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Change processes in therapy: Case studies in Process-Experiential / Emotion-Focused Therapy

Appendix A • Differential DSM-IV-TR Criteria for Depressive Disorders

Table A1. Differential DSM-IV-TR criteria for depressive disorders.

Major Depressive Episode	Minor Depressive Episode ¹	Dysthymic Disorder	Mixed Anxiety-Depressive Disorder ¹
Impairment varies from mild to severe, but there must be either clinically significant distress or some interference in social, occupational, or other important areas of functioning	One or more periods of depressive symptoms that are identical to Major Depressive Episodes in duration, but which involve fewer symptoms and less impairment.	There may have been a previous Major Depressive Episode provided there was a full remission (no significant signs or symptoms for 2 months) before development of the Dysthymic Disorder.	Individuals whose presentation meets these criteria would be diagnosed as having “Anxiety Disorder Not Otherwise Specified”
A. Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; B. at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.	A. At least two (but less than five) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; B. at least one of the symptoms is either (1) or (2):	A. Depressed mood for most of the day, for more days than not, as indicated either by subjective account or observation by others, for at least 2 years B. Presence, while depressed, of two (or more) of the following:	A. Persistent or recurrent dysphoric mood lasting at least 1 month. B. The dysphoric mood is accompanied by at least four (or more) of the following symptoms:

¹ New diagnostic categories that require further study have been placed in Appendix B of the DSM-IV-TR. This appendix contains a number of proposals for new categories and axes that were suggested for possible inclusion in DSM-IV. The DSM-IV Task Force and Work Groups subjected each of these proposals to a careful empirical review and invited wide commentary from the field. The Task Force determined that there was insufficient information to warrant inclusion of these proposals as official categories or axes in DSM-IV.

Major Depressive Episode	Minor Depressive Episode	Dysthymic Disorder	Mixed Anxiety-Depressive Disorder ¹
(1) Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful). <input type="checkbox"/>	(1) Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful). <input type="checkbox"/>		being easily moved to tears <input type="checkbox"/> worry <input type="checkbox"/>
(2) Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others) <input type="checkbox"/>	(2) Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others) <input type="checkbox"/>		anticipating the worst <input type="checkbox"/> hypervigilance <input type="checkbox"/>
(3) Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. <input type="checkbox"/>	(3) Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. <input type="checkbox"/>	poor appetite or overeating <input type="checkbox"/>	
(4) insomnia or hypersomnia nearly every day <input type="checkbox"/>	(4) insomnia or hypersomnia nearly every day <input type="checkbox"/>	insomnia or hypersomnia <input type="checkbox"/>	sleep disturbance (difficulty falling or staying asleep, or restless, unsatisfying sleep) <input type="checkbox"/>

Major Depressive Episode	Minor Depressive Episode	Dysthymic Disorder	Mixed Anxiety-Depressive Disorder ¹
(5) psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down) <input type="checkbox"/>	(5) psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down) <input type="checkbox"/>		irritability <input type="checkbox"/>
(6) fatigue or loss of energy nearly every day <input type="checkbox"/>	(6) fatigue or loss of energy nearly every day <input type="checkbox"/>	low energy or fatigue <input type="checkbox"/>	fatigue or low energy <input type="checkbox"/>
(7) feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick) <input type="checkbox"/>	(7) feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick) <input type="checkbox"/>	feelings of hopelessness ... of pessimism ... or despair ... <input type="checkbox"/> low self-esteem ... or self confidence ... or feelings of inadequacy ... <input type="checkbox"/>	hopelessness (pervasive pessimism about the future) <input type="checkbox"/>
(8) diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others) <input type="checkbox"/>	(8) diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others) <input type="checkbox"/>	poor concentration or difficulty making decisions <input type="checkbox"/>	difficulty concentrating or mind going blank <input type="checkbox"/>
		low self-esteem ... or self confidence ... or feelings of inadequacy ... <input type="checkbox"/>	low self-esteem or feelings of worthlessness <input type="checkbox"/>

Major Depressive Episode	Minor Depressive Episode	Dysthymic Disorder	Mixed Anxiety-Depressive Disorder¹
(9) recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide <input type="checkbox"/>	(9) recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide <input type="checkbox"/>		

Source: (American Psychiatric Association, 2001).

Appendix B • PE-EFT Outcome Research

In the York I depression study, Greenberg and Watson (1998) studied the effectiveness of PE-EFT in comparison to person-centred psychotherapy for depression. Thirty-four unmedicated adults (Global Assessment of Functioning (GAF) >50), 25 women and 9 men, mean age of 39.64 ($SD = 11.97$), who met the DSM-III-R (American Psychiatric Association, 1987) criteria for major depression were randomly assigned to one of the two treatments. Measures used included the Beck Depression Inventory (BDI; Beck, Ward, Mendelsohn, Mock, & Erbaugh, 1961), Symptom Checklist-90-Revised (SCL-90-R; Derogatis, Rickels, & Roch, 1976), the Rosenberg Self-Esteem inventory (Bachman & O'Malley, 1977), the Inventory of Interpersonal Problems (IIP; Horowitz, Rosenberg, & Baer, 1988) and the Working Alliance Inventory (WAI; Horvath & Greenberg, 1989). There were no significant differences on termination between the groups on the BDI. A BDI score of <10 was considered recovered. There were, however, significant differences in favour of the PE-EFT group in the areas of greater improvement in self-esteem ($p < .02$), reduction in overall symptoms ($p < .01$), and fewer interpersonal problems ($p < .0001$). In addition, by mid-treatment clients undergoing PE-EFT showed quicker response to treatment on all outcome measures than those in the person-centred treatment (Greenberg & Watson, 1998).

The working alliance appeared to be an overarching factor in the success in both treatments. Greenberg and Watson (1998) hypothesised that the client-centred therapy “seemed to work by validating people’s inner experiencing and helping them to use their experiences as a guide to the creation of new meaning and action” (p. 221). In the PE-EFT group clients referred to “both the relationship and the dialogues in the chairs as helping them to change” (p. 221). It could be said that the addition of the specific active tasks at appropriate moments within the sessions seemed to hasten and enhance recovery. This study provided preliminary evidence for the probable efficacy of experientially orientated approaches in treating depression. Limitations of this study include the use of self-report measures alone to assess outcomes at termination. The generalisation of the results is only applicable to depressed clients

with a GAF >50 who had fewer than three prior episodes of depression. The role of allegiance may have also confounded the results. “Therapists were used as their own control and could be viewed as possibly favouring the use of active experiential interventions” (p.221). However, the researchers stated that there were no therapist effects for either treatment. There is also a significant use of empathic responding in the PE-EFT condition thereby making it difficult to separate the addition of the PE-EFT interventions from the therapists’ beliefs that empathic attunement was a key ingredient in treatment.

Client data was taken from the York I depression study and analysed by Weerasekera, Linder, Greenberg, and Watson (2001). The researchers examined the development of the working alliance in both PE-EFT and client-centred therapy. Results revealed that the alliance predicted outcome as early as session three. In addition, the alliance-outcome relationship varied with the alliance dimension. This was shown in measures of goal, task, or bond on the WAI (Horvath & Greenberg, 1989), in outcome measures (symptom improvement versus self-esteem, relational problems) and when in-treatment alliance was measured. Further analyses revealed that early alliance scores predicted outcome independently of early mood changes. Although no treatment group differences were found for bond and goal alliance, the PE-EFT group showed higher task alliance scores in the mid-phase of therapy. The level of pre-treatment depression didn’t affect alliance formation.

The York II depression study by Greenberg, Goldman, and Angus (2001, as cited in Elliott, Greenberg, & Leitaer, 2004) replicated the York I study by comparing the effects of client-centred therapy and PE-EFT on 38 clients with major depression. The 14 men and 24 women were randomly assigned to one of the two (16 to 20) session treatments: relational client-centred therapy or PE-EFT. Analysis revealed an effect size of .71 in favour of PE-EFT. The investigators then combined the York I and II samples to increase the power to test for differences between the groups. Statistically significant differences were detected on all indices of change for the combined sample, which provided evidence that the addition of the PE-EFT interventions to the client-centred empathic relationship improved outcome.

Goldman, Greenberg, and Angus (2006) published further analyses of the findings of the York II study. At the end of treatment, 100% of participants in the PE-EFT

group were no longer depressed compared with 95% of the relational client-centred group. Results on clinical significance were similar to or better than those from other studies (see Goldman et al., 2006). Analysis revealed a mean overall comparative effect size of .33. for PE-EFT versus person-centred therapy. Several factors should be considered when interpreting these findings. Therapist and researcher bias could have affected the results if therapists were biased towards seeing the person centred approach as less effective than the PE-EFT. The researchers considered that therapist and researcher bias could have confounded the results but subsequent analysis of the bias did not yield significant results (Goldman et al., 2006).

In the York II study (2001) 84% in the client-centred condition and 95% in the PE-EFT condition met the reliable change index RCI criteria (as cited in Goldman et al., 2006). When the samples from the York I and II studies were combined, 86% of clients in the client-centred condition and 89% of the PE-EFT condition met the RCI criteria (as cited in Goldman et al., 2006). By way of comparison, it is interesting to note that, in a review of the National Institute of Mental Health (NIMH) Treatment of Depression Collaborative Research Program, Ogles, Lambert, and Sawyer (1995) found that for clients who completed at least 12 sessions and 15 weeks of treatment, 50% of clients in the Cognitive Behavioural therapy (CBT) condition and 64% of clients in the interpersonal therapy (IPT) condition met the reliable change index (RCI).

Watson, Gordon, Stermac, Kalogerakos, and Steckley (2003) conducted a randomised control trial study comparing PE-EFT and CBT in the treatment of major depression. Sixty-six unmedicated, depressed clients, mean age of 41.52 ($SD = 10.82$), underwent a series of 16 weekly psychotherapy sessions. There were eight CBT therapists and seven PE-EFT therapists involved. Allegiance effects were controlled for by having an expert in each modality train and supervise the therapists. At the end of their training the therapists were considered competent in their trained approach and adhered to that approach. However, there was no formal assessment of that competency in the trained approaches.

There was no difference between groups (comparative $ES = .11$) in terms of clients' depression, self-esteem, dysfunctional attitudes and general level of distress, and this finding is consistent with the majority of outcome studies (Watson et al.,

2003). However, there were differences between the two treatments in terms of clients' reports of their interpersonal problems as measured by the Inventory of Interpersonal Problems (IIP; Horowitz et al., 1988). Clients in the PE-EFT group were significantly more self-assertive and less overly accommodating, less self-sacrificing, less domineering and controlling. Watson et al. (2003) suggested that the greater improvement in clients' interpersonal functioning may be as a result of the therapeutic relationship's modelling empathy, acceptance and positive regard. In addition, specific tasks of PE-EFT may have helped clients' to improve their interpersonal functioning, since in two-chair and empty-chair tasks, clients are encouraged to express their needs and to request changes in appropriate, non-blaming ways and to listen to the other's response. There were several limitations cited by the researchers. For ethical reasons a wait-list was not employed and the small sample size meant that small effect sizes could not be detected. In addition, all the data collected was from self-report measures and there were no evaluations made by external observers. The method of recruitment of clients and a high rate of attrition may have implications for the generalisability of the findings. There were no long-term follow-up data collected.

A study conducted by Goldman et al. (2006) aimed to determine whether the addition of specific PE-EFT interventions to the client-centered relationship common to both treatments enhances outcome in the treatment of depression. The addition of PE-EFT interventions to the relational conditions was found to increase the effectiveness of the treatment. The PE-EFT group showed superior effects for the alleviation of depressive and general symptom distress. In the combined York I and II sample analysis, PE-EFT showed superior results on all outcome indices, including relief of symptom distress, and improvement on interpersonal functioning and self-esteem measures. In a recent follow-up study conducted by the York II team the maintenance of reduction in depression over 18 months was investigated (Ellison et al., 2009). The Longitudinal Interval Follow-up Evaluation for depression (Keller et al., 1987) was administered at the beginning of each six-, twelve- and eighteen-month follow up interview to obtain evaluations of the previous six months. The BDI, SCL-90-R, RSE and IIP were also administered at the 6-month and eighteen month follow-up periods. Overall, there was support for the hypothesis that the addition of PE-EFT

interventions to the relational conditions of client-centred therapy would lead to increased maintenance of therapy gains (reduced depression) across follow-up assessments (Ellison et al., 2009). PE-EFT clients maintained treatment gains of minimal or non-depressive symptoms for a significantly longer period of time across the follow-up periods. From clients' self-reports PE-EFT appeared to have led to more active and effective ways of dealing with emotional distress in the follow-up periods.

In summary, the developers of PE-EFT have conducted numerous well-designed outcome studies that provide evidence that PE-EFT is an efficacious treatment for depression in adult populations. The addition of the PE-EFT interventions to the client-centred empathic relationship improved outcome and led to increased maintenance of therapy gains in PE-EFT clients. Whilst there was equivalence when compared to CBT there were differences between the two treatments in terms of improvement in interpersonal problems in favour of PE-EFT.

Change processes in therapy: Case studies in Process-Experiential / Emotion-Focused Therapy

Appendix C • Poster

RESEARCH AND FREE COUNSELLING

Are you depressed? Are you aged between 18-25?

If so, you may be eligible to participate in a doctoral research project that provides 12 free emotion-focused counselling sessions

A therapy known as Process-Experiential Emotion-Focused Therapy (PEEFT), taught at the university since 1997, has been found to be effective with depression with adults. In PEEFT, therapists work to assist people to become aware of, accept and make sense of their emotional experiences. Depressed clients receiving PEEFT have been found to have improvement in interpersonal problems, self-esteem and reduced risk of relapse.

The therapy is provided by a recently trained, doctoral-level, probationary psychology student, educated in PEEFT in the School of Public Health in the Department of Counselling Psychological Health

**Please contact Melissa Harte
maharte@students.latrobe.edu.au
for information and to organise an appointment.**

Change processes in therapy: Case studies in Process-Experiential / Emotion-Focused Therapy

Appendix D • Beck Depression Inventory – Second Edition (BDI-II)

The BDI, introduced in 1961, was derived from clinical observations about attitudes and symptoms displayed frequently by depressed and infrequently by non-depressed psychiatric patients (Beck, Steer, & Garbin, 1988). The BDI has been described by Nezu, Ronan, Meadows, and McClure, (2000) as the most widely used self-report instrument for measuring depressive symptom severity in both research and clinical settings. In addition, according to Shaver and Brennan (1991) and more recently others (e.g. Whisman, Perez, & Ramel, 2000) the BDI has become the standard by which the validity of other scales for measuring depression is evaluated.

The BDI-II was developed in order to adhere more closely with the diagnostic criteria for major depressive episode in the text revision of the 4th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR; American Psychiatric Association, 2001). Like the BDI-the BDI-II is a 21-item self-report that assesses the severity of depressive symptomatology in adolescents (13+) and adults (Beck & Steer, 1987; Beck, Steer, & Brown, 1996), not only in psychiatrically-diagnosed patients but also in normal populations (Beck et al., 1988; Steer, Beck, & Garrison, 1986).

Participants are asked to choose one statement from among the group of four statements in each question that best describes how they have been feeling. Each item or symptom is rated on a 4-point scale ranging from zero to three, and the inventory is scored by summing the highest ratings for each of the 21 items. The total scores can range from zero to 63 with higher scores indicating increased levels of depression. Cut-off scores can serve as guidelines for understanding symptom severity: minimal depression (0-13), mild depression (14-19), moderate depression (20-28) and severe depression (29-63).

In the revision process for the BDI-II, four items (weight loss, body image change, somatic preoccupation and work difficulty) were dropped and replaced by four new items (agitation, worthlessness, concentration difficulty and loss of energy) in order to index symptoms typical of severe depression. Two items were changed to allow for increases as well as decreases in appetite and sleep. In addition many of the statements

(or alternatives) used in rating the other symptoms were reworded (Beck et al., 1996). As well as this the time frame of the BDI-II was extended to two weeks (versus the “past week, including today” in the BDI) in order to be consistent with the DSM-IV criteria for major depression. The BDI-II has been found to demonstrate high internal consistency among college students ($\alpha = .93$) and among clinical outpatients ($\alpha = .92$; Beck et al., 1996). Validity coefficients were reported by Beck, Steer, and Garbin (1988) as ranging from .66 to .86. For example, the BDI-II was found to correlate .71 with the Hamilton Rating Scale for Depression and to correlate .68 with the Beck Hopelessness Scale (Nezu et al., 2000).

Beck Depression Inventory: BDI-II (Beck, Steer, & Brown, 1996)

This questionnaire consists of 21 groups of statement. Please read each group of statements carefully, and then pick out the **one statement** in each group that best describes the way you have been feeling during the **past two weeks, including today**. Circle the number beside the statement you have picked. If several statements in the group seem to apply equally well, circle the highest number for that group. Be sure that you do not choose more than one statement for any group, including Item 16 (Changes in Sleeping Patterns) or Item 18 (Changes in Appetite).

1 Sadness

- 0 I do not feel sad.
- 1 I feel sad much of the time
- 2 I am sad all the time
- 3 I am so sad or unhappy that I can't stand it.

2 Pessimism

- 0 I am not discouraged about my future.
- 1 I feel more discouraged about my future than I used to be.
- 2 I do not expect things to work out for me
- 3 I feel my future is hopeless and will only get worse

3 Past Failure

- 0 I do not feel like a failure.
- 1 I have failed more than I should.
- 2 As I look back, I see a lot of failures.
- 3 I feel I am a total failure as a person.

4 Loss of Pleasure

- 0 I get as much pleasure as I ever did from things I enjoy.
- 1 I don't enjoy things as much as I used to.
- 2 I get very little pleasure from the things I enjoy.
- 3 I can't get any pleasure from the things I used to enjoy.

5 Guilty Feelings

- 0 I don't feel particularly guilty.
- 1 I feel guilty over many things I have done or should have done.
- 2 I feel quite guilty most of the time.
- 3 I feel guilty all of the time.

6 Punishment Feelings

- 0 I don't feel I am being punished.
- 1 I feel I may be punished.
- 2 I expect to be punished.
- 3 I feel I am being punished.

7 Self-Dislike

- 0 I feel the same about myself as ever
- 1 I have lost confidence in myself.
- 2 I am disappointed with myself.
- 3 I dislike myself.

8 Self-Criticisms

- 0 I don't criticise or blame myself more than usual
- 1 I am more critical of myself than I used to be
- 2 I criticise myself for all my faults.
- 3 I blame myself for everything bad that happens.

9 Suicidal Thought or Wishes

- 0 I don't have any thoughts of killing myself.
- 1 I have thoughts of killing myself, but I would not carry them out.
- 2 I would like to kill myself.
- 3 I would kill myself if I had the chance.

10 Crying

- 0 I don't cry any more than I used to.
- 1 I cry more than I used to.
- 2 I cry over every little thing.
- 3 I feel I want to cry but can't.

11 Agitation

- 0 I am no more restless or wound up than usual.
- 1 I feel more restless or wound up than usual.
- 2 I am so restless or agitated that it's hard to stay still.
- 3 I am so restless or agitated that I have to keep moving or doing something.

12 Loss of Interest

- 0 I have not lost interest in other people or activities.
- 1 I am less interested in other people or things than I used to be.
- 2 I have lost most of my interest in other people or things.
- 3. It's hard to get interested in anything

13 Indecisiveness

- 0 I make decisions about as well as ever
- 1 I find it more difficult to make decisions than usual
- 2 I have greater difficulty in making decisions than I used to.
- 3 I have trouble making any decisions

14 Worthlessness

- 0 I don't feel that I am worthless
- 1 I don't consider myself as worthwhile and useful as I used to.
- 2 I feel more worthless as compared to other people
- 3 I feel utterly worthless

15 Loss of Energy

- 0 I have as much energy as ever.
- 1 I have less energy than I used to
- 2 I don't have much energy to do very much.
- 3 I don't have enough energy to do anything

16 Changes in Sleeping Pattern

- 0 I have not experienced any change in my sleeping pattern
- 1a I sleep somewhat more than usual
- 1b I sleep somewhat less than usual.
- 2a I sleep a lot more than usual
- 2b I sleep a lot less than usual
- 3a I sleep most of the day
- 3b I wake up 1-2 hours early and cannot get back to sleep.

17 Irritability

- 0 I am no more irritable than usual
- 1 I am more irritable than usual
- 2 I am much more irritable than usual
- 3 I am irritable all the time

18 Changes in Appetite

0 I have not experienced any change in my appetite

- 1a My appetite is somewhat less than usual
- 1b My appetite is somewhat more than usual.
- 2a My appetite is much less than before
- 2b My appetite is much greater than usual
- 3a I have no appetite at all
- 3b I crave food all the time

19 Concentration Difficulty

- 0 I can concentrate as well as ever
- 1 I can't concentrate as well as usual
- 2 It's very hard to keep my mind on anything for very long
- 3 I find I can't concentrate on anything

20 Tiredness and Fatigue

- 0 I am no more tired or fatigued than usual.
- 1 I get more tired or fatigued more easily than usual
- 2 I am too tired and fatigued to do a lot of the things I used to do
- 3 I am too tired or fatigued to do most of the things I used to do

21 Loss of Interest in Sex

- 0 I have not noticed any recent change in my interest in sex.
- 1 I am less interested in sex than I used to be.
- 2 I am much less interested in sex now.
- 3 I have lost interest in sex completely.

Change processes in therapy: Case studies in Process-Experiential / Emotion-Focused Therapy

Appendix E • Depression, Anxiety and Stress Scale (DASS)

The DASS, developed in Australia is a set of three self-report scales designed to measure the negative emotional states of depression (D), anxiety (A) and stress (S), in older adolescents (17+) and adults, using a dimensional approach (Lovibond & Lovibond, 1995). This inventory was initially developed to assess the core symptoms of anxiety and depression while maintaining maximum discrimination between the two scales. The Stress scale was added later when factor analyses indicated its presence (Lovibond & Lovibond, 1995). The DASS is a 42-item self-report measure, where each of the three scales contain 14 items, which are then divided into subscales of 2-5 items with similar content (Lovibond & Lovibond, 1995). These scales are represented by the acronyms of DASS-D for the depression subscale, DASS-A for the anxiety subscale and DASS-S for the stress subscale.

Participants were asked to use a 4-point severity/frequency scale (0 *did not apply to me at all* to 3 *applied to me very much, or most of the time*) to rate the extent they had experienced each state (Lovibond & Lovibond, 1995). Following the work of Spielberger, Gorsuch, and Lushene (1970) on anxiety, the DASS was designed to emphasise *states* rather than *traits* by asking participants to respond to the items by rating the degree to which each symptom was experienced over the past week. Scores for the three DASS scales are obtained by summing the scores for the 14 items. For most purposes, scores on the DASS may be interpreted relative to the means and standard deviations for the full normative sample (Lovibond & Lovibond, 1995). Raw scores on the DASS can serve as guidelines for understanding symptom severity: normal (0-9), mild depression (10-13), moderate depression (14-20), severe depression (21-27) and extremely severe (27+). Comparisons between the DASS scales may be facilitated by conversion to Z-scores, using these normative values. The alpha values for the 14-item scales in the normative sample are: Depression .91; Anxiety .84; and Stress .90 (Lovibond & Lovibond, 1995).

Antony, Bieling, Cox, Enns and Swinsen (1998) conducted a series of studies to verify the reliability and validity of the DASS scales with a clinical sample of patients who had been diagnosed using DSM-IV (American Psychiatric Association, 1994).

The authors concluded that the DASS distinguishes well between features of depression, physical arousal (anxiety), and psychological tension and agitation (stress). In addition, the 1998 study assessed the internal consistency of the DASS Scales in a sample, which included both clinical patients and non-clinical volunteers by computing Cronbach's alphas. The Cronbach's alphas for the DASS Depression, Anxiety, and Stress subscales were .97, .92, and .95, respectively. Consequently, according to Antony, et al. (1998) the DASS appears to be an excellent instrument for measuring features of depression (D), hyperarousal (A), and tension (S) in clinical and non-clinical groups.

The DASS has a high reliability and exhibits high convergent validity with other measures of anxiety and depression in both clinical and community samples (Brown, Chorpita, Korotitsch, & Barlow, 1997; Crawford & Henry, 2003).

DAS S Name: _____ Date: _____

Please read each statement and circle a number 0, 1, 2 or 3 which indicates how much the statement applied to you *over the past week*. There are no right or wrong answers. Do not spend too much time on any statement.

The rating scale is as follows:

0 Did not apply to me at all

1 Applied to me to some degree, or some of the time

2 Applied to me to a considerable degree, or a good part of time

3 Applied to me very much, or most of the time

- | | | |
|---|--|---------|
| 1 | I found myself getting upset by quite trivial things | 0 1 2 3 |
| 2 | I was aware of dryness of my mouth | 0 1 2 3 |
| 3 | I couldn't seem to experience any positive feeling at all | 0 1 2 3 |
| 4 | I experienced breathing difficulty (eg, excessively rapid breathing, breathlessness in the absence of physical exertion) | 0 1 2 3 |
| 5 | I just couldn't seem to get going | 0 1 2 3 |
| 6 | I tended to over-react to situations | 0 1 2 3 |
| 7 | I had a feeling of shakiness (eg, legs going to give way) | 0 1 2 3 |
| 8 | I found it difficult to relax | 0 1 2 3 |

9	I found myself in situations that made me so anxious I was most relieved when they ended	0 1 2 3
10	I felt that I had nothing to look forward to	0 1 2 3
11	I found myself getting upset rather easily	0 1 2 3
12	I felt that I was using a lot of nervous energy	0 1 2 3
13	I felt sad and depressed	0 1 2 3
14	I found myself getting impatient when I was delayed in any way (eg, lifts, traffic lights, being kept waiting)	0 1 2 3
15	I had a feeling of faintness	0 1 2 3
16	I felt that I had lost interest in just about everything	0 1 2 3
17	I felt I wasn't worth much as a person	0 1 2 3
18	I felt that I was rather touchy	0 1 2 3
19	I perspired noticeably (eg, hands sweaty) in the absence of high temperatures or physical exertion	0 1 2 3
20	I felt scared without any good reason	0 1 2 3
21	I felt that life wasn't worthwhile	0 1 2 3
22	I found it hard to wind down	0 1 2 3
23	I had difficulty in swallowing	0 1 2 3
24	I couldn't seem to get any enjoyment out of the things I did	0 1 2 3
25	I was aware of the action of my heart in the absence of physical exertion (eg, sense of heart rate increase, heart missing a beat)	0 1 2 3
26	I felt down-hearted and blue	0 1 2 3
27	I found that I was very irritable	0 1 2 3
28	I felt I was close to panic	0 1 2 3
29	I found it hard to calm down after something upset me	0 1 2 3
30	I feared that I would be "thrown" by some trivial but unfamiliar task	0 1 2 3
31	I was unable to become enthusiastic about anything	0 1 2 3
32	I found it difficult to tolerate interruptions to what I was doing	0 1 2 3
33	I was in a state of nervous tension	0 1 2 3
34	I felt I was pretty worthless	0 1 2 3
35	I was intolerant of anything that kept me from getting on with what I was doing	0 1 2 3

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36	I felt terrified	0 1 2 3
37	I could see nothing in the future to be hopeful about	0 1 2 3
38	I felt that life was meaningless	0 1 2 3
39	I found myself getting agitated	0 1 2 3
40	I was worried about situations in which I might panic and make a fool of myself	0 1 2 3
41	I experienced trembling (eg, in the hands)	0 1 2 3
42	I found it difficult to work up the initiative to do things	0 1 2 3

Psychometric Properties of the Depression Anxiety Stress Scales (DASS)

Antony, Bieling, Cox, Enns and Swinsen (1998) conducted a series of studies to verify the reliability and validity of the DASS scales. To examine the concurrent validity of the DASS Scales, correlations with other measures of depression and anxiety were computed. Correlations between the three DASS Scales and the Beck Depression Inventory (BDI-II), the Beck Anxiety inventory (BAI), and the State-Trait Anxiety Inventory (STAI-T) were calculated from a clinical sample of patients that had been diagnosed using DSM-IV (American Psychiatric Association, 1994). The diagnoses included panic disorder, (n = 67), obsessive-compulsive disorder (n = 54), social phobia (n = 74), specific phobia (n = 17), and major depressive disorder (n = 46). The resulting correlation coefficients are displayed in Table E1. The DASS-S scale correlated moderately well with measures of depression and anxiety. As expected, the DASS-D scale correlated most highly with the BDI-II and moderately with the anxiety measures. The DASS-A scale correlated most highly with the BAI and was moderately correlated with the STAI-T. The study by Antony et al (1998) indicated that the DASS distinguishes well between features of depression, physical arousal (anxiety), and psychological tension and agitation (stress).

Table E1. Correlations of the Depression Anxiety Stress Scale (DASS) Subscales with other measures of anxiety and depression in clinical patient groups

Measure	DASS-S	DASS-D	DASS-A
DASS-D	.63	-	
DASS-A	.74	.44	-
BDI-II	.62	.77	.57
BAI	.64	.42	.84
STAI-T	.59	.65	.44

The 1998 study assessed the internal consistency of the DASS Scales in the entire sample, which included a nonclinical sample of volunteers (n = 49) by computing

Cronbach's alphas. The Cronbach's alphas for the DASS Depression, Anxiety, and Stress subscales were .97, .92, and .95, respectively. Consequently, according to Antony, et al. (1998) the DASS appears to be an excellent instrument for measuring features of depression (D), hyperarousal (A), and tension (S) in clinical and nonclinical groups.

Appendix F • Profile of Mood States (POMS)

The POMS was developed to provide a rapid (less than 10 minute), economical method of assessing transient, fluctuating active mood states for individuals eighteen years of age and older. The original scale, developed by McNair, Lorr and Droppleman (1971) consisted of words that people used to describe their psychological distress and their feelings. The POMS Standard assessment is a factor-analytically derived inventory that measures six identifiable mood or affective states. The variables measured include mood disturbance across six domains; *fatigue-inertia*, *vigor-activity*, *tension-anxiety*, *depression-dejection*, *anger-hostility*, and *confusion-bewilderment*. Factor analytic replications provide evidence of the factorial validity of the six mood factors, and an examination of the individual items defining each mood state supports the content validity of the factor scores (McNair et al., 1992).

The POMS assessments are suitable for both research and therapy and have a wide range of applications. Designed to assess current mood states and mood changes, the POMS is considered an ideal instrument for measuring and monitoring treatment change in clinical, medical and counselling centres (McNair et al., 1992; Nyenhuis, Yamamoto, Luchetta, Terrien, & Parmentier, 1999). The POMS consists of 65 words or brief phrases. The paper-and-pencil self-report format was designed for easy recording, scoring, and profiling of responses. Participants were asked to read each item carefully, then respond to a 5-point Likert scale ranging from 1 (*Not at All*) to 5 (*Extremely*) based on how they were feeling *during the past week, including today*. The POMS can be readministered as frequently as every week and can be utilised to assess mood states in the *present moment*, *during the past week* and *other* (another timeframe specified by the researcher).

Construct validity has been demonstrated in a study conducted by Nyenhuis et al. (1999). The researchers invited participants to complete a Visual Analog Mood Scale (VAMS), an 8-item series of analog scales measuring sadness, tension, fear, anger, confusion, fatigue, happiness, and energy; a POMS; the Beck Depression Inventory (BDI); and the State-Trait Anxiety Inventory (STAI). The POMS was found to correlate highly with corresponding VAMS scales, with Pearson coefficients ranging

from .54–.70. In addition, the POMS Tension scale correlated significantly with both the STAI State ($r = .72$) and Trait ($r = .70$) score and the POMS Depression scale correlated significantly with the BDI ($r = .69$). Discriminant validity was also shown in that the POMS scales were consistently more highly related to corresponding measures of mood (mean $r = .66$) than non-corresponding mood scales (mean $r = .49$). Alpha coefficient and other studies have found the POMS to exhibit a highly satisfactory level of internal consistency, with Cronbach's alpha ranging between .63 and .96 for the POMS subscales, and for the total score, the range is between .75 and .92 (McNair et al., 1992).

In addition, the POMS inventory has undergone a recent technical update (McNair & Heuchert, 2005). This technical update presented new data and developments in administration, scoring and interpretation. New improved, easy-to-use, easy-to-score forms have been also been designed and I have used these in this study (McNair & Heuchert, 2005).

Profile of Mood States					
Client code _____			Date _____		
Directions: Describe HOW YOU HAVE BEEN FEELING DURING THE PAST WEEK INCLUDING TODAY by checking one space after each of the words listed below					
FEELING	Not at all	A little	Mod	Quite a bit	Extremely
Friendly	0	1	2	3	4
Tense	0	1	2	3	4
Angry	0	1	2	3	4
Worn Out	0	1	2	3	4
Unhappy	0	1	2	3	4
Clear-headed	0	1	2	3	4
Lively	0	1	2	3	4
Confused	0	1	2	3	4
Sorry for things done	0	1	2	3	4
Shaky	0	1	2	3	4
Listless	0	1	2	3	4
Peeved	0	1	2	3	4
Considerate	0	1	2	3	4
Sad	0	1	2	3	4
Active	0	1	2	3	4
On edge	0	1	2	3	4
Grouchy	0	1	2	3	4

FEELING	Not at all	A little	Mod	Quite a bit	Extremely
Blue	0	1	2	3	4
Energetic	0	1	2	3	4
Panicky	0	1	2	3	4
Hopeless	0	1	2	3	4
Relaxed	0	1	2	3	4
Unworthy	0	1	2	3	4
Spiteful	0	1	2	3	4
Sympathetic	0	1	2	3	4
Uneasy	0	1	2	3	4
Restless	0	1	2	3	4
Unable to concentrate	0	1	2	3	4
Fatigued	0	1	2	3	4
Helpful	0	1	2	3	4
Annoyed	0	1	2	3	4
Discouraged	0	1	2	3	4
Resentful	0	1	2	3	4
Nervous	0	1	2	3	4
Lonely	0	1	2	3	4
Miserable	0	1	2	3	4
Muddled	0	1	2	3	4
Cheerful	0	1	2	3	4

FEELING	Not at all	A little	Mod	Quite a bit	Extremely
Bitter	0	1	2	3	4
Exhausted	0	1	2	3	4
Anxious	0	1	2	3	4
Ready to fight	0	1	2	3	4
Good-natured	0	1	2	3	4
Gloomy	0	1	2	3	4
Desperate	0	1	2	3	4
Sluggish	0	1	2	3	4
Rebellious	0	1	2	3	4
Helpless	0	1	2	3	4
Weary	0	1	2	3	4
Bewildered	0	1	2	3	4
Alert	0	1	2	3	4
Deceived	0	1	2	3	4
Furious	0	1	2	3	4
Efficient	0	1	2	3	4
Trusting	0	1	2	3	4
Full of pep	0	1	2	3	4
Bad-tempered	0	1	2	3	4
Worthless	0	1	2	3	4
Forgetful	0	1	2	3	4
Carefree	0	1	2	3	4

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FEELING	Not at all	A little	Mod	Quite a bit	Extremely
Terrified	0	1	2	3	4
Guilty	0	1	2	3	4
Vigorous	0	1	2	3	4
Uncertain about things	0	1	2	3	4
Bushed	0	1	2	3	4

Appendix G • Helpful Aspects of Therapy (HAT) Form

Client code _____

Date _____

HELPFUL ASPECTS OF THERAPY FORM (H.A.T.) (10/93)

1. Of the events which occurred in this session, which one do you feel was the most **helpful** or **important** for you personally? (By "event" we mean something that happened in the session. It might be something you said or did, or something your therapist said or did.)
2. Please describe what made this event helpful/important and what you got out of it.
3. How helpful was this particular event? Rate it on the following scale. (Put an "X" at the appropriate point; half-point ratings are OK; e.g., 7.5.)

HINDERING <-----				Neutral ----->				HELPFUL
1	2	3	4	5	6	7	8	9
---+--	---+--	---+--	---+--	---+--	---+--	---+--	---+--	
E	G	M	S		S	M	G	E
X	R	O	L		L	O	R	X
T	E	D	I		I	D	E	T
R	A	E	G		G	E	A	R
E	T	R	H		H	R	T	E
M	L	A	T		T	A	L	M
E	Y	T	L		L	T	Y	E
L		E	Y		Y	E		L
Y		L				L		Y
		Y				Y		

4. About where in the session did this event occur?

5. About how long did the event last?

6. Did anything else particularly **helpful** happen during this session?

YES NO

(a. If yes, please rate how helpful this event was:

- _____ 6. Slightly helpful
- _____ 7. Moderately helpful
- _____ 8. Greatly helpful
- _____ 9. Extremely helpful

(b. Please describe the event briefly:

7. Did anything happen during the session which might have been **hindering**?

YES NO

(a. If yes, please rate how hindering the event was:

- _____ 1. Extremely hindering
- _____ 2. Greatly hindering
- _____ 3. Moderately hindering
- _____ 4. Slightly hindering

(b. Please describe this event briefly:

Appendix H • The Working Alliance Inventory Form (Short Client Version)

Client code _____				Date _____		
<p>The Working Alliance Inventory – Short Client Version (Horvath and Greenberg, 1989)</p> <p>Below is a list of statements about your relationship with your therapist. Consider each item carefully and indicate your level of agreement for each of the following items. Please circle the number that most accurately represents your answer.</p>						
Does not Correspond at all		Corresponds Moderately		Corresponds Exactly		
1	2	3	4	5	6	7
1. My therapist and I agree about the things I will need to do in therapy to help improve my situation.						
1	2	3	4	5	6	7
2. What I am doing in therapy gives me new ways of looking at my problem.						
1	2	3	4	5	6	7
3. I believe my therapist likes me.						
1	2	3	4	5	6	7
4. My therapist does not understand what I am trying to accomplish in therapy.						
1	2	3	4	5	6	7
5. I am confident in my therapist's ability to help me.						
1	2	3	4	5	6	7
6. My therapist and I are working towards mutually agreed upon goals.						
1	2	3	4	5	6	7
7. I feel that my therapist appreciates me.						
1	2	3	4	5	6	7
8. We agree on what is important for me to work on.						
1	2	3	4	5	6	7

9. My therapist and I trust one another.

1 2 3 4 5 6 7

10. My therapist and I have different ideas on what my problems are.

1 2 3 4 5 6 7

11. We have established a good understanding of the kind of changes that would be good for me.

1 2 3 4 5 6 7

12. I believe the way we are working with my problem is correct.

1 2 3 4 5 6 7

Appendix I • Change Interview Form

Change Interview

Client Initials _____ Interviewer _____ Date _____

Assessment (circle one): after session 4, 8 or 12 or follow up at 6 months

Client Change Interview Schedule (9/99)

After each phase of treatment, we ask clients to come in for an hour-long semi-structured interview. The major topics of this interview are any changes you have noticed since therapy began, what you believe may have brought about these changes, and helpful and unhelpful aspects of the therapy. The main purpose of this interview is to allow you to tell us 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. This interview is videorecorded and digitally voice recorded for later transcription. Please provide as much detail as possible.

2. General Questions:

1a. What medication on you currently on? (Interviewer records on form)

Psychopharmacological Medication Record (incl. herbal remedies)

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

1b. What has therapy been like for you so far? How has it felt to be in therapy?

1c. How are you doing now in general?

2. Self-Description:

2a. How would you describe yourself now? When you describe yourself as a person what comes to mind?

2b. How would others who know you well describe you?

2c. If you could change something about yourself, what would it be?

2d. In the screening interview you described your self as

How does this compare with how you see yourself now?

(What is similar? What is different? How do you understand these similarities and differences?)

3. Changes:

3a. 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?)

3b. Has anything changed for the worse for you since therapy started?

3c. Is there anything that you wanted to change that hasn't since therapy started?

4. Change Ratings:

(Go through each change and rate it on the following three scales)

How much it bothered you in the last seven days including today in comparison to how it bothered you before?

(1 being not at all to 7 for maximum possible)

Change List

Change	<u>Change was:</u> 1 - <u>expected</u> 3 - neither 5 - <u>surprised</u> by	<u>Without</u> <u>therapy:</u> 1 - unlikely 3 - neither 5 - likely	<u>Importance:</u> 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

5. Attributions: In general, if there have been any changes, 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)**6. Helpful Aspects:** Can you sum up what has been helpful about your therapy so far? Please give examples.

General aspects

Specific events

7. Problematic Aspects:

7a. What kinds of things about the therapy have been hindering, unhelpful, negative or disappointing for you?

(For example, general aspects. specific events)

7b. Were there things in the therapy which were difficult or painful but still OK or perhaps helpful? What were they?

7c. Has anything been missing from your treatment?

(What would make/have made your therapy more effective or helpful?)

8. Suggestions. Do you have any suggestions for us, regarding the research or the therapy? Do you have anything else that you want to tell me?

ADDED LATER

9. Session Attendance. Have you found it difficult to attend weekly sessions? And if so why? Would fortnightly sessions be more suitable to you?

Appendix J • Experiential Therapy Session Form

EXPERIENTIAL THERAPY SESSION FORM

(8/02, © R. Elliott)

CASE _____ SESSION _____ DATE _____ THERAPIST _____

I. Process Notes

1. Brief summary of main episodes and events of session:

2. Unusual Within-therapy Events (e.g., late, interruptions, challenges, out-of-mode)

3. Important Extra-therapy Events (e.g., relationships, work, injury/illness, changes in medication, self-help efforts)

4. Ideas for next time (from self & supervision):

II. Overall Session Ratings:	
1. Please rate how helpful or hindering to your client you think this session was overall. (Circle one answer only) THIS SESSION WAS:	<p>Hindering: 1 = Extremely. 2 = Greatly. 3 = Moderately. 4 = Slightly. 5 = Neither helpful, nor hindering; neutral. Helpful: 6 = Slightly. 7 = Moderately. 8 = Greatly. 9 = Extremely.</p> <p>1 2 3 4 5 6 7 8 9</p>
2. How do you feel about the session you have just completed with your client? (Circle one answer only)	<p>Felt sense: 1 = Perfect. 2 Excellent. 3 = Very good. 4 = Pretty good. 5 = Fair. 6 = Pretty poor. 7 = Very poor.</p> <p>1 2 3 4 5 6 7</p>
3. How much <u>progress</u> do you feel your client made in dealing with his/her problems in this session? (Circle one answer only)	<p>Session: 1 = A great deal. 2 = Considerable. 3 = Moderate. Progress 4 = Some good. 5 = A little. 6 = Didn't get anywhere. 7 = In some ways my problems have gotten worse this session.</p> <p>1 2 3 4 5 6 7</p>
4. <u>In this session</u> something <u>shifted</u> for my client. S/he saw something differently or experienced something freshly:	<p>Something shifted: 1 = Not at all. 2 = Very slightly. 3 = Slightly. 4 = Somewhat 5 = Moderately. 6 = Considerably. 7 = Very much.</p> <p>1 2 3 4 5 6 7</p>

III. Client Modes of Engagement: Please rate (circle the appropriate number) the extent to which your client was engaging in each of the following modes of engagement during the session:				
Absent	Occasional (1–5% of responses)	Common (10–20% of responses)	Frequent (25–45% of responses)	Extensive (≥ 50% of responses)
1	2	3	4	5
1 2 3 4 5	1. <u>External</u> : Attending to other people, external events; may be specific or general.			
1 2 3 4 5	2. <u>Purely conceptual</u> : Formulating things in linguistic or abstract terms without reference to concrete experiencing.			
1 2 3 4 5	3. <u>Somatic</u> : Attending to chronic pain or illness signs.			
1 2 3 4 5	4. <u>Containing/distancing</u> : Avoiding or holding painful or frightening feelings or experiences at bay.			
1 2 3 4 5	5. <u>Internal attending</u> : Turning attention inward to clear feelings, thoughts, images or bodily sensations.			
1 2 3 4 5	6. <u>Experiential search</u> : Examining unclear internal experiences with curiosity; staying with vague or ambiguous experiencing.			
1 2 3 4 5	7. <u>Active expression</u> : Displaying or enacting strong, vivid, specific reactions.			
1 2 3 4 5	8. <u>Interpersonal contact</u> : Trusting, opening up to therapist.			
1 2 3 4 5	9. <u>Self-reflection</u> : Standing back from experience in order to develop meaning perspective.			
1 2 3 4 5	10. <u>Emergent action</u> : Applying results of experiential work to problem-solving and productive action.			

IV. Process-Experiential Treatment Principles: Please rate how well you feel you applied each of the treatment principles below, using this rating scale:	
1	Much improvement in application needed: I felt like a beginner, as if I didn't have the concept.
2	Moderate improvement needed: I felt like an advanced beginner, who is beginning to do this, but needs to work on the concept more.
3	Slight improvement in application needed: I need to make a focused effort to do more of this.
4	Adequate application of principle: I did enough of this, but need to keep working on improving how well I do it.
5	Good application of principle: I did enough of this and did it skilfully.
6	Excellent application of principle: I did this consistently and even applied it in a creative way.
1 2 3 4 5 6	1. I was <u>empathically attuned</u> to the client's experiencing (by letting go of presumptions, entering client's world, resonating from own experience, sorting through variety, grasping what is important and readjusting understandings as experiencing evolves).
1 2 3 4 5 6	2. I expressed <u>empathy</u> /understanding, <u>presence</u> /genuineness, and <u>prizing</u> /caring to my client.
1 2 3 4 5 6	3. I facilitated client-therapist <u>collaboration</u> and mutual involvement in goals and tasks of therapy, through experiential teaching, goal/task identification and negotiation.
1 2 3 4 5 6	4. I facilitated <u>different client micro-processes</u> at different times in the session, as appropriate to the client's tasks or subtasks. (Circle: internal attending, experiential search, active expression, interpersonal contact, containing/distancing, self-reflection, action-planning)
1 2 3 4 5 6	5. I facilitated <u>progress</u> on central therapeutic tasks by identifying, tracking, and offering opportunities to return to them, within and across sessions.
1 2 3 4 5 6	6. I facilitated client <u>self-development</u> through reflecting/supporting/symbolizing new experiencing, inner strength, client agency, or empowerment.
1 2 3 4 5 6	7. <u>Overall Rating</u> : In general, I carried out PE principles and tasks.

Task Resolution and Intervention Scales

Instructions. For each therapeutic task on the following pages, rate each of the following using the scales provided:

***Resolution Scales:** Rate how far the client got on each therapeutic task, regardless of the therapist task intervention; circle the furthest point reached on the scale.

***Presence Rating Scale:** Use this scale to rate the extent to which you attempted to engage the client in each of the therapeutic task activities listed below.

***Quality Rating Scale:** Use this scale to rate how well or skillfully you think you facilitated (vs. interfered) with each of the therapeutic tasks listed.

Note that tasks may overlap; it is possible to work on two tasks at the same time (e.g., Empathic Exploration and Focusing or Two chair dialogue; Empathic Prizing and Meaning Creation).

1. <u>General Empathic Exploration for Problem-Relevant Experience:</u>			
A. <u>Task Resolution:</u>			
0	Marker absent.		
1	Marker present: Problem-relevant experience; client expresses personal interest in an experience that is (circle & describe:) powerful, troubling, incomplete, undifferentiated, global, abstract or primarily in external terms: _____		
2	Discusses problem in an external or abstract manner.		
3	Turns attention to internal experiencing; may re-experience previous events; searches edges of awareness; differentiates or elaborates global or missing aspects of experiencing.		
4	Experiences some clarification of experience, including clear marker for another task (such as a conflict split). What got clearer: _____		
5	Expresses a sense of more fully understanding, appreciating and owning the experience in its complexity or richness (“Now I know what that’s all about”).		
6	In addition to the above, feels a marked, general sense of relief, empowerment or determination about the experience (such as knowing what to do about it).		
B. <u>Task Intervention:</u> Facilitate client re-experiencing; reflect unclear, emerging experience, encourage differentiation or elaboration of experience.			
PRESENCE		QUALITY	
1	Clearly absent	1	Significant interference with task
2	Possibly present	2	Moderate interference
3	Present but brief	3	Slight interference; more needed/missed marker
4	Present, moderate length	4	Neutral; not applicable
5	Present, extended in length	5	Slightly skilful facilitation
		6	Moderately skilful facilitation
		7	Excellent facilitation of task

2. Empathic Affirmation of Vulnerability:			
A. Client Task Resolution:			
0	Marker absent		
1	Marker: Mentions strong negative self-related feeling and expresses distress about it; describe form of vulnerability: _____		
2	Describes deeper feelings in response to therapist's empathic affirmation.		
3	Expresses more intense vulnerability.		
4	Seems to touch bottom; expresses dreaded emotion or painful aspect of self in full intensity.		
5	Describes or expresses reduced distress, greater calmness.		
6	Expresses sense of self as whole, acceptable or capable.		
B. Task Intervention: Provides genuine, empathic, affirming presence as client descends into dreaded vulnerability, then supports re-emergent client growth-oriented experiencing.			
PRESENCE		QUALITY	
1	Clearly absent	1	Significant interference with task
2	Possibly present	2	Moderate interference
3	Present but brief	3	Slight interference; more needed/missed marker
4	Present, moderate length	4	Neutral; not applicable
5	Present, extended in length	5	Slightly skilful facilitation
		6	Moderately skilful facilitation
		7	Excellent facilitation of task

3. Developing and Maintaining a Safe Working Alliance (Especially first 5 sessions or after break, transition or crisis in therapy.)

A. Rate current level of client working alliance:

0	Client drops out of therapy or announces decision to stop because of alliance problems.
1	Client physically present but safe, working environment not yet achieved.
2	Work on trust/bond: Begins therapy, but worried that therapist will misunderstand, judge, or be insincere, intrusive or untrustworthy.
3	Work on therapeutic focus: Trusts therapist and begins to engage in therapy process, but has difficulty finding and maintaining a focus, is scattered or generally defers to therapist.
4	Work on goal agreement: Therapeutic focus located but ambivalent about change, not firmly committed to working toward goals related to main therapeutic focus; sees the causes of his/her problems differently from therapist.
5	Work on task agreement: Committed to change, but has difficulty turning attention inward; questions the purpose and value of working with emotions/experiencing; has expectations about tasks and process that diverge from those of therapist.
6	Productive working environment: Client trusts therapist, engages actively in productive therapeutic work.

B. **Task Intervention:** Facilitate alliance formation through meta-communication, demonstration of caring, empathy; negotiation of therapeutic focus, goals, and tasks.

PRESENCE		QUALITY	
1	Clearly absent	1	Significant interference with task
2	Possibly present	2	Moderate interference
3	Present but brief	3	Slight interference; more needed/missed marker
4	Present, moderate length	4	Neutral; not applicable
5	Present, extended in length	5	Slightly skilful facilitation
		6	Moderately skilful facilitation
		7	Excellent facilitation of task

4. <u>Relationship Dialogue for Repair of Alliance Difficulties</u>			
A. Client Task Resolution:			
0	Marker absent (therapeutic work proceeds without difficulty)		
1	Marker: Implies or mentions complaint or dissatisfaction about nature or progress of therapy, or therapeutic relationship. (Withdrawal: disengages from process; Confrontation: challenges, questions therapy); describe: _____		
2	Accepts task, presents complaint or dissatisfaction directly or in more detail. (Withdrawal difficulty: Admits to difficulty)		
3	Explores nature, possible joint sources of complaint/dissatisfaction/difficulty; seeks both to understand therapist side and to elaborate, understand own part in difficulty.		
4	Develops, describes shared understanding of source of difficulty.		
5	Reaches a new view of general nature or mutual roles in therapy; explores practical solutions with therapist.		
6	Expresses genuine satisfaction or obvious renewed enthusiasm for therapy.		
B. <u>Task Intervention</u> : Raise and facilitate mutual dialogue about difficulty.			
PRESENCE		QUALITY	
1	Clearly absent	1	Significant interference with task
2	Possibly present	2	Moderate interference
3	Present but brief	3	Slight interference; more needed/missed marker
4	Present, moderate length	4	Neutral; not applicable
5	Present, extended in length	5	Slightly skilful facilitation
		6	Moderately skilful facilitation
		7	Excellent facilitation of task

5. <u>Clearing a Space for Attentional Focus Difficulty:</u>			
A. Client Task Resolution:			
0	Marker absent		
1	Marker: Attentional Focus Difficulty: Reports or evidences being stuck, overwhelmed, or blank.		
2	Attends to internal “problem space.”		
3	Lists concerns or problematic experiences.		
4	Sets concerns or problems aside; uses imagination to contain or create psychological distance from problems, may identify most important concern to work on.		
5	Appreciates cleared internal space; enjoys relief, sense of free or safe internal space.		
6	Generalizes cleared space; develops general appreciation for need, value or possibility of clear/safe space in his/her life.		
B. Task Intervention: Helps client clear an imagined internal/bodily space, list, set aside problems; helps client appreciate cleared space or identify concern to work on.			
PRESENCE		QUALITY	
1	Clearly absent	1	Significant interference with task
2	Possibly present	2	Moderate interference
3	Present but brief	3	Slight interference; more needed/missed marker
4	Present, moderate length	4	Neutral; not applicable
5	Present, extended in length	5	Slightly skilful facilitation
		6	Moderately skilful facilitation
		7	Excellent facilitation of task

6. <u>Experiential Focusing for an Unclear Feeling:</u>			
A. Client Task Resolution:			
0	Marker absent		
1	Marker: Unclear feeling: Presents or confirms vague/nagging concern, or discusses concerns in global, abstract, superficial, or externalized (circle one) manner.		
2	Attends to the unclear concern, including whole feeling.		
3	Searches for potential descriptions (felt quality words, images) for unclear feeling; checks descriptions for accuracy) (without feeling shift)		
4	Feeling shift: Explores labelled feeling more deeply, until bodily sense of discomfort eases and experienced lack of clarity disappears.		
5	Receives feeling shift: stays with, appreciates, consolidates feeling shift; keeps self-criticism at bay.		
6	Carrying forward: develops new in-session task, explores implications for change outside of therapy.		
B. <u>Task Intervention</u> : Encourages focusing attitude, search for label/handle, exploration of labelled feeling, receiving of feeling shift, and carrying forward.			
PRESENCE		QUALITY	
1	Clearly absent	1	Significant interference with task
2	Possibly present	2	Moderate interference
3	Present but brief	3	Slight interference; more needed/missed marker
4	Present, moderate length	4	Neutral; not applicable
5	Present, extended in length	5	Slightly skilful facilitation
		6	Moderately skilful facilitation
		7	Excellent facilitation of task

7. <u>Facilitating Expression of Feelings with Emotional Expression Difficulties:</u>			
A. Client Task Resolution:			
	(No zero point)		
1	Pre-reflective reaction to situation without awareness; emotion blocked from awareness ("I have no feelings.").		
2	Limited conscious awareness of emotion ("I'm not sure if I'm feeling something.").		
3	Unclear feeling ("I don't know what I'm feeling.") or prepackaged description ("I know what I'm feeling without having to check.").		
4	Negative attitude toward emotion ("Feelings are dangerous or irrelevant.").		
5	Difficulty with appropriate level of emotional expression to therapist/others: Excessive or premature disclosure ("I've told you too much about myself already!"); or perception of therapist/others as unreceptive ("You can't be interested in what I'm feeling.").		
6	Successful, appropriate expression of emotion to therapist/significant others.		
B. Task Intervention: Encourages emotional expression with appropriate response modes, tasks (e.g., evocative/exploratory response, Focusing, Empathic Exploration, Chairwork).			
PRESENCE		QUALITY	
1	Clearly absent	1	Significant interference with task
2	Possibly present	2	Moderate interference
3	Present but brief	3	Slight interference; more needed/missed marker
4	Present, moderate length	4	Neutral; not applicable
5	Present, extended in length	5	Slightly skilful facilitation
		6	Moderately skilful facilitation
		7	Excellent facilitation of task

8. <u>Re-telling/Re-experiencing of a Traumatic/Painful Experience (non-PRP):</u>			
A. Task Resolution:			
0	Marker absent (abstract, superficial or prepackaged descriptions of an event/experience).		
1	Marker present: Refers to a traumatic/painful experience about which a story could be told (e.g., traumatic event, disrupted life story, nightmare). Nature of experience: _____		
2	Elaboration; begins detailed, concrete or factual narrative of particular event/experience; describes what happened from external or logical point of view.		
3	Dwells on important moments or aspects of trauma, re-experiences parts of it in session.		
4	Differentiates personal, idiosyncratic, newly emerged meanings of the experience from an internal point of view.		
5	Thoughtfully weighs and tentatively evaluates alternative, differentiated views of the experience.		
6	Integrates previously unconnected or inconsistent aspects of the experience; expresses broader or more integrated view of self, others or world.		
B. <u>Task Intervention</u> : Facilitate client re-telling/re-experiencing through unfolding and exploration process.			
PRESENCE		QUALITY	
1	Clearly absent	1	Significant interference with task
2	Possibly present	2	Moderate interference
3	Present but brief	3	Slight interference; more needed/missed marker
4	Present, moderate length	4	Neutral; not applicable
5	Present, extended in length	5	Slightly skilful facilitation
		6	Moderately skilful facilitation
		7	Excellent facilitation of task

9. <u>Unfolding Problematic Reactions:</u>			
A. Client Task Resolution:			
0	Marker absent		
1	Marker: Describes unexpected, puzzling personal reaction (Circle: behaviour, emotion reaction). Describe: _____		
2	"Re-enters" the scene, recalls and re-experiences the time when the reaction was triggered.		
3	Recalls salient aspects of stimulus situation. Explores both own internal affective reaction to situation and own subjective construal of potential impact of stimulus situation.		
4	Reaches "meaning bridge." Discovers link between problematic reaction and own construal of potential impact of stimulus situation.		
5	Recognizes this as example of broader aspect of own mode of functioning that is interfering with personal needs, wants, views, or values.		
6	Full resolution: Develops broad new view of important aspects of own mode of functioning and what self-changes wants to make. Begins to feel empowered to make change(s).		
B. <u>Task Intervention</u> : Systematic-evocative-unfolding: helps client review in detail perceptions and emotions involved in problematic reaction; helps client explore broader implications.			
PRESENCE		QUALITY	
1	Clearly absent	1	Significant interference with task
2	Possibly present	2	Moderate interference
3	Present but brief	3	Slight interference; more needed/missed marker
4	Present, moderate length	4	Neutral; not applicable
5	Present, extended in length	5	Slightly skilful facilitation
		6	Moderately skilful facilitation
		7	Excellent facilitation of task

10. Creation of Meaning for Meaning Protest:			
A. Client Task Resolution:			
0	Marker absent (emotional arousal with vagueness or confusion).		
1	Marker: Describes an experience discrepant with cherished belief in an emotionally aroused state. (Life event: _____ Cherished belief: _____)		
2	Clarifies, specifies nature of cherished belief and emotional reactions to challenging life event.		
3	Searches for origins of cherished belief; develops hypothesis.		
4	Evaluates and judges continued tenability of cherished belief (in relation to present experience); expresses desire to alter cherished belief.		
5	Revision: Alters or eliminates cherished belief.		
6	Describes nature of change needed or develops plans for future.		
B. Task Intervention: Facilitates client meaning work; helps client symbolize felt meaning of painful life event and describe and ultimately re-examine challenged cherished belief(s).			
PRESENCE		QUALITY	
1	Clearly absent	1	Significant interference with task
2	Possibly present	2	Moderate interference
3	Present but brief	3	Slight interference; more needed/missed marker
4	Present, moderate length	4	Neutral; not applicable
5	Present, extended in length	5	Slightly skilful facilitation
		6	Moderately skilful facilitation
		7	Excellent facilitation of task

11. <u>Two-Chair Work for Conflict Splits:</u>			
A. Client Task Resolution:			
0	Marker absent		
1	Marker: Describes split in which one aspect of self is critical of, or coercive toward, another aspect. Describe two aspects, whether attributed or somatic form: _____		
2	Clearly expresses criticisms, expectations, or "shoulds" to self in concrete, specific manner.		
3	Experiencing chair agrees with critic ("collapses"); primary underlying feelings/needs begin to emerge in response to the criticisms. Critic differentiates values/standards.		
4	Clearly expresses needs and wants associated with a newly experienced feeling.		
5	Genuinely accepts own feelings and needs. May show compassion, concern and respect for self.		
6	Clear understanding of how various feelings, needs and wishes may be accommodated and how previously antagonistic sides of self may be reconciled.		
B. <u>Task Intervention:</u> Facilitates client dialogue between conflicting aspects of self.			
PRESENCE		QUALITY	
1	Clearly absent	1	Significant interference with task
2	Possibly present	2	Moderate interference
3	Present but brief	3	Slight interference; more needed/missed marker
4	Present, moderate length	4	Neutral; not applicable
5	Present, extended in length	5	Slightly skilful facilitation
		6	Moderately skilful facilitation
		7	Excellent facilitation of task

12. <u>Two-Chair Enactment for Self-Interruption Splits:</u>			
A. Client Task Resolution:			
0	Marker absent		
1	Marker: Engages in or describes how one part interrupts another part. (Interrupted emotion, incl. attributed form, person: _____)		
2	Actively enacts own possible self-interruptive process, in concrete, specific manner.		
3	Contacts and differentiates feelings of passivity and resignation.		
4	Clearly expresses interrupted emotion.		
5	Self-assertion. Clearly expresses need associated with the emotion.		
6	Feels empowered, envisages or plans new actions in the world in order to meet need.		
B. Task Intervention: Helps client enact self-interruption or blocking process, including voicing of suppressed aspect of self.			
PRESENCE		QUALITY	
1	Clearly absent	1	Significant interference with task
2	Possibly present	2	Moderate interference
3	Present but brief	3	Slight interference; more needed/missed marker
4	Present, moderate length	4	Neutral; not applicable
5	Present, extended in length	5	Slightly skilful facilitation
		6	Moderately skilful facilitation
		7	Excellent facilitation of task

13. <u>Empty-Chair Work for Unfinished Business:</u>			
A. Client Task Resolution:			
0	Marker absent		
1	Marker: Blames, complains, or expresses hurt or longing in relation to a significant Other. (person: _____)		
2	Speaks to imagined Other and expresses unresolved feelings (e.g., resentment, hurt).		
3	Differentiates complaint into underlying feeling; experiences and expresses relevant emotions (e.g., sadness, anger) with a high degree of emotional arousal.		
4	Experiences unmet need(s) as valid and expresses them assertively.		
5	Comes to understand and see Other in a new way, either in a more positive light or as a less powerful person who has/had problems of his/her own.		
6	Affirms Self and lets go of unresolved feeling, either by forgiving Other or holding Other accountable.		
B. Task Intervention: Helps client express unresolved hurt, anger, unmet needs to imagined other; may help client enact role of other.			
PRESENCE		QUALITY	
1	Clearly absent	1	Significant interference with task
2	Possibly present	2	Moderate interference
3	Present but brief	3	Slight interference; more needed/missed marker
4	Present, moderate length	4	Neutral; not applicable
5	Present, extended in length	5	Slightly skilful facilitation
		6	Moderately skilful facilitation
		7	Excellent facilitation of task

VI. Experiential Response Modes: Use this scale to rate the degree to which each of the items below was present in this session:				
Absent	Occasional (1–5% of responses)	Common (10–20% of responses)	Frequent (25–45% of responses)	Extensive (≥ 50% of responses)
1	2	3	4	5
1 2 3 4 5	1. <u>Personal Disclosure</u> : Share relevant information about self.			
1 2 3 4 5	2. <u>Process Disclosure</u> : Share own here-and-now reactions, intentions or limitations.			
1 2 3 4 5	3. <u>Awareness Homework</u> : Foster experiencing outside of session.			
1 2 3 4 5	4. <u>Action Suggestion</u> : Encourage client to try things out in the session (“coaching”: feeding lines, proposing mental actions, directing attention).			
1 2 3 4 5	5. <u>Structuring Task</u> : Set up and offer specific help for continued work within a specific therapeutic task (including proposing, creating context, or offering encouragement for task engagement).			
1 2 3 4 5	6. <u>Experiential Teaching</u> : Provide general information about nature of experiencing or treatment process/tasks.			
1 2 3 4 5	7. <u>Experiential Formulation</u> : Describe the client’s specific difficulties in PE terms, such as emotional avoidance or action on the self.			
1 2 3 4 5	8. <u>Empathic Re-focussing</u> : Offer empathy to client about what client is having difficulty facing, in order to invite continued exploration.			
1 2 3 4 5	9. <u>Empathic Conjecture</u> : Tentative guess at immediate, implicit client experience (usually with “Fit” Question).			
1 2 3 4 5	10. <u>Process Observation</u> : Non-confrontationally describe client in-session verbal or nonverbal behaviour (usually with Exploratory Question).			
1 2 3 4 5	11. <u>Fit Question</u> : Encourage client to check representation of experience with actual experience.			
1 2 3 4 5	12. <u>Exploratory Question</u> : Stimulate client open-ended self-exploration.			
1 2 3 4 5	13. <u>Evocative Reflection</u> : Communicate empathy while helping client to heighten or access experience, through vivid imagery, powerful language or dramatic manner.			
1 2 3 4 5	14. <u>Exploratory Reflection</u> : Simultaneously communicate empathy and stimulate client self-exploration of explicit and implicit experience, through open-edge or growth-oriented responses.			

Change processes in therapy: Case studies in Process-Experiential / Emotion-Focused Therapy

1 2 3 4 5	15. <u>Empathic Affirmation</u> : Offer validation, support, or sympathy when client is in emotional distress or pain.
1 2 3 4 5	16. <u>Empathic Reflection</u> : Accurately represent most central, poignant or strongly-felt aspect of client's message.

VII. Content Directive Interventions: Use this scale to rate the following items:				
Clearly Absent	Possibly present	Present but very brief and "in-mode" (e.g., tentative, in answer to question)	Present, brief, in "expert" manner	Present, extended, "expert" manner
1	2	3	4	5
1 2 3 4 5	1. Gives News: Responses intended to tell the client something new about self or others (i.e., interpretations). Describe:			
1 2 3 4 5	2. Offers Solutions: Responses intended to modify client behaviour with regard to presented problems (i.e. general advice). Describe:			
1 2 3 4 5	3. Offers Expert Reassurance: Responses directly intended to make the client feel good or less bad, given from an "expert" position. Describe:			
1 2 3 4 5	4. Disagrees/Confronts: Responses intended to correct, criticize or point out discrepancies. Describe:			
1 2 3 4 5	5. Nonexperiential Task/Content Direction: e.g., introduce new subject/task such as problem-solving or client analysis of third parties. Describe:			
1 2 3 4 5	6. Purely informational questions: gathers specific information without encouraging exploration. Describe:			

Change processes in therapy: Case studies in Process-Experiential / Emotion-Focused Therapy

Appendix K • Observer Checklist for Validation of Adherence to PE-EFT Form

OBSERVER CHECKLIST FOR VALIDATION OF ADHERENCE TO PEEFT

Please use the checklist below as guide to you when ensuring the PEEFT model has been adhered to. Where it was not necessary for particular PEEFT skills to be used please place a tick beside (N/A).

- Please view the first 10 minutes, a mid 10 minutes and the final 10 minutes of videotaped sessions.
- In each of these segments use the scale below to ascertain whether each task or intervention was adequately adhered to

Client Initials _____ Interviewer _____ Date _____

Please rate by marking with a cross on the scale

- a. *Empathically responds when relevant to do so (i.e. by accurately reflecting thoughts, feelings and behaviours as presented)* N/A

Always	More often than not	About half the time	Not often	Never

- b. *Is respectful toward the client (i.e. is 'for' the client, wants to help, regards the client as unique and self-determining, assumes goodwill and respects confidentiality)* N/A

Always	More often than not	About half the time	Not often	Never

- c. *Is genuine (i.e. authentic, flexible, spontaneous, non-defensive, consistent and open)* N/A

Always	More often than not	About half the time	Not often	Never

d. <i>Identifies and reflects problem-relevant experience by asking general exploratory questions</i>					N/A
Always	More often than not	About half the time	Not often	Never	
<hr/>					
e. <i>Appropriate probing of content</i>					N/A
Always	More often than not	About half the time	Not often	Never	
<hr/>					
f. <i>When client is vulnerable, only empathises</i>					N/A
Always	More often than not	About half the time	Not often	Never	
<hr/>					
g. <i>Maintains a safe working alliance</i>					N/A
Always	More often than not	About half the time	Not often	Never	
<hr/>					
h. <i>When the alliance is under pressure, counsellor seeks dialogue about it</i>					N/A
Always	More often than not	About half the time	Not often	Never	
<hr/>					
i. <i>Facilitates emotion expression when the client is in difficulties</i>					N/A
Always	More often than not	About half the time	Not often	Never	
<hr/>					
j. <i>When client is puzzled or unclear about a felt-sense, initiates appropriate Focussing strategies</i>					N/A
Always	More often than not	About half the time	Not often	Never	
<hr/>					

k. <i>Facilitates expression of feelings that may be difficult to express</i>					N/A
Always	More often than not	About half the time	Not often	Never	
l. <i>Helps client to re-tell traumatic experiences</i>					N/A
Always	More often than not	About half the time	Not often	Never	
m. <i>Uses systematic ways of unfolding problematic reactions</i>					N/A
Always	More often than not	About half the time	Not often	Never	
n. <i>Assists in the creation of meaning for meaning protest</i>					N/A
Always	More often than not	About half the time	Not often	Never	
o. <i>Accurately identifies and implements two-chair work for conflict split</i>					N/A
Always	More often than not	About half the time	Not often	Never	
p. <i>Accurately identifies and implements two-chair work for self-interruptive split</i>					N/A
Always	More often than not	About half the time	Not often	Never	
q. <i>Accurately identifies and implements empty-chair work for unfinished business</i>					N/A
Always	More often than not	About half the time	Not often	Never	

Change processes in therapy: Case studies in Process-Experiential / Emotion-Focused Therapy

Appendix L • Initial Screening Interview Form

Initial Screening Interview	
Name: _____	
Address: _____	
_____	Gender: Male <input type="checkbox"/> Female <input type="checkbox"/>
Date of Birth: _____	Age: _____
Phone: home: _____	Mobile: _____
Email address: _____	
Family of origin – ethnicity _____	
Place in Family of origin _____	

Educational background: _____	

Occupation: _____	

History	
Description of problem _____	

Age of initial onset: <i>Early</i> : before age of 21: _____ <i>Late</i> : after age of 21 _____	
Intensity (severity) and duration of symptoms _____	

Previous treatment _____	

Any changes _____	
Somatic concerns (headaches, stomach aches etc.) _____	

History of drug or alcohol use _____	

Any evidence of other psychological disturbance _____	

Coping Strategies _____	

Concerns in terms of: These concerns should be present problems or difficulties, and should be worded "I feel," "I am," "I can't," "My thinking," and so on.

1. Symptoms

- Crying
- Loss of weight / increase in weight
- Poor appetite / increased appetite
- Insomnia / hypersomnia nearly every day
- Fatigue or loss of energy nearly every day
- Restlessness / agitation
- Other _____

2. Mood

- Depressed mood – most of day, nearly every day
- Worry / anxiety
- Anticipated the worst
- Irritability
- Hypervigilance
- Suicidal
- Other _____

3. Specific performance/activity (e.g., work)

- Loss of interest or pleasure in all or almost all activities, most of the day, nearly every day
- Diminished ability to think or concentrate
- Indecisiveness nearly every day
- Other _____

4. Relationships

- Difficulty maintaining
- Inappropriate
- Other _____

5. Self-esteem

- Feelings of worthlessness
- Pessimism
- Feelings of inadequacy
- Excessive or inappropriate guilt nearly every day
- Other _____

Client's Initials: ____ Today's Date: _____

<p>Concern Ratings Client ID Today's date: _____</p> <p>Instructions: Rate each of the following problems according to how much it has bothered you during the past seven days, including today.</p>							
	Not At All	Very Little	Little	Moderately	Considerably	Very Considerably	Maximally
1.	1	2	3	4	5	6	7
2.	1	2	3	4	5	6	7
3.	1	2	3	4	5	6	7
4.	1	2	3	4	5	6	7
5.	1	2	3	4	5	6	7
6.	1	2	3	4	5	6	7
7.	1	2	3	4	5	6	7
8.	1	2	3	4	5	6	7
9.	1	2	3	4	5	6	7
10.	1	2	3	4	5	6	7
Additional Problems:							
11.	1	2	3	4	5	6	7
12.	1	2	3	4	5	6	7

Duration of concerns Client ID Today's date: _____

Instructions: Please rate how long each of your problems has bothered you at roughly the same level (or higher) as it does now.

	less than 1 month	1-5 months	6-11 months	1-2 years	3-5 years	6-10 years	more than 10 years
1.	1	2	3	4	5	6	7
2.	1	2	3	4	5	6	7
3.	1	2	3	4	5	6	7
4.	1	2	3	4	5	6	7
5.	1	2	3	4	5	6	7
6.	1	2	3	4	5	6	7
7.	1	2	3	4	5	6	7
8.	1	2	3	4	5	6	7
9.	1	2	3	4	5	6	7
10.	1	2	3	4	5	6	7
Additional Problems:							
11.	1	2	3	4	5	6	7
12.	1	2	3	4	5	6	7

Change processes in therapy: Case studies in Process-Experiential / Emotion-Focused Therapy

Appendix M • Participant Information Sheet

School of Public Health
Department of Counselling and Psychological Health

Participant Information Sheet

INVESTIGATION OF IN-THERAPY EXPERIENCES AND TREATMENT EFFECTS
FOR DEPRESSED YOUNG PEOPLE COUNSELLED WITH PROCESS-
EXPERIENTIAL EMOTION-FOCUSSED THERAPY (PEEFT).

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Participants and Aims of Project

The aim of this project is to investigate the in-therapy experiences and the treatment effects for young people suffering moderate to severe levels of depression when they are counselled using Process-Experiential Emotion-Focussed Therapy (PEEFT).

Procedures

You as a client/participant will be invited to contribute to the research by completing questionnaires, allowing videotaping of your sessions and taking part in interviews. Participation in the research is voluntary. The therapy under investigation is Process-Experiential Emotion-Focussed Therapy (PEEFT), an experiential therapy that emphasises the quality of the client-therapist relationship and offers efficient techniques to assist clients to deal with emotional experience in the present moment.

Potential client/participants need to exhibit discernable and quantifiable levels of depression and be aged between 18 and 25. Diagnoses of Moderate to Severe depression levels, assessed by the completion of a set of depression inventories, will be required for acceptance into the research program. The depression inventories take about 30 minutes to complete. If accepted into the research your descriptive background information will also be collected: gender, age, ethnicity, educational background, and occupation.

You will undergo a minimum of 12 one-hour weekly PEEFT counselling by me, a probationary psychologist, and trained PEEFT therapist. Participation is voluntary but if for whatever reason you decide to withdraw from the research aspect of the project your counselling can continue with me if you wish or it might be appropriate to refer you to another agency for what remains of the twelve-session contract. Students of the university can be referred to the University Counselling Service and for those not of the university, they can be referred to another counselling agency.

With your permission your counselling sessions will be video-taped. Treatment sessions will also be observed by my supervisor, Dr George H. Wills, because he will be contributing to the analysis of change processes. His observation and / or watching video footage will also be utilised so as to determine whether the PEEFT was delivered at an optimum level of competency and adherence and to assist in understanding therapist and client processes. Levels of depression will be reassessed at sessions 6 and 12 and at a 12 month follow-up. At completion of each session you will be asked to complete a Helpful Aspects of Therapy (HAT) form (5 minutes duration). You will be asked to complete a Profile of Mood States (POMS) form (10 minutes duration) at the end of every second session. At session 4, 8 and 12 a Short Form of the Working Alliance Inventory would be completed (5 minutes duration). In addition, at session 4, 8 and 12 a Change Interview would be conducted by Dr George Wills and videoed (30-60 minutes duration). During this interview the HAT forms and previously videoed sessions could be called upon to assist you to recall significant events/change processes resulting in a potentially a collaborative result. Dr George Wills conduct a follow-up interview at 12 months will include an adapted Change Interview (also video-taped).

Risks of harm

You will not be subjected to any physical interventions. As the forum for the research involves counselling for depression, you will be invited to talk about personally-meaningful, possibly painful, experiences. However, you will be guided and facilitated in this by me, a trained counsellor, and will process this material in a way and a pace that is comfortable for you. You will be psychologically supported throughout the research and counselling process. If, for some reason, there is no discernable improvement in your depression levels at the end of 12 sessions, further sessions, conducted by me, will be offered to you free of charge or you will be able to access free counselling through La Trobe Counselling service if you are a student, or another agency if you were recruited from another setting.

Privacy, Confidentiality and Data Use

All information supplied by you will be treated as completely confidential. Privacy and confidentiality of specific forms will be respected in that data will be presented anonymously and descriptions of specific informants will be restricted to categories (gender, age, place in the family of origin etc) directly relevant to assist readers with interpretation. No names will be put into the questionnaires. Each consent form and questionnaire-set will have a common alpha-numeric identifying code which will be stored separately in locked filing cabinets.

The results of the research may be presented in conferences or published in professional journals or other publications, however your identity will not be divulged in these publications. Final results from the study will be available to you upon request. Data will be kept for a total of 5 years from the date the research commences (1st February, 2007). After five years data will be shredded and deleted from research hard-drives. However, non-identifying data entered onto a computer database may be kept beyond 5 years and used in other kinds of research investigating various aspects of the current research question. Data that might be preserved for further use by other researchers may include: demographic information, quantitative data of outcome effectiveness, transcripts of interviews, qualitative analyses of interview material. These data will have no identifying information contained within them. This material would only be made available to students who have an interest in furthering or replicating the present study. Permission for use of this material would be sought from the principal investigator, Dr. George Wills. These will be kept for no longer than a total 15 years after their collection.

Benefits to Participants and Society

In this situation where the therapy and research are intertwined, individuals will receive the potential benefit of free therapy for their depression and other incidental psychological conditions. Client/participants will potentially benefit from the one-on-one counselling by initially becoming better informed about their own psychological processes and subsequently by experiencing diminishing depressive symptomatology. Together with their own personal benefits clients will know they are contributing to worthwhile research that will assist others with similar problems.

Your rights

You are entitled to confidentiality with regard to any information that you divulge during the course of treatment. Should you wish to withdraw from the research at any time, you are at liberty to do so. Furthermore, you have a right to require that all traces of your participation be removed from the project records within six weeks of finishing. If you do withdraw, there will be no disadvantages, penalties or other adverse consequences. If you are a La Trobe University student, participating in the research, your withdrawal will in no way influence your progress through your course of study. In addition, if you wish to withdraw from the research aspect of this project you can continue your therapy sessions if you wish but you are also entitled to receive advice about other therapeutic resources available to you.

Further information or complaints

Any questions regarding this project may be directed to the Senior Investigator; George H. Wills (see contact details above) or Secondary Investigator, Paul O'Halloran (see contact details above) or the Associate Investigator; Melissa Harte (see contact details above). The conduct of the research will follow the guidelines of the National Health and Medical Research Council Statement on human Experiments. If you have any problems, questions or complaints that the investigator has not been able to answer to your satisfaction or about the ethical procedures, please do not hesitate to contact the Secretary, Faculty Human Ethics committee, Faculty of Health Sciences, La Trobe University, 3086. Barbara Doherty, Ph: 03 9479 1794 (b.doherty@latrobe.edu.au).

Thank you for your interest in our research.

Yours sincerely

Appendix N • Participant Consent Sheet

School of Public Health
Department of Counselling and Psychological Health

Participant Consent Sheet

**INVESTIGATION OF IN-THERAPY EXPERIENCES AND TREATMENT EFFECTS
FOR DEPRESSED YOUNG PEOPLE COUNSELLED WITH PROCESS-
EXPERIENTIAL EMOTION-FOCUSSED THERAPY (PEEFT).**

Declaration Regarding Participation

I, _____ have read and understood the Participant Information Sheet, and any questions I have asked have been answered to my satisfaction. I agree to participate in the project, realising that I may withdraw at any time. I agree that research data provided by me or with my permission during the project may be included in a thesis, presented at conferences and published in journals on the condition that neither my name nor any other identifying information is used.

In addition, I agree to allow Dr. George Wills, the principal supervisor of this study to observe treatment sessions as he will be contributing to the analysis of change processes and monitoring competency and adherence to the method.

Name of Participant (block letters) _____

Signature _____ Date _____

Name of Investigator (block letters) _____

Signature _____ Date _____

Appendix O • Detailed Session Description of Sarah's Therapy Sessions

Session 1: 3rd August.

Sarah wanted to talk about a problem she had with flushing. Despite being quite open about her issues and readily answering questions, she was somewhat tentative and would not elaborate freely on her experiences. Her responses were often hastily spoken and quite brief. So rather than ask more and more questions I decided to work with the issue of the flushing directly. The marker for the *reprocessing task* of *systematic evocative unfolding* is when a client describes an unexpected, puzzling personal problematic reaction. I encouraged Sarah to describe an incident when the flushing occurred and notice her *felt-sense* in order to explore her internal reactions.

I asked whether the sensation associated with her flushing was present with her "...right now" and where she felt it in her body. With her eyes open, Sarah described feeling "it in my chest and cheeks," a "heavy" pressure "that I get with just general anxiety." She described perceiving an orange rectangle with fuzzy edges in her chest. Thoughts arose: "[I] become really conscious of what I'm saying... how I'm acting... alright when others are talking... sometimes I think I'm boring so why would people want to listen." Most of her friends are chatty and "go on and on and on," where she tends to be "the listening type person... people won't judge me for anything I say." Sarah was aware, however, that she missed out "[I] don't say what I want to say sometimes... I sit back." She reported being able to express her thoughts and needs at home and with small groups but would sit back in large groups.

I again encouraged Sarah to think of a recent situation when she found herself flushing. Sarah had been taking ballroom dancing classes and recalled last week's individual session. At the beginning of the class she was fine. In her recollections she was aware of the mirrors and people looking at her. Her dance instructor made jokes and she could feel her face starting to get "a little red... but by the end of the session my face was like burning... my feet were icy cold." I asked her to repeat the story but more slowly. The PE-EFT intervention of systematic evocative unfolding involves slowing the storytelling right down and incrementally retracing the events

sequentially. This is intended to increase body awareness of the events to be realised. In order to enhance the process and re-evoke the bodily felt-sense I encouraged Sarah to imagine entering the dance hall and explain in great detail what she did next. Whilst dancing with her teacher she noticed her face redden when he began to ask personal questions. As she recalled his questions her sense of uneasiness was apparent. He asked her “what do I like doing... [and] about the boy I was sort of seeing.” Sarah felt anxiety throughout her body. I wondered whether this dance instructor had moved too far into Sarah’s personal space. I reassured her that I would respect her need for space and was mindful of working only to a depth and pace that was comfortable to her.

As she returned to the recollection of her dancing, Sarah was aware that her cheeks were feeling “rosy” that her face was very red. “Oh my God my cheeks are getting red... I want to walk out but I can’t.” I invited her to notice her chest, and recall him asking her those personal questions. She grimaced. Sarah was concerned about being judged by her teacher and I was curious as to where that may have come from. “I judge people so much on what they look like, what they do and I think I’m quite judgemental and then I put those views back onto myself.” Her honesty was candid. “Do you feel you don’t live up to your own expectations?” I gently enquired.

I feel I don’t try... I choose to wear these clothes because it’s too hard to choose something nice... because it might look crap and someone might judge me for it... where if I just wear track suit pants I’m just wearing track suit pants and I’m comfortable and I don’t care if people judge me for wearing track suit pants... at night I dress up and I don’t mind people judging me because I look good...

Sarah’s attention returned to the lesson and she was aware of the other instructors watching her. Had she had that feeling of people watching her before? She immediately remembered being a young girl of five or six attending an independent school. There was a practice whereby “if you did something wrong you’d all sit in a circle and whoever did anything wrong would have to stand in the middle of the circle... the teacher would tell them off in front of everyone and so.” Sarah choked

back the tears and I was horrified. Sarah and Gina were often in the centre of the punishment circle “well that’s what I remember... I associate being the centre of attention as not a good thing for me.” I asked her to connect with her body, her bodily experience or *felt-sense*. Sarah felt an unease “just everywhere... like humiliation...” I asked her what the “little” Sarah needed. She wanted her mother and I encouraged the “adult” Sarah to enter the scene in her imagination and reassure her inner child as she felt the harsh scrutiny of the teacher and judgement from her peers. Unfortunately, “little” Sarah had no idea of what she had done *wrong* to deserve this treatment and no understanding of the punishment process.

At this point Sarah explained that her bodily felt tension was subsiding, a partial *felt-shift*, but she was aware that “little” Sarah was still crying. “She’s really confused and embarrassed.” I encouraged Sarah to comfort “little” Sarah until she felt reassured. I enquired as to whether her mother had comforted her and told her she was beautiful as a little girl. “I don’t remember... she didn’t play with us much... it’s interesting because I always have issues with mum and Gina had issues with dad.” I asked Sarah to revisit the punishment circle and notice her bodily felt-sense “[I] don’t feel like I’m all alone.” We returned to the dancing scene and I asked her to imagine her teacher telling funny jokes whilst they danced. Throughout the session Sarah’s face had been unresponsive but now she smiled warmly and her face lit up.

However Sarah’s painful recollections returned. “I just want to dance... just feel I can’t... I feel like I’m holding back... I want to dance like I want to...” She was worried she wouldn’t be able to do it and that she would be judged. Sarah had grown up feeling judged as not being good enough. When she went out with Gina they were constantly compared because they were twins: “I’ve always felt my sister is prettier than me... she’s more photogenic... when we go out all the boys love Gina...” Gina was driving home one night and a car pulled up beside them. “Oh you girls are really hot but the driver is hotter...” shouted one of the boys inside. I was appalled and Sarah sobbed deeply: “I just hate it.” She felt she must be attracting this to herself somehow, so I challenged that belief. “Even when I’m not with her... I still don’t feel pretty... like I try to stay positive.”

The session was coming to a close and I wanted to reassure Sarah that the work we would do over the next twelve sessions would enable her to get in touch with knowing

who she was and finding her self-worth. “There is nothing more beautiful than a person who feels confident and strong inside themselves and can walk with their head held high and it doesn’t matter what they wear.” I said. Sarah nodded and said she felt “definitely better.”

On her Helpful Aspects of Therapy form Sarah wrote; “talking to the little me when I was 6 -7 at school... I acknowledged the event and how I felt and was able to comfort the girl.” This was moderately helpful. She found “getting events off her chest about comparison with sister” was also moderately helpful.

Session 2: 10th August.

Sarah said she had been “really scared” about going dancing last week, although she talked herself through her distress and managed to get to the lesson. However, after forty minutes she did have a “hot flush... I had to go and get a drink, then my teacher came and we had a chat and he was really nice and then it was all fine.” Sarah was aware that her instructor “wasn’t as jokey and so I was a lot more relaxed... but I realised I go red when he gives me a compliment.” She was aware of something similar at her work with the predominantly male staff. “It’s like they’re analysing me or something... I get a bit intimidated or embarrassed.”

Sarah chastised herself for not being able to accept a compliment. She was able to accept compliments from Gina but didn’t believe males. “I think they’re just being nice...” She recognised that even if people told her she looked good she didn’t feel good and “I don’t want to be better than someone... but I do that comparison in my head.” I asked Sarah to notice where in her body she felt this sense of comparison. “My face” she replied. She became aware of the dilemma of wanting to avoid such situations and yet desiring to “face” them. The pressure “to get over this” was felt in her shoulders. I introduced the *experiencing task of focusing* with the aim of deepening Sarah’s understanding of her experience.

I asked Sarah to close her eyes and facilitated Sarah to *clear the space* (see Chapter 3 and Table 3.5) and then whilst facilitating a full body scan I asked Sarah to notice pressure and tension in her body. She noticed what she described as a brown, jelly-like area in her abdomen that felt like a nervousness that was unconnected to the pressure in her shoulders. She estimated that it had been there for four or five months

and its presence coincided with a difficult breakup with her boyfriend of ten months. “I know it will all work out... I like being single at the moment, so much better with uni and everything.” She missed “just knowing I could call him... I just feel really alone... more like a lost feeling.” Sarah had felt lost for the last two to three years: “I like questioned my life... kind of everything I was doing wasn’t good enough... I’m not living life as well as I could... I want to do more with my life... wasting.” I was surprised at this young 21-year-old feeling like she was wasting her life. “I don’t think I’m living how I want to live but I don’t really know what I want to do... I just want to have fun with what I do.”

I asked Sarah to revisit the sensations in her body. The pressure in her shoulders was now more prominent. Sarah’s high expectations of herself appeared to be the source of this pressure, as her mother was very accommodating, “she never says you have to do your homework I just do,” and her father didn’t appear to have much influence. However, “he didn’t come to graduation or my netball finals.” Rubbing her eyes Sarah recalled the events of her grade six graduation. “We were still seeing him around that time and he didn’t come... he didn’t show up... mum was sitting in the front seat and she was just crying... it was so embarrassing...” I wondered if Sarah wanted to be noticed by her father. “Yeah, I suppose but... dad isn’t one for giving much encouragement... I think he just knows we’re going to do well in our study or whatever.” Young Sarah felt sad and I encouraged her to have an internal conversation with her father about how disappointed she was that he was not there, and what she needed from him, and to ask him to tell her he was proud of her. She sat silently as she reflected on this internal dialogue.

I asked Sarah to return to the memory of the dancing instructor’s compliment and she experienced a “rush.” She was resistant to accepting the compliment, feeling it genuinely in her heart but not in her head “I let it in... but I kind of don’t believe it and no matter how many compliments I get I turn it into the negative.” I encouraged Sarah to trust the dance teacher’s good intention. Sarah further complicated the process “I don’t want to be seen like I’m up myself...” Laughingly, I acknowledged that “makes it hard...” and Sarah agreed.

Sarah recalled another school event. She had been doing something with a friend and “thought it was really good and the teacher said something... really put me

down... in front of the other kids... I just felt really crushed.” I asked Sarah to invite “adult” Sarah to explain to this teacher how she had done nothing wrong and the teacher should know better than to crush the spirits of beautiful little girls. Sarah felt a relief at the conclusion of that process, a *felt-shift*, and added that “‘little’ Sarah wants to go home and tell mum, she wants to leave the school... I don’t think me and Gina ever said anything to mum.” Fortunately, the girls were removed from the school after grade three.

A further body scan revealed that there was still the sensation of a pressure in Sarah’s shoulders and chest but the brown jelly-like sensation in her abdomen was almost gone. The sensation in her chest was in relation to her father’s absence at her grade six graduation. Sarah acknowledged she was upset at the time but “I think I kind of squashed it...” She needed her father to acknowledge her and say she was beautiful “I think I need him to actually say it.” Sarah had believed she was close to her father before he left “but I don’t feel like we were that close... he’s quite a closed person.” Sarah felt she had to manage on her own and received little reassurance from him after he left. There was unfinished business with him but the session time was up, though Sarah contemplated having a conversation with her father, “that’s what I need to do.” There was shift for Sarah from squashing her needs and wants to having a desire to assert herself. Sarah reported on her Helpful Aspects of Therapy form that doing the focusing exercise, identifying that she needed to talk to her father and working with letting in compliments was really helpful.

Session 3: 17th August.

Sarah had had a good week. She still struggled with accepting compliments from her dance teacher but by the end of her last dancing lesson her face was only slightly red. Sarah raised her eating issue. “I always eat to avoid... at work I’m terrible... just eating to avoid talking to people... I’ve been doing that a lot in the past few weeks... I don’t know whether that’s because I don’t really have a best friend.” At her placements she found it really difficult to just chat and connect with people. I asked Sarah to explain the eating-thing. “I wake up in the morning and I know if I’m going to have a day where I eat a lot because at breakfast... I’ll think about what I can buy or if there was cake in the fridge... I would eat it at breakfast.” Things had improved somewhat

recently as she had disciplined herself to eat regular meals. Also “I have this thing about finishing stuff... when I have biscuits if I don’t eat them all I’ve so much anxiety... there were eight biscuits and two left... I was full but I couldn’t stop thinking about those two biscuits. ” As the girls grew up their mother had been insistent that they eat everything on their plate. Sarah attributed her food concerns to “stress.”

As Sarah told me about a number of difficult situations she was encountering, she seemed quite remote from her feelings. I acknowledged that she was indeed under a lot of pressure from many different sources and so suggested the experiencing task of focusing to assist her to process these experiences. I encouraged her to close her eyes and *clear the space*, and facilitated a systematic body scan to look for areas of pressure and tension in her body. She felt a constriction in her throat that made breathing difficult, and envisioned a black narrow hard tube. I asked was it difficult to express herself verbally, and she said “in everyday life I often hold myself back from saying what I would want to say... I think I like screen myself, like how or what I think they’ll react to what I say.” At placements, Sarah felt uncertain about her position and was aware that she needed to assert herself but was hesitant. I encouraged her to seek out her supervisor to talk about her difficulties, and she felt confident to do so.

Sarah’s tension shifted to her chest. I invited her to think of another occasion when she felt this tension, and Sarah recalled getting the bad news that her mother had cancer. I enquired gently as to whether she was OK to talk about that and she agreed she was. Sarah had responded pessimistically to the news of her mother’s illness and wanted to know what would happen once the diagnosis had been made. She had feared the worst as the tumour was malignant and the doctors had been unable to find the primary source. I was concerned that Sarah felt she may lose her mother but she said, “I wasn’t worried about that... I was probably just more sort of selfish as well that I didn’t want to look after her or have that responsibility...” Before being ill, her mother worked a great deal and the girls had to manage on their own. I wondered whether the eating and this sense of aloneness were connected. “I think it’s also that wanting to avoid feeling a lot.”

Her eating was particularly problematic when she was relaxing. “I can’t sit down and like watch TV unless I’m eating... not so much at night but during the day...”

Sarah again felt that restriction in her chest. “The thought of being at home isn’t a nice feeling... it’s because mum’s at home... I don’t like eating or even being at home when mum’s there.” When Sarah eats, she said her mother makes comments; “don’t eat that or you won’t eat your dinner” and “do I need to take that off you?” Her mother also made rules about TV watching she thought unreasonable, and Sarah described her mother as “controlling... she has complete double standards.” Sarah had all sorts of advice she would like to give her mother in relation to her cancer

I haven’t had cancer myself but my idea of cancer is you really need to re-evaluate your life... and mum says she has but I think she hasn’t at all... she hasn’t changed anything... I think until she does she’s not going to get better... I could say 100 things she should do...

Sarah sounded like the parent. The doctors suggested counselling for her mother but she had been only once in the past few months. Holding back the tears Sarah said “but I don’t want mum to think she can’t rely on me.”

I felt Sarah couldn’t express her anger, though I acknowledged that I heard and understood her. I asked her to check in with her body again and to search for anything else that she might want to verbalize. After a long pause Sarah said there was something “but I can’t say it.” I explained that there wasn’t much I hadn’t encountered in my life and that I hoped in time that she could express herself freely with me. I reassured her that I would not be critical or judgmental. In the meantime she could journal or find some other means of expression. Unexpectedly, she began to tell me what concerned her most.²

The issue had distressed Sarah for the last 18 months. She cried openly. “It’s just really hard... I just feel so judged... hard to come to terms with it... ...I still totally freak out about telling someone... now that’s happened to me I look at everyone so differently.” She felt burdened by her situation and said “I just want a teenage life... I’m so responsible... ...I don’t want to be so serious.” Sarah reported that she

2 Some information offered by Sarah in this session has been omitted because she was confiding a secret and even though her identity is protected by a pseudonym, on ethical grounds it seemed important to respect her privacy.

“analyses every person I meet... will or won’t they [understand]... I don’t think I should screen people like that.” I was concerned that Sarah might not see an ordinary life for herself, but she reassured me. “I’ll get married... but just really hard at the moment to kind of see what will happen.” Our session time had ended and I was aware we had only just begun to process this latest disclosure. Sarah’s last comment was that “everybody had responsibilities.” I agreed but acknowledged the amount of responsibility she carried was far more than most people of her age. I reiterated that she was courageous and capable and that she needed to be gentle with herself, not judge herself so harshly. I was concerned about her and suggested she contact me if she needed to. She assured me that she would be fine.

Sarah reported on the Helpful Aspects of Therapy (HAT) Form that she found it helpful to say what was on her mind and that she had someone to talk to about her situation. In addition, she found comparing and analysing the different responses she had also helpful.

Session 4: 24th August.

During the week Sarah had what she called a “sort of breakdown” and felt really incompetent. “I was so stressed that I was shaking... I wasn’t really there.” At one of her placements, she had to prepare reports for the assessments she had conducted, and her supervisor demanded rewrites: “this was my third time... she rewords what I write... it wasn’t the content... it’s just how I’m expressing it.” The supervisor tended to pay more attention to Sarah’s shortcomings than achievements, and Sarah struggled, despite having discussed other issues with this supervisor. Her other placement was more structured, the supervisor was supportive and feedback was constructive. Sarah attributed her sense of incompetence to an inadequate level of basic English as a result of having attended that independent school from prep to grade 3. “I got to grade 4 and I didn’t know... ..all those basic things... so long to learn verbs and nouns.”

Sarah had been stressed about her uni work “but I know I can do it... I can get it all done.” Upon further empathic exploration, it seemed the issue contributing to the “breakdown” was the situation with her mother. Tears welled in her eyes as she explained that the tests had shown another malignant growth and the search for the

primary tumour had been unsuccessful. "Mum's like really sad... when I got home she was like sulking... I'm really not used to it... she started crying and telling me about... I was like why didn't you ask one of us to come with you... ...I felt like she thought she was all alone." Sarah couldn't understand why her mother wasn't attending counselling, but recounted her mother as saying "really... what am I meant to talk about, what I'm going to do before I die?" Sarah said, "I go 'why don't you talk about what you're feeling now.'" She was bewildered at her mother's inability to confront her illness. "I understand it would be really scary but she doesn't get it... ...she doesn't want to look at anything..."

Sarah was angry. "I think it was like when she first met her partner... (*tearfully*) it just feels like she left us." When the girls were 16 and doing Year 11, their mother used to go every Friday and Saturday night to stay with her boyfriend, leaving the girls alone. "So now when she's at home at weekends crying and wants us to do something... I'm like well you haven't done anything for so long and you haven't been here... I'm like why don't you go to [his house]."

Her sadness returned as she told me about a uni friend whose mother had cancer. This friend had been her mother's primary carer for over a year, administering injections, preparing meals and getting her to the hospital almost daily. "She's so good... I can't even have a fifteen minute conversation with mum without getting angry... getting angry at her is not very supportive... I feel terrible." I gently suggested *empty chair* work for unfinished business with her mother, but Sarah was very apprehensive. "Me and Gina have tried to talk to her but she doesn't listen... it always ends up in a fight... she gets angry with us because we're twins, we're close and we always end up on the same side." I agreed it must have been difficult for them and also for their mother. Sarah was reluctant to enact this issue with her mother and so I chose a different approach.

I drew Sarah's attention to the shift between anger and sadness and she said she noticed it as pressure in her shoulders. I suggested the experiencing task of focusing. I realised that the issues with her mother were too confronting at this time and saw that it might be possible to access her underlying dilemma more gently through her bodily felt-sense. I asked Sarah to close her eyes and to consider her mother as we "cleared the space" and did a systematic scan looking for pressure and tension in her body.

Sarah described the pressure as two dark green rubbery strips, one on each side of her neck. “Mum’s sad... she’s dependent.” Sarah realised her mother needed support “but I really don’t know how to... she’s trying to be independent but I feel guilty... like I should do more.” I suggested Sarah ask her mother what she needed and then assess what she was prepared to do.

I asked Sarah to revisit her felt-sense. “I think it’s the expectations I’m putting on myself or like I’m making everything more stressful than it should be...” Sarah expected to be able to manage all these stressors and not be stressed. “I suppose I wish I could be more efficient in what I’m doing.” Sarah left her assignments unfinished to create a sense of being busy. Her “head” criticised the practice but her “heart” said “if I did everything at once I wouldn’t feel busy... I wouldn’t have anything to do.” But being constantly busy had the potential for burn-out. The idea of actually finishing something in one sitting was very anxiety-provoking but I asked her to pay attention to the relief that also ensued. She found this difficult. Over the last year her study load had increased dramatically and the idea of relaxing seemed only possible when the course was complete. I encouraged Sarah to take time-out outside of session to relax by using the “clearing the space” technique, taking deep breaths or getting in touch with her bodily felt-sense and paying attention to that.

The pressure in Sarah’s shoulders had lessened significantly, which was a *felt-shift*, but she still experienced some tension so I explored further. She described a heavy weight in her arms. “Part of me doesn’t want to relax...” I asked her to listen to that and consider that it had been there for a purpose. “It sort of realised it doesn’t have a function anymore.” I explained that being busy was often used as a strategy to keep emotions and difficulties at bay. The tension lifted. A further body scan revealed an uneasy sensation in her stomach that had something to do with her appearance and putting on weight. Once again, I asked her to symbolise the sensation. She described a red rubbery dome-like structure, which she acknowledged held all her insecurities.

Sarah gained a great deal of weight last summer and spent the winter on a strict diet. She had without realising become too thin and her family and friends criticised her. I asked her to refocus on the sensation and she said, “it’s gone to my face...” Intrigued, I enquired if it had anything to do with the flushing. She agreed. “It was like fuzzy all over my face...” I asked what that meant to her, and with tears choking her

voice she said, “I don’t like being me.” Sarah had attempted to change her appearance. “[I] lost weight but didn’t feel that good...” I asked her to search within and locate that part of herself that knew she was a worthwhile extraordinary person and was beautiful as she was. She located it “right in the middle of my body.” I encouraged her to explore and become familiar with that place. Tears welled. “I feel like instead of living in there (*pointing to her heart*) I always live in my head.” I answered, “that’s where your true beauty is.” She agreed. “My head rules over... so always deciding on things instead of just doing what I want to do...” I said that our minds are full of all the introjected voices of our parents but “your heart holds your truth, your essence... the knowledge that knows what’s good for you... so get in touch with that and live everyday that way... be it... enjoy it...” Sarah explained that she felt good and the session came to an end.

On the Helpful Aspects of Therapy form Sarah reported that “asking mum what I can do for her” was helpful. In addition, “finding my inner voice and being able to sit with it and knowing I can relax when I do this” was also helpful.

Session 5: 31st August.

Sarah was annoyed that the reports handed into her placement supervisor had come back needing to be redone in a different format. Her mother was embarking on six weeks of radiotherapy and according to Sarah was looking drawn and unwell. “I think the way I’m dealing with it is just not thinking about it and so I feel a bit bad... I totally forgot that mum’s going to radio - and didn’t remember until I got home...” Home was no longer the place to relax.

... she can’t relax, that’s probably where I get it from... she can never not be doing something... she will never just come and talk to us... so some mornings mum gets up and I don’t know what to say to her, like she just stands there...

Sarah’s anger was palpable and understandable. When the girls got their drivers’ licences their mother had stopped driving them around. “Even now when I want to go down the street she’ll not drive me and it just annoys me... when we were 18 she said

‘you have to do everything for yourselves.’” I was also aware of Sarah’s sadness. She said, “I’m over it (*rubbing her eyes*) I can’t be bothered... there’s the part of me that doesn’t care but the other part does.” The idea of the two-chair enactment task really concerned Sarah and so I suggested working with the conflict split internally through focusing. But “no I don’t even want to... (*with tears*) too much to think about... I’m just getting angrier and angrier.” Sarah’s vulnerability and obvious stress levels indicated to me that gentle emphatic affirmation was the appropriate response.

Last year the girls were going to move out of home but they were unable to afford to. “...So just kept living there but it’s got harder and harder... if I had a choice I wouldn’t... but I don’t think I could go away [at the end of the year] if she wasn’t OK...” Sarah felt she would never be really close to her mother. “As soon as I can move out I’d like to see her every now-and-then but it’s not like I have to see her all the time.”

According to Sarah, her mother had a fairly negative view on things and constantly offered advice. “She doesn’t help me with anything but will tell me what to do.” As I listened to Sarah I realised she also offered advice about what her mother “should” do. I suggested Sarah might consider discussing with her mother how they might change the way they communicate with each other. “I’m sure I could listen to her more... sometimes I want to talk to her and not get advice.” I explained the technique of active listening and turn-taking. Sarah was surprised. “It doesn’t matter what you are talking about, usually someone’s giving advice or you’re giving advice too and that’s like every conversation you have.” However, I explained sometimes people just want to be heard and being given advice can be aggravating and disempowering. Sarah smiled. I suggested when she felt the compulsion to offer advice she ask questions. I laughed as I realised I too was giving advice. Sarah contemplated “I think how I respond to mum... that would make a difference.”

I gently questioned Sarah as to whether she had compassion for her mother. “I do have compassion... because I work in health and you see so many people... there are so many worse things.” Significantly, Sarah said “I want to learn how to be empathic.” She had observed one of her supervisors show support in group supervision for a student who had to go into surgery the next week. “[She] wasn’t like making the student feel worse or that’s terrible... but the way she did it you could see there was so

much empathy... you could tell she did really care.” We discussed how really connecting to your clients in a relational way can make a difference to the outcome. One of Sarah’s placements was in a centre where they don’t give advice. “These families have to live with these kids for the rest of their lives and we don’t know their kids as well as they do... it does work really well.” I acknowledged that Sarah showed empathy at times but also presented a protective “guardedness” which was lessening as we got to know each other. Despite Sarah’s reluctance to take part in enactment tasks, I felt the trust was building.

Sarah reported on the HAT that “identifying how me and my mum interact... to realise why I feel angry and also how I talk with her so as I can change that” was helpful.

Session 6: 14th September.

It had been two weeks since I last saw Sarah. One of her placements finished last week and the reports were finally submitted. Her mother was doing better, going out more and had started seeing a counsellor as part of her treatment. Sarah was pleased. “I am better towards her.” Sarah was generally doing well.

I was saying to Gina the other week since I’ve been coming here I’m really doing so much better... all our friends are like having breakdowns... (*laughingly*) I’m like I feel fine... this has really helped me... my eating’s so much better... just [had] a *click*... I’ll be fine... been a lot happier...

Sarah had a group project to complete as part of her final assessment. She had “never been a good writer” and felt really apprehensive so I suggested we use a focusing task to work with her anxiety. I instructed Sarah to think of the group project as she scanned her body for areas of pressure and tension. My aim here was to facilitate a more directed intervention. Sarah noticed pressure in her upper chest. She visualised a solid green cylinder containing words that were “stuck.” She knew in her head she had the words but they are just not available. Her confidence was lost. In grade 4 when she moved from the independent school to regular school,

[I] didn't know how to write but I didn't realise... I didn't know... so I was shocked... one time we had to put a poster in the wall and had to write our name and a few other things... someone just said 'you don't even know the difference between a capital and a lower case...' I'm like no what's that...

I asked Sarah to look at the poster to ascertain whether it was OK. For Sarah there was a sense of thinking it was fine when it wasn't. "That's why when I'm reading something I think it's OK but..." The cylinder was now more transparent.

Sarah recognised that part of the issue was confidence in her creative ability. I encouraged Sarah to find a way to release the words from the cylinder and make them available to the part of her that knows how she wants to say things. Smiling she said, "what keeps coming to mind is like structure... but I don't want that... I want to do it my own way." So the struggle for Sarah was to find a structure that still enabled her to be creative. I asked her to again focus on the cylinder. Would the cylinder give her the words? "I just asked it and it said I could just have them." Sarah was surprised it could be that simple. The cylinder no longer had a function. All she needed to do was practise and have confidence that she can make good use of those words.

Sarah then became aware of a dark circular pressure in the front of her head. "It's frustration... [about] life... why isn't my life as good as other people's... I don't have as much fun... I very rarely go overboard in my enthusiasm..." Sarah listened to her friends' stories of what they get up to and "[I] can't go out and relax for a minute... I feel so responsible... I want to be able to have that feeling of no responsibility." I acknowledged that Sarah and her sister have had to fend for themselves for a long time and "you haven't been able to be a kid." I asked her to contemplate being care-free and responsible at the same time. She noticed this in her chest. "It's a fun feeling." I recognised the desire for freedom but the need for some structure.

I asked Sarah to consider sitting on the couch and relaxing. "When I think of it I go (*crouching her whole body*)." The thought of sitting on the couch and not doing anything seemed impossible for Sarah. She felt it in her head. I explored further. "It's like my face (*putting both hands to her face*). She was surprised "I thought it would be (*touching her stomach and chest*)...but this is in my face..." I asked her to track back.

Sarah remembered being about 15 and that when Gina started going out with her first serious boyfriend. "She wasn't there anymore... I had to sit by myself." Food became Sarah's friend. "It didn't start off with eating a lot or whenever I sat down." it was gradual. "I think it was more that she wasn't there." I directed Sarah to her body. She held her hand to her chest where she visualised a long, thin, solid, black image. Sarah felt sad but "I tried not to show it..." I asked Sarah to have an imaginary conversation with Gina explaining how she had felt. This helped to shift the tension somewhat but more remained.

"It's just like I have no friends... I did but I felt like I didn't." I asked Sarah to stay with and further explore this sense of loneliness. "I'm a loser... I think I'm not an interesting person." For Sarah the loss of her sister's attention left her feeling lonely and unimportant. Even though Sarah thought they wouldn't always do things together she had this subconscious belief that they should, and Sarah acknowledged she was angry with Gina when she went off with her boyfriend. I encouraged her to again have an inner conversation with Gina. After a long pause I checked in. "I'm just talking to her... I just didn't know what to do with myself..."

I encouraged Sarah to find that part of herself that liked being on her own, was accepting of herself, and that knew she wasn't a loser but was an interesting person. I asked her to imagine being able to relax without having to be busy. "I'm relaxing but there's still... shouldn't I be doing something." Sarah's mother and sister criticise Sarah because she doesn't consistently contribute to the household tasks. "I'll do it when I'm ready... when it really annoys me." This was Sarah's structure and she wanted the freedom to do it in her time. I asked her to notice her body. It "feels good" she said. Acknowledging that it was OK to want to do it differently was important to Sarah. As a final check I asked her to think about sitting on the couch. "I'm bored!" We both laughed. The tension had shifted.

Sarah reported that the insight that "structure is important to a degree... because I can generalise it to many areas of my life" was helpful. Interestingly, "feeling the happy energy in my stomach" was also helpful.

Session 7: 21st September.

Sarah was tired and stressed. She talked to me about an eight-year-old boy she'd been working with over the last seven weeks. He had an injury but was making excellent progress. She showed real compassion towards him but knew she could only do so much in the remaining two sessions. "I just want to make sure I get him on the right track." Sarah's active interest in this little boy intrigued me and I hypothesised that she may have liked someone to care and to assist her when she struggled with issues as a child.

Sarah was planning to dance at the weekend workshop. She had no further flushing incidents and felt very comfortable with her dance teacher. At the end of her class her "dance teacher didn't have anyone next and so we had a quick practice... everyone was sitting around the edge watching and I didn't even go red... I stuffed up... I fell over (*laughing*)... [but] it was fine." I was thrilled for her. Sarah still felt embarrassed at times but "I just take a breath... [say] it's going to go away... it's fine."

Sarah's mother had been in a lot of pain but refused to take painkillers, and Sarah acknowledged that she was angry again. "Her psychological state is so bad... I don't want to look after her but I feel like having to... I just have no sympathy... I feel terrible." I asked whether Sarah felt worried about her lack of compassion. "Nan had a go at us for not being compassionate enough... I understand where Nan is coming from." The girl's grandmother appealed to them to be considerate of their mother after all that she had done for them. "What has she done for us in the last five years?" said Sarah. I acknowledged it must be difficult for her to watch her mother in so much pain knowing a few painkillers would help her be more comfortable. "It makes you depressed... I don't think she's even trying to increase her intake... she's losing a lot of weight... she's not doing things that could make her feel better." I asked Sarah whether when she felt bad she does things to make herself feel better. She paused "as I say that maybe I'm like that... I think I can probably be like that sometimes because I know with the vestibulitis... (*with tears in her eyes*) that's been really worrying me in the past week..."

Sarah had been attending a specialist physiotherapist who had suggested an exercise regime for her vestibulitis. "It still hurts... it's just too much... I just try to think that everything is going really well... it's just that and mum... I'm like they're

sort of big things... (*crying*) I just don't know what to do." The pain was present still despite her taking medication and using relaxation techniques and Sarah cried at the thought of living with vestibulitis for the rest of her life. "...There's no treatment for it... you can't even have surgery... I'm giving this physio- a really good go... I just feel like I have to do something." Sarah remembered the pain started about three years ago, "...it's so interconnected with... my relationship... breaking down as well." I asked whether Sarah would like to work with this in a focusing exercise because I believed there was a possibility of unpacking some of the contributing psychological issues. Sarah looked pleased. "Sometimes I think I have a negative perception of sex anyway."

I invited Sarah to close her eyes, take a few deep breaths as we "cleared the space." I then asked her to formulate a question related to the vestibulitis and to repeat this question internally whilst I conducted the body scan. Sarah noticed pressure in her left shoulder. It appeared to be in the shape of a "kidney-bean," had a kidney-bean colour and had a fabric texture. This reminded her of a cushion in her Nan's house but she didn't want to elaborate. I respected her need to keep things private and so took another approach and asked her to focus on the qualities of the kidney-bean. She noticed she could open it up like a purse and look inside. It was "fluffy... like a dark warm place... a homey feel... it just seems sad... feels like I'm in there... I think my Nan's there as well... (*crying*) I love her so much... she's had a really hard life." Sarah wanted to give her grandmother a hug but was unable to "say what I feel... I can't say anything that would make up for her whole life or console her enough." Whenever Sarah was sad her grandmother was there, "she just always talks to me and it's really good"

Sarah had a good relationship with her grandmother but "mum and her don't have the best relationship... really similar with how we are with mum... I get the impression that Nan never clicked with mum..." I wondered how the question Sarah asked at the beginning of the focusing related to her Nan. Sarah disclosed she had asked was "why is the pain there?" After some further exploration Sarah said "maybe Nan went through this too."

I asked Sarah to revisit the pressure in her shoulder. "It's like a chest that's full of trinkety things... like coins and jewellery and stuff." I asked her to forage around and

pull out something that had meaning for her. “In my head it’s about money... you have to have money to be happy... I think if I had a lot of money guys would think I’m a valuable person... I think I only believed it since I had this problem.” Sarah thought that if she couldn’t “give sex... I’d have the money.” She realised “...it’s silly...,” and that she would find someone to accept her, and decided to “put the chest in the ocean or something.” The pressure in her shoulders had reduced to an experience like thin wooden strips. “It’s about me liking me.” Sarah felt she was “so much better” about that now but the vestibulitis “it’s just crap luck... I know it’s nothing bad... but I just find it so annoying.” I encouraged her to really connect with her anger. “I really go up and down... I know it doesn’t really matter when I think of other people with cancer or something.”

Sarah felt she was being taught “a lesson... something about perseverance... I get the feeling at the end of this... experiences really shape you... want to change who I am...” Her head started spinning but she was able to stay with the sensation, and her thoughts turned to “me relaxing... I sat on the couch all week and didn’t eat...” I asked Sarah to connect with the experience of relaxing her whole body. I said “it frees you to experience good things... sex can be a good thing.” Sarah replied “I think I associate it with negative things... once you’ve had sex things change... it seems like if you don’t have sex it’s better... I think I become a bit dependent.” The word “slut” came to Sarah’s mind. “It’s just always been my opinion... I think it must come from mum... I did think that about mum.” Sarah’s parents separated when she was about six and Sarah struggled to see that it was OK for her mother to have a sexual relationship. She was wary of the judgments of others. “I think it’s a judgment that people make about girls and I worry would people make that about me.” Adult Sarah recognised that “it’s all fine” to have numerous sexual partners but the younger Sarah needed reassurance. I suggested she have an imagined internal dialogue with those aspects of her that struggled to know that sex was OK. I asked Sarah to get in touch with the part of her that wants to make choices about being in a sexual relationship where she felt good about herself. “Yeah... that feels good.”

Sarah reported in her Helpful Aspects of Therapy form that “going through all the different emotions/events from the vestibulitis” and realising “a lot about my values”

were extremely helpful aspects of the session. She also found discussing her young client and obtaining a different perspective about his difficulty was helpful.

Session 8: 5th October.

Within the last fortnight Sarah had gone for a holiday up north to check out the idea of taking up summer jobs on the coast for about three months. She was really looking forward to the experience of working and living away from home but was concerned about making friends. It had taken “two months to get to know the boys at work, [to] stay after work and have a chat...” The friend she was to travel with “makes friends easily but the friends don’t last a long time... she’s a really flirty person... we’re quite different...” Sarah hadn’t slept the past few nights as she was really unsure about going and was worried about her sister. “She’s really self-conscious at the moment... you know how I’m the one who’s usually self-conscious... she’s never felt ugly and she feels really ugly at the moment.” Gina explained to Sarah that she now understood what Sarah had gone through last year and had also become aware that people only talked to her because she was attractive. Fortunately, Sarah was able to be supportive of her sister as she was feeling confident and her eating was under control.

Despite raising concerns about her working holiday and her sister, Sarah wanted to work with the “the sex thing” because “last week was really good... it really helped...” In addition, she said

I have this thing with really good-looking guys... I end up giving a really cold... defensive... like this boy I was talking to he was really hot and he said I just seemed really controlled... (*pause*)... that’s so it... I am so controlled... whereas with people who know me I’m so much more relaxed...

I shared with Sarah that when I first met her I also found her very contained but once I got to know her I found her warm and sincere. I also explained that this particular style may have been learnt.

We had used the focusing exercise last session as a means of processing the issues around the vestibulitis and so we repeated the process. Sarah easily identified an area

in her chest that she described it as a cloudy-grey, fuzzy, hollow cylinder. When she focused on the symbol “I get an image like sometimes my words get stuck... it’s like I have this big secret.” She’d come to terms with the situation but “I think it’s just that I analyse people before I even know them to see what they might think or something... I think the problem is the fact that I feel like I’m deceiving people.” The not telling was “kind of eating away at me.”

I asked her where she felt this “eating away?” Sarah pointed to her solar plexus and I conjectured “a sort of fear.” Sarah stated it was her “conscience.” She was reminded of a friend at school who had liked the same boy as she did. Sarah had gone to the formal with him but her friend began seeing him behind her back. Sarah remembered how sad she felt and questioned her friend, “why didn’t you tell me?” Unfortunately for Sarah “everyone knew...” This past situation resonated with the current one for Sarah because she wanted to ensure that she didn’t “lie” to anyone.

Holding her throat, Sarah spoke with a croaky voice. “I don’t know what I’d say... I know I’d probably cry... I don’t want to be like that... I know if I’m fine with it... the chances are that the person I am with will be more OK with it.” Sarah needed to believe that there were people who would “be OK with this... and I need to know that I can talk about it... without crying... or freaking out.” I invited Sarah to locate a place within herself that felt the “freak out” and she gestured to her chest area. She was worried that if she told “someone they’ll tell people.” Sarah was reminded that when she was told something she will often talk to Gina about it. However, in her work Sarah was aware she had to hold confidences and we explored how she could sit comfortably with such containment.

Sarah was still aware of pressure in her chest. She described it as a flat stretched out maroon circle sitting in her chest. Negative statements came to Sarah’s awareness: “sex is bad... sex is not pleasurable.” Focusing on the first statement I enquired where that view had come from. “That’s generally my impression from like friends, relationships and parents.” I asked what Sarah thought about sex. “I think it’s good but I feel like boys like use you... which is bad.” Sarah’s body experienced sex as “not pleasurable... the stuff before is much more fun... the sex is always like, when’s it going to finish.” I asked Sarah to imagine sex without pain but she found this difficult so I asked her to focus on the pleasurable aspects.

We gently moved from the pleasurable aspects to when she would begin to notice the pain. I asked her to recall a time where she had experienced no pain at this point. Sarah was able to do this but said, “it wasn’t very good.” We both laughed. “It takes a lot of effort to concentrate and try to imagine it without pain... I can imagine being relaxed but then the pain.” I asked Sarah to observe herself having painless sex and she found this easier. I also asked her to connect to the part of herself that felt good about her body and that felt spontaneous, alive and free. She enjoyed this. The bodily felt-sense had shifted slightly but still persisted. Upon further reflection Sarah recognised that she felt undeserving of a life of spontaneity and painless sex. I gently said that she was indeed worthy of such a life and more, and added “I’ve seen that lovely spontaneous side of you when your face lights up and your eyes sparkle.” I encouraged her to show that side more to others. She replied “...I feel a little bit hesitant... in case people don’t like me.” I encouraged her to notice that part in her and focus on that for a moment.

Sarah remembered occasions at high school when she would say “...hi to someone or said things and they haven’t been reciprocated.” I asked the adult Sarah to explain to the younger Sarah that not everyone is going to like her and sometimes she might get that reaction. Sarah acknowledged that her guardedness was about protection. In order to feel less protected Sarah felt she needed to be 100% happy with herself. I wondered if she might be asking a bit too much and we both laughed, “well 95% then... and confident in myself... I think I’m 85% [now].” In order to feel more confident Sarah wanted to be viewed “as an interesting person... more when I first meet people...” I asked Sarah to explore through her bodily felt-sense where she experienced this 85% within her and let it expand to 100%. She was able to do this and I likened it to feeling comfortable in her own skin.

To test her new sense of confidence I asked her to imagine walking up to a guy she was interested in. “I get anxiety just here (*touching her chest*)...” We discussed how there are risks in social interactions and that excitement can often be confused with anxiety. I asked her to imagine her conversing with him in an easy and flowing way. I also reminded Sarah how she struggled at first with her dance teacher but after a while her interactions were more spontaneous and natural. Sarah’s bodily felt-sense had shifted and despite there being some lingering sensations our session time was up and

she was happy to leave it there. Her parting remarks were in relation to the flushing. “I was at dinner... and I felt myself going a bit red but it just didn’t bother me and then it just went away... so happy.” I said that was a fantastic gauge as to how she was progressing.

On the Helpful Aspects of Therapy Form Sarah wrote “filling up my self-confidence to 95%-100% made me realise I am almost at the point I want to be and that I do feel comfortable in myself.” A second helpful event was the visualisations of observing herself having pain-free sex.

Session 9: 12th November.

Sarah was quite calm today despite having had an argument with her mother and not having heard from a “boy” she kissed last weekend. Sarah and her mother had argued over doing the shopping. I wondered if Sarah felt concerned at her level of anger directed towards her mother, as she said, “the only reason I feel bad is because she’s sick... if she wasn’t sick I would have refused to do it.” The radiation treatment had caused her mother’s skin to blister and Sarah was aware of the pain her mother experienced. Her mother had lost more weight and Sarah remarked how small she appeared. However, Sarah remained quite scathing about her mother’s attitude to her illness and recovery. “She’s really doing so much... even though she’s resting she’s not really resting... she’s not helping herself... she did the gardening and was carrying all these bricks.” Her mother had booked in for meditation classes but had done too much during the day and was unable to attend the evening class. “She just doesn’t get it... to relax and actually rest.” I acknowledged that it must be hard for Sarah to watch her mother go through this and for a moment she connected to her sadness.

I wondered whether I should encourage Sarah to work with the issues about her mother but remembered she had been quite unwilling to do so in the past. I also remembered that we had committed to work with the vestibulitis and so suggested we turn our attention to that. Sarah said “I had a moment in the car the other day... it was just about sleeping with people and my issue with that.” She had listened to a CD that explained it doesn’t matter how many sexual partners you have had as long as the experience is positive and conducted with dignity. However, when Sarah thought about the possibility of a one-night-stand she felt the guy might potentially use her for

sex. “I still don’t think I could sleep with anyone unless I was going out with him. I supported her need for boundaries. Sarah was also concerned that she lost herself when she became sexually involved. “I think it’s like my physical, and don’t know whether its spiritual... isn’t kind of in line about having sex.” Her sense of self was still developing.

Sarah was aware that her reserved behaviour was also “how I avoid being hurt... I don’t think like that’s my natural response... that’s like my intellectual response... cautious... like trying to contain it so something bad doesn’t happen.” I recognised a conflict split which is a marker for the two-chair task. We established that one was the “controlled” critical part and the other was the “free” spontaneous part. Fortunately, Sarah was willing to explore the split through the two-chair enactment task and moved to the “controlled” chair. Sarah described her felt-sense as she sat in that chair. “My body has a tight... *(pause)*... thing around it... contained... I know my limit... I’m predictable.” She spoke from the controlled aspect to the spontaneous one. “When you’re in control I can make mistakes that could ruin my life... do something embarrassing... that other people will judge me for... kissed the boy.” The freer aspect had emerged and she changed chairs. “When I sit here... when I’m free it’s only when I’m really drunk... it’s when I let myself be in this state... which makes it worse because I’m more out of control... because I’m so contained all the time.” However,

when I feel free it just feels like there’s no restriction on my body... and that it’s not that I say anything different or I act different it’s just I think I am more relaxed and I give a different energy to people... I think [I’m] open and friendly... things will happen... I like being like this... it makes events more enjoyable and it means I have more fun...

Sarah changed chairs. “If I left you in charge all the time it wouldn’t be right... I don’t trust you... the only reason I don’t trust you is because of what happened.” Sarah continued to chastise her free spirited side, which responded, “I know I made a mistake but I have learnt... I came to realise that there are just so many other worse things that could happen.” Sarah’s free side acknowledged that boundaries were needed. Sarah’s controlling side agreed that it was important for her to express her

freedom to a certain extent and offered a solution. "It'd be good to start to go out and not have a drink... suddenly in the past year and a half I seem to like to drink every time I go out... I'd like for me to go back to not drinking." The two aspects were in agreement that a couple of drinks would be fine and "I don't have to drink to be free." Animatedly, Sarah returned to her original chair and we discussed the integrating process.

However, she added, "I have this slight anxiety... what happens if I go out and can't feel it... or being around drunk people is just." I asked Sarah to locate the anxiety in her body and she pointed to her upper chest. She closed her eyes and described the sensation as soft, green and oval. "I would like to meet a boy who would like to go out with me... but I feel like I'm closing them off because I can't have sex... the sex may be unenjoyable... part of me knows it will hurt." I acknowledged that it was evident to me that Sarah wanted sex. We both laughed. "I know that's the thing... and I'm so frustrated." Again a conflict spilt was evident and so we returned to the two-chair task.

Interestingly, Sarah chose the controlling chair for the aspect that knew sex was going to hurt. "You shouldn't want to sleep with random people." Sarah saw this view as one of her strongly held beliefs. "You get judged." Sarah was also concerned about the consequences: "I don't want to get hurt... I've seen [what] my friends go through... they've been a mess... that scares me." Sarah moved chairs

I just want sex... I just want to be a normal 21-year-old... instead of having you watching over me all the time... you're always saying something to me... you restrict what I do... I get out of control when I drink because then I don't have to listen to you... so it means my judgement gets swayed... I think it's for the better most times but if you just relaxed... I'd be able to relax as well... I just want... sex.
(*laughing*)

Sarah changed chairs. Seriously, "if I let you have sex what if it hurt... I don't want you to go through any more pain..." She recognised the virtues of this protective stance but that it was also constraining. I enquired as to whether this side wanted sex. Sarah slowly said, "yes... I want a casual relationship too." The two aspects were in

agreement but Sarah wanted reassurance that sex wouldn't be painful. The spirited aspect knew sex doesn't hurt but was unable to reassure the other aspect. Sarah's physiotherapist had suggested increasing the medication as a means of minimising the pain. Sarah returned to the controlling chair but felt that increasing the medication was "not quite the answer... I think I'm really scared that what if I do really like sex... (*smiling*)... I'm scared what the control side will do if I like sex... maybe I'd lose part of me." I asked Sarah to sit with this realisation and check in with herself if she would really lose part of herself. "I'm not going to lose it... it will just relax a little bit... (*long pause*)... they know (*pointing to other chair*) that liking sex is good and want to like sex... but I'm just scared."

Sarah felt "there's something..." and I asked her to notice her body to locate it. After a long pause "I found it... right in here (*pointing to her lower abdomen*)... like my first boyfriend... I had a few bad experiences and then never really liked sex... and I think that not enjoying sex was better." I encouraged Sarah to go to that moment when she made that "choice" that it was better not to enjoy sex. Sarah looked puzzled. I encouraged her to explain to the other aspect that she had made a choice not to enjoy sex. Sarah closed her eyes and as a result of her internal dialogue experienced a felt-shift. I encouraged her to sit with the newness and she noticed her heart was beating really fast "I think that's relief..." and I offered that it could be excitement about having sex. Sarah returned to her original chair laughing that's "really good... I've talked about this to many people and I've never come to that... so strongly... I can't believe I think that or thought that."

I reaffirmed the importance of Sarah listening to her intuition and being comfortable with herself and her beauty. "Everywhere I go in the past few weeks everyone's been telling me how stunning and beautiful I am... the boy I kissed last Friday night said I was really hot...my mum's friend said [I was] just glowing... a different person." Tears welled in my eyes as I recalled Sarah's words to me when she first started counselling. "I just want to be beautiful." Sarah cried too. I acknowledged Sarah's determination and commitment and that she was feeling her beauty "from the inside as well as people noticing on the outside."

Sarah reported on her Helpful Aspects of Therapy Form that discussing her issues around sex and identifying "a belief I had which I never realised I had" was extremely

helpful. Sarah also found “contrasting the controlled me and the free me” through the two-chair work was extremely helpful.

Session 10: 18th October.

Sarah’s weekend “was a disaster... I went out and I didn’t really feel like going... that boy ignored me... I’m so anti-boys now... *(laughing)* I hate them all... I think that’s why I haven’t kissed anyone like that for such a long time.” Sarah felt “crushed” and was concerned that she “went straight back down...” after doing so well. “On Monday I had my first real ugly day in ages and I ate... today I feel a little bit more in control.” I reassured her that a stronger more resilient sense of self took time to develop. In addition, Sarah’s mother had finished her last round of radiotherapy treatment and wanted to give up work. She approached the girls with an ultimatum that unless they contributed \$80 per week to the household expenses the house would be sold. Sarah who supported herself financially in every other way was furious “I’m not going to pay \$80 to live at home.” A major conflict arose where both the twins and their mother considered the other party to be inflexible and unrealistic. Their mother felt the girls were very hard to live with and Sarah said, “I am sure I am.” I acknowledged that Sarah was indeed “very definite about things.”

Sarah had finished most of her assignments and was turning her attention to her working holiday trip up north. She had resigned from her part-time jobs. “I’m really worried about going... that I won’t fit in and that I won’t make friends...” I suggested we could explore her concerns through a focusing exercise in addition to furthering the exploration around the vestibulitis. Sarah was still experiencing physical pain during her physiotherapy exercises. “After last week... feel like my mind’s ready and I’m ready but physically it’s literally like *(making a fist with her right hand)* it’s not going to give an inch.” Sarah had increased the dose of her medication and despite feeling obvious effects said “I’m still just as sore.” I responded that “it’s almost as if you’ve got an argument between your brain and your body.” Sarah agreed and I suggested two-chair work.

Sarah easily designated a head-chair and a body-chair. Initially she sat in the head-chair. “I’m 90% ready but this *(both hands gesturing to the other chair)* is like the last 10%... why aren’t you ready.” Moving to the body-chair “I’m still trying to protect

myself from getting hurt... keep myself closed like this.” She motioned her hand up and down her chest as the part in her body that’s holding back. It’s “just like I could cry... just like that shit feeling... *(long pause)* I associate it with disappointment... I thought of dad... when he’d say he was going to come to netball and never show up... avoiding disappointment.”

The vestibulitis developed during the end stages of a relationship three years ago. Sarah thought the problem had to do with pressure from guys to have sex. She felt ambivalent about having and not having sex. I asked Sarah to sit with that dilemma. She experienced a “tingling, like buzzing...” in her arms and legs. “I do feel pressure from... also friends like whenever we talk about sex... I don’t think they have any comprehension of what it’s like.” She habitually hid her emotions from everyone but Gina, so friends never realised when a breakup hurt her. She felt people don’t listen to her.

I asked Sarah to revisit the part of her body that feels pain with sex and suggest the idea of letting go. “In sex I don’t want to let go... of the pain in that area because *(pause)* I feel like once it’s gone you’re *(the head)* going to forget everything that you’ve been through... move on with your life without... learning anything.” Sarah swapped chairs. “My head is worried as well... I will just move on... my behaviour hasn’t changed... like what have I learnt?” Sarah had contemplated this during the past week. “I don’t think I’m a more compassionate person because of it and I think that’s really sad... I should be with mum... and Gina... and to some degree with clients.” I asked Sarah where compassion comes from and she placed her hand on her heart. I asked her whether she really would forget what she described as “the hardest three years of my life.” Sarah acknowledged that attending so many professionals gave her insight about “how I’d like to treat my clients...” and that she would remember “how hard I’ve worked... and all the things I’ve learnt about myself and other people.”

I encouraged Sarah to ask her body “do you have any compassion?” and swap chairs. Sarah could not sense much compassion. “Why should I have compassion for other people when I have to go through this myself... my underlying thing with everything... just deal with it.” I recognised this was more of a head statement so I asked Sarah to connect to her body and she responded “it just doesn’t know what compassion is.” As a five-year-old Sarah remembered “I’d show compassion and it

turned out wrong... the response to me would be negative... so I just associated being compassionate with like giving too much of yourself and... not receiving anything back... I don't know how to be compassionate." I wondered whether Sarah had been shown compassion and her "first response is no." Gina at times had shown compassion but Sarah often felt confused because the compassion had been peppered with criticism. Recently, when Gina had been crying, Sarah felt she was "so hard... I'm just so heartless." I explained that I saw Sarah's behaviour more as a defence mechanism. Sarah also acknowledged that if she showed compassion to her body she would be "allowing it to never get better... it's alright if it's sore forever." I was curious as to how this belief developed, when Sarah asked "what is compassion?"

I explained that compassion was "a mixture of love, empathy, concern, consideration, [and] warmth." Sarah added, "when someone's really like interested in your circumstances..." and I concluded "wanting to understand... showing care... an energetic thing... acceptance... no judgement..." Sarah acknowledged, "that's hard for me to do that... I would like to be compassionate." I encouraged her to identify compassion as a place in her body and after a long pause Sarah said "if I let my body be compassionate for itself... I don't want to be in pain anymore... I think it's connected with loving myself... then I think about if I actually loved myself I think I'd be up myself." I explained that finding the strength of knowing herself was often a humbling experience. Sarah agreed.

Sarah noticed there was still something else. I asked her move to the head-chair. "I think I'm more accepting of you now but... I just need to be more comfortable with who you are." I asked Sarah what she thought about her body and she replied "I think it's good... but my mind says [the pain] shouldn't be there." I conjectured that Sarah's mind was pushing her body against its will. "Yeah, that's it exactly... my head's telling me I need to go to the physio, take my medication, do my exercises." Sarah was committed to this program and logically was doing all she could. However, "I'm getting really tired and sometimes I wonder how much longer I can keep doing this when you're not responding." I encouraged Sarah to ask her body what it needed and she swapped chairs. "I'm not responding because I'm not ready... it's yelling at me..." and she moved back to the head-chair. "Why not... that's so stupid... you've had this

for three years... and then suddenly... I think it's about... it's not about a boy... it's about me feeling connected to you and being one with you."

Sarah's "body" responded "I don't think you listen to what I'm saying... sometimes I don't want to have sex, I don't want to have sex and you shouldn't force those things just because you think you should." Back in the head-chair Sarah said "you should have sex every day, every time you see your boyfriend for like multiple times." Sarah had gleaned this belief as a result of complaints made by ex-partners that there was not enough sex in the relationship. "I feel like because you can't have sex all the time that's why my relationships fail." However, Sarah also realised that when she no longer liked the guy but was unable to end the relationship she didn't want to have sex with him. Sarah also held the belief that relationships where the partners don't have sex often are dysfunctional. I explained that intimacy and acceptance were important components of a healthy relationship and that sex was not the only way to show love. Sarah's body had been putting out a clear message and her head realised it hadn't been listening.

From the body-chair Sarah's "body" asked for acceptance and "I need you to listen to me... and also before you eat." Sarah's "body" needed time out "to process my emotions and my feelings and things that happen... and I'm not just going to get over it... and you don't need to get involved by overanalysing... I just need to be in that experience so then I can move on." Sarah's head agreed to "wait... and not suppress any of your emotions." Agreement was reached that processing time would be set aside each day. Sarah returned to her original chair. I encouraged her to notice her body in interactions with her mother and sister and whether compassion was present. "My head's just spinning but my body's like... relaxed... it's like relieved."

On her Helpful Aspects of Therapy Form Sarah wrote "when I found agreement between my body and my head in regard to my vestibulitis, my body relaxed and my head listened" and this was greatly helpful.

Session 11: 26th October.

Sarah's academic life was ending "it hasn't really sunk in... I'm a bit uneasy about... I'd like to find a job before I go up north... I know what I want." She had been applying for a number of jobs and didn't seem to think this was an unreasonable

expectation. Despite an average academic record Sarah felt confident that “I have things to offer... I know I’ll find my perfect job.” As we talked Sarah realised that “I shouldn’t rule out that I might not get a job until after my trip.”

Sarah was at times “still a bit short” with her mother but had been able to show her mother compassion during the week. When her mother had become distressed after gardening and had gone to her room, Sarah interrupted her phone call and went to support her: “I tried to be [compassionate] I think I was half way.” The chef at work had also instigated conversation with Sarah for the first time “and I was trying to... like get on his level.” However, Sarah had found no time for Gina who was struggling with issues with her boyfriend. “I don’t have anything to say, I can’t give you any advice... I told her she was being an idiot.” Sarah was interested to know whether being “compassionate for everyone... could almost be overwhelming...” I agreed that for some people this might be an issue.

It seemed Sarah had been up and down through the week. She had not done her physiotherapy exercises as she felt her “body is still just not ready.” I suggested a focusing exercise as Sarah had a great deal going on but no specific issue was salient. She visualised a hard square red pressure sitting on top of her head: “I think it’s my personality... I think I find it hard for people to get to know me... for me to let them.” I asked Sarah to notice her bodily felt-sense as she talked. She visualised a whitish cream thin tube running along her sternum and felt nauseous. “I think it’s about being scared... that people won’t like me.” I encouraged her to stay with that sensation and identify when she had first felt this. Sarah remembered a girl in Grade 1 at the alternative school. The sick feeling developed into more “like a hollow feeling...” Sarah recalled “the situation was when she told the teacher about something and then it went into one of those circle things... and I didn’t know why... I think she misinterpreted... people often misinterpret what I say... more offended than I realise.” There had been a misunderstanding and Sarah found herself punished. “I decided to screen what I was going to say.” In order to reprocess the incident I encouraged Sarah to find more appropriate words that she could say to that teacher and confront her in her imagination. “I wouldn’t change what I said I’d just explain it more.”

Sarah focused on the hollow feeling again and Gina came to mind. "I feel that she'd judge me... not when we're at home but when we're out... I get the impression I judge her... I think whatever she does reflects on me... people always compare us." Sarah remembered starting high school: "Gina wasn't very friendly... then that's what people thought of me... she just didn't like to be friends and it didn't bother her, it bothered me." I was reminded of how close Sarah and Gina were, and yet as twins they experienced an ongoing struggle to live separate lives. Sarah noticed an "evil dark grey cloud" in her chest. Gina "can be really annoying... I suppose I want people to know the Gina I know... I think... she's really fragile... like I have to protect her." It appeared that as Sarah had become more empowered Gina became vulnerable. "...on Tuesday I was really down and Gina was really happy... it's always the way."

Sarah believed going up north would help break this symbiosis. "I feel I can leave and disconnect but I feel like she'd still worry about me... she doesn't know what to do if she's not worrying about me." Sarah continued, "I'm worrying about her... I don't know what I'd do if like she got sick... if she was dying or something." At this point reassured Sarah and was rather dismissive of her concern. I said "you know what you would do... you'd be right beside her, that's what a sister would do." But Sarah went on, "I suppose I'd be like overly emotional like more... I'm not really emotional with other people and death doesn't really phase me... I feel like I struggle to cry but I know Gina's [death] would be different... that scares me." I returned the focus to Sarah's leaving. "I know I can do it but it's like separating... it is like forever." I responded, "with every change it's like something dies... it's not surprising you feel it's a little bit like dying." Sarah replied, "what if I miss her?" I asked Sarah to imagine Gina with her, sitting together but separate: "we're still a little bit connected." I acknowledged that as twins they would always have a unique connection.

Sarah visualised that the dark cloud had condensed into a dark spot which she recognised as "fear... what will I be without Gina... I know we have been a lot more separate over the past few months." The session was drawing to a close and I reminded Sarah how far she had come and her excitement at starting a whole phase of her life. A body scan revealed some tension in her head. After a few moments of focusing on it Sarah said, "it's the stress of life... I think I need not to get so stressed

about things...” We both laughed. I encouraged her “to take it in your stride one step at a time.”

Sarah reported on her Helpful Aspects of Therapy Form that “separating from my sister... was helpful because it needed to happen and for me to realise that I will be OK” and the “personality scanning... letting my guard down” was also helpful.

Session 12: 16th November.

It was two weeks since our last session and Sarah was smiling and vivacious. She had applied for a position in Sydney and the organisation had rung to ask her to provide more information. She was very excited. Most things in her life were going well “the only thing that has been bad is boys.” The young man she had kissed had ignored her again. “I was... crushed.” Sarah was surprised that it affected her so much. “I don’t know... I really get down about it... makes everything go to crap...” She shared a decision she had made. “When I first started therapy I was, like, I want to have pain free sex before the last session.” She went on to explain a missed sexual opportunity

I was with this boy for the whole time and he’s really hot and I went to the after party... and he stayed over and he’s like so gorgeous... I couldn’t do it... and the next day I had like regret and I was like so torn. I didn’t want to because... I was just really scared... it was a perfect opportunity... I don’t think I was worried it would hurt... I was worried how emotionally I would be afterwards.

I supported Sarah in her choice not to have sex.

Sarah’s mother was doing better and said she would miss Sarah when she was away. “I’m like no I’m not going to [miss her].” but Sarah felt the separation would enable her to “actually want to speak to her when I see her.” A little bit unexpectedly I then enquired, “how’s the compassion going?” She said, “I’ve been more aware of how not compassionate I am... I think I find it hard.” Sarah had been at an event with a friend “she wore heels and I wore flats and half way through she goes ‘my feet are really sore.’ I’m like it was your choice I don’t care... every other person is feeling the same way deal with it.” In contrast Sarah had been on a supervised visit of a hospital and

had felt “so sorry...” for one of the mothers. “She had a Down syndrome baby... she’s just going to need a lot of support... just what she’d have to go through.” That felt like compassion to me!

I returned to the issue of the “boys.” I was aware this was our last session and wanted to facilitate some processing for Sarah in the relationship area. “I think at the moment... I feel really boring... I don’t talk about myself.” At social functions Sarah found it difficult to “talk about crap... it gets a bit dead too quickly.” I suggested that asking questions might be a useful way of managing awkward situations. Sarah had noticed that those friends that “speak crap... meet people the easiest and form quicker relationships... [but] they may not be as long lasting.”

Sarah had a great deal going on and so I suggested a focusing exercise. She felt pressure in her jaw. “It’s about me being too sensible... my body feels like it wants to let go... but my head’s like.” These statements were distinct markers for two-chair work and I invited Sarah to either have a conversation in her inner world or we could set up the chairs. Sarah decided to do the two-chair enactment task and allocated one chair as the sensible part of her and the other chair for the part that wanted to “do what I want to do... just having fun...my body.” She immediately sat in the chair that she also described as her body, the free and easy side. I wondered if this was a rebellious aspect. Laughingly, Sarah agreed. However, “I feel that I can’t...like can’t let it out.” This was the sensible side and I suggested she changed chairs.

I feel like I overanalyse the situation and I stop feeling... I don’t stop feeling I notice what you’re feeling by trying to analyse it to see what will happen like in the future... every possible thing that could happen... because I’m always sensible I just can’t just let loose or do what you (*pointing to other chair*) want to do and then it puts extra stress on because you’re always pressuring me to do something but I can’t do anything... if I do something I then worry about it more.

Sarah swapped chairs. “I just want you to know how much more fun it is to be free... but I also get that my body is still scared.”

I encouraged Sarah to stay with that scared feeling and notice where she felt it in her body. The felt-sense in her chest related to concern about being judged by others and not being good at doing things such as dancing. “If I don’t think I’m good at it I’m not going to do it... let alone in front of people... because they might think I’m crap.” Interestingly, Sarah was unaware that most people can’t dance as she had a tendency to observe only the best dancer in the room. “It’s the same as if I see one pretty person... I’m not that pretty... I’m just so selective on who I compare myself to.” Sarah’s default position was to see the negative in a situation and praise for Gina made her feel unattractive. I encouraged Sarah to attend to that blinkered judging part of herself and she acknowledged she didn’t want to be better than other people. Importantly, Sarah now believed she was pretty.

Sarah returned to the issue with guys. “With guys that I like... I feel rejected...” I encouraged her to remember kissing the boy. “I just distanced [myself] like pulled away...” she located a heavy sensation over her shoulders, chest and solar plexus, “like a [grey] ball filled up on one side... it’s just like to protect myself.” I asked how long it had been there for and she said since she was “three or four.” Her father had left when the twins were six and there was a great deal of tension in the house prior to his leaving. “I think I just withdrew and just relied a lot on Gina.” Sarah had felt she could not rely on people and “I still feel like I can’t... the only person I trust is Gina.” Sarah had needed to withdraw in order to protect herself. “I think I’m scared about how sad I’d be if like with rejection... I don’t like being sad... I’m just worried I’d become too sad...” I asked where that really deep sadness originated. “I think it’s just I’m pissed off with dad back from when I was little.” I encouraged the little Sarah to speak to her dad. “But I’ve had this conversation with him so many times.” I suggested that her relationship with her father was the model on which her relationships with young men were based and it was important for her to voice her anger and disappointment. She said, “It’s about accepting that he did the best he could.” I challenged this, because her anger as a primary emotion was valid and justifiable. I was curious to know if there was anything “under” the anger. “Just sad” she said without tears. I encouraged her to stay with that.

The sensation in Sarah’s chest had intensified and was “really dark and heavy...” She was able to stay with the sadness and the sensation lightened. I asked her to notice

her father and their connection: “it’s OK but there’s not much of a connection.” The session had run well over time and I realised there was only so much we could achieve in this last session around the issues with her father and so I brought the session to an end by enquiring as to whether it was an OK place to finish. I realised we had been unable to finalise the two-chair work we had started and because of the time I was reticent to move Sarah to the other chair. Therefore only a partial resolution was achieved in this session. We discussed how Sarah had become “sensible” in order to protect herself from being hurt and that there may still be further issues to work with in respect to her father. Sarah reported on her Helpful Aspects of Therapy Form, that “realising how much dad has influenced my interaction with people was helpful because I was able to see where the emotions were coming from and then be able to modify my thinking about them.” In addition Sarah stated that “establishing that me and Gina could both be beautiful” was also helpful.

Appendix P • Detailed Session Description of Katie's Therapy Sessions

The following recollections of the sessions with Katie are taken from reviewing video recordings of sessions, rereading of case notes and my past session recall of process decisions I made within sessions. At the end of each meeting Katie was asked to record helpful aspects and I have included these brief jottings.

Session 1: 16th March

Katie arrived on time to her first session and proceeded to tell her story while I offered opportunities for exploration by gentle open-ended questioning, affirmation and empathic conjectures. The Process-Experiential Emotion-Focused Therapy (PEEFT) approach encouraged me to be *present* to Katie by being attentive, open and curious but also alert for an appropriate marker, an outward visible sign she was grappling with a particular issue and potentially ready to “work with” that issue.

The main concern she brought to this session was her weight. She experienced “panic” when she felt she had gained weight and this would trigger a restriction in her food consumption. She wanted her weight to stay at a level she intellectually knew was too low. She openly questioned whether she “likes being sick” and felt stuck in some sort of compulsion. She said that when she felt good about her weight, she felt good about herself. I assured Katie that I would not be telling her she had to eat and that it was more important for me to encourage an opportunity for openness between us. She acknowledged that if I did tell her she had to eat that she would definitely lie to me as she does with her boyfriend and family.

Katie described her mother as a very supportive, strong, straight-down-the-line person who was not sympathetic and “won’t give into” her. Significantly, Katie remembered an event that she said triggered her laxative abuse and prompted her to restrict her food intake. Her mother had said something that deeply upset her. Despite not remembering the exact statement, Katie, realised that the words themselves were not that hurtful. When a strong reaction is felt to be somewhat puzzling the PE-EFT model uses an intervention called Systematic Evocative Unfolding. I asked her to slow her recollection right down so she could reflect on and reconnect to the experience of

this event. Katie recalled looking in the mirror. She was putting on some clothes and they seemed quite tight. Katie felt struck by a realisation she had put on weight and at that very moment her mother made what seemed a perfectly innocent remark. “You need to do some exercise because you’re starting to put on weight,” or words to that effect. Katie recalled that her body went stiff, her anxiety shot up and she was really upset and began to cry. Katie only sat in this realisation for a moment and I questioned whether she really experienced the significance of this pivotal moment in the life of her eating disorder. I briefly considered deepening this experience but this was our first session and the therapeutic relationship was only fledgling. I was also aware of how well guarded young people are especially those with deep-seated issues that manifest as eating disorders. Katie said her behaviour changed significantly after that event.

Up until the prescription for the antidepressants, exercise ruled Katie’s life. She experienced bodily tension that was only alleviated by vigorous cardiovascular exercise. Katie described how attractive she thought “thin” was. When she saw the bones protruding at her neckline she felt relief that she had reached a “success-point.” She stated that “everything else in my life was shit but this was my source of happiness.” Katie acknowledged she had made herself “like this” and was addicted to magazines that show very thin women like Nicole Ritchie. Katie recognised intellectually that Nicole was too thin on the one hand, but thought she looked really good on the other.

This was a clear conflict split, which is a marker for the PE-EFT Enactment task of two-chair work. I gently introduced the technique and Katie accepted with somewhat apprehensive enthusiasm. I placed two extra chairs parallel to the two chairs we already occupied. We located the part of Katie that thought Nicole Ritchie was “gorgeous” and in the opposite chair was the part of Katie that knew Nicole Ritchie was “too thin.” Katie was drawn to the first chair where she expressed the attractive qualities of the waif-like celebrity. Katie, when sitting in the other chair, was quick to recognise that Nicole didn’t have a womanly figure, it was more child-like, and that there were many unhealthy sacrifices undertaken to “look like that.” Katie developed a flowing dialogue between the two aspects and moved easily between the two chairs

until she identified, while sitting in the first chair, that people would notice her and be concerned for her in her current state.

Katie said that while “being small” she had a sense of “being noticed,” not by anyone in particular, but that she “liked” this. She was always the thinnest and the smallest and people would do things for her and she liked that. Katie described her parents as very overprotective. She was “mothered” by her friends at school and her sister and brother, who are both younger, still did things for her. Earlier in the session, as she had sat crossed legged on her chair, I too had a sense of wanting to mother her and put a cocoon around her to protect her. Katie found the idea of looking after herself and being responsible, difficult, and yet she was quick to state that she “can do it” and has learnt how to look after herself since leaving home. Katie moved to the other chair. “I am happy to move on and grow up” but she quickly shifted back into being “small” and to the other chair. We reflected upon the “power in being small.” She stated she “would never misuse it.” As I reflected on this shifting, I was struck by how tall Katie actually was. Her long legs stretched out in front of her as she sat on the chair and yet this “sense of smallness” pervaded her presence. The chairs had become more clearly defined as “child” and “adult” aspects. As the session was drawing to a close it was not appropriate to explore this conflict split further at that time.

Katie described “right” and “wrong” in relation to her behaviour around healthy eating but had a great deal invested in staying the way she was. “I am too comfortable the way I am... I could get worse mentally... fine with these problems... stay where I am feels the right thing to do right now.” I asked what of the other side? “It just has to accept it.”

At the close of the session I gestured Katie to move back to her original chair, and enquired about what she had found helpful. Katie stated that bringing up “issues that I thought weren’t issues” was useful, and that she had developed a new awareness about being “little.” We discussed the concept of making decisions and how ideally the parts that we explored would work together to promote change. However, for Katie one part of her was not ready despite the other part having all the information necessary for change and knowing what should be done. Katie reported that she found the session helpful as “it brought up reasons for why I am the way I am and why I want to

be thin” and “talking about my mother and what she said was a reason for beginning the eating disorder.”

Session 2: 30th March

We met two weeks after Katie’s first session. She looked tired and fatigued and reported feeling “up and down” during the past fortnight. She had found it hard to attend university and just wanted to withdraw from the world. “I can’t pretend to be happy” and “everything seems to be a problem.” It was raining outside and she described a sense of crying inside. Her eating had been very restrictive and her boyfriend tried to feed her but she vehemently rejected his attempts.

Katie questioned whether she was depressed and said there were many people far worse off than her and that she was not “low enough... I don’t want to be worse than what I am and use that.” In the same vein she felt she shouldn’t take up other people’s time as there were others that needed help more than she did. “I shouldn’t be getting help... not worthy of getting help... I feel petty compared to others.” She had seen a very thin woman who could hardly walk. She was so thin that “she was about to die thin.” This had shocked Katie as she wanted to “pick her up and take her to the medical centre.” Katie, revealing great compassion, knew how that woman had become the way she was and stated that “it is not worth it.” At this point, I anticipated that Katie was looking for a balance in her life where she can be happy with her weight and satisfy other people’s expectations as well. She was unable to see a point where change might occur.

Katie recalled how the medication had affected her. Her anxiety had “perked” her up. But now she felt nothing, was blank, and there was nothing to occupy her mind. She was used to having the anxiety to consume her thoughts and drive her actions. She looked around the room as if looking for it. She described her anxiety as “it,” as if it was somehow external to her and had left her. I asked her whether she wanted to talk outwardly to it or perhaps internally. The distinction here was whether to introduce an enactment task, for example empty chair or an experiencing task such as focusing. She was uncertain so I asked her to search her body for it. She located a pressure in her chest. I said, “Something has gone and left you (*pause*),” “lifeless” she replied. Her life force or drive had been stripped away very quickly by the effects of

the medication. I asked her to close her eyes and visualise “it, the anxiety.” She located it in her chest and said that sometimes it spread outwards. It consisted of light and bright colours and had a lighter core. Using the focusing method we explored the bodily-felt symbol further. I encouraged her to communicate with it and she declared that it had no words. However, Katie sensed that its role was to measure how she felt towards a thought, “a gauge thing.” I offered a hypothesis that this was her “life force.” She reflected on this for a while. Katie commented that acknowledging its presence was useful and she could potentially work with it and manage it, and then she paused and said “even control it.” We both laughed as we recognised that Katie certainly liked to “control” things. Katie then reported she felt “fresh,” more hopeful and not so low.

In PE-EFT terms, this *felt-shift* can lead to new thoughts and feelings. “Things will come round and I will find a job I will find ways of being at peace with things.” At the end of the session Katie reported that “understanding my anxiety, classifying what it is, how it looks and how it feels” was useful for her. In addition, “I learnt something I can understand and be able to manage.” Katie also reported talking about her problems and “releasing everything” very helpful.

Session 3: 20th April

Three weeks had passed since the last session and Katie was late. She cited exams and unwellness as explanations for her postponements. Unfortunately, having such long breaks between sessions can signify difficulty in maintaining the therapeutic momentum, and may weaken the alliance and halt deeper exploration. However, I value maintaining a non-judgmental stance, whilst keeping in mind that exploration of these issues may be therapeutically useful. The early stages of this session were spent re-establishing the therapeutic relationship. Similar themes emerged in relation to Katie’s fatigue, questioning of her behaviour around food intake and how hard it was to get to classes. I continued to work with the issues around Katie’s eating disorder because the developers of the PE-EFT model encourage investigation of the most salient, present-moment experiences of the client.

Katie had just completed a mid-semester exam, which resulted in her running late. She was quite flustered but looked well. She declared she did feel good because it was 24°C outside, “a perfect day.” Katie recognised on some level she was wasting her life

and the thought of looking back in 10 years to this time really dismayed her. However, on the other hand, the thought of putting on weight really “freaked” her out. She knew she’d feel better if she ate, but was very resistant to increasing her intake. Katie explained that she made it harder for herself by shifting the goal posts in her desire to get thinner. For example, she recognised that if she had a Body Mass Index of 5% (50% is considered normal) she could challenge herself to get to 2%. Making it more difficult somehow provided a sense of accomplishment. Katie believed this was, the one thing she could control, “the only thing I have going for me.” She “thrives on that loss of weight achievement.” However, she also knew it was not sustainable. She remembered the time her face was really drawn and she could feel the loose skin sitting on the bones. She acknowledged she had lost muscle mass and her tracksuit pants fell off her as she had no “backside” to hold them up. This had been a real sense of accomplishment for her.

Katie just talked for most of the session and I gave her space to express herself freely. Near the end she said she was nervous about coming to counselling but realised this was one place where she felt safe to be truly honest about her behaviour. I acknowledged how hard it was for her to let go of these behaviours and that she was operating out of a state of “what she should be doing.” I asked her to consider that she accept “where you are right now,” that she wanted to change but that at that moment it was too big a leap. She would like “to have normal problems but this is so huge... just such a waste...” I encouraged her to accept the small things, like a perfect 24°C day, as some things take time to work through. Katie was visibly relieved by my acceptance of her “being ok right now.” She said it sounded good as she wanted “to feel ok right now... to be at ease and content.” She subsequently experienced what she described as “a calming feeling.” Katie reported that “being able to accept where I am right NOW... and that even though I am not where I SHOULD be, I’m happy and content where I am now.” There was a noticeable shift in her energy as she left the session to rejoin her perfect 24°C day.

Session 4: 27th April

In this session, Katie again complained of feeling very tired. Her energy was somehow darker than last session and she appeared thinner than I had seen her before. She was

very definite about not being ready to change yet. She described being so hungry but that she just can't eat. "When I say it... it sounds stupid" she declared. I acknowledged her struggle. As Katie continued to explain her ongoing frustrations and the realisation she was wasting her life, I observed that her mind and her body were in conflict. I suggested the enactment task of two-chair work. As mentioned previously this intervention is indicated when there is a conflict between two aspects of self. In Katie's case there was a conflict between her body and her mind. Interestingly, as we set up the chairs Katie described the two aspects as the "brain" and the "body." Such a conflict often develops into some sort of conflict between the "shoulds" and the "wants." I anticipated that bringing these sides into creative contact ideally would develop an integrative solution.

Katie initially headed for the chair that represented her "body" and declared "I'm so hungry, I feel better if I eat." Her body was crouched and stooped and her voice small and timid. She moved quickly to the chair that represented her "brain." Katie strongly retorted "but when you eat you will put on weight... not straight away... but then you will feel worse... you will just have to deal with it." Her voice was louder and overpowered the body's voice. Returning to the chair of her body, Katie recognised that she would fade away to nothing and that she was tired of wasting her life. The brain again reiterated the warning. The body was very aware that her brain would not let her eat. She became quite anxious when she thought about putting on weight. Katie felt there was no way around this dilemma, as the brain declared, "you are just not allowed to" eat. I encouraged the idea of a compromise, but the brain said if the body was to eat more she'd take more laxatives, which was not a satisfactory trade-off. The brain was not willing to offer anything else. The brain always won and Katie was too tired to fight it: "when the brain gives in I feel so guilty." The brain "knows what's best," the body could only eat when the brain let it and "only from certain food groups." The body just wanted to be normal and do normal things. "It is like a prison... you thought you were free but you were not." I asked why the brain was so hard on the body. Katie said that the body had made the brain angry by believing it would feel better if it put on weight. However, putting on weight unfortunately only resulted in her feeling depressed. The body had let the brain down and now it was being punished indefinitely. Katie's brain does not want to work with her body. "I just,

I can't, just can't... I think about it all day... I'd rather go through the physical pain than mental pain... rather feel crap in my body than crap inside my mind."

I introduced the concept that the brain needed the body but the brain retorted that the body was "not bad enough to have an opinion... it would need to pass out." I explained to Katie that I was a bit concerned for her body and that if it didn't get enough food it might die and the brain may have no choice about that. Katie feared she'd never become well but said she didn't want to die. Katie couldn't see the future and didn't want to. There were also so many rules around food, she "can't drink normal soft drink... only diet or zero..." Katie's brain spoke to her body in terms of "you." As I reflected on this with Katie, she declared her brain "is like an abusive parent." She quickly acknowledged, however, that her parents weren't like that as they were affectionate, despite the fact that she did not like being touched. Katie had read a book recently about a small boy who had been abused by his mother.

My brain is like the abusive mother and I am the child that can't escape... my body is... that is how I relate to it now that I have said it... feel like I am being abused... body can't escape, can't get out of this rut, can't tell somebody, can't get help, it just can't... the brain is too overpowering... too scared of my brain... don't know what to do.

I considered this was a major insight for Katie.

I explored the issues around whether Katie's brain had any compassion for her body and I reminded her of her compassion for the thin woman she saw. She didn't like her body and was ashamed of it. I asked her if there was anything she could do to help her body. She remained silent for quite some time, then said, "I want to look after you... I will pamper you with nice products and treatments... that's all I can give at the moment." I asked Katie to go to the "body" chair and she reported that she felt "a bit better... a step in the right direction... build on this." She was struck however with how "hard it is to be this body... the brain is so evil... my brain loves me but won't give me food... I don't want to be in the prison anymore... you are abusing me... I deserve better." She found it was very challenging to speak up. As the session time had come to an end I asked Katie to return to the original chair because leaving her in the

chair of her brain would actually leave her body even more disempowered. I reflected that she had been working through some pretty difficult issues and wondered where her emotions were. She stated that her emotions were controlled by her brain as well.

Katie reported that she had found it useful to separate her body and her brain. I reflected on how apart they are and indicated there was further work to do to reach a compromise or integration between the two aspects. In PE-EFT terms, we had achieved a partial resolution whereby the body had found a voice and could identify its needs and wants. However, the brain had such an intimidating stance that despite a little softening it was unlikely in this one session that Katie could achieve full resolution of the conflict split. Katie said she was intrigued that her mind had total control over her body... “My body feels like it’s in a prison.”

Session 5: 4th May

The session began with Katie again describing tiredness, exhaustion and low motivation. Katie spoke of not having the energy to be close to anyone, not even her boyfriend. “[I wish he’d] get off me and let me breathe” she declared but quickly interrupted herself by stating he “is not always like that.” She wondered what people thought when they looked at her. Since she was quite young her hair had become part of her identity and she commented that she was very particular about it. Recently, she had begun to realise that her body or its thinness had also become a significant part of her identity. It was “not so much about being thin as what it is to be my own... it is mine. People know me for that... if I lose that what would I have?” Katie said that when she felt out of control with her weight it had the same “feeling” as when her hair was badly cut or dyed incorrectly by the hairdresser.

We further explored her attitudes to her hair and weight. She felt “paranoid” if her hair was “not right... stuffed up” by a hairdresser. I asked Katie to notice her body reaction and she revealed that there was tightness in her chest. She stated “...don’t care what it looks like as long as it’s healthy... don’t care what I dress like as long as I’m thin.” I acknowledged these aspects are strongly associated with her identity and what she saw herself to be. Disjointedly she declared “I like to have my own way... concerning myself... if someone takes that from me or takes my control from me... obviously I can’t cut my own hair... have to leave it to someone else ...” Katie said she

didn't know why she felt so strongly about these issues, but it was apparent to me that the unclear felt-sense she experienced was very present in the session.

Subsequently, I invited Katie to explore the issues around her hair, weight and identity more directly using an experiencing focusing exercise. Having asked her to close her eyes, I guided her to "clear a space" in her mind to create room for experiential processing. My objective was to encourage Katie to become more aware of her bodily sensations and be less cognitively driven. She searched her bodily sensations and effortlessly pinpointed the area in her chest and in her throat. Katie visualised it and described it as "dark" with a "hard darker core." It told her "I don't like the way I am... it tells me what to do." She felt it had been there "forever" and its purpose was "to make me feel like crap." Katie said "it's solid and can't be broken... just there... it's something from my thoughts... formed from my thoughts... I'll think it and then I'll feel it" as she gestured to her chest. "It's not always there... different thoughts affect it... [feeling] excited and happy where I am... can go if [boyfriend] around," however, it feeds off negative thoughts. Katie said much of her thinking was negative and she had no energy to turn the thoughts around. "It controls me... it stops me from doing things... comes back if he [boyfriend] wants to get too close... and when you're on your own" she lamented. We discovered that in order for it to dissipate it was not just necessary to think good thoughts, "I need to feel good." Katie felt good when she was happy about her weight but said "it'll always be there... no matter how many things I receive... just there." I hypothesised that this black core held a lot of power, took up energy, stopped her body from having what it needed and stopped her from feeling good. She agreed.

The sensation in Katie's chest had then lessened in size, a *felt-shift*, but she was exhausted. It appeared she had succumbed to her exhaustion, could not concentrate and was unable to process the sensation further. Rather than persevering I encouraged her to open her eyes and we discussed the experience. She was contemplative and said that it was useful to know that the black core fed off negative thoughts. I reflected on the role of the black core and its hold on her.

Katie's father was a "real worrier" and she did not want to talk to him about her troubles because it "makes him worse." She had told people about our sessions but they just "don't get it." Her mother was quite dismissive. She felt "bad about talking

about mum like that” and I explained that I was not judgmental about her mother and didn’t see her as a bad mother. Katie said, “mum doesn’t have worries... I don’t know why I look to her... if mum gave in to me I would be worse off... I need that push... no sympathy, NONE (quite animated)... she thinks... she knows what’s best for me...” Katie remembered her mother’s words, “you’ll regret it if I don’t push you hard.” There was an incident when Katie’s younger sister was vomiting in the toilet and her mother dragged her along to look, asserting “that is not so bad... there is nothing wrong with it.” Katie said her mother was “not mean” but her way of doing things “is not for me... I’m real sensitive.” Her mother implored Katie not to be “so sensitive,” to which Katie responded, “I’m like this.” Her mother would then counter by stating, “I’m like this.” Katie was by this stage quite animated as she recalled these events. Katie reported on her HAT form that talking about her mother, “being simply able to get it all off my chest” and “finding out how my thoughts made the core of my anxiety worse,” were useful aspects of the session.

Session 6: 11th May

Katie had had a good week and declared that she had lost some weight and was feeling energetic. She reiterated that she was “happy where I’m at.” Katie again faced the dilemma of being at a low weight that she knew was not sustainable yet she wanted to maintain optimal energy levels.

A serious incident had occurred in the University where a female student had been stabbed a number of times by another female student in the toilets of the main library. The attack was random. Katie described the event as “horrific” and said that she was “feeling vulnerable... about going to public toilets now.” Being aware of Katie’s potential levels of anxiety, I explored Katie’s reactions to the incident and ensured she had a true account of the event.

I further enquired into how the incident affected Katie now and she said she would “look around at people... the taxi driver today... he was really creepy... just looking at me.” She also felt intimidated by the people who lived in her neighbourhood and remarked on the inappropriate behaviour and language of the residents. Katie had been raised in a really nice area in the country and was not used to things like that. I asked her, had there been other times in her life where she had felt

like this. “My teacher showed me too much affection... he didn’t do anything... he didn’t attempt to touch me...” I asked how she’d handled that. She hated going to his class, felt intimidated and thought “it was just me.” Interestingly, Katie only told her mother months later about what happened. “He’d just be very close to me... I didn’t know it was worth worrying about... he gave me the creeps.” I asked about how she related to him and she explained “I was genuinely friendly... he was my teacher... I had been close to teachers before... like when I lost my friend...”

Katie went on to explain that in a period of about two years three significant people in her life had died tragically. In year 11, a friend had been driving the family car when it crashed into another car resulting in the five people being killed. A number of months later, her cousin was killed as a result of a car accident when a drunk driver ran into his car. Then, tragically, the teacher who had supported Katie through these devastating occurrences was also killed by a car. “He was everyone’s favourite teacher... he would give that bit extra... concerned... made you feel better... he grew up with my dad... it was a bit of a rough time... full on.” There were two really huge funerals in Katie’s hometown. I enquired into the level of support Katie had at the time and she said people came to the school from the city and asked, “how do you feel?” Katie questioned that sort of help. “I was angry and I didn’t want to talk about it... needed to do it on my own...”

I asked about the state of Katie’s relationship with her mother at the time when these incidents occurred.

She wasn’t there for me... she said something ... it has always been in my mind... never forgiven her for this... at the time of the funeral... I wanted to talk to her about a problem... she said ‘I can’t deal with this at the moment, tell your father.’

Katie and I both nodded in acknowledgment and she continued by saying

I don’t want to think too much into it... I sort of don’t need her on that level anymore... I know she always cares for me, and that sort of

thing... but I've wanted it for so long now I'm ok without... I was sick of feeling like I really wanted it... I'll be all right.

I asked when did Katie make this decision and she replied

now... when I think of it now... mum will always be like that... she was the one... who helped me with all the counsellors sort of thing... she stayed by my bed when I was scared to go to sleep... but then there is something that comes out of her mouth that is really insensitive... I would never do that to my kids... there are things I would do the same and do differently...

I reflected that Katie had come to accept her mother but there was "sadness" in that. Katie said she felt she had missed out on something, and attempts to talk to her mother openly in the past had got nowhere. Reflectively, she said that she didn't like thinking about it because she was not going to get what she needed. Katie again reiterated how her mother pushed her to do things attesting "I only want you to be the best you can be." I stated that this "cruel to be kind" way of being had a cost to which Katie responded "yeah... it does, give me the shits... I wish I had that reassurance... even if I don't do well."

At that time I noticed that Katie leaned toward her right side. I had felt some pressure in my right shoulder and decided to reflect this back to her "could it be that you are weighed down by something?" Katie's immediately responded "no" but as I inquired further "are you carrying something of hers?" Katie contemplatively stated, "I don't want to have to deal with her disappointment and the negative things she's got to say... so I let things be." I explored more of the interactions between Katie and her mother and decided to introduce empty chair for unfinished business. I set up an enactment task and asked Katie to envisage her mother present by describing what her mother was wearing and to imagine that her mother would be receptive to listening to her. Katie easily found her voice and began by stating

I find it difficult when you are patronising... you don't think things through... when I want to tell you about a problem you shrug it off... give me nothing back... you don't show me the affection I need... you think you are making me strong... I need you listen to me... the whole story... not just pretend to listen and agree... truly understand. I want you to know how difficult it is for me... just wish you would ask how I am. I want you to know I am a sensitive person and there is nothing wrong with being sensitive... I am allowed to be like that.

I asked Katie what it was like to have said those things and she responded, "I shouldn't have to say it!" I was aware that Katie was past anger and was more resigned to the situation. We sat silently and then Katie kicked out her left foot in the direction of the chair. We both laughed. I encouraged her to kick the chair again and she pushed the chair over and it hit the floor. I moved the chair away but I was aware the release was short lived as the resignation returned.

Katie said "if I keep talking about it I am going to feel worse... can't be bothered dealing with it." I commented that, "it is almost like you don't need your mum" to which Katie responded "yeah... scares me... like... I wish I had no worries." Katie was reminded of the good things her mother had done for her and said how she tries her best. I stated "I get it... there's a difference between doing and being" to which Katie replied, "I had a good week and I'm ok." Katie reported on her HAT form that she found "saying what I wanted to my mother if she was in an understanding mood" helpful.

Session 7: 25th May

Katie looked thinner and uncharacteristically drab. She was worried about the effects of the laxatives. Katie felt nothing at the moment "just living... just existing." I enquired as to whether there was still a fight between her body and mind. She agreed. "There are so many rules... and if I do break one I have to pay for it." I asked where the rules have come from. "I think it's... a consequence sort of thing." She had felt extremely unwell yesterday and "couldn't eat anything... it's almost like I'd like to feel

hungry and stop myself but I couldn't even... so I get no reward." I invited her to consider the connection between her body and mind but she changed the subject.

Katie was intrigued by the idea that chronic fatigue could be linked with depression, and that it could be a "mental thing and not a physical thing." Her boyfriend had been doing some reading on the web in the library and had made that assertion and she was worried he thought she might be putting it on. However, Katie was able to distinguish the difference in her body between the exhaustion of the chronic fatigue and depression "this is whole body feeling where that was just here..." (*pointing to her chest*). Without a pause, Katie went on. She had no money, needed a part time job and had "nothing to get excited about... nothing to wake up for." I reintroduced the idea of the body and mind being separate but again she talked on. "I want to know that I control putting food in my mouth and when I am not hungry there is nothing to control."

I asked Katie to reflect on her body sensations, to which she replied, "I feel that exhausted. I can't think about it." I responded by stating "the exhaustion is quite an interesting process because it prevents you from being hungry, prevents you from thinking about being hungry, or thinking anything much... staying in a numb state of exhaustion it stops everything." She agreed.

Katie consented to the Two Chair work. Her body reported "I'm really tired and feel sick... putting food in doesn't make any difference... I'm just nothing." Her mind replied "I am really tired too... we have to follow the rules otherwise we will feel worse." Katie's body responded "I don't feel anything... numb... not existing as I should be... don't want to be tired anymore... I want to get up in the morning and have the energy for a full day." I encouraged her by coaching her with assertive statements and she went on and said "I want to feel good... alive... I don't want to sleep all the time." She returned to the "mind" chair and said, "I'm too tired to think... so you are just going to have to deal with what had been laid out... I AM ALWAYS GOING TO WIN!"

Katie paused and we both sat with the realisation of the enormity of this statement. The rules were like a default position to fall back on. Finally, I made a conjecture "both are exhausted and in the same state... both acknowledge the state of the other... some common ground... not a good place to be but both in the same

place.” Katie replied, “you’d think then that I’d think that something needs to change because we are both in the same place but no... because...” simultaneously we both asserted “the rules are there.” She continued, “I know what I have to do to feel better, but I don’t want to do it... I have to eat properly.” Katie’s body was slumped forward in the chair with her hands holding up her head and her elbows on her knees. “I don’t know what I want... gets me down ... one day I’ll get friggin’ cancer... I know what I am doing is wrong... I know there is something in the laxatives that can give you cancer.”

Katie’s despair deepened. She expressed having nothing, no incentive to get better and that she was “so stuck.” We both sat in the silence of her despair for some time. In PE-EFT terms, it can potentially be a very powerful experience for a client, if she is able to fully express a feared, dreaded aspect, such as despair and have it fully received by a therapist who senses the feeling in its full intensity and values her with no reservations. This encounter has the ability to promote change. I reflected, “it is hard to find the right answer,” to which she sat up straight and replied, “I don’t have any.”

At times, a spontaneous upward move takes place, but if not, the therapist may ask the client to imagine what it would be like if the problem were removed. After pausing for some time, I took the lead and asked her to consider what she wanted to do with her life. She said she wanted to do something meaningful, to help others, not be so caught up in herself. I wondered if it was too far away. Katie said “I can think about it in my future... I can see it.” I asked Katie to see the person she might be in ten years’ time. Katie replied that she would be probably a bit bigger but similar to what she was now. I asked her to see her sitting in the chair in front of her, where her body had sat. “I would have had a kid by then and have a nice relationship.” I enquired as to whether the “Katie-in-ten-years” would have any information for the “Katie-now” as how she got to where she was in the future. I gestured for Katie to sit in the opposite chair and get a sense of the Katie-in-ten-years-time. Katie contemplated silently for a few minutes and then said “feed your brain... think about more important things like what you want to do...” She found this difficult and reflected on how having kids scared her as she would have to put on weight, not only while pregnant but even to become pregnant.

Katie moved back to the chair of the brain, which now represented a more doubting, defeatist aspect. I asked Katie to ask again “how did you get to where you are” and wait for an answer. There was no answer. I challenged Katie gently by hypothesising that there was a response but she may not be able to hear it and asked her to recall what she’d said earlier in the session. I reminded her, “you said ‘I do know what I need to do but I just don’t want to,’ remember?” Katie moved chairs spontaneously and clearly stated animatedly “you’ve got to eat... yep... that’s what it boils down to.” I reiterated by saying that her body had told her, the Katie-in-ten-years-time had told her and that many others had certainly told her “to eat.” Katie reflected and mumbled, “my brain is fucking too powerful.” She continued to speak from her future aspect.

Allow this body to eat in order to get here... you need to work co-operatively with the body in order to feel happy... don’t be so stuck with the rules that are not real reality... they are not rules of life... they are rules you make me live by... I don’t want live by them anymore.

I asked Katie to repeat this last statement twice more with more assertion. She did so but tentatively.

We discussed the hold of the brain and Katie responded that, “it’s evil.” I encouraged her to make her brain her “friend” as it was resourceful and clever and had helped her manage past difficulties and situations in her life. I presented to Katie the concept that her brain had perhaps developed all these survival strategies and that perhaps she might consider using her brain to help her unravel them to uncover a more productive set. In a playful yet assertive voice Katie’s last words to her brain were “I will deal with you later.” We both laughed and Katie moved back to her original chair. Katie’s exhaustion had lifted and she stated that she knew she would get there and that she will not always feel like this. I encouraged Katie to journal and perhaps set up a dialogue with the “Katie-in-ten-years-time” so to enable a pathway between where she was now and where she might be in the future. Katie reported on her Hat form that splitting herself up into “Katie-in-ten-years-time” was helpful as it

gave her something to work towards. She also remarked that “just talking to reassure me that I can get through this” was useful.

Session 8: 1st June

Interestingly, in this session Katie looked radiant. Her eyes were sparkling and she was full of energy. She wore a trendy, pale-pink, tracksuit-type jacket-top and her positive energy was palpable and contagious. As we reflected on the last session Katie described how tired she had been in the session and how difficult had been for her to talk and attend to the things we did and talked about.

Katie then enthusiastically stated, “I’m so close to taking the next step but just can’t...” Intrigued, I asked her to explain what the next step was. In a very quiet voice she said, “stop the laxatives... I am so close to doing that.” I was curious and somewhat excited by this revelation. However, in the next breath she explained her fear of taking the next step. “I’m afraid I’ll be anorexic and stop eating altogether.” Her resolve continued “had enough... wasting money... enough of feeling really sick as well as awful” despite being somewhat conditional “not ready to eat properly yet.” Acutely aware of our last session and the mind/body split, I enquired as to which part of her was giving her permission to even contemplate this bold move. “My mind has” she confidently replied. I reflected that something had shifted. “I don’t want to get to thirty and have bowel problems for the rest of my life.”

Katie had been seeing her doctor on a regular basis and standard blood checks had showed no abnormalities. Katie wanted to know that she had done no irreversible damage to herself, as this reassurance would be an incentive for a new start. She was animated, clear thinking and decisive. Katie jokingly stated, “I need a new addiction to dwell on!” We both expressed amusement at this possibility. I commented on how “bright and bubbly” Katie was in this session. These were traits she had described about herself in our screening session and it was refreshing to see them so evident. I wondered whether I was witnessing a less critical, more openly observant, less self-obsessive aspect of Katie emerging.

Katie declared she had seen a DVD entitled “The Secret.” The instigators of the program argue that we are the creators of our future and that if we utilise the power of positive thinking together with creative visualisations and passion, we can manifest

our ideal life. The main element is to change the way you think by reframing it positively and being grateful. It is no surprise that some of the philosophies are taken from well-known spiritual teachings but in this case they are repackaged in a modern, westernised way to appeal to the average person. Katie would like to put her faith in “The Secret” and embrace some of the ideas to change her life. However, she was “disturbed” to find out that one of the people in the documentary was exposed to be a fraud. Other people have also criticised the program “I don’t want people to contradict my beliefs... like mum.” I explained that there were many ideas contained within the program that she might find quite useful, and encouraged her to find what resonated for her and work with that. She agreed: “it’s about feeling good about life and everything... and having the feeling inside you.” I added that by living out of her passion and having the energy to do that, life potentially could flow. The intent of this mode of interaction with Katie was to foster her sense of hope.

Maintaining the mind/body split focus, I enquired as to how these two aspects felt in relation to her decision. Her body wanted to focus on the positives of this decision but as far as her mind was concerned there were still “the rules.” I hoped to encourage a co-operation between body and mind and Katie encouragingly stated, “if I am hungry I will eat.” Contemplatively, she went on “it has made me the biggest liar too... I have a disease... know what I am doing is wrong... feel really guilty... but I still do it anyway.” I hypothesised, “it sounds like you want to be more honest and more real about where you are and with the people who care about you?” She doesn’t want to lie about having eaten when she hasn’t. However, she had become so used to lying that she was unsure about what was real “such a pattern of lying... you yourself didn’t even know... I’ll end up in a loony bin... that is what I am afraid of.” Katie wondered that if she became well “what will I spend all my energy on... what will I spend my time thinking about... I’ll have so much time on my hands.” I likened her experience to a person who gives up smoking and how the habit takes time to break. For Katie, the energy that had been used to ward off negative feelings can now be used for more positive, constructive pursuits. Katie described how she intended to cut down the laxative use and then she would “feel she is doing something about it... if I just chuck them I’ll get into panic mode.”

Katie explained that hearing other people's stories helped her to feel more hopeful and that watching the "The Secret" had helped her to feel good about herself. However "it didn't last... had an argument with my boyfriend." He was studying furiously for his exams and now they were over he wanted to go drinking with his mates. Katie told him off but then said, "he felt bad... I had him wrapped around my little finger... don't want to have that power to make him feel bad." I acknowledged that, yes it is important to assert yourself, but it is important to communicate respectfully and not misuse that power. She stated, "I don't have a problem with saying how I feel. I always thought I wanted that power... but now when I had it I don't want it... I hate the thought of needing him..."

Katie found talking positively about life and the steps in wanting to make changes helpful. In PE-EFT terms, this session was about consolidation of the experiential aspects that had emerged. One of the relevant humanistic principles involves the growth tendency that moves clients toward hope. This tendency is not a defensive avoidance but an expression of needs and action tendencies. It could be hypothesised that having touched her despair in the last session Katie now felt stronger, a greater sense of agency, empowered and more able to cope. She reported that talking about the steps in wanting to make changes, about stopping the laxative use and talking positively about life and life changes was very helpful.

Session 9: 22nd June

As a result of a recording malfunction I do not have videotaped recordings of Katie's next two sessions to review in detail. Consequently, the following recollections are taken from case notes.

Katie missed two sessions. The first was cancelled as a result of exam preparation and feeling unwell. On her way to the last session she was overcome by a bilious attack, vomited all over herself, and subsequently returned home. Katie attributed this attack to laxative abuse. I was curious as to the shift in Katie's resolve about taking the laxatives but she persisted with her story and I did not follow that line of enquiry. She said she had had a terrible week and explained the events in detail.

Katie didn't sit her exam and went to her doctor to obtain a medical certificate for special consideration. Katie's doctor recognised that the counselling had been

productive for Katie as her mood state had significantly improved. In addition, she suggested that Katie recognise she had a “problem” and investigate more specialist care in relation to her eating disorder. Katie seemed resigned in relation to this and somewhat surprisingly, not too overly concerned. She explained that her family was supportive but that she doesn’t “feel sick enough” to warrant any extra attention or support. “I feel there are others who are worse off than I am.” We discussed the practical implications of what would be involved in relation to such specialised care and whether she would like me to speak to her doctor. She had agreed in principle with her doctor to get assistance outside the counselling. Her doctor was looking into the possibility of an outpatient eating disorders clinic. In addition, Katie provided consent for me to consult her doctor.

Katie was somewhat despondent and removed from her feelings. I introduced a focusing exercise and after encouraging her to mentally ‘clear the space,’ I directed Katie to notice her body sensations. She described a sense of fear in her chest. She further explained that the “fear had been there as long as I can remember.” I encouraged her to explore this sensation in her chest by inquiring into its shape, colour, texture and depth. This inquiry revealed a memory of Katie when she was four or five years old in the schoolyard. She remembered there were some Grade 6 boys but she was unable to articulate or understand what was going on. She said she felt frozen. She was unable to recall any more details or remember the event any more clearly. Katie, however, did recall the elder brother of a friend walking her home and remembered how frightened she was of him and not wanting to be near him. I asked her to notice the sensation in her chest and she reported it had shifted slightly, a “feeling shift,” but was still there.

Only a partial resolution was possible without a fuller recollection of the circumstances, so we couldn’t fully reprocess the event. Katie’s fear prevented her from full exposure to this event and it was vital for me to work only at the pace and the level of Katie’s preparedness and readiness so as not to overwhelm and/or re-traumatise her. At that time there apparently seemed no connection between Katie’s internal experience and her present circumstances. Katie may have experienced some insight subsequently. Full resolution is not always possible in session but is potentially obtainable in next or subsequent sessions. In order to explain Katie’s experience from

a therapeutic perspective I hypothesised that she was experiencing herself as a frightened vulnerable little girl unable to protect herself in the face of what appeared to her as an uncertain situation. Allowing herself to consider entering an eating disorders clinic, either as an outpatient or an inpatient, may have had similar qualities to her recalled experience and have triggered this fear reaction. I further hypothesised that her fledgling sense of agency was potentially being undermined by her middle-aged female doctor, who was encouraging her to consider she had a “problem.”

On her HAT form Katie said that talking about the next steps in what she described as her recovery, was useful. In addition, talking about her childhood experiences, including her anxiety, and feeling her emotions was also helpful. Upon reflection, I think it was at this stage of our time together I was starting to become aware that the counselling was no longer about Katie's depression but more about managing her eating disorder. Working holistically was my primary aim as in the PE-EFT model counselling sessions are directed by what is present for the client in the moment in the session, a position I have upheld throughout. However, I was also mindful of Katie's overall wellbeing, which encouraged me to consult with her doctor.

Session 10: 29th June

In this session Katie just needed to talk. She had become aware that she has a “problem” and wants someone to diagnose that “problem.” On the one hand she wanted to know what was “wrong” as that would be worthwhile and important, but on the other hand she felt she was not “unwell enough.” She explained this in terms of meeting an anorexic and being told by them that “no, that is not what you have.” She was waiting for someone to tell her what was “wrong.” She was waiting for something to happen, “something bad to make me change my ways.” Katie had informed me in the screening session that she had been diagnosed with an eating disorder and so I was curious about this desire to have a diagnosis of anorexia confirmed. I wondered if she was somehow daring the people around her who cared about her, including me, by inducing them to do something. I saw myself in a predicament. I purposely decided not to diagnose Katie's eating disorder as “anorexia” despite acknowledging it was indeed the condition to which she had succumbed. It is my understanding that diagnoses can be useful if the client benefits from knowing such information.

However, in the case of Katie and other young people with eating disorders, it can potentially align the young person's emerging fragile identity with the identity of disorder. Katie had already said to me that the only thing she could succeed in was losing weight and that this gave her a sense of accomplishment and achievement. Her body thinness was also an integral part of her identity. and Katie had indicated to me her penchant for popular women's magazines that depicted thin smartly-dressed celebrity women. There are also many websites where such young women can become completely absorbed in identifying with the "lifestyle choice" of anorexia.

Katie talked about how she had to lie to everyone to keep her story going. Now that she had decided to seek treatment at an eating disorders clinic she didn't have to "do anything" and everyone was off her back about what she "was doing." She described herself as manipulative and spoke openly and freely of what she was capable of doing. I was acutely aware that I too may have been part of the manipulation. However, I preferred to take Katie at face value and trusted my instinct that our therapeutic relationship enabled her to be open and frank with me. Interestingly, Katie had expressed an interest in continuing with the counselling after the twelve sessions. I had discussed with my supervisor, Dr Wills, this possibility and he agreed it would be appropriate. When I informed Katie that her sessions could continue she was very excited. Intriguingly, Katie stated on her Helpful Aspects of Therapy form that being able to talk freely and openly was very helpful to her.

Session 11: 6th July

Katie was running late. She looked really smart, carefully groomed and well dressed. Her anxiety had increased in the last week as she worried about potentially losing her boyfriend and that she might revisit that state from last year when she thought she "was going insane." I asked where she felt this in her body to which she replied "I feel it in the same place here (*pointing towards her solar plexus*) and then it spreads over my whole body..." Katie explained her irrational fear that her boyfriend would leave her.

I hate not being in control... hate that someone has something over me... I said to him... if you can't handle it now break up with me

now... actually more of a reassurance for me... I needed to hear that because I knew he would say no... I am such a liar... (*laughing*) ... twisting words around to get something else... I needed that reassurance.

I conjectured that perhaps it was quite appropriate for her to feel anxious as she was dealing with pretty big issues. "I don't want to deal with them," she retorted.

Katie as a small child needed constant reassurance. I was reminded of little Katie standing alone in the school yard feeling intimidated by those larger boys and related this to her. Katie described the "feeling was in the same place and it goes up into the back of my throat and... (*gagging sound*) ...it's what I feel now... same anxiety... as I've had all my life." I asked her if there was something in the memory of those boys. She explained they were a "lot taller... just bigger people... still feel...I'm not an adult I'm a kid... people older than me have so much authority over me... at school really intimidated by a person who was even a year older." I asked Katie about the sensation in her chest and she closed her eyes and she recognised it immediately. She described it as "solid in the middle, fuzzy and when it gets worse it goes all through my body... sort of feels gross."

I encouraged Katie to go back to the event in the schoolyard. I asked her how the experience might have played out if she was able to ask for help and whom might she ask. She imagined an older girl might have looked out for her but she didn't know anyone. I asked her to consider the "adult Katie" going into the scene to look after the "younger Katie" and enquired as to what the adult might do. Katie said "I'd pick her up..." and soothingly "it'll be ok, you'll be fine." I enquired as to how her chest felt now to which she responded "feels good... feel a sense of happiness... like a relief." Katie sat in silence and I invited her to explain what was happening. In her inner view she was looking around the school area, she noticed "her heart was pounding... she did not know how to get out of the situation, don't know how to change it... just feel scared." Having created some reassurance, Katie was more able to explore the memory of the schoolyard event. Another memory emerged and she opened her eyes. She recalled that all through school she would get really anxious, to the extent of

panic, if she knew a boy liked her “...same feeling... I suppose because I wasn’t in control they were... it just came to me then.”

I encouraged Katie to close her eyes again and enquire inwardly as to why she was so frightened of the boys. My intention for doing this was to ascertain whether there had been any trauma or abuse. Katie sat in silence for some time and then again opened her eyes. She recalled

patches [of time] were I was ok... changed schools... eager to go... all of a sudden I became this intimidated person that... used to be loud... SRC in year 7, dux, had such a good year... just don’t know how I went from that to complete opposite... just completely bottled and shut off... no anxiety before... but then became just paranoid about what people thought and a lot of anxiety... whole personality changed.

I was again reminded her of the little girl in the schoolyard with no support. She felt she had no one as everyone had their own groups. I asked “like the little girl just watching... does that resonate?” Katie replied, “I just hated that that happened to me... I just wasted nearly most of my high school being frightened and feeling sick and having a lot of mental things.” I enquired as to whether her mother had noticed this change. Katie replied that she “kept it within myself... I was very bottled then.”

We discussed how her father always took her to school on the way to work and her mother picked her up. Her father always reassured her, but her mother would do so less often. She refused to pander to Katie’s fear, treating it the same way as the eating disorder now. Dad had a breakdown about that time, and Katie recognised many similarities between his symptoms and her patterns, putting it down to “genes.” So, a lot of her motivation has been to spare him anxiety.

Katie denied minding that mum “doesn’t get it” and focused on the visible ongoing outward signs of support. Her boyfriend was similar in offering to help but not really understanding what she needed. I acknowledged hearing all the logical explanations but was wondering how the “little inner girl” felt about her mother not understanding. Katie responded in the third person “I think she’d feel down about it... but me has now gotten over it...” In accordance with the PE-EFT philosophies I

explained the therapeutic benefits of working through painful experiences and how as adults we work it all out cognitively but there are often emotions locked in past unresolved events that require reprocessing. Katie remembered that she was having panic attacks at a really young age and I asked her what she needed when she was younger. Katie responded that she needed her mother to reassure that she would be ok. The session ended.

Katie had found it difficult to stay with her bodily-felt internal experience and preferred to work and process primarily from a cognitive framework. I recorded in my case notes “the little girl needed something she was not getting and so was working hard to be noticed.” Katie reported on the HAT that talking about her mother was helpful. She recognised that she needed reassurance from her mother and it was OK to be annoyed with her mother for not providing that reassurance appropriately to her needs.

Session 12: 20th July

It was two weeks since our last session. Katie’s voice was assertive and strong. With very little encouragement she said I “started to realise a few things... that **maybe I am angry with mum.**” My immediate response was unreserved surprise. She continued “one night I was lying in bed and I was just thinking in my head what I’d say to her and I don’t know but maybe **I’m doing this so she’ll notice...** I don’t know if I am...” This revelation was quite astounding to me, because Katie had not shown such reflective insight during or between sessions in the past. This was in my opinion a fundamental core issue for Katie.

In PE-EFT terms, the anger Katie described was an emotion not fully experienced, but as guarded as Katie was, it was a major shift out of the fear reactions she had been presenting with in previous sessions. I affirmed Katie’s statement and responded “it sort of resonates...” In addition, her words had a core chilling quality to them and I responded viscerally by experiencing “goosebumps all over.” She asserted “so many times I’ve gone over what I’d say to her... I could write a letter but I’d prefer to say it to her.” I gently enquired as to whether she would like to practice saying it to her by means of an empty chair an Enactment Task. She responded, “but I know she won’t

listen... she'll keep retaliating right through." Katie completely ignored my suggestion and so I asked her to just tell me what she would like to say.

Katie continued animatedly but somewhat disjointedly

... don't care she doesn't help me with recovery... I just want her to know that I'm not ok... I **am** not ok ... I **do** have an eating disorder... it's not as though I can cover it up (*holding her arms out to show herself*)... she's really in denial about it and I just feel frustrated with her... I put it in the back of my mind because I didn't want to get angry with her and she's my mum but I actually got frustrated... but then I feel really guilty... she'll say 'don't talk to me about it, talk to a therapist about it' (*loudly*) I need to talk you about it... you need to know what I am going through... all she has to do is listen... I don't want her to say anything back or help me through... I know she can't make me better I just want her to know and tell her.

I had been following Katie's flow of reflections and the word "sensitivity" popped into my mind and said "it's the sensitivity... you're a sensitive person (see Aron, 1998)! There is nothing wrong with being sensitive by the way." Katie responded assertively "I am a sensitive person." I reflected her sentiments by summing up "get me... know me... hear me... take notice of me." Katie agreed "yeah" and she continued speaking whilst maintaining her assertion.

[I] want to say it and hang up after... I know I'll get drilled for it or something... she's one of those sort of people that can say the smallest thing but it can be really hurtful... I'm like maybe all mothers are like that... I'm like... no they're not (*screwing up her face in disgust*)... (*pause*) ...oh she's always like 'don't be so soft' sort of thing... so many people have helped me and just cared... that's all I want... someone to care ... maybe if someone cared about me getting better maybe I might want to.

Katie continued,

I'm trying... I'm getting help... I tried to do it on my own I can't... not just a matter... can't anymore... I thought I could... there was a point where I thought I could... I chose not to... and now just can't...

I encouraged her to explain to her mother about active listening where the listener is asked to not interrupt and wait until the speaker has finished. I stated that this was potentially an opportunity for Katie and her mother to become closer and communicate more effectively. Katie responded, "she knew it was coming ... she knew it would be an eating disorder I would latch onto." Katie affirmed that "this is my life..." I acknowledged that she had made a big connection and it was evident by her demeanour that something in her had shifted. We both simultaneously let out a huge sigh and then laughed together as a release. "I just needed to tell you... to let it all out... hope you don't mind" she uttered. I stated that it felt like a potential turning point and Katie beamingly responded I'm "happy about that."

Katie added that dad often phoned her but mum may not for months. She expressed resentment at this. She then noted that mum's family also has problems, with one of her sisters being an alcoholic. I observed this as interesting and was curious as to whether Katie's mother used "I'm ok" as a coping strategy. "Mum's sort of... 'let's not talk about it now' ...like there's nothing wrong." Katie and I grimaced and held out our arms to the side and simultaneously we said "look at me."

The session was nearing the end and I informed Katie that I had met with and consulted her doctor. As there were no outpatient services for people with eating disorders and Katie was not at a stage that required hospitalisation we would work together with a dietician/nutritionist to assist her further in her recovery. "Team Katie" was designed to empower Katie to take charge of how she wanted to manage her eating disorder. Further, my aim in developing "Team Katie" was to avoid a hospital admittance which I saw as possibly quite detrimental. Katie declared "I'm so excited... feels reassuring... feels good not doing it all on my own." Katie was also very appreciative that I offered to continue to see her free of charge. Her energy levels had significantly improved and she had enrolled in four subjects next year so she

could complete her degree the following year. She also had secured a part-time job where she worked two four-hour shifts per week. “I feel really good and excited.”

Katie reported on her Helpful of Aspects of Therpy form that “talking about mum... discussing that I am angry with her and how I want her to care about me... [and] talking about how I approach the situation” was extremely useful.

Extra sessions

Katie no longer had depression according to the inventories, but ethically I felt it was in Katie’s best interest to continue with the counselling. I recognised continuing to see Katie would not affect the research regarding the twelve sessions but would interfere with any follow-up measures. We agreed to assess the situation after a further six sessions and even though sessions were videotaped, only the BDI-II and the DASS would be readministered after that time. I took case notes and the following information was taken from those written documented recordings.

Session 13: 3rd August.

Katie attended this session with her boyfriend. However, she talked more about her anger with her mother. I wrote it was like “the lid is off and the rage is emerging.” Katie saw her doctor, who was looking for a suitable dietician. Katie’s boyfriend appeared very supportive. I listened to his concerns and observed his genuine affection for Katie as he gently touched her coat with his fingers. He had noticed her mood had changed and was pleased that she was moving not only to acknowledge that she has a problem but also that she was willing to do something about it. Katie’s mood in the session was very positive. She had not yet spoken to her mother about what she needs from her but had tried to talk to her dad. She doesn’t want to worry him but I encouraged her to consider that honesty might be what he would like more. Katie stated that she found being able to talk openly in front of her boyfriend with me was helpful.

Session 14: 17th August.

It was two weeks since our last session. Katie was exhausted and quite disorientated. She had inadvertently gone off her medication and this had triggered migraines and

nausea. She had not contacted the nutritionist but still intended to. She had been home last week and talked with her family. She was pleased that they had responded well. Katie was very clear she wanted her mother to be more caring but also recognised her mother was doing her best and that their relationship had improved. The session was cut short because Katie found it difficult to talk and concentrate.

Katie's doctor had been unable to locate a suitable dietician/nutritionist and as a student Katie had no money to pay for a private partitioner. Subsequently, I consulted with a supervisor at a local college for alternative therapies that trained nutritionists to a bachelor level. We were able to organise appointments through their student clinic for Katie to see a fourth year trained nutritionist and naturopath under supervision at no charge. I explained Katie's other medical concerns and the supervisor assured me that they had the expertise and would be happy to support her transition to health.

Session 15: 24th August.

Katie was thrilled that I had organised the appointments for her. She was very excited as she had been feeling so stuck. Again, she reiterated that she wanted to make changes but had no idea how or what to do. She had managed to obtain a new prescription for her medication and described just feeling tired and awful.

Katie was going home that coming weekend for a twenty-first party and she described feeling a "tightness" in her chest at the thought of seeing her friends. I encouraged her to do a focusing exercise. She agreed. The sensation was experienced as "like wearing a black solid metal vest" and she saw it was connected with the weight of going home, with situations where she felt stressed about and with people looking at her. Katie wanted her friends to accept her as she was. She was surprised by the sensation of the heaviness and was able to connect it to guilt and feeling bad about the laxative use.

Katie also recalled that when she commenced taking the pill at age seventeen, she developed a more womanly figure and did not like it. Not surprisingly, the idea of putting on body weight also had this heavy weighted feeling. Katie talked of retreating and going overseas. Her home town was so small and it's all about "image, image, image" there. The judgmental nature of the small town annoyed her and she preferred the city where people were less critical.

Katie recalled that she felt she was a very plain looking child and most people didn't notice her. Now that she was "anorexic" people were noticing her and gave her more attention. It made her feel sick to think they were only noticing her now. Katie liked gay guys and likened herself to them. She liked being what she described "over-the-top" like them. Katie further explained, that she found it very painful to be in the presence of people who were judgmental, which often resulted in her getting "fired-up" and angry.

Session 16: 21st September.

Katie had initially requested weekly sessions with me, but it was four weeks since we last met. As far as I knew she was attending the student clinic. Katie looked very pale and lifeless. She said she felt "numb" and her will to "beat her condition" had vanished. She has identified more fully with being "anorexic" and less of a person who has an eating disorder. Katie has been looking at websites and was surprised to find that most people with anorexia have had abuse in their backgrounds. She doesn't feel her background "was bad enough" for her to have anorexia. Trauma is not objective, but is defined by the reaction. She was somehow distorting her experience and I attempted to acknowledge that her sensitivity and her perception of her background were significant without aggrandising or minimising it.

I asked her to imagine herself feeling well and she was easily able to envisage herself well in one year's time. I further asked her to imagine an extra 200g of body weight. She grimaced but then relaxed as she imagined allowing the weight to spread evenly over her thin frame. She found comfort in these visualisations and her hope and vitality increased. She said she did not want to give up and I wrote she "walked out with purpose and life."

Session 17: 5th October.

Two weeks had passed and Katie was not coping. She had cancelled everything and gone home. Her mother had been very supportive. She described how "nothing" she felt and how "empty... like when my friends died." The sadness she felt now was the same as when those three friends had died was the same now. We discussed how shocked she had been by their sudden tragic deaths. She said she wanted to control

everything in her life but knows she cannot control her death or can she? She talked about “just fading away.” She explained that she had no real purpose to her life and nothing to look forward to. She had not found her “wings yet.” There was a gap between where she was now and being “well” and she didn't know how to get there. Significantly, a shift in her energy had occurred within the session and we both noticed it. Katie changed the subject and talked more animatedly. She had arranged for her dad to attend our next session and talked about how she was going “out for dinner” with her boyfriend and other friends. “Oh I feel better now... I go into those states but know I will come out of them eventually...” she said. I explained that sometimes when you “touch the bottom” there is only one direction out and we both looked up.

Session 18: 12th October.

I heard from Katie's doctor that she wanted to attend the next session. Katie's doctor arrived early and was quick to express her concern about Katie's further drop in weight. The doctor felt Katie was going through the motions and not actively taking advantage of the support provided. It was also acknowledged that since the diagnosis of anorexia the decline had been rapid. I also reported that she had missed many sessions with me. Katie and her father arrived. Katie's doctor was very direct and took charge. Katie acknowledged that she was indeed attending appointments but then going away and “doing my own thing.” Katie was surprisingly open and up-front. Her father appeared a caring man and was eager to know what he could do. Katie also said her boyfriend thought it was “now time to go to hospital” and she agreed. Katie somehow knew it had to get to this and was resigned to it. Katie's doctor agreed to organise the paperwork for an inpatient admission at the local hospital that had a specialised treatment area for eating disorders.

Katie was a bit overwhelmed at sitting in the presence of all of us but I reassured her that we would all be there for her. Katie's doctor declared that she was unable to continue to be responsible to maintain her physical health and that hospitalisation was the only course of action. As we were unsure of the timing of the admission, I made an appointment for the following week. However, sadly, I also explained to Katie that it was potentially not possible to continue with this counselling whilst her

physical health was so compromised. On some level I felt I had let her down. In hindsight, I would now advocate more strongly for Katie to stay out of hospital. Aware that our relationship was within a research setting I was on the one hand relieved that Katie was no longer my responsibility but sad that I had not a better alternative to offer her. I decided not to ask Katie to complete the BDI-II or the DASS.

Later, I was able to talk to the supervisor of the student clinic at the college and she confirmed that Katie was not taking the transition program seriously and even with enthusiastic encouragement by her team Katie had ignored recommendations. Despite this, Katie had become a favourite amongst the students and the supervisor and they were aware that she was off to hospital. In fact, according to the supervisor she attended the clinic at her last appointment session to say goodbye and thank them for their efforts. There was not a room available at the hospital for Katie to be admitted via normal means and so she and her boyfriend attended the emergency department and she was able to secure admission that way. Katie was in hospital for 6 weeks.

Appendix Q • Detailed Session Description of Ava's Therapy Sessions

Session 1: 11th May.

Ava was tired, her course of study involved a huge work load and she couldn't "be bothered doing it." She worked part-time in a jewellery shop and she couldn't be bothered doing that either. However, she acknowledged that going to university or work did get her out of the house. She was in her final semester of her course and was hoping to go overseas later in the year.

Ava was worried about her sister who had slipped a disc in her back and was awaiting surgery. Her sister was in a great deal of pain and Ava wanted to help her. Ava and her sister were very close and her move to interstate five years ago was very distressing "the worst time." Ava was doing her Victorian Certificate of Education (VCE) when her sister moved away. Already stressed by the pressure of Year 12 and completing her VCE Ava experienced extreme levels of panic and anxiety. During this account Ava gesticulated a great deal and fidgeted compulsively with her hands and pulled at her hair and clothes. She spoke rapidly and animatedly pleading for her sister to "please come back." Her sister had been "there" for her while they lived together in the family home and then she had left. Apparently the move was really sudden as her brother-in-law's younger brother had died of a drug overdose and he wanted to return to his home state to be with his family.

I enquired as to whether Ava could feel anything in her body when she thought about her sister. She replied "yeah... this might sound funny but I have so much to say that I lose my breath (*holding her hand to her upper chest*)... so much I want to say about her... wish she was back... a tight feeling." Ava explained that often she had so much to say that when her sister returned home for a weekend she would "freeze up... so much to say so little time." She doesn't want to burden her sister with her problems but then regrets not doing so later. Often they then argue rather than talk. Whilst still at home her sister acted like a buffer between her mother and Ava because she had "gone through all that I'm going through now with mum... gives me advice... sick of hearing dramas... [she] doesn't want to take sides."

I encouraged Ava to “tell me what you want to tell your sister?” Ava explained she was seeing someone and wanted to share the experience. The relationship was in its early stages and Ava had not been in a relationship since the painful split with her ex-boyfriend nearly two years ago. Ava went onto to explain the ongoing problems with her mother, “she really... how do I put it... (*raising her arms and pushing them down*) ... [she] is suffocating me.” Ava gave an example from the previous evening where she had wanted to go out for coffee with the new guy and her mother had asked aggressively “why do you have to go out for coffee? ... you saw him last night!” Her mother then proceeded to get very upset, yelling, screaming and berating her for always going out. Ava pulled a tissue out of the tissue box and started to pull at it saying “I just wanted to get away.”

Ava wanted her mother to sit down, be reasonable and just talk to her about what she wanted, but instead she would screech the following barrage

there is no talking to you... a person can't talk to you... there is no
getting through to you... you are the way you are and that's it...
whether I talk to you like a human or an animal you are just like that...
you are that way and that's it!

Shocked but with great compassion I asked how Ava felt when she was spoken to like that. Animatedly

I'm just like... (*gesturing*) pull my hair out... I just put it aside... that's
just mum... I have come to this point in our relationship and that's
it... she's not going to change... I am not going to completely change
for her otherwise I would be completely locked in the house... I
wouldn't be able to do anything... I think I have just accepted that this
is as good as it gets... been like this for a long time... it's funny because
I'm so close to her (*opening her arms outwards*) but so distant.

Ava needed her mother when she was going through “all that bad stuff” often requesting that she come home from work to be with her. Her mother would then

complain that Ava only needed her when she was sick and criticise her when she was well enough to leave the house. Ava recognised that she became defensive and would retaliate. She couldn't "go to dad for things like that... [and] friends can only do so much." Ava again pulled at her hair. It was a viscous cycle that had no sign of changing according to Ava, they just had to "learn to live with each other... until one day I'll get married and leave the house or whatever." Ava's mother would lament "look what you are doing to me... look what you have done to me." I questioned Ava to see if she believed she was the source of her mother's problems and she said "I did at the start... but then nah... she's always the victim... she makes a person feel worse that they already are."

Ava's mother warned her about trusting other people. When Ava had a falling out with a friend and her mother rather than sympathising, irritably said "I warned you about her... no good to have too many friends... your only friends are your family... you trust too many people too easily... they end up hurting you." This had been an ongoing tirade since Ava was young. She described the effects of this deterrent as putting "a paranoia in me... [see] people are bad and will do something." Ava described subsequently having difficulty in maintaining friendships and a need for constant reassurance that she was "a good person." Ava wanted to be open and trusting, know she's a "really good, kind, person" and have a chance to experience life for herself. Her mother

gets in my face... 'you shouldn't be like that... you should... being like that is weak... don't let people walk all over you and use and abuse you.' I just... confused (*grabbing her head*)... and I don't know what to do... and I don't believe what I am saying... I am a really good person... I don't believe it the words come out of my mouth... I need to hear it from other people... so I go out there and I try... you know... constantly need reassurance... 'hey Ava you're great' ...I should get it from myself... I need to know it for myself... I know all this.

It was not surprising Ava was confused. She wanted to believe in herself but her mother's voice drowned it out. Ava had a dream that within the next three years she

would meet someone, fall in love, get married and move out. “Having those things will fix the situation... but I don’t think they will... won’t fix how I think about myself... *(tearfully)* not an easy fix.”

Ava cited her sister as a “hard act to follow.” Her sister met at sixteen and fallen in love, a young man of the same nationality, finished university, secured a job and married all according to the expectations of her family. Ava’s relationship was with a young man who was not accepted by the family and Ava was “a complete opposite from what they wanted.” Picking at her clothes Ava said she was angry that her parents expected her follow in her “sister’s shoes.” But quickly minimised her situation “so weak... people much worse off... you should be grateful for what you have... feel bad for feeling sad or angry... or not appreciating what I have... so caught up with being sad.” Her mother saw Ava as a “problem child” but Ava declared “I’m not on drugs... I’m not promiscuous... she should be grateful for how I have turned out... I haven’t had it easy.” However, her mother would retort “that’s your own fault... I warned you... I told you so... and now there you go.” I offered “a no win situation.” Ava felt her mother was “cursing her life” because she would say that her own children will be problem children and then she would understand what it was like for her.

Ava explained how her mother would harass her when she went out, “there are phone calls... there are messages... and phone calls and messages... I’m out with a guy I really like... I have to put it on silent and pretend it is not her... abusive messages.” Ava would lie that she was at university at times when she wasn’t because her mother would not bother her there. “She’s not letting me be 21... doesn’t trust me... can’t prove [to her] I’m not lying.” Ava let out a huge sigh. We sat in silence and tears welled in her eyes. She dreamt of being strong and stable enough to leave home, “last night just cried... I want those happy things now.” She thought she had talked too much and felt “so stupid... a sook... feel bad for feeling sad” I explained that her emotions were telling tell her something and her head was trying to tell her everything was all right when it was not. She sat silent. I said

you are sad for a reason because it is really hard and there doesn’t seem
like there is an end in sight... hard to live in that house with no

respect... you are resourceful and intelligent... trying to do the right thing... everything you do... can't get it right.

Ava said “don't feel my age sometimes... feel like a kid... restrictions... boundaries... young 12 year old... taken me longer to grow up... friend knows so much about life... I'm naïve.” Ava recognised that her mother had overly sheltered and protected her on the one hand but criticised her for not being independent on the other. She recalled how her mother would compare her to others and told her she couldn't do anything and then put undue pressure on her to perform. Ava recognised she was still a student and given the time she would be able to be independent and make decisions for herself. “The more pressure... I feel like dropping everything... sometimes haven't performed to best of my ability... couldn't be bothered... purposefully sabotaged... to be average... they're never satisfied...”

The session concluded with me encouraging Ava to talk freely with me about her difficulties and that I “heard” her. She replied “get this tightness off me.” Something had shifted and she let out a big sigh of relief. Ava wrote on her Helpful Aspects of Therapy form “when the therapist told me she was there for me (rather than my sister) and that I could tell her all the things that I can't tell my sister. This felt like a weight had been lifted from my shoulders... relief... like pressure in my chest was released. I cried when I told the therapist about what ‘I wish’ to happen like a dream I have that would resolve all the issues I'm facing now.”

During our first session it was important for Ava to tell her story, a marker for the Narrative. Ideally the end-state of utilising this Reprocessing task was the relief Ava described. In addition, there were times of vulnerability and through my empathic affirmation I wanted Ava to have felt understood.

Session 2:1st June.

Ava was late. She had missed three sessions and was nervous. Throughout session she pulled at the sleeves of her black cardigan to cover her hands and constantly crossed the front panels around her upper body as if she was wrapping herself up. Periodically she would rub her eyes and adjust her hair. On the way to last week's appointment she had been in a car accident and her car had had to be towed away. Despite the accident

being the other person's fault Ava panicked at the scene. In the session she was distressed at the thought of not having a car, having to hand-in assignments and her up-and-coming exams. "Yesterday... just couldn't move." She described that her muscles ached all over and she felt like she had the flu but she knew she didn't. She had stayed in bed until 2pm but still felt unrefreshed. She had spoken to her sister for an hour but noticed that she had to be doing something at the same time, like paying bills and cleaning up "have to keep doing something... even watching TV... get up every ten minutes." I commented on the contrast of feeling so flat and then this buzzing around.

Ava sadly explained to her sister "if you knew you wouldn't wake up the next day... I would be ok with that... no feeling, no drive to live... wouldn't want it or make it happen but if it was to happen..." Ava was reminded of her mother who constantly compared her to others and the pressure she put her under, "gives me a headache!" She felt a constant struggle to comply as she did not deliberately want to go against her mother but often did. If her mother nagged her about getting a job Ava found she did not want to get a job. She likened it to strong warnings about taking drugs "and because you know it is forbidden it makes you more curious."

Ava's parents more concerned about the damage to the car and organising insurance. I asked how she was and tears welled up in her eyes.

Mum always plays the victim... even when it is not about her she'll make it about her... the energy between us is so cold... even when there is no conversation... would love to sit on the couch with my mum and just talk about stuff like what my mum and sister do... only happens once a year when she is not mad at me or disappointed...

I asked Ava to notice how she had been pulling her cardigan across herself as she had been talking. She said she wished she could walk around all day with her arms folded that way because it felt tight and secure. In bed she would have every corner of her doona tucked in tightly around herself and not move. I suggested it was a form of nurturing herself and enquired as to what she was feeling in her chest. She reflectively replied

like it's numb... numb all over... walking around... don't feel like I am physically here... doesn't feel like it should be... feel like I'm somewhere else... (*animatedly gesticulating*) happens when I am driving... really bad... sometimes I'll be driving for ten minutes and I don't know how I got here, I don't remember... I know where I'm going... zone out... I know I'm not paying attention... in a daze.

I explained that this experience could be a coping mechanism that happened when things get too much. I also wondered whether she could hear her mother's voice criticising her behaviour and enquired as whether it felt like "mum was in your head all the time." Ava agreed and said was talking too much about her mother. I reassured her that it was safe to express herself openly with me.

"I feel like I've been bashed... all over but I haven't." I asked whether she could feel the bruised feeling and invited her to close her eyes so she could more easily connect with it, "it hurts all over... so tense." I further encouraged her to notice the tension in her body and breathe into it and relax a little. My aim for this intervention was to slow Ava down as her anxious chatter was animated and often disjointed. I acknowledged she was really suffering at the moment, evidenced by this sensation of feeling battered and bruised. Ava stopped and let out a deep sigh and yawned "my hands ache... my fingers ache." She said she felt a "release of the tension" in her body but was tired now. I suggested "what would your body be telling you?" She replied "... sounds so cheesy... 'start loving me' was the first thing that came into my head... body crying out 'just love me there is nothing wrong with me'..." Mirroring each other we crossed our arms across our bodies and swayed slightly as if rocking a hurt child. Ava said

it is so true... I do this (*pulling at her clothes*) I try to hide it... constantly... I'm adjusting my hair or myself because I think it's out of place, it doesn't look right... [think] people are constantly judging me on the way I look... don't open your mouth too much... makes me tense... my body goes 'stop it... be comfortable with me... with your

skin not being perfect... there is nothing wrong with it... people don't judge you about things like that...' always been like that.

Again I notice the presence of her mother's voice looking for fault but encourage her to look after her body. Stroking her own thigh and patting her knee soothingly Ava said "we've been through a lot... connect with it again... I feel disconnected from it." I encouraged Ava to notice the little things in her body as it can lead to a sense of feeling more whole.

I became aware of calmness around Ava as she sat quietly. She agreed "I feel it... the whole body thing... I can feel it." We reflected on the earlier gesturing of her hand across her leg and she described it as "rubbing the skin off" where now it was gentler. I asked her to consider whether this heightened anxiety and tension that included the "battered and bruised" feeling may be related to the accident. As we wrapped up the session we briefly discussed her up-and-coming exams, graduating and finding a job for six months she again pulled her cardigan around her and said "thinking about things are stressing me out."

Ava reported on the Helpful Aspects of Therapy form that closing her eyes and thinking about what her body was telling her was helpful because it made her realise that her body was constantly communicating with her. In addition, she found taking the time to really feel the aching, bruised feeling throughout her body was also useful.

Session 3: 8th June.

As a result of a recording malfunction I do not have videotaped recordings of Ava's next two sessions to review in detail. Consequently, the following recollections are taken from case notes.

Ava came to the session stressed, anxious and worried about her impending last two exams. She was procrastinating by doing housework instead of studying. During the session she talked and talked. Every now and then I would ask her where she felt the anxiety in her body. Despite my attempts to slow down the process, she persistently continued. Finally, she arrived at her main concern "a fear of death." All her friends said that she shouldn't talk about it but I asked her to openly tell me about her fears. I then introduced the Experiencing task of focusing. I asked her to close her

eyes and we formally “Cleared a Space” which potentially enables therapeutic focus and subsequent productive processing of experience. I invited Ava to turn inward and direct her attention to notice where the tension resided in her body in relation to her fear of death. She felt it in her chest, a “black, hard prickly thing.” Its revelation was so overwhelming Ava suddenly opened her eyes. We discussed how frightened she was.

Ava went on to explain how in the past she would go to a place in her imagination. This place was a warm beach where the sun would be shining. Again encouraging her to close her eyes and I asked her to explain what she “saw” of these surroundings. She described the environs together with her sensations and experiences in great detail. I suggested that she might like to use this visualisation to help her cope with the black, prickly mass in her chest. She could potentially be able to develop a dialogue with it. She immediately and spontaneously started to work on getting the sun to burn up the mass. The energy in the room significantly changed. She stretched and yawned. Ava was excited by the prospect of having some control over this “thing” that had controlled her as long as she could remember.

Ava wrote of the session “definitely the most helpful event today was visualising my fear and how I could overcome it by creating and thinking about a place where I feel completely happy and in control.” In addition, “seeing my fear, picturing it, confronting it, looking straight at it and with a sense of talking to it” was greatly helpful.

Session 4: 26th June.

Ava missed a session as a result of sitting her final exams. When she arrived she again was agitated, picking at her clothes and jumper. She explained that she had not slept well and feeling really tired. Ava was still very frustrated with her mother but didn’t like talking about her in a negative way. Ava changed the subject by recalling a dream she had had. In this dream a friend had died and even though she was very upset and crying there were no tears. I encouraged her to tell me the story about her friend. Her friend had become an ex-friend because this friend would exclude Ava and talk behind her back. The falling-out had never been properly resolved. I suggested Ava imagine her ex-friend in an empty chair in front of her. The Enactment Task of the Empty Chair is concerned with unfinished business with a significant other. Ideally it

enables the client to let go of resentments and/or unmet needs in relation to the other. There is an opportunity for self affirmation, understating or holding the other accountable.

Ava was somewhat reluctant but decided to give-it-a-go. I facilitated the process by asking Ava to imagine her friend sitting in a chair I had placed opposite her. I encouraged her to imagine what clothes her friend was wearing, notice her facial expressions and really get a sense of her sitting there. I instructed Ava to speak to the imagined friend and express how she really felt in relation to the treatment of her by this friend. Ava found it difficult to make eye contact with the chair. She fidgeted with her long black hair, combing it with her hair-clip and feverishly pulled at numerous knots. This frenetic pulling at her hair was quite distressing for me to observe and I needed to keep breathing deeply to maintain and model my composure. I was aware Ava energetically needed me to hold the space for her notwithstanding her nervousness. However, despite being so anxious she was able to hesitantly say what she wanted to express. Fortunately, Ava reported a great relief at having gone through the process and experienced a shift in the perception of her friend which she did not elucidate upon.

Ava wrote “confronting her [friend] about her feelings towards her and what happened between us” was an important and helpful event. “This event was helpful in that I felt I got all the things I needed to tell her off my chest. I felt a sense of relief and had closure.”

Session 5: 29th June.

Ava was wearing a lovely white winter jacket and despite her noticeable agitation she looked well. Her mother had been ill, complaining of a sore bloated stomach for some weeks which now required a colonoscopy investigation. Ava was concerned but said she didn’t show her mother her fear. Her mother always “had something wrong with her... always complaining about something... she’s always thinking the worst.” Having recognised Ava’s fear I asked her where she noticed it in her body. She replied “in my stomach for some reason... like nausea.” She went on to describe her trip to the session that day where she was playing her music loudly and “was in a daze... in the biggest daze... almost missed the exit.”

Ava had finished her exams and now her parents were pressuring her to find a job. She was hoping to find work in a hospital. She was looking forward to being more independent but her mother complained “you be independent... you can’t survive for one day on your own let alone be independent.” Ava’s mother compared her with others forcing her Ava to have to concede her inability to be independent. “They’re different to me... I can’t multitask... I’m bad with time... I’m organised but I procrastinate... these people have different characteristics.” Ava nervously pulled a tissue out of the box and started fidgeting with it. Yesterday she felt so much pressure in her head that she developed a tension headache. She was looking forward to the summer because she could be outside and away from the house.

Ava turned her attention to her father and explained that he was very quiet and kept everything to himself. “He thinks the same about me as mum but does doesn’t say anything... but when he does verbalise it, it hurts more than when mum says it.” She was surprised and distressed that he wanted her to go out and get a full-time job with no recognition of how hard she had worked to finish her degree. “I was your little girl... you supported me... sounds like mum’s words... then he was all right again.” I affirmed that it must have been a real shock for her when he said that. “They call me the ‘problem child’... I don’t think I’m that bad... my sister is the ‘golden child’... I use it as a joke ‘your favourite daughter is on the phone’...” But it was not that funny. I enquired as to when she became aware that she was the ‘problem child.’ She was fourteen and started questioning her parent’s decisions. She wanted to stay over at her friends and when they refused she lied and went behind their backs. Ava was frustrated because her other friends were doing much worse things at the time. “The more she restricted me the more I used to go out... the biggest thing, when I was fifteen... which played the biggest role in how I am now, how I think and my anxiety... was a guy I met at the time... I was infatuated... he was two years older.”

Ava met this young man through her cousins but he was of a different nationality and religion to her family and they were forced to hide the relationship. When her parents found out

it was like I was belted like no tomorrow... I remember I had bruises and scratches on my face... the punch-ons we got into... the worst

thing I could have ever done to her was to be with that guy... I killed her somehow... I never thought it as that... they are very traditional... I would never judge a person by that... he wasn't a good guy... he is someone I wish I could erase from my memory... that's how much trouble... I was always in the background for him... he had someone else as well.

The relationship lasted on-and-off for about six years and had been officially over for the last two years. Ava recognised that he was not a suitable partner not because of his nationality but because of his treatment of her. Pulling at thread on her coat "he didn't respect me... I know that now... I even knew that then." I offered "you needed someone?" Ava replied "it was all I knew of love... so many reasons I stayed with him...I felt comfortable with him."

Ava explained that in relationships she gets attached very quickly and "smothers them." She explained that her next relationship also ended badly. Ava felt she was not a good judge of character and had lost confidence in herself as a result of these failed relationships. Ava still dreamt of finding the right guy. "I'll start loving myself when someone else starts loving me... I know it doesn't work that way." Her most recent ex was violent "I am a weak person... I stayed in a bad relationship because I was too scared to come out of it." He was aggressive, jealous and possessive. Eleven months into this second major relationship and at her Year 12 graduation he hit her. He was remorseful and she remained in the relationship for seven more months. Even though he did not hit her during this time he "would get really close... get in my face and yell." She retaliated and yelled back and finally ended it. Ava rebounded back to her first boyfriend for about a year but he had a girlfriend. Finally she ended that too.

Ava was proud of herself for ending those relationships and getting through. She recognised she can't change the past but felt she could learn from it. I asked her why she thought she was drawn to these men. Interestingly she relied

my mum is the man of the house... I don't want it to be like that... dad is the wife... she brings home the money... I didn't want to wear the pants... I want the man to look after me... my personality... I need to

be looked after... can't protect myself... that's why I was drawn to them... that mentality...

Ava said she had changed and would never allow herself to be in a violent relationship again. She "still long[ed] for that person who is going to be my protector, my saviour... nurture me and love me... that's what I need... can't stand on my own two feet... never going to find it..." I asked her to contemplate what she had just said and after a long pause she said "I can't be on my own." I enquired as to how often did her mother tell her that. Ava sighed and replied "pretty often." Her mother regularly reinforced the belief that Ava can't look after herself. I delved a little further utilising an empathically conjecture. Holding my hand over my upper chest I said "you used the word weak before is that how you feel on the inside?" She nodded and I asked her where she felt that in her body. She held her hand to her heart and with tears in her eyes that did not fall she sighed "[I'm] weak... can't do anything." We sat in a long silence.

Ava then explained how she really liked the new guy she was seeing but he didn't like her in the same way. She had become attached again. Greg was 28 and didn't see himself in a relationship at that time. She was aware that he was using her and "I don't know why I am hanging on... cause I'm stupid." Ava became aware of the camera and embarrassingly confessed said "he was my first... more attached because of that... I felt comfortable with him even though I couldn't say I love him... I felt secure... don't feel he'll treat me badly like they treated me... not controlling or possessive... he does respect me." She didn't feel disgusted by her decision to have sex with him but did express a sense of discomfort and unease about it. "No point to say I regret it but I don't want to make excuses."

Ava felt right about being with Greg, however, "he is nice but sometimes he isn't nice... could be nicer... I want him to show me... saying things but showing me you care are two different things... I act on the things I say... I'm not all talk." He sees the relationship as "sex but just friends" which doesn't make sense to Ava. "He uses me if he needs something... I set up his computer, internet... go out of my way... tells me he appreciates it but doesn't show it." Her friends encouraged her not to be so

generous with her time and be a “mean bitch.” Ava wants to be herself and doesn’t “understand that kind of mentality... playing the game.”

Ava was surprised we hadn’t gone overtime and said “[I] feel like I’ve been here for two hours... embarrassed... feel better now.” I affirmed Ava’s lovely fresh, honest way of being in the world. I was aware that she had pressures from many sources encouraging her to be different and that I saw her as intelligent, warm and caring. She sighed and said “I wish more people said that.” Again she sighed with noticeable relief. In this session I determined that Ava needed an opportunity to further tell her story, the Narrative marker, without judgment or ridicule from me. I attended to Ava’s immediate experiencing as she journeyed through the unfolding of her narrative and facilitated a safe environment for her to tell me openly about her problematic relationships. Coincidentally, Ava reported that talking about her past and present relationships and how they had affected her was greatly helpful.

Session 6: 27th July.

Four weeks had passed and Ava had missed three scheduled sessions. Despite making an effort to appear happy she looked tired and ashen. She had travelled north for a holiday and despite a fear of flying had managed three separate flights within the seven day trip. On the first flight a passenger had seen her distress and supported her by sitting next to her and distracting her with conversation. She spent two days with her sister before travelling on to spend time with her fiends and cousins further north. Her sister’s back was improving and she no longer needed the operation. Ava had passed her exams but had not done as well as she had hoped.

Since her return Ava and her mother had been getting on well as they had missed each other. They had been talking the night before in Ava’s bedroom quite happily. Her mother started criticising Ava’s ex-girlfriend and Ava “zoned out” letting her mum just talk on and on. Ava received a phone call and her mother stayed in the room. The conversation was brief but when it ended her mother grilled Ava for information about who was the caller, where was she panning to go and so on. Ava felt her “whole body [was] crushed,” her head began to ache like a “ton-of-bricks” had hit her. They started yelling at each other and Ava demanded her mother leave her room. “She is a control freak... control my life, control my friends... never stop.” Ava

grappled with the notion of hating her mother “[I] hate myself more because I see myself in her... when I say I hate my mum, God forbid, I would never say that... never feel that... but at times I do.” She was able to forgive, forget and justify her father’s flaws more easily than she could her mother’s, “she should know better... we should be able to work together.”

Ava’s mother reminded her daily that she was “a constant disappointment... the decisions I make or how I am or what I think or feel [are] not right... not the way they should be... need to change me in order to make her happy.” I asked where Ava felt that in her body and she pointed to her heart “it hurts... I know she is proud of me in some ways.” We discussed how Ava tried to change herself to accommodate others and how stressful that was. “[I] always wanted people to like me... more for people not to dislike me... any relationship I’ve always wanted to prove that I’m a good person... the only way I know is if someone tells me.”

Ava’s extended family get-togethers consisted of gossiping about the faults and failings of others. Ava was often the topic of this scrutiny, “I walk into a room with my family... feel their eyes burning me... I know they are thinking something... I’m hurt by the smallest thing... everything affects me... I should feel comfortable with my family.” Ava was reminded of the daughter of her cousin who was one and a half years old, “she loves me... doesn’t judge me... stay and play with her forever... I wish people were like that.” I said “it touches you [that little girl?]” Tears welled in Ava’s eyes and she cried. I reiterated “you are good enough and you do deserve to be respected.” She retorted “I’m a sook!” and continued “sometimes I zone out... sounds morbid... I can’t see myself in five years time or the near future... I can’t see myself anywhere... it’s like I don’t exist anymore... this is it, my life ends here... it makes me so sad... this can’t be it... I just can’t.”

We discussed Ava experiences of zoning out. “It feels like I’m nowhere... if you picked me up and just took me out of this life... wouldn’t affect anyone... no one would notice... no one would care... (*with a heavy sigh*) it would be like there was never an Ava.” After some silence I reiterated that “there is an Ava” to which she responded through her tears “she’s fucked in the head.” I acknowledged that she was indeed struggling to cope with a hypercritical family that watched her every move. She had become sensitive to their every gesture and subsequently worried about

everything. I affirmed that her reactions were actually quite normal. I hypothesised that she coped by utilising the defence mechanisms of making herself “fit-in” or “zone-out” but she could “lose herself” as a potential consequence. After a long pause she replied “I can see that... if I’m not there no one is going to watch me.”

Since completing her studies Ava has had little to distract herself apart from finding a job and that has not been easy. I asked about her relationship and she said “oh, that’s another problem... even there I am trying to change who I am... constantly proving I can do this.” She was afraid of being alone “even if I only see him for five minutes a day to do something for him I’m not alone... I should be happy alone or not alone.” I responded “that’s what your head says (*pointing to my head*) what about... (*pointing to my heart*)?” Ava said that her head and heart disagree all the time,

my head says ‘he’s not worth it... stop seeing him... if he calls don’t answer... stop doing things for him...’ but this (*pointing to her heart*) says ‘you’re kind, you’re nice... you can’t pretend to play the whole hard-to-get person... do things for him for him he’ll get to see the good in you... he’ll appreciate you... he’ll wake up one day and go he needs you...’ that’s the mentality of my heart. My brain says ‘that’s not the way it goes... that’s ideal... in reality people don’t care about other people...’ this says (*pointing to her head*) ‘there are only a few Ava’s around... the rest of the world is shit...’

I commented that there seemed to be “an argument going on in there.” Laughing Ava responded “it is a war.”

Ava found it difficult to tell Greg how she really felt and I offered the Enactment task of the Empty Chair. I perhaps could have suggested Two Chair work but Ava’s vulnerability was more prominent and I was aware we may not have enough time to fully explore the Conflict Split that had become evident. Ava felt she already knew what he was going to say and she would feel devastated “if this is all I can have with him I’ll have that.” I asked her whether she loved him and Ava sighed as responded decisively “no... I want to... does that make sense... I want to love him.” I

hypothesised that “he’s not very lovable because he was not very good to you... but you hang around anyway...” “I hang around because I think he can love me and if he loves me I can love him!” I gently challenged her “is that good for you?” Ava explained that she was comfortable with him because he also suffered from anxiety “he’s like me but a stronger me... someone who knows how to control it... he’ll calm me down... he says ‘you can fight it on your own...’ ...goes back to the same thing I can’t expect him to save me for this.”

Ava wanted to be saved by him and reiterated her dream of being looked after by a man. However, he doesn’t have the qualities she dreamt about “it is more like what I imagine of him.” I empathically conjecture “he’s not giving you what you need... it hooks you in.” Ava sat silently contemplating and then tearfully she replied

I’m twenty-two in a month... I honestly think... I’ve been in love... with the wrong person... but I have never been loved by anyone... I’m sad about that... I must be a really bad judge of character because the people I attract are just not right for me... I keep telling myself ‘I’m not going to make the same mistake...’ I’m being punished... all my life always feel I’m being punished.

She sat silently and continued

I have a photo in my phone of the two of us... it’s the closest I can get to a relationship at the moment... I look at the photo and I try to imagine I don’t know who I am looking at and try to analyse what that person’s feeling at that moment by the expression of the face... it makes me sad because I look at that photo and she’s so genuine... they’re not working together... they’re not on the same wavelength... it’s sad.

I speculated that she had “a whole body response” when she looked at that photo and yet there was part of her that goes back to him.

Interestingly, in the session Ava's phone rang and it was him. She did not answer it but realised immediately he was ringing to ask her to do something for him and not to ring just to see how she was. "He's so arrogant... why am I so attracted to arrogant people?" I asked her to answer her own question to which she laughingly replied "I think they love themselves and I wish I could love myself." I explained that arrogance is an observable negative trait. Ava said "any normal girl..." I stopped her and affirmed that she was a normal girl who was struggling with difficult issues. With tears in her eyes she pleaded with me "what do I do?" Our session time was up and I gently but with a sense of humour said "we'll answer that question next week." Ava said "stay tuned..." and we both laughed and said together "to be continued." She sighed and said "it's time... dam..." I replied "yeah, it's time."

Ava reported that talking about spending time with her cousin's daughter and how it made her feel loved and happy was helpful, "it made me cry, [and] I felt a sense of release." In addition, she was able to acknowledge how much it affected her when she was judged.

Session 7: 3rd August.

Ava was late. Her sister had come to visit and her mother had lost her voice so the house was quiet. I asked Ava about her relationship and she immediately pulled her cardigan tightly around herself. When they had first met she had taken a photo of him with her now ex-girlfriend and emailed it to him. They had been working on his computer and she saw the photo and asked him to delete it. He calmly but assertively explained that as she was no longer friends with this girl she didn't feel comfortable that he still had the photo. He proceeded to taunt her by saying "if I saw her in public I would talk to her." She became very upset and he retorted that her upset was "one of the reasons he could never be in a serious relationship with her." She reluctantly apologised in order to "make peace." I asked Ava whether she felt trapped in this relationship and she said

no... if I do I'm trapping myself... it's company... I'd rather feel lonely with someone that be lonely alone... he's not great company... not always a good time... the more I see him the more I'm put off by his

personality... what am I doing... then I really like him... it just swings...

I encouraged Ava to notice how she felt when she was with him. She was reminded of feeling quite relaxed at times but then “not completely relaxed.” She liked the idea he did not know her past, that it was like a fresh start but he provoked her to react and often made assumptions about her. He “knows nothing about my life and shouldn’t assume to know me... I would like to get to know him.” Ava explained that when they were together “that way” (sexually) she would not feel comfortable and “cold and yuck... I’m constantly conscious he will be picking up all the flaws and faults about me... he has made me feel so bad about myself... so ugly... been up all night crying.”

I offered Ava an opportunity to talk to him utilising the Enactment task of the Empty Chair but noticed some reluctance. I subsequently suggested working with the two aspects of Ava in relation to Greg utilising Two Chairs. I explained the task and set it up by acknowledging that in one chair was “Ava that wanted to be with him” and in the other was “Ava who didn’t want to be with him.” Ava “who wanted to stay with him” was the most present and eagerly explained her reasons for wanting to stay in relationship with him. She was attracted to him physically and it was hard to walk away because he was the first person she had been intimate with. Ava changed chairs. She recognised that he was arrogant, not good company and would often not treat her well. Kicking out her foot she knew she “deserves better.” I spurred her on “yes, you deserve better.” The other side responded. Ava was aware that she was unable to let go of someone that easily and that she was vulnerable. “I had given a really big part of me... ideally I want to see myself with him... it’s the way I have been brought up... I have an image in my mind that the longer I stick around, the more that I do for him, the more that he sees that I’m willing to do things for him... one day he’ll realise I am what he’s looking for.”

An almost chastising response emerged. “You’re expectations are unrealistic.” This aspect highlighted that Ava was wasting time, missing opportunities to meet new people, do things she really wanted to do and could be possibly more hurt in the long run. Ava’s reply to this was of recognition but that she would deal with the heartache “when it comes and if it comes.” She was aware that she did not love him because

“there was nothing to be in love with him about.” I put forward the idea that because Ava has been intimate with him she now felt she had to love him. “Yes... sort of to make it right so I don’t regret what I have done... I guess I’m hoping I grow on him.” The other side replied

do things that don’t make you feel bad... be around people that don’t make you feel ugly or not worth dating... when in reality you are not all these things... you’ve got more intelligence... you let him intimidate you... he quit school in year 9... can you imagine marrying this person... couldn’t have an intelligent conversation with him... cause he’ll think he’s right, shut you down straight away... he’ll swear at you and tell you where to go because he doesn’t know any better... *(laughingly)* he’s aging, he’ll be grey soon... you’re still young and fresh.

The more vulnerable aspect of Ava had no response but I encouraged her to sit in that chair anyway. She recognised what had been said was true and I noticed she was “completely crushed over here.” Ava felt she was “wrong” and the other side was “right.” I explained it was a differing perspective and there was no right and wrong. I asked if she could still maintain her dream but perhaps not with this man. “Then it’s imaginary... even if this isn’t the dream as I dreamt it is still a reality... I settle for this if this is all I can get.” Ava described a pressure from the family and outside to find a partner and settle down “there’s not enough time.” She admitted this pressure was a “big part” of her deciding to have sex with him “ok if I do this then he’ll stick around and it was really silly of me to do because it’s so not going to happen.”

Ava’s sister had explained to Ava that she made choices as a result of how she felt emotionally and not logically or rationally. I explained that perhaps her emotions and logical aspects were not working in tune with one another and that the process work we were undertaking would potentially assist in cooperation between the two. I highlighted this by hypothesising she was sitting in her “heart space” in this chair and her more logical aspect was sitting opposite. I encouraged her to talk from her heart. “My heart is saying... I want to love him... I want him to love me... I didn’t know

him well enough [when I slept with him] now I know him a bit better and I don't like what I know but there are parts I like." I enquired as to whether her heart wanted to stay in relationship with him and she said "no." We sat in silence and she said she felt lonely "there are so many things wrong with me... who's going to love me for me?" I asked her to remember all the good things about herself "I do... [but] I'm disappointed in myself... I'm constantly reminded by people that my faults outweigh the goods parts... I'm failing them... I'm failing myself... I'm a failure... who's going to want to love or want to be with a failure" I suggested that she might be fearful of being lonely.

The session was drawing to a close and I wanted to bring the focus back to the relationship and so enquired as to whether she could do anything about her relationship. Interestingly, she sadly responded "I know I thought I had no control over it but I do... I feel lonely again." I reminded her of the other Ava that presented her with many other possibilities. "I don't know that I believe it but I'm open to it" she replied. The more assertive side of Ava reminded her of her sister and her friend. "She's not around often... the heart Ava pushes that Ava away... she's not dominant in this relationship." I had been concerned that this more logical dominant aspect was too assertive and was therefore mindful of the more vulnerable aspect being overridden. So with this new information in mind I encouraged the two aspects into dialogue and whether they could work cooperatively together. Ava's heart aspect declared she needed the logical, rationality, clear thinking and confidence. She expressed a desire to listen more to this rationality. Ava swapped chairs "it's about time... I look forward to working with you!" Ava returned to the chair she sat in at the beginning of the session and was visibly excited and energised "feels good... feels better... more at peace."

Ava reported that talking to the two parts of her personality (emotional Ava and logical Ava) and coming to an agreement was greatly helpful. She also found it useful to work through why she was holding onto her relationship.

Session 8: 10th August.

Ava had been sick and she looked really tired and drawn. Her sister had been visiting and had just left the day before. Ava explained that she had been "really emotional and

hormonal.” I asked about how she felt about Greg and she said “[I] don’t call him... really just nothing anymore.” Intrigued, I enquired as to whether she thought the relationship was over. “I do but I don’t... I don’t care anymore... if he wasn’t to call me I would probably get over it.” She recalled a conversation he had had with her mother which helped her to see “he’s not what I thought... he’s not at all what I want!” Ava was horrified that he had spoken to her mother as an equal, “in my eyes he’s not her equal... didn’t sense that respect.” Ava was delighted that her mother then said after the meeting “Princess you deserve so much better... he’s not right for you... [he] doesn’t have the level of maturity or intellect you have.” Ava was thrilled “for the first time my mum said I was smart!” Ava was excited that this interaction had provided an opportunity for her and her mother to “bond” and to have found some common ground.

In order to determine Ava’s resolve in relation to Greg I gently raised a hypothetical question, “if he came to you now and wanted sex what would you do?” She sighed “I don’t know.” I enquired further “so do you think he has noticed a change in the way you’re interacting with him?” “Oh I hope so... I am completely different... like I don’t care anymore what I say to him... if he says something or makes a comment... I just tell him straight out... brush it off... two months ago prim and proper...” I enquired as to whether the work we had done last week had been useful. She agreed it had and went on to explain how she had changed.

At the weekend she returned his laptop on the way from work and before going out for dinner with friends. She needed to change before picking up her friends and had about an hour spare. When she arrived at his house he was busy on his computer and so she sat on a lounge chair watching TV. After a while she changed into her evening clothes and despite paying little overt attention to her he did notice her. The time came for her to leave but he made a move to the couch and called her over to him. They had sex.

The whole thing was different because I felt good about myself and he really reinforced it... pretty much for the first time he commented on how I looked and how it made him feel... I really did feel good whereas at other times he’s criticised that way that I look or not wanted to be

with me because I don't look good... that's one of the things I really hated about him and turned me off because he's so big on the image thing... have to look your best the whole time... not realistic... for the first time I did look good that night, I felt good about myself and he acknowledged it... *(laughing)* it sounds so tarty!

I responded "you had some power in this." "I know... I got something out of it... for the first time I used him for something... *(shrieking with laughter)*... I'm so embarrassed."

Ava explained that she had then left and gone to pick up her friends and they went out for dinner and onto a nightclub. Interestingly and unknown to her he was a disc-jockey at the same nightclub but she ignored him.

He talks to lots of girls and I feel jealous... even though he's not my boyfriend there is an emotional attachment... I feel like he is part of me and I don't want to see other girls around him.... I wish I had the strength to do that now... play the whole hard-to-get game.

I remind Ava she had choices that she may not have realised before. She recalled past sexual encounters with him

it never feels ok afterwards... maybe during or the lead-up, it's like that's my time where I feel attached and there's a physical and emotional attachment on my behalf... I don't know what he's thinking... but then after it the attachment breaks and then I'm like on a down again... I'm on a high and then I'm on a down... like I'm on drugs... like it's a rollercoaster and sometimes it's worth it... best choice would be to stop... I'll be honest... I have stupid thoughts... the dream... the more you give of yourself the more you put up with... he'll realise he wants to be with you in other ways... Ava the dreamer lives in a fairytale... people are out there for themselves... why can't

people be more like me... why can't people be honest and caring and good... makes so much sense.

Further, Ava never asked to be reimbursed for things she bought for his computer despite her being a student and him having fulltime employment. She liked to do things for others because it made her feel good but she expected nothing in return. However, in a friendship she would ideally like to be treated equally unlike him who "doesn't care about anything but himself."

I encouraged Ava to be around people who are more like her and she identified her sister as someone who not only understood her but liked her. Ava was of the opinion her sister had to like her because she was 'family' but I challenged this myth, and she remembered times when they did dislike each other. Ava believed you have to love your parents and your parents had to love you. I gently challenged this myth also and we discussed the concept of unconditional love and acceptance in relationships and she said "that's definitely not [him]... he doesn't accept me for who I am." I acknowledged that part of Ava that wanted him to turn into "that man on the white horse and sweep you off your feet..." She finished my sentence "[and] save me... it's not going to happen... silly silly girl." I disputed her statement about herself being silly and affirmed her use of her imaginary world as an important coping strategy.

Through a mini-focusing process I asked her to close her eyes and imagine her *imaginary* world. My aim to do this was to create some sort of bridge or connection between her world the world she perceived as *reality*. In PEEFT terms I was using the task of Focusing but it was a variation and somewhat out-of-mode. There was sunshine, brightness and a feeling of wellbeing. I then asked her to get a sense of the real world which was "sort of blacker." She wanted the real world to move into her world but then said "I am colouring it in... sky sunset yellow-orange in my world... putty white in this grey city... they are side by side... I have a bird's-eye-view... get the people out... shadows of the city from the buildings... not so dark and dreary." I ask her to create a bridge or connection. "It's like a field... grass, like a park and she's walking into the park." Ava started to feel anxious but remained open to the task. She explored this new world "lot's of things to see... bigger than imaginary world." She

appeared calm and was smiling. When she opened her eyes she said “I want to go back... I could have stayed there.”

Ava reported that having the conversation with her mother about the shortfalls of her lover was helpful, “as I realised for the first time she was on my side and we could communicate.” She also liked “building a bridge between my imaginary world and the real world.” Ava also reported it was slightly hindering “talking about her intimate relationship with [her lover] and whether it would continue.” I was struck by the incongruity of Ava’s detached attitude towards her lover, recognising that the relationship was unsatisfactory in so many ways and yet the ongoing desire for it to continue.

Session 9: 17th August.

Ava was late again. She wore drab clothes and again looked quite ashen. She declared “where do I start!” Her mother had found her mobile phone bills and had proceeded to compile a list of the phone numbers she had rung or received. Her mother then had rang the numbers on the bill to determine who the number belonged to and added their name to her list of phone numbers. She had repeated this with phone calls made by Ava from the home phone. In addition, her mother had found Ava’s bank statements and calculated her expenditure. “I went mental... I ripped everything up and chucked it in the bin...” Holding my hands to my face I was visibly horrified and I groaned “that’s terrible.” She responded “I feel stuck... I feel like I’m a kid... she’s crazy... I feel so paranoid... if I go out she’ll assume I’m with whoever and she’ll start calling people... how embarrassing for me.” Ava felt her mother had been doing this for a long time “I thought she’d stopped! I’m not even secretive.” I responded with disdain “it is such an invasion of privacy.” I enquired as to whether Ava had told her sister and she said she had. Even talking privately with her sister had been difficult. When Ava took the portable phone to the garage her mother followed and insisted on listening in on the conversation. Ava retreated to the garden to achieve some privacy. Her sister encouraged Ava to talk to her father because she found it difficult to help from such a long distance and didn’t like being “caught in the middle.” However, Ava knew if her father took Ava’s side on anything “she goes ballistic.” Ava said “all I could so was laugh when I was telling my sister... I tell my mother everywhere I go but she

doesn't believe me." Ava was also constantly being questioned about "where is all your money gone?"

I don't make much money and so when I get it I spend it... I don't do drugs... [or] play the rich bitch... she thinks I go out there and buy my friends with money... 'you're paying someone, you can't have no money...' I have no money why can't she understand?

Ava scratched her head.

I was aware that Ava loved and respected her mother but this behaviour had really unsettled her and I subsequently raised the question of what would she do about this situation. "I don't talk to her any more... I don't fight back... I just listen or I just walk away and she just talks to herself in a loud voice... no matter what room I'm in I hear her just talking to herself... [as if I was there]." Ava had been restricted from using the car so recently she had to walk to work. By car the trip would be five to ten minutes but to walk took nearly an hour. Frustratingly, when Ava was only five minutes from work her mother turned up and drove her the last little way. In addition, when Ava had had the car accident earlier in the year her mother had used the insurance payout for some household items and not replaced the car. On another occasion, Ava caught her mother going through her handbag claiming to get a cigarette. Her mother pulled out automatic teller receipts and crumpled pieces of paper scrutinising everything, muttering "what are you hiding?" Ava responded irately that she was not hiding anything and "don't go looking through my bag." Further, Ava needed to fill a repeat prescription for her anxiety medication and asked her mother to do it for her. Her mother responded by questioning why she still needed the medication and to go and tell her doctor she does not need it anymore. Ava put her hands in her head and leaned forward. We sat in her despair.

Ava couldn't sleep and was having really bad dreams. She was feeling really paranoid. I reassured her that it was understandable and enquired whether it might be possible for her to stay with friends or other family members for a while.

hell no... she'd disown me... [saying] 'are we beating you up that you up that you can't stay home.' It's always what are other people going to say... could stay with a million and one cousins or girlfriends but she won't have it and it'd give her more reason to check up on me... to follow me... she follows me sometimes in the car...

I asked Ava where she felt this in her body and she replied "in my back... feel like she's jumping on my back." Ava was hunched over rubbing her eyes "don't know what to do... (*long pause*)... I'm stuck." I was aware of Ava's vulnerability and chose further empathic exploration rather than introduce a task at this stage.

I asked Ava what she would ideally like to do. She fantasised on the idea of going overseas but felt she was too scared of being alone. She recognised that if she could find full-time work that would help. Her mother had been home a great deal lately because she had been unwell and so they were spending too much time together. She had put in many job applications and had a few return phone calls but no interviews. I was curious to know whether Ava was ready for the workforce. Interestingly she replied "I'm so scared... I'd do anything to go back to uni..." Ava rubbed her eyes and hid her face in her hands. I asked about Greg and she groaned "he's doing my head in as well... I think that's done, he hasn't called me for a bit... tried calling him... I think it's over... I'm upset but what can you do." Ava leant forward scratching her head and pulled at her hair. "Take me away... put me in hospital." I echoed "take me away, look after me."

Last night Ava could not sleep "sitting up like a zombie... I just don't care...but then started thinking stupid things... (*almost whispering*)... how would she feel... like if I just wasn't here anymore... just died or something." I assured her I understood those feelings and why it seemed like the only alternative. Ava did not cry as we sat with this realisation. I also recognised how difficult it would be for her to go home. She was going to work straight from the session and I enquired as to what it would be like when she got home after work. "I'd go straight to bed... wouldn't sit with them..." She mumbled and then suddenly raised her head saying loudly and angrily "I don't want to be around you... not only do you invade my privacy by opening my mail but being next to you... you are invading my time with myself." Ava wrapped her arms

around herself. I had pulled a chair next to me and invited her to continue her dialogue to the empty chair but she said “I can’t talk to her... she’ll yell back... I know everything she’ll say... oh I just wish Prince Charming would come.” Ava keeps pulling at her hair “it’s so thin!” and scratching her head. She had found some sleeping pills in the cupboard the other day and just wanted to take a couple so she could sleep “so I don’t have to feel that aloneness anymore.” I enquired as to whether it had ever been this bad before and she was remembered that it had and by doing nothing “in a few days it will pass.” With rapid speech she described a cycle of things being ok for awhile but “then shitty again... it’s just never ending... nothing I can do... all I can do is hope and pray to God that I will find a job... and don’t have to see her face.”

Ava felt talking to dad was worth a try. Tears welled in her eyes as she described a feeling of bugs growing inside her, under her skin. I enquired as to whether she had had that sensation before. She said “I was driving here I was like getting this tightness in my chest... like having a panic attack but I wasn’t... stupid mother, stupid mother, stupid bitch... why are you treating me like this...” I coached her gently to say the words more loudly and then she said “because she can... feels like pulling my hair out... itchy everywhere.” I conjectured that she was seething but I also noticed sadness. She explained she was “too angry to cry... I feel nauseous... like throwing up... then I feel like sleeping and doing nothing.” I encouraged her to stay with these emotions.

I’ll never meet someone while I’ve got these problems with her...
(*rubbing her head*)... no one wants a head case... that isn’t stable... I
know they see... I’m the worst judge of character... stupidest most
----- girl there ever was... (*leaning over and her head in her hands*)... I
talk about being really smart... not socially smart or emotionally
smart... she never believes me... I told her something that happened to
me when I was seven or eight years old and she didn’t believe me...
why would I lie about something like that... when my boyfriend hit me
she asked what did I do to deserve it... (*scratching her head*) who says
that?

Ava looked quite dishevelled and was very anxious about being late for work. I was concerned for her and encouraged her to stay with friends over the weekend and contact me if she needed. I was aware she had talked about dying but assessed she was not actively suicidal. The session ended with me reassuring her that there was nothing “wrong” with her and that I considered her mother’s behaviour as abominable. Ava reported that telling me about her mother’s behaviour had been helpful and she felt she had got “all her anger” off her chest.

Session 10: 24th August.

Ava had survived the week by managing to work every day. Her mother had returned to work also and so they had minimal interactions and she had not told her father about her mother’s behaviour. I noticed Ava’s energy was very low. She was in pain. Last October Ava had decided to have braces put on her teeth to straighten them. The dentist had tightened the braces the day before and her teeth and jaw were very sore. I enquired as what was present for her and she explained that she was having difficulty sleeping. She would be wide awake until 2 or 3am and when she finally fell asleep she would wake up at 1 or 2 in the afternoon of the next day. Her appetite was also affected and she would not eat for hours at a time. I was aware there was “a heaviness under the tiredness.”

I’m so over everything... I’m still sad... upset... I’m so drained... I feel like dry... all the water in me has been sucked out... I feel like a desert... drained... no life... just telling you this now is drying out my throat... no water... everything, mum, home, Greg, everything... (*rubs eyes*)... he didn’t call last week and a half... stuff this... I don’t care... I didn’t call... went out on Saturday night and he was there and I didn’t talk to him... he called a few days later.

I asked her directly if she had caught up with him and her answer was quite ambiguous. I was aware that I had potentially played the disapproving mother and that she may have distorted her answer to please or defer to me. Deference is

“commonly defined as the submission to the acknowledged superior claims, skill, judgment and so forth of another person” (Rennie, 1994, p. 428).

Ava had described feeling dry and empty and I was aware of a sense of doom and heaviness. In past sessions I had found it difficult to introduce any tasks or interventions as Ava had been vulnerable, and / or needed to tell her story which according to the model required only gentle empathic exploration. In this session, I was keen to explore her depressive symptomatology more deeply. In my opinion the Experiencing task of Focusing was indicated as Ava had described her symptoms in symbolic terms. I reintroduced the task, explained its semi-meditative nature and the purpose of the task and invited her to close her eyes. I did a formal Clearing of the Space and a systematic body scan searching for areas of pressure and tension in her body. Ava immediately identified an area of pressure in her stomach. She described it as like a green flat piece of glass that was hard to see through. She was aware of five or six people who she felt did not like her and they were pushing her and putting pressure on her. She identified that this pressure had been present since the beginning of high school when she was about thirteen years old. Transition to high school had been difficult for her as she was “fat” and had few friends. She had been teased. Fortunately she did develop some good friendships and lost most of the weight.

I asked Ava to refocus on the people she saw in her inner world. She asked them to go away but two remained. One was her ex-boyfriend. She recognised that she was hanging onto him

I think by holding onto the memory of him and what happened with him it is the only way I can explain why I am the way I am... if I let him go and I feel good in me then I'll be lost and I won't have a reason anymore... won't know who I am.

I presented the idea that was it possible to still have the memories but not to have to hang onto them anymore as it was potentially preventing her from moving forward and making changes in her life. She saw she could move away from him but “before I let him go I need him to feel bad.” I asked whether she sensed that he might ever feel bad and she shook her head. I suggested that she had a choice. Ava still struggled but I

encouraged her to call on the “wiser all-knowing Ava” to assist her in the process. Ava as she watched him move away experienced a felt-shift, let out a huge sigh and swayed slightly from side to side. It was sad to let go and she felt empty. I asked her to notice the green symbol again. It was half the size and she wanted to throw it away and smash it. I encouraged her to do so. Again she breathed deeply, yawned and finally coughed.

I then asked Ava to search her body again for any other areas of pressure and tension in her body. She rolled her neck from side to side and identified pressure in the back of her neck. She described it as a “grey shadow... a force.” Tears welled in her closed eyes. This pressure had been there since she was very young, about six years old. As she described it’s qualities she moved her chair back away from me and leaned over resting her elbows on her knees with her face in her hands. Noticing it was difficult for her I asked if she wanted to stop the process. She declined. I asked how this pressure got there. After a long silence Ava recognised that her mother had put it there. I enquired if it was to do with the expectations her mother had placed on her. Ava agreed it had and leaned over further, her chest was nearly touching her thighs. I enquired as to what it was telling her or needing from her. She said it said “let it go.” I wondered whether it was something to do with standing up for herself. I also felt it was important for her to be reminded that she was a good, kind intelligent person who could be proud of herself. Ava sat up straight and took a deep breath. “Was there was something reassuring about sitting in that space” I enquired. She nodded and continued to take deep breaths. She reported that the pressure in her shoulders had lifted and she was aware that “I’m ok.” This sensation of feeling ok spread throughout her body and she described it as a blue energy, “it’s beautiful.” The session ended by me slowly and gently asking Ava to ground herself and open her eyes.

Ava reported that she found the Focusing very useful because she connected with knowing that everything was going to be ok. “I felt like I had finally closed the door on my past.”

Unfortunately, the sound recording of Ava’s next two sessions was extremely poor. Utilising my case notes I have been able to piece together the main aspects of the sessions.

Session 11: 14th September.

Ava was full of emotion. In a somewhat hysterical manner she said “I am laughing but... I’ve been hanging for today... something has happened... I feel like it didn’t happen... not sure how to feel... nothing or everything.” Ava wanted to tell me but was unsure what to say and where to start. Finally, after taking a deep breath Ava explained she had gone to her doctor for a check up and through a series of tests the doctor had determined she had had a miscarriage. She felt it all made sense but she didn’t realise at the time. “Oh my God I’m so lucky but I’m so upset... big kick in the head... kick myself...” I was aware of her contained but hysterical state and gently enquired as to how this might have come about. She remembered having unprotected sex with Greg at the beginning of their sexual relationship. There had been little contact between them recently, but she did contact to tell him what had transpired. He responded dismissively by saying he was sorry it had happened to her but the same thing had happened to his ex-girlfriend as well. “What was I thinking... there was no ‘us’... what an idiot... I’m such an idiot... feel disgusting... like a whore...” Ava leaned over rubbing her eyes and said “stupid girl... that’s what makes it so disgusting... he doesn’t give a shit about you...” It was her birthday last week and he had not contacted her in any way to acknowledge her special day.

Ava began to cry “...sad... because I now really, really, really see him... (*long pause*)... I still had that hope... this is it... this is the eye opener for me... it had to be that extreme for me to get it... why do I let it come to that?” Ava blew her nose and turned to check herself in the one-way mirror behind her. I acknowledged that she looked beautiful but once she regained her composure she talked on. He now has a girlfriend. Her sister was pregnant. Ava saw the irony of her ability to get pregnant when not even in a relationship and the situation of her sister who had to wait for so long. Ava went on to explain her last menstrual period and how she had noticed really large clots, “why is my period so strange?” She had inspected a soft bright red mass that wouldn’t break up and even though she wondered what it was “didn’t think anything of it.” She also recalled noticing what was “almost like skin... [that] I couldn’t unravel...” We surmised that this had been early stage embryonic material. Ava contemplated her new awareness and realised it had been “a potential baby... the thought that it was there... can’t get my head around it.”

I asked her whether she might like to say goodbye to this lost part of her. “I don’t know... I’m sad but I’m not sad.” I enquired as to whether she was unable to quite own or connect with it. She agreed. I was aware of her sadness and explained to her that despite feeling relief there was still a grieving process around the loss of something she didn’t even know she had. Ava wanted to stop speaking “feel like I’ve spoken enough... your turn.” I felt it important to acknowledge Ava’s grief and encourage her to reach out for support. “I don’t want anything from anyone” she replied leaning over with her head in her hands and pulling at her hair.

Ava described “a heaviness” in her shoulders and I introduced a Focusing task. I asked her to close her eyes and really connect with her pain. She rubbed her eyes and pulled at her hair. Ava was able to recognise her need to be perfect and the pressure she would put herself under in order to “be” perfect. She began to get in touch with a sense of the loss of the baby and the loss of the relationship that never really was a relationship. Ava recognised that this sadness would take time to heal. I encouraged her to talk to Greg in her inner world as the idea of introducing an Empty Chair intervention may have been too confronting for her. Ava sat bold upright and took a few deep breathes, “[I] feel like hitting him...” I urged her to tell how she really felt and if possible find a way to let go. She was overwhelmed by nausea and rocked in her chair. Fortunately, Ava was able to stay with the discomfort and experienced a considerable felt-shift. She realised she would be ok, that things happened in life and she needed time on her own to heal. I encouraged her to create a space where that healing could take place and where she could grieve without scrutiny. Ava reported that the focusing helped and talking about what had happened in general had been useful. She understood she needed “time to grieve and understand the hurt and loss.”

Session 12: 21st September.

It was two weeks since the last session and Ava was looking well. She wore a royal blue lightweight top and blue jeans. The colour suited her and she didn’t look so pale and drawn. She was somewhat pensive, however, as she had had contact with Greg and was finding it hard to let go. She had rung him “stupid I know...” but I disagreed. I felt she was looking for closure and to make sense of what had happened. She felt like an “idiot.” She explained how last Friday she had gone out with a friend of her sister’s

for a sort of date. They went to a bar where Ava often went to on a Friday night with her friends. She was anxious she might run into Greg and she did. A very awkward meeting resulted in Ava wanting to leave. She managed to compose herself by going to the Ladies room. However, on the way back to her date she had to walk past him dancing with another girl.

I wanted to vomit, cry... vomit all over him and this girl... it was so bad... he was disgusting... he did it on purpose... he was watching me as I walked past him... dancing with this tart... I was just gutted... not because I wanted him... I just felt yuk... disgusted... after everything that had happened... I was just so gutted...

Fortunately, Ava's date was really attentive and "introduced me to all his friends... he was proud to be with me... nice... [but] Greg was ashamed to be with me and would hide from me in public..." I enquired as to whether Ava would like to tell Greg how she really felt and introduced the Empty Chair. She was hesitant and kept talking.

"He's so shallow... I must be really unattractive..." I questioned Ava about this and she wanted to know

why I am not good enough for him... same with her ex I wanted to know what it was about me they couldn't love, like or want or desire... if there was something I could do to change it I would... how bad is that... my whole life I always tried to change myself for other people.

I was aware that her parents and particularly her mother had compared her to her cousins and sister and lamented that she was not more like them. I hypothesised that somehow her parents had taught her the only way to know herself was in reference to others and not about accepting herself as being okay as she was. She had somehow lost the ability to know herself as being an okay person. I paraphrased Ava's own words "what do I have to do or change myself for Greg to care for me, love me and want to be with me?" Ava sat silently and then nodded "[that's] so sad... it's shit... it's insane, fucked... completely fucked..."

Ava remembered when she tried to change something about herself she would go to extremes. I encouraged her to find herself in this moment by closing her eyes and “get a sense of who you are.” Tears welled in her eyes. “Feel like none of it is real... like it always happens when I’m in the car and when I’m here.” She remembered a dream she had during the week. Her friend was Muslim and Ava would attend some of the ceremonies. She loved the chanting and the beauty of the rituals. In this dream she heard the chanting coming from the sky where there were brilliant colours and she saw the stars as clear and bright. Ava felt was overwhelmed and started crying in her dream. She was about to kneel respectfully and was enchanted by the sounds and the beauty. Her mother suddenly appeared and grabbed her arm as if to pull her up and take her away. They struggled. Ava woke up “freaked out.” I recognised this was happening in Ava’s life. She would try to find her own way and her mother would hold her back.

I was aware that Ava changed herself to suit others and so I asked her who the Ava was that came to counselling. Did she feel the need to be someone I expected her to be or was she “herself.” Ava was silent for a moment and then shrugged her shoulders and said animatedly “me... I think I am more me than I am in real life.” We both sigh and laugh at this realisation. I am aware that her relationship with me was authentic and genuine and I encouraged her to bring more of that “real” self into the outside world. I was curious as to whether my brazen hypothesis had been confronting for her and she responded “no, I feel you understand.” I further asked her to take my understanding, caring and acceptance of her into her life and to be true to herself.

Ava wanted to get off her medication but I encouraged her to do that slowly with the help of her doctor. I had offered Ava extra sessions and she said she would consider the option and let me know. Ava reported that “when Melissa said to take home with me an understanding that she cared and was still there for me, and that she really understood me as a person helped me a lot.” Ava also added that the realisation through her dream and how she was treated as a child helped to explain why she was as she was.

Extra sessions.

Ethically I felt it important to continue counselling Ava. I recognised continuing to see her would not affect the research regarding the twelve sessions but would interfere with any follow-up measures. We agreed to assess the situation after a further six sessions and even though sessions were videotaped, only the BDI-II and the DASS would be readministered after that time. Six weeks later Ava returned. I took case notes and the following information was taken from those written documented recordings.

Session 13: 2nd November.

Ava was very agitated. She has gone off her medication and endured many difficult family issues. Her father has had a heart operation. Ava had recently graduated and was trying to apply for an honours position next year. She could hardly speak. I suggested a focusing. Ava described a black empty hole in her solar plexus. She felt it had been there for a long time probably since she was small child. Ava was overwhelmed as she recalled being a small child playing in the park. I asked her to assist “little” Ava by bringing “adult” Ava into the scene. Ava moved her chair back away from me and said she just wanted to run away. She said “adult” Ava was stupid, should know better and can’t help “little” Ava. Ava saw no point in retreating to her imaginary world because when she wakes up everything was still the same. I asked her what she would like to wake up to. Ava replied “a glowing her!” I then encouraged Ava to find that glowing aspect in her and explore whether that can neutralise the black hole. She was hesitant and explained the glow was not strong enough yet. I encouraged her to use her imagination to magnify the energy, fill the black hole and her entire being with white light. She was able to do this. She was speechless and unable to articulate her experience. Ava found the experience greatly helpful and wrote on her HAT form “throughout the focusing exercise I saw/imagined myself as... my ideal sense of self... in a place where I am happy, pure and protected.”

Session 14: 28th November.

Ava had both good news and bad news. She had found a full-time administration job in one of the large hospitals and could no longer come to counselling. She had tears in

her eyes as she told me and said she would miss me and the sessions. She had also met a man whom she liked very much and who was good to her. He was of Greek nationality and about ten years her senior. She was still off her medication and has had no major panic attacks. She recognised that she was still highly anxious but she preferred not to be taking the medication. Her sleeping had not improved but Ava was hoping the new job would make a difference to her life. I was aware she was embarking on a new life and through a focusing I encouraged her to look at the past and allow the “new” to enter.

I enquired as to how Ava was in relation to the miscarriage and Greg. She explained that she thought about them every day. She mentally found herself comparing Gino with Greg and hoped that would stop eventually. Ava was able to visualise her new life. I encouraged her to take a moment to look back and notice the sadness of the loss of her life past but be open to the joy and excitement of her new life. Ava felt a significant felt-shift of tension in her stomach. She was able to say goodbye to Greg and felt less distressed about the miscarriage. Ava was able to turn toward her new life full of opportunity and possibility. Ava wrote on her HAT form “it was a way to say goodbye to the past and welcome the new, a chance to let go of the past.”

Change processes in therapy: Case studies in Process-Experiential / Emotion-Focused Therapy

Appendix R • Detailed Session Description of Chloe's Therapy Sessions

The following recollections of the sessions with Chloe are taken from reviewing video recordings of sessions, rereading of case notes and my past session recall of process decisions I made within sessions. At the end of each meeting Chloe was asked to record helpful aspects and I have included these.

Session 1: 8th August.

Chloe appeared a little brighter than last week. Despite the long distance travelled and being “a bit resistant to get up and come,” Chloe readily engaged in sharing her concerns. She was doing a placement in a chiropractic clinic and explained that because of her sensitivity was often aware of the “negative energy” of some people. Her main concern was the lack of emotional support and reassurance from Steve. “He doesn’t show his emotions and I’m such an emotional person.” I asked Chloe to notice her body when she talked about Steve. She felt it in her “heart and solar plexus... boyfriend died at 16... first love... starting point for all boyfriends.” I acknowledged that it was hard to “trust ongoingly they will be there.” Her parents divorced when she was three and she was aware of the resulting anxiety. I was acutely aware of her strong felt-sense and suggested the Experiencing task of Focusing. It seemed a radical step so early in the relationship but I explained the task to Chloe and she agreed to try.

I invited Chloe to close her eyes, “cleared the space” and conducted a systematic “body-scan” searching for sensed pressure and tension. Chloe described the sensed pain in her head and shoulders, and symbolised it as a black rectangular shape with unclear edges and a hard dull plastic texture. Focus on the area brought “disappointment... about myself” to her mind. The “sadness” she carried in her shoulders had been there a long time and was connected with things from the past. She was disappointed by life and had been “let down by people.” I asked her to think of a time when this being let down was really evident. She recalled when she was five, her then eight year old cousin pushed himself up against her and “started to do things.” I offered, “not the sort of things boy cousins should do.” Her mother had

“thought it was funny.” Chloe felt she had somehow deserved it. Tears fell. I asked Chloe if she could see her mother’s face. “She’s laughing...” I clarified, “what he did was wrong and she thought it was funny.” I encouraged her to speak to her mother. Chloe remarked she “should have punished him... he should be sorry for what he did.” She wiped the tears from her eyes.

I encouraged Chloe to tell her cousin in her inner world what he did was not OK. She sat silently telling him and finally took a deep breath. I further encouraged her to confront her mother and suggested she may like to ask adult Chloe to support five-year-old Chloe in this confrontation. “She doesn’t want to listen” she said but I gently urged her to continue as it was the expression of her suppressed reaction that was important. Chloe wanted “them to listen and recognise and understand what happened and not to laugh.” Afterwards, Chloe sighed with relief and reported her inner child was “a lot happier.”

I asked Chloe to revisit that pressure in her shoulders. It was “definitely less but still there.” Chloe had navigated the process of Focusing extremely well and I enquired, “is it OK to keep going, or is that enough for today?” She agreed to continue. She immediately recalled an 18 year old boyfriend when she was 14

...was mean to me... he sexually forced me... he lay on top of me and had sex with me... he was too heavy to push off... didn’t want to scream and say no because I didn’t want to bother other people.

I asked her to recall the scene and ask for what she needed. After a long pause, “He’s confused... he thinks I deserved it.” Chloe agreed on some level she had deserved it but later realised “I didn’t deserve it... I didn’t even know what sex was then... he looked at me and said he couldn’t understand how it was my first time... he expected me to be more easy than I was.” Chloe was shocked to realise that he saw her as a “slut.” I asked Chloe to contemplate that she was “not like that” and “sit in that knowing of who you really are...” She sat more upright and breathed in deeply. “I kept having sex with him after that because I thought if I didn’t he’d hurt me... I felt wrong... betrayed... I was scared... he’d do something to me if I did anything wrong.” Chloe felt this sense of “wrong” and “blaming herself” in the back of her neck and

chest. She came to realise that it was he that was in the wrong “I was too young to know better...” I reassured her that none of it was her fault. I explained that staying with him was a survival strategy because at fourteen she had no resources to manage this situation. She experienced a noticeable felt-shift “such a release of stuff... feels good.”

I wrote in my case notes that Chloe “was able to focus on the bodily felt-sense really easily, got in touch with her emotions and was able to make meaning of these events releasing her from shame and guilt around these experiences.” Chloe reported on her Helpful Aspects of Therapy Form that “closing my eyes was a good technique to really feel and see where the pain comes from...” She found the mediative state of the Focusing extremely helpful “going into myself and bringing up things that I was not aware that were still presently an issue for me” and “realising how much these past events continue to be a burden.” In addition, Chloe found my “understanding and restating what had happened was wrong helped my confusion of all the past events” and “feeling the lift of that heaviness... and telling/confronting those people” was also extremely helpful. Unfortunately there was a lot of noise outside our room and Chloe found this hindering. At times, when encouraging Chloe to stand up for herself, I made suggestions in a lightly humorous fashion. Chloe found this somewhat hindering and wrote “I would prefer soft tones to keep me in the meditative state.”

Session 2: 17th August.

Chloe had a “full-on week.” Her step-mother had overdosed and was in hospital. She has a half-brother, 19, and two half-sisters, 17 and 12. Chloe explained that her overweight stepmother had “been taking drugs for years... [she] used to be a nurse... sacked because stealing from drug cabinet... no job since.” Chloe said her father “gets angry for no good reason... takes his frustrations out on the kids and yells at them.” Chloe didn’t have “good” relationship with her father and was often the brunt of his frustration. Cassie, her blond-haired blue-eyed twin was the “golden child,” totally opposite to the dark-haired brown-eyed Chloe and had “emotionally always been the older one.”

Chloe had been unable to contact Steve and was distressed at his not being able to support her at this difficult time. I explored how her need for reassurance may be a

result of not getting acknowledgement as a child. “If [my father] wasn’t yelling... my step-mother was... she’s a bitch... now she’s just messed up... I can understand where she came from... why she did what she did but it still doesn’t change I was affected by it.” Chloe was surprised her twin Cassie managed to avoid being affected. I asked Chloe to reflect on where she noticed all this in her body. She pointed to her chest and I again considered introducing the Experiencing task of Focusing. The PEEFT marker here was that Chloe was overwhelmed by multiple concerns which indicated the “Clearing the Space” task. Having identified a clear felt-sense, she was open to exploring it further. Chloe commented that she had felt very vulnerable when doing the Focusing last week and I reassured her that I would gently guide her at a comfortable pace and depth.

Chloe experienced a great deal of pressure and tension at the back of her neck and the top of her shoulders. She described it as a black moulded amour that would protect her from the onslaught of her family. She recalled as a little girl of about six having to try and “stand tall” in relation to her sister, mother and step-mother. Her twin Cassie was “bigger... looked after me... what she said goes... she was pretty... it was hard to stand next to her.” Chloe felt tension in her left shoulder, which was “where she used to stand... she’d always tell me what to do... she’d make the decisions.” I encouraged Chloe to remember a significant event in relation to her sister. In a child-like voice Chloe described an incident when at 9 her sister did not want to play with her and told her “I wasn’t good enough for them” and stopped protecting her in the playground. Tears fell as she explained, “some boys at school put me up on the monkey bar... I was scared of heights... and pulled my trousers down.” The only way to get off was to fall, and despite not being physically hurt she was frightened and humiliated. She went off by herself and “tried not to cry.” I encouraged her to call on “adult Chloe” and have an internal conversation with those boys and her sister about their behaviour. After some time she took a deep breath and sat up straighter in her chair. The tension in her shoulders shifted, and she smiled.

I then asked her to notice whether the sense of the effect of her critical stepmother was present with her. She recalled she was eight when her half-brother was born. Chloe and Cassie had to do the housework after school so their step-mother could sleep “we had to do everything... change his nappies.” Chloe tried to read her step-

brother's books. "[I] couldn't read or do up my shoelaces and she'd tell me I was stupid... she should've sat me down and taught me." I asked Chloe to talk to her step-mother in the scene she recalled but her step-mother wasn't listening. She "was watching TV," which she did a lot. I invited adult Chloe to enter the scene and explained that it was hard to get attention from a person who was in so much pain and subsequently had nothing to give. "She was always on something... that's why she doesn't listen." Chloe was able to understand that this behaviour from her stepmother was not about it being her fault but she still "feel[s] stupid."

I encouraged Chloe to find that part of herself that knew she was not stupid and to look at her achievements. "It's hidden... under a fear of failure," which blocked access to her confidence. I reiterated that she had achieved a great deal and was a good person. She sat silently and then said, "I know... but I don't believe it." I asked her to have an internal conversation with that fear of failure. She sat silently in what appeared to be deep reflection (processing). When I enquired as to what was happening she replied, "they're listening to me now... I'm having a conversation with them... I'm telling them what I need..." Chloe sat more upright and breathed deeply. The pressure in her head and heart was less. I encouraged her to be assertive about what she needed, knowing she had the confidence to stand up for herself.

Chloe found talking about her step-mother and "bringing up the monkey-bars episode" was extremely helpful. So too was recognising that the fear of failure covered confidence and "knowing" she was not stupid. The meditative state of the Focusing provided a means for her to locate that fear of failure, talk to it and subsequently imagine discussing it with her family. This was also extremely helpful.

Session 3: 24th August.

Chloe was struggling with her school work and "constantly thinking I'm stupid and can't do it." Overwhelmed, she sat silently. "Lot of pressure... screws with my head... frustrates me I can't do things so simple like everyone else can." Chloe was confused and emotional so I again suggested the Focusing task.

Chloe easily identified a sense of great pressure in her chest, it was red with black edges and took up a great space. This tension resonated with the feelings of being stupid. When asked where this had come from, she remembered being four, playing

in the backyard with her brother, twin-sister and cousin. They were teasing her. Chloe was aware of a tightness in her throat, which she identified as anger. Crying and laughing at the same time she whimpered, “they took my Barbie.” Her stepmother didn’t intervene. I was struck by the smallness of Chloe’s voice and I imagined a very tiny girl struggling to be heard. The cousin in the scene was the cousin who’d pressed himself up against her. I encouraged Chloe to assertively “tell him” how she felt about what he did through an internal dialogue with him. Chloe sat for a long time, tears rolling down her face. She was really angry but experienced “blocking out,” being unable to be angry even internally.

I invited Chloe to notice her bodily felt-sense. It had become bright red and she was acutely aware of her anger. Chloe had observed her father’s indiscriminate angry outbursts and recalled her mother’s warning that anger “should be controlled... I get frustrated and angry, then I get confused and don’t know what to do.” There appeared no safe way for her to express this anger. “Feel embarrassed if I let it out... don’t know how to release it so it wouldn’t be out of control.” I suggested an internal dialogue with her stepmother but Chloe became exhausted. I asked her to reconnect with her bodily felt-sense. There was “more red and less black.” The black was “fear.” I enquired if she could “take this red mass surrounded by black outside of yourself.” Chloe replied “it’s stuck! ... it’s hanging onto me...” I explained that both fear and anger are adaptive emotions and that it’s perfectly acceptable and understandable for her to be angry with her stepmother and cousin. However, it seemed that a part of Chloe resisted being angry.

Within the focusing task, I asked Chloe to get in touch with that part that didn’t want to be angry but Chloe found this confusing. I identified a self-interruptive split and introduced the two-chair task. I was somewhat hesitant to suggest this but fortunately Chloe readily accepted the challenge. The energy in the room changed significantly from heavy and oppressive to being recharged and invigorated (a felt-shift). Chloe sat immediately in the chair which interrupted the anger. She readily expressed “you should be a lady and not present yourself as your father does... people will judge you and think that’s who you are and you’ll be like your father... losing control.” She felt a reply and moved to the other chair. “It’s okay to be angry... it’s okay to express your feelings and not bottle them up because it leads to worse

problems... causing disease..." From the other chair, "it's not okay to yell and scream in front of people." We both laughed as she immediately returned to the other chair again "but if you do it in your own time then it's okay."

I explained to Chloe she can appropriately express her anger "but what is that? I don't know how... I get confused about the right way... I've only seen how not to do it." Chloe wanted to learn how to express her anger appropriately

rather than taking it to my room and waiting eight hours after the actual event has occurred or bottling it up... it's a lot better for my health to express anger at the time... and then I won't be like my father.

Chloe explained she would get angry "at the wrong people... should tell the person you're angry at... rather than random people that just come near you." Chloe often found herself confused when she became angry. I suggested she ask questions. In addition, I surmised the confusion occurred as a result of the internal struggle as to whether it was OK to be angry in the first place and/or express that anger. I encouraged Chloe to allow the two aspects to work collaboratively through a series of chair swaps. "We can work together... allow me to express my feelings appropriately... I can see anger is a good thing... seen so many ways where expressing anger has turned to violence and I choose not to do that..."

Chloe returned to her original chair. "Took a while but good to go through that to see what's underneath... seem more connected now..." We discussed the practical aspects of appropriate anger expression. I explained how it was important to take a moment to connect with her bodily felt-sense, allow herself time to ascertain why she was actually angry and if needed take appropriate assertive action. Chloe lamented that she was often angry with herself. I asked her to think about the struggle she was having with her studies. Notice her bodily felt-sense and ask herself what she needed. She could ask herself such questions as "do I need help, do I need a break, do I need to talk to someone about what I need?" I also encouraged Chloe to connect with her part that knows she can do the work, is intelligent and creative. Chloe said at the end of the session she felt "good... less confused."

Chloe reported on the Helpful Aspects of Therapy Form “the conversation between two chairs... debating between my two angers” was extremely helpful as it enabled her to understand how “to be angry appropriately therefore less confusion.”

Session 4: 28th August.

“Last week was a huge rollercoaster” as Steve had not contacted Chloe as arranged. She had “been crying for three hours worried something had happened to him.” He’d been at his cousin’s wedding and didn’t have his mobile phone. Despite being “smashed,” he finally rang three hours later and they talked for some time. However, “he fell asleep on me... I’m so upset... I’m trying to speak and you’re just not there.” Her despair was palpable. Chloe further reflected “[I was] just plummeting... didn’t want to be here... this is really bad. Why am I thinking these things just because he won’t contact me... I haven’t been this bad since I was sixteen” when her boyfriend David had died. “I don’t know why I’m acting this way... want to take my brain out, fix it and put it back in, (*with hand gestures*) like a Rubik’s cube... I don’t know what’s wrong.” Silently, I suspected that Steve’s temporary disappearance had triggered Chloe’s grief over the loss of David and perhaps her father’s departure when she was only three. I explained to her that the work we were doing brought buried issues to the surface and these strong reactions were quite probably connected to her unresolved grief.

I invited her to explore this despair. She replied “yes, but I’m just holding back tears... scared to let it go...” Chloe was concerned that if she left the session with swollen eyes from crying people would wonder “what’s wrong with her.” Chloe only cried “in the shower by myself... at least when I get out you can’t really tell...” When David had died, she cried so much that she would come out of her bedroom each morning “looking like an absolute mess... I just see the faces of my sister and my mum... their despair at not being able to help... even people down the street looking at me...”

Tears welled in Chloe’s eyes and I handed her some tissues. I said “you aren’t alone in your grief.” She responded, “I still feel like that... it’s quite nice that you feel what I’m feeling...” I asked Chloe to return to her bodily felt-sense. She replied, “I’m talking around it... not sure how to let go of it...” I encouraged her to close her eyes

and just notice the sensation. My aims were to gently approach and explore her bodily felt-sense by intending to the processing of her pain rather than promoting a cathartic release, which she did not think was useful. Chloe explained,

crying takes all my energy away and I'm just pathetic for the rest of the day... I cried for a long time when David died... I cried every day for a year and then... I stopped and then (*laughing*) I kissed a boy... I'm afraid if I start to cry I won't stop.

I reassured her I wouldn't let her leave the session feeling overwhelmed.

Chloe closed her eyes and took a few deep breaths. She described a large square black block with red edges across her chest, there since David died and was now evident again since she was parted from Steve. "They both left," she said. Sadness and grief were in the black box with red edges of fear, but there was a "white light in the middle of it... like a diamond." The blackness had a protective quality but also represented "stubbornness." Anger and frustration were also qualities of the black box. Chloe became aware of a struggle between liberating the little white diamond and remaining in the blackness of perceived protection. She felt the little white diamond was "naive... she says it's OK to express your feelings." From last week's session, I was reminded that part of Chloe wanted to express herself freely and openly but was not sure how. "So, this blackness holds you back... holds that naivety in place," I proposed. She nodded. I invited Chloe to again return to her bodily felt-sense. I wondered if the struggle between the desire to freely express herself (the little white diamond) and the need to contain her feelings (the black box) symbolically represented the source of some of her ongoing confusion. She agreed that she wanted to follow her instincts but didn't trust them. Chloe needed acceptance and to feel less confused, to feel safe enough to let go of the black box.

I was aware that I wanted Chloe to "let go" of the black box and so I metaphorically took a step back and reassured her that if she was not ready that was OK. Chloe wanted to let go but there was "too much confusion" and she needed "to understand it's OK to get support from other people... just stubborn." I asked Chloe to return to her felt sense, notice if there were any openings or flaws in the box and

describe what she saw. "It's like a glass cage that the white light... given a chance... break open by itself... the white light is [ready]... the black box isn't..." We identified Chloe's stubbornness as being in the way and I asked her to connect with it. We explored the positive and negative qualities of stubbornness and again Chloe became confused. "Notice the glass case now." Chloe replied, "it starts to open and I close it again... it's like not wanting to let go... afraid of what will happen... that protection I've had... my diamond's quite vulnerable."

I found the symbolism of the diamond had potential significance and proposed to Chloe that despite its small size, her diamond was very tough and resilient. "I think she's stronger than you think." Chloe nodded. Careful again not to push my agenda I reiterated, "I do understand it's difficult... there is a choice in this moment... it's OK either way." Chloe wanted "to release her so much" as she wiped away tears. I enquired if she could call on anyone to help her open the box. Chloe chose the protector Archangel Michael whom she had called on in the past. "I'm afraid to ask him to stay with me because he has other people to look after." I encouraged Chloe to ask for his help and she said "he keeps talking to me and I keep running away... I break it... I keep putting the box back together... don't know how to stop it forming again."

Somewhat creatively I thought of what we know angels to look like and remembered angels' wings were made of feathers. I suggested Chloe place some of Archangel Michael's feathers in her box as protection until she felt ready to put something else there. Do the "feathers do something to the blackness of the box?" I enquired. Chloe sat upright and took a deep breath and said "I broke it." Breathlessly and with great admiration and compassion I said "well done." We both laughed. Chloe remarked "[I can] breathe more easily... energy's still there..." but less of it. I encouraged her to take a few deep breaths and noticed a palpable sense of relief.

Our session had gone overtime but this was a significant and powerful experience for Chloe. Before she opened her eyes, she described a significant vision of seeing "myself crying in the street... still crying by myself but it's OK to cry when you're upset about something." Chloe reported that talking about how counselling brought things to the surface, and subsequently understanding what to expect, was extremely

useful. In addition, “releasing the diamond... feelings of release... understanding I have support from higher beings □ Archangel Michael” was also extremely helpful.

Session 5: 14th September.

It was two weeks since our last session and Chloe looked well despite contracting a virus. Over the past few weeks she had contemplated breaking up with Steve. “Don’t want it to be like this anymore... just want to give up.” I enquired as to whether giving up was something she did. “I run away from everything if it’s too hard... easier to give up.” Interestingly, they had organised to meet in South Africa for a wedding in a few weeks’ time. “We’ve spent more time apart than together...” I suggested that there was something about this guy. She said, “I tend to latch on and don’t let go... I’m looking for another David and I think I’ve found him...” I enquired, “are you worried about losing him?” She agreed she was. Steve had been more forthcoming with expressing his love for Chloe and again she lamented at wanting a normal relationship. In order to have that he would need to;

get a visa and come here... I can’t leave uni because it’s the only thing I’m actually proud of... I don’t want to end up in a dead end job... don’t want to walk around thinking I’m stupid because I don’t have any qualifications... I’ve worked hard... I started there and want their degree... two years to go...

I was aware of a sense of heaviness in my chest and reflected this back to Chloe “so it’s all here.” Despite my remark, Chloe said her inability to eat concerned her most. She had lost weight and was struggling to eat. She would prepare a really appetising meal only to feel full after eating only a small portion. I invited her to get in touch with the “part of her that didn’t want to eat” through a Focusing task and noticing her bodily felt-sense.

Chloe symbolised a protective grey cloud-like area that spanned from her throat right down into her abdomen. She recalled being a teenager looking at the dress and behaviour of people. She wanted to look perfect so her peers wouldn’t pick on her. Body image became very important to her. I asked Chloe to focus on the grey area and

she identified it as something to do with a “sense of control.” Many aspects of her life were out of control. Steve was overseas and she was behind with her studies as a result of being unwell. I encouraged her to find a way to regain control apart from not eating. “I’ve tried so many times but it doesn’t seem to work.” I asked where this feeling of needing to control things came from. She remembered when as little girl her mother and sister “tried to control my life.” When Chloe wanted to go off and be by herself, they’d say, “don’t be stupid.” On another occasion they told her off for “skipping in the mall.” She was twelve. I encouraged “little Chloe” to call on “adult Chloe” to advocate for her and “stand up to them.” Despite finding this challenging, Chloe was able to effectively say what she needed to, stating that it “feels good.”

I encouraged Chloe to connect back to the part that doesn’t want to eat. Chloe spontaneously returned to her teenager memory and the adult Chloe counselled the teenager on better ways to eat and stay healthy. She encouraged her teenager not to pay “so much attention to being a certain way” as there would be “repercussions later.” Chloe recognised that Steve not “being here” was the trigger for not eating. She couldn’t control his coming to Australia and she struggled with “not knowing what’s going to happen” and not knowing “what he says is real...” She doesn’t believe he wants to be with her and loves her. Chloe connected with the idea that she doesn’t deserve love. I encouraged her to find the part that knows “you are lovable.” She located it but it was “very small... hidden... buried” and damaged by ex-boyfriends. This aspect of Chloe was very “weak” and in need of support, healing and nurture. Could she take care and love this aspect and allow it to live within her? Tears welled as Chloe integrated this aspect into her chest, recognising she needed time to heal. I enquired as to the grey cloud and Chloe explained it was “lighter.”

As the session was ending Chloe explained she was not telling Steve the full story about her not eating as she didn’t “want to scare him off.” She also found her limited diet very uninteresting and we discussed how she could find things to eat just to get eating again. “I’ll eat hot chips” she said laughingly and with conviction. Chloe reported that she found the meditative state of the Focusing and “finding the part of me that knows she is loved” extremely helpful. In addition, in relation to her eating disorder, “realising that the part of me was so battered is connected to the anorexia”

and “talking about where the anorexia may have stemmed from” was also extremely helpful.

Session 6: 21st September.

Chloe wore pink. “I needed to wear colour today.” In the past few days Chloe had eaten well and was feeling better about herself but was still “constantly putting myself down.” In her admin job she had a good boss who despite her making a major mistake said “oh okay,” and fixed the problem. She had been expecting the worst and was admonishing herself, saying, “you idiot.” I reassured her that there are some reasonable human beings in the world. “Well yeah, I’m finding that everything around me is really good... I’m realising it was me causing all this crap in my head... it’s a pattern that I’m reinforcing constantly.” I invited her to explore this unless she wanted to work on something else. She said “there’s something I’m getting towards but don’t know exactly what it is.”

This unclear felt-sense was a marker for a Focusing but I enquired a little further if she had a sense of what it might be. After some deliberation she reiterated that she saw this “pattern of... constantly putting myself down.” I said, “part of you knows you are okay and another voice keeps putting you down...” Chloe declared “a fear of failure.” I added “and perhaps a fear of success.” Chloe recognised “going towards that... but pull myself back.” Clearly a split had emerged and I subsequently introduced the Enactment Task of Two Chair work. (At the time I used the language of a self-interruptive split but actually set up the chairs for a conflict split).

After some deliberation the chairs were designated as the two parts of her. Chair one represented the underdeveloped part of Chloe that wanted to be successful and the second chair represented her fears in relation to being successful. Chloe gravitated immediately to the chair that represented her fears. “You can’t be successful because you’ll fail...” Changing to the other chair, “if you don’t get over those fears you won’t get anywhere or do anything.” when Chloe returned to the fearful chair I asked Chloe to get in touch with those fears.

Being successful puts a lot of pressure on you... people look up to you... expect more from you... being not successful don’t have to deal

with all that pressure... you can sit on the sideline and watch the world go by... you don't have to be noticed, smart or intelligent.

Chloe swapped chairs. "I want to be successful... looked up to... I want to be noticed for my intelligence and share my knowledge... puts a good feeling in me... I feel more confident with myself." However, Chloe from the fearful chair recalled that when she didn't know things she became confused and felt stupid. People would "talk about you and... realise that you are stupid." In the lunch room at work some of the staff played a quiz game. Chloe didn't know the square root of four hundred but knew the duodenum was part of the small intestine. I asked her to swap chairs. "I felt fantastic because they looked at me 'she's actually quite intelligent.' I felt confident... I do know stuff." Chloe had also successfully written letters for her boss.

Chloe felt she had missed out on the basics at school and was "the queen" of procrastination. She returned to the fearful chair and realised her procrastination was actually more about "fear of not doing it right." There were days when she just "can't do it... brain is just not working." I asked about times when fear had taken over and confusion had set in. "Sometimes I'll stop and I'll be better the next day... sometimes don't have that option... kind of try to keep going... got to perform." Chloe felt a pressure in her chest and feeling a "bit stuck... I think I'm dyslexic... sometimes I look at numbers, I write them down and they're completely different." I explained that if exposed to extreme stress and/or trauma, children can often find it difficult to learn and subsequently end up with gaps in their knowledge. When the autonomic nervous system is activated preparing the body for fight or flight, cognitive functioning within the frontal lobes is suppressed (Levine & Kline, 2007). Survival is paramount. It was quite possible that Chloe may have a form of dyslexia but in the scope of the counselling work I felt normalising her experience in context with her childhood experiences might be informative.

I asked Chloe to consider useful aspects of fear, some caution being necessary in life. Chloe agreed but struggled to express this to the other side. Again she was "stuck." (In hindsight this stuckness was not only about Chloe's propensity for stuckness but also because I had set up the two-chair task incorrectly as a conflict split and not a self-interruptive split). I encouraged her to sit with the stuckness: "Just allow

it to be there.” Chloe disliked feeling stuck. We worked with this through Focusing. She felt heat in her chest and solar plexus and sensed bright orange red “like anger.” It had been present since she was five. She recalled having trouble writing and “staying in the lines... no one taking any notice of me, so just try to hide it so no one will notice.” Chloe wanted someone to help her but the teacher was too busy. I encouraged her to ask the “adult Chloe” to enter the scene to gently hold “little Chloe’s” hand to assist her to form the letters and teach her how to write. Again Chloe was reminded of not being able to tie her shoelaces. She learnt to do it by watching others. I acknowledged Chloe’s resourceful intelligence and creativity. “Still feel like it’s taken me longer to do things and always trying to catch up to everyone... always the last one... I know I can just need a little extra help... wasn’t given that... now set up a pattern that I constantly need help all the time.”

Chloe felt she wore a persona of intelligence. At high school Chloe “there was this girl who thought I was really smart and was shocked when I couldn’t do something... didn’t do well in my VCE... people expecting me to do well and I didn’t... didn’t have the basics to work from.” No one would have realised Chloe had these gaps in her knowledge because she had become clever at hiding them and not asking for help. Chloe laughed. “I managed to get through school without knowing my times tables.” Again, I highlighted Chloe’s brilliant resourcefulness and her persistence “I want to believe it... but then I just don’t... [need] reassurance from outside.” I reminded her of her success in the lunch room and the excellent letter she had written for her boss. I encouraged Chloe to allow that part that knows she was brilliant and the part that wants to be successful to become aware of each other. She sat quietly searching for those scattered parts but kept “getting blocked by negative feelings.” Chloe sat with her dilemma and then “had a shift... positive affirmation helps negatives reduce.” The session had gone well overtime.

Chloe reported that the Two Chair work and the Focusing were extremely useful. “Focus centring work really enabled me to discover that I negatively prevent myself from moving forward and prevent any good change.” Chloe found the somewhat abrupt end of the session slightly hindering and wished “I could have kept going with moving past the negative aspect of preventing a change during the focusing work. Unfortunately it took me a long time to get there and would have liked to have kept

going.” Chloe did add “I really admired how Melissa dealt with wrapping up the session really well and subtle.”

Session 7: 5th October.

Chloe was exasperated. She had suffered a urinary tract infection, taken a course of antibiotics, got a cold, had been constipated for four days, taken something to alleviate that and ended up with diarrhoea for two days. In addition, the fish for dinner went off, she ran out of protein for her protein shakes and it took over an hour to eat a piece of toast.

What’s going on... left last session so agitated... we ran out of time... so whole time been... constantly aggro... it was aggravation towards myself... self-sabotage... there’s a circular pattern that’s been happening for the last two weeks... I’m kinda stuck...

Excitedly and somewhat challengingly I exclaimed, “good... it’s right there... are you ready to shift out of this?” We both laughed and she moaned, “I’m really over it... maybe I needed those two weeks.” I recognised that Chloe needed to “wrestle” with this internal aspect that was making her life difficult at the moment and contemplated Two Chair work or Focusing. After some deliberation Chloe decided on the Focusing and closed her eyes. I conducted a “clearing the space” and a “full body” scan, asking Chloe to search for sensed areas of pressure and tension in her body in relation to the aggravation she had felt in the last two weeks. She reported tightness in her shoulders, neck and back of her head: a heavy, dull, dark-green, metal brace that had been present since the beginning of secondary school. It was exhausting to carry around due to its weight and acted as a form of protection that supported her.

I asked Chloe to reflect on her bodily felt-sense and to be aware of any thoughts or memories that might arise. Chloe recalled that in primary school she had no friends. However, in high school she had developed a lovely figure with large breasts and a thin waist and subsequently received a lot of attention from the boys. She “didn’t know how to handle” the attention. It was exciting and overwhelming at the same time. Chloe recalled the boys “pulling my bra straps... they used to poke me in the

back so I'd push my boobs in front of me... I didn't understand what was going on... it was just embarrassing." I encouraged "adult Chloe" to explain to "little Chloe" how lecherous young boys can be. Chloe laughed. I encouraged Chloe to revisit this heavy protective mechanism she carried on her shoulders and she became aware there was anger present. She was unable to shift the amour because it was stuck fast with layers of attachment.

I suggested we look at the underneath layers first and work bottom-up. Under the amour was "like a black spongy tar... keeping it all together... anger." Within the black tar and she saw "light flashes of white light underneath... star inside... seems to be in my heart but my heart is contained by the tar" and the amour. I summarised what I understood, "there is this star in your heart, this tar is all around it and then there's this metal-type armour sitting on the top of that... quite heavy... protecting that beautiful star inside." She nodded. "The star is a lot bigger than last time and still in its glass cage but it's a glass cage that can be opened."

Upon contemplation, Chloe felt the tar represented her "anger with myself causing myself to sabotage and create a negative aspect of everything... towards my mother... a little for my dad... towards my cousin." I asked Chloe to bring each person into her inner world and find a way to express her anger towards each one in turn. Chloe's cousin appeared first and tears welled in her eyes. I explained that anger and sadness can often co-exist. After a somewhat long silent process, she reported the anger dissipated. Chloe then recalled how her mother hadn't protected her. As an adult, Chloe had made futile attempts to talk to her mother who only became defensive and dismissive. I suspected Chloe was struggling, and suggested that maybe she just needed to ask her mother to listen. Chloe agreed and was able to more comfortably express herself in her internal world. Tears welled and after some time Chloe said, "she's listening."

Chloe shifted her attention to her father. "I don't even want to deal with him; he's just an idiot... I'm so angry because he's such a fool, such a disappointment." Initially, Chloe said "lots to talk about" but it wasn't too long and she found she was "not getting anywhere... I'm blocking myself..." I encouraged Chloe to "just notice the block... [and] don't give up." Chloe did feel like giving up and I suggested she locate the white star and connect with that. Chloe stated "that protection I created for myself

was there because no one else protected me... especially not my mum... expected dad to look after us... he was always with some woman.” I noticed confusion on Chloe’s face and asked her to sit with these realisations, asking “adult Chloe” to explain to little Chloe that marriages sometimes fail. I also realised that “little Chloe” was still feeling unprotected and asked “adult Chloe” to “bring little Chloe into you” to support, protect and nurture her. Instantly, little Chloe was “in the arms of adult Chloe.”

Chloe became aware that she could protect herself now but “sabotage still comes back... it doesn’t have a form... out of control... just jumps everywhere... try to catch it... like a little ball that’s hard to catch.” Sabotage kept interfering with her ability to look after herself. “I don’t want to work with it I want to get rid of it” said Chloe. Jestingly, I said “it’s as stubborn as you are... you created it.” She laughed and said “there is an orange case... I keep putting it inside and it keeps getting out... it’s like an ADHD kid that’s running around without control. It needs something to stop it and slow it down to prevent it from interfering all the time.” I questioned whether accepting its presence was possible. “It seems that it feeds on the agitation that I get...” Chloe said she needed to pay attention, talk to it and listen to what it needed in that moment. It had “settled down... not going into its box” laughed Chloe. Humorously, I said “it might just have to be a free radical for a while.”

Mindful of the time, I reminded of Chloe about the unfinished business with her father. She sat quietly and began to realise the dynamics of why her mother left him and recognised his devastation at being left. “He lost everything... and he didn’t deal with it... pushed it to the side... agitated a lot... stepmother was awful...” Chloe spent some time in an internal dialogue with her father and then said “I want to take that anger and give it back to him because I had taken on his anger.” Symbolically, Chloe relinquished the anger, the black tar shifted and Chloe sat upright, stretched her shoulders and took a couple of deep breaths.

Chloe said there was a “little bit left... that anger with myself... allowed myself get to this stage.” I noticed that Chloe was harder on herself than she was on anyone else and proposed acceptance as an antidote. However, Chloe saw this chastising of herself as “what gets me going.” I suggested she reframe this anger towards herself as drive and motivation. Chloe was experiencing ongoing shifts and the session was drawing

to a close but she determinedly was eager to rid herself of any remnants of the black tar of suppressed anger. Chloe was aware that most had shifted but some unidentified anger was left. Chloe was able to identify the last remnants as “stubbornness.” I asked her to reframe this trait as “determination.” She found that useful and said “I’m determined to do well at school... determined to get healthy but... am I worthy...” I acknowledged that getting in touch with this level was important and asked her to reflect on her white star and the knowledge of her worthiness. She sat quietly for a moment as she visualised the last of the amour dissolving away. She immediately opened her eyes, said ‘that’s great,’ spontaneously jumped up out of her seat and joyfully hugged me.

Chloe reported that working with the self-sabotage and anger was extremely useful. In addition, having internal conversations with the people that were connected to her anger, realising the underlying causes of the self-sabotage and finally removing the amour were also extremely helpful events.

Session 8: 26th October.

Chloe spent two weeks in South Africa to attend a friend’s wedding and see Steve. She enjoyed seeing the animals in the game reserves but found the racism confronting. She had been really unwell as finding food with no wheat or dairy was difficult. Subsequently, she felt ill. As she recalled these events she cried “hard to be sick... I was so ill for two weeks... it was the only two weeks I was going to see him.” She hadn’t wanted to come across as “a sook but I was really clingy... I had missed him so much... emotions were going insane...” Steve would take control of things and “constantly making sure I do things... he’s such a perfectionist... he has control of what’s happening between us... I’m waiting for him to come over here... I have no control over that.” Steve asked Chloe to trust him but “I don’t trust anyone.” The plan was that at the end of the year Steve, 32, would come to Australia for two years whilst Chloe completed her studies and then they would return to the UK. “He needs to come here to see if it works... I don’t want to see if it works. I want it to work.”

I stated that it felt like there was a lot going on for Chloe to which she responded, “don’t know how to deal with it really.” Again this sense of being overwhelmed is a marker for Focusing. However, Chloe chatted on. She continued to question her

relationship with Steve. "I was wondering, am I expecting too much... am I wanting a David type of person in Steve... or am I settling for second best... but I adore him so much... trying to push him away at the same time." I was also aware that Chloe "the woman" was reduced to Chloe the "little girl" because she was so unwell. Chloe cried "[I'm a] bit over it." I encouraged her to close her eyes and I set up the Focusing task.

Chloe felt pressure and tension in her back, shoulders, neck and head. The pressure appeared like a tarnished black amour weighing her down with grey underneath. Upon reflection Chloe identified that this pressure was "constant thoughts in my head." Some thoughts had been ingrained by her mother and others had been generated by Chloe herself. Chloe explained that she was "disappointed with how I acted in the last two weeks." I explained that under the circumstances it wasn't surprising that she had struggled. Travel, different food, reconnecting with Steve, being confronted with racism are all anxiety provoking events. It appeared these additional stressors affected the highly sensitive Chloe physically. Tears fell. This made sense to Chloe but she felt as though she should have acted differently. Chloe would have liked to pay "more attention to him... and satisfied with the attention that I was getting... just be happy where I was with him rather than worried about the future."

I asked Chloe to refocus on her body. The black had shifted but the grey now presented itself. The heaviness had lifted somewhat but she was left with the unrealistic expectations of herself. I asked Chloe to focus on the greyness. Chloe was again reminded that Steve might be her "second best..." but was also aware that "the way I act pushes him away and I may lose him." This tapped into her separation anxiety following her father's departure and David's death. I reminded Chloe that she deserved a good life and relationship. She located her sense of deservingness as buried deep in the "diamond" located in its glass cage within the greyness. "I know I deserve happiness but negative thoughts come in saying I don't." Chloe recalled her parents' relationships. "I've learnt from seeing... they had had such horrible relationships filled with anger that I get a sense that mine must be like that." I encouraged Chloe to make a choice in that moment that she didn't want a relationship like that. Chloe said, "I'm seeing patterns." Her parents had got married because her mother was pregnant at 16. "They didn't really know each other." Chloe was concerned that even though she and

Steve had been together for many years they didn't really know each other either. I asked her to get a deep sense within her whether she felt she really knew Steve. "I think I do," she replied. I reminded her that she had a great deal more life experience, more maturity and more awareness than her parents. Excitedly she said, "[I] didn't see that."

Chloe explained that the "black tar is covering the positive side of things... so much negativity... just black covering everything." I asked her to find a way to lift off that blanket of negativity to expose the "jewels" underneath. Chloe was able to visualise the blackness lifting. She sat straighter in her chair and felt "much lighter." The diamond kept going back in her glass cage and Chloe searched for other ways to protect herself by surrounding herself with love and calling on angels. The grey pressure in her chest was still present but Chloe described it as more like sticky grey fairy-floss. Chloe needed love and support from those around her to turn the grey into fairy-floss "pink." I asked her to imagine sunshine beaming from outside within and from within outwards. The grey dissolved. Chloe said she still felt a pressure in her head as a result of negative thoughts from others. We discussed ways in which she could manage this.

In her Helpful Aspects of Therapy Form, Chloe stated being reassured that how she felt was OK was helpful. "I was thinking that everything I was feeling and thinking was not normal. It was very helpful and reassuring to get an outside opinion to why I was thinking and feeling the way that I was." In addition, the focusing allowed Chloe to be "grounded and concentrate on the session more and identify what was really going on." She also liked being able to "offload" at the beginning of the session.

Session 9: 16th November.

Chloe looked cheerful despite feeling distressed about her two exams. She again mentioned her struggle with study and understanding basic concepts together with her ongoing battle as "queen of procrastination." Chloe complained that her sensitivity rendered her open to external influences. I explained that as a "highly sensitive person" (see Aron, 1998) she becomes easily overstimulated and needs to respect her sensitive nature by taking "time-out" to nurture herself.

Again Chloe's main concern was Steve and his controlling behaviour. "I start off thinking that I can change that... but can't expect him to completely change... I'm the one letting him take control." Steve was expected to arrive for a two week holiday in February and find work and organise a visa. "Otherwise we'll get married... I want him to ask me rather than having to do it... because that's the one thing I'm hanging onto is 'will you marry me... I want you...' sometimes I don't feel wanted by him." Chloe "forget[s] that he does love me and I indulge in the 'no I'm not wanted...'" Despite there being no marker present, I decided to introduce a Focusing task with the intent of directing Chloe's process to a more internal focus.

I formally "cleared the space" and conducted a "full body" scan. Chloe identified pressure and tension on the left-hand side of her neck and shoulder. A heavy grey cloud symbolised the pressure in that area that had become present during the relationship with Steve. "I'm waiting for him" and felt sad and alone. "[I'm] waiting for him to come and rescue me..." I added "like a knight in shining armour on a white horse... get on bended knee and propose to you and be with you forever and ever... every little girl's dream." Chloe nodded and we both laughed.

I asked Chloe to sit in her "dream" and from there notice "reality." She said "I'm sad... lots of confusion and anxiety... gloomy... she's just waiting until things get better." Chloe identified that reality was in her head and her dream was in her heart. "The fantasy pulls me out of the gloom." I explained that a dream or fantasy world was important, but the occasional "reality check" was also needed. A conflict split had emerged and I asked Chloe whether she would like to work with the Two Chairs. She readily agreed and as soon as I put the chairs in place she jumped into the chair that represented her dream world. "I love fantasyland... my life has always been about fantasy" and it was easy for her to connect with it. I asked her to explain to "gloomy reality" why her "fantasyland" was so important to her. "Important to get away from things... to think of other things rather than doom-and-gloom... I don't know whether that's the right thing to do... I'm nearly 27." I encouraged Chloe to have her fantasyland. "It creates hope... and it's somewhere I can escape and think that things are OK... but it doesn't feel like reality." Chloe swapped chairs.

"Gloomy reality" responded. "It's not reality and it's just thoughts and they may not come true... just fantasy... not real." Chloe paused and laughingly returned to the

fantasyland chair like an excited child. Giggling and almost swinging her legs “it’s fun being in fantasyland.” Solemnly, Chloe swapped “it’s better to be in reality than escape to a world that might end up being a disappointment.” I explained that the role of reality was to provide a crucial “reality check” that often promoted safety considerations. Chloe was surprised by this. “I thought it that it was just negative!” She was reminded of her recent trip to South Africa and the need to be more watchful than here in Australia. She said of reality, “it creates awareness, protects you from going too far and grounds you back... it can still have hope but brings you down to the ground.” Returning to the “fantasyland” chair Chloe begrudgingly acknowledged “reality.” Animatedly,

fantasyland is just the ultimate high and coming from the gloom to fantasyland gives me a massive smile... I’ve joked to my friends about the knight in shining armour and Bridget Jones and Mr Darcy... it gives me hope... allows me to think positively but I do understand what you’re saying that does bring me down to earth because life does have things go up and down and not everything is always perfect... it’s just the happiness that I want from reality but just can’t get there until... I’m actually fantasising actually... but sometimes I get stuck there.

Chloe had long recognised that the transition between fantasyland and stark reality can be a rude awakening and it was possible to get “stuck... It’s one extreme or the other... no in between.” I wondered whether procrastination was connected to fantasyland and she agreed. Chloe only saw reality as a picture of “doom, gloom and negativity whereas over here it’s a lot more positive and I feel a lot more alive...” It appeared to me that reality had to let go of some of the doom-and-gloom as there could be no point residing there if that was all it had to offer. If Chloe was to get on and do things she ideally didn’t want to be held back by the procrastination that resided in fantasyland.

Chloe acknowledged that despite feeling a lot better on the side of fantasyland “it’s coming together and I can think those things and bring myself back down to reality...”

so it's not always going to be perfect." I encouraged Chloe to swap. When she sat in the reality chair she described a pressure in her head on the left side. I ask her to focus on that and moved my chair to sit opposite her. Chloe described this pressure as "anger at being alone." Chloe had experienced being alone most of her childhood. She craved support and people around her. She'd had no friends in primary school and had retreated to her fantasyland and imaginary friends for comfort. I encouraged adult Chloe to explain to little Chloe that she would look after her now but there was more. She wanted to be wanted.

Chloe called on Archangel Michael to assist her to remove the sensed black pressure that was present in her head. I was curious that she always called on only one angel and said, "it's like you want one and only one just for you." Chloe agreed "like Steve... I can just have him and that's it... I don't need anyone else." I encouraged Chloe to find multiple sources of support. Her head felt a lot lighter. I encouraged her to create a bridge between reality and fantasyland. Easily and spontaneously Chloe created the bridge and could move between the two internally. I enquired what reality felt like and her stomach gurgled almost as a reminder that her body was also located in reality. I asked her to be aware of the two domains and notice how integrated or separate they might be as she traversed through her daily life. Chloe noticed negative thoughts returning and as the session time was up I asked her to allow herself to reconnect with her internal white diamond and bask in its light. "Feels good" she said. Chloe reported on her Helpful Aspects of Therapy Form that she wasn't suicidal anymore, and that "discovering it's OK to have both fantasy and reality joined" and using the Two Chairs was extremely helpful.

Session 10: 23rd November.

Chloe was again late but looked really well. All her friends were getting married and she felt she was "waiting around like a loser." She challenged Steve: "Are you leading me on?" Fortunately, he sent a lovely text message stating that in the past he didn't know how he felt but now he knows he loves and really wants her. Tears welled in her eyes. "Everyone's together except us... I'm just waiting for him all the time." Chloe was concerned that he was not being realistic about his trip in February. "He thinks he's coming here... he's so positive about it all... like it's going to happen... look for a

job, get a job and get sponsored in two weeks! He says 'you're being too negative...' I'm just in reality."

Chloe lamented that their whole relationship was based on waiting for his calls or messages and now she waited for him to come to Australia. "Shouldn't all be about Steve... if he sends me a message I stare at it for ages... I keep as many of them as I can on my phone... I stew on them... life kind of revolves around that." I was aware how disempowering the waiting was and asked whether she could get on with her life despite the waiting. Chloe had spent four years waiting and was uncertain how to reclaim her life. She was still stuck living at home, studies had completed for the year, and her admin job was boring. She wanted to hang out with her friends but all her close friends were overseas and she didn't know the new ones well enough yet. She wanted to move out of home but had no money and a thought of going over to see Steve was dismissed as too expensive. She was aware that the logical part of herself "makes sense a lot" but the emotional part "is just insane... I don't know what I want." Chloe's energy was quite scattered and I decided that a formal clearing the space and a focusing may assist her to be more grounded in her body.

Chloe closed her eyes and I formally facilitated the clearing the space process and the body scan. A pressure resided in the back of her head and shoulders like a grey heavy weight. Tears fell. "I want to be needed... to be loved." I enquired as to how she noticed that in her body and whether "to be loved" was something she had been waiting for. It was, but she hadn't realised that. She symbolically saw an old wooden gate covered in barbed-wire that kept people out. She could open it but didn't want to. In the past when she had opened it she'd got hurt. "Even with friends now I don't trust them... they let me down... Steve's the only one who hasn't, and even he lets me down sometimes." Steve responded to her in a way that reassured, supported and respected her. "I look to Steve for all those things now... it seems too much to ask for." I encouraged her to call on the adult part of herself to reassure her inner child. "[I do] sometimes but still comes back." I asked to see the little girl waiting and wanting to be loved and needed. Chloe connected with various little Chloes but when asked to reassure them, "how can I say it if I don't believe it myself... resisting... everything is blocked."

Chloe was suspended in “waiting to be loved and reassured” as if it needed to come from the outside. “I thought friends were supposed to do that, but I’ve never met anyone I could completely put my trust in.” I suggested she might consider whether she could perhaps be a good friend to herself “be your own best friend... be good to yourself.” She giggled at the thought but questioned how. I asked her to search within for the answer to that question. She described a rock-like crystal in her chest and a vision of her seeking out social contact but no one there. “I’ve sort of stopped growing in a way... being on my own just not being with other people... I’m still stuck at home at 26.” I reminded Chloe that she had made choices about some aspects of her life. She had travelled, lived overseas and began her studies later. In addition, I explained that as human beings we often are confronted with the dilemma of a desire to be connected with others but can find that daunting and subsequently retreat into a desire of wanting to be on our own. We explored Chloe’s expectations of others, the predicament of having our needs met by them and the often experienced mismatch with what people are actually prepared to give. I asked Chloe to focus on her inner crystal behind the gate and she saw people there but couldn’t touch them. “I can easily open it... once I open it and start talking to them and trusting them to listen and they don’t...” I explained that it was not the job of our friends to meet all our needs and we need to seek out other multiple resources to fulfil our lives. “So stuck in old patterns... I keep going back to them if something doesn’t work... but (*laughingly*) the old patterns don’t work either.”

I suggested Chloe open the gate and experience that. “[I] need to accept that I can’t go to one place for all the answers for everything.” The idea of a one-stop-shop was very appealing to Chloe, but she recognised, not realistic. I encouraged her to observe others and determine what she can safely ask from them. I also asked her to get in touch with activities that expanded her and made her “heart sing” so she could navigate this rather uninteresting period of her life. She declared she felt a “lot better.” In addition, I challenged Chloe to determine whether she wanted “waiting” to dominate her life or reclaim her life by taking responsibility and making enthusiastic choices of how to live it. I was surprised at my directive “coaching” positive psychology approach and wondered how Chloe had responded. She acknowledged that her rebellious side had emerged in opposition but taken as a whole said “it’s all

good.” Chloe stretched her neck and shoulders and breathed deeply. I explained that this transition period was difficult.

Chloe reported the focusing was extremely helpful because it enabled her to become aware that “a lot of the problems were caused by me not letting others in or trusting them and that it is not others’ responsibilities to fulfil my needs.” Chloe also recognised she needed “to be kind to myself and take charge of my life with different activities rather than spending all my time waiting for others.”

Session 11: 30th November.

Chloe failed her biochemistry exam by three marks and had to sit a supplementary exam. She was baffled that she had not passed as she had never failed an exam before. “I feel stupid.” In addition, she had renewed a friendship with a girl from primary school. Interestingly, this girl was really different “ just not me... she’s adorable... don’t think I can handle hanging out with her friends... why am I so judgmental?” Chloe was surprised at herself. I explained that as children we recognised differences in others but it’s the judgments about the differences that are socially implanted and subsequently expressed through our parents.

As Chloe grew up she “did a lot of drugs... I look and judge them... I have no right to do that... I’m not perfect... really disappointed with myself.” I suggested that her new awareness was an opportunity to reconsider aspects about herself and make choices about how she wants to view others. But Chloe continued to admonish herself. “I keep going to the same thing... I wake up and I’m depressed... have no idea why... keep going over things... feel a bit stuck... I stress out about things I shouldn’t.” Chloe did see some shifts in her thinking: “Starting to understand where they’re coming from and what’s triggering it... talk to myself out of getting stressed or freaked out... slow process.” When she found that she had failed the exam she didn’t want to tell anyone “but I had to cancel six things this weekend and so I had to tell them... but my stomach started cramping, went to the toilet about three times... the IBS goes spastic...” Chloe recalled that over the past few weeks she had been “eating better, haven’t been so stressed... maybe if I calm down... my stomach will steel down by itself.”

In the past (before counselling) the distress may have lasted two days but she noticed the strong feelings of sadness and anger only lasted the morning. I encouraged Chloe to acknowledge her progress and to recognise that change often involves a period of transition whilst old patterns of behaviour are replaced with new more functional ones. I also reminded her that life was not a series of happy days but often involved experiencing the full gamut of all emotions. Depression also has an adaptive function in which it bids us to stop, think, take stock and choose a strategy for action. It becomes problematic if the state lingers and/or attempted strategies are thwarted or fail leaving the person feeling despondent. The best way to manage fluctuation in mood is to become aware and pay attention to what you need. "It's so simple... yet I don't do those things," Chloe said. She was concerned about how to study for the supplementary exam and we briefly brainstormed a few ideas. This solution-focused strategy is considered out-of-mode in terms of the PEEFT model.

In an attempt to calm Chloe's overwhelmed state I suggested a focusing task. Following the clearing of the space and full body scan, Chloe identified pressure in her head, neck and chest. A dark grey cloud surrounded her head and neck area and a thick black-brown tar encapsulated her heart. She also noticed a mesh covering her heart and brain. "Disappointment at my brain" came to Chloe's mind as she focused on the tension within her. Chloe also noticed blockages between her head and heart. The thick toffee-like tar and the mesh represented the disappointment and expectations from her father and stepmother. Rather than speaking to them she wanted to "speak to myself." I suggested that conversation could involve reassuring herself that she was intelligent, capable and knowledgeable. But "I don't believe all that stuff... I don't believe in myself."

Chloe's antidote was to think more positively by recognising her achievements. I also suggested she remove the mesh symbolically. In line with Chloe's beliefs, I asked her how she might remove the black-brown tar and the mesh that surrounded her heart and brain. She chose Jesus and Archangel Michael to assist her and sat for a long time processing her inner experience. Finally, Chloe said she understood that "the disappointment is the disappointment at myself and life and if I let go and speak to people the disappointment will subside." Interaction with people could offer her a frame of reference that could assist her to drop unrealistic expectations of herself and

others. Chloe sat for a long time deeply immersed within her inner world but nodded when she felt the process was complete. Tension had lifted somewhat in her chest area and she saw a lovely pink heart. However, Chloe was still aware of a tension in her neck that represented a “fear of failure.” By recognising these blockages, processing her experience within her inner world, Chloe was able to “unblock” these pressures and allow energetic movement between these areas. I suggested she radiate herself with golden-white light to assist the process. Chloe felt a sadness and said it’s “hard to fit into a normal world when you’re not normal... see other things.” Chloe’s spiritual experiences had contributed to her sense of isolation as it was a part of herself she often hid. Her sadness was related to how to manage knowing and seeing what she knows and sees and who to trust with such revelations. Dealing with the subsequent judgments from others was also difficult.

Chloe reported that “talking/venting what had been going on in the last week... realising I was slowly improving and utilising the information received from the sessions... focusing seeing the blockages between the heart and the brain” had been extremely useful.

Session 12: 7th December.

On the tram, Chloe ran into an old high school friend. He was still with his high school sweetheart, was now an engineer, bought a car, a house, has his own business, and owned a dog. Chloe questioned what she had done in the past ten years. She acknowledged that she had travelled but lamented that now with no money she was living with her mum. “I failed the exam again... got there and couldn’t remember anything... been running away from everyone... set me back two years...” Chloe’s distress was palpable. “I know what I want but I’m stuck... I realise I’ve been running away from things for a very, very long time... still waiting...”

Chloe explained that she was “not feeling very good... at the same time I know I’m really smart... I try hard and I just don’t get the results and I don’t know what I’m doing wrong... I’m going backwards.” A friend pulled out of the course. “Maybe I’m reaching too high... not going to be one of those fantastic naturopaths that know everything... I’m too lazy... if there was someone I was treating I would put in 110% but maybe not get it right...” I was curious to observe this self-limiting way of being

only to discover that Chloe had not yet received her result from the resat exam. A conflict split was evident here and I offered Two Chair work or a focusing. Chloe gravitated to the idea of a focusing but I felt an enactment might actually be more useful. So I suggested we start with the Two Chairs but utilise the focusing strategies as required.

One chair represented the aspect that “can’t be bothered” and the other represented the aspiration of “being a good naturopath.” Chloe immediately gravitated to the side that “can’t be bothered.” Chloe “tries so hard... don’t get anywhere... never going to get there... not great sitting here with this feeling... if you don’t try you don’t end up with the hurt and disappointment and the knowledge that you are stupid.” I encouraged Chloe to really get a sense of “you can’t do it.” She noticed tension in her throat and heart. I passed her some tissues. She felt anger and disappointment with “myself... my brain just can’t remember things... I sat the exam... they changed it a bit but it screwed with me because I couldn’t get past the fact I’d failed in the first place...” Chloe was aware that being a naturopath was a responsible profession and was concerned that her lack of knowledge may inadvertently cause her to harm her clients. Chloe feared she may get it wrong “so much riding on it... it’s about helping people... I want to help them not make it worse.” When Chloe was younger she was “getting it wrong a lot... only in last couple of years figured out what is right and wrong from my own point of view” and not the view introjected by her parents. I noticed a momentary shift and asked Chloe to comment on the dream of being a good naturopath. “Sometimes it feels like a fantasy.” Once in that chair she said, “it’s a goal I really want to achieve to prove to myself I can do things... I’ve got this far... I’m worth something... I’ve done something with my life because I’ve got a career... I’ve got the answers rather than saying ‘I don’t know...’ I can’t do that anymore I’m going to be 27 next week... too old to say ‘I don’t know’ I’m not a kid anymore.” Having this dream was important to Chloe as it gave her confidence.

However, Chloe swapped chairs “what do you expect next year... more failure, more hurt... if you give up now you’ll give up all that... you don’t know any of your muscles... anatomy, physiology well enough to continue.” Chloe however, declared, “I’m not at that point where I’m going to give up” and swapped back. “No, I don’t

want to give up right now... you'll be stuck in that boring job... I can't do that for the rest of my life... because I'll feel more like a failure... and I'll be even more depressed." Chloe was surprised that she actually felt more confident when sitting in this chair. She felt expanded in her heart and some excitement in her solar plexus. But "I still keep wanting to go back there... I go so far and then go back because I just think 'what's the point... I'm a failure.'" She moved back into the deflated chair. Chloe was "scared" by the responsibility and again by "the fear of failure" but saw "a glimpse of happiness" on the other side. As she moved chairs she acknowledged some happiness and a desire to be there. But in spite of this the fear of being "back there again" quickly remerged. I said, "it feels like that's always the ending," pointing to the despondent chair. She agreed and found herself sitting in the "can't be bothered" chair yet again. I wondered if she was jealous of her more confident self. "Absolutely, I look at other people... I want to be that." My sense was this argument between these two aspects was deeply entrenched and despite my efforts to establish a dialogue and a natural softening between them, I was struggling.

The despondent side openly admired the confident side. I asked if the confident side I was quite scathing of its counterpart. Chloe agreed that the confident "side doesn't like this side and I'm quite jealous of that side... I'm so stupid... why should I stay in this side doesn't make sense... there's no positivity over here." I hypothesised that the withdrawing tactics might have been useful for the sensitive Chloe as she grew up. After much deliberation Chloe declared, "I needed to say 'I don't know,' to play the ignorant card a lot because it helped to keep me going... stopped me from getting talked at... putting more stress on me when you don't really know... could just avoid..." Chloe "was just scared of those responsibilities... if I was wrong..." the consequences were dire. I asked her to return to the confident chair and asked whether she had heard what had been said. She acknowledged that she had "but..." I suggested she hold the "but" as that was somehow interfering with each side being truly heard. "I get the 'but' straight away... hard to get in my head though." Using this technique we had managed to get a representation of how Chloe's mind worked.

I asked Chloe to take a compassionate stance towards her despondent side but she was she said, "I don't want it." I decided to propose a renaming of these aspects of herself. The despondent side held the more "female" attributes of sensitivity,

compassion and acceptance whilst the confident side held the more “male” attributes of strength, power and confidence. I explained that we needed the positive attributes of both aspects and I believe this finally made sense to Chloe. “There is just more understanding about why that’s there... (*pointing to the despondent chair*), very confusing being in that position...” I asked Chloe to symbolically remove the dark grey blanket of depression shrouding the other chair. When she then sat in that chair she declared it “doesn’t feel as black.” She continued, “I want to get in touch with your qualities because you drive us... but I’m important too because I hold compassion... just can’t keep going full force without having me there.” From the confident chair:

I’ll give you the confidence and happiness to move forward and [we can] use compassion together to help people... shouldn’t be so harsh on each other... I know I’ve been doing that for a while and you’ve let me do it, so I kind of took over so I’ll try to meet in the middle... I want what you’ve got... you don’t have to be fantasy, you can be real.

I wanted to applaud and welcomed Chloe back to her original chair. “Oh, that feels a lot better... I’m happy we chose to do it that way,” she said. Utilising the Two Chairs was certainly challenging but as a result of this somewhat elaborate enactment she had found resolution. Spontaneously, Chloe declared, “I don’t feel so bad about that part anymore.” I invited Chloe to attend another session if she wished but for various reasons this did not eventuate.

On her Helpful Aspects of Therapy Form, Chloe reported that “talking between two chairs of male and female parts of myself” was extremely useful. She described her male aspect as “practical strong, [and] passionate” and her female aspect as “compassionate, but dwells on things too long” suffering depression and fear. “Understanding that both are important to have and to work together” was also extremely helpful.

Appendix S • Clients' Analyses of Change as Identified and Reported in the Change Interviews

Sarah's Change Interviews.

Sarah liked that the sessions were weekly. She reported that after four sessions she was enjoying life more and noticed her thinking was different despite not much behaviour change. "If I go and eat a whole lot of food I don't put myself down about it..." She attributed these changes to the therapy "...because it helps to identify... the feeling around the situation or... kind of find a strategy I can use to change it, to find out more about it." Sarah explained that the techniques helped "...bring up those emotions..." and that talking about what's going on for her worked well. She appreciated that I was willing to work creatively and collaboratively with her rather than be prescriptive about what interventions I used and attributed my genuine interest in her as important in assisting her to open up.

Sarah reported that she "enjoyed" therapy because she left sessions feeling happier and by session 8, she was feeling more confident, less self-conscious and less judgmental and socially she was managing better. A significant change for Sarah was that she was feeling more relaxed and connected with her body. She was learning to trust her body as a source of information that was potentially useful for her. Sarah attributed these changes to therapy as "the main source... but also my dancing has helped a lot as well..." The experience of using current day events to connect to past events particularly appealed to Sarah "...because it makes you realise how things relate and gives you more relevance for how you are feeling now..." At the second Change Interview, Sarah reiterated the benefits of conversing with me and the specific interventions. "...just create the space and find the feeling I think that's really useful and having a conversation... between all the different parts or different people... me just like talking to myself as a younger person was useful..."

Sarah had made considerable progress by the end of our 12 sessions together. She reported that she had "...a better understanding of what is going on..." her interactions with people had improved and she'd been a lot more positive in her view of relationships and life in general. She liked the idea of listening to her body that the

focusing task had fostered and the two-chair work had espoused. The movement towards integrating head and body resulted in better eating management for Sarah. She attributed this to therapy. Sarah also made an interesting evaluation that the work had a cumulative effect that it was difficult to isolate single events that had contributed to the changes. It just “clicked” for her. She said “...I think was the accumulative effect of the therapy techniques, the therapy techniques worked well for me, they just did... because you didn’t have the therapist telling you what to do... you had to figure it out yourself...”

Whilst Sarah found aspects of the therapy a bit painful it was her decision about what was she discussed and “...you don’t talk about things like that often so it’s nice to get them off your chest...” Outside therapy her mother’s cancer and subsequent treatment was a compounding factor to our work together as she was often reluctant to work directly with issues in relation to her mother directly. Despite this she did experience some improvement in the relationship with her mother. Sarah’s dancing classes had been a highlight for her and interestingly she said “...therapy has helped with that as well...” *The therapy had changed her life.*

One month after our twelfth session Sarah reported that she was happy, relaxed and feeling beautiful and had amazingly experienced painless sex. During the following six months Sarah however, experienced a minor relapse, which she attributed to a number of contextual issues; her two-month holiday romance broke down, triggering temporary disordered eating and grief reactions, she had become estranged from her friends after being away over the summer and she was still looking for appropriate work. Despite the setback she acknowledged that life was stressful at that time and she had improved overall as a result of therapy. Things improved considerably for Sarah in the following six months and despite having landed her dream job, living interstate and enjoying a more fulfilling work-life, she realistically recognised that life itself could be challenging.

Katie’s Change Interviews.

Katie identified that she had been sceptical about the counselling at first but the sessions had been something “really different” from other treatments she had experienced in the past. The therapy “has challenged me to think about it in different

aspects...” Talking openly was very helpful but challenging to hear some of her illogical thoughts said out loud. “It is good to know that somebody else holds my thoughts... it is like I am taking them out of me and sharing them...”

The working alliance was important to her. Katie felt accepted and understood. “Melissa makes me feel like it is alright to be where I am at and she lets me know that I am doing the best that I can...” She valued the time devoted to her where she could say what she liked and nobody to judge her. Katie found my positive attitude encouraging. “I have never had that in therapy; it’s kind of been like my link with God...” She described the experience of therapy “very comforting and the reassurance of somebody saying you’re worth it and your fine and your okay like you’re a good person or something, that’s all you want to hear...”

Katie found that the two-chair work “opened up my awareness” and helped her to understand the dynamic between her mind and body. “My brain was completely controlling my body and not allowing my body to get better... I feel like my body was in a prison... I have never really understood my thought process... I just never looked at it that way...” The focusing task had also been useful “visualising what feeling I get when I am anxious... [what it] looks like... the texture of it and that sort of thing... going back to my childhood, where I was, I didn’t realise that it completely stemmed from it...”

Katie described herself after the eighth session as “more positive... a bit more happy... instead of feeling guilty about things... more clear-headed... which is really exciting... I just think it has helped me, heaps... something that I didn’t expect.” She attributed these changes to therapy. After the twelfth session Katie said “I’ve just had so many turnarounds during the whole thing... haven’t ever progressed this far to be able to reveal this much of myself with anyone else... it’s continuing to improve... feeling more positive and better about things... more secure.”

At the six-month follow up interview Katie said “since therapy I feel I can get over my anxiety a lot quicker... I can think more logically about things,” and “[I’m] definitely more independent... a lot more alive with people and can organise myself a lot better...” and her relationship with her parents had improved. She had been more able to stand up to people and had severed her relationship with her boyfriend.

Ava's Change Interviews.

Despite finding therapy “emotional” Ava found it enjoyable to talk things out. She had been able to apply some of the techniques within the focusing at home to calm herself if stressed. She attributed therapy to feeling less anxious and noticed she was not so concerned about how people viewed her. Ava began to acknowledge that it was okay for her to have feelings and didn't need to chastise herself because she felt a certain way.

Interestingly, in her first Change Interview, Ava presented a paradox. She explained that most of the work was focussed on the here-and-now and that she would have liked to work with the deeper underlying issues. However, she was compelled to tell her here-and-now story in the first three sessions and found revisiting the past very painful and challenging which often encumbered the work. In addition, the here-and-now issues were often the most salient.

After session 8 Ava said she was doing “better,” was a bit more confident and said “...I think differently, I understand things a little bit better now, I can sort of rationalise things...” Significantly, she was more accepting of herself when she felt down and felt more mature in her attitude towards herself. Her relationships had improved “...I've learnt a lot about myself through them I guess and about how I am through them.” Ava mentioned the tasks as specific interventions that assisted in bringing about change for her; the empty chair work in session 4 with her estranged girlfriend and the two-chair work in session 7. Despite feeling uncomfortable about the tasks but she “...absolutely enjoyed it...” The two-chair work in particular, helped her to identify the emotional and logical aspects that were involved in her decision making. The reduction in internal conflict she reported resulted in some integration and a sense of “peace.” Ava found the focusing exercises useful; “...time to be with my own thoughts ...slow down life in my head and ...put the pieces right... that's what it felt like. I really enjoyed that...”

The therapeutic relationship was important to Ava. My reported warm, caring, understanding responses and non-judgmental attitude assisted Ava to feel like “... she's on my side even if I am wrong... and then at times when I am wrong I can acknowledge it through... the dialogue we have...” She was able to talk openly with me. Ava acknowledged it took some time for her to settle into the work and develop a

trusting relationship with me. When asked about her missed sessions Ava said she was struggling with the dilemma of bringing experiences up from the past but my accepting of her helped her to keep coming to sessions. My acceptance of Ava enabled her to "...I can be Ava... just... just me, like not the me that I think everybody else wants me to be..." Ava said she felt I shared her burden. One year later Ava felt the work we did together gave her the confidence to go overseas and refuse her psychiatrists assertion that she had bipolar and should take anti-psychotic medication. She acknowledged that she definitely knows herself better, feels stronger and that the therapy was a journey of "finding me."

Chloe's Change Interviews.

Chloe reported in the first of her series of Change Interviews that she had noticed a "change for the better" despite feeling somewhat overwhelmed because "bringing everything up has been quite difficult." She was expressing herself more readily with people and was seeking support which she would have never have done that without counselling. She also realised that "it's okay to feel a certain way... it's okay to express yourself in appropriate ways..."

Over the series of sessions Chloe connected that she had unresolved issues from the past and realised "...how those past things have actually affected me and continued to affect my life now..." Whilst the processing of these traumatic experiences had been painful and at times hard to acknowledge, Chloe found it useful to understand where some of her current issues were coming from. Rather than dwell on her difficulties Chloe was "...starting to understand where the triggers are coming from... would take a more positive outlook so listening to music or something that might bring me out of that trying to continue on with life..." In her second Change Interview she explained she was more aware "of what I was going through and how to look at things differently..." She was managing her suicidal thoughts "they do come occasionally but they're not as bad, nowhere near as they were before..." Chloe acknowledged she was able to "look after myself a lot more." She continued to reach "...out to people..." She had compassion for herself and therapy had been "helpful in my understanding of my life... the understanding of not being so hard on myself..."

it's helped me to understand my stubbornness and the point of view of myself... understanding really of what's been going on really..."

She described the focusing task as "fantastic because I can actually express what I'm feeling without... someone looking at me... she just has a way to guide me through... in touch with what's going on... she's not leading at all..." Chloe found the chair work really useful... acknowledging that there are two parts... the negative thoughts and positive thoughts. reality and fantasy." Chloe had become more aware of her emotions. "I can express them and I definitely have a little bit more control over [them]... they're not as erratic as they would have been... just understanding that the things that I'm feeling are okay..." Her anxiety had "definitely decreased especially at work... I'm talking myself through the anxiety rather than just trying to get over it..." Chloe found talking helpful and felt supported, well matched and connected with me. she reported that I validated her emotions and experience and gave her permission to accept herself.

Despite experiencing a setback when her boyfriend arrived from the UK Chloe was aware that she hadn't regressed to her pre-therapy state "...oh heaps better than I was..." Despite burying herself under her study she had "...been social, more in control, more self respecting as well." Dealing with issues from her past, working within her spiritual beliefs and with relationship issue were important aspects of our therapy work.

Appendix T • Personal Descriptors of Sarah, Katie, Ava and Chloe

Table T1. Personal descriptors of Sarah, Katie, Ava and Chloe taken at the initial screening interview, after sessions 4, 8 and 12 and at follow-up interviews.

	Screening	After session 4	After session 8	After session 12	Follow-up
Sarah	Opinionated Quiet No nonsense Down to earth Spiritual Strong work ethic Motivated Stand offish Reserved	Same	Same but Not so quiet Fun Intelligent Multi-tasking Smiling Serious Controlling	Same but Driven Confident Motivated Happy Opinionated but compromising	Same but Bit lost Thoughtful Opinionated Driven Mellow Not so quiet
Katie	Outgoing Person who tells the jokes Person who likes to be the centre of attention, Emotional Moody in an “up and down” way.”	Same but More content More at ease	Same but More positive Happy	Same but Happier More open	Same but More assertive More independent More alive with people Organise myself a lot better Less moody

	Screening	After session 4	After session 8	After session 12	Follow-up
Ava	Anxious Nervous Always thinking Intelligent Loyal A good friend	Same but Not so caring of what other people think	Same but More confident More mature and grown up	Same but A “great” friend More to me than being anxious and nervous	Same but More independent More confident More mature Write my own rules
Chloe	Bubbly Confident on the outside but not on the inside Friendly Loving Caring Always put others first	Same	Same but Looking after herself better	Same but More confident Reaching out more	Same

Appendix U • Client Assessed Helpful Aspects of Therapy (HAT)

Sarah's HAT forms.

Talking was important for Sarah. She wrote after session one “getting events off her chest about comparison with sister” was also moderately helpful. After session three she reported that she found it helpful to say what was on her mind and that she had someone to talk to about her situation. After session seven she found discussing her young client and obtaining a different perspective about his difficulty was helpful.

The *task* of systematic evocative unfolding utilised in session one was very helpful. Sarah wrote “talking to the little me when I was 6 -7 at school... I acknowledged the event and how I felt and was able to comfort the girl.” The two-chair enactments in regard to her vestibulitis were reported by Sarah as helpful. In session nine “contrasting the controlled me and the free me” through the two-chair work and in session ten “when I found agreement between my body and my head in regard to my vestibulitis, my body relaxed and my head listened” was greatly helpful. Sarah also commented on the usefulness in session 7 of “going through all the different emotions/events from the vestibulitis” and realising “a lot about my values” were extremely helpful aspects of that session. In session 12 again she mentioned emotions. “Realising how much dad has influenced my interaction with people was helpful because I was able to see where the emotions were coming from and then be able to modify my thinking about them.” The last statement wrote on her HAT form was “establishing that me and Gina could both be beautiful” was also helpful.

Katie's HAT forms.

Katie reported on her HAT forms that *talking* freely and openly was very helpful to her. She stated this nine times over the twelve assessments. After session one Katie wrote “talking about my mother and what she said was a reason for beginning the eating disorder.” She reported after her fifth session “being simply able to get it all off my chest” and “finding out how my thoughts made the core of my anxiety worse” were useful aspects. After session 8 she documented that talking about the steps in wanting to make changes, about stopping the laxative use and talking positively about

life and life changes was very helpful. Again in session 9 Katie said that talking about the next steps to what she described as her recovery, was useful. In addition, talking about her childhood experiences, including her anxiety and feeling her emotions was also helpful. Katie also found it useful to separate her body and her brain using the two-chair enactment *task*.

Ava's HAT forms.

For Ava it was the *working alliance* and the *talking*. After session one Ava wrote on her HAT form “when the therapist told me she was there for me... that I could tell her all the things... this felt like a weight had been lifted from my shoulders... relief... like pressure in my chest was released.” In session 12 “when Melissa said to take home with me an understanding that she cared and was still there for me, and that she really understood me as a person helped me a lot.” Talking about her past and present relationships and how they had affected her was greatly helpful. And after session 9 Ava reported that telling me about her mother's behaviour had been helpful and she felt she had got “all her anger” off her chest.

Ava was more cautious about engaging in the *tasks* and often overwhelmed and vulnerable. In session 2, Ava stated that closing her eyes and thinking about what her body was telling her was helpful because it made her realise that her body was constantly communicating with her. In session 3 “visualising my fear and how I could overcome it by creating and thinking about a place where I feel completely happy and in control” was greatly helpful. In session 11 Ava reported the focusing helped and talking about what had happened in general had been useful. She understood she needed “time to grieve [about the baby] and understand the hurt and loss.” The empty-chair session in session 4 was an important and helpful event for Ava. The two-chair enactment in session 7 where she talked to the two parts of her personality (emotional Ava and logical Ava) was greatly helpful. A slightly hindering aspect was reported by Ava after session 8. She wrote “talking about her intimate relationship with [her lover] and whether it would continue.”

Chloe's HAT forms.

Chloe also found *talking* extremely helpful. After session 4 Chloe reported that the talking brought things to the surface which subsequently alerted her to what to expect when we engaged in the task work. She also liked being able to “offload” at the beginning of the session. “Talking about where the anorexia may have stemmed from” was also extremely helpful. After session 11 she wrote “talking/venting what had been going on in the last week... realising I was slowly improving and utilising the information received from the sessions...” was extremely useful. The semi-mediative state of the Focusing *task* was particularly helpful for Chloe.

Closing my eyes was a good technique to really feel and see where the pain comes from... going into myself and bringing up things that I was not aware that were still presently an issue for me... realising how much these past events continue to be a burden... feeling the lift of that heaviness... and telling/confronting those people

In addition, “the conversation between two chairs... debating between my two angers” was extremely helpful for Chloe as it enable her to understand how “to be angry appropriately therefore less confusion.” At her last session Chloe reported that “talking between two chairs of male and female parts of myself... understanding that both are important to have and to work together” was also extremely helpful. Chloe commented on the working alliance on her HAT form. “I was thinking that everything I was feeling and thinking was not normal. It was very helpful and reassuring to get an outside opinion to why I was thinking and feeling the way that I was.” Hindering aspects were noise outside the therapy room during session one and my lightly humorous suggestions whilst she was still within a focusing. She wrote that “I would prefer soft tones to keep me in the meditative state.”

Appendix V • Summaries of Bodily Felt Sense, Symbolic Representation, Episodic Memory, Emotional Arousal and Felt-shifts

Table V1. Sarah: Summary of bodily felt sense, symbolic representation, episodic memory, emotional arousal and felt-shifts.

Session and task	Body experience / Felt-sense	Symbolic representation	Episodic memory	Felt-shift / Symbol shift / Primary Emotion
1. Systematic evocative unfolding Punishment circle	pressure in her chest and cheeks an unease “just everywhere... like humiliation...”	orange rectangle with fuzzy edges in her chest	little girl in the punishment circle then comforted by adult self	tension subsided primary <i>shame</i> felt expressed her need to be reassured “I don’t feel like I’m all alone” felt relief → <i>shift</i>
2. Focusing <i>Accepting compliments</i>	pressure in her shoulders – high expectations of herself	brown, jelly-like area in her abdomen	difficult breakup with her boyfriend of ten months father’s absence at her grade six graduation – IC ³ put down at school by teacher – IC	partial shift primary <i>shame</i> felt symbol gone full body relief → <i>shift</i>

- 3 I use the abbreviation IC to denote an imaginal confrontation or an internal conversation within a focusing task with a significant other / perpetrator. The client is encouraged to imagine a significant other/perpetrator in their “mind’s eye” or in their imagination rather than use an empty chair. Confrontation and assertions of the client’s needs is encouraged within the client’s imagination rather than out loud at an

Session and task		Body experience / Felt-sense	Symbolic representation	Episodic memory	Felt-shift / Symbol shift / Primary Emotion
3.	Focusing Eating issue	constriction in her throat that made breathing difficult tension shifted to her chest	a black narrow hard tube	difficult to express herself news that her mother had cancer issue that concerned her most	<i>anger</i> and <i>sadness</i> distress divulging her concern <i>disgust</i> at herself – tears → <i>shift</i>
4.	Focusing Expectations of herself	pressure in shoulders an uneasy sensation in her stomach sensation in face	two dark green rubbery strips, one on each side of her neck a red rubbery dome-like structure fuzzy all over her face	stressed about assignments abandonment by mother at 16 put on lots of weight last summer “I don’t like being me”	anger sadness she can relax tension lifted → <i>shift</i> primary shame/ <i>disgust</i> release of tears acceptance → <i>shift</i>
5.	Vulnerability <i>Relationship with mother</i>	rubbing eyes tears		her mother’s unavailability at 18 got licence mother stopped driving them had to look after herself	expression of <i>anger</i> and <i>sadness</i> – tears → <i>partial shift</i>

empty chair or therapist. Some clients find the empty chair enactment too confronting in the initial stages of therapy. Please note Paivio and Pascual-Leone (2010) use the term imaginal confrontation (IC) to denote empty chair work and Empathic Exploration (EE) to denote what I refer to as imaginal confrontation or an internal conversation.

Session and task	Body experience / Felt-sense	Symbolic representation	Episodic memory	Felt-shift / Symbol shift / Primary Emotion
6. Focusing <i>Gaps in knowledge</i>	pressure in her upper chest	a solid green cylinder containing “stuck” words	move to regular school in grade 4	ask cylinder for the words → transparent and vanished. expression of the frustration/ <i>anger</i> <i>shift</i> → joy
	pressure in front of head	a dark circular pressure	her life not as good as others	
	face		alone on couch at 15 b/c of Gina’s first boyfriend →	expression of <i>sadness</i> at being alone and <i>anger</i> towards Gina → <i>shift</i> relaxed → <i>shift</i> humour at being bored
	pressure in her chest	long, thin, solid, black	food only friend – IC Gina loneliness – IC Gina	
7. Focusing <i>Vestibulitis</i>	pressure in her left shoulder	kidney-bean shape and colour and fabric texture full of trinkets	cushion in her nan’s house – loves her so much it’s about money if I can’t give sex I’ll have money	distress tears of <i>sadness</i> ↓ pressure in shoulders
	pressure reduced	→ thin wooden strips	felt bad about self taught a lesson “slut” mother judgements about sex	<i>anger</i> at vestibulitis spinning → relaxing acceptance sex is ok → <i>shift</i>

Session and task		Body experience / Felt-sense	Symbolic representation	Episodic memory	Felt-shift / Symbol shift / Primary Emotion
8.	Focusing <i>Vestibulitis</i>	pressure in her chest	a cloudy-grey, fuzzy, hollow cylinder	I have a secret lack of trust	
		solar plexus	eating away at me	friend dated a boy she liked	<i>fear</i> that no one will like her
		pressure in her chest	flat stretched out maroon circle	sex is bad undeserving of a spontaneous happy life & painless sex	recognition that not everyone will like her → comfortable in herself and body → <i>shift</i>
9.	Two-chair <i>Conflict</i>	CONTROLLED chair – tight and contained			
		SPONTANEOUS chair – sense of freedom, relaxed, open	soft, green and oval	sex hurt with first boyfriend – never said	frustration at not having sex - both sides want sex recognition of choice of not enjoying sex → relief
		anxiety - upper chest		being told she was beautiful	excitement → <i>shift</i> tears of joy
		lower abdomen			


Session and task		Body experience / Felt-sense	Symbolic representation	Episodic memory	Felt-shift / Symbol shift / Primary Emotion
10.	Two-chair <i>Conflict</i>	HEAD chair – ready for sex BODY chair – closed pressure in chest tingling in legs and arms		vestibular pain disappointment holding in emotions as 5 year old child shown little or no compassion	<i>sadness</i> finding compassion acceptance for herself body relaxed → <i>shift</i>
11.	Focusing <i>Relationship with Gina</i>	top of her head felt nauseous hollow sensation in stomach chest ↓ tension in head	hard red square a whitish cream thin tube running along her sternum evil dark grey cloud condensed into a dark spot	Grade 1 – punishment circle misunderstood IC - teacher screen what she said Gina's critical judgments ... what will I be without Gina the stress of life	<i>fear</i> of not being liked <i>disgust</i> <i>anger</i> at Gina <i>fear</i> of Gina dying but <i>sadness</i> she will be ok → <i>shift</i> no need to get too stressed – humour

Session and task	Body experience / Felt-sense	Symbolic representation	Episodic memory	Felt-shift / Symbol shift / Primary Emotion
12. Two-chair <i>Conflict</i>	SENSIBLE/HEAD chair – overanalyses SPONTANEOUS/ BODY chair – rebellious, free and easy but fearful of being judged, rejected heavy shoulders, chest and solar plexus	like a [grey] ball filled up on one side	before father left she withdrew and relied on Gina IC – father	<i>shame</i> <i>fear</i> <i>anger</i> and deep <i>sadness</i> → <i>shift</i> partial resolution

Table V2. Katie: Summary of bodily felt sense, symbolic representation, episodic memory, emotional arousal and felt-shifts.

Session and task	Body experience / Felt-sense	Symbolic representation	Episodic memory	Felt-shift / Symbol shift / Primary Emotion
1. Systematic evocative unfolding Mirror Two-chair <i>Nicole Ritchie</i>	body stiff anxiety all over CHILD-like chair – need to be looked after More ADULT chair – independent	power of being small	looking in the mirror and heard her mother’s remark about putting on weight parents and siblings did things for her being small at school meant being noticed	shock, <i>fear</i> realisation of significance of event → <i>partial shift</i> articulation and understanding of being small → <i>partial shift</i>
2. Focusing <i>Affect of Medication</i>	pressure in her chest sometimes it spread outwards	light and bright colours and had a lighter core it had no words a gauge thing	sense of lifelessness since going on medication	curiosity felt “fresh,” more hopeful, not so low → <i>shift</i> humour at the idea of controlling it
3. Narrative <i>Eating disorder</i>		wasting her life the thought of looking back in 10 years to this time really dismayed her	time her face was really drawn and she could feel the loose skin sitting on the bones	being accepted by me “being OK right now” a calming feeling a noticeable shift in her energy → <i>shift</i>

Session and task		Body experience / Felt-sense	Symbolic representation	Episodic memory	Felt-shift / Symbol shift / Primary Emotion
4.	Two-chair Conflict	BODY chair – crouched and stooped and her voice small and timid	brain always won like a prison punished indefinitely like an abusive parent	so many rules around food	my brain is like the abusive mother and I am the child (body) that can't escape
		BRAIN chair – voice was louder and overpowered the body's voice		parents weren't like that as they were affectionate	<i>anger</i> - body says I deserve better → <i>partial shift</i>
5.	Focusing <i>Identity – hair and weight</i> Narrative <i>Mother</i>	tightness in her chest and in her throat	dark with a hard darker core - solid and can't be broken... been there forever – “I don't like the way I am” formed from and feeds off negative thoughts	It controls me... it stops me from doing things... comes back if boyfriend gets too close... and when on own	sensation in chest lessened in size → <i>partial shift</i> exhausted and unable to continue
				Mother dismissive and insensitive sister vomiting mother dragged her along to look	<i>anger</i> at mother “I'm like this” exhaustion lifted → <i>partial shift</i>

Session and task	Body experience / Felt-sense	Symbolic representation	Episodic memory	Felt-shift / Symbol shift / Primary Emotion
6. Emphatic exploration <i>Grief</i> <i>Mother</i>	leaning toward her right side	being weighed down by mother's disappointment in her	three significant people in her life had died tragically funerals - mother emotionally unavailable	<i>sadness</i> <i>anger</i>
Empty-chair <i>Mother</i>	Katie kicked out her left foot in the direction of the chair kicked the chair again pushed it over	kicking out at her mother	past interactions with her mother	<i>anger</i> , resignation laughter → <i>shift</i>
7. Emphatic exploration	chronic fatigue – whole body thing and depression “was just here” (<i>pointing to her chest</i>)	exhaustion “I can’t think about it”	 rules	deep despair / <i>sadness</i>
Two-chair <i>Conflict</i>	BODY chair – numb MIND chair – rule bound	“I’m just nothing...” “I AM ALWAYS GOING TO WIN!” stuck Katie-in-ten-years “you’ve got to eat” break the rules		hope / optimism exhaustion lifted → <i>partial shift</i>

Session and task		Body experience / Felt-sense	Symbolic representation	Episodic memory	Felt-shift / Symbol shift / Primary Emotion
8.	Narrative <i>"The Secret"</i>	radiant, eyes sparkling full of energy	"The Secret" DVD think more positively	her eating disorder "has made me the biggest liar"	hope be more honest and more real with self and others
9.	Focusing <i>Her problem</i>	sense of fear in her chest there as long as she can remember	felt frozen	four or five years old standing in the school yard - Grade 6 boys unable to move	<i>fear</i> elder brother of a friend walked her home – sensation shifted slightly → <i>partial shift</i>
10.	Narrative <i>Diagnosis</i>	diagnosis of anorexia and entering an eating disorders clinic		lying and manipulating	relief to speak openly
11.	Focusing <i>Fear her boyfriend would leave</i>	sensation in solar plexus - spread through whole body throat gagging sensation in chest	fear boyfriend will leave her – need to control feel like a kid solid in the middle, fuzzy and when it gets worse it goes all through whole body feels gross	constant need for reassurance as a kid boys in school yard <i>adult Katie going into the scene to look after the younger Katie</i> fear of boys liking her changing schools mum didn't get it dad reassured her dad's breakdown	anxiety / <i>fear</i> felt shift feels good... feel a sense of happiness... like a relief → <i>shift</i> <i>sadness</i>

Session and task	Body experience / Felt-sense	Symbolic representation	Episodic memory	Felt-shift / Symbol shift / Primary Emotion
12. Narrative <i>Mother</i>	anger at mother	I'm doing this so she'll notice	interactions with her mother	assertive <i>anger</i> <i>disgust</i> at her mother's behaviour → <i>shift</i>

Table V3. Ava: Summary of bodily felt sense, symbolic representation, episodic memory, emotional arousal and felt-shifts.

Session and task		Body experience / Felt-sense	Symbolic representation	Episodic memory	Felt-shift / Symbol shift / Primary Emotion
1.	Narrative Relationship <i>with sister with mother</i>	lose breath (hand to upper chest) a tight feeling	so much to say freeze up	visits home	global distress
		suffocating	pull my hair out dream “one day I’ll get married and leave” problem child feel like a kid	overprotected yet criticised for not being more independent mother’s behaviour ranting and raving	tears – <i>sadness, anger</i> tightness shifted she let out a big sigh of relief → <i>shift</i>
2.	Vulnerability Accident <i>Mother</i>	no feeling	suicide ideation no drive to live – not existing under pressure		global distress
		headache wrapping cardigan around herself chest feel bashed body hurts all over... so tense	hide numb - zoning out	mother compared her to others every corner of her doona tucked in need to feel safe mother criticising her	 deep breathes – release of tension body rocking whole body calm → <i>shift</i>

Session and task		Body experience / Felt-sense	Symbolic representation	Episodic memory	Felt-shift / Symbol shift / Primary Emotion
3.	Focusing Fear of death	felt in her chest	black, hard prickly thing use visualisation of sun to burn up the mass	go to a place in her imagination	deep seated <i>fear</i> sense of safety sense of control → <i>shift</i>
4.	Narrative Dream		dreamt a friend had died crying but no tears		frustration
	Empty-chair Ex-friend	avoided eye contact with chair frenetic hair pulling		past experiences with friend – being excluded or ignored	severe distress → sense of relief and closure → <i>shift</i>
5.	Narrative Past relationships	stomach - nausea		mother often unwell	fear
	Vulnerability		Ava - problem child Sister - golden child	mother's beating criticism of her first boyfriend	despair
		hand to her heart	I am weak – can't look after myself	recent boyfriend – first sexual partner	tears in her eyes shame affirmation by me - felt better → <i>shift</i>

Session and task		Body experience / Felt-sense	Symbolic representation	Episodic memory	Felt-shift / Symbol shift / Primary Emotion
6.	Narrative	her heart hurts	wants to de loved / liked	argument with mother	global distress
	Mother		change herself to accommodate	scrutiny at family get- togethers	
		zoning out	others	little niece's unconditional love	tears of appreciation sense of release → <i>shift</i>
	Greg		feels like I'm nowhere – never		tears of despair
	Vulnerability		was an Ava	photo of them together	
			head / heart split – “like a war”		
7.	Two-chair	STAY with Greg	I'm a failure		fearful of loneliness
	Conflict	chair – he was her first HEART – emotional			co-operation between logical and emotional sides
		LEAVE Greg chair – you deserve better HEAD – logical	I have control		visibly excited and energised “feels good, feels better, more at peace” → <i>shift</i>

Session and task	Body experience / Felt-sense	Symbolic representation	Episodic memory	Felt-shift / Symbol shift / Primary Emotion
8. Narrative Greg	felt different looked and felt good	<i>tarty</i> – “I used him for something”	conversation mother had with Greg	confident laughter
Focusing Bridge	imaginary world reality	sunshine, brightness and a feeling of wellbeing sort of blacker -field of grass as connection		calm and was smiling → <i>shift</i>
9. Vulnerability <i>Mother's invasion of her privacy</i>	in my back hunched over rubbing her eyes hid face in hands pulling her hair scratching her head	stuck... like kid... paranoid feel like she's jumping on my back “take me away... put me in hospital.” like a zombie	mother's invasion of privacy - list of phone numbers / expenditure can't sleep suicidal ideation	global distress deep resignation and despair
Empty-chair <i>Mother</i>	tightness in chest pulling hair out... itchy everywhere hunched over head in her hands nausea scratching her head	bugs growing under skin	aged 7 mother didn't believe her	I don't want to be around you tears – sadness too angry to cry seething disgust partial release of anger → <i>shift</i>

Session and task		Body experience / Felt-sense	Symbolic representation	Episodic memory	Felt-shift / Symbol shift / Primary Emotion
10.	Narrative <i>Depressed</i>	dryness in throat...	dry... all the water sucked out... like a desert... drained... no life...		
	Focusing <i>Ex-boyfriend</i>	pressure in stomach	a green flat piece of glass that was hard to see through 5 or 6 people there	transition to high school hanging onto ex- boyfriend – IC	let him go huge sigh → <i>shift</i> smashed green glass
		pressure in the back of her neck chest on her knees	grey shadow... a force	six years old mother's expectations	tears of sadness sat upright pressure lifted "I'm ok." beautiful blue energy → <i>shift</i>
11.	Narrative Vulnerability <i>Miscarriage</i>		kick myself like a whore		global distress disgust sadness grief at loss
	Focusing <i>Grief</i> <i>Greg</i>	heaviness in shoulders	need to be perfect	IC – Greg	anger disgust "I will be okay" considerable felt-shift → <i>shift</i>
		sat bold upright and took a few deep breathes nausea rocked in her chair	feel like hitting him		

Session and task		Body experience / Felt-sense	Symbolic representation	Episodic memory	Felt-shift / Symbol shift / Primary Emotion
12.	Narrative <i>Greg</i> <i>Dream</i>	hard to let Greg go gutted at seeing him		change herself to be loved/accepted	disgust at herself tears of despair
		chanting coming from the sky - brilliant colours - stars clear and bright	Muslim temple praying mother tried to take her away		crying in her dream aware she was her real self in therapy → <i>shift</i>
13.	Focusing <i>Not good enough</i>	solar plexus	a black empty hole	as a small child playing in the park	white light filled black hole “I saw my ideal self... in a place where I am happy, pure and protected” → <i>shift</i>
14.	Emphatic exploration <i>New job</i> Focusing <i>Last session</i>	tension in her stomach	look at the past and allow the “new” to enter	let go of Greg less distressed about the miscarriage	sadness at loss felt a significant felt-shift in stomach → <i>shift</i>

Table V4. Chloe: Summary of bodily felt sense, symbolic representation, episodic memory, emotional arousal and felt-shifts.

Session and task		Body experience / Felt-sense	Symbolic representation	Episodic memory	Felt-shift / Symbol shift / Primary Emotion
1.	Focusing Cousin <i>Mother</i>	pain in her head and shoulders	black rectangular shape with unclear edges and a hard dull plastic texture	disappointed people let her down at 5, 8yo cousin inappropriate sexual encounter mother laughed IC with mother and cousin	sadness sighed with relief → <i>partial shift</i> in shoulder pressure <i>he</i> was wrong “such a release of stuff... feels good” → <i>shift</i>
		revisited pressure back of her neck and chest	blamed herself	at 14, 18yo boyfriend forced her to have sex	
2.	Focusing Monkey bar incident Critical stepmother	pressure and tension at the back of her neck and the top of her shoulders	a black moulded amour that would protect her from the onslaught of her family	aged 9 boys left her hanging on monkey bar with pants pulled down IC boys and sister	tears global distress a deep breath and sat up straighter in her chair - shoulders tension shifted → <i>shift</i> sat more upright and breathed deeply pressure in her head and heart was less → <i>shift</i>
				at 8 couldn't read or do up shoelaces – IC stepmother	

Session and task		Body experience / Felt-sense	Symbolic representation	Episodic memory	Felt-shift / Symbol shift / Primary Emotion
3.	Focusing They took my Barbie	great pressure in chest	red with black edges and took up a great space	feelings of being stupid at 4 teased by brother, twin-sister and cousin – “they took my Barbie” IC cousin angry outbursts by father difficult to express appropