with a client.

A final challenge in managing my role as both researcher and therapist was moving back and forth from distance to closeness during data analysis. I found data analysis to demand a certain critical distance so I was better able to understand the client's process, but while attempting to maintain a critical distance, there were times that I also noticed myself as the therapist in the data. Questions such as "Am I doing a good job?" and "Who am I as a therapist?" arose during the process. Furthermore, finding my place in data construction was challenging. I had questions about my voice in the analytic process as well as how to understand my role in the representation of data in a case to which I felt closely connected.

For this reason, I found Thorne's (2008) framework for the interpretive description of qualitative data helpful. Interpretive description acknowledges the role of the researcher in the construction of knowledge. In viewing my role as an interpreter of the data, the end product came to be understood as a constructed truth, and therefore pressures to create an objective or "right" truth dissolved. Furthermore, Thorne (2008) encouraged journaling during data analysis. This was a practice I maintained throughout the analytic process. I found it helpful to explore frustrations, surprises, and anxieties in a way that helped me regain a critical distance from the data in some cases, and in other cases, helped to inform data analysis. A final reassurance for me as therapist and researcher in this case was the knowledge that my supervisor, two committee members, and client also played a role in constructing the end project. All four of these individuals had the opportunity to provide alternative interpretations and offer suggestions for revising the work. This helped to minimize research intrusion during data analysis and ultimately improved the quality of the dissertation.

Conclusion

Case study research is highly engaging and complex for the therapist, client, researcher, and reader. It demands special sensitivity to the comfort of the client and therapist in the construction of the case. Case study research has a long history in psychotherapy but has only recently reemerged as an acceptable and perhaps even appealing option to modern researchers.

What follows is a chapter dedicated to the history of case study research in psychotherapy and then two chapters presenting two distinct case studies using the same clinical example of a case of EFT for BN. It is hoped that each of these three chapters

can be appreciated independently for their unique contributions to psychotherapy research and practice. It is also hoped that collectively these chapters are understood as a broad argument for the relevance of case studies in psychotherapy research today.

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CHAPTER 2

CASE STUDIES IN PSYCHOTHERAPY

Case study research has a long history in psychology and is strongly associated with the development of prominent theoretical orientations in psychotherapy across the 20th century. Psychoanalytic, behavioral, person-centered, and cognitive approaches all owe homage to case study research for the communication and proliferation of their unique approaches to the treatment of human psychological affliction. It was through case study research that Sigmund Freud first articulated his theories on hysteria (Breuer & Freud, 1895/1957), Burrhus Frederic Skinner came to understand and eventually communicate the behavioural principles associated with behaviour therapy (Skinner, 1953), Carl Rogers demonstrated his unique approach emphasizing the therapeutic relationship between client and therapist (Rogers, 1942), and Aaron Beck first described the techniques associated with cognitive therapy (Beck, 1970). It is no coincidence that the case study was used by each of these prominent figures in psychology. The case study appeals to researchers and readers alike because it provides a glimpse into the nuanced application of psychotherapy theory and technique to a specific individual with a specific presenting concern. Despite its strong history in psychotherapy, the case study nearly vanished from peer-reviewed literature in the late 1990's and early 2000's (McLeod, 2002).

The purpose of this chapter is to further understanding of the role and status of case studies in psychotherapy history and make an argument for the on-going relevance of quality case study research in psychotherapy today. The chapter begins by tracing the history, contributions, and developments of case study research in psychotherapy by

linking it to four seminal and representative individuals situated within different theoretical orientations: Sigmund Freud, who introduced the case study approach in psychotherapy from within psychoanalysis, B. F. Skinner, who promoted the n of 1 case study design from within behaviorism, Carl Rogers, who was the first to incorporate psychotherapy transcripts in case study research from within person-centered therapy, and Aaron Beck, who first illustrated his widely popular approach using case study research from within cognitive therapy. The criticisms and political environment that eventually led to the demise of the case study in psychotherapy will then be discussed in addition to the response of case study proponents within the psychotherapy community. One of the most important outcomes of this response has been the development of five modern, systematic approaches to case study research as articulated by McLeod (2010). These approaches are briefly explored along with a sixth alternative approach to case study research in psychotherapy that utilizes modern mixed methods techniques. Finally, an argument is made for the ongoing relevance of quality case study research in psychotherapy.

A History of Case Studies in Psychotherapy

Case Studies within Psychoanalysis

The field of psychotherapy is indebted to the case study for the development and proliferation of its theoretical and practical knowledge. This now deeply ingrained research tradition was the first form of psychotherapy research conducted, beginning with Freud and Breuer in the late 1800's (Breuer & Freud, 1895/1957). In *Studies on Hysteria* written in 1895, Breuer and Freud utilized case studies of five patients to illustrate the novel treatment of hysteria they named psychoanalysis (Breuer & Freud, 1895/1957). It

was through these papers that psychoanalytic theory and technique was first communicated. Following *Studies on Hysteria*, Freud published several other famous case studies including Dora in 1901, the Rat Man in 1909, and the Wolf Man in 1918 (Gay, 1989).

It is perhaps not surprising that the case study was the method Freud used to provide evidence for psychotherapy treatment. He was originally trained as a medical doctor (Hergenhahn, 2009) and it was from encounters with patients as a medical doctor that he began to formulate theories about the psychological origins of hysteria, sleep disorders, paralysis, and fugue states (Arlow, 1993). Given his background, Freud would have been accustomed to the rich tradition of case studies in medicine and would have naturally applied this methodology to his research on patients presenting with these medically untreatable illnesses.

Drawing from research methods in medicine, Freud constructed cases based on his own case descriptions, theoretical understandings, interpretations, and remarks regarding the success of each case (Gay, 1989). He stressed the empirical observation of clients and utilized this data to guide client diagnosis and treatment and also to construct cases and develop theory (Gay, 1989). In some examples, he built theory from single case studies (see Freud, 1920/1999), and in other cases, he aggregated and synthesized several case studies (see Breuer & Freud, 1895/1957).

Freud's method of developing theory from case studies has been described as the "fusion of inspiration with scientific self-discipline" (Gedo, Sabshin, Sadow, & Schlessinger, 1964, p. 749). Gedo et al. (1964) utilized *Studies on Hysteria* to examine the clinical evidence for psychoanalytic theory. They reduced the case histories in

Studies on Hysteria into 309 discrete statements. These statements were then categorized according to Waelder's (1962) schema for the classification of psychoanalytic propositions: observational data, clinical interpretations, clinical generalizations, and clinical theory. After classifying the 309 discrete statements, Gedo et al. (1964) studied the line of evidence Freud may have used to build his theories by correlating clinical theory with generalizations, interpretations, and then observational data, working from the highest to the lowest level of abstraction. In this way, they created "inductive pyramids" representing the inductive reasoning Freud may have used to build theory. Gedo et al. (1964) suggested that the tightness of Freud's inductive reasoning could be determined by the degree to which clinical theory could be traced to observational data. It was concluded that while there was an element of creativity in Freud's theories, the tightness of his inductive reasoning was impressive.

Not everyone has responded positively to Freud's case study method. Freud's traditional psychoanalytic approach to case studies has received much criticism, both close to the time of their release and in more recent years (see Ellenberger, 1972; Eysenck, 1987; Spence, 1989; Sulloway, 1991; Watson, 1913). One criticism of the method was the lack of attention Freud gave to conducting research in an ethical way. While he made minor alterations to protect the identity of clients, he typically selected subjects retrospectively and therefore did not regularly obtain consent (McLeod, 2010). A second criticism was the lack of methodological rigor employed. The only data Freud collected were clinical case notes, and he based interpretations exclusively on these notes or recollections from memory. He never used objective measures of outcome, external reviewers, nor did he elicit the client's point of view. Limitations of this approach

include the impossibility of recalling all significant information, retrospective writing which allows for the reconstruction of the session according to the therapist's assumptions, the representation of only the therapist's point of view, and finally, the lack of checks and balances to ensure completeness and correctness of interpretations (McLeod, 2010). Furthermore, this lack of methodological rigor increases the likelihood of researcher bias, including the opportunity to force observations to fit pre-existing theory (Sulloway, 1991). Generally, the argument against Freud's case studies is that they were not based on sound evidence and therefore were not scientific.

In response to these criticisms, psychoanalysts have pointed to the inability of science to capture complex psychological phenomena. Psychoanalysts in support of this case study tradition have argued that it is impossible to measure psychoanalytic constructs without trivializing, reducing, or distorting them (Arlow, 1995; Shedler, 2002). Commenting on the inability of questionnaires to capture elements of a client's internal life, Shedler (2002) wrote, "The only 'instrument' sensitive enough to do so is the empathically attuned and dynamically sophisticated clinician given free rein to practice his or her craft" (p. 433). Some psychoanalysts have even argued against the use of recording equipment. Recording a session is viewed as an intrusion on the psychoanalytic situation impacting both spontaneity and intimacy and therefore also altering psychoanalytic process (Arlow, 1995).

Other psychoanalysts believe empirical research to be unnecessary. For example, Brenner (1982) argued that being a participant in the psychoanalytic situation, which includes only therapist and client, is the only way to understand a client's internal experience. He believed that the therapist was in the best position to access the data

required to construct a case. Waedler (1962) also argued that the psychoanalytic situation was the laboratory that was sufficient for understanding a case. He reported, "The outsider knows next to nothing about psychoanalytic interpretations as they are actually given by competent analysts" (Waedler, 1962, p. 622). To proponents of the traditional psychoanalytic case study, the therapist, who was in direct contact with the client, was in the best position to access the data required to construct a case. Methods from modern science, including questionnaires and session recordings, interfered with or were unable to capture the complexity of the situation.

With the ardent support of psychoanalytic researchers, the traditional style of case study research in psychoanalysis continues today. This style of case study emphasizes the therapist's capacity to construct a case based on case notes and observations without the use of objective measures of outcome. Case studies conducted in this way have received much criticism due to the lack of checks and balances in place to verify interpretations. Historically, Freud, the father of psychotherapy used this style of case study to illustrate and provide evidence for the theories and methods associated with psychoanalysis, and he was quite successful in this regard.

Case Studies within Behaviour Therapy

While Freud's psychoanalysis was becoming established, researchers within experimental psychology were contributing to learning theories as early as the 1910's. Pavlov had already discovered classical conditioning by observing that a dog could learn to salivate to the sound of a bell (Hock, 1995), Thorndike (1911) had established the law of effect by observing trials where cats eventually learned to escape from puzzle boxes, and Watson and Rayner (1920) had discovered conditioned emotional reactions in their

experiments with Little Albert (Fishman, Rego, & Muller, 2011). A new paradigm emerged in psychology that emphasized objective measurement, deductive inquiry, psychometric sophistication, and quantitative methods (Fishman, 1999).

John B. Watson is often given credit for launching behaviourism from within this paradigm (Fishman, Rego, & Muller, 2011). In his manifesto, *Psychology as the Behaviorist Views It* (Watson, 1913), he argued that if psychology was to be taken seriously as a science, it must apply itself as a real science by becoming objective and deterministic using precise observation and measurement. This necessitated a shift in focus from the unobservable, for example, the unconscious mind in psychoanalysis, to what could be publically viewed and adjudicated. Therefore, observable behaviour became the object of study.

Subsequent researchers within behaviourism rejected the traditional case study methodology used within psychoanalysis and pursued a more methodologically rigorous approach emphasizing observation, measurement, prediction, and control (Hergenhahn, 2009). The case study tradition that was formed within behaviourism and later adopted in cognitive therapy is often referred to as n=1, n of 1, or single-subject design. Like Freud's case studies, n of 1 studies conducted by the early behaviorists, including Pavlov, Watson, and Thorndike, are some of the most famous research studies in psychology.

It is important to note that this movement towards a more sophisticated science within behaviourism in the 1920's and 1930's was during a time that large N designs and statistical inference were already available (Morgan & Morgan, 2009). Interestingly, even though both behaviourists and proponents of large group designs typically ascribed to a similar modernist worldview, behaviourists staunchly supported the n of 1 case study

method as the most appropriate design for understanding an organism's behaviour. Skinner was perhaps the most vocal behaviourist in this regard, and the remainder of this history of case studies within behaviourism will focus on Skinner's contributions to case study methodology and behaviour therapy as a whole.

Skinner was an enthusiastic supporter of single-case research and derived the behavioural principles of operant conditioning through his n of 1 studies using rats (see Skinner, 1930) and pigeons (see Skinner, 1948). In *Operant behavior*, Skinner (1966) wrote that his preference was to study "one rat for a thousand hours than a thousand rats for an hour each, or a hundred rats for 10 hours each" (p. 21). In his behavioural experiments, he discovered that when data was aggregated, the result was smooth, gradual learning curves that did not represent the actual learning process he observed in animals, thus obscuring the complexity of the subject matter (Morgan & Morgan, 2009). He argued that measures of central tendency told him nothing about the process of learning in a single organism. Therefore, although already popular in psychological research in the 1920s and 1930s and mainstream in the 1930s and 1940s, he found large-group designs and aggregated data to be both impractical and misleading (Morgan & Morgan, 2009).

There were many distinct and innovative features of the n of 1 case study method used by Skinner. Skinner collected mass amounts of quantitative data on a single case. He selected a target behavior for observation and continually measured this behaviour as an outcome variable, thereby precisely tracking the history of a single organism's learning process and trajectory. For example, to measure learning, Skinner placed a rat in box that was equipped with a lever that when pressed would dispense food (Skinner,

1930). When the rat would eventually, by accident, press the lever, a food pellet would appear. Subsequent lever pressing behaviour increased in a predictable way. By measuring a single, observable behaviour, Skinner was able to understand the process of learning through positive reinforcement. He continued with this method and later discovered the principles of negative reinforcement and escape and avoidance learning. Furthermore, Skinner supported the conclusions from his n of 1 studies by replicating experiments with another single organism (Goodwin, 2010). Another distinct aspect of the case study tradition that emerged from within behaviourism was the emphasis on outcome and evaluation (Lambert, 2013). It was within behaviourism that the use of pre- and post-testing was first introduced (McLeod, 2010). Measuring outcome variables before and after intervention provided a more objective method for measuring change.

Much work in the field of experimental psychology laid the groundwork for the later emergence of behaviour therapy as well as the application of n of 1 studies to humans (Iversen, 2013). After years of experimental research, Skinner provided a first outline for behaviour therapy in his 1953 book *Science and Human Behavior*, and during the 1950's, behaviour therapy emerged (Fishman, Rego, & Muller, 2011; Truscott, 2010). Based on the principles of social learning theory, operant conditioning, and classical conditioning, behaviour therapy emphasized the observation and manipulation of behaviour to achieve goals. Hans Eysenck, the head of clinical psychology at the University of London, and Joseph Wolpe, a psychiatrist from South Africa helped to form behaviour therapy as a distinct movement (Fishman, Rego, & Muller, 2011). Eysenck (1964) later edited one of the first compilations of case studies within behaviour therapy. Wolpe created a treatment for overcoming phobias, which he coined systematic

desensitization, and he often used the case study to document, evaluate, and disseminate his approach (see Wolpe, 1959; Wolpe, 1971; Wolpe & Abrams, 1991). The origins of behaviour therapy are strongly linked to the n of 1 case study tradition (Fishman, Rego, & Muller, 2011).

Case Studies within Person-Centered Therapy

From the 1930's to the 1950's, person-centered therapy developed alongside, yet independent of behaviour therapy. Rogers was the father of person-centered therapy and a pioneer of psychotherapy research methods. For his contributions as both a researcher and clinician, he is perhaps the most influential psychotherapist in history (Truscott, 2010). Early in his career as a psychotherapist working with problem children, he became disappointed with the available psychotherapy literature. Rogers claimed the literature lacked empirical research on available therapeutic approaches (Elliott & Farber, 2010). Rogers argued that psychotherapy should be subject to scientific inquiry and dedicated his career to the investigation and development of scientifically supported forms of psychotherapy (Elliott & Farber, 2010).

In 1939, Rogers began a research program at Ohio State University (Elliott & Farber, 2010; Muran, Castonguay, & Strauss, 2010). During his time there, Rogers and his colleagues (1942) developed a method for recording interviews using phonograph records and proceeded to audio record the first ever psychotherapy session. This innovation revolutionized case study methodology in psychotherapy. It provided verbatim access to previously inaccessible data and psychotherapy researchers no longer had to rely on case notes or memory to reconstruct cases. As Rogers and his colleagues sought methods to analyze the first ever psychotherapy transcripts, they eventually took

to classifying individual therapist and client responses in an attempt to understand the connections between the two (Elliott & Farber, 2010). In doing this research on moment-by-moment processes, Rogers invented psychotherapy process research (Castonguay & Strauss, 2010; Elliott & Farber, 2010). This allowed for the study of how psychotherapy unfolded and laid the groundwork for subsequent process research. For example, task analysis, which creates and verifies models of how clients resolve specific therapeutic tasks (see Greenberg, 1984) and comprehensive process analysis, an analytic strategy for understanding significant events in therapy (see Elliott et al., 1994), both evolved from Rogers' work. An additional methodological innovation that arose from the use of phonographic recordings in case studies was obtaining consent from clients prior to recording sessions, which was still a rarely practiced procedure at that time (McLeod, 2010).

In 1942, Rogers published *Counseling and Psychotherapy*, a book that contained the first fully transcribed psychotherapy case study. He used the transcripts in this book to illustrate his person-centered psychotherapy approach. This contribution fully introduced person-centered therapy to the psychotherapy community and also provided evidence for the importance of transcripts in case study research. Many subsequent researchers, even those within the behaviour therapy movement, began using transcripts as data from which to construct case studies (see Wolpe, 1970).

Later at the University of Chicago, Rogers pursued systematic group designs to explore psychotherapy outcome research (Muran, Castonguay, & Strauss, 2010; Rogers & Dymond, 1954). His work here laid the groundwork for randomized control trials (RCTs; Elliott & Farber, 2010), a research approach that would later dominate the field.

Rogers' transition to large group designs in the 1940's and 1950's may initially appear antithetical to his previous work and character. He was a strong supporter of the case study method and was rooted in the humanist movement that emphasized the client's subjective experience (Truscott, 2010). To better understand this transition, it is important to know that Rogers was fundamentally a scientist. When he was young, his family moved to a farm and his father stressed the scientific management of the farm (Elliott & Farber, 2010; Hergenhahn, 2009). Rogers became intensely interested in agricultural experiments and initially enrolled in university to study agriculture (Hergenhahn, 2009). After pursuing history then training at a seminary, he eventually found his way to clinical psychology (Hergenhahn, 2009). Rogers was a pragmatic man with an inquiring mind and throughout his life sought answers using scientific inquiry. As a scientist and a pragmatist, in his career as a psychologist he sought the methods he believed would be most appropriate, or perhaps influential, in conveying the theory and techniques of the person-centered approach. After pursuing group outcome research, Rogers turned his efforts towards combining qualitative process research with quantitative outcome research, thereby inventing process-outcome research (Elliott & Farber, 2010). Later in his career, he became dissatisfied with positivist approaches to research and sought more interpersonal, exploratory approaches to understanding human phenomena, much like those found in modern qualitative traditions (Elliott & Farber, 2010).

During his career, Rogers was a pioneer as a psychotherapist and researcher. The case study approach had a prominent presence in his research endeavors, was influential in initially establishing the approach, and held a strong position in the person-centered

tradition more generally. In addition, Rogers' contributions to case study methodology have made a substantial impact on subsequent case study research. Introducing psychotherapy transcripts through the use of phonograph recordings increased the validity of case reports and opened up analytic options that continue to evolve today. Furthermore, regularly obtaining consent from clients prior to data collection was an important advancement in the ethical practice of case study research.

Case Studies within Cognitive Therapy

The cognitive therapy movement emerged during the 1960's. At this time, the limitations of learning based theories as explanations for human behaviour were becoming evident and information processing models from within computing science launched a general interest in the study of human cognitions (Lambert, 2013; Truscott, 2010). Beck, like other psychotherapists at the time, had grown dissatisfied with both psychoanalysis and behaviour therapy (Hollon, 2010). Beck was originally an ardent psychoanalysis and early in his career had set out to test the psychoanalytic theory that depression was caused by anger directed towards the self (Hollon, 2010; Truscott, 2010). What he discovered instead was that depressed individuals typically thought of rejection and failure. Beck built on this idea and began developing a theory that cognitions played a role in the development and maintenance of depression. By 1970, Beck had formulated an innovative approach to the treatment of depression and named this approach cognitive therapy (Hollon, 2010).

Cognitive therapy, as it is known today, is typically associated with the outcome focused, large group design, evidence-based treatment movement (Muran, Castonguay, & Strauss, 2010). While cognitive therapy certainly gained popularity and esteem by

quickly establishing itself as an evidence-based treatment, the case study method played a large role in developing a knowledge base and describing innovations in practice within cognitive therapy (McLeod, 2002). There are many examples of influential early and later case studies that were used to illustrate cognitive therapy to other practitioners. In fact, Beck first described his approach in the 1970 article, *Cognitive therapy: Nature and relation to behavior therapy*, in which he used a case report of "Mrs. G." to illustrate cognitive therapy techniques. Beck later presented a series of case reports at the Association for the Advancement of Behavior Therapy to describe in detail the components of his proposed treatment (Hollon, 2010). Interestingly, Beck, like Freud, originally trained as a medical doctor (Hollon, 2010), and he too would have been accustomed to the tradition of case studies within medicine and likely found case studies to be a practical and persuasive means to communicate his approach.

Later case studies within cognitive therapy have been used to record innovations in practice as well as illustrate the work of the cognitive therapy master, Beck, himself. For example, in 1978 Beck co-published a case study illustrating the negative cognitions of a middle-aged man (Kovacs & Beck, 1978). Beck (1989) later used a case report to demonstrate how to connect therapy plans to session-by-session work in Wedding and Corsini's, *Case studies in psychotherapy*. More recently, Beck has used case studies to demonstrate novel applications of cognitive therapy, for example, cognitive therapy for individuals who recently attempted suicide (Berk, Henriques, Warmann, Brown, & Beck, 2004), for clients with schizophrenia who were not taking medication (Christodoulides, Dudley, Brown, Turkington, & Beck, 2008), to illustrate the "schema-focused" phase of treatment for depression (Young, Rygh, Weinberger, & Beck, 2008), and for involving

families in the treatment of a client with schizophrenia (Perivoliotis, Grant, & Beck, 2009). In many of these case studies, a series of cases were used to illustrate the approach.

Cognitive therapy has always carried a strong research tradition (Lambert, 2013). Case studies have certainly been part of this tradition, but large group designs have also played a prominent role in building empirical support for cognitive therapy. During the time of developing and establishing cognitive therapy, there was a paradigm shift within psychotherapy research towards large group designs (Molloy, Murphy, & King, 2007). This likely contributed to Beck's movement towards large group designs and the downturn of case study research in cognitive therapy more generally. Already in 1977, Beck had conducted an RCT of cognitive therapy for depression (Hollon, 2010). Beck's future endeavors often involved the creation of treatment manuals for specific disorders for use in RCTs in order to promote the establishment of cognitive therapy as an evidence-based treatment. While large group designs quickly established cognitive therapy, more recently there has been a call for renewed interest in case study research from within the cognitive therapy community (see Borckart et al., 2008; Sharpley, 2007). A discussion of the paradigm shift that ultimately led to the demise of the case study in psychotherapy research follows.

The Demise of the Case Study

Despite it's long history in psychotherapy research, the case study has been out of favour for 50 years. The use of case studies declined to such an extent that they nearly vanished from peer-reviewed literature in the field (Leitenberg, 1973; McLeod, 2002). The demise of the case study can perhaps be linked to two independent, yet related

movements. First was the push towards large group designs to establish evidence-based treatments in psychotherapy. This was part of an effort to situate psychotherapy as a recognized and reputable form of treatment for psychological illness. A second contributing factor was the growing chorus of criticism directed towards case study methodology in psychotherapy that became more prominent in the 1960's and continued through to the 1990's. Both of these movements will be explored.

The Evidence-Based Treatment Movement

Large group designs were possible in the 1920's and 1930's (Morgan & Morgan, 2009), yet the arrival of large group designs and statistical inference did not initiate the disregard of single-case research. The knowledge contributions of both case studies and large group designs were valued in the field. The movement towards embracing large-group designs and abandoning case studies did not begin until the late 1950's and 1960's. An influential and now famous article published in the 1950's marked a turning point in psychotherapy history. Hans Eysenck (1952), a well-known psychotherapist from within behaviour therapy, published a review of 19 large N studies reporting results on the effectiveness of psychotherapy treatments. His conclusions shocked the psychotherapy world. Eysenck (1952) reported that there was no evidence to support the effectiveness of psychotherapy, and further, that psychoanalysis was less helpful than no treatment.

In response to this article, the 1950's and 1960's were marked by rapid growth in psychotherapy research (Muran, Castonguay, & Strauss, 2010). There was an increase in the quantity and quality of research as practitioners sought to provide counter-evidence to Eysenck's damning article (Lambert, 2013). Also during this time, the National Institute of Mental Health (NIMH) began funding conferences and research programs in order to

establish an evidence base for psychotherapy treatments (Muran, Castonguay, & Strauss, 2010). In the 1970's, the NIMH oversaw the Treatment of Depression Collaborative Research Program, a large clinical trial comparing cognitive-behavioural, interpersonal, & pharmacological treatments (Muran, Castonguay, & Strauss, 2010). In 1975, Sloane and colleagues conducted the first controlled clinical trial comparing dynamic psychotherapy, behaviour therapy, and a waiting-list control (Sloane, Staples, Cristol, Yorkston, & Whipple, 1975). A new era of psychotherapy research emerged in which researchers sought to establish the most efficacious treatment for specific mental illnesses (Chambless & Ollendick, 2001). Such research called for large group designs, random assignment of participants, and control groups in order to establish a convincing evidence-base for psychotherapy practice. At a time when psychotherapy was desperate to prove its worth, it is not surprising that RCTs became increasingly popular.

In 1995, the Task Force on the Promotion and Dissemination of Psychological Procedures of Division 12 (Clinical Psychology) of the American Psychological Association identified and published the first list of evidence-based treatments (Chambless & Ollendick, 2001; Elliott, 1998). This publication included criteria for establishing evidence-based treatments, which emphasized RCTs, and also a recommendation that graduate programs include theoretical and applied training in evidence-based treatments (Chambless & Hollon, 1998; Elliott, 1998; Fishman, Rego, & Muller, 2011). The impact on the field was phenomenal. RCTs quickly gained a reputation as the gold-standard research design and other forms of research, including the case study, were no longer valued as research designs that could contribute valuable knowledge (Barkham, Hardy, & Mellor-Clark, 2010; Elliott, 1998; McLeod, 2010;

Peterson, 2004). If psychotherapy researchers wished to influence policy, they would most likely be able to do so using RCTs. Evidence-based treatments came to be largely understood as treatments for which RCTs provided evidence.

Not surprisingly, the heavy funding and support of RCTs to establish evidence-based treatments also had an impact on psychotherapy practice (Angus et al., 2010). Although practitioners within cognitive therapy embraced this movement, practitioners within person-centered therapy and the humanist movement never fully did (Muran, Castonguay, & Strauss, 2010). As a result, cognitive and cognitive-behavioural therapies quickly became established as evidence-based treatments for a wide range of psychological illnesses, while approaches from within the humanist movement have received little recognition as efficacious due to the few RCTs conducted within these traditions. As a result, these approaches have become perceived as less desirable. The ripple effect from the evidence-based treatment movement has been far-reaching and has impacted the types of research as well as therapeutic approaches supported by large institutions such as hospitals, universities, and research funding bodies.

Criticisms of Case Study Methodology in Psychotherapy

A second factor contributing to the demise of the case study was criticism of case study methodology. Freud's case study methodology received much criticism, both at the time of their release and in more recent years. Many argued that his method was sloppy, not properly scientific, and introduced the strong possibility of researcher bias (Eysenck, 1959, 1987; Watson, 1919). Yet, some researchers, especially those within the psychoanalytic tradition, continued using a case study methodology similar to that of Freud's. Their case studies were also reconstructed from case notes or memory, the

client's perspective was rarely elicited, and few checks and balances were in place to ensure the correctness of interpretations (McLeod, 2010). The continuation of case study research in this form was problematic for two reasons: one, case studies lacking in an appropriate methodology continued to be produced; and two, methodologically flimsy case studies often obscured the higher quality case studies that were being produced thereby exacerbating perceptions of the case study in psychotherapy as unscientific.

From the 1960's through to the 1990's, clearly articulated criticisms of the case study approach within psychotherapy arose. Shapiro (1961) argued for the need to introduce experimental control and objective measures that could sufficiently capture complex psychological variables. Bolgar (1965) and Dukes (1965) pointed to the problem of generalization to a larger population. Leitenberg (1973) identified problems of description and measurement. In many case studies, descriptions of the client, measurement procedures, and treatment procedures were lacking, and further, statistical tests and reliable, objective measures were rarely used.

Criticisms of traditional case study methodology also came in the form of re-analyses of famous cases such as Dora, the Rat Man, and the Wolf Man from both psychoanalytic and other perspectives (see Bernheimer & Kahane, 1986; Billig, 1997; Buckley, 1989). For example, after accessing two unpublished records from Breuer and Freud's (1895/1957) previous publication, Ellenberger (1972) reported that Anna O. had not suffered from hysteria and that even Freud himself was aware she had not been cured by psychoanalysis. In another case, Bernheimer and Kahane (1986) discovered information Freud chose to exclude from his case of Dora. The lack of transparency and

selective reporting of past case studies have led to general doubt about the validity of case studies within psychotherapy.

Another criticism of case study methodology was that they were used as a form of rhetoric or argument to persuade readers and were therefore biased (McLeod, 2010). This is the case especially when researchers are motivated to provide evidence for an innovative approach to therapy and have not embedded proper checks and balances in the research design. At its extreme, without a clear research design, few objective measures, or descriptions of treatment procedures, psychotherapists are granted enough freedom to misrepresent data for personal gain. Spence (1986, 1989, 1994) has been most vocal in this regard. He argued that case study methodology led to the overlooking of contradictory evidence, a process for which he coined the expression "narrative smoothing". In narrative smoothing, he argued, a researcher omits some details and enlarges others. This process may even take place during therapy sessions when a psychotherapist elicits certain stories from a client and ignores others.

A further criticism of case studies was that they did not provide causal information and therefore had limited value. If a researcher could not say with some degree of certainty that client change could be attributed to therapy, it has been argued that findings had no meaning (McLeod, 2010). Finally, case studies have been criticized for being embedded with ethical problems, the most criticized of which is the inability to guarantee anonymity to participants (McLeod, 2010).

These criticisms of case study methodology contributed to the perception of case studies in psychotherapy as unscientific. This perception was especially problematic following Eysenck's (1952) article reporting that there was no evidence to support the

effectiveness of psychotherapy. Since then, there has been a drive in psychotherapy towards developing credibility by being scientific, largely through the use of large group designs. The case study, therefore, lost its appeal. The result has been a near absence of case studies in psychotherapy literature, training programs, research programs, and institutionally-based care centers in recent times.

A New Era of Case Study Research within Psychotherapy

Modern Approaches to the Traditional Case Study

In the face of criticism, some proponents of case study methodology have responded. In the 1990's and 2000's, select researchers began designing case studies that addressed some of the methodological pitfalls of previous designs (see Elliott, 2002; Etherington, 2000; Fishman, 1999; McLeod, 2010; Stiles, 2007). The challenge for these researchers has been to conduct methodologically rigorous case studies while still preserving the valuable qualities of traditional case studies in psychotherapy (McLeod, 2010). As stated by Burton (1959) over 50 years ago, the goal of the modern case study is to "preserve the essence of the case study method and yet not be limited by it" (p. iv). The result of these efforts, visible only recently, has been the development of five specific genres of case studies in psychotherapy: the hermeneutic single case efficacy design (Elliott, 2002), n of 1 time-series case studies, narrative case studies (Etherington, 2000), theory-building case studies (Stiles, 2007), and pragmatic case studies (Fishman, 1999). Each genre is couched within a different research tradition, geared towards different types of knowledge, and situated at a different stage of development. These five genres of case studies in psychotherapy have been clearly outlined by McLeod (2010). In addition to these five genres, modern mixed methods approaches offer an additional

opportunity for psychotherapy researchers to generate rigorous case studies. Borrowing from mixed methods approaches, a researcher can follow a research design from data collection to interpretation in a flexible, yet systematic way. The five genres as articulated by McLeod (2010) and a sixth more general mixed methods approach to psychotherapy case study research are briefly described below. These modern approaches to case study research have contributed to the resurgence of case study research within psychotherapy.

Five genres of case study research in psychotherapy. McLeod (2010) has articulated five genres of case study research in psychotherapy. One of these approaches is the hermeneutic single case efficacy design (HSCED). Elliott (2002) developed the HSCED in response to the need for an outcome-based case study design that was congruent with all therapeutic approaches including those valuing a more relational and exploratory stance (McLeod, 2010). The fundamental purpose of an HSCED study is to evaluate therapy outcome in a way that addresses the shortcomings of mainstream psychotherapy research (Elliot, 2002). For example, the HSCED study recognizes the inability of RCTs to make causal inferences at the individual level and asserts the potential for outcome research to make case-by-case claims about what causes what in therapy. A unique feature of the HSCED study is the quasi-judicial framework that is used to more rigorously measure therapy outcome. In this framework, client change is evaluated using both affirmative and skeptic arguments and these arguments are sent to external judges to adjudicate therapy effectiveness (see Elliot, Slatick, & Urman, 2001). With its emphasis on involving multiple researchers, exploring questions of causation, and using a legalistic mixed-method approach to case evaluation (Stephen, Elliott, &

McLeod, 2011), the HSCED offers a unique opportunity for outcome measurement within a case study design.

A second distinct case study approach is the n of 1 time-series case study, also known as single subject designs or n=1. This approach has roots in experimental psychology, for example, with Skinner's laboratory-based behavioural research on rats, and has never ceased to be a part of the research tradition within behaviourism. Current n of 1 time-series case studies in psychotherapy place emphasis on establishing baseline functioning, reliable and valid outcome measurement of observable behaviour, and accurate week-by-week descriptions of interventions (McLeod, 2010). Collecting data in this way allows a researcher to analyze possible linkages between intervention and client change as well as make claims regarding overall therapy outcome. Researchers within this tradition seek to make generalizations based on the accumulation of multiple n of 1 time-series case studies (McLeod, 2010). This approach offers a practical, flexible method of measuring weekly target behaviours that allows for arguments that intervention influenced outcome. With its emphasis on outcome, n of 1 research is typically conducted within the behavioural or cognitive-behavioural paradigm.

A third genre, the narrative case study (Etherington, 2000), aims to tell the story of therapy from the client's point of view (McLeod, 2010). Like the HSCED, emphasis is placed on creating a rich case record, but the types of data gathered and the end report are quite distinct from an HSCED study. Guided by a desire to tell the client's story, there is less reliance on self-report measures of outcome, therapist session notes, and therapist interpretations. Sources of information include autobiographical retrospective accounts of therapy, diary entries, recordings of therapy sessions, interviews, and artifacts

associated with the therapy (McLeod, 2010). For example, Etherington and Bridges (2011) used session notes and interviews to explore clients' lived experience of endings in therapy. A unique aspect of the narrative case study is the involvement of the client in data collection and story construction. Reports from practitioners and clients have indicated that client involvement in recreating their therapy story is a means of deepening clients' understanding of their therapy experience in a way that can be therapeutic (Sommer, 2003).

Theory-building case studies (Stiles, 2007, 2009) are another genre. In this type of case study, the researcher gathers a large number of observations and uses this data to refine and articulate theory (McLeod, 2010). The goal of theory-building case studies is to convey how well a theory informs a particular case and what kinds of changes to the theory are necessary to increase fit between the case and theory (McLeod, 2010). There are eight steps in conducting a theory-building case study which include developing a theoretical starting-point, selecting a case, constructing a rich case record, immersing oneself in the case, applying the theory to the case, identifying gaps in the theory, refining the theory, and testing the revised version of the theory (McLeod, 2010; Stiles, 2007). The data collected varies from transcripts of therapy sessions (see Brinegar, Salvi, Stiles, & Greenberg, 2006) to detailed session notes (see Karon, 2008). Theory-building case studies also support the use of mixed methods (see Hill et al., 2008; Kasper, Hill, & Kivlighan, 2008). An example of this style of case study is Watson, Goldman, and Greenberg's (2007) case study that sought to refine emotion-focused therapy theory by analyzing three poor and three good outcome cases that were identified through a RCT.

The final genre of modern case studies as articulated by McLeod (2010) is the pragmatic case study. The purpose of the pragmatic case study is to document everyday therapeutic practice (McLeod, 2010). The father of the approach, Daniel Fishman, is editor of one of two psychotherapy journals specializing in case study research, *Pragmatic Case Studies in Psychotherapy*. In his book *The Case for Pragmatic Psychology*, Fishman (1999) outlined specific guidelines for generating rigorous, acceptable, and publishable case studies. Some of these guidelines include strict recommendations for the inclusion of a rich case description, a description of the therapist's theoretical orientation, and the use of analytic techniques to draw valid inferences. His approach combines the *traditional paradigm* in psychological research, which is more experimental and quantitative in nature, and the *interpretive paradigm,* which is more naturalistic and qualitative in focus, therefore supporting a mixed methods design (Fishman, 2005). Fishman's major contribution has been in making the distinction between the traditional case study, lacking in rigor and controversial, and the pragmatic case study (McLeod, 2010). Pragmatic case studies are not intended for generalization or for studies exclusively focused on outcome, but rather are intended to provide an example of how a theoretical orientation can be applied to a specific client problem (McLeod, 2010).

Pragmatic case studies do not follow a traditional article format that begins with a literature review and ends with a discussion. While traditional elements are embedded in pragmatic case studies, there are additional sections specific to psychotherapy that require an author to be transparent about aspects of the case. For example, authors are required to include information regarding the case context, the guiding conception, an assessment

of the client's problems, goals, strengths, and history, a case formulation and treatment plan, a thorough description of the course of therapy, and a discussion of how feedback information was used. These additional components require an author to report sufficient information for a reader to understand the case as well as develop alternative interpretations. Chapter 3 presents a case study written in this style.

The five modern genres as described by McLeod (2010) offer an opportunity for practitioners to conduct systematic case studies. The methodological advancements inherent in these modern designs increase the reliability of case study research thereby making it possible for case studies to contribute to the evidence base for psychotherapy theory and practice (McLeod & Elliott, 2011).

Modern mixed methods and case study research in psychotherapy. Another emerging development that has the potential to contribute to rigorous case study methodology in psychotherapy is modern mixed methods research. Mixed methods research has been around since the early 1900's, but it was not until the 1990's within the field of program evaluation that mixed methods concepts and methods developed more fully (Johnson & Gray, 2010). Currently, formal mixed methods research designs have been described (see Creswell & Plano Clark, 2011) and they function as a guide for data collection, analysis, and interpretation. This provides a framework for the production of high quality mixed methods research. At this time, case study researchers within psychotherapy have the opportunity to generate rigorous case studies drawing from mixed methods approaches.

Mixed methods research, like pragmatic case studies, is guided by the philosophical assumptions of pragmatism (Creswell & Plano Clark, 2011; Feilzer, 2009;

Morgan, 2007). A pragmatic stance allows a researcher to use both distance and closeness between researcher and participant, both deductive and inductive approaches, and both formal and informal language as required to answer research questions (Creswell & Plano Clark, 2011). In pragmatism, the questions asked are of primary importance over the methods used and the fundamental guiding idea is to employ 'what works' (Creswell & Plano Clark, 2011).

Mixed methods research is promoted in three of the five genres of case studies in psychotherapy described by McLeod (2010): HSCED, theory-building case studies, and pragmatic case studies. A primary difference is the extent to which the research draws from modern mixed methods approaches. While there are examples of mixed methods case studies in psychotherapy (see Hill et al., 2008; Kasper, Hill, & Kivlighan, 2008), these case studies rarely follow the standards of mixed methods research proposed in the literature. For example, selecting a research design, sharing the reason for combining data, articulating separate qualitative, quantitative, and mixed methods research questions, being clear about the timing of quantitative and qualitative data collection, and also clearly articulating the ways in which qualitative and quantitative strands of data are merged are all important aspects of rigorous mixed methods research (Creswell, 2014). Modern mixed methods approaches, therefore, have much to offer case study research in psychotherapy. Drawing from mixed methods approaches, researchers in psychotherapy could clearly articulate a specific research design and follow that design from data collection to interpretation thereby creating a methodologically rigorous case study.

A second difference between mixed methods case studies embedded within one of the currently articulated five approaches (McLeod, 2010) and mixed methods case studies

more generally is the type of question asked. HSCED studies seek to answer questions of outcome and causation from within a quasi-judicial framework using multiple judges, theory-building case studies attempt to refine theory, and pragmatic cases document everyday practice. There are mixed methods research questions that do not easily fit into one of these three genres of case studies in psychotherapy.

Take this hypothetical case as an example. A researcher wishes to track therapy outcome of a client with trichotillomania by measuring weekly incidents of hair pulling and at the end of therapy would like to explore, from the client's perspective, the story of how the therapy was experienced. Within this research, there are elements of an n of 1 case study, for example, the weekly measurement of hair pulling and the focus on outcome. There are also elements of a narrative case study, for example, the goal to explore the client's experience. The quantitative research question might be, 'To what extent do incidents of hair pulling change over the course of therapy?'. To answer this question, the researcher might draw upon the client's record of hair pulling incidents. The qualitative research question might be, "How does the client experience change in therapy?". To answer this question, the researcher might conduct a post-therapy interview with the client. The overall mixed methods question might be, 'How can change in a case of trichotillomania be understood when examining incidents of hair pulling over the course of therapy and the client's perspective on change?". The researcher would first collect quantitative data and then use qualitative data to understand quantitative results more fully. This is an example of a unique research question that does not fit within the five genres of psychotherapy case study research as described by McLeod (2010), but can be systematically explored using a mixed methods design.

Researchers within psychotherapy have the opportunity to draw from modern mixed methods approaches to conduct high quality case study research that can easily adapt to the research questions posed. Chapter 4 presents a mixed methods case study that draws on modern mixed methods approaches. It uses a convergent parallel mixed methods design to explore therapy outcome using pre- and post-therapy questionnaires and pre- and post-therapy interviews with the client.

The five modern genres as described by McLeod (2010) in addition to modern mixed methods approaches provide templates for practitioners to conduct high quality case study research in psychotherapy. These approaches are ushering in a new era of case study research in psychotherapy. Another factor contributing to the re-emergence of case study research within psychotherapy has been the increasing dissatisfaction with RCTs, an interesting turning point in the history of psychotherapy research that will be briefly explored.

Limitations of Randomized Control Trials

In addition to modern approaches to the traditional psychotherapy case study, a second factor contributing to the resurgence of case study research within psychotherapy has been the growing dissatisfaction with RCTs. Angus et al. (2010), Chambless and Ollendick (2001), Elliott (2002), and McLeod (2010) have articulated criticisms of RCTs. These criticisms have been aggregated into six categories and are presented below.

First, RCTs are not feasible research designs for most practitioners. RCTs require large numbers of participants as well as experimental control. Experimental control demands the creation and implementation of treatment manuals, procedural training of many practitioners, and a staff of researchers to collect and analyze data. The vast scale

of RCTs makes them an expensive and time-consuming form of research not feasible outside of giant research institutions.

Second, the scale of RCTs makes it nearly impossible for researchers to gather or represent data from the perspective of the client. Only standardized, quantitative outcome measures are typically used to measure dependent variables. One consequence of this is that clients are given no voice. Published RCTs exclusively represent the voice of the researcher and this is conveyed in the types of questions asked, the quantitative outcome measures selected, and the interpretation of results.

Third, many are beginning to realize the limited value of aggregated data. Morgan and Morgan (2009) have argued that group means reduce variability, thereby masking the complex and variable nature of human phenomena, an argument that mirrors Skinner's (1966) disregard for aggregated data because it masked the learning curves of the individual rat or pigeon. Simply put, aggregated data cannot predict individual behaviour and may have limited correspondence to individual data.

Fourth, while RCTs have been commended as capable of providing causal information, the causal information provided is limited to drawing connections between general treatment and outcome, for example, claiming that treatment A led to outcome A. While this information can be helpful, RCTs are not able to give insight into the nature of this connection, for example, providing information about how change occurred. For this reason, Elliott (2002) argued that RCTs are *causally empty*. In an RCT, causality is inferred by determining temporal precedence and evidence that treatment and outcome covaried, but there is no way to understand the *specific nature* of the relationship between treatment and outcome, for example, there is no explanation of how change occurred

(Elliott, 2002). Furthermore, RCTs promote understanding of causality at a group level, not an individual level. The process of change is so complex, consisting of events occurring both in and outside of therapy, that it is difficult to understand causation for even one individual. Waedler (1962) commented on the complexity of the process of change for one individual:

> Our subject matter lies partly in the past – the life history of a person….All variables are closely interrelated; we have no chance of observing the change of one without the simultaneous change of many others. Our subject is changing while we are working with him, is maturing or declining, and is assimilating experience in the process of living. We are definitely interested in an individual and his destiny and not content with statistical answers. (p. 627)

RCTs promote understanding of causality at a group level by examining few dependent variables, not at an individual level examining multiple dependent variables. This greatly diminishes the potential of large-scale research designs to contribute to a true understanding of causality.

A fifth criticism is that the generalizability of results from RCTs is questionable. This criticism is especially interesting and ironic given that the lack of generalizability has been a central criticism of case study methodology (see Eysenck, 2004). There are several factors that make generalization from RCTs problematic. First, to conduct RCTs, researchers attempt to obtain as pure a sample as possible. In setting restrictive selection criteria, the sample becomes non-representative of a community sample where co-morbid conditions and complex profiles are common. For example, Westen and Morrison (2001) conducted a meta-analysis of studies published between 1990 and 1998 that reported on

the efficacy of manualized treatments for panic, depression, and generalized anxiety disorder. They reported inclusion rates of only 36% for panic, 32% for depression, and 35% for generalized anxiety disorder. While exclusion criteria is appropriate, they reported that many of these studies excluded clients who presented with comorbid conditions which were commonly encountered in practice, and further, that the existence of co-occuring diagnoses impacted treatment response. Therefore, the treatments under study had unknown effects for a community sample. It was concluded that the external validity and clinical utility of RCTs are questionable.

A second factor that makes generalization problematic is that RCTs mandate the use of treatment manuals in order to maintain experimental control. There are many arguments against the use of treatment manuals, one of the strongest of which is that the treatment of an individual is most effective when a practitioner is able to respond flexibly. With restrictive selection criteria and the use of treatment manuals, RCTs do not represent typical practice. RCTs, therefore, lack external validity and clinical utility.

A final criticism of RCTs is that they favour certain therapy approaches. RCTs require sophisticated knowledge in advanced statistical techniques, and as a result, most RCTs are conducted in university settings. Researchers within universities conduct RCTs on therapies with which they are familiar. Most favour cognitive-behavioural therapy given the large evidential base cognitive-behavioural therapies acquired in their early support and use of RCTs. Cognitive-behavioural therapy, therefore, has been highly researched and has become more widely recognized as an evidence-based treatment than other therapies. In the United Kingdom, where RCTs also became the gold standard of research through the recommendations of their national health body organization, the

National Institute for Health and Clinical Excellence, it is now being discovered that the range of available therapies has been reduced (Guy, Loewenthal, Thomas, & Stephensen, 2012). This creates the unfortunate reality of limited choice of service provision for both practitioners and clients. As a partial response to this crisis in America, in 2005 the APA Task Force on Evidence-Based Practice credited the systematic case study as capable of contributing to research on effective psychological practice (Borckardt et al., 2008).

The two factors described above, the development of new methodologies for use with case studies and the recognition of the limitations of RCTs, have helped to usher in a new era of case study research within psychotherapy. While much can be done to further the development of modern case study genres and lessen the gap between RCTs and other forms of research, the case study is appearing as a more acceptable and rigorous form of research in the field.

The Enduring Advantages of Case Studies in Psychotherapy

The history of case studies in psychotherapy is rich, beginning with the publication of *Studies on Hysteria* written in 1895 (Breuer & Freud, 1895/1957) and continuing with much support and innovation into the 1950's. Psychoanalytic, behavioral, person-centered, and cognitive approaches all relied on the case study to communicate and illustrate their unique therapy approaches. After enduring much criticism and hardship in the 1960's through to the 1990's, case study methodology was refined through the work of various researchers who contributed to the development of five modern genres of case study research within psychotherapy (see Elliott, 2002; Etherington, 2000; Fishman, 1999; McLeod, 2010; Stiles, 2007). Case studies have

recently emerged as a new, appealing, and systematic method of gathering knowledge about the therapeutic encounter.

After exploring the history of case studies in psychotherapy, what remains to be clearly articulated is an argument for the on-going relevance of quality case study research. The future of case studies within psychotherapy is hopeful, and with clear communication of what the case study has to offer, its future may be secured. Case studies offer a unique, flexible, and feasible form of psychotherapy research in addition to a memorable, narrative form of knowing (McLeod, 2010). There are several other features of the case study that make it indispensable to the field.

Case study designs respect the complexity of psychotherapy research. This is possible because a single case is observed. Data is not aggregated, and therefore the complexity of individual experience is not obscured, nor is meaningful variation in data lost. In addition, case studies allow for ongoing measurement over time. This makes it much more sensitive to behavioural change than single pre- and post-measurements typical in large group designs (Morgan & Morgan, 2009). Furthermore, with one individual, a large number of observations become possible (McLeod & Elliott, 2011). Researchers are able to study many dependent variables to better measure and understand the intricate patterns of change that so often characterize psychotherapy research. Overall, by studying one individual, complex phenomena can be understood in the context of the case as a whole (McLeod, 2002; McLeod & Elliott, 2011).

Case studies are also indispensable as a means of bridging research and practice in training programs (Moran, 2011). In reading case studies, students develop and improve case formulation skills and this in turn improves students' clinical effectiveness

(Eells & Lombart, 2003; Eells, Lombart, Kendjelic, Turner, & Lucas, 2005). This is not surprising since case studies offer one of the few ways in which early trainees gain access into what theory looks like in action (Mackrill & Iwakabe, 2013). In writing case studies, students further develop case formulation skills and have the opportunity to receive feedback on interventions and interpretations (Mackrill & Iwakabe, 2013). Furthermore, case studies are a comprehensive way to assess a student's competence (McLeod, 2010). The "practice-based research training" (Henton, 2012) offered by case studies is an invaluable tool for both trainees and instructors.

Another argument for the on-going relevance of quality case studies is a rebuttal to the criticism that they are not generalizable. While case studies are not generalizable in the traditional sense, there are ways to generalize knowledge produced in case study research. One of the primary ways in which this can be done is through the accumulation of multiple case studies investigating a similar treatment for a similar client concern (Fishman, 1999; McLeod, 2002; Morgan & Morgan, 2009). In constructing a database of case studies, enough evidence can be built in support of a specific approach for a specific problem. This makes claims for the generalization of case study findings possible. The potential of a series of case studies to be used for generalization has been endorsed by the Task Force on the Promotion and Dissemination of Psychological Procedures of Division 12 (Clinical Psychology) of the American Psychological Association. This task force claimed a treatment could be considered evidence-based if a series of high quality case studies demonstrated treatment efficacy (Chambless & Ollendick, 2001). Another way in which case studies can be generalized is through the metasynthesis of multiple case studies (Iwakabe & Gazzola, 2009). For example, common themes can be identified in

case studies focusing on similar clinical concerns. These themes can be used to build theory by examining them alongside current clinical practice and theoretical knowledge (Iwakabe & Gazzola, 2009).

If practitioners produce high quality, systematic case study research and the advantages of case study research become more broadly recognized within the field, case studies may once again become a respected form of research within psychotherapy. The argument here is not that case studies be favoured at the expense of all other research designs, but rather that the unique knowledge contributions of case studies be recognized. While RCTs offer an opportunity to understand causality in terms of *what* occurred, case studies offer insight into *how* something occurred. While RCTs are indispensable for identifying what generally works in therapy, case studies are a tool for exploring the meaning of findings, including contradictory findings that so often emerge. Methodological pluralism in the field is an opportunity to both broaden and deepen understanding of complex therapeutic phenomena. By embracing case studies in our field once again, we will usher in a new era of high quality research where we draw upon the strengths of a variety of methodological approaches to better understand the complex nature of the therapeutic encounter.

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CHAPTER 3

EMOTION-FOCUSED THERAPY FOR BULIMIA NERVOSA: THE CASE OF JANE

Organizational Preamble

The organization of this paper follows the framework and procedures required for Pragmatic Case Studies in Psychotherapy (PCSP), a journal dedicated exclusively to case study research and methodology. Daniel Fishman, the journal's editor, proposed these standards and principles in order to encourage researchers to be more methodologically rigorous in their case study research (Fishman, 1999). In the interest of creating a detailed and rigorous case report, I have chosen to follow these principles.

The goal in writing a pragmatic case study is to describe and interpret a particular psychotherapy case (Fishman, 2013). Pragmatic case studies provide an example of how a specific theoretical orientation can be applied to a specific client concern and therefore are intended to generate practical knowledge (McLeod, 2010). They are not primarily outcome focused. Researchers are encouraged to use both quantitative and qualitative approaches to generate high quality, rigorous case studies (Fishman, 2005).

The PCSP journal does not support the traditional format of published articles. Authors are asked to follow an outline unique to the journal. This outline was created specifically for case studies in psychotherapy and requires researchers to include information that promotes the creation of a methodologically rigorous case study. The outline for a pragmatic case study in psychotherapy includes 11 sections (Fishman, 2013). These sections as well as a brief description are as follows:

1. Case Context and Method: Authors are asked to provide information regarding the setting of the case, the methodological strategies, as well as strategies used to improve credibility, for example, the use of supervisors, third-party interviewers, and objective measures. This section mirrors the methods section in traditional articles.
2. The Client: A brief description of the client is provided to introduce the reader to the case.
3. Guiding Conception with Research and Clinical Experience Support: Authors provide information regarding the specific approach used when working with the client, the goals of treatment, as well as the therapist's background and experience. This section requires authors to refer to relevant published literature and therefore includes aspects of a traditional literature review.
4. Assessment of the Client's Problems, Goals, Strengths, and History: A longer, more thorough description of the client, the client's presenting problem, the client's history, and her strengths and weaknesses is provided in this section.
5. Formulation and Treatment Plan: In this section, authors share their own conceptualization of the client and a rationale for selecting the specific treatment for the client. The plan for treatment is described.
6. Course of Therapy: This section provides an opportunity for authors to describe in depth the happenings of the particular case. It is the largest piece of data provided on the case. Authors are encouraged to use therapy transcripts as examples to back interpretive descriptions and to organize the

course of therapy according to different phases of therapy and themes. This tends to be the most substantial section of pragmatic case studies. The goal is to provide enough descriptive information to give evidence to interpretations and also enough information for independent readers to evaluate the case based on their own interpretations.

7. Therapy Monitoring and Use of Feedback Information: Authors are asked to describe how the therapy was monitored, for example, what checks and balances were in place to ensure the appropriateness of the therapy for the client. Supervision, journaling, and eliciting client feedback are all ways in which a therapist might monitor therapy progress.
8. Concluding Evaluation of the Therapy's Process and Outcome: In this section, qualitative and quantitative indicators of process and outcome are described. Authors are asked to include multiple types of data to aid in the interpretation of therapy outcome, for example, objective measures, a therapist's description of the case, interviews, and third-party reviewers. This section includes elements of a results and discussion section of a traditional article.
9. References
10. Tables
11. Figures

Fishman's major contribution to case study research has been the formulation of this unique outline for the creation of high quality, rigorous case studies in psychotherapy (McLeod, 2010). This outline includes elements from both qualitative and quantitative

research traditions (Fishman, 2005). In following this outline, authors provide sufficient contextual information to promote an understanding of the unique case and sufficient objective measures to support conclusions regarding therapy outcome. This paper follows this unique outline. In doing so, the goal is to generate practical knowledge and also contribute to the growing body of rigorous case study research in psychotherapy.

Case Context and Method

Clinical Setting

This research study was done to partially fulfill the requirements of a doctoral degree in counselling psychology. Therefore, therapy and supervision took place at a university-based community clinic. Services were provided free of charge. Given the time constraints of the doctoral degree, therapy was offered over 17 weekly sessions.

Therapist

The therapist, Kendell Banack, was a third-year counselling psychology doctoral student at the time of therapy. She had received graduate training in emotion-focused therapy (EFT) and formal EFT Level 1 training from Dr. Leslie Greenberg at the York University Psychology Clinic. In addition, she had received EFT training specific to eating disorders from Dr. Joanne Dolhanty and Dr. Adele Lafrance Robinson. Ms. Banack was also the researcher and writer in this case, and therefore, the first person will be used in this paper.

Research Team and Supervision

Two other therapists were part of the research team. They too were using EFT with clients diagnosed with bulimia nervosa (BN) and they also participated in bi-weekly supervision. Supervision was provided by two experienced registered psychologists.

The first was a university professor and psychologist who obtained his PhD and training in EFT at York University. The second was a clinical supervisor who practiced from a variety of experientially based and other theoretical orientations. Supervision included case conceptualization and video review.

Rationale for Selecting the Client

"Jane" was one of five clients who participated in this research study. All five clients showed improvements in the areas of psychiatric distress, emotion regulation, compensation, and binge eating, and therefore, selecting a client was difficult. After deliberation with the team, Jane was selected for the following reasons: (a) I was the therapist and had more detailed knowledge of the case; (b) the case record was especially complete and included my own personal notes; and (c) this case of Jane exemplified common dynamics in families with young women who have eating disorders, for example, the struggle to create boundaries with an over-bearing mother and the struggle to attach securely to an absent father. Challenges with this separation-individuation process in individuals with eating disorders is common and was of interest to me. Selecting the case of Jane for the common aspects of her story as well as the unique and interesting aspects of her story is consistent with purposeful selection as proposed by Thorne, Reimer Kirham, and MacDonald-Emes (1997).

Methodological Strategies

The goal of this study was to offer an in-depth picture of EFT for BN in the case of Jane, exploring both session-by-session process and outcome. A convergent parallel mixed methods design guided data collection and analysis (Creswell & Plano Clark, 2011). The design calls for both quantitative and qualitative data to be independently

collected in the same phase of research and then independently analyzed prior to being merged for analysis and interpretation (Creswell & Plano Clark, 2011). The rationale for selecting the convergent parallel mixed methods design is that a more comprehensive understanding of a complex research topic is possible when using both quantitative and qualitative data (Creswell & Plano Clark, 2011).

To further enhance the rigor of this case study, several additional strategies were used. Jane was diagnosed with BN according to the DSM-IV-TR (American Psychiatric Association, 2000) using the Eating Disorders Examination (EDE; Cooper & Fairburn, 1987). Therapy sessions were videotaped and these tapes were used during supervision. I also reviewed selected clips between sessions for case formulation and learning purposes. Furthermore, Jane completed process and outcome measures at the end of each session. Finally, in preparing this document, a statistician was consulted regarding the methodological and statistical aspects of the paper, and multiple readers from my dissertation committee offered insights and suggestions.

This study sought to answer the following questions:

- Qualitative question: How can the content and process of EFT for BN, including session-by-session client change, be described and interpreted in this particular case?
- Quantitative questions: To what extent do psychological and behavioural symptoms of BN change from session to session? To what extent do client reports of the working alliance change from session to session?
- Mixed methods question: What results emerge about client change in therapy when combining client reports about what was most helpful in each session to

weekly behavioural and psychological symptom change and ratings of the working alliance in this particular case?

Qualitative data collection.

Transcripts of therapy sessions. Sessions were audio and video recorded. Several sessions from the beginning (sessions 1 to 2), middle (sessions 8 to 9), and end (sessions 16 to 17) of therapy were selected for in-depth analysis. These sessions were transcribed by research assistants and a professional transcriptionist. The transcripts provided verbatim information regarding the process and content of therapy.

Session and supervision notes. Weekly session notes were kept and contained descriptions of session events, unusual within-therapy events, important extra-therapy events, and suggestions for future work. Supervision notes were also kept. These notes summarized discussions during supervisory sessions and included a description of the working case conceptualization, the techniques and treatment approach used in the preceding session, treatment goals for the upcoming week, and the exploration of research intrusion on the therapy process. Session and supervision notes helped to guide case formulation as well as interpretations regarding therapy process and outcome. They were also used to obtain information about sessions that were not transcribed.

Helpful Aspects of Therapy (HAT; Llewelyn, 1988). The HAT is a brief five-item, open-ended self-report questionnaire. Clients are asked to describe the most helpful event in the session and what made this event helpful. This measure is useful for identifying what the client perceived to be helpful in the session and whether this was consistent with the theoretical orientation used (McLeod, 2010).

Qualitative data analysis. To analyze the transcripts of therapy sessions, I used interpretive description as the analytic framework (Thorne, 2008) and incorporated elements from McLeod's (2000) method for the qualitative analysis of psychotherapy transcripts. Thorne et al. (1997) proposed interpretive description as an alternative qualitative research approach for the applied sciences. Thorne et al. (1997) argued that grounded theory, phenomenology, ethnography, and other popular qualitative approaches proposed objectives and methods that were too rigid to explore the research objectives and knowledge sought in the applied sciences. Essentially, in interpretive description, a researcher combines descriptive approaches while also interpreting the data with the goal of producing meaningful, practical knowledge (Thorne, 2008). Researchers are encouraged to repeatedly immerse themselves in the data using analytic notes, memos, and flags to ultimately produce an interpretive description of the data (Thorne et al., 1997).

The strategies proposed in McLeod's (2000) method for the qualitative analysis of psychotherapy transcripts fit well within the interpretive description approach. I adhered to the following analytic steps as proposed by McLeod (2000). For each session, I first read and listened to transcripts while writing memos. In the second reading, I highlighted main events, themes, and analytic insights and compiled these notes into a summary. In the third reading, I marked stories Jane had shared over the session as well as the topics we had covered and then wrote a summary of stories and topics. After compiling these descriptive notes, I constructed a summary representation of each session that was both interpretive and descriptive. The session summaries describe the content and process of the session and also provide a framework for understanding how what happened may

have been useful (McLeod, 2000). Session summaries, included in the Course of Therapy section, include segments of transcripts in order to provide evidence for my interpretations and to allow for the interpretations of others. While not formally included in the qualitative analysis, session and supervision notes guided case formulation and were also used to obtain information about sessions that were not transcribed. The HAT was included in the mixed methods analysis.

Quantitative data collection.

Report of Binge Eating and Compensation. This measure was created for this study and was modeled after several items of the EDE-Q (Fairburn & Beglin, 2008). It requested that Jane record the number of binge eating and compensation episodes over the past week (see Appendix A).

Difficulties in Emotion Regulation Scale (DERS; Gratz & Roemer, 2004). The DERS is a 36-item self-report questionnaire with six subscales: non-acceptance of emotional responses, difficulties engaging in goal directed behaviour, impulse control difficulties, lack of emotional awareness, limited access to emotion regulation strategies, and lack of emotional clarity. It is a measure of difficulties with emotion regulation. Due to the length of the questionnaire, only six items with the highest factor loadings on each of the six subscales were used (see Appendix B). For example, the item "When I'm upset, I feel guilty for feeling that way" was selected to represent the scale non-acceptance of emotional responses because it had the highest factor loading (.91) out of the six items for that scale (Gratz & Roemer, 2004). Higher scores indicate greater difficulties in emotion regulation. Good internal consistency and adequate convergent,

discriminant, and predictive validity of the full item scale has been reported (Gratz & Roemer, 2004).

Working Alliance Inventory, Short Form (WAI-S; Kokotovic & Tracey, 1989). The WAI-S is a widely used self-report measure assessing the strength of the working alliance between therapist and client from the client's perspective. It consists of 12 items rated on a 7-point Likert-type scale and has been revised from the original 36-item version (Horvath & Greenberg, 1989). It is based on Bordin's (1979) model of three components of the working alliance: the bond between therapist and client, agreement on the goals of treatment, and agreement about the tasks required to achieve goals. These three subscales, bond, goals, and tasks, can be used individually. When used individually, scores range from 4 to 28 with higher scores indicating a stronger working alliance. High internal consistency has been reported (Tracey & Kokotovic, 1989). Concurrent and predictive validity have been evidenced through significant correlations with other measures of the working alliance and outcome, and good construct validity has been established (Horvath & Greenberg, 1989; Horvath & Symonds, 1991). In this study, the WAI was used to better interpret merged qualitative data from the HAT and quantitative reports of psychological and behavioural symptom change.

Quantitative data analysis. Quantitative data from baseline to follow-up were examined using visual analysis and effect size analysis. Visual analysis is a common analytic strategy in single-subject designs (Gage & Lewis, 2013; Iverson, 2013; Morgan & Morgan, 2009) and is useful in cases where conventional parametric and nonparametric tests cannot be used because data violates the assumption of independent observations (Borckardt et al., 2008). In this study, few baseline and follow-up

observations were obtained and therefore it is difficult to make conclusions about differences between baseline, treatment, and follow-up phases. Nevertheless, it is possible to visually examine level shifts, trends, variability, and overlap in the data to obtain a picture of change over the course of treatment. In addition, as much data as possible is provided to allow readers to make their own hypotheses and conclusions regarding Jane's course of change over treatment.

In addition to visual analysis, the statistical significance of psychological and behavioural symptoms of change was examined using effect size analysis to estimate the magnitude of treatment effect. This method involved using the formula [$d = \underline{x_A} - \underline{x_B} / SD_{AB}$], where x_A is the mean of baseline, x_B is the mean of treatment, and SD_{AB} is the pooled standard deviation of baseline and treatment (Busk & Serlin, 1992). Cohen's (1988) original standards (.20 = small effect, .50 = medium, & .80 = large) were used to interpret the magnitude of effect. For this study, $d < 0.50$ indicates a small effect, $d =$ 0.50 to 0.80 indicates a medium effect, and $d > 0.80$ indicates a large effect.

Integrating qualitative and quantitative data. Parallel mixed data analysis (Teddlie & Tashakkori, 2009) was the guiding framework for data integration. The goal of merging data was to better understand what session events may have precipitated psychological and behavioural symptom change and the role of the working alliance in client change. Due to the large amount of qualitative data gathered from each session, the event in each session identified by Jane in the HAT as the most helpful was used in mixed analysis. The session events Jane identified as most helpful were arranged chronologically alongside Jane's reports of psychological and behavioural symptoms of BN and the strength of the working alliance in an integrated data display (Onwuegbuzie

& Combs, 2010). The most helpful event in each session was emphasized and weekly symptom change was used to provide a context for understanding the possible significance of these events. Later, ratings from the WAI were used to better understand the role of the working alliance in client change.

Evaluating mixed methods research. Validity in mixed methods research requires the use of strategies that address potential pitfalls in data collection, such as an unequal sample size in each strand, data analysis, such as inadequate methods of converging or displays that are difficult to interpret, and interpretations, such as not resolving findings that are discrepant (Creswell & Plano Clark, 2011). For this study, legitimation as described by Onwuegbuzie and Johnson (2006) was the term used to refer to the validity of mixed research. Onwuegbuzie and Johnson (2006) offered nine types of legitimation that can be used to evaluate the validity of mixed research. These strategies were largely adhered to in this study and a select number are described below.

Sample integration legitimation requires that both qualitative and quantitative data be collected from the same individuals. If so, the generalizability of results is enhanced. In this case, Jane was the only individual and both quantitative and qualitative data was collected from her. Although statistical generalizations from the case of Jane to a larger population are not encouraged, collecting both strands of data from Jane enhances the quality of any theoretical or naturalistic generalizations.

Weakness minimization legitimation refers to using the strengths of one approach to compensate for weaknesses in the other. In this study, qualitative data provided contextual and therapy process information to complement quantitative outcome data.

Quantitative questionnaires were used as objective measures of outcome and signposts to better understand the significance of events in the HAT as identified by Jane.

Paradigmatic mixing legitimation can be challenging in mixed methods research because of the antithetical philosophical assumptions that traditionally belong to qualitative or quantitative research alone. Pragmatism, as described by Fishman (1999), was adopted for this study so that competing epistemological, ontological, or methodological stances would not mar the quality of results. Fishman (1999) encouraged a type of pragmatism he described as moderate constructionism. In this pragmatism, it is acknowledged that while there is a true reality, it is not possible to know this true reality. In spite of this, Fishman (1999) argued that theories and practices of use can be discovered. Adopting Fishman's (1999) pragmatism allowed me as a researcher to use both distance and closeness, deductive and inductive approaches, and formal and informal language in a practical way for this study.

The final type of legitimation that will be mentioned is multiple validities legitimation. This type of legitimation refers to safeguarding the quality of individual qualitative and quantitative strands. In this case, procedures such as triangulation of data, supervision, and member checks were used to enhance the credibility of qualitative data, and well-described procedures, sound instruments, and recommended analytic strategies were used to enhance the reliability of quantitative data. The quality of the data and results produced in the individual strands increases the likelihood of quality meta-inferences from combined data. For a more complete description of the types of legitimation that were used as a guide to safeguard the quality of mixed research in this study, see Onwuegbuzie and Johnson (2006).

The Client

At the time of treatment, Jane was a 22-year-old Caucasian woman who met diagnostic criteria for bulimia nervosa (BN) according to the DSM-IV-TR (American Psychiatric Association, 2000). She was a third year university student with a desire to become a lawyer. Jane described herself as tired, lacking in motivation, and apathetic about school. She reported dissatisfaction with her current personal life as well as past family issues she described as significant. Jane suffered from anorexia nervosa between the ages of 12 and 15 and said she had been suffering from BN for about six years.

Guiding Conception with Research and Clinical Experience Support

EFT for Bulimia Nervosa

Difficulties with emotion expression and regulation are common in individuals with eating disorders (Guinzbourg, 2011; Haedt-Matt & Keel, 2011; Pascual, Etxebarria, & Cruz, 2011). Emotions are experienced as painful, unbearable, and overwhelming (Dolhanty, 2006; Harrison, Sullivan, Tchanturia, & Treasure, 2010). To cope, individuals with eating disorders displace negative emotion onto the body which leads to disdain for the self, especially body weight and shape (Dolhanty & Greenberg, 2007). While this is painful, pushing down emotions by binge eating or dispelling emotions by purging provides temporary relief as well as a sense of control (Aldao, Nolen-Hoeksema, & Schweizer, 2010; Dolhanty, 2006). For these individuals, controlling food intake and engaging in compensation are a means to cope with and control otherwise overwhelming emotions (Anestis et al., 2007; Polivy & Herman, 2002). In EFT for BN, binge eating and compensation are viewed as mechanisms of emotion regulation (Dolhanty, 2006).

In EFT, processing emotion by numbing or distracting is viewed as problematic because the valuable information emotions convey is lost. Emotions, in EFT, are viewed as fundamentally adaptive and growth-promoting (Greenberg, 2011a). They provide essential information about the self in relation to the environment, thereby functioning as a signaling system to what is personally important (Greenberg, 2011a). Being attuned to emotions prepares the self to react appropriately to the environment. For example, a woman walking down a back alley may be startled by a shadowy figure quickly approaching. In an instant, she may experience tension creeping up her spine, quickened breathing, and an increased heart beat. These sensations may be labeled as fear, and fear is associated with a need to fight or flee. Furthermore, within parameters, the physiological changes she is experiencing will help her to act. If this woman is truly in danger, fleeing or preparing herself to fight would be highly advantageous. Seeking comfort in sadness or setting boundaries when angry are other examples of adaptive emotion processing.

In the case of eating disorders, past experiences may have re-organized fundamentally adaptive emotions into maladaptive emotion schemes that have become rigid ways of responding to the world (Dolhanty & Greenberg, 2009). Past experiences of criticism lead to shame, a sense of not being good enough in the other's eyes, and a fear of expressing one's true self. Experiences of rejection, for example a caregiver's emotional disengagement or lack of presence in the home, lead to anxiety or a fear of abandonment. These emotional experiences are painful and become problematic when individuals continue to experience these emotions in changed circumstances. An overall

goal of EFT is to help clients to access and process this painful, stuck emotion to facilitate the transformation of problematic emotion schemes (Greenberg, 2011a).

Goals of Treatment

The first goal of treatment and basis for all other work in EFT is to facilitate a working relationship with the client (Greenberg, Rice, & Elliott, 1993). It is in the presence of an empathic, attuned, and non-judgmental relationship that painful emotions are safe to be explored, tolerated, and transformed (Greenberg, 2011a). With the therapist as a coach, the client is guided towards experiencing and processing otherwise overwhelming emotion (Dolhanty & Greenberg, 2007; Greenberg, 2002).

The second goal of treatment is to facilitate the resolution of therapeutic tasks (Greenberg, Rice, & Elliott, 1993). To achieve this goal, clients are encouraged towards experiential rather than conceptual processing (Greenberg, Rice, & Elliott, 1993). A therapist helps a client to attend to internal experiences, heightens emotion when appropriate, and ultimately works towards creating meaning from the experience. A therapist also support clients in their session-by-session growth, guiding them to take ownership of the shifts within themselves, and encouraging them to participate in therapeutic decisions such as the content of a session or avenues for exploration (Greenberg, Rice, & Elliott, 1993). A combination of experiential processing with emotional arousal and a strong therapeutic relationship are associated with good therapy outcome (Greenberg, 2002).

Therapeutic Techniques

EFT intervention is guided by the client's experience of emotion processing challenges in the session, referred to as *markers* (Greenberg, 2011a). There are two

markers that are particularly salient in clients with eating disorders: first, feelings of self-contempt or criticism towards the self, and second, unresolved feelings towards a significant other such as shame, anger, or guilt (Dolhanty, 2006; Dolhanty & Greenberg, 2009). Feelings of self-contempt are a marker for *two-chair* work. In two-chair work, a client is asked to differentiate between two parts of the self, typically a harsh, unaccepting part of the self referred to as the critic and the part of the self that experiences the criticism, the experiencing self (Greenberg, Rice, & Elliott, 1993). The critic is instructed to berate and attack the self, and through two-chair work, the self eventually experiences primary, adaptive emotions such as anger at a boundary crossing or sadness at loss. This motivates the self to express needs to the critic, for example, to back off. If fully resolved, the critic softens and the two parts of the self that were previously in conflict are integrated and develop a working relationship where the self-protective values of the critic are appreciated and the self becomes a more powerful player in the construction of the self (Greenberg, Rice, & Elliott, 1993; Greenberg, 2011a). In EFT for BN, rather than differentiating the critic from the experiencing self, first the eating disorder is typically differentiated from the experiencing self (Dolhanty & Lafrance, 2011). Therefore, the eating disorder, or some aspect of the eating disorder such as the voice that scares the client into exercising, becomes envisioned as a separate entity. This promotes the discovery and exploration of the feelings and needs of the self with less interference from the messages of the eating disorder.

An intervention referred to as *empty-chair* or *unfinished business* helps to resolve previously unresolved feelings (Greenberg, 2011a). A marker for empty-chair work is the expression of hurt, blame, or longing towards a significant other (Greenberg, Rice, &

Elliott, 1993). In EFT for BN, unresolved feelings are typically towards a mother and sometimes a father. Common themes include attachment and identity injuries (Dolhanty & Lafrance, 2011). Attachment injuries are present when caregivers have been experienced as absent. Children with an attachment injury long to be loved unconditionally and securely but develop a fear of abandonment and shame. In the case of an identity injury, a caregiver is experienced as judging and invalidating. In response, children develop a sense of shame about their unique selves and attempt to become the image of what the parent wants them to be (Dolhanty & Lafrance, 2011). When a marker for empty-chair work or unfinished business is present, a client is invited to bring the imagined other into the room. The chair work is fully resolved when a client is able to express unresolved feelings and associated needs to the other, the other is seen as more positive or less powerful, and the self is able to let go of the unresolved feeling (Greenberg, Rice, & Elliott, 1993). In unfinished business chair work for eating disorders, clients feel and express the pain of early losses to the other and may also come to understand the development of the eating disorder (Dolhanty, 2006).

Phases of Treatment

Three phases of treatment have been identified in EFT for depression: bonding and awareness, evoking and exploring, and transformation (Greenberg & Watson, 2005). These phases also seem to apply to EFT for BN, with possible variations in the timing of progression through the phases.

In the first phase of treatment, bonding and awareness, therapists work towards building a working relationship with the client (Greenberg & Watson, 2005). This is facilitated through empathic attunement and the communication of empathy but also

through agreement on a rationale and focus for treatment. In EFT for BN, a therapist shares her conceptualization of the eating disorder as a mechanism to regulate painful emotion. During this phase, additional psychoeducation including the detrimental effects of eating disorders, defining normal eating, and providing a rationale for exploring painful emotions may be helpful. The other aspect of this first phase of treatment is to increase awareness of internal experience. For individuals with eating disorders, this is inherently challenging. Emotions may have been avoided for years, to such a point that the individual could be characterized by alexithymia, an inability to identify internal experience (Dolhanty & Greenberg, 2007; Guinzbourg, 2011; Troop, Schmidt, & Treasure, 1995). Therefore, in EFT for BN, much time and coaching may be spent on facilitating clients' awareness of their internal experience in this first phase of treatment. A client's capacity to become aware of and regulate their emotional experience impacts the quality of later processing as well as outcome (Watson, McMullen, Prosser, & Bedard, 2011), and therefore much attention is given to this initial work.

In the second phase of treatment, evoking and exploring, the therapist and client work towards evoking problematic emotions, generally embedded in past negative experiences. To evoke emotion, a therapist follows the client's pain compass (Greenberg, 2011b). For example, a therapist pays attention to the client's non-verbal behavior, vocal quality, and word use to discover what is particularly salient to the client. Once evoked, the therapist facilitates the processing of emotion through the use of chair work or other tasks so that clients are able to access primary, adaptive emotions, such as anger, fear, or sadness. In EFT for BN, chair work is frequent, may begin as early as the first or second session, and may be used every session (Dolhanty & Lafrance, 2011).

During chair work or other tasks, a therapist helps clients to become aware of the sensations in their bodies, symbolize them using words, express the emotion, and then identify the associated need.

The final phase, transformation, entails reflecting on experience so that clients are able to develop new self-understandings (Greenberg & Watson, 2005). After engaging in unfinished business with a critical mother and expressing a need for unconditional acceptance, a client with an eating disorder may have a new appreciation of past hardships and experience self-compassion for enduring these hardships rather than shame or self-criticism for not being good enough. In developing new ways of viewing experiences, clients are freed from rigid ways of responding and more able to develop alternative responses, including making alternative decisions about how to regulate emotion (Greenberg & Watson, 2005).

Assessment of Client's Problems, Goals, Strengths, and History

Jane was in her early twenties at the time of seeking therapy for BN. She was binge eating three to ten times a week and engaging in multiple methods of compensation including restricting food to 1600 calories a day, weekly laxative use, exercising two hours every day, and attempting to vomit about three times a month. After binge eating, Jane would exercise for an additional half hour. Jane reported rarely eating an entire meal, but would instead eat small portions of food throughout the day. She typically ate the same foods for breakfast, lunch, and dinner. Jane shared feeling apathetic, irritable, fatigued, and lacking in motivation over the last year. She reported sleeping only six to seven hours a night and waking up frequently over the course of a night.

Jane was a high-achieving student with a desire to attend law school. She enjoyed playing volleyball and competing in triathlons. Jane reported having a few close friends and a boyfriend, but said the eating disorder took away time she would rather spend with these individuals. She liked the idea of eating out or going for drinks with friends, but even the idea of consuming unknown calories was very stressful for her. Jane therefore declined invitations to join friends for lunch or drinks on the weekend, and if she did join friends, she would typically tell them she had already eaten.

Jane was living at home, but also spent time house-sitting for others on holidays for a week or month at a time. Her mother, father, older adopted brother, and younger sister also lived at home. She described her mother as a diva with a tendency to over-exaggerate, not respect boundaries, and compare Jane's accomplishments to her own. Her mother was a medical doctor and had a history of depression. Jane's father managed a large construction company. She reported having a better relationship with him than with her mother. Jane described her father as an inspiration because he had been an alcoholic during her childhood but had been sober for 12 years. Jane had an older adopted Vietnamese brother. She described him as volatile, an excessive drinker, and a drug user. Jane shared that she tried to avoid contact with him. Jane's reported that she did not have a strong relationship with her younger sister, largely due to the ten-year gap in their age.

Jane had a history of anorexia nervosa which began when she was 12 years old. This was during a time that Jane experienced bullying at school and also when her parents were contemplating divorce and Jane's mother inappropriately confided in her regarding the details of their marital struggles. Jane said she attended a hospital-based in-

and out-patient anorexia nervosa treatment program for approximately three years. After this time, Jane reported the eating disorder turned into something more closely resembling BN. The only other therapy Jane sought in the past was a few sessions of what she described as family-based therapy where she and her therapist discussed the dynamics within her family. She reported that her family did not attend these sessions.

Client Strengths and Goals

While Jane typically pushed down emotions outside of therapy, she was able to attune to her internal experience early in therapy and showed no signs of alexithymia. Her ability to access and label her internal experience allowed us to explore her emotional experience relatively quickly. Jane also had the capacity to reflect on past experiences and connect these to current emotional or interpersonal challenges in her life. Another strength Jane brought to therapy was her motivation to change. She had struggled with an eating disorder for ten years and was "fed up with obsessing" and tired of the control it had over her life. Her goal was to obsess about food and exercise less and to get rid of the eating disorder.

Formulation and Treatment Plan

In EFT, it is important to develop a focus for treatment, however, case formulation and treatment planning is not based on early assessment but rather on the moment-by-moment unfolding of the client's experience (Greenberg & Goldman, 2007). In being with the client, a therapist discovers what is most salient to the client, makes process diagnoses regarding emotional stuck points, and then guides the client's focus to what seems to be important in that moment (Greenberg & Goldman, 2007). The client's core pain is followed as a guide to developing a treatment focus.

Early in therapy, several markers for important therapeutic work emerged. Jane was very critical of herself for having the eating disorder, not working harder at school, and not finding more time to spend with friends. She strived for perfection in appearance, eating habits, school, and athletics. Jane shared feeling tired of the eating disorder, yet talked about feeling the need to "hold the image up" and the fear of others' judgments if she gained weight or was not at the top of her class. There was a sense that she was her worst critic, and by holding herself to her own standards, she protected herself from the criticisms of others.

Interpersonal problems with her mother and father were revealed over the course of therapy. Jane described her mother as a diva who lacked boundaries in their relationship. She was able to share that her mother was competitive and made comparisons between her own and Jane's accomplishments, but after expressing negative thoughts and feelings about her mother she was often overwhelmed with guilt. The guilt, a secondary emotion, seemed to conceal and block the processing of anger, an emotion that would have been helpful in setting boundaries, and it also seemed to block the processing of sadness around missing out on having a mother who loved her unconditionally. Jane typically spoke fondly of her father, but eventually expressed feeling unsure of his love for her because of his emotional distance. After such expressions of longing for love from her father, Jane was also overwhelmed with guilt.

Based on the over-arching goal of treating the eating disorder and my conceptualization of the eating disorder as a mechanism to regulate emotion, primary treatment objectives were to help Jane become aware of her internal experience as an important signaling system, explore the impact of the critic on the self, and process

blocked emotion in what I understood as an identity injury with a critical mother and an attachment injury with an emotionally absent father.

Course of Therapy

Seventeen weekly therapy sessions occurred over five months. The three phases of treatment are described below with descriptions of sessions from the beginning, middle, and end of therapy embedded within these phases. Excerpts from transcripts are included. Punctuation indicates the flow of spoken words and was not corrected for proper grammatical style. The letters "T" and "C" are used to indicate therapist and client.

Phase 1: Bonding and Awareness

Session 1

The session began with Jane talking about two days in the previous week when she could not exercise because of admission interviews for law school. Jane said what made it especially stressful was that she felt out of control around food and worried about not having time to burn off excess calories if she over-ate. She described a binge episode where she felt called to over-eat: "It would like just call me basically, like, 'The potatoes are there. You should have like a couple. They look so good.' " Jane also described feeling "obsessive" about food and compensation, and expressed frustration with these consuming thoughts as well as anger at herself for engaging in this cycle.

I wanted to become more aware of the sequence of experiences that preceded an episode of binge eating, and therefore asked Jane to recall the last time she had eaten what she had considered to be a large amount of food. Jane shared an episode of over-eating a few days earlier that had been preceded by feeling very tired and overwhelmed

with the demands of school. She described eating as "numbing". Jane then continued to share how she often wished to sleep in, watch television, or say no to the requests of others for help, but felt compelled to stick to a rigid schedule of restricted eating and frequent exercise. It seemed that Jane was torn between two parts of herself: a part that felt tired of the demands of the eating disorder, and another part that wanted to maintain the high expectations for success she had set for herself. I noted this as a marker of internal conflict and guided Jane towards separating these parts of herself.

T: It sounds like this is really a struggle for you, like there's this part of you that's pushing yourself, pushing yourself and, and going to the gym and, and working hard and setting these strict schedules and then there's this other little part of you that's starting to say like, "Jane, I'm tired. Jane, I don't want to be doing all this all the time. I like parts of it but it's like, a bit much for me," or something.

C: Yeah, I think that's – I didn't really think of it that way but I think that's a good way to think of it. Like, and when you say that, it makes me think of this year, like in school, I found I don't have as much motivation, and I just, f-feel like it's maybe the part of me saying that – so much, I push myself so much to get these marks and like, bad, that some of me kind of says like, "You know what, it's not always that fun to study" like…(voice quivering slightly).

T: Right, right, like, "I want to have a little bit of fun. Let me have a little bit of fun or relax a little bit or something.

C: Mmhmm.

T: Yeah, that was painful for you to think about, to like have that part of you so tired.

C: Yeah, and it makes me feel kind of weak sometimes that it's like I can't…

T: Weak.

C: Because, no because, I know, I guess maybe not really weak in the sense of just how different people would see it. Before, I guess I should explain it – more of how I feel like that. I know that it's understandable, that it's perfectly logical that I can't do all of that, but I feel sometimes that other people see me as, "She does everything, oh, she's so, amazing" and, and okay, people don't come up to me and describe me as amazing all the time, but it's some – having like a good resume, good marks and like always having, you know, f- ma-making time for other people and boyfriends and friends and family that other people see that and are impressed and they kind of like that too so that's also a drive. It sounds superficial but…

T: It's almost like, 'good girl'. Is that a way to describe it?

C: Yeah, like, "Hold the image up".

T: Yeah, yeah, and other people kind of admire that. It's like you're on this pedestal because you set yourself apart in some way.

C: Yeah, and I do like being able to do all these things, but then sometimes, it's like, "Okay, well, something has to give" like "This a-all cannot happen at once".

T: Right, right. It's like, "This is good to have", but there's that part of you saying, "This is too much. I can't keep on doing all this". Is that kind of what…

C: Yeah, that's, pretty much it. Yeah.

Very quickly in this sequence, Jane's experience deepened when she connected with the part of her that did not want to spend so much time studying. Jane's ability to pay attention to her emotional experience this early in therapy made it easier to

understand her experience and some of the areas in which she seemed to be stuck, for example, feeling weak when she was tired. The themes of perfectionism and finding identity through being the "pretty" and "smart" girl who excelled at everything developed over the remainder of the session.

Jane later shared an 'aha moment' when she made the connection that being perfect was a way to please others and therefore avoid conflict and judgment. For example, Jane described her brother as an explosive child who would yell, scream, and throw things at family members. She said she would do whatever she could to please him to avoid a fight. Jane also shared that she was bullied in junior high because she excelled academically and did not drink or smoke. She said the bullying was especially painful because while she appeared perfect on the outside, those bullying her did not understand how difficult her family life was. Jane reported she denied herself food in order to be skinny so she at least could not be teased for being fat.

To heighten the internal conflict and ambivalence about change that emerged at the beginning of the session, I encouraged Jane to think about some of the advantages of the eating disorder and what she would risk in giving up the eating disorder over the course of the following week. At the end of the session, Jane said that she had enjoyed the session, especially making connections between things in her life, and felt as though we had just "touched the surface".

Session 2

Jane began this session by sharing an unexpected story about how she was able to eat a controlled snack in the evening despite having a mid-term the following day. This was the first time in six months that she had not over-eaten in the evening. Jane noticed

feeling no pride for this achievement, but rather increased stress both the evening before and the following morning. I asked Jane to place herself back in that experience, so we could explore it moment by moment. Jane described picking out the snack the evening before, going to her bedroom, sitting on her bed, and studying. I invited her to attune to her internal experience and she shared how tense and distracted she felt. Jane identified an internal dialogue around how she would do poorly on the midterm if she did not study. While Jane was exploring this, I observed how critical she was of herself for having the eating disorder. She blamed herself for not trying hard enough to get rid of the eating disorder and concluded that she must be lazy. I tried to separate out the binge eating voice so Jane would be able to direct her anger towards the eating disorder.

C: By doing it, it helps me cope but it just makes it worse too because it's the problem and then – but that's part of how I feel guilty. I feel like, well okay, so the cure is food but then the problem is food. But then I feel, I feel guilty and, s – maybe not, not stupid but like, incapable, of like just, just bad that, "Why have I not fixed this?" Like, clearly it's either not of value to me or I don't try hard enough and then all of those things are bad qualities.

T: Right, right. It's almost like the food is like, "Come to me Jane. I'll take care of you". It's like, almost this seductress, almost like – but then later, it makes it so much worse for you. Then you're mad that you're – you've – you fell for it or something.

C: Yeah, cause then you get caught up and it feels so good at the time, but then – or it doesn't feel like anything at the time, which is better, than feeling bad.

T: Yeah, "Jane, I'll distract you. Jane, come and eat. This will, this will distract you in the moment".

C: Yeah, for sure.

T: Ahh, yeah, yeah. And then y-you didn't do that last night, so it's like, those feelings stuck with you and you got up this morning, it's like, they are still here and this is really, uncomfortable.

C: Yeah, well it just made me feel – like I could tell this morning I was like, tense. And, and, um, even last night going to bed I was like not so proud. I was just like, "I do not feel good. I-I feel stressed out," more so than about like my midterm, but yeah.

T: Right, right. So, so, one of the things that you lost so to speak by not overeating last night was this, distraction? And then, there's this uncomfortable feeling after, it's like – trying to figure out how to…

C: Get – like how to, feel better without that.

Here, Jane seemed to follow my view of her struggle with binge eating and did not reject the idea of separating out the binge eating voice from her own experience. She also seemed to agree that binge eating helped to distract or numb out feelings. During the session, Jane continued to criticize herself for not being able to focus, not being able to fix the eating disorder, and for binge eating in secret. I noted these criticisms as markers for two-chair work. Rather than placing her critic in the chair, I wanted to continue working towards externalizing the eating disorder, and therefore invited Jane to place the binge eating voice in the chair and asked her to share with the binge eating voice what it was like to be taunted to eat.

C: Well, it just makes me…feel…really (sigh)…

T: Mmhmm. Feel really…?

C: Really tired and really, upset with myself, that something like – can I say "you" or what not?

T: Yeah, yeah, yeah.

C: You would have all this, control over me (voice starts to break, crying). And it makes me feel, weak too that, I feel like I'm not in control of myself and I feel like I should be stronger, and have the power to say no, and it makes me feel even worse because I feel like I'm wasting so much time at home not doing things to free up other time. I just spend it sitting around, thinking about food or binging, and then wasting hours trying to go to the gym and purge and it just makes it really, bad, and, and then I feel so guilty and ashamed, that if someone ever saw me, or if people knew I did these things. And it just makes it almost impossible to go home because I get afraid that I know exactly what's going to happen.

T: Hmmm, it's like, "I don't feel safe in my own home". I can't rest…

C: Yeah, cause I know I can't control, and when I go home, there's food there, and you just, make me think about it all the time, and I can't think of anything else, and it's not relaxing, and it should be a place where I can go and relax, but it's not, and it's because of that…

T: Like it almost scares me. Like I feel unsafe? Or…

C: Yeah. Well I feel scared about what's going to happen because, just from habits, I know exactly how I'm going to feel when I get there. I'm going to feel anxious, and uncomfortable, and that's not what I should be feeling when I go home.

Jane began processing emotion very early in this chair work. She described herself as feeling tired and then shared emotions such as guilt, shame, and anxiety that I noted as secondary emotions. I tried to refocus Jane on her feeling of being tired as that seemed to be most salient to her.

T: Yeah – tell her how tired you are.

C: Well, I feel really tired. I feel like that you take over all of my time, and that it takes all the time from the things that I want to do and the things I can accomplish. It takes up so much time working out, which makes me physically tired and sore, and then it makes me tired mentally just spending all this time beating myself up about something that I shouldn't even have to deal with, like, this shouldn't even be a problem. And it just, it makes me feel so tired trying to fit your needs, and, it's not – like I know that the real Jane doesn't want that (voice fades and cracks) to take up all that time.

Here Jane showed signs of sadness again. To heighten this, I invited her to share with the binge eating voice what she misses.

T: Right, right. Tell her what you miss in-in losing all that time. Tell her what you miss.

C: Well, I miss lots of things. I miss being able to study, and just be calm and en – and enjoy learning things, and I miss being able to go s-see my friends, and I miss p- f- being able to just work out and enjoy it and not have it be super stressful and not have it be un-fun. And I miss, a lot, being able to just enjoy time I spend with my friends and not (voice cracks) even thinking about food and not having to

cancel on them because, I know I can't handle this situation, and when I could, but it's your fault. Because it's not me.

T: Right, right, right. Tell her that again.

C: (sniff) Well, it's not me. It's you and I don't understand, why you're – you've been like, part of m – part of me. Because I always thought that I would deserve to not have that problem (crying).

T: Right, tell her you don't deserve to deal with this.

C: I don't! And I feel like I dealt with this for so many years and I don't understand why you can't just go away and leave me alone (voice cracks, crying).

T: Right, right, right, right, right (speaking very softly). Yeah, tell her what you need.

C: (sniffs) Wh-what I need?

T: Yeah, what you need from her.

C: I need you to just stop. S-stop taking over my entire life. And stop taking things away from me. Stop (sniffs) taking away the enjoyment of having a meal and stop taking away all my time and mental – all, all my time from my friends, through working out, and through obsessing over food. And I – and I need t-to spend that time doing fun things, and I need you to just stop (sniff) taking it away and making me so obsessed with planning out everything so that it-it's all perfect and works just according to the plan and I need you to stop that so that I can just do something fun once in a while or, or enjoy things.

After sharing what she missed, Jane placed blame on the eating disorder for these losses in her life. During this dialogue, she conveyed mostly sadness, but there also

seemed to be anger emerging from the sadness, especially when she blamed the eating disorder and told the eating disorder she did not deserve this kind of treatment.

After this chair work sequence, Jane shared that she was able to vividly visualize the binge eating voice as another person sitting in the chair. She described the eating disorder voice as a girl who was prettier, smarter, and very mean. She had black hair. I asked Jane if this person was familiar to her. Jane shared it reminded her of being bullied in junior high when she was just trying to be herself. She described how she felt she could not talk about the secret struggles within her family so she had hoped the eating disorder would serve as an outward sign of pain so that others would be caring.

Rather than receiving care and compassion when in junior high, Jane continued to be bullied at school and also was judged by her parents for having an eating disorder. Therefore, to finish the session, I invited Jane to bring her 12-year-old self into the room to share with her what she needed to hear at that time. Jane's voice cracked and the first thing she shared with her 12-year-old self was that she did not have to be perfect and she did not have to try to fix things in her family. Jane continued to tell her 12-year-old self that she did not have to be the best at everything, that she is important, and that, "You are a good person because you're you and it's not because of what you get." Jane shared that she was feeling less tense and more motivated after the session.

Phase 2: Evoking and Exploring

Session 8

Sessions 3 through 7 were spent increasing Jane's awareness of her internal experience in response to the eating disorder. We engaged in chair work with the eating disorder every session and Jane was able to identify feelings of sadness for all the things

she missed out on in life by following the voice of the eating disorder. Partway through these sessions, Jane had recognized that the eating disorder voice was a voice of her own, and we therefore began using the terms eating disorder voice and critic interchangeably.

By session 6, markers of unfinished business with her mother emerged. Jane was able to identify how problematic interactions with her mother triggered negative emotions and at times episodes of binge eating or restraint. We engaged in unfinished business chair work with her mother in both sessions 6 and 7. During this work, Jane expressed sadness that her mother was not more supportive and accepting. In response, the mother in the chair cried, talked about the difficulties she had growing up, and told Jane that she did not appreciate how hard she had tried to be a mother. Jane described this presentation of her mother as "diva mom". The secondary emotion of guilt for making her mother feel bad surfaced during both these pieces of chair work.

In the eighth session, Jane began by sharing a couple of unexpected stories. First, she reported that she did not go to the gym prior to a morning exam, despite typically not skipping workouts on exam days. Second, Jane shared that she cut a workout 20 minutes short. Both of these events were unusual and significant, but Jane reported feeling stressed rather than proud of herself for compensating less over the week. We explored what was going on for her in the moment, and she reported feeling a sense of having to brace herself for something bad to happen. The bad she anticipated was gaining weight, being judged by others for getting fat, and failing at everything. She labeled the tension as anxiety. I conceptualized this anxiety as a part of Jane that was scaring her to exercise, and therefore proposed two-chair work.

T: Can we try something with that, right now? I just, um, want you to come over here to this side (Jane moved to opposite chair) and we've done this already a little bit, but like, I want you to scare her. Be that part of you that scares her?

C: For like the working out or for other things too?

T: Yah, working out. Start there.

C: Well, I mean if you stop one day then you're either going to have to eat way less that day because the amount that you would burn in the gym is equal to quite a bit of food and then you know that you can't even do that, so…then you're probably going to end up that way if you're going to do that, like three weeks, four weeks, that probably, that could be a pound of weight gain, and then that might add up, that would be like 15 pounds in a year, then you add that, and year after year after year after year after year, and then where are you going to be? You're going to be like obese or something, and you're going to be – everybody is going to wonder what happened to you and why you just decided to let yourself go…

T: Right.

C: …and why you just, you know, couldn't keep it up, like that, you, you've got to make it look easy and then if people like see, (voice breaks) see that, they're going to see, they're going to think like, "Oh, she couldn't even do – she must have something really wrong with her. It was so easy for her and she couldn't even do that."

The critic's tone of voice was very matter-of-fact and condescending. Jane's voice broke while conveying the message of the eating disorder and I wondered if she

had begun to experience the impact of the message. Therefore, I asked Jane to switch to the experiencing chair.

T: Right. Right. Right. Okay. Now come over here (Jane switches chairs). What's going on over here now that you hear that? Can you describe to me what is going on in your body?

C: I just feel really like small and really like, like, "Oh, my gosh" like, "This is insurmountable" and like…

T: Tell her that.

C: It just makes me feel like you say these things and that I (sigh), I just like, it just makes me so afraid that what you say is true and that somehow I'm going to end up being (voice breaking) some person who like, nobody wanted to be around and that everyone is just mean to, or be some out of control person, and it just, makes me feel so, really afraid that that would happen, because I don't want that to happen and I do want to look a certain way but, I mean, it just, makes me scared that, (sniffling) that I won't be able to achieve that unless I spend so much time…

T: Tell her about those tears.

C: Well, it just makes me feel like that, I have to, when they say things like that like it makes me feel like I have to spend the rest of my life just working to ach- achieve this, which is silly because it's not even like my goal (crying), like I don't want to be a supermodel, I don't want to be the prettiest person like that's not what's, what I mean to do. Like, I want, I want to be like successful in my career and happy, and I don't know why you can scare me so much into thinking that this is so much more important than spending time doing other things.

T: And tell her what you would miss out on if you have to keep this up.

C: Well, if I have to keep this up, like I might not be able to do nearly as well in school. I won't be able to – I'll miss a lot of time on relationships and I'll also miss a lot of time, just sort of, you know, sticking it to the workout or binging or whatnot (tone of voice deepening and crying stops). It's like, wasting even more time and I'll just miss out on you know, hanging with my friends and when you scare me into not having experiences with them, like going out for dinner or going on a vacation because I can't workout, and I just miss out on so many experiences, and then all the extra time that I spend worrying about it, like when I should be focused in a class or when I miss somebody, focused on what they're doing. All that extra time that I don't get to fully experience.

T: Right. Right. What's going on inside right now, Jane?

C: I just, I would say, I feel kind of like angry. Just like that it's, how can you take so much from me, so much of my time, so much of my – it's not even the gym time. Like if it was just the gym time, that would be different.

T: Right.

C: Even, like it's the, it's the, all the other time I spent worrying and worrying about these things that, (voice softening and breaking) like, probably wouldn't even happen, but it's just like, I just feel like mad that I'm never going to get to fully be in the moment with things, or fully experience things because I'm so busy worrying about something so dumb.

Jane was able to identify feeling small and afraid in response to the part of her that scared her to exercise, and then a new sadness emerged. She expressed valuing

beauty and thinness less than a career and happiness. Jane's presentation then shifted when her voice deepened and the tears stopped. With a simple probe, Jane identified anger towards the part of herself that pushed her. This was one of the first times Jane expressed the adaptive anger that seemed to be boiling underneath the sadness. Jane later expressed a need from this newly experienced anger and told the critic to leave her alone and allow her to think about things beyond food and compensation.

After expressing this need, I asked Jane to switch to the critic chair. Jane began by scaring herself into believing she would gain weight and be unhappy if she stopped working out. The critic then began to talk about the protective role she plays.

C: At least here we keep it, you know, the stress, nobody else has to see it, it's just in your head.

T: Mmmm.

C: But if the stress is then about you, you stopped working out, and I was quiet and then you gained weight, then it not only – it's going to stress you out just as much but then everyone else is going to judge you and look at you too.

T: Right. Grossed out and stressed out by the way you look?

C: Yeah.

T: What's the tone over here?

C: This (sigh) I, I feel like it's, this part of me is kind of like ang- this part is sort of like angry because I feel like I, I have a purpose (voice wavering).

T: Mmhmm.

C: But also, (pause) I don't know, trying to take over but then also feeling like I know it's not, like I shouldn't be in that parts, like…(sigh).

T: So it's like you're, you're…

C: Conflicted, like I, like I feel the fear part of me wants to move, it wants to say back off and just be more, you know, to serve the purposes it's meant to serve.

T: Right.

C: But it just is also afraid of what will happen if it backs off.

T: Right, so there's that part of you that scares you. You're saying it's like still sending that message, but there's a part of it that is like a little worried.

C: Yeah, it's like if I wasn't here you could completely fail.

T: Right. So, so that's the part that scares her, right? But it's, but it's like there's something else that she's like, kind of questioning that message right now?

C: Yeah, yeah, like I feel the part that scares her is like, or is partly questioning itself and knows that like, if I keep doing this, like, like I can't keep it up. But (pause) yeah, just, I, I guess just conflicted, like I want to make everything good and make it so you're scared of the things that are bad, and you don't do anything bad, but then I also notice that I'm so much of a bully…

T: Hmmm.

C: Just you know, like backlash.

T: Right. Can you tell her that?

C: Well, I think that (voice breaks), I think it's clear like in the bingeing and stuff that if I bully you so much, that you just, you can't take it (crying) and sometimes you just have to get away from it, just 'cause its, 'cause I know that it's not so much that other people (crying) are nearly as mean to you as I'm as mean to you and that like, so many other people think you're so much more awesome than I

think you are (crying) and partly that's because I made you so scared of it. I really do (crying). And I also don't want you to end up getting rid of me entirely, because I was so mean.

Here, the critic seemed to soften. She argued that she plays a very important role for Jane, helping her maintain an image of perfection in order to protect against judgment and failure, but at the same time, the critic recognized that she has become something of a bully. Later in the experiencing chair, Jane told the critic she has to bully her less.

In the following excerpt, I noticed that Jane's pleas for the critic to acknowledge her hard work sounded similar to what Jane had said she had wanted from her mother in a previous session. I therefore transition Jane into unfinished business chair work.

C: It just makes me feel so tired (crying) that I put in – tried so hard and then you can't even say good job. You just say like, "You still suck". Like…

T: Right. You still suck. Is this familiar to you?

C: Yeah, I feel that I always sort of think that, like (sniff), I think like (sniff), I feel like I try, even with the working out and things, like I try and make it better, I try to not workout or I try to work out.

T: Right.

C: And people don't see like how hard it is for me, how hard I work.

T: Yeah. How, working so hard and not getting recognition for it, is that familiar to you?

C: Yeah, I feel like, it's like…

T: Is this kind of like mom over here in the chair?

C: Yeah, that like, like working so hard and having someone just, like her saying, like "Well I worked harder because my family had no money".

T: Can we bring mom into it now, because it seems like this is something with mom, right? Something unfinished with mom, right?

C: Yeah. Yeah.

T: Can you imagine your mom in the chair right here? So tell her what it's like to be trying so hard and to never be given the credit for it.

C: Well it just makes me feel so small and tired (crying) and like whatever I do, it's never going to be enough.

T: Right.

C: It's never, it's never enough and whatever it is, you've always done it better or you've done more.

T: Yeah, yeah.

C: And that even if I did it great, it's like not that big of a deal like…

T: Tell her what you're feeling right now? How does this make you feel?

C: Just makes me feel like so defeated and think like, can you not just be – I'm sort of mad. Are you so full of yourself, you just care about what you did? Like, can you put that aside for a second, and recognize what I did and put away your role and just to like you know what, like even in school and stuff, like yes, you have paid money for me to go to school.

T: Mmhmm.

C: You did not write any of my exams.

T: Mmhmm.

C: You did not study any hours for me and I'm grateful for the money and, but can you put that aside for two seconds, just to say, "You know what, good job, like, you worked really hard for that."

T: What do you want? Tell her what you need from her.

C: The things, some of the things I worked really hard at, and I need you to recognize that it's nothing to do with you.

Even though Jane was crying throughout this segment, she began to acknowledge anger towards her mother. She asserted that her achievements had nothing to do with her mother. I got the sense she was trying to claim a separateness from her mother, and a hope to not be judged by her for being different or imperfect. This seemed to highlight the identity injury with her mother. This type of injury can be resolved by the mother conveying unconditional love for the child, in her own uniqueness, as an individual separate from herself rather than a reflection of her own self. Unfortunately, in this session, when Jane was asked to be her mother in the chair, she did not respond to Jane's pain or expressed need. Rather, a response Jane described as typical of her mother emerged.

T: So be your mom right now. How do you respond to that?

C: (pause) I feel like she, like I would say, like, I always tell you you work hard, like I always say, like, you did it, and you, I don't understand how you're thinking that like I didn't validate it and like, I mean, also, when we are talking about things, like we can only be so happy if like, your brother and sister didn't do as well. We can't be overly happy for you or they'll feel bad about themselves.

T: Yeah, yeah, so come back over here, I'm going to switch you quick. So she's sitting over there, "I did say that to you", right?

The response of the mother in the chair was clearly unhelpful, so I asked Jane to move back to the experiencing chair to get a sense of the impact of this message in response to her expressed need. Jane expressed sadness that her mother did not acknowledge her hard work, but also resentment towards her mother for competing with her. After expressing her feelings and reasserting her needs to her mother, I invited Jane to switch back to the other chair. Below is the subsequent response.

C: Well, honestly, I would just be so upset and like I cannot believe you were even saying that I would compete with you…

T: Mmmm.

C: And these things, and I supported you and I did all of these, I, like, drove you to all your, your volleyball practices so you could do that, and I, I made sure that we had food in the fridge and stuff and like, it's not my fault that you feel so unvalidated if like I just, I tried and, and I, you know, you're saying that I don't even validate that you try. Well, I tried to be a good mom and stuff and you just said I was terrible and you're saying that I compete with you and that's just totally misjudging my ethics, like I would never do something like that and I can't believe you even say that about me, like it's so, it's just so rude and so judgmental and…

T: Ah. It's like you're being very rude right now asking for this right now. You're asking for way too much and I can't believe you said that to me.

C: Yeah, and it's so mean to me and you think that I'm the one being mean here, like that is so rude. You're saying that I don't give you anything and you're not recognizing any of the things that I've done for you.

Jane described this response as "diva mom" and said it was familiar to her. I asked her to switch to the experiencing chair to get a sense of how this "diva mom" response impacted her.

T: Right. Right. Okay. Come over here (Jane switches to experiencing chair). So tell her what it was like to hear that – how do you feel right now?

C: I feel like at first I feel really upset and guilty and feel, I'm really sorry. I felt bad that I said that.

T: Yeah.

C: And then part of me, but then, right now…

T: Yeah.

C: I feel bad as soon as she said that but then as soon as I sat in the chair I'm thinking like, I am so mad that you are doing this again and saying, like pulling the same circle of like (sigh), just being completely irrational and I, like, I'm not saying you didn't love me, you didn't, you don't do all these things, I'm just saying that you like, some of the things that you say, they're small, and you probably don't even realize it, but they're really hurtful.

T: Right. Right.

C: And if you could just do that in the future. I, I'm not saying that you didn't love me, I'm not saying that you didn't put in lots of work, it's just that some of the things you said made me feel really bad about myself and made me feel like I was

not wanted or was not, you know, didn't work hard, or nothing I did would ever compare, with, like none of my accomplishments, they're so pale in comparison to yours.

Jane's first reaction was guilt, but here it transformed to adaptive anger towards her mother for grossly misinterpreting her message. I invited Jane to share with her mother what it was like when she responded like a "diva" after her request for acknowledgment.

C: And it might not be a really big deal to you but it is a big deal to me (voice breaking).

T: Tell her that again.

C: It's really important to me, it's really important to me to think that you are someone who thinks I worked hard and not just your competition, or just someone that's, that you want to one up. It would really mean a lot to me (crying) if you just said, you know, "I'm really proud of you. You worked really hard, and you did a lot of these things that I couldn't have done for you, and I'm really proud of you."

T: Right. This looks really sad Jane.

C: Yah, 'cause I just, I imagined her saying that and I just felt like she never said that.

T: Right.

C: I always feel like it's got some kind of extra, "It's because of me."

T: Right. Right. And it's like this is what you longed for.

C: Yeah.

T: And when I was growing up, this is what I longed for.

C: And even with the eating disorder, like it was almost like, "You got better because we did this, and because we made you do this, and because this…". You know, like it's so defeating to have someone just take it all the time.

Here the identity injury surfaced again when Jane expressed how mom took away all of her accomplishments, including her own recovery from anorexia nervosa when she was young. This piece of chair work ended without the mother in the chair shifting towards reconciliation and without Jane seeing her mother in a more positive light. When debriefing the chair work, Jane shared an "aha moment". She came to the realization that she treated herself in the same way that her mother treated her: she never acknowledged her own accomplishments. Jane shared that she hoped to cut some time off a work out or take a break and watch television the following week.

Session 9

This session began with Jane sharing that she had not taken a rest day from exercise over the following week. She reported she would like to get eating "under control" prior to reducing exercise because at this time it felt too threatening to exercise less if she continued to binge eat. While I could have explored and processed her fear of decreasing exercise, I explored what getting eating under control meant for Jane. Knowing Jane's history of anorexia nervosa, I was worried that she might have a desire to restrict food. She quickly reassured me that she was not hoping to restrict, but rather believed she should increase her intake once again, this time from 1800 to 2000 calories a day. What getting eating under control meant to Jane was eating meals consisting of healthy foods over the course of the day and not binge eating.

Jane described how she was tired of eating the same thing for breakfast, "grazing" throughout the day, and never eating a proper meal. She shared how satisfying it would be to eat a meal, especially if she could do so with her friends or boyfriend. Jane told a story of a lunch date with her girlfriends over the past week when she had not allowed herself to order lunch. She yearned for the normal, healthy meals that others seemed to enjoy. Jane and I discussed these hopes and explored what specifically she would like to achieve over the next week. Jane reported she would like to eat a few dinners.

In preparation for this new goal, we discussed again how binge eating seemed to be a mechanism to decrease anxiety. For example, she was more likely to binge eat when stressed about school. In the past when she had not acted on the urge to binge eat, the anxiety persisted and she needed to discover alternative methods to cope. We also discussed how grazing was a method to avoid eating an entire meal and how the eating disorder would likely make it difficult for her to eat dinner. Jane agreed that she would likely feel anxiety if she did not binge eating or graze but rather ate a meal. We therefore discussed behavioural coping strategies such as being mindful of what she was doing in the moment, going out for a walk, and reading a book. After discussing these strategies, I got the sense that Jane was feeling anxious. I invited her to attune to her internal experience.

T: Tell me what's going on for you.

C: Well, I just feel like that, um, inside of my, my core is like is very tense.

T: Right.

C: I guess my legs, I feel like…and I notice playing with my hands which I normally do when I feel uncomfortable.

T: Right. Right.

C: Not that you're making me feel uncomfortable, but the situation.

T: Yeah, and I am witness to this, so it's like somebody, like I am watching this. So that's uncomfortable.

C: And kind of that feeling, um, when you, you hold your breath, like bracing yourself for, like, "Oh my gosh, this is going to go bad. This is going to go bad."

T: Right. Right.

C: And, um, holding that in, I can feel just like my eyes, they feel like they're more going all over the place than in a normal conversation.

T: Yeah. How would you name this emotion? What is it that you're experiencing?

C: I would say that this is like definitely anxiety. Cause this is how I feel like when I get asked a question in class or when I'm getting a test back, or the same feeling, or when I want to ask someone something, and I'm like, "Oh, (deep inhale) I don't know how this is going to go".

T: Right.

C: The same feeling.

T: And maybe even around eating, or like before binge eating or eating generally or whatever…

C: Yeah, yeah, definitely I feel the same way actually, when I – it's not in the beginning of a binge, but in the end of the binge I start to feel that, like, "Ah oh. Ah oh".

T: Yeah, so this is really uncomfortable, right?

C: Mmhmm.

T: Yeah. Have things shifted right now or are things different right now, or is it still…

C: I still feel – I still feel something like that, yeah.

T: Yeah. Okay. Okay. So keep focusing on that. I know it's really uncomfortable and you spend time in your life trying to distract, so keep focusing on that.

C: Mmhmm.

T: I know it's uncomfortable, keep focusing on that, and breathing into those tense places.

C: Mmhmm.

T: And keep paying attention to what's going on in your body.

C: Mmhmm.

T: You can describe it to me if you like.

C: I just um, what was I going to say? Uh, (pause) I feel very much like also my breathing is very controlled and I'm very much like, like thinking about it and um, it's, also that my mind is sort of racing with, or how I feel normally in this situation is all the bad scenarios are coming and…

T: All the bad.

C: …all that sort of fear as well as…

T: What's the bad?

C: Well, for instance, in the binging, it's like, "Oh my gosh. What have I done? What have I done? What have I done?" Whereas this situation when I think about the meal eating, and like, it's, "Oh, my gosh. I just ate all this food". I feel sort of really bad about doing that.

T: Right.

C: Even though it's not bad and it's what I wanted to do, and then I think like, "Oh, I want a snack. Oh, I shouldn't have a snack. A snack will make you feel calmer", and then thinking, "I'm not going to be able to stop. Oh my gosh, I just ate this and then I'm going to binge tonight."

Here Jane was able to notice many different facets of her internal experience including sensations in her hands, legs, abdominal area, and eyes. These sensations seemed familiar to her, and she was able to label them as anxiety. This anxiety seemed similar to the anxiety that preceded binge eating. For this reason, I asked Jane to stay with the emotion for a while. She was able to tolerate this wave of emotion in the session with me, and I hoped this would make her better equipped to tolerate this emotion outside of the session. I noted that Jane was critical of herself when imagining eating a meal, and therefore tried to heighten the voice of the critic in order to move into two-chair work.

T: Absolutely. Absolutely. Yeah, yeah, yeah. And it sounds like some of that anxiety – it was almost like in the background when you said something else is going on, it was like…almost like there's this criticism or something too? Like, "You shouldn't have done that."

C: Yeah. Just because I, yeah, just criticism for having all of that at once and knowing that I often will then binge afterwards and the criticism of like, "Well, you screwed this up and now you're going to screw up again."

T: "You screwed it up. You screwed it up". It's kind of like, "You're a failure", or it's like…

C: Yeah, and just like, then it's like, "Oh you're going to screw up again. Oh, you always screw it up".

T: Right.

C: "You suck so much at this and like you can never change".

The self-critical split is very apparent here. I could have easily launched Jane into two-chair work here, but allowed her to continue to explore this criticism and it's impact on her.

C: Yeah, yeah, and just kind of also, that part of me, even if it's like, "Whatever, even if I screwed it up, like I tried something new, like, I, I tried that", like that, I don't know, just that I'm someone who – I'd like to think that I'm an outgoing person and I think people would actually describe me as a friendly person who is willing to have fun and stuff (voice breaks). But a lot of things, I'm just really scared to try new things (crying).

T: Right. Right. What's going on right now?

C: Well, I just think of like, how, um, sort of sad, like how much fun I have like going out with my friends like, sometimes I don't want to go but then I go and have so much fun (crying) and like my friends are so nice to me and stuff but that, that I just feel so sad that I'm so scared to miss those things.

T: Right.

C: And then I think, sorry, then I think back to like every single day that I've eaten toast and fruit and yogurt and how I feel sort of pathetic, like that I am so scared to do something different or even that like, like…(crying). I don't know, this is something stupid, but I just thought of it, because when I first started university, I

told myself, "You know what, after I write an exam, I'm going to reward myself and I'm going to have a Tim Horton's donut". I never even ate a Tim Bit there…(crying and sniffing). And I had four straight fours in my first year of university and I never even did that. My first and second year.

At this time, Jane was very emotionally engaged and clear about the impact that the critic has had on her life. The story of the donut clearly portrayed how debilitating the critic had become and how much power it had in Jane's life. The self-critical marker for two-chair work had presented itself, and Jane was already processing some of the losses associated with having a rigid critic, therefore, I invited Jane to engage in two-chair work.

T: Can we bring this alive with the critic in the chair now because these are some things, some things that seem really important. I just want to hear you ask this out loud, to that critical part of yourself that's making you feel anxious or like you're a failure. What's, what's going on? Tell that critical part of you what's going on.

C: I just sort of say like, I just feel like, (crying) like, I, I try so hard. People always tell me, like, you know (crying) like, you try hard. My friends are all impressed with me and I know I try so hard because of what I know. Like, I never, like, I sleep like five hours a night and then I'm out at school and I know that I try hard and I get results (crying) but I just wish that it could be (deep inhale) – I know that sometimes you back off and it's happiness, but I wish that there could be something more than that, like a reward or like you know, then, then it would be okay to relax instead of you just saying, "Oh, this is motivation to work towards the next goal", like, then I could just be more in the moment and we could just

celebrate and that you would just stop making me feel that instead of being such a critic, you could be more of a motivator and just stop saying all the things like that I did wrong and need to worry about and instead, relish in some of the things that I tried really, really hard for and that I deserve a break, or I deserve something fun, like that I, that, that I'm deserving of these because I worked really hard (crying) and that it's not just – and I find that you always veil it, like, "Oh now we've got to work so hard for the next thing", like yeah, that's important and it's good motivation, but, it's just, I want to be able to celebrate that thing too and like I worked for that, and I deserve to be happy or have a little break or whatever, like, whatever fits.

T: So what do you need from her?

C: I just want, I understand that as a critic you are important, and I want you to be able to tone it down when the reward happens and for you to just be able to step aside and let me just you know, be, be able to celebrate it instead of just critiquing me and saying, "Okay, well you could have improved. You could have done a bit better", or, "Well I guess this means you need to do something more". Just letting, just stepping back and letting me celebrate that and be in that moment and be happy, or let myself do something else to celebrate.

T: Right. And even for like tomorrow, is there something that you want her to do that you need from her for tomorrow to help you accomplish the goal that you want to?

C: Well, what I want you to do is that, after, I know that after dinner, it's going to be you saying, "Do this", you know, "You're not going to be able to do that", you

know, “You’re not going to be able to not binge tonight or graze or snack”, or whatnot, and I want you just to stop that and just say instead, “Tonight is going to be hard. We’re going to…” and even like you can team up with the planner. We can make a plan of what we’re going to do after dinner, like watch a show and read a book or something, but just not tell me, “You suck. You suck. You’re going to fail. You’re going to fail”. Instead, say like, “Okay, we’re going to team up and we’re going to try hard and we’re not going to graze after. We’re just going to try and do other things”. And instead, motivate me instead of being so negative.

T: Okay. Come over here and see what she says. So what do you say to that?

C: I just (sigh)…I feel like this part of me is sort of, feels a little bit, like I feel a little bit like how my mom felt, kind of like, I do so much for you, like I, you would never get this far without me and I tried like really, really hard to, you know, to work hard in school, to work hard to be nice to people, you know, do all these other things and you just feel that you’re unappreciative. That part of me here feels like that (crying), but then I think that I feel also kind of bad, like (crying) I’m a big bully and sort of like, that, it…that she’s so sad about missing out on other parts of her life and kind of missed out on celebrating lots of things and being really happy (crying) and like I just feel so bad that I made her miss things. And like, right now, I’m thinking of when like, she did like a triathlon and the next day it was just like, “You’re going to get fat. You have to work out the next day”, instead of like “You just did a freaking triathlon! Nobody does that at 20”,

like, “Good job”, and, (sniffling) just that I feel sort of guilty that I didn’t pay attention to those things.

Jane was engaged and needed little coaching from me. She was crying throughout most of chair work and seemed to be grieving the losses she had sustained at the hands of the rigid critic. She also connected with the idea that she deserved to be treated better. When exploring the sadness, Jane acknowledged the important role of the critic while also clearly expressing her needs. This may be viewed as Jane forming a more nuanced and developed understanding of the critic, not simply as a force of bad working against her good, but as a part of herself that is important, albeit in a downsized, more flexible form. When Jane switched to the critic chair, a familiar message from the critic emerged briefly. Interestingly, Jane noticed the similarity between this reaction and that of her mother’s. After this, the critic’s presentation changed quite dramatically. The critic cried as she admitted how hard she had been on Jane and even described herself as a bully. The critic then acknowledged some of Jane’s past accomplishments.

Below, Jane continued speaking from the critic, proposing how she might work with Jane to achieve her new goal of eating meals.

C: I want to say that it’s going to be really hard for me to not be able to criticize you, but I’m going to, try to, just, I don’t really know how, I feel like I’ll just try to not say anything and, or try to say like positive things like that we can do this and try to acknowledge all of your other accomplishments that were, I mean, from an outward perspective seems like it would be so much harder, and that hopefully that will help you feel good about doing these next goals, and good motivation.

T: And so, “I want to make you feel good”, is that…?

C: Yeah. I just, I don't want her to feel so like, anxious all the time. I feel bad that I make you feel so anxious about things like, it's one thing that you feel anxious for a task. It's another thing that you feel anxious about, like a cookie, like, that I feel bad that those things, that I've put those things in such high priority on the list and then I wish that I could just sort of tone it down.

T: Right. Yah, "I'll try to tone it down" (whispering).

C: Or maybe not tone it down, but switch them to being motivating, to being positive.

The critic softened and shared some ideas about how Jane's needs may be accommodated, so I asked Jane to switch to the experiencing chair.

T: Right, okay, let's come over here and see what it's like over here. So first tell me what it feels like to hear that?

C: It feels, it feels, it feels good to hear that you want to be a motivator and I think it's hard because I think that, that, she is such a loud voice in my head.

T: Tell her that.

C: I think, I think that you're so loud in my head, and probably one of the loudest voices.

T: Mmhmm

C: And I would really, really like for you to be more positive because that can only make me feel way better about myself and it makes me happy to know that you think that I can probably do it, and you didn't say anything doubting me, so, I think that, I, I feel good like that it was, that it's not so much of you saying, like, I know you're mad if I say that like, "You're kind of being mean. You're being

annoying", but I feel good that you want to try to motivate me and try to be more positive, and I think that will help both of us.

T: Right. So it kind of feels nice, like she's a bit apologetic and this feels good and there's a part of you that still knows that she's a really strong voice, and she could still hurt you.

C: And a part of me that knows that like, I don't think that I can ever let that go, like that huge critic of myself, but I just feel that that critic can also be a good critic.

T: Tell her that! "I don't need you to go away, I just…"

C: No, and I feel that you're one of the most important parts of me, that that's why I've been so successful at school, in triathlon training, and keeping to like you know, principles I believe in…

T: Yeah.

C: And expressing my opinions, and I don't want that to stop thinking that lots of times it's really important, but I just want you to also be happy for me, and be motivating because I feel so much of the fear tactics, that it only works for so long and I think that we've seen that this year that I have such difficulty focusing because I was just so beat down of being critical and trying to work so hard without acknowledging it.

T: Right. Right. So it's like you have hurt me in the past…

C: I feel like it's with my mom, it's like, "We can move on, just you need to change your tone".

T: Right. Yes. And it's like, "I don't need you to go away. We can move on", it's like, "I value you", or, or it's like, "You are important because you helped me accomplish or stay true to the things that I value…"

C: Yeah.

T: "…like being a good student and helping me and whatever, but I do hope that you can do this – to motivate me in a good way, in a different way that doesn't put me down."

C: Yeah. That's not like so mean and making me feel terrible.

Here Jane expressed a new understanding of the critic as an important part of herself that helped her to live in accordance with her values. She talked about working together and moving forward with the critic if the critic was able to become more supportive. This seemed to suggest that she was moving towards reconciling or at least partially reconciling aspects of the self that had been rigidly in conflict. Jane again made a comparison between her mother and her critic saying that, like her mother, she did not want to discard the critic, but rather had a desire to enter into a more helpful, supportive relationship. Jane ended this piece of chair work by stating she would keep the critic in line. This suggested a much more powerful sense of self and a shifting power differential between self and critic. Jane seemed to have resolved the two-chair work to this degree because she became aware of and labeled her feelings, expressed them to the critic, and identified the needs associated with these feelings. I hoped that with time and repetition, this adaptive processing of emotions would become more automatic and make it unnecessary for Jane to use binge eating and purging as a means to regulate emotion.

Phase 3: Transformation

Session 16

In sessions 10 through 15, Jane and I engaged in chair work regularly, both two-chair work with her critic, and unfinished business with her mother and even her father. Jane was gaining more of a stronghold with her critic and had negotiated increasing her daily caloric intake and eating the donut she had always wanted as a reward for doing well in school. Chair work with her father began in session 10 after Jane identified that her father never verbally expressed that he loved her and she reported guilt for wanting this attention. Themes of an attachment injury with her father evolved over several sessions and during chair work, Jane eventually expressed a need for love from her father. Themes during chair work with her mother included hurt from being blamed for having an eating disorder, and the criticism rather than love she received from her mother.

In session 16, we began by discussing the separation-individuation process individuals navigate in order to develop healthy attachments as well as an intact sense of identity. Jane and I discussed the attachment or identity injuries that may occur if parents are not supportive of their children through this process. We discussed a possible attachment injury with her father, and Jane reported that an identity injury with her mother resonated with her very much.

Jane also reported that she could not remember what she had eaten the previous two days nor could she recall what she had eaten that morning for breakfast. She described her thinking as less obsessive. We celebrated these shifts and the subsequent extra time Jane had to think about things other than food.

Jane then shared a story of becoming angry with her family the previous week. On Thanksgiving Day, when her family was gathered in the living room, her mother had teased her about earning marks in university by being a "brown-noser". In the moment, Jane said she had noticed she was angry and had an urge to "boycott" family dinner by sitting at the table and not eating. Rather, she said she noted her right to be angry and expressed to her mother that the comment had bothered her. With no apology from her mother, Jane said she coped by breathing, removing herself from the room, and calling a friend to talk about how she felt. Jane shared that she was able to eat dinner with her family and even had a dessert, all without binge eating after.

We discussed how well Jane had navigated this situation, yet Jane expressed lingering hurt from her mother's comments. Therefore, I proposed unfinished business chair work with her mother. In the beginning of the chair work Jane noted grinding teeth, a tense jaw, and tight abdomen in the presence of her imagined mother in the chair. She described her mother as seeming powerful, competitive, belittling, and almost like a judge. The emotion she put to her experience was anger, and she was able to express this to her mother with a need for less criticism and more love. Jane then expressed to her mother how hard she had worked to earn her marks and overcome her eating disorder. Jane also shared that she was a sensitive person and criticism hurt. She expressed a longing for a mother who truly knew her. The need coming out of this newly expressed sadness was for her mother to be accepting of her including her emotions and sensitivities, which Jane noted might be quite distinct from her mother's.

Here is an excerpt from the chair work in which Jane expressed what it had been like to have a mother who never acknowledged her hardships.

C: I mean, the other day, when my mom, she made a comment, and I was saying something to you, and you were saying something about how your dad was an alcoholic and blah, blah, blah, and I had no idea about that and I said, "Well, my dad was an alcoholic too." And you said, "Well, you don't know anything about that." Well, yeah, I do.

T: Right.

C: And maybe I don't remember a ton of when he was actually in that, but I sure remember the aftermath.

T: Right.

C: And everything that happened after.

T: Right.

C: And to me, I just think, I feel like she has no validation that my life is kind of hard too.

T: Right. It's just like no validation or recognition.

C: Yeah, like I feel like it was just like, that her relationship with my dad, she thinks that's totally separate and that she thinks the eating disorder was my fault (crying). And it was all like, just like, that I didn't have any problems in my life.

T: Yeah.

C: I just feel like, I don't know (crying) I feel like stupid saying that sometimes, like a rich white girl like saying, "My life is over. It's so hard" (crying). I don't know, I think it was hard.

T: Yeah.

C: And I think that…

T: Can you tell her that? This is really important.

C: … (crying) and it really was hard and you don't recognize that. That it was really hard (sigh) and like, (sigh) that lots, a bunch of my friends have not been through any of the things that I've been through and I, I feel stupid and guilty complaining about that, but I just think that it really was hard and not everybody had to deal with an eating disorder for ten years, not everybody's dad left and then came back and then worked all the time and was never there, and (crying) not everybody's mom was depressed, not everybody's brother threw things at family members and left and was doing drugs in their house and blah, blah, blah, like, not everybody else did that and I just feel like, she thinks that just because there was like oh, a roof over our head and money and like I got to go to volleyball practice that it was fine.

T: Right. Right. So just because you took me to volleyball practice, it doesn't mean it was okay.

C: Yeah, and I just feel like she never knows that but it was actually hard.

T: Then tell her that.

C: I just think you never understand that I actually struggled too.

T: Yeah.

C: And that like people would be, a lot of other people are surprised when I say, "Oh, this is what happened" (sigh). And it just, it just makes me so mad that you don't acknowledge any of what I have been through.

Jane was very assertive in this piece of chair work. While she noticed the guilt and sense of being judged as a complaining rich girl, she pushed beyond this and asserted

that she did in fact experience hardship in her life. The underlying feeling that emerged was anger and she expressed this anger to her mother with a high degree of emotional arousal. Jane continued by asking her mother, "What does it take for me to deserve to feel this way? Like what does it take? 'Cause clearly what I've had happen to me is not enough." After Jane expressed her need for her mom to acknowledge the unique struggles she had endured in her life, I asked her to switch to her mother's chair.

C: To me, I just (sigh), I just feel that I just (sigh), all the things that I experienced are so different from what you've experienced and you'll never know how hard those things were, but I find it hard to understand how hard what you experienced was, and I think that I tried really hard to do what I could to fix things and I thought it was like enough, but I just think that, like I just, I, I don't know, I feel like I'm sorry, that it was really hard for you and that like, I never meant to think (crying) that the eating disorder was your fault and like, I, I, I didn't really think about, I guess how things with me and your dad afterwards would have affected you and stuff. I always knew that things were hard for your brother, but I always thought that you were okay 'cause you never said that something was wrong.

T: Right.

C: And I just, I just feel like that I'm really sorry and that I never really realized how much it impacted you with the things I said, I just thought it was just me being off-handing, making comments and things and (crying) I just, I don't know, I guess I just never really thought about how the experience was for you and…I just sort of thought about it for myself.

Here Jane's mother softened. She cried, apologized, and expressed that she did not understand Jane's experience. I quickly switched Jane to the experiencing chair to explore the impact of this message.

T: Right. Right. Right. Okay. Come over here Jane. Go into your body and notice what's going on right now.

C: Um, I feel a little bit like, I honestly feel a little bit dizzy.

T: Dizzy?

C: But more, not like I'm going to faint or anything, but just more I think like…a little lighter, like I just feel like (inhale and exhale), in a good way, like just that it's been more like…like as if you just, you know, ran a really long race and then you're like, "Ooh, it's done. Oh, my God".

T: Yeah.

C: Um, or after you get in an argument with someone (inhale and exhale).

T: Right.

C: Yeah, I feel sort of…like a big, I don't want to say, just like something big happened. Like I feel it. I want so bad for her to say like, "This is really hard", and that's really all I want (crying), to say like, "I understand how hard it is for the eating disorder. It's like every day you fight it, every day. Like, it never stops".

T: Can you tell her that. That's important. It's so important.

C: Just like I've been trying and trying (crying) and like, I remember it just makes me mad, like you think I've gone on for eight years without it, like you can't, I

have tried so many things, I've tried every, every day I try (crying). Every day I try. Like, and it's just really hard.

T: Right. Right.

C: And I'm glad that you would at least understand that it could be something that's hard, but I try a lot.

T: Right. Right.

C: Every week it's like, "How am I going to try this week? How am I going to try this week?" It's not just, "Oooh, I'm sad about being emotional, and that fact that I feel ill about this", like…

T: It's like this has been so, so exhausting and difficult for me.

C: Yeah, it's just that I have tried. It's just hard to try alone.

T: Tell her that. This is hard to do alone.

C: It's hard to do alone and I feel like you're so judgmental of me that…you consider me weak if I say anything to you.

T: Right. Right. So what do you need from her Jane?

C: I need her to just acknowledge how hard, that I have put in effort and it's just something that is really hard to deal with.

After this segment, we switched one more time to the mother's chair. Jane's mother softened further and expressed to Jane how hard it must be to overcome an eating disorder because she knows how hard Jane works in other areas of her life. Back in the experiencing chair, Jane noted relaxation in her shoulders and jaw and described feeling relieved. This piece of chair work resolved to the extent that Jane had come to see her

mother in a more positive light and also as a human being with her own weaknesses and challenges in life.

Session 17

This was the last session Jane and I had together. At the beginning of the session, Jane reported that she had accomplished what she had wanted in therapy and felt she had made progress, especially with eating. She noted that she was eating over 1800 calories every day, had not binge eaten in two and a half weeks or used laxatives in two months, and was more accepting of her body. Jane also said that she felt more entitled to her emotions and that the critic was not as pervasive or strong an influence. One area she hoped to continue to work on was introducing one rest day into her weekly exercise regime. We engaged in a brief chair exercise with the part of her that scared her to exercise. Jane negotiated with the critic to allow her to take a risk and to "close her eyes" on the one day a week she hoped to not exercise.

Jane noted several times that what she got out of therapy was unexpected. She had expected therapy to be similar to the hospital-based treatment for anorexia nervosa she had received years earlier. What was unexpected to Jane was how little we spoke about food, and she expressed that this was a relief to her. She said that she had always been aware that her problem was not with food, but rather with things going on in her life such as challenges with her parents and the strength of the critic along with the pursuit of perfection. In therapy, she said she did not need someone to tell her she was engaging in unhealthy eating habits. Jane spoke of how validating it was that I recognized the painful life experiences that had contributed to the binge eating and purging. She came back to this theme of having an unexpected therapy experience over the course of the session,

and in the final minutes before closing, shared that while the gains she got out of therapy were unexpected, she believed they would be longer-term gains that she would carry with her throughout her life.

During the session, Jane spoke of longing to tell her parents that she had attended therapy and still struggled with an eating disorder. She believed that sharing this information might be risky, but she wanted to feel closer to her parents and supported by them. Jane spoke of her struggle to assert her own identity with her mother, for her own uniqueness and needs to be recognized, and her desire to express to her directly, "I'm a different person than you, like, I am someone who is more emotional perhaps and that's just how I am". Jane shared how she had become more accepting of her emotions and felt entitled to them, and it therefore felt okay to be different from her mother. She also said she no longer believed emotions were indicative of weakness. Jane shared that this prevented her from eating when she felt bad.

Jane also highlighted the attachment injury with her father. She shared that her dad had texted, "I love you", over the past week, and that this had meant a great deal to her. Jane seemed to have developed a different view of her parents over the course of therapy. She shared that while her parents were at fault for their past behaviour, they too had hardships and did not have exemplary parenting or coping skills modeled for them when they where young.

Jane talked about shifts in her view of herself. Rather than labeling herself as a complaining, rich girl, she saw herself as someone who had endured hardships in her life and who had worked hard to overcome these hardships. She shared a sense of being empowered by this new understanding. Rather than criticizing herself for wasting her

time with the eating disorder, she expressed compassion towards herself for her own recovery process taking time and compared this to the process of grief taking varying amounts of time for different people. Jane also shared several stories of times when she was brave and took risks in her life, for example, she put her mind to gaining 30 pounds when she was recovering from anorexia nervosa, succeeded, never wanted to go back, and now believed she could do it again.

Near the end of the session, I shared a poem with Jane that used clinging to a log in tumultuous water as a metaphor for an eating disorder as a life saving device during times of turmoil. The poem portrayed the slow recovery process after the waters have settled, including first learning how to tread water, then swimming around the log, and then swimming to shore. Jane shared how scary it was to completely let go of the eating disorder, as it had been her life saving device. She believed she was no longer clinging to the eating disorder but at the stage of treading water. At the end of the session, Jane expressed appreciation to me and for her therapy experience. I expressed my appreciation for Jane's honesty and openness during our time together.

Therapy Monitoring and Use of Feedback Information

Therapy was monitored via requesting feedback from Jane during or at the end of therapy sessions. Her feedback regarding weekly behavioural improvements made me feel comfortable proceeding with the course of treatment. Therapy was also monitored through bi-weekly group supervision which included video review and discussion. Supervision sessions aided in conceptualizing the core pains that needed to be resolved in order for Jane to experience relief from the eating disorder. For example, conversations in supervision helped to highlight the identity injury Jane had with her mother as well as

the attachment injury she had with her father. This helped me to notice and work with these themes over the course of therapy. Quantitative data collected at the end of each session was not made available to me until the end of therapy in an attempt to minimize research intrusion and increase the likelihood of honest and accurate reporting from Jane.

Concluding Evaluation of the Therapy's Process and Outcome

Qualitative Indicators of Outcome

At the end of therapy, Jane no longer perceived herself as a rich, complaining Caucasian girl who had an eating disorder because she was too lazy to change. Rather, she connected painful experiences growing up, such as her mother disclosing marital struggles, her father's emotional absence, a difficult brother, and bullying, to her use of perfection and the eating disorder as survival mechanisms. She held her parents accountable for their shortcomings and was also mindful of their own difficulties growing up. At the end of therapy, Jane was engaging in more social activities with friends, had disclosed to her boyfriend that she had an eating disorder, and seemed increasingly satisfied with her interpersonal relationships generally. Jane seemed to be developing a closer relationship with her father and was asserting boundaries with her mother, yet still felt quite distant from them.

At three-months follow-up, Jane reported that she had told her mother about therapy. She reported her mother had not responded like a "diva" but instead had supported her. She had also visited her physician who had prescribed Celexa for anxiety and recommended relaxation classes. Jane reported she was continuing to make progress and was enjoying herself and her life. At six-months follow-up, Jane reported she was doing even better. She reported that she continued to be mindful of her internal

experience, especially when feeling anxious, and confided in her boyfriend when she needed support. She also said she was making many new friends in law school. While she was disappointed she had not completely cut out one day of exercise, she was pleased she had reduced this workout to half the length it had been in the past. Jane reported feeling less guilt and occasionally enjoying high calorie foods.

Quantitative Indicators of Outcome

Visual analysis of data in Figure 3.1 suggests decreased frequency of binge eating from baseline (M = 6.5) to treatment (M = 1.76) with an additional reduction in follow-up (M = 0.5). Frequency of binge eating with a sense of lost control also decreased over the course of therapy from baseline (M = 6.5) to treatment (M = 1.29) with a further reduction in follow-up (M = 0). Effect size analysis of baseline and treatment means indicates a large treatment effect for binge eating (d = 2.66) and binge eating with a sense of lost control (d = 3.24). Level differences, trend, and effect sizes suggest treatment effects, although caution should be used given the limited baseline observations and baseline trend in the direction of treatment (Iverson, 2013; Morgan & Morgan, 2009).

Baseline variability and trend in the direction of treatment is possibly due to a demand function that influenced Jane's behaviour between baseline 1 and 2 measurements. After baseline 1, Jane was aware she would be asked to report episodes of binge eating the following week. In addition, Jane was invited to participate in the study at the time of baseline 1. The potential influence of measurement as well as early treatment effects may have altered the course of Jane's behaviour prior to the commencement of therapy. Despite great variability in baseline data, variability in

treatment and follow-up is not nearly as great suggesting stabilization of binge eating by the end of treatment.

Within treatment, there seems to be two phases indicated (see Figure 3.1). From session 1 through 9, Jane reported binge eating at a frequency that met DSM-IV-TR criteria for BN ($M = 2.89$), yet after session 9, Jane no longer reported binge eating more than once per week ($M = 0.5$). This suggests a clinically significant reduction in episodes of binge eating from the first to the second phase of treatment.

Interestingly, Jane reported episodes of binge eating without a sense of lost control in the weeks after sessions 2 through 8 and again after session 12 and in follow-up. This suggests that in some episodes of binge eating, Jane had an increased awareness of what she was doing and also a heightened sense of agency in regards to whether or not to engage in the behaviour. This increased awareness and sense of control occurred prior to the substantial reduction of binge eating episodes after session 9. This points to the potential importance of increased awareness of one's actions as well as a sense of agency as a precursor to change in frequency of binge eating.

Similar to binge eating, reduced episodes of compensation are indicated in Figure 3.2. Frequency of compensation decreased from baseline ($M = 7$) to treatment ($M = 1.59$) with additional changes in follow-up ($M = 0$). Effect size analysis of baseline and treatment means indicates a large treatment effect ($d = 2.88$). Therefore, treatment may have influenced how often Jane engaged in compensation methods. In addition, variability in data reduced from baseline through to follow-up indicating that Jane's behaviour became more stable over time. Limited baseline observations, baseline variability, and a baseline slope in the direction of treatment make it difficult to interpret

treatment effects. It is possible that early treatment and measurement effects influenced Jane's behaviour prior to the first session of therapy.

In Figure 3.2, the split-middle line of progress (White, 1971) was used to indicate the trend in treatment data for compensation. The split-middle line is calculated by dividing the treatment phase into two halves, identifying the mid-date using a horizontal line and the mid-rate using a vertical line for each half of the treatment phase, and then drawing a trend line connecting the two sets of intersecting lines. The trend line is then adjusted to ensure that 50% of data points fall above and 50% below this line. For a full description of this procedure see Wolery and Harris (1982). The split-middle line of trend estimation in Figure 3.2 indicates only a slight change in episodes of compensation over the course of treatment. However, it is notable that after session 12, variability in the data decreased and Jane no longer engaged in compensation methods more than once per week. In this second phase of data from session 12 onwards, frequency of compensation per week no longer met DSM-IV-TR criteria. In follow-up, Jane reported not engaging in episodes of compensation in the week prior to measurement.

Decreased difficulties in emotion regulation are indicated from baseline ($M = 18$) to treatment ($M = 16.6$) with additional changes in follow-up ($M = 9.5$). This change in means scores from baseline to treatment produced a small effect ($d = 0.44$) indicating that treatment had a questionable impact on emotion regulation. Despite the small effect size, there is a clear downward trend in treatment and an upward trend in baseline data (see Figure 3.3). The split-middle line of progress (White, 1971) was used to indicate this downward trend in treatment data and shows decreased difficulties in emotion regulation over time. This trend seems to continue in follow-up. Again, caution should be used

when interpreting differences between baseline and treatment data given the limited baseline observations.

In Figure 3.3, considerable overlap exists between baseline data for emotion regulation and data from the first 11 sessions of treatment. This early overlap between phases is not uncommon in clinical case studies (Parsonson & Baer, 1992), and in this case does not seem to contradict the usefulness of treatment. Rather, it is possible to identify two phases within the treatment data. Prior to session 11, difficulties in emotion regulation (M = 18.8) were similar to that of baseline data (M = 18). From session 11 to 17, difficulties in emotion regulation decreased (M = 12.8). It is possible that therapy events prior to or in session 11 precipitated reduced difficulties in emotion regulation.

Interestingly, this shift in emotion regulation was preceded by a reduction in episodes of binge eating after session 9, and occurred prior to a reduction in episodes of compensation to once a week after session 12. Therefore, in mid-therapy after sessions 9 through 12, Jane seemed to make substantial improvements in behaviours related to BN and emotion regulation. In addition, a sequential progression of change is indicated: first improvement in binge eating, then emotion regulation, and then compensation.

Integrating Qualitative and Quantitative Indicators of Change

To better understand client change over the course of therapy, especially mid-therapy events that may have precipitated behaviour change between sessions 9 through 12, the HAT was examined alongside quantitative data. After each session, Jane used the HAT to describe the session event she found most helpful, completed the WAI as an indicator of the strength of the working alliance, and also reported on difficulties in emotion regulation and behavioural symptoms of BN from the previous week. This data

is presented in an integrated data display (Onwuegbuzie & Combs, 2010) in Figure 3.4. To explore this data, the most helpful events of therapy were first interpreted alongside difficulties in emotion regulation and behavioural symptoms of BN. Later, ratings from the WAI were used to better understand client change in this case.

The most helpful events in therapy Jane identified in sessions 1 through 5 included vocalizing needs, exploring the adaptive nature of emotions, and engaging in two-chair work with the self and the eating disorder. Overall, the work that was done in these first five sessions focused on Jane's relationship with herself. For example, in the HAT, Jane reported that she found it helpful to learn about her own emotions as well as engage in two-chair work with "my 13 year old self", "my eating disorder", and "the part of me that is the 'planner'". Between sessions 1 through 5, there was no decrease in the frequency of binge eating or compensation and very little change in difficulties in emotion regulation.

In sessions 6 though 12, therapy work seemed to focus on unfinished business with significant others in Jane's life. Out of the seven sessions from session 6 to 12, six involved unfinished business chair work with either her mother or father. In the HAT, Jane identified unfinished business chair work as the most helpful event in four of these six sessions: session 6, 8, 10, and 12. In addition to unfinished business, two-chair work occurred in three of the seven sessions. Jane identified this work to be one of the most helpful events in two of these three sessions: session 8 and 9. There was a high frequency of chair work in these sessions, especially unfinished business chair work, and the nature of this work is explored alongside quantitative indicators of change below.

Session 6 was the first session that chair work with a significant other occurred. In session 6, Jane identified "discussing emotions to my mother" as the most helpful event. This refers to unfinished business chair work where Jane had expressed anger to her mother for not noticing or acknowledging how hard she had worked to overcome the eating disorder when she was in the treatment program for anorexia nervosa and how hard she had worked generally to attain accomplishments in her life. There seemed to be a slight decrease in frequency of binge eating and compensation in the week following this session, yet very little change in difficulties in emotion regulation.

Jane identified the most helpful event in session 7 to be "speaking about primary and secondary emotion". The majority of the work in this session involved unfinished business with her mother during which Jane continually felt guilt. Jane felt guilt when the mother in the chair "fell apart" after Jane expressed sadness to her for not being there. She also felt guilt when the mother in the chair became the "diva" after Jane expressed anger for not letting her feel what she feels. At the end of the session, we discussed guilt as a secondary emotion that seemed to cover the primary emotions of sadness and anger. After this session, there was a slight increase in the frequency of binge eating and compensation as well as difficulties in emotion regulation as compared to the previous session.

In session 8, Jane identified "speaking to the fear mongering part of me and my mom" as the most significant event. The work in this session began with two-chair work with the part of Jane that scared her to exercise and evolved into unfinished business chair work with her mother. Jane noted the parallels between her mother and the critic. Both were very hard on her and failed to acknowledge her accomplishments. In this

work, she expressed sadness that seemed to transform into anger towards her mother for competing with her and putting her down each time she accomplished something new. At the end of this session, Jane seemed to better understand one of the roles of the critic, which was to protect her, but the mother in the chair did not soften. There was a slight decrease in the frequency of binge eating and compensation in the week following this session, yet very little change in difficulties in emotion regulation.

Jane indicated that a two-chair intervention directed at her critic not allowing rewards for her successes was the most helpful event in session 9. After this intervention, the critic softened, apologized for not allowing rewards, and Jane expressed that she was deserving of rewards. It was in the week following this session that Jane did not binge eat for the first time in years. Little change was noted in frequency of compensation and difficulties in emotion regulation.

In session 10, Jane referred to an unfinished business intervention with her father as the most helpful event. In this work, she expressed to her father how painful it was that he was emotionally disengaged. Jane identified the guilt, a secondary emotion, she felt for wanting his attention and expression of love, and then shifted into sadness for the loss of not having a father who attended to her and an associated need for her father to listen and be present. The father in the chair did not soften. Jane again did not binge eat in the week following this session, and a slight decrease in the frequency of compensation was noted, yet little change in difficulties in emotion regulation was evident.

Jane identified the most helpful event in session 11 as acknowledging her personal qualities such as being kind, compassionate, and understanding. During chair

work in this session, Jane expressed to her mother that it hurt her to have only her academic and extra-curricular accomplishments validated and that she longed for her mother to validate her personal qualities, such as being kind. After this work, Jane decided that she herself would validate her own good qualities. In acknowledging her own positive qualities, Jane responded to her own needs that had yet been unmet by her mother. While there was a slight increase in the frequency of binge eating and compensation, it was in the week after this session that Jane reported reduced difficulties in emotion regulation, a change she largely maintained over the remainder of therapy.

In session 12, Jane identified chair work with her father as the most helpful event. In this piece of work, Jane processed feelings of sadness, anger, and resentment towards her father after an event the previous week when he had blamed her for overshadowing his 50th birthday with the receipt of acceptance letters to multiple law schools. The need that surfaced was for love from her father and also for acknowledgement of her as a person. The outcome was a softening of the father in the chair who apologized to Jane for blaming and overlooking her. It was in the week after this session that variability in frequency of compensation decreased. Jane compensated only once per week in the remainder of therapy. Changes in difficulties in emotion regulation and frequency of binge eating were also largely maintained. Overall, while education about emotions and two-chair work continued in these mid-therapy sessions and over the entire course of therapy, sessions 6 through 12 were saturated with unfinished business chair work with her mother and father and Jane indicated in the HAT that these events were some of the most helpful in therapy.

Jane indicated that the most helpful events in sessions 13 through 17 were planning to eat a donut, exploring perfectionism through two-chair work, sharing with the mother in the chair how hard the eating disorder had been for her, and using the last session to express her journey in therapy and future goals. Two-chair work continued at a frequency similar to sessions 6 through 12, yet less unfinished business chair work occurred. Jane maintained improvements she had made in emotion regulation, binge eating, and compensation in these sessions.

Two important aspects of client change in EFT for BN in the case of Jane emerge when examining these reports about the most helpful events of therapy alongside changes in psychological and behavioural symptoms of BN. First, unfinished business chair work with a significant other seemed to play an important role in Jane's recovery. It was after sessions 9 through 12 that the most marked changed in binge eating, compensation, and difficulties in emotion regulation occurred, and it was the several sessions preceding and during these sessions that unfinished business chair work with her mother and father occurred. In segments of this work, there were moments of her mother and father softening. It may have been a shift in the imagined mother or father that aided change. The significance of unfinished business chair work in Jane's recovery is consistent with the literature suggesting that parents, especially mothers, play an important role in recovery from an eating disorder (Dolhanty & Lafrance, 2011).

A second interesting aspect of client change that emerged from integrated data is that emotion regulation seemed to play a role in maintaining therapy gains for Jane. While Jane was able to binge eat and compensate at a reduced frequency without significant change in difficulties in emotion regulation earlier in therapy, it was when a

more dramatic decrease in difficulties in emotion regulation occurred after session 11 that variability in frequency of binge eating and compensation decreased. The capacity to regulate emotion seemed to have helped to maintain change. This is consistent with the literature that suggests that maintaining recovery in eating disorders is closely linked to improvements in the capacity to regulate emotion (Federici & Kaplan, 2008).

The role of the working alliance in client change. The events described above may be linked to the changes evident in Jane over the course of therapy. Moreover, results from the Working Alliance Inventory further inform this picture of client change over treatment. In Figure 3.5, the three components of the working alliance proposed by Bordin (1979) are plotted: agreement on the goals of treatment, agreement on tasks required to achieve treatment goals, and the bond between therapist and client. The total possible score on each of the scales is 28. While Jane reported the bond to be high throughout therapy, agreement on goals and tasks began low and improved over the course of therapy. By session 2, Jane seemed to agree on treatment goals, but did not more fully agree on the tasks required to achieve treatment goals until session 9. Therefore, while Jane had bonded with me early in therapy, she did not at first feel confident that the tasks associated with EFT, for example, exploring her feelings and engaging in chair work, would help her to address current struggles with BN. It is from session 9 onwards that variability in agreement on tasks declines, and also after this time that Jane made significant behavioural changes, first in binge eating, then emotion regulation, and then compensation.

Therefore, it seems that a strengthening of the working alliance, in addition to unfinished business chair work with her mother and father, precipitated behaviour

change. It is also possible that there was a reciprocal relationship between chair work and the working alliance. In engaging in the unfinished business chair work, Jane not only processed emotions and experienced behavioural change but may have become more confident that EFT tasks could address her struggles with BN. This in turn may have freed Jane to participate more fully in the tasks associated with therapy, including unfinished business work, thereby allowing for a deeper therapeutic experience. The changes Jane made mid-therapy during the time of high frequency unfinished business chair work and increased comfort with the tasks associated with therapy highlights the importance of unfinished business chair work and also the importance of the working alliance as a facilitator of change in EFT for BN. It is not surprising that the working alliance may have played an important role in client change. The working alliance has long been known as a predictor of treatment outcome (Horvath & Symonds, 1991).

Reflections on the Case

This is an example of EFT for BN in a good outcome case. While Jane was still working hard to avoid binge eating and compensating at the end of therapy, follow-up data indicates that Jane was able to maintain, and in some cases, make additional changes up until the final measurement at six months post-therapy. Through chair work, the impact of self-criticism was experienced and responded to, and unresolved issues with her parents surfaced and were partially resolved. Even so, complete resolutions were not attained and certain topics that still held pain for Jane were not explored in-depth, for example, past bullying in school and troubling experiences with her adopted brother. Additional sessions to explore these topics and solidify change may have been beneficial.

Limitations

While it is interesting to interpret therapeutic events that may have been mechanisms of change, the complexity of psychotherapy and human change make it nearly impossible to causally link mediators to outcome variables. There is always the possibility of a time-lag between mediators and outcome variables as it may take the client time to understand and implement new ways of being (Greenberg, 1986). Furthermore, there may be interactive or reciprocal relationships between mediators and outcome variables (Jensen, Hougaard, & Fishman, 2013). These limitations guide a clinician and researcher to cautiously draw insights from the chronological sequence of therapy events while being mindful of the therapy as a whole, including the context, therapeutic goals, individual client and therapist factors, and the appropriateness of the timing of interventions.

This therapy was confined by the time limitations of a doctoral research study. The natural ending point of therapy may have been much later. In addition, extra attention was given to this case, given that it was the focus of a doctoral study. This extra attention included journaling, supervision, research, and additional time in case conceptualization. It is unknown how this extra attention may have influenced outcome. It has been suggested that the extra attention is therapeutically advantageous to clients who are the focus of a case study (McLeod, 2010).

The generalizability of case study research is an often discussed topic (see Eysenck, 2004; McLeod, 2010; Yin, 2009). While it is not possible to make general statements about EFT for BN in other cases, this case study provides an example of how a specific theoretical orientation can be applied to a specific client problem (McLeod, 2010). This particular case of Jane illustrates the application of EFT to BN. Therefore, it

can be used to understand the theory and general treatment principles of EFT for BN, which may be applied in other cases (McLeod, 2010; Yin, 2009). Furthermore, in building a collection of case studies, as is the goal in journals such as PCSP, evidence gathers for certain interventions for specific client problems, and therefore the more traditional claims about generalizability of findings may eventually be possible.

Member Check and Personal Statement from the Client

In the final stages of preparing this document and obtaining final assent, a copy of the dissertation was provided to Jane along with a cover letter preparing her for the read. Jane was asked to pay attention to particularly sensitive, possibly identifying information and was also invited to provide feedback on any aspect of the dissertation. This closing procedure is recommended by McLeod (2010) as a way to promote consent and confidentiality.

Jane closely read the document over the course of several weeks and chose to provide feedback via email. She made several suggestions for changes in emphasis, particularly related to several quantitative and qualitative indicators of outcome. Changes were made as indicated and Jane provided final assent for the release of the report. In a final email, Jane enclosed the following personal statement to be included with the report:

> I, the client written about in this case study, have had the opportunity to read *Emotion-Focused Therapy for Bulimia Nervosa: The Case of Jane* by Kendell Deanna Banack. I have been able to provide feedback to ensure the case report is an accurate representation of my therapy experience.

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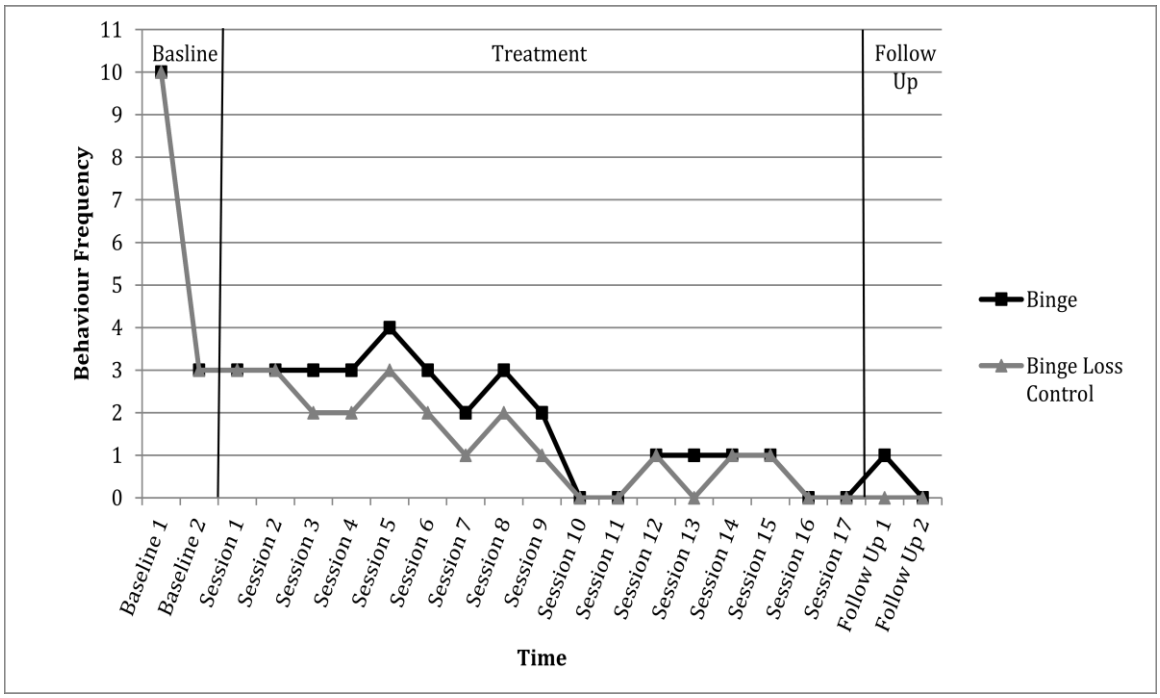


Figure 3.1. Weekly episodes of binge eating and binge eating with a sense of lost control from baseline to follow-up.

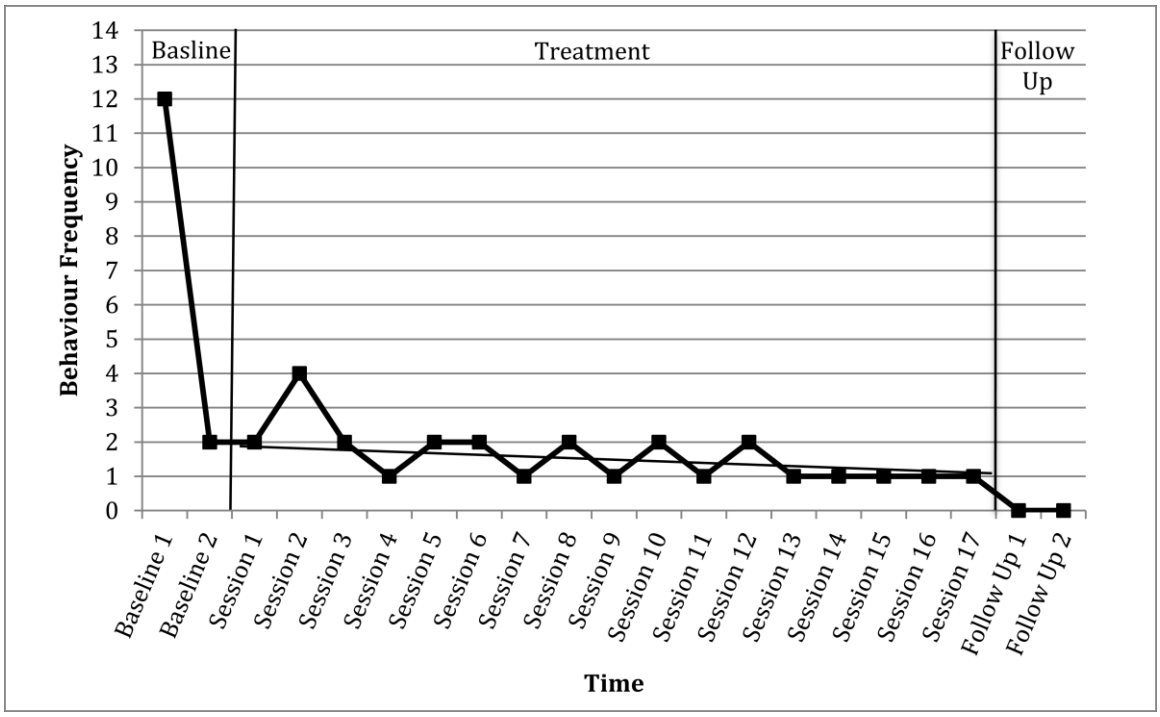


Figure 3.2. Weekly episodes of compensation from baseline to follow-up. The trend line denotes the split-middle line of progress (White, 1971).

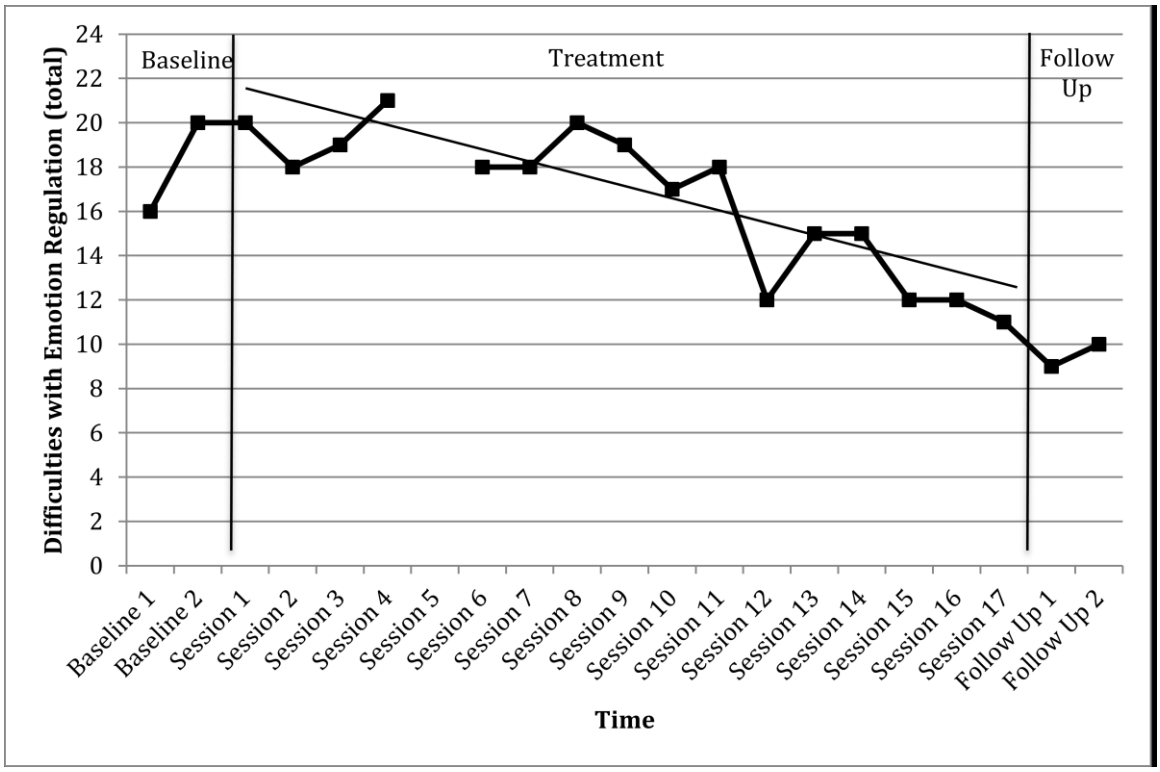


Figure 3.3. Difficulties in emotion regulation from baseline to follow-up. The trend line denotes the split-middle line of progress (White, 1971).

Figure 3.4. Integrated Findings: Session-by-session diagram of helpful events, the working alliance, and outcome data.

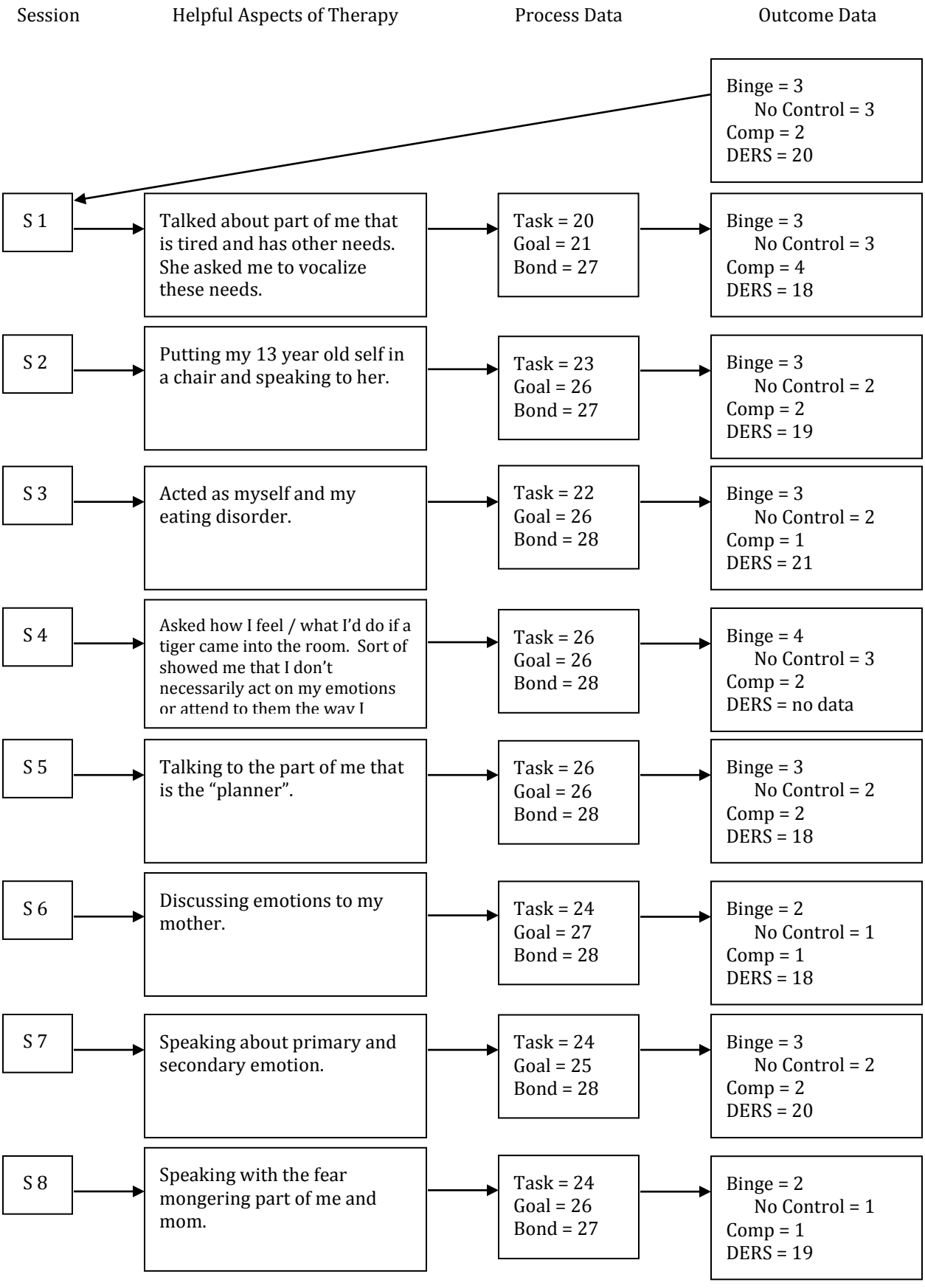
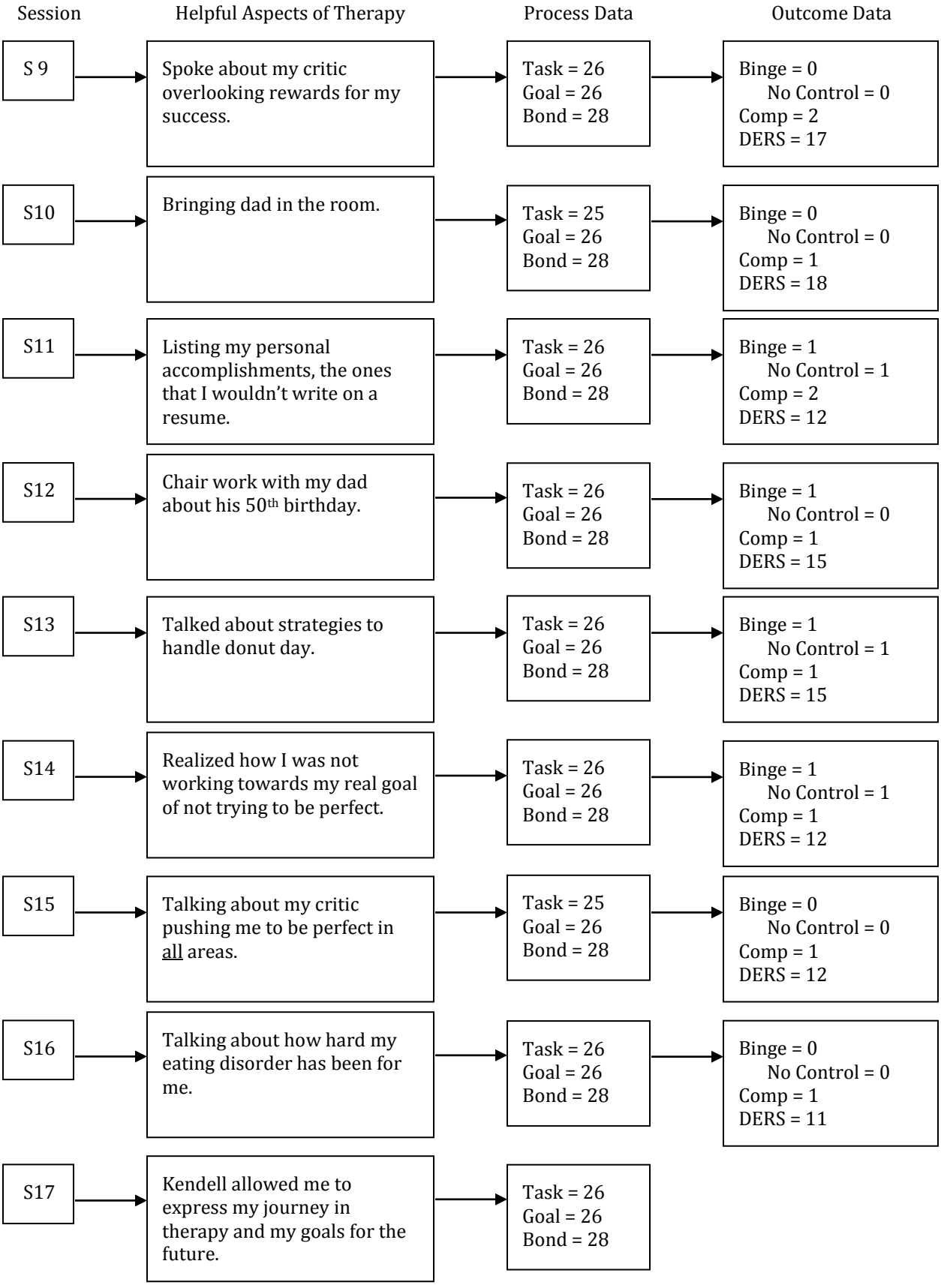


Figure 3.4. continued



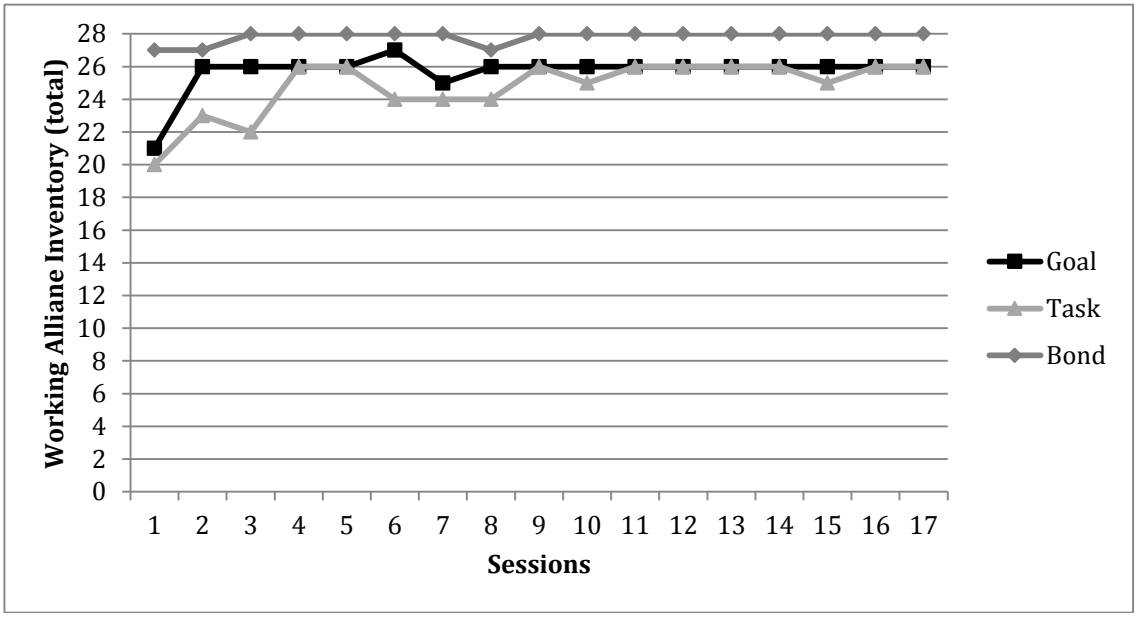


Figure 3.5. Client self-reported subscales of the Working Alliance Inventory across treatment.

Appendix A

Report of Binge Eating and Purging

Please fill the appropriate number in the box on the right. Your therapist will not see this information until you are no longer receiving counselling from her. We are asking you for this information so at the end of therapy we can get a sense of whether there was change in some of your eating patterns. For this reason, please give your most honest answer.

Over the past week, how many times have you eaten what other people would regard as an unusually large amount of food (given the circumstances)? ☐

……..On how many of these times did you have a sense of having lost control over your eating (at the time that you were eating)? ☐

Over the past week, how many times have you fasted, made yourself sick (vomit), taken laxatives, diuretics, or diet pills, or exercised in a "driven" way (or used other methods) as a means of controlling your shape or weight? ☐

Appendix B

Difficulties in Emotion Regulation Scale (DERS)

Please indicate how often the following statements apply to you by writing the appropriate number from the scale below on the line beside each item:

1	2	3	4	5
almost never (0-10%)	sometimes (11-35%)	about half the time (36-65%)	most of the time (66-90%)	almost always (91-100%)

_____ 1) I have difficulty making sense out of my feelings.

_____ 2) I am attentive to my feelings.

_____ 3) When I'm upset, I believe that I'll end up feeling very depressed.

_____ 4) When I'm upset, I feel guilty for feeling that way.

_____ 5) When I'm upset, I have difficulty concentrating.

_____ 6) When I'm upset, I lose control over my behaviors.

CHAPTER 4

A CASE STUDY OF OUTCOME IN EMOTION-FOCUSED THERAPY FOR BULIMIA NERVOSA

Literature Review

Bulimia nervosa (BN) is characterized by episodes of binge eating followed by compensatory behaviours such as vomiting or misuse of medications, enemas, or laxatives to avoid weight gain. Cardinal features of this disorder include over-estimation of shape, over-estimation of weight (Fairburn & Beglin, 2008), and affect dysregulation (Kanakam, Krug, Raoult, Collier, & Treasure, 2013). Current recommended treatments for BN focus on treating over-estimation of shape and weight.

Current treatments that focus on treating over-estimation of shape and weight have been moderately successful (Cooper & Fairburn, 2011; Fairburn, 2008), yet are also associated with low rates of treatment compliance (Palmer, Gatward, Black, & Park, 2000), high rates of attrition (Bulik et al., 2007; Shapiro et al., 2007), and high rates of relapse (Federici & Kaplan, 2008). For this reason, there is a call for effective psychological treatments (Hart et al., 2011; Simon et al., 2005). Emotion-focused therapy (EFT; Greenberg, 2011) has been argued as a suitable treatment for eating disorders because it directly addresses the affect dysregulation challenges inherent in these individuals (Dolhanty, 2006; Dolhanty & Greenberg, 2007; Dolhanty & Greenberg, 2009).

The present study examines pre- and post-therapy qualitative and quantitative outcome data for a young woman receiving 17 sessions of EFT for BN. The goal of the study is to explore psychological and behavioural change in a client after EFT treatment

from the perspective of both the client and therapist thereby providing initial empirical evidence for the use of EFT for BN. This study may help researchers and clinicians alike to better understand the role of affect regulation in BN, thereby promoting an alternative paradigm for conceptualizing and treating BN.

The researcher and writer of this paper was also the therapist in this case. This inevitably created the context for the writer to convey an insider perspective of the case, sifted through her experience of the client. For this reason, the first person is used throughout the paper.

Affect Regulation in Bulimia Nervosa

Difficulty with affect regulation is a hallmark of BN (Guinzbourg, 2011; Kanakam et al., 2013; Kanakam & Treasure, 2013; Kaye, 2008). Affect regulation involves the skills of recognizing, expressing, and tolerating unpleasant emotion (Greenberg, 2011), tasks that are challenging for individuals with BN (Guinzbourg, 2011; Harrison, Sullivan, Tchanturia, & Treasure, 2010; Pascual, Etxebarria, & Cruz, 2011). In the absence of effective affect regulation skills, high levels of negative affect are common in this population (Haedt-Matt & Keel, 2011), and furthermore, individuals with BN have a low tolerance for negative affect (Anestis, Selby, Fink, & Joiner, 2007). The resulting picture is that of an individual regularly experiencing painful emotions and not knowing how to cope.

Not surprisingly, individuals with BN turn to alternative, maladaptive strategies in order to soothe, numb, or push down painful feelings (Aldao, Nolen-Hoeksema, & Schweizer, 2010; Dolhanty, 2006). For example, high levels of negative affect are often antecedents to bulimic behaviours, which provide reliable, yet temporary relief (Haedt-

Matt & Keel, 2011). In a study by Crosby et al. (2009), participants rated mood and recent behaviours at six semi-random intervals throughout the day over a two-week period. On days that participants reported higher negative emotion they also reported increased behavioural symptoms of BN, and further, these behavioural symptoms typically occurred later in the day (Crosby et al., 2009). In a similar study, participants recorded mood and behaviours over three random intervals throughout the day in a two-week period (Engelberg, Steiger, Gauvin, & Wonderlich, 2007). Here too it was found that negative mood preceded episodes of binge eating and purging (Engelberg et al., 2007). Given the close link between behavioural symptoms of BN and negative mood, many researchers have come to understand binge eating and compensation as emotion regulation mechanisms used in the absence of adaptive emotion regulation skills (Anestis et al., 2007; Dohanty, 2006; Polivy & Herman, 2002).

Using binge eating and compensation to regulate emotion does not come without a cost. The cycle is often profoundly disturbing to individuals with BN and associated with high levels of shame (Troop & Baker, 2009). In addition to associated shame, engaging in rigid patterns of eating, binge eating, and compensating take considerable amounts of time and ultimately restrict life activities (Klump, Bulik, Kaye, Treasure, & Tyson, 2007). Not surprisingly, many individuals with BN consider their quality of life to be low (Klump et al., 2007). Furthermore, a plethora of physical health consequences are associated with the illness. These include gastrointestinal, cardiovascular, renal, menstrual and fertility problems, dental, dermatological, fluid, and electrolyte abnormalities, and osteoporosis (Fabbian et al., 2011; Simon, Schmidt, & Pilling, 2005). It has been estimated that individuals with eating disorders are some of the highest

consumers of health care services (Simon et al., 2005; Striegel-Moore et al., 2008). Finally, using bulimic behaviours to regulate emotion shuts the individual off from the experience of both negative and positive emotion (Dolhanty, 2006). This makes it difficult for the individual to connect in a meaningful way to others during social interactions as well as to their own accomplishments and life experiences, experiences that normally would produce feelings of joy, pride, or satisfaction. While temporary relief can be found using binge eating and compensation strategies, these strategies dramatically impact physical health, quality of life, sense of self, and ability to connect with others.

Current Treatments

The role of emotion in the development, maintenance, as well as relapse of eating disorders has long been understood (Bruch, 1978). For this reason, treatments specifically addressing the emotion processing difficulties inherent to this disorder have been recommended (Harrison et al., 2010; Troop, Schmidt, & Treasure, 1995). Some treatment approaches that include aspects of emotion regulation training are acceptance and commitment therapy (Hayes, Strosahl, & Wilson, 1999), mindfulness-based therapy (Segal, Williams, & Teasdale, 2002), dialectical behavioral therapy (Linehan, 1993), and EFT (Greenberg, 2011).

Interestingly, the most widely accepted, researched, and recommended treatment for BN is cognitive-behavioural therapy (CBT; Cooper & Fairburn, 2011; McIntosh, Carter, Bulik, Frampton, & Joyce, 2010). In CBT, the client's over-evaluation of shape and weight is considered the core pathology driving dietary restriction, which ultimately leads to hunger, and in turn, binge-eating and compensatory behaviours (Cooper &

Fairburn, 2011; Fairburn, 2008). Treatment focuses on food and weight concerns and includes regular meal planning and weight monitoring (Fairburn, 2008). While this treatment has found some success, a significant number of clients do not respond to CBT (Federici, Rowa, & Antony, 2011).

In a meta-analysis of treatment for BN including studies on CBT and behavioural therapies (Thompson-Brenner, Glass, & Westen, 2003), it was found that only 32.6% of individuals who entered treatment recovered and the remaining individuals continued to exhibit clinically significant symptoms of BN at post-treatment. In a more recent study, Steinhausen and Weber (2009) reviewed 79 BN treatment outcome studies and reported that 45% of clients with BN who completed treatment fully recovered, 27% improved, and 23% presented with what was described as a chronic form of the disorder. Other challenges associated with current treatments include low rates of compliance (Federici et al., 2011; Palmer, Gatward, Black, & Park, 2000), attrition rates estimated between 6 to 37% (Bulik, Berkman, Brownley, Sedway, & Lohr, 2007; Shapiro et al., 2007), high rates of relapse (Federici & Kaplan, 2008), and complete treatment refusal (Federici et al., 2011). In addition, many individuals develop subthreshold levels of BN following treatment (Berkman, Lohr, & Bulik, 2007).

It is possible that the popular conceptualization and treatment of BN is not complete. It seems that dissatisfaction with weight and shape is not enough to drive an eating disorder. Many women experience body dissatisfaction and do not engage in bulimic behaviours or meet criteria for an eating disorder (Kaye, 2007; Polivy & Herman, 2002). Polivy and Herman (2002) proposed an alternative way to conceptualize the weight and shape concerns so common for individuals with eating disorders. They

suggested that eating disorders emerge when individuals use an obsession-like focus on weight and shape as an attempt to gain emotional control and solve issues of identity (Polivy & Herman, 2002). For example, individuals with eating disorders may attempt to find emotional fulfillment and meaning by pursuing a perfect body, or seek a sense of self-efficacy through mastering control over eating. It is by pursuing emotional control and attempting to solve issues of identity that the sense of self becomes tied up with weight and shape. Having one's identity associated with the eating disorder may be one of the reasons why receiving treatment is so profoundly frightening to an individual in the throes of BN. This may partially explain the resistance to treatment that is so commonly associated with eating disorders.

Current treatments do little to address the affect regulation needs of individuals with BN. This could be related to the poor outcomes and high rates of relapse associated with popular treatments (Thompson-Brenner et al., 2003). In a qualitative study by Federici and Kaplan (2008), clients with anorexia nervosa provided accounts of recovery and relapse after intensive treatment at the Toronto General Hospital. Treatment included inpatient CBT, nutritional rehabilitation, and a manualized outpatient CBT protocol for up to one year (Federici & Kaplan, 2008). At one year post-discharge, the women who had relapsed partially attributed relapse to low awareness and tolerance of negative emotions (Federici & Kaplan, 2008). According to Federici and Kaplan (2008), many of these women reported that they had learned little in regards to identifying and tolerating unpleasant emotion. Similarly, in a study by Kanakam and Treasure (2013) that reviewed the neuropsychological traits of individuals with eating disorders, it was found that affect regulation difficulties persisted in the recovery phase of the illness for

many individuals who had received treatment. In summary, many individuals who have received traditional treatments often continue to suffer from BN post-treatment (Berkman et al., 2007).

Emotion-Focused Therapy for Bulimia Nervosa

There is a call for effective, alternative psychological treatments for eating disorders (Hart, Granillo, Jorm, & Paxton, 2011; Simon et al., 2005; Thompson-Brenner et al., 2003). EFT (Greenberg, 2011) may be a promising alternative. While traditional therapeutic treatments typically focus on the over-evaluation of weight and shape so common in this population, EFT therapists and researchers conceptualize symptoms of BN such as binge eating and purging as methods to manage overwhelming and painful emotion (Dolhanty, 2006; Dolhanty & Greenberg, 2007). By focusing on emotions as the gateway to change, many discussions regarding meal planning and weight monitoring become unnecessary, potentially ameliorating resistance to treatment and reducing high dropout rates. The goal of treatment is to replace the eating disorder with more adaptive emotional processes such as identifying, processing, and regulating painful emotions (Dolhanty & Greenberg, 2009). If emotion regulation strategies are learned, the eating disorder is no longer required as a method to avoid, numb, or sooth painful emotion (Dolhanty, 2006).

In EFT, therapists play the role of emotion coach (Dolhanty, 2006; Greenberg, 2002). Therapists help clients to approach, accept, tolerate, and then symbolize painful emotion using words (Greenberg, 2011). Therapists guide clients to identify the needs associated with emotion so they understand the meaning of emotion in the context of their experience and the action the emotion is mobilizing them to do. For example, if a

client's mother criticized her for not achieving a higher grade in school and the client felt sad, the therapist, as an emotion coach, would help the client to notice and name this sadness and then explore a potential need for comfort. Tolerating painful emotion in this way and learning to regulate it in the context of an empathic relationship helps to transform the emotion (Greenberg, 2011). This promotes resiliency in the client to better cope with painful emotion in the future.

Tasks to facilitate the transformation of emotion include working with self-interruptive splits to promote clients' understanding of how they shut down their feelings, two-chair work to resolve conflicts with the self and promote the development of a more compassionate stance towards the self, and unfinished business chair work to resolve previously unresolved feelings (Dolhanty & Greenberg, 2007; Greenberg, 2011). EFT treatment is consistent with recommendations to employ approaches that directly promote the identification and expression of emotions for the treatment of eating disorders (Crosby et al., 2009; Engelberg, Steiger, Gauvin, & Wonderlich, 2007; Troop, Schmidt, Treasure, 1995).

Purpose of the Study

The present study examined pre- and post-therapy qualitative and quantitative outcome data for a young woman who received 17 sessions of EFT for BN. The goal of the study was to explore whether change on measures of general distress, eating disordered behaviours and concerns, and emotion regulation occurred over the course of therapy, and further, to understand client and therapist's perspective of change. There is only one known published empirical study of EFT as a treatment for eating disorders. It is a qualitative case study examining EFT for AN (Dolhanty & Greenberg, 2009). The

current study is unique in its focus on BN, inclusion of the client's perspective of therapy, and the mixed method design guiding data collection and analysis. It seeks to describe the outcomes of an original and promising approach to the treatment of BN with the hope of illuminating new and effective ways of treating this disorder.

A mixed method case study format was chosen because it allowed for the flexible and feasible observation of complex human phenomenon in a case where there were many variables of interest and multiple sources of evidence (Creswell & Plano Clark, 2011; Stiles, 2007; Yin, 2009). This study was guided by the following questions:

- Qualitative question: How does the client understand change from pre- to post-therapy and to what does she attribute change?
- Quantitative question: To what extent do psychological and behavioural symptoms of BN change from pre- to post-therapy?
- Mixed methods questions: To what extent do the client's interpretation of change and quantitative indicators of symptom change converge or diverge? To what extent does the therapist's interpretation of symptom change converge or diverge with qualitative and quantitative client reports of symptom change?

Due to the in-depth nature of case study research and the large amount of personal information gathered from the client, certain peripheral facts of the case were changed to protect client confidentiality.

Method

Design

A convergent parallel mixed methods design was used for this study (Creswell & Plano Clark, 2011). In this design, both quantitative and qualitative data were

independently collected in the same phase of research and then independently analyzed prior to merging for analysis and interpretation. Equal priority was given to both qualitative and quantitative data. The convergent parallel mixed methods design was selected in order to obtain a more comprehensive understanding of the topic given the complexity of the research problem (Creswell & Plano Clark, 2011).

Procedures

Preparation of therapists and supervisors. Three therapists at the PhD level of training in counselling psychology participated in the study. All were advanced female doctoral students with clinical experience in eating disorders, and two were registered psychologists. Two senior registered psychologists provided bi-weekly group supervision. The first was a university professor of counselling psychology who obtained his PhD from York University with Dr. Leslie Greenberg as supervisor. The second was a clinical supervisor for graduate students with over 20 years of experience who practiced from a variety of theoretical orientations such as hakomi, CBT, and EMDR. In terms of biases, all three therapists and two supervisors reported favoring experiential-based therapy approaches, with three of the five team members describing EFT as their primary theoretical orientation. To facilitate a common understanding of EFT, the team met for five seminars prior to the commencement of therapy. These seminars involved didactic components, video review, experiential practice, and discussion with special emphasis on EFT as it applied to BN.

Client recruitment. Recruitment posters were posted across a Canadian university campus providing information about BN and asking those interested in participating in a free therapy study to contact the principal researcher. Nineteen women

responded to the posters and engaged in an initial phone conversation with the principal researcher in order to assess for basic inclusionary and exclusionary criteria. See Appendix A for the telephone screening. Inclusionary criteria included participants who (a) were 18 years old or older, (b) met DSM-IV-TR diagnostic criteria for BN at the time of assessment, (c) reported a BMI between 18 and 35 kg/m2, and (d) provided consent for participation in this study. Exclusion criteria included (a) the presence of a psychotic disorder, (b) imminent risk of suicide, (c) current substance abuse or dependence such that the substance use was the primary need for intervention, (d) a BMI less than 18, and (e) an intention to obtain other psychological treatment while participating in this study.

Of the nineteen women, nine were interested in participating and met basic criteria for the study. The remaining ten were provided referral information. In the second phase of screening and assessment, each woman met individually with the principal researcher for a standard intake interview to further assess inclusionary and exclusionary criteria, symptoms of eating disorders, and to gather basic information about presenting issues, physical and mental health, and social adjustment. These interviews typically took one hour. After the interview, individuals were invited to complete the Eating Disorders Examination Questionnaire (EDE-Q 6.0; Fairburn & Beglin, 2008) to assess key behavioural and attitudinal features of eating disorders, the Symptom Checklist-90-Revised (SCL-90-R; Derogatis, 1992) to assess for psychiatric symptoms and distress, and a six-item version of the Difficulties in Emotion Regulation Scale (DERS; Gratz & Roemer, 2004).

Five of the nine individuals met study criteria and were invited to participate. The remaining four individuals were provided referral information. Prior to the

commencement of therapy, the five selected participants met with a member of the research team for a thorough discussion of study procedures and to obtain informed consent. It was at this time that participants completed the pre-therapy interview and the remainder of the pre-therapy questionnaires. Five individuals, rather than one, were invited to participate in order to account for possible attrition as well as to decrease pressure on clients to continue participation in research or complete the entire course of therapy.

Selecting a case. Analyses of pre- and post-therapy outcome for each of the five participants indicated improvements in general psychiatric distress, depression, eating disorder attitudes and concerns, binge eating, compensation, and emotion regulation. In theory, any one of the five participants could have been selected for an in-depth study, yet certain complicating factors in some of the cases guided the selection process. For example, personality disorders, cultural factors, and histories of sexual abuse were additional aspects of the lives of some of the participants. While these factors are not uncommon in cases of BN and interesting, I wanted to closely examine EFT in as pure a case of BN as possible, and therefore selected Jane for this case study.

In many ways, the case of Jane is an interesting and representative case of BN. For example, Jane was a Caucasian woman from a high socioeconomic background (Guinzbourg, 2011) with parents who responded to her emotional reactions in ways that were not always growth promoting (Dohanty, 2006). Furthermore, she had a history of anorexia nervosa, and after early intervention and partial recovery, she later suffered from BN. This is a very common cross-over pattern in the course of eating disorders (Vaz-Leal, Santos, García-Herráiz, Monge-Bautista, & López-Vinuesa, 2011), and a pattern of

particular interest to me given the additional associated treatment complications for individuals with BN and a history of anorexia nervosa such as frequent hospitalizations, lower BMI, and poor treatment response, possibly due to the retention of characteristics such as perfectionism from the previous disorder (Vaz-Leal et al., 2011). Finally, Jane was also of interest because I was the therapist for this particular client and therefore had a far more complete sense of her therapy experience.

Therapy. Jane received 17 sessions of therapy over the course of four months. While brief, the session length was modeled after a study of CBT and pharmacotherapy for women with BN and a history of anorexia in which clients attended 19 sessions over 20 weeks (Vaz-Leal et al., 2011). EFT was the form of treatment used. Therefore, symptoms of BN, such as binge eating and purging, were conceptualized as methods to manage overwhelming and painful emotion (Dolhanty, 2006; Dolhanty & Greenberg, 2007).

My general treatment goal was to help Jane become aware of, identify, process, and regulate painful emotion so that she would no longer require the eating disorder to avoid, numb, or sooth painful emotion (Dolhanty & Greenberg, 2009; Dolhanty & Lafrance, 2011; Greenberg, 2002). When expressing emotion in therapy, I aimed to guide Jane to express previously shut out primary emotions, a person's most fundamental, innate, and direct reactions to a situation (Greenberg, 2011). Prominent techniques used to promote the exploration and transformation of emotion included two-chair work with self-critical splits and self-interruptive splits to resolve conflicts within the self and promote the development of a more compassionate stance towards the self. Another frequently used technique was unfinished business with Jane's mother and father

to resolve previously unresolved feelings and experiences of shame (see Dolhanty & Greenberg, 2007; Greenberg, 2011).

Therapeutic work in EFT depends on and demands a strong working relationship between therapist and client, and as such, the first treatment phase emphasizes bonding and emotion awareness (Greenberg, 2011). It is within the context of a safe and validating relationship that a client begins to trust the therapist as a coach and guide during painful exploration of emotion. In the beginning stages and throughout therapy, I sought to build a trusting relationship with Jane and regarded technique as secondary to this goal.

Measures

Qualitative and quantitative data was gathered at pre- and post-therapy. Follow-up quantitative data was gathered at three- and six-months. No qualitative follow-up data was gathered at three- and six-months for feasibility reasons. For a procedural diagram of data collection, please refer to Figure 4.1.

Qualitative indicators of outcome.

Pre-therapy interview with client. The pre-therapy interview was adapted from the Change Interview from the Network for Research on Experiential Psychotherapies (www.experiential-researchers.org/). The purpose of this interview was to understand Jane's hopes for therapy and how she perceived her problems. The pre-therapy interview was semi-structured and conducted by a member of the research team who was not the therapist. A sample protocol is provided in Appendix C. This interview was conducted a week prior to the commencement of therapy.

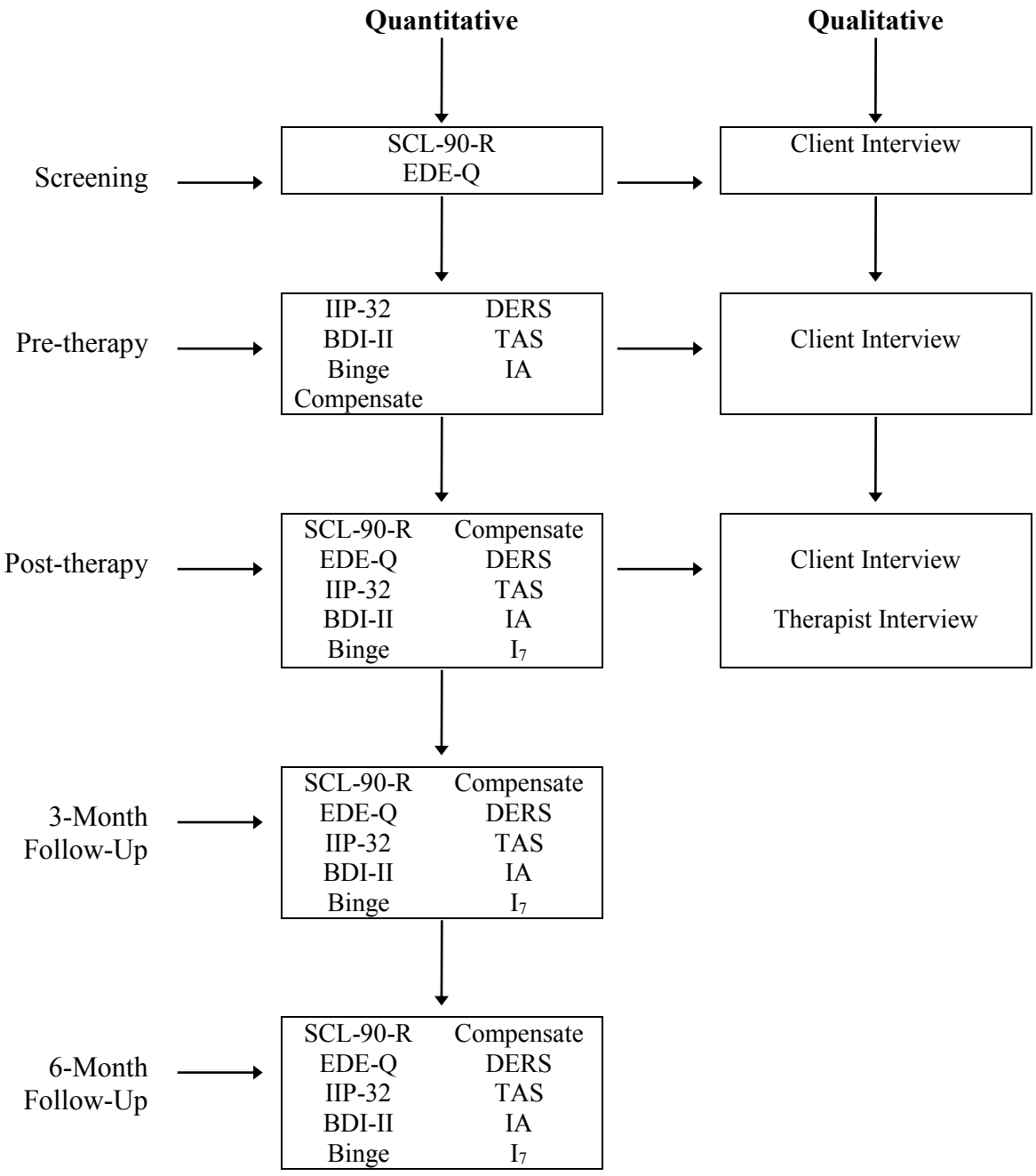


Figure 4.1. Procedural diagram of data collection. SCL-90-R = Symptom Checklist-90-Revised; EDE-Q = Eating Disorder Examination Questionnaire; IIP-32 = Inventory of Interpersonal Problems-32; BDI-II = Beck Depression Inventory-II; Binge = episodes per week; Compensate = episodes per week; DERS = Difficulties in Emotional Regulation Scale; TAS = Toronto Alexithymia Scale; IA = Interoceptive Awareness Scale of the Eating Disorders Inventory – 2; I_7 = Eysenck Impulsiveness Questionnaire.

Client Change Interview Protocol (Change Interview; Elliott, Slatick, & Urman, 2001). The Change Interview is a semi-structured interview meant to be an empathic exploration of the client's experiences of change (see Appendix D). While flexible, the semi-structured format focused the interview in order to avoid the accumulation of an overwhelming amount of data, which is common in post-therapy interviews (McLeod, 2010). This interview included client ratings of change for (a) how much change was expected, (b) how likely change would have been in the absence of therapy, (c) how important the change was, and (d) how the client explained the cause of the change (Elliott et al., 2001). The interview typically requires about 30 to 60 minutes. A member of the research team who was not the therapist conducted the interview in the week following the final therapy session.

Exit interview with therapist. The post-therapy interview with the therapist was adapted from the Change Interview (www.experiential-researchers.org). A sample protocol is provided in Appendix E. This interview was designed to get a sense of the therapist's perspective of therapy, including how the therapist perceived the client, what changes the therapist had noticed in the client from pre- to post-therapy, as well as a description of the therapist's theoretical orientation. This interview was conducted by a member of the research team in the week following the final therapy session.

Qualitative data analysis. Pre- and post-therapy interviews were transcribed by two undergraduate research assistants. After therapy termination, the principal researcher checked the accuracy of transcripts while listening to interview recordings. Deductive thematic analysis using the constant comparison method was used for qualitative analysis (Creswell & Plano Clark, 2011; Lincoln & Guba, 1985). A list of 14 a priori codes based

on quantitative pre- and post-outcome measures were used to analyze the client post-therapy interview. Emergent codes were created and used during the coding process in order to capture meaning conveyed by Jane that was not encompassed by a priori codes. Codes were reexamined for fit with the text. From the codes, six themes were derived. The client pre-therapy interview was used to aid in the interpretation of merged qualitative and quantitative data. The post-therapy interview with the therapist was used to provide additional corroborating evidence for the case.

Quantitative indicators of outcome. The Symptom Checklist-90-Revised (SCL-90-R; Derogatis, 1992) is a 90-item self-report measure used to assess psychiatric symptoms and distress on nine primary dimensions: somatic complaints, obsessive-compulsiveness, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, and psychoticism. It was developed to reflect patterns of psychological symptoms found in medical and psychiatric clients (Derogatis, 1992), although it is appropriate for use with psychiatric or non-psychiatric populations (Derogatis & Unger, 2010). Respondents rate each item on a 5-point Likert-type scale according to how distressed they have been over the past seven days, with higher scores indicating greater distress. A total score, the Global Severity Index, was used in this study as well as subscale totals to better understand change.

The Inventory of Interpersonal Problems-32 (IIP; Barkham, Hardy, & Startup, 1996) is a 32-item self-report measure of interpersonal distress, shortened from the original 127-item measure (Horowitz, Rosenberg, Baer, Ureno, & Villasenor, 1988). The 32-item IIP is intended mostly for screening purposes, but is widely used by many clinicians and researchers as a measure of therapy outcome (Barkham et al., 1996).

Respondents report the degree to which each item has been a problem for them on a five-point Likert-type scale ranging from 0 (not at all) to 4 (extremely). The eight subscales, domineering/controlling, vindictive/self-centered, cold/distant, socially inhibited, nonassertive, overly accommodating, self-sacrificing, and intrusive/needy, can be used individually or summed for a total score of interpersonal problems. Summed scores can be converted into standard T scores (M = 50, SD = 10) and norms are available for males and females. The IIP has high reliability and validity (Barkham et al., 1996; Horowitz, Alden, Wiggins, & Pincus, 2000). The internal consistency of the overall scale is .93 (Barkham et al., 1996). Test-retest reliability coefficients are comparable to the longer version. Convergent validity has been demonstrated by comparing scores on the IIP-32 with other assessments of psychological symptoms, specifically depression, anxiety, and global measures of psychological symptoms. The total score and subscale scores were used for this study.

The Beck Depression Inventory – Second Edition (BDI-II; Beck, Steer, & Brown, 1996) is a widely used 21-item self-report measure of depression rated on a 4-point Likert-type scale raging from 0 to 3. Total scores range from 0 to 63 with higher scores indicating greater severity of depression. Symptoms of depression measured by this scale include irritability, hopelessness, guilt, weight loss, and fatigue. High internal consistency, with alpha coefficients ranging from .81 to .86, has been reported for non-psychiatric and psychiatric populations respectively (Beck, Steer, & Garbin, 1988).

The Eating Disorders Examination Questionnaire (EDE-Q 6.0; Fairburn & Beglin, 2008) is a 28-item questionnaire modeled after the Eating Disorders Examination interview (EDE; Cooper & Fairburn, 1987). The EDE-Q has been used in many

treatment studies to aid in the diagnosis of eating disorders (Túry, Güleç, & Kohls, 2010). It primarily measures behavioural and attitudinal features of eating disorders. The EDE-Q produces four subscales: restraint, eating concern, shape concern, and weight concern. High convergent validity has been reported between the EDE-Q and EDE (Reas, Wisting, Kapstad, & Lask, 2011), although the EDE-Q tends to generate higher scores when assessing concerns about shape and binge eating (Fairburn & Beglin, 1994). Good concurrent validity and acceptable criterion validity has been demonstrated for the EDE-Q (Mond, Hay, Rodgers, Owen, & Beumont, 2004). In addition, satisfactory inter-rater reliability and internal consistency have been demonstrated (Reas et al, 2011; Berg, Peterson, Frazier, & Crow, 2012). Norms for undergraduate women are available (Luce, Crowther, & Pole, 2008). The total score was used for this study.

The Difficulties in Emotion Regulation Scale (DERS; Gratz & Roemer, 2004) is a 36-item self-report measure of difficulties in emotion regulation. Respondents rate on a 5-point Likert-type scale the degree to which each statement applies to them. There are six subscales which can be used independently or summed for a total score: non-acceptance of emotional responses (nonacceptance), difficulties engaging in goal directed behaviour (goals), impulse control difficulties (impulse), lack of emotion awareness (awareness), limited access to emotion regulation strategies (strategies), and lack of emotional clarity (clarity). Higher scores are indicative of greater difficulties with emotion regulation. Internal consistency coefficients range from .84 to .93 and test-retest reliability is acceptable (Gratz & Roemer, 2004). Items were based on the convergent perspectives of several experts in the area of emotion regulation. Substantial convergent, discriminant, and predictive validity in nonclinical samples have been reported (Gratz &

Roemer, 2004). As the measure is psychometrically young, no clinical cutoff scores or norms are available. The total score was used for this study.

The Toronto Alexithymia Scale-20 (TAS-20; Bagby, Parker, & Taylor, 1994) is a 20-item self-report measure of alexithymia. Alexithymia describes someone who has difficulty identifying and describing internal emotional states and has a tendency towards externally-oriented thinking (Bagby et al., 1994). It is a trait associated with eating disorders, especially anorexia nervosa (Troop, Schmidt, & Treasure, 1994) and has been used as a measure of alexithymia in individuals with BN (Carrano et al., 2011). The TAS-20 has three subscales: difficulty describing feelings, difficulty identifying feelings, and externally-oriented thinking. Respondents rate each item on a 5-point Likert-type scale. The scale demonstrates high internal consistency (Bagby et al., 1994) and adequate convergent, discriminant, and concurrent validity (Bagby et al., 1994). The total scale was used for this study.

The 10-item Interoceptive Awareness Scale of the Eating Disorders Inventory – 2 (EDI-2; Garner, 1991) was used for this study. The EDI-2 has been widely used for the measurement of outcome for clients' with eating disorders (Túry et al., 2010). The interoceptive awareness scale of the EDI-2 measures awareness of and reaction to one's own physiological and emotional states and also the ability to discriminate between hunger and satiety, and feelings and sensations (Garner, 1991). Sample items include: "I get frightened when my feelings are strong" and "I get confused as to whether or not I am hungry". Responses on the 6-point Likert-type scale are transformed into a 4-point scale to reduce probability of over-diagnosis, for example, scores of 1, 2, and 3 are rescored as 0 and scores of 4, 5, and 6 are rescored as 1, 2, and 3. The internal consistency of the

scale is .84 (Eberenz & Gleaves, 1994). Convergent and discriminant validity has been established (Espelage et al., 2003).

Two scales from the 54-item Eysenck Impulsiveness Questionnaire (I_7; Eysenck & Eysenck, 1978) were used for this study: impulsiveness and venturesomeness. The impulsiveness and venturesomeness scales consist of 19 and 16 items, respectively, and are answered in a yes/no format. Impulsiveness and venturesomeness are considered two distinct components of impulsiveness (Eysenck & Eysenck, 1978). Impulsivity is defined as saying and doing things without thinking, for example, acting in the spur of the moment without awareness of associated risks. It is correlated with neuroticism and psychoticism (Eysenck & Eysenck, 1978). Venturesomeness is defined as sensation seeking and risk-taking and is correlated with extraversion (Eysenck & Eysenck, 1978). Those scoring high on venturesomeness are typically aware of risks, but decide to take chances. Both have been used as measures of impulsivity in women with eating disorders (Claes, Nederkoorn, Vandereycken, Guerrieri, & Vertommen, 2006; Kane, Loxton, Staiger, & Dawe, 2004; Waxman, 2009). Venturesomeness and impulsivity are positively correlated (r=0.38) and have good internal consistency in female samples, 0.83 and 0.78, respectively (Eysenck, Pearson, Easting, & Allsopp, 1985). Norms for adult women are available (Eysenck et al., 1985).

The Report of Binge Eating and Purging simply asks clients to record the number of binge eating and purging episodes over the past week (see Appendix B). It was created for this study and was modeled after several items in the EDE-Q (Fairburn & Beglin, 2008). It consists of three items and provides a means of tracking behavioural symptom change from pre- to post-therapy. Binge eating was defined as eating what

others would consider an unusually large amount of food in one discrete period of time. Compensation was defined as fasting, purging, exercising in a "driven way", or ingesting diet pills or diuretics in an effort to control shape or weight.

Quantitative data analysis. Results for quantitative pre- and post-therapy outcome data were compared to published data using an effect size analysis to estimate the magnitude of treatment effect (d = the difference between scores in this study divided by the standard deviation of published data). Cohen's (1988) original and still widely used standards for interpreting the magnitude of effect are as follows: 0.20 indicates a small effect, 0.50 medium, and 0.80 large. This analytic technique has been used in other mixed methods case studies (see Hill et al., 2008; Kasper et al., 2008). For this study, $d <$ 0.50 is interpreted as a small effect, d = 0.50 to 0.80 is a medium effect, and $d > 0.80$ is a large effect. In case study research, the rationale for using standard deviations from published data is that the individual under study could have been a member of the population from which the standard deviation was derived. In this case, all standard deviations were gathered from studies with participants with eating disorders, primarily adult women with BN.

Integrating qualitative and quantitative data. To explore the extent to which qualitative and quantitative findings converged or diverged, an analytic framework guided by a parallel mixed analysis integration strategy was used (Teddlie & Tashakkori, 2009). After analyzing each data strand independently, a side-by-side comparison for merged data analysis (Creswell & Plano Clark, 2011) was used to compare client symptom change on a variety of measures represented by effect sizes to the client's perspective of symptom change. Equal weight was given to qualitative and quantitative

data. Comparing qualitative and quantitative indicators of change gave additional insight into the significance and degree of client change. Findings from the therapist's interview aided in the interpretation of combined qualitative and quantitative data from the client.

Participants

Client. Jane was a 22 year old Caucasian woman with a history of anorexia nervosa who met diagnostic criteria for bulimia nervosa (BN) according to the DSM-IV-TR (American Psychiatric Association, 2000) at the initial assessment. She reported feeling apathetic, lacking in motivation, stressed, and fatigued in the few months prior to therapy. Jane was attractive, typically formally dressed, and began to dress more informally near the end of therapy. In the pre-therapy interview, she reported that she was taking a multivitamin, calcium, and birth control medication and that she never did drugs and hardly drank due to associated calories and a fear of acting "stupid". Jane was currently in the third year of university studies and was applying for law school at the time of the initial assessment.

Jane said she was 12 years old at the onset of anorexia nervosa and weighed only 69 pounds at her lowest weight. She described the following year as a restoration year, but reported the eating disorder came back again, this time more closely resembling BN. At the time of assessment, Jane reported avidly counting calories for the past eight years and said it interfered with studying. She had a system of tracking binge eating and compensation to ensure she would not average more than 1600 calories per day. When binge eating, she reported eating anywhere from 400 to 1200 calories in one sitting. Eating in restaurants was stressful for Jane and she would read menus online in order to select low-caloric foods prior to attending. Although Jane was living at home, she

frequently house-sat at a home she described as the "Costco-house" because it was well stocked with food. To cope, she would place a pad lock on the fridge for fear of eating uncontrollably.

Compensation methods included skipping meals, laxative use, and driven exercising. Jane said she exercised for approximately 90 minutes every day but would add an additional 20 minutes to an hour to compensate for binge eating. She had followed this routine for two years, even in extreme circumstances, for example, the day after participating in a triathlon. Jane reported attempting self-induced vomiting about three times a month, but it was not working for her. At the initial assessment, Jane reported binge eating 10 times and compensating 12 times in the previous week.

Jane came from a family with a high socioeconomic background. Her mother was a medical doctor and her father managed a large construction company. She described her relationship with her mother as difficult and described the boundaries in their relationship as unclear. For example, when Jane was 12, her mother had confided in Jane when her marriage was in jeopardy and she was contemplating divorce. She also described her mother as a "diva" who tended to exaggerate and become dramatic when upset, often talking about how difficult her own life had been and how Jane therefore should not complain or speak of challenges in her own life. Jane said her mother had a history of depression and grew up with a father who was an alcoholic in a family with a lower socioeconomic background. Jane reported that her own father had been an alcoholic but stopped drinking when she was nine years old. Despite not responding to her gestures of affection, for example, not returning the words "I love you", Jane

described having a good relationship with her father and said she knew that he was proud of her.

Jane had an older adopted Vietnamese brother and a younger sister. She described her brother as a drug addict and reported they never spoke to one another. He had physically pushed and hit her in the past, and Jane reported that her parents did little in response. She reported pleasing her brother in order to avoid conflict. She described her relationship with her younger sister as distant, mostly due to the large difference in their age. At the time of therapy, Jane was living with her mother, father, brother, and sister while attending university. Her family was unaware that she continued to struggle with an eating disorder.

Jane reported a history of bullying. Beginning when she was 10, classmates would tease her for being smart, not drinking, and coming from a wealthy family. At the time of therapy, she reported having a few close friends. Jane described herself as a "chronic dater" with a history of manipulative boyfriends. She described her current boyfriend as much better than past boyfriends and also said that he was unaware of her past and current struggles with an eating disorder.

Jane had been in therapy previously for the treatment of anorexia nervosa when she was 12 years old. She attended an in- and out-patient eating disorder hospital-based treatment program for three years where she received care from a nutritionist, individual psychologist, and a family psychologist. When she was 18 years old, she attended what she described as family-focused therapy on her own.

Therapist. At the time of data collection, I was a 27 year old, Caucasian, third-year doctoral student studying counselling psychology with five years of clinical

experience. I identified myself as an experiential therapist working from a humanistic foundation. I had received graduate training in EFT and also Level 1 EFT training from Dr. Leslie Greenberg at York University Psychology Clinic. My work with eating disorders is from an EFT perspective and involves pscyhoeducation around emotions as well as regular chair work during which clients are asked to play the role of the eating disorder, the critic, or another person in their life.

Therapist and Researcher Reflexivity

Playing the roles of therapist and researcher can pose certain risks associated with ethics and validity such as the client feeling unduly influenced to consent to research and loss of therapist or researcher objectivity (McLeod, 2002). To minimize the impact of influence, consent for research was obtained prior to the commencement of therapy, another member of the research team governed the consent process over the course of therapy, and consent was again sought post-therapy (McLeod, 2010; Winship, 2007). Methods used while managing dual roles of therapist and researcher included supervision, journaling, and using multiple readers of the case material in order to explore alternative perspectives.

Results

Qualitative Indices of Outcome

The six themes that emerged from the semi-structured post-therapy interview with Jane are described below with excerpts from the verbatim transcript as illustrations. Ellipses are used to indicate places where words were deleted in order to shorten presentation. Minimal encouragers from the therapist such as “Mm-hmm” were not included.

Theme 1: "I'm doing much better"

In several places throughout the interview, Jane referred to changes she experienced over the course of therapy. Many of the changes she mentioned were also captured by a priori codes derived from the quantitative pre- and post-therapy questionnaires. The changes Jane talked about, specifically those linked to quantitative indicators of change, were included in the mixed methods analysis of pre- and post-therapy outcome.

In the post-therapy interview, Jane referred to some general changes she had noticed in her wellbeing, for example:

> I think that the anxiety was making me very upset before and very sad. I don't want to say that I was depressed, like not quite that severe, but I feel a lot more, well, I guess a lot less, upset on a day to day basis.

In addition to general changes in wellbeing, Jane referred to changes in behaviours and concerns typically associated with eating disorders, such as a decrease in binge eating and compensation. For example, when asked how she is doing now in general, Jane stated that:

> I found that my anxiety, especially around food and such has decreased a lot, and that I'm more able to tolerate situations that were really stressful before, and, yeah, just that overall the binging has really subsided a lot and, that, I'm starting to try to work on that excessive exercising but then, also, yeah, like I haven't used laxatives or anything in probably two months or so, a few months, yeah, so that was a good change. And the binging has been, I mean, maybe once in the past month.… I think the main point is like, the anxiety has decreased and the

> preoccupation with all that has really decreased for me. I feel like it's, um, definitely helped me a lot, a lot.

Furthermore, Jane said, "I've also found that I'm more able to tolerate situations like going out for dinner, or, just being around food." These responses suggest that Jane perceived changes in behaviours and concerns typically associated with eating disorders over the course of therapy.

When asked "What changes, if any, have you noticed in yourself since therapy started?" Jane described an experience she had during therapy when she took a risk and ate a donut.

> I always wanted to, eating a donut was like sort of like this big … when I first went into university I was all "Whenever I write an exam, I'm going to eat a donut" and then that never happened because of course it was, sort of taboo. So we had donut day over the course of therapy, and I went and bought myself a donut and had a donut and that was like one, risk type thing.

A donut had been a forbidden food to Jane, and taking the risk to reward herself with a donut was something she later described in the post-therapy interview as "something really positive that happened."

There were times in the interview that Jane indicated continued hope for change. She discussed her hope of becoming less critical of herself, cutting back on exercise, and a hope that she would eventually tell her parents that she had attended therapy. Here is one example of Jane acknowledging her progress while also sharing her hope for continued change.

> I think I'm doing much better. I think I've still got a ways to go, but I definitely … I was sort of like, desperate, feeling very desperate I guess would be a good way to describe it. And now I'm feeling much more hopeful that I can sort of get to where I eventually want to be.

Theme 2: "We talked about just how I'm feeling"

Jane often referred to her experience of learning about emotions, paying attention to how she was feeling, and labeling emotions during the interview. Jane had had prior therapy for anorexia nervosa and indicated how different this EFT therapy experience had been for her. For example, when asked, "What has therapy been like for you so far?" Jane stated, "A lot of the experience was different from what I had before. One of the things that I really enjoyed was like the whole aspect of not talking about food and talking about, completely, just how I'm feeling." Focusing on emotions allowed Jane and the therapist to take the focus off of food and move into her experience.

Over the course of the interview, Jane mentioned many emotion regulation tasks she had learned that she had found helpful, for example breathing, identifying emotions, and tolerating emotions. When asked about what she believed had brought about some of the various changes she had noted in herself since therapy started such as decreased anxiety, binge eating, and laxative use, she shared:

> Well, first of all, the emotion piece, like, learning to pay attention to your emotions and the secondary emotions, or, primary emotion is causing the secondary emotion, and, in therapy we also talked about slowing things down, and labeling your emotion and so that I found very helpful.

This seems to indicate that Jane attributed some of the changes she had experienced in therapy to being with her emotions in a new way.

Near the beginning of the interview, Jane talked briefly about some of her early childhood learning about emotions.

> I found that for the most part my family was sort of like, emotion, like bad. It had this sort of taboo, and I think I've learned that I'm more of an emotional person than my parents, and, that, that's fine.

The approach to emotions used in therapy was very different from what she learned about emotions in her family. Jane seems to suggest that an important part of her healing experience was to accept her own emotional experience, and here she labels this as being a more "emotional person" than her parents.

Theme 3: "Nobody is perfect"

After discussing some of the changes that Jane had noticed in herself over the course of therapy, she was asked, "Is there anything that you wanted to change that hasn't since therapy started?". Jane mentioned that she still hoped to cut down on exercise as well as tell her parents about therapy. She then said that some of her goals had shifted over the course of therapy. Below is a quotation from Jane as she shared about these changing goals.

> I think that, yeah, ultimately some of the changes that I had hoped for in the beginning were changes that would've been unproductive to myself. So, for instance, I was hoping to be able to eat like perfectly and such and I realized that some of those goals that I had set out to accomplish were, like, were striving for perfection and things that I didn't really want anyway. Some of the things that I,

> that I didn't end up accomplishing … was all, was better for me, yeah, in terms of accepting that nobody eats like that, like nobody is perfect. Because that was one of the bigger realizations that I had like, like a lot of my goals were misaligned with what I really needed, what I really wanted.… I don't think that would've happened without therapy.

This seems to suggest that part of what Jane had wished for through therapy was a perfect recovery in the sense that she would no longer have to engage in compensatory behaviours because her eating patterns would be perfect. Jane seems to indicate a shift in goals away from striving for perfection, and perhaps, towards a more accepting stance towards herself as a human being, who, like other human beings, was imperfect, even in eating habits. Here again she attributes this change to therapy.

Theme 4: "I have been successful voicing my feelings"

In addition to learning about emotions, Jane talked about finding her voice in the presence of her family members. Here, Jane talks about the shift away from shutting down her own felt experience and towards finding voice.

> I've been trying more to, and I think that I have been successful in voicing, sort of my feelings more towards my family. One of the things that I felt I learned in therapy was, it's important to sort of, think about your emotions and what you were feeling. And, I think before I used to try to hide that a lot from my family, and just be, or feel guilty, for feeling whatever I had felt. And through therapy, I've been able more to express that and try to, act on those emotions in an more appropriate way towards my family as opposed to just shutting down or anything.

Another thing Jane mentioned in this passage is the guilt that used to cover up the other emotions she was feeling. Guilt was a common reaction Jane experienced in response to her emotions. She seemed to scold herself for the anger she sometimes felt during interactions with family members. This move away from shutting herself down to connecting with her right to feel and also her capacity to voice her feelings seems to be a significant shift in Jane's orientation towards herself and her world. Later in the interview, she shared so succinctly and profoundly, "You can feel something. Like, you have the right to feel".

Theme 5: "These people did something wrong"

Near the end of the interview, Jane was asked, "Were there things in the therapy that were difficult or painful but still okay or perhaps helpful?". As exemplified below, Jane talked about the difficulty she had when discussing some of the events she had experienced in the past.

> I think talking about a lot of the instances that had happened in the past and situations where my parents acted or people around me acted in ways that they shouldn't have, but I always felt guilty cause I felt like, "Oh their life was so difficult"…. Talking about those situations was difficult but it was helpful to be, to be able to say, like, 'These people did something wrong'. Was it really their fault? It kind of was.

This shift towards placing blame on someone else for their inappropriate actions rather than internalizing guilt or shame when remembering past events seems like a significant shift in Jane. She acknowledged that it was difficult to blame others, but that it was also helpful.

Here is another example of Jane acknowledging the poor behaviour of her parents in the past.

> I think one thing that was sort of difficult too was to play my parents in the chair. That was difficult, especially since I would want to play them in a certain way, like want them to be understanding in that, but I guess sometimes, you know, they're not going to be.

Jane here referred to the unfinished business chair work where she placed either her mom or her dad in the chair and engaged with them in order to share how she was feeling. Part of the task involved role-playing her parents' response. Again, this excerpt seems to indicate that Jane is acknowledging that other people, especially in this case her parents, sometimes acted in inappropriate or hurtful ways. Rather than camouflaging this reality, Jane seems to express an awareness that others are not always understanding, and that this is, in fact, not her fault. Allowing herself to blame others for their actions seems to relieve her of the need to displace negative associations or feelings onto herself.

Theme 6: "Having someone was really important"

At several points throughout the interview, Jane talked about the importance of having someone present to help her process experiences. For example, "Just having someone to work though some of the issues of my past experiences. That, having someone to, a third party to just comment on them and think, and you know, give me feedback about that." This was one of her responses to the question regarding what she believed had caused some of the changes she had experienced.

Also, at the end of the interview, Jane was asked by the interviewer, "Do you have anything else that you would like to tell me?". She replied, saying:

> I guess I had touched on most things. The one thing that was really positive for me too that just to add, was that, I found [the therapist] to be really empathetic, and really understanding, and that I think was a huge, made a huge difference for me. She wasn't just, someone like sitting in a chair, and "How do you feel about this?", like she, I could tell she was, not necessarily feeling the emotions with me but very present in the session emotionally, and that definitely, I think, helped, a lot.

This quote especially seems to point to the importance of the therapeutic relationship to Jane. She seems to indicate that she needed more than someone to sit with her while she explored her experiences, and rather, that she benefitted from a therapist who was present with her, emotionally attuned, and sat with that pain with her as she experienced it in session.

Quantitative Indices of Outcome

Table 4.1 displays pre-therapy to follow-up data from this current study and means and standard deviations from published data. Jane's pre- and post-therapy ratings were lower than published data for both the SCL-90-R and IIP-32. From pre- to post-therapy, effect sizes for both measures are small (d = 0.27 and -0.42, respectively). When examining the subscales of the SCL-90-R, phobic anxiety, paranoid ideation, and psychoticism changed little from pre-therapy to follow-up. From pre- to post-therapy, the depression (T = 62 and 48, respectively), anxiety (T = 58.5 and 52, respectively), and somatization (T = 49 and 41, respectively) subscales decreased. Both depression and anxiety continued to decrease through to the six-month follow-up. From post-therapy to the six-month follow-up, changes are noted in obsessive-compulsiveness (T = 53 and 37,

Table 4.1

Scores on Outcome Measures at Pre- and Post-therapy and Three- and Six-Month Follow-up Compared to Published Data

		Present study				Published data
		Pre	Post	3 mths	6 mths	*Mean (SD)*
SCL-90-R		0.47	0.28	0.17	0.14	1.40 (0.70)
IIP-32		0.53	0.78	0.94	0.84	1.90 (0.60)
BDI-II		27	1	0	0	15.96 (9.04)
EDE-Q		4.73	2.09	1.39	1.07	3.73 (1.06)
Binge		10	1	1	0	4.70 (9.10)
Compensation		12	1	0	0	6.60 (10.80)
DERS		115	59	56	58	126 (31.5)
TAS		45	34	33	54	56.40 (12.70)
IA		3	1	4	1	12.23 (6.85)
I_7	Impulsiveness	4	3	3	4	8.50 (3.50)
	Venturesomeness	5	6	5	3	7.10 (3.50)

Note. SCL-90-R = Symptom Checklist-90-Revised, Global Symptom Index (published data from Castellini et al., 2013); IIP-32 = Inventory of Interpersonal Problems-32 (published data from Arcelus et al., 2009); BDI-II = Beck Depression Inventory-II (published data from Hill, Craighead, & Safer, 2011); EDE-Q = Eating Disorder Examination Questionnaire (published data from Hill, Craighead, & Safer, 2011); Binge episodes per week (published data from Schaffner & Buchanan, 2010); Compensation episodes per week (published data from Schaffner & Buchanan, 2010); DERS = Difficulties in Emotional Regulation Scale (published data from Harrison, Sullivan, Tchanturia, & Treasure, 2010); TAS = Toronto Alexithymia Scale (published data from Johnston, Startup, Lavender, Godfrey, & Schmidt, 2010); IA = Interoceptive Awareness Scale of the Eating Disorders Inventory – 2 (published data from Olatunji et al., 2012); I_7 = Eysenck Impulsiveness Questionnaire (published data from Claes, Vandereycken, & Vertommen, 2002).

[a]Binge and compensate values are reported as frequencies. Reductions in scores indicate positive outcome. Higher scores on all measures indicate higher levels of the construct. All means and standard deviations reported from published data are from populations with eating disorders.

respectively), interpersonal sensitivity (T = 56 and 50, respectively), and hostility (T = 49 and 40, respectively). Interestingly, gains in decreased somatization were not maintained from post-therapy to six-month follow up (T = 41 and 53, respectively). Overall, depression and anxiety trended downwards from pre-therapy to six-month follow-up. With less anxiety and depression, it seems that other experiences of distress began to shift during follow-up, for example Jane indicated decreased interpersonal sensitivity and hostility towards others.

The subscales of the IIP-32 convey an interesting picture of interpersonal problems from pre-therapy to follow-up. From pre- to post-therapy, Jane reported an increase on the domineering-controlling subscale (T = 42 and 55, respectively) and decreased social inhibition (T = 53 and 44, respectively). These changes may be positive as they may indicate that Jane is more comfortable being herself in social situations. Conversely, the subscales of overly-accommodating (T = 47 and 60, respectively) and intrusive-needy (T = 44 and 55, respectively) increased over the course of therapy. While intrusive-needy decreased back to the pre-therapy level in follow-up, the higher score on the overly-accommodating subscale was maintained and an increase in self-sacrificing was noted from post-therapy to six-month follow-up (T = 51 and 57, respectively). Therefore, while there does not seem to be substantial change in interpersonal problems for Jane over the course of therapy, it does seem that Jane continued to be passive in social situations, sacrificing herself for the benefit of others, and possibly relying on others to provide external validation.

The BDI-II confirms decreased depressive symptoms as indicated in the SCL-90-R (see Figure 4.2). At pre-therapy Jane was much more distressed on the BDI-II than

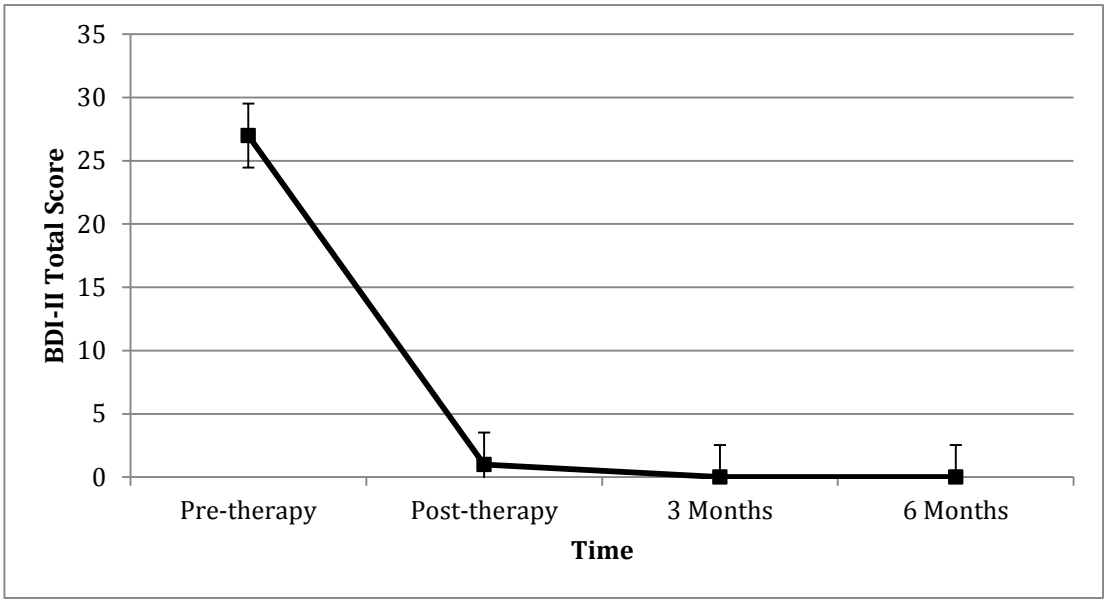


Figure 4.2. Symptoms of depression from pre-therapy to follow-up. Error bars represent standard errors of measurement.

clients in published data and a large change in depressive symptoms is noted from pre- to post-therapy (d = 2.88) with changes maintained in follow-up. Therefore, Jane indicated fewer feelings of hopelessness, guilt, and physical symptoms such as fatigue post-therapy as compared to pre-therapy and these changes were maintained in follow-up.

On measures specific to eating disordered behaviours, attitudes, and concerns, Jane's pre-therapy ratings were higher than published data on the EDE-Q. A large change was noted from pre- to post-therapy on the global scale (d = 2.49) as well as the four subscales: restraint (d = 2.64), shape concern (d = 2.22), eating concern (d = 1.21), and weight concern (d = 1.63). In addition, a medium change was noted from post-therapy to three-month follow-up (d = 0.66) on the global scale with a general downward trend from pre-therapy to six-month follow-up. Change in pre- to post-therapy eating disorder behaviours is also indicated by change in the frequency of binge eating and compensation. Jane reported binge eating 10 times a week and compensating 12 times a week pre-therapy and reported engaging in these behaviours only once a week post-therapy. These changes were maintained in follow-up. The pre- to post-therapy change in binge eating (d = 0.99*)* and compensation (d = 1.02) indicate a meaningful decrease in typical behaviours associated with eating disorders compared to clients from published data. See Figure 4.3 for changes in overall EDE-Q scores from pre-therapy to follow-up.

There was a large magnitude of effect from pre- to post-therapy on the DERS (d = 1.78) and the TAS (d = 0.87), and a small change on the IA (d = 0.31). Hence, Jane improved in her ability to identify sensations in her body, describe and label these sensations, and regulate emotion through strategies such as breathing over the course of

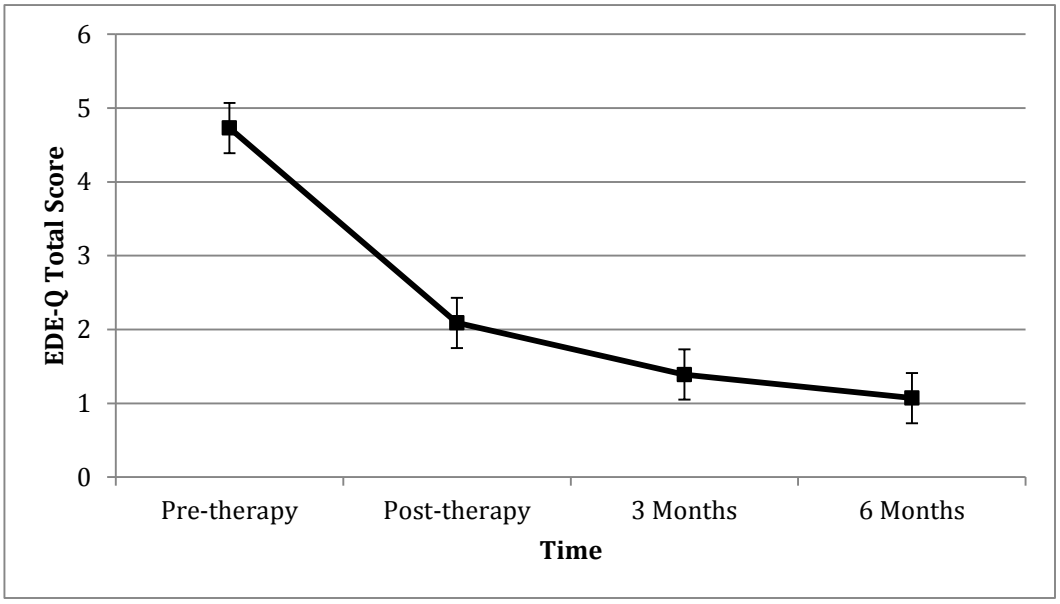


Figure 4.3. Eating attitudes, behaviours, and concerns from pre-therapy to follow-up. Error bars represent standard errors of measurement.

therapy. In follow-up, a large increase on the TAS is noted from three- to six-month follow-up (d = -1.65) indicating that Jane experienced increased difficulty identifying and describing feelings over the six months following therapy, yet effect sizes in follow-up for the DERS and IA are small. See Figure 4.4 for changes in overall DERS scores from pre-therapy to follow-up. On a measure of impulsiveness (I_7), a small change in impulsiveness (d = 0.29) and a small increase in venturesomeness (d = -0.29) were reported from pre- to post-therapy. A medium decrease in venturesomeness is noted between three- and six-month follow-up (d = 0.57).

At the three and six month follow-up, Jane's scores on all measures were lower than mean scores of published data. In the case of the SCL-90-R, BDI-II, EDE-Q, DERS, and frequency of bingeing and compensation, Jane's scores improved from post-therapy to follow-up. Therefore, Jane reported a further decrease in psychiatric symptoms, depression, and behaviours and concerns typically associated with eating disorders such as shape concern, weight concern, binge eating and compensation, as well as a further increase in her ability to identify, describe, and regulate emotion. At the three- and six-month follow-up, Jane no longer met diagnostic criteria for BN according to the DSM-IV-TR (American Psychiatric Association, 2000). Overall, large change is noted on most scales from pre- to post-therapy, and while some changes continued through follow-up, change seemed to level off in the six months following therapy indicating that Jane was generally functioning at a steady level post-therapy.

Integration of Data

Pre- to post-therapy changes captured by a priori codes in the post-therapy client interview, largely represented by the theme "I'm doing much better", were compared to

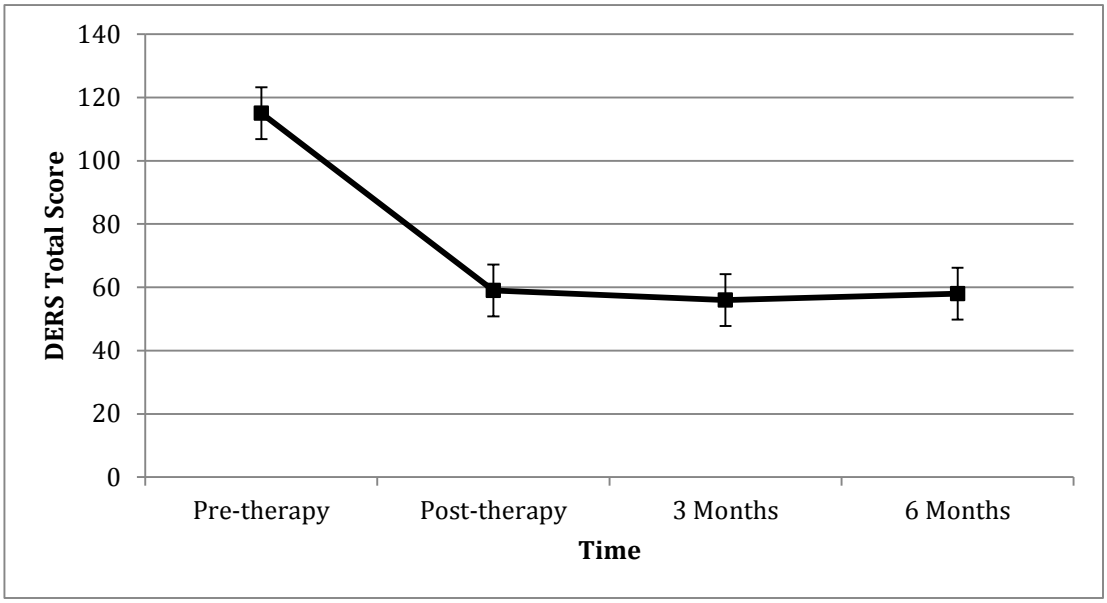


Figure 4.4. Difficulties in emotion regulation from pre-therapy to follow-up. Error bars represent standard errors of measurement.

Jane's self-report quantitative outcome data to explore areas of convergence or divergence. Equal weight was given to qualitative and quantitative data. Table 4.2 provides a side-by-side comparison of qualitative and quantitative data for each outcome variable.

Psychiatric distress is an area where quantitative and qualitative results seem to diverge. The effect size for psychiatric distress is small, however, quotes from the interview indicate that Jane thought significant change had occurred in this area. In the post-therapy interview, she described moving from desperation to hope and from high to low anxiety. It therefore is surprising that a small effect size was found in the area of psychiatric distress. It is possible that the SCL-90-R was not sensitive to the kind of distress experienced by Jane. Jane's pre-and post-therapy score on the SCL-90-R fell within the normal range. Furthermore, the SCL-90-R captures features of psychiatric distress such as paranoid ideation, psychoticism, phobic anxiety, and hostility, aspects of distress Jane was not directly asked about in the post-therapy interview and which may or may not have been related to her experience. In the pre-therapy interview, one of the changes Jane said she was hoping for over the course of therapy was to feel less stress overall. She reported that this change was very important to her and would only be somewhat likely without therapy. This points to the significance of Jane reporting less distress, specifically anxiety at post-therapy.

Similar to the SCL-90-R, the effect size for interpersonal problems as measured by the IIP-32 was small, and in addition, Jane's pre-therapy score fell within the normal range. While the quantitative data indicates few changes in interpersonal problems, qualitative data indicates some change related to interpersonal problems with her family.

Table 4.2

Side-by-Side Comparison of Qualitative and Quantitative Indices of Change

	Post-therapy Interview Quotes	Effect Size
Psychiatric Distress	I was sort of like, desperate, feeling very desperate I guess would be a good way to describe it. And now I'm feeling much more hopeful that I can sort of get to where I eventually want to be. I feel a lot less, anxiety, less anxious. I think that the anxiety was making me very upset before and very like sad.	small
Interpersonal Problems	I'd say that, family situations, maybe a bit of an improvement, but I think that's still, I'm working on that. Telling my parents about therapy, which I haven't been able to do yet, and I'm hoping that…eventually I'd be able to tell them.	small
Depression	I don't want to say that I was depressed, like not quite that severe, but I feel a lot more, well, I guess a lot less upset on a day-to-day basis. I wouldn't consider myself as a depressed or like down person.	large
Restraint	I allow myself to eat more on a day to day basis and not feel guilty about that. Nobody eats like that, like nobody.	large
Shape Concern	There are certain aspects of my body that I don't really like, but I'm sort of working towards trying to accept them and I think that I've made some gains in that but it's something again that I'm still trying to work on. The preoccupation with all that has really decreased for me	large
Eating Concern	I found that my anxiety, especially around food and such has decreased, a lot. I'm more able to tolerate situations like going out for dinner, or just being around food.	large
Weight Concern	There are greater proportions of the days of the month now where I say, "Okay, my body's okay. I can accept this".	large
Binge	I found that I've been able to stop the binging for the most part. The binging has been, I mean, maybe once in the past month.	large

Compensation	I'm starting to try to work on that excessive exercising but then, also, yeah, like I haven't used laxatives or anything in probably two months or so, a few months, yeah, so that was a good change. The exercises have been difficult for me so I shouldn't say that that has changed much, but the laxative use has stopped.	large
Emotion Regulation	I've been able more to express that and try to act on those emotions in a more appropriate way towards my family as opposed to just shutting down or anything. Breathing, or writing, those are some of the things that were really helpful.	large
Alexithymia	We also talked about slowing things down, and labeling your emotion and so that I found very helpful. One of the things that I felt I learned in therapy was, it's important to sort of, think about your emotions and what you were feeling.	large
Interoceptive Awareness	What was helpful, okay so yeah, being able to identify the emotions and be mindful of them. First of all, the emotion piece, like, learning to pay attention to your emotions.	small
Impulsivity	none	small
Venturesomeness	We had donut day over the course of therapy, and I went and bought myself a donut and had a donut and that was like one, risk type thing. I guess one thing outside of session was taking the risks, for instance the donut day, or just challenging food fears that I had had…. It never ended as catastrophically as I would've thought.	small

Note. Indices of change were derived from variables measured by pre-post quantitative outcome questionnaires. Qualitative Data: Indices of change were used as a priori codes for post-therapy interview analysis. Verbatim quotes from the post-therapy interview are provided. Quantitative Data: Psychiatric Distress = SCL-90-R (Symptom Checklist-90-Revised); Interpersonal Problems = IIP-32 (Inventory of Interpersonal Problems-32); Depression = BDI-II (Beck Depression Inventory-II); Restraint, Shape Concern, Eating Concern, and Weight Concern = subscales of the EDE-Q (Eating Disorder Examination Questionnaire); Binge = Binge episodes per week; Compensation = Compensation episodes per week; Emotion Regulation = DERS (Difficulties in Emotional Regulation Scale); Alexithymia = TAS (Toronto Alexithymia Scale); Interoceptive Awareness = subscale of the EDI-II (Eating Disorders Inventory – 2); Impulsivity and Venturesomeness = subscales of the I_7 (Eysenck Impulsiveness Questionnaire).

In the post-therapy interview, Jane continually reflected on past experiences of feeling unheard and also a desire to disclose her struggles with an eating disorder to her family. While this remained unchanged, she did note slight improvements in communication with her family as well as continued effort towards this goal. In the pre-therapy interview, Jane did not indicate that she hoped to improve relationships with family members over the course of therapy, but she did indicate an overall hope to improve relationships with others as well as a curiosity about whether family issues had contributed to the eating disorder.

Unlike psychiatric distress and interpersonal problems, qualitative and quantitative data related to depression both clearly capture significant change in degree of psychological distress over the course of therapy. In addition, depression was strongly indicated in the pre-therapy interview. Below is Jane's response to the question, "How are you doing now in general?" in the pre-therapy interview.

> This year in school I feel like I've been a little more apathetic, in like I don't have the drive I usually do…just kind of feeling overall like, tired, and lacking motivation, which may be a result of, I - I don't know if it, I just feel like I pushed myself really hard for the past little while and just kind of like, I don't want to do any of this any more. Not that I don't enjoy it but I'm just like feeling tired and kind of like I want a break.

This is very different from Jane's description in the post-therapy interview where she described herself as doing much better and generally less upset. The large effect size from pre- to post-therapy provides additional corroborating evidence for this change in experience of depression.

Large change seems to be indicated by both qualitative and quantitative data on measures specific to eating disordered behaviours, attitudes, and concerns. Shape concern is one area Jane shared she still hoped for change, and yet, it is not surprising that the effect size for shape concern is large. Jane's pre-therapy score on the shape concern subscale of the EDE-Q was more than three standard deviations above the mean, but at post-therapy, fell within the normal range for young women. While Jane shared she is still dissatisfied with aspects of her body, this dissatisfaction no longer seemed to reach clinical levels, and unfortunately, many individuals without eating disorders regularly experience dissatisfaction with body weight and shape (Tantleff-Dunn, Barnes, & Gokee Larose, 2011). Furthermore, Jane made large gains in reducing the frequency of binge eating, and this is reflected by both qualitative and quantitative data. Jane does express, however, that compensation through excessive exercise had been difficult to decrease. Regardless, compensation through food restraint and laxative use decreased dramatically, and this change is likely what is reflected in the large effect size for compensation. In the pre-therapy interview, Jane indicated that she hoped for change in the frequency of binge eating and purging, in her comfort level going out for dinner with friends, and decreased shape and weight concerns over the course of therapy. She believed change would be unlikely without therapy and also said that making these changes was very important to her.

On two of the indices of change related to emotion, qualitative data seems to confirm quantitative data. A small divergence seems to exist in regards to interoceptive awareness. In the post-therapy interview, Jane indicated increased mindfulness and attention to emotion, however, only a small effect size is indicated in the quantitative

data. Interoceptive awareness is an indicator of an individual's ability to recognize internal cues and emotions such as hunger, satiety, and fatigue and difficulty with interoceptive awareness is common among individuals with anorexia nervosa (Garner & Olmsted, 1984). At pre-therapy, Jane indicated high interoceptive awareness on the IA, for example, she reported she is not easily frightened or confused by feelings and is able to identify emotions. In addition, both the pre- and post-therapy interoceptive awareness scores fall far below the mean for individuals with BN. Despite this, Jane's qualitative report indicates an increased ability to identify emotions, and this is verified by quantitative and qualitative data for the emotion regulation and alexithymia variables, for which there is a high degree of overlap. Jane did not mention a hope for change in emotion regulation skills and therapy in the pre-therapy interview. However, in the post-therapy interview when asked "In general, what do you think has caused these various changes?" she largely talked about learning how to be mindful of emotions, identify emotions, slowing experiences down, and breathing, all of which are tasks of emotion regulation. Overall, a significant change in capacity for emotion regulation is indicated by the quantitative and qualitative data, and while this change was not an initial goal of Jane's, she seems to understand emotion regulation as an important mechanism of change that contributed to the other changes she experienced.

Finally, on the two indices of impulsiveness, impulsivity and venturesomeness, both qualitative and quantitative data suggest little change in impulsivity, yet discrepant results seem to exist in the area of venturesomeness. Despite the small effect size on the venturesomeness subscale of the I_7, Jane reported increased risk taking behaviour in the post-therapy interview. At several points, she shared a specific example of a significant

event in therapy when she had eaten a donut. Jane had wanted a donut as a reward for completing exams after her first year of university, but had denied herself this pleasure for years. During therapy, Jane made and followed through with the plan to purchase and eat a donut, an act that was completely outside of the rules she had fastidiously followed as part of the eating disorder regimen. Venturesomeness on the I_7 measures an individual's enjoyment of and interest in trying new experiences as well as doing things that may be slightly frightening. While the effect size in this area is small, the qualitative data certainly indicates a significant increase in venturesomeness as signified by the event Jane identified as donut day.

Excerpts from the Post-therapy Interview with the Therapist Related to Change

In my post-therapy interview conducted by a colleague, I noted significant change in frequency of binge eating and purging as well as eating concern. For example, I reported a decrease in food restriction.

> She was eating 1600 calories a day and she was really obsessive about it…. And she's at the point now where she's at 1800, but she's sometimes, like a couple of sessions she came in and she said like "I don't even know what I ate for breakfast for the past few days." She started losing that obsession around food.

I also identified changes in Jane's capacity to regulate emotion and provided an example of this in the context of an interpersonal problem Jane had recently encountered with her family. This quote also exemplifies how Jane was able to express to others that she had been wronged rather than internalizing the blame.

> It was Thanksgiving Day and she was at home and her family was around and her mom and dad and brother and sister were in the living room and she was just

passing through. Her mom just starting picking on her and saying like, "Oh, Jane, you didn't really get those marks, you just got those marks in school because you brown nosed with your professor and you didn't really get into law school. It's because you're irritating and you irritated your TA.". Just really minimizing what she was doing. And she noticed she that was feeling angry and that that was valid and she went up to her room and used some of her emotion regulation strategies. She found deep breathing helpful and journaling and she actually called her friend, which was helpful as well, and later went down and talked to her mom and told her that it made her upset that she said that…. And she even noted that before that, when something like that would happen, she would just boycott family dinner, and it was Thanksgiving Day which would have been a perfect time to boycott family dinner, and in her head, she was like, "I'm angry right now. It's not appropriate to not eat because I'm angry. I'm going to do something else."

Overall, there were many consistencies between my perspective of change and Jane's perspective of change. An additional noteworthy aspect of change I shared in the post-therapy interview was a curiosity about whether Jane was disappointed in the degree of change she had experienced. I described a sense that part of the perfectionism Jane experienced also contributed to a goal of having the "perfect recovery" and I wondered whether the research also put extra pressure on Jane in this regard.

Discussion

This case study illustrated change that had taken place in an individual with BN after 17 sessions of EFT that focused on emotion processes that had become maladaptive

in her life. At the beginning of therapy, Jane experienced moderate depression, extensive eating restraint, considerable shape and weight concern, and high frequency of binge eating and compensation as measured by pre-therapy questionnaires and an interview. More specifically, Jane was feeling stressed about school as well as unmotivated, apathetic, and exhausted. She expressed a desire to be closer to others and to engage in her life without having to invest as much time counting calories and compensating after a binge episode. At the end of therapy, Jane reported improvement in depression, eating concerns, and eating behaviours as measured by post-therapy questionnaires and an interview. She became more comfortable going out for dinner at restaurants, ate a donut she had wanted for several years, and shifted away from striving for perfection. At post-therapy, Jane no longer met criteria for BN according to the DSM-IV-TR (American Psychiatric Association, 2000). At the three- and six-month follow-up, further improvement was noted.

In the post-therapy interviews, both Jane and I attributed change in eating disordered behaviors and concerns to learning how to process emotion in a more adaptive way. At pre-therapy, Jane, like other individuals with BN, tended to constrain her emotions and internalize distress (Guinzbourg, 2011). Constraining emotions and internalizing distress is a way an individual with BN turns emotions inward, often in the form of maladaptive shame, disgust, or confusion, in cases where an outward expression of emotion may be appropriate (Dolhanty & Greenberg, 2007; Greenberg, 2011). For example, in the post-therapy interview Jane referred to criticism she had received from her mother. In this case, it may have been highly appropriate for Jane to be angry at her mother for accusing her of unfairly acquiring her grades in university or sad for not

having a mother who encouraged and supported her. When internalizing emotion, the adaptive expression of emotion to the other is lost, and the self is left to absorb the unexpressed emotion. For many women, emotion is so painful that it is displaced onto the body and felt as "being fat" which contributes to the painful cycle of restraint, binge eating, and compensation (Polivy & Herman, 2002). At post-therapy, Jane had moved away from passive behaviours to solve interpersonal problems such as boycotting family dinners and not eating, and had begun to identify the emotional reactions she was experiencing in response to interactions with her family.

This transition from displacing emotion onto the self and towards experiencing anger and sadness is extraordinarily challenging for individuals with BN because it requires placing blame on someone, often a beloved mother (Dolhanty & Greenberg, 2007; Dolhanty & Lafrance, 2011). In the pre-therapy interview, Jane noted unclear boundaries in her relationship with her mother and described how her mother would share troubles with Jane when distressed. A mother playing a role more closely resembling a friend who relies on the young daughter for emotional support is a typical dynamic in families with an eating disorder (Dolhanty & Greenberg, 2007). Given this enmeshment, an individual with an eating disorder is often protective of her mother and much more willing to blame herself for not being strong-willed enough to overcome the eating disorder (Dolhanty & Greenberg, 2007; Polivy & Herman, 2002).

Through unfinished business chair work, I guided Jane to express emotion to the mother in the chair, thereby re-creating a more adaptive emotion process, which allowed Jane to either set a boundary with her mother or to grieve that her mother has been unable to give needed care or love. Jane referenced this unfinished business chair work in the

post-therapy interview, and reported that it was difficult to play the real mother in the chair, a mother who may respond critically to her expression of hurt or anger. Despite this, Jane was able to express hurt to her mother. This made it unnecessary to displace emotion onto her body, and, in the context of her real life example, she was able to eat with her family at dinner rather than deprive herself of food.

While much chair work was used over the course of therapy, change occurred in the context of a strong working alliance. In the post-therapy interview, Jane reported how important it was for her to have someone present to help her process the painful, stuck emotion she had been avoiding. This is not surprising as the working alliance has long been known as one of the most important therapist influenced factors of change (Horvath & Symonds, 1991; Duncan, Miller, Wampold, & Hubble, 2010). In EFT for eating disorders, the relationship between client and therapist is especially important. The therapist plays the role of an emotion coach, helping the client to explore and make sense of her internal experience, a role typically played by parents (Dolhanty, 2006; Greenberg, 2002). Individuals largely learn about emotions, what they mean, and how to respond to them in childhood (Greenberg, 2002). In some families, parents have not had the best emotion coaching in their own childhood, thereby passing unhelpful approaches to emotion processing from generation to generation. For example, in some families it is a sign of weakness to show sadness. In this case, the child is scolded and told, “don’t be sad” or “big girls don’t cry”. Such messages can be utterly confusing to a child who may in time respond to the dropping sense of sadness in her body with shame. The role of the therapist then is to work through the shame, be with that client in the experience of the

sadness, and coach her to respond to that sadness in a more adaptive way, for example, by seeking comfort.

Not surprisingly, not all of Jane's concerns were alleviated after 17 sessions of therapy. Interpersonal problems were still indicated at post-therapy. Jane expressed a hope for continued change within her family, including being more open with them about her experience. The presence of continued interpersonal problems after treatment for BN is common (Klump et al., 2007). It is perhaps that change in social adjustment requires additional time as the client navigates her way through her social world experimenting with a new way of being. Furthermore, Jane sought therapy for personal change and yet at the end of every therapy session she re-entered an unchanged social system. In the context of Jane's family, being overly-accommodating, self-sacrificing, and non-assertive may be adaptive. For example, in the pre-therapy interview Jane described pleasing her brother to avoid conflict. While still living at home, it likely will be difficult for Jane to feel comfortable expressing herself freely.

In addition, while Jane had made substantial gains in identifying the critical part of herself that drove her to high achievement, a shift away from perfectionism was just beginning to be realized. She had strongly connected with a sense that she set unrealistically high standards for herself, and yet was still hard on herself in aspects of her recovery process, for example, not cutting back on exercise as quickly as she had hoped. Perfectionism is a common personality trait in eating disorders, especially anorexia nervosa, and is also associated with clients like Jane who have a history of anorexia nervosa. Research suggests that the retention of personality characteristics such as perfectionism make it more difficult to treat individuals with BN and a history of

anorexia nervosa (Vaz-Leal et al., 2011). It is unclear if additional change would have occurred with additional sessions, although it is notable that in the post-therapy interview Jane expressed a wish for an increased number of sessions and for sessions to occur twice a week.

Implications for Practice

This case of EFT for BN provides evidence for the usefulness of the approach for individuals with BN. EFT offers an approach to the treatment of eating disorders that focuses on the individual's internal experience of her world, thereby decreasing focus on food and weight management. EFT techniques and tasks aim to allow for the experience of emotion, decrease the power of the internal critic, and access unresolved painful emotions, all within the context of a secure working alliance (Elliott, Watson, Goldman, & Greenberg, 2004). It is through this process of learning how to identify, label, and regulate emotion that the eating disorder becomes an unnecessary mechanism of emotion regulation, and why profound change can occur without intensive monitoring of weight and food intake. This approach to the treatment of eating disorders has the potential to reduce treatment dropout and attrition rates as well as improve treatment compliance. Jane, who had a previous experience of traditional treatment for eating disorders, reported how much she had appreciated taking the focus off food and having the freedom to discuss the things she knew were contributing to the eating disorder. This research confirms previous literature pointing to the promise of focusing on affect regulation for the treatment for BN (Federici & Kaplan, 2008; Harrison et al., 2010; Troop, Schmidt, & Treasure, 1995).

Limitations

While pre- to post-therapy change was indicated in this treatment study, there are certain factors related to single-case design and psychotherapy outcome research that place limitations on conclusions drawn. Length of treatment was a constraint of this study. Jane may have benefitted from longer-term treatment. In addition, extraneous factors that were not encompassed by selected outcome measures or interviews may have contributed to client change, such as client life factors occurring outside the therapy hour.

Research intrusion on the therapy process may also have influence results (McLeod, 2010; Stone & Elliott, 2011). Jane may have been cued by outcome measures to attend to the outcomes of interest to the researcher both during therapy and in the post-therapy interview. There is also evidence to suggest that research may have therapeutic effects, for example, Jane may have benefitted from reflecting on her experience when completing questionnaires (Stone & Elliott, 2011). Furthermore, research intrusion on the therapy process may have influenced the therapist. Research suggests that therapists who are engaged in research give extra attention and prepare more for clients who are part of their own case study (McLeod, 2002). Moreover, because I was both researcher and therapist, my own biases and allegiance to EFT may have influenced results.

While in our separate post-therapy interviews Jane and I attributed change to learning how to process emotion in a more adaptive way, it is not possible to make causal conclusions about EFT tasks and techniques used in this study and symptom change. Finally, it is not possible to generalize results to other therapists or clients with BN. Possible research intrusion on the therapy process, therapist biases, therapist allegiance to EFT, and other client extraneous variables may have influenced results. At the same time, McLeod (2002) recommends that through the accumulation of many case studies,

generalizations may be made. Despite the limitations of a single-case design, the case study offers a flexible, feasible means of recording and reporting innovations in practice (Fishman, 1999; McLeod, 2010). This study may provide a spark leading to additional, larger scale research studies of EFT for BN.

Implications for Research

More case studies are required to determine the specific casual mechanisms influencing client change when using EFT as an approach for BN. Furthermore, studies with larger sample sizes could be used to examine the application of EFT to BN more generally. Another tool to aid in the generalization of findings would be to replicate findings with additional case studies (McLeod, 2002). In addition, BN is an illness that commonly co-occurs with other axis I and axis II disorders (Thompson-Brenner et al., 2003). Additional studies examining EFT as a treatment for a client with BN and a comorbid condition could increase applications to the BN population generally.

Recently, EFT has been combined with a family-based approach to allow for work with mother-daughter dyads in therapy (Dolhanty & Lafrance, 2011). This approach is promising because it offers the opportunity for the mother to learn the role of the emotion coach within a supportive therapeutic environment. Additional research in this area would allow for the exploration of this approach in comparison to EFT or other treatments alone. Finally, this study utilized a convergent parallel mixed methods design. Mixed methods designs provide an opportunity to obtain a rich understanding of clinical outcomes, and are therefore recommended for other research studies of EFT for eating disorders as well as case studies generally.

Member Check and Personal Statement from the Client

In the final stages of preparing this document and obtaining final assent, a copy of the dissertation was provided to Jane along with a cover letter preparing her for the read. Jane was asked to pay attention to particularly sensitive, possibly identifying information and was also invited to provide feedback on any aspect of the dissertation. This closing procedure is recommended by McLeod (2010) as a way to promote consent and confidentiality.

Jane closely read the document over the course of several weeks and chose to provide feedback via email. She made several suggestions for changes in emphasis, particularly related to several quantitative and qualitative indicators of outcome. Changes were made as indicated and Jane provided final assent for the release of the report. In a final email, Jane enclosed the following personal statement to be included with the report:

> I, the client written about in this case study, have had the opportunity to read *A Case Study of Outcome in Emotion-Focused Therapy for Bulimia Nervosa* by Kendell Deanna Banack. I have been able to provide feedback to ensure the case report is an accurate representation of my therapy experience.

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Appendix A

Screening Phase 1: Telephone Screening

Describe the study:

The objective of this study is to develop a better understanding of an emotion-focused therapy for adult women with symptoms of bulimia nervosa. Emotion-focused therapy has been indicated as a helpful treatment for eating disorders and we want to better understand how and in what ways it is helpful.

This study is being conducted by Kendell Banack in partial fulfillment of requirements for a doctoral degree in Counselling Psychology at the University of Alberta. Some findings from this study may be written up as a case report in a dissertation.

If you are eligible for the study and decide to participate, you will be asked to attend 16 to 22 consecutive weekly sessions of individual Emotion-focused therapy at the Education Clinic, University of Alberta. Therapy will be provided free of charge. Weekly sessions will last about an hour. The day and time of these weekly sessions will be negotiated between the therapist and yourself and will depend on when therapy rooms are available in the clinic. The therapists participating in the study are doctoral level clinicians with experience and training in eating disorders and Emotion-focused therapy.

Participation in this study will include the completion of interviews before and after therapy and also the completion of questionnaires at the end of every session.

Interested so far?

Date: _____

Pseudonym: _____

Are you 18 years old or older? Y / N

Are you a student at the U of A? Y / N

Symptoms: _____
_____
_____

Symptoms (over past 28 days) > 2x/wk over last 3 months
Binge Days: ____ # Episodes: ____ Y / N
Compensatory Days: ____ # Episodes: ____ Y / N

Suicidal: Are you currently preoccupied with thoughts of suicide?
_____
_____

Substances: Do you currently have problems with your use of alcohol or drugs?
_____
_____

Checklist of Criteria

- 18 or older
- Bingeing and compensating on average twice a week for 3 months
- No imminent risk of suicide
- No substance abuse or dependence apparent
- No intention to obtain other treatment if participating

Intend to obtain other psychological treatment if participating in this study
Y / N _____

Any anticipated / foreseeable interruption in treatment from now to June 2012?
Y / N _____

Additional Information:

_____
_____
_____
_____

Interested in participating? Y / N
Eligible? Y / N

If no, why not? _____
If no, offer referral information.
Referral information offered? Y / N

If yes, when can we schedule a time to meet to more thoroughly discuss the study and determine your eligibility? (duration of meeting – 1.5 hours)
Date: _____
Time: _____
Location: _____

Appendix B

Report of Binge Eating and Purging

Please fill the appropriate number in the box on the right. Your therapist will not see this information until you are no longer receiving counselling from her. We are asking you for this information so at the end of therapy we can get a sense of whether there was change in some of your eating patterns. For this reason, please give your most honest answer.

Over the past week, how many times have you eaten what other people would regard as an unusually large amount of food (given the circumstances)? ☐

……..On how many of these times did you have a sense of having lost control over your eating (at the time that you were eating)? ☐

Over the past week, how many times have you fasted, made yourself sick (vomit), taken laxatives, diuretics, or diet pills, or exercised in a "driven" way (or used other methods) as a means of controlling your shape or weight? ☐

Appendix C

Interview Protocol: Pre-Therapy Interview with Client

Interviewer: Date:
Inteviewee: Time:
Place:

General Approach. Facilitate an empathic exploration. For each topic, use open-ended questions plus empathic understanding responses to help the client elaborate on his/her experiences. Use the "anything else" probe (e.g., "Are there any other changes that you have noticed?") in a non-demanding way until the client runs out of things to say.) This task should take **20-30 minutes**.

Topics:

1. Current medications (include dose, how long, last adjustment, herbal remedies)

2. How are you doing now in general?

3. Therapy:
    a. Please describe the main problems you are having right now that led you to seek therapy.
    b. Attribution: In general, what do you think has caused these issues you have just described? (source?)
    c. What is motivating you to seek therapy at this time? (What is it that is bringing you here at this particular time?)

4. What changes are you hoping to notice in yourself over the course of therapy?
   (If not organically shared in questions, ask about change in the following areas: weight & shape concerns / frequency of binge eating & compensating / relationships with friends & families / awareness, identifying, & describing emotions / coping with emotions / feeling distressed, blue, anxious, angry, scared / doing things without thinking & risk-taking)
    a. How likely do you think these changes would be without therapy?
    b. How important are these changes to you?

Change	Without therapy: 1-very unlikely 2-somewhat 3-neither 4-somewhat 5-very likely	Importance: 1-not at all 2-slightly 3-moderately 4-very 5-extremely
1.	1 2 3 4 5	1 2 3 4 5
2.	1 2 3 4 5	1 2 3 4 5
3.	1 2 3 4 5	1 2 3 4 5

4.	1 2 3 4 5	1 2 3 4 5
5.	1 2 3 4 5	1 2 3 4 5
6.	1 2 3 4 5	1 2 3 4 5
7.	1 2 3 4 5	1 2 3 4 5
8.	1 2 3 4 5	1 2 3 4 5

5. What are some of your fears associated with therapy?

6. Helpful Aspects: What do you anticipate might be helpful about therapy?

7. Problematic Aspects: What kinds of things about therapy are you worried might be hindering, unhelpful, negative, or disappointing for you?

8. What kinds of things about therapy do you anticipate might be difficult or painful, but still OK or perhaps helpful?

9. Suggestions / Additional Questions: Do you have anything else that you would like to tell me?

Adapted from the Network for Research on Experiential Psychotherapies http://www.experiential-researchers.org/

Appendix D

Interview Protocol: Post-Therapy Interview with Client

Interviewer: Date:
Client Initials: Time:
Case ID: Place:

Interview Strategy: This interview works best as a relatively unstructured empathic exploration of the client's experience of therapy. Think of yourself as primarily trying to help the client tell you the story of his or her therapy so far. It is best if you adopt an attitude of curiosity about the topics raised in the interview, using the suggested open-ended questions plus empathic understanding responses to help the client elaborate on his/her experiences. Thus, for each question, start out in a relatively unstructured manner and only impose structure as needed. For each question, a number of alternative wordings have been suggested, but keep in mind that these may not be needed.
- Ask client to provide as many details as possible
- Use the "anything else" probe (e.g., "Are there any other changes that you have noticed?"): inquire in a non-demanding way until the client runs out of things to say

Introduction:
Thank you for coming in.
This interview will take any where from 30 to 60 minutes.
The topics we will be covering today include any changes you have noticed since therapy began, what you believe may have brought about these changes, and helpful and unhelpful aspects of therapy.
The main purpose of this interview is to allow you to tell me about the therapy and the research in your own words.
This information will help us to understand better how the therapy works; it will also help us to improve the therapy.
Please provide as much detail as possible.

General Questions:
1. Current medications (include herbal remedies)

Medication Name	For what symptoms?	Dose/ Frequency	How long?	Last Adjustment?

2. What has therapy been like for you so far? How has it felt to be in therapy?

3. How are you doing now in general?

Self-Description:

4. How would you describe yourself? (If role, describe what kind of ____? If brief/general, can you give me an example? For more: How else would you describe yourself?)

5. How would others who know you well describe you? (How else?)

6. If you could change something about yourself, what would it be?

Changes:

7. What changes, if any, have you noticed in yourself since therapy started? (For example, are you doing, feeling, or thinking differently from the way you did before? What specific ideas, if any, have you gotten from therapy so far, including ideas about yourself or other people? Have any changes been brought to your attention by other people?)

8. Has anything changed for the worse for you since therapy started?

9. Is there anything that you wanted to change that hasn't since therapy started?

10. Change Ratings: (Go through each change and rate it on the scales:)
    a. How much did you expect or were surprised by this change?
    b. How likely would this change have been if you hadn't been in therapy?
    c. How important or significant to you personally is this change?

Change	Change was: 1-expected 2-somewhat 3-neither 4-somewhat surprised 5 – very surprised	Without therapy: 1-very unlikely 2-somewhat 3-neither 4-somewhat 5-very likely	Importance: 1-not at all 2-slightly 3-moderately 4-very 5-extremely
1.	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
2.	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
3.	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
4.	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
5.	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5

6.	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
7.	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
8.	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5

Attributions:

11. In general, what do you think has caused these various changes? In other words, what do you think might have brought them about? (Including things both outside of therapy and in therapy)

Helpful Aspects:

12. Can you sum up what has been helpful about your therapy so far? Please give examples. (For example, general aspects, specific events)

Problematic Aspects:

13. What kinds of things about the therapy have been hindering, unhelpful, negative or disappointing for you? (For example, general aspects. specific events)

14. Were there things in the therapy that were difficult or painful but still OK or perhaps helpful? What were they?

15. Has anything been missing from therapy? (What would have made your therapy more effective or helpful?)

Review Pre-therapy Change Ratings

16. Show client the change ratings from the pre-therapy interview, ask: How do you pre-therapy ratings compare with your post-therapy change ratings? (What is similar? What is different? How do you understand these similarities and differences?)

Closing:

17. Suggestions / Additional Questions: Do you have any suggestions for us, regarding the research or the therapy? Do you have anything else that you would like to tell me?

Adapted from the Network for Research on Experiential Psychotherapies http://www.experiential-researchers.org/

Appendix E

Interview Protocol: Post-Therapy Interview with Therapist

Interviewer:
Inteviewee:
Date of Interview:
Time of Interview:
Place of Interview:

Introduction:
Thank you for coming in.
This interview will take any where from 30 to 60 minutes.
The topics we will be covering today include how you perceive your client and any changes you have noticed in her since therapy began, what your process has been through therapy and a little bit about your theoretical orientation.
The main purpose of this interview is to allow you to tell me about the therapy and the research in your own words.
This information will help us to understand better how the therapy works; it will also help us to improve the therapy.
Please provide as much detail as possible.

Therapist's Perception of the Client and her Progress:

Client Description:

1. How would you describe your client?

2. If there is something about your client that you believe still needs to change, what would it be? (Anything that you think still needs to change in your client)

Changes:

3. What changes, if any, have you noticed in your client since therapy started? (For example, Is she doing, feeling, or thinking differently from the way she did before?)

4. Has anything changed for the worse for your client since therapy started?

5. Is there anything that your client wanted to change that hasn't since therapy started?

6. Change Ratings: (Go through each change and rate it on the following three scales:) (Can show this to the therapist)
    a. How much did you expect or were surprised by this change?
    b. How likely would this change have been if she hadn't been in therapy?

c. How important or significant do you think this change is?

Change	Change was: 1-expected 2-somewhat 3-neither 4-somewhat surprised 5 – very surprised	Without therapy: 1-very unlikely 2-somewhat 3-neither 4-somewhat 5-very likely	Importance: 1-not at all 2-slightly 3-moderately 4-very 5-extremely
1.	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
2.	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
3.	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
4.	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
5.	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
6.	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
7.	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
8.	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5

Attributions:

7. In general, what do you think has caused these various changes? In other words, what do you think might have brought them about? (Including things both outside of therapy and in therapy)

Helpful Aspects:

8. Can you sum up what you think has been helpful about the therapy with this client so far? Please give examples. (For example, general aspects, specific events)

Problematic Aspects:

9. What kinds of things about the therapy do you suspect have been hindering, unhelpful, negative, or disappointing for your client? (For example, general aspects, specific events)

10. Were there things in the therapy that seemed to be difficult or painful for the client but still OK or perhaps helpful? What were they?

Therapist's Process

11. How has being the counsellor for this client been like for you? How has it felt to be the counsellor in this case?

12. How would you describe your working relationship? (rate on scale of 1 – 10)

13. What was challenging about working with this client?

14. What was enjoyable about working with this client?

15. What have you learned from working with this client?

Therapist's Theoretical Orientation

16. How would you describe your theoretical orientation?

17. You were asked to use EFT…
    a. How was this for you? Challenges?
    b. In what ways do you believe EFT has had to be adapted for this particular client?
18. Has anything been missing from your treatment plan/approach? (What would make/have made your therapy more effective or helpful?)

19. Suggestions / Additional Questions: Do you have any suggestions for us, regarding the research or the therapy? Do you have anything else that you want to tell me?

Adapted from the Network for Research on Experiential Psychotherapies http://www.experiential-researchers.org/

CHAPTER 5

CONCLUSION

The primary goal of this dissertation was to test and illustrate the use of emotion-focused therapy (EFT) for bulimia nervosa (BN) through the use of two distinct, yet related case studies employing mixed methods designs. The secondary goal was to situate these case studies within a broader examination of the history and value of case studies in psychotherapy research. Movement towards large group designs and randomized control trials as the gold standard of research has contributed to a dramatic decline of case study research in psychotherapy in recent years (McLeod, 2002). Researchers and practitioners within the field have begun to argue that case studies contribute unique knowledge, and therefore hold an important place alongside other forms of research if we are to have a holistic body of literature that offers both breadth and depth of knowledge (Borckardt et al., 2008; Fishman, 2005). This three-paper dissertation has attempted to highlight the usefulness and limitations of systematic case study research using a historical review of case studies in psychotherapy and two case studies of EFT for the treatment of a client with BN.

Clinical Implications

Current recommended treatments for BN focus on treating a client's over-estimation of shape and weight. These treatments are moderately successful but are also associated with low rates of treatment compliance (Palmer, Gatward, Black, & Park, 2000), high rates of attrition (Bulik et al., 2007; Shapiro et al., 2007), and high rates of relapse (Federici & Kaplan, 2008). EFT offers an approach to the treatment of BN that focuses on an individual's internal experience, thereby decreasing focus on food and

weight management. In EFT, the eating disorder is conceptualized as a mechanism to regulate emotion (Anestis et al., 2007; Dohanty, 2006; Polivy & Herman, 2002). The goal is to help a client learn how to identify, label, and regulate emotion so that the eating disorder is no longer required.

Chapters 3 and 4 presented two unique studies of one case of EFT for BN. They are the only known empirical studies of EFT for the individual treatment of BN. The study in Chapter 3 was written in the style of a pragmatic case study. It illustrated the use of EFT for BN and also provided evidence of a positive outcome based on decreased behavioural symptoms of BN and fewer difficulties in emotion regulation. The extensive use of transcripts and detailed descriptions of techniques in this study will help practitioners to better understand the application of EFT for BN. The study in Chapter 4 was a more outcome focused case study and utilized quantitative measures as well as interviews with the client pre- and post-therapy to understand client change. It provided evidence for the usefulness of EFT for BN in this one case. Together, these studies provide empirical support for the use of EFT for the treatment of BN and confirm previous literature pointing to the promise of addressing the affect regulation difficulties inherent to the disorder (Harrison et al., 2010; Troop, Schmidt, & Treasure, 1995). Furthermore, this unique approach to the treatment of BN has the potential to reduce the high treatment dropout and attrition rates associated with the more traditional treatment approaches as well as improve treatment compliance.

Research Implications: The Unique Contributions of Case Study Research

Chapter 2 summarized arguments for the on-going relevance of case study research in psychotherapy. These arguments for the value of case study research can by

exemplified by the studies presented in Chapters 3 and 4. One of the unique contributions of the case study approach is a more memorable, narrative form of research (McLeod, 2010). While a reader of Chapters 3 and 4 may not remember the precise variables measured, analyses conducted, or formal statistical conclusions drawn, it is likely that the story of Jane and her long struggle with BN, the unhelpful family interactions that likely initiated and maintained the disease, and her movement towards emotional acceptance are remembered in a meaningful way. This more familiar way of knowing is particularly important in a clinical setting where practitioners are face to face with other human beings with their own unique stories. It has been argued that knowing in this way aids clinical case formulation and improves subsequent clinical treatment (Eells & Lombart, 2003; Eells, Lombart, Kendjelic, Turner, & Lucas, 2005).

Respecting the complexity of human phenomena can be challenging when limited to aggregated data, discrete measurement, and few dependent variables. In Chapters 3 and 4, the case study approach allowed for the study of complex phenomena in the context of a case as a whole. In Chapter 3, continuous measurement was obtained over the course of 17 sessions of psychotherapy. Dependent variables included frequency of behaviours associated with BN and difficulties in emotion regulation as well as the working alliance as a weekly process measure. Furthermore, transcripts of therapy sessions were used to better understand the content and process of the treatment approach as well as possible mechanisms of change. This data provided an in-depth, descriptive glimpse into an innovative approach to the treatment of BN in a way that practitioners may be able to draw clinical insights and explore new practice directions. Large scale research designs are limited in their capacity to gather information regarding the context

of participants' lives, multiple dependent variables, and qualitative data generally. Also, while large scale designs are capable of providing causal information, discrete quantitative measurement of few dependent variables limits the ability to draw conclusions about *how* change occurs (Elliott, 2002). Similarly, in Chapter 4, multiple measurements of outcome were obtained including qualitative indicators of change. This data contributed to a richer understanding of therapy outcome that included the perspective of the client. Outcome measurement to this depth is not feasible in large scale designs. These observations support McLeod (2002) and McLeod and Elliott's (2011) assertion that case study research respects the complexity of human psychological phenomena.

Another unique contribution of case study research as exemplified in Chapters 3 and 4 is the capacity to bridge research and practice specifically in the context of psychotherapy training. Henton (2012), Moran (2011), and Mackrill and Iwakabe (2013) have argued for the better integration of research and clinical practice in training programs. Case study research offers the opportunity for students to improve case formulation skills, receive feedback on interventions, and learn new approaches to treatment (Eells & Lombart, 2003; Mackrill & Iwakabe, 2013). In the context of this dissertation, engaging in case study research allowed me as a student to become serious about my knowledge of EFT and it's specific application to BN. My clinical learning as part of this research project included formal training in EFT from Dr. Leslie Greenberg, formal training in EFT as applied to eating disorders from Dr. Joanne Dolhanty and Dr. Adele Lafrance Robinson, immersing myself in the literature, clinical experience, and bi-weekly supervision from an expert in EFT. This training was required for this

dissertation, but has also helped me to establish an area of expertise as a psychologist. A different dissertation research program would not have afforded me the opportunity to develop clinical skills to this degree. Overall, engagement in case study research has the great potential to benefit trainees as well as experienced practitioners by offering a narrative, hands on form of knowing that respects the complexity of human psychological phenomena.

Limitations of the Case Study Approach

Like other research approaches, case study research has its limitations. Primarily, it is highly ethically sensitive. Case study research poses unique challenges to obtaining truly autonomous, informed consent (Gavey & Braun, 1997; Winship, 2007). It can also intrude on therapy process (McLeod, 2010) and be difficult to guarantee client confidentiality given the vast amount of personal data collected (McLeod & Elliott, 2011). With careful planning and sensitivity, these ethical issues can be addressed, and authors such as McLeod (2010) have gone to great lengths to describe such procedures. In addition, Chapter 1 explained how these ethical issues were addressed for the studies presented in Chapters 3 and 4. Using strategies such as process consent (Grafanaki, 1996), altering peripheral client facts as is recommended in the Journal of Pragmatic Case Studies in Psychology (PCSP) guidelines for authors, and involving the client as a co-researcher (Stone & Elliott, 2011) are examples of practical strategies to address ethical concerns. Other research designs typically do not require such diligent attention to ethical concerns, so researchers not prepared to seriously address the ethical issues of case study research would be wise to explore alternative research approaches.

There is a limited capacity to generalize findings from a single case. The issue of generalization is one of the most criticized limitations of case study research (Iwakabe & Gazzola, 2009). Large group designs allow one to conclude that findings apply to the larger population from which the sample was drawn. This type of generalization is not possible from a single case. For this reason, some have argued that case studies do not offer valuable knowledge (Eysenck, 2004). In response to this general criticism, Flyvberg (2006) commented that formal generalization is "considerably overrated as the main source of scientific progress" (p. 226), and furthermore, that other forms of knowledge have value and are capable of contributing to knowledge accumulation.

While it is true that generalization from case study research is not possible in the traditional sense, several authors have proposed innovative approaches to generalization in case study research. Stiles (2007) described how case study research can contribute to theory which in turn can be applied to other cases. Iwakabe and Gazzola (2009) outlined several strategies, for example, meta-analysis of single cases or individual case comparisons of closely paired cases that can be used to discover general aspects of therapy that are helpful or hindering. Fishman (1999) argued for the development of a case study database. McLeod (2002) and Morgan and Morgan (2009) also advocated for generalization through the accumulation of case study research.

In the context of the studies presented in Chapters 3 and 4, possible avenues for generalization include the following. First, readers may learn about the unique aspects of EFT for BN such as increased frequency of chair work and common challenges with the separation-individuation process for individuals with this disorder and apply this knowledge to other cases. Furthermore, if additional case studies exploring EFT for

eating disorders are published, generalizations regarding treatment principles could be made. Lack of generalization in the traditional sense is a true limitation of case study research, but researchers can still contribute valuable knowledge using case study research and may also explore innovative approaches to generalization.

Towards Methodological Pluralism

This dissertation was used to examine EFT for BN using case study methodology and it also more broadly sought to make an argument for the value of systematic case study research in psychotherapy. The purpose of this dissertation was not to promote case studies as the new gold standard of research in psychotherapy, but rather, to encourage recognition of the unique and necessary knowledge contributions of case studies. What is hoped for in the future is recognition of the value of both case studies and large group designs. The studies that are part of this dissertation exemplify some of the advantages of case study research. They illustrate an innovative approach to the treatment of BN, offer a memorable, narrative way of knowing, and give insight into the process and content of EFT for BN. If additional smaller scale studies on the treatment of BN using EFT were accumulated, other practitioners may be inspired to conduct much larger studies. By combining case study research that promotes an understanding of therapy process and larger scale research that provides evidence of therapy efficacy, a broader, more convincing and understandable body of literature would be created that has the capacity to influence practitioner treatment decisions.

The possibility of establishing reciprocal relationships between large scale group research and single case studies has been explored by others in the field. Flyvberg (2006) argued that large scale studies provide rule-based knowledge that helps practitioners to

build basic foundational understanding, and case studies provide context-dependent knowledge that helps practitioners to gain competence and expertise. Franz (1992) proposed that large scale studies produce general knowledge and case studies examine the applicability of this knowledge. McLeod and Elliott (2011) highlighted the potential for large scale designs to contribute knowledge about causality and case studies to identify specific factors leading to outcome. Stewart and Chambless (2010) reported that practitioners are more likely to adopt evidence-based treatments when a case study is reported in the article. Borckardt et al. (2008) identified the utility of case studies for testing evidence-based treatments for a different disorder than the one for which it had been established. Furthermore, RCTs may follow a case study that records innovations in practice (Borckardt et al., 2008). Another unique example of a reciprocal relationship between large scale designs and case studies was a series of case studies following an randomized control trial with difficult to interpret results. Several good and several poor outcome cases were identified for single case analysis in order to better interpret the results from the randomized control trial (see Goldman, Watson, & Greenberg, 2011; Watson, Goldman, & Greenberg, 2011). Continuing to explore the strengths of different research approaches would undoubtedly contribute to a more holistic, useable body of literature for practitioners and enable researchers to pursue more sophisticated research questions in the future.

General Conclusion

This dissertation presented two unique studies of one case of EFT for BN and situated these case studies within a broader examination of the history and value of case study research in psychotherapy. Chapter 2 provided a selective historical review of case

studies in psychotherapy. The evolution of the case study was illustrated by anchoring methodological developments to four key individuals within different orientations, exploring the demise of the case study, and then discussing the emergence of the modern case study as a systematic and rigorous form of research. Tracing the contributions of case study research across history provides a context for understanding the role case studies played in laying the foundation for much of our psychotherapy knowledge today. Chapter 3 was written in the style of a pragmatic case study. It outlined the session-by-session process of EFT for BN in the case of Jane. This mixed methods case study illustrated the capacity of case study research to offer an in-depth understanding of an innovative treatment approach as well as a narrative form of knowing which can inform practice. Chapter 4 described the outcome of EFT for BN using the same case of Jane. This unique, more outcome-based case study drew from modern mixed methods approaches. This allowed for a systematic, yet flexible examination of the research questions. In this study, quantitative data as well as client and therapist perspectives were used to generate of more comprehensive understanding of change from pre- to post-therapy and into follow-up. The capacity to generalize findings from these studies may be discovered in the accumulation of a series of case studies exploring EFT for BN. As a whole, this dissertation explored EFT for BN while also pointing to the potential of case study research to contribute to theory and practice in psychotherapy.

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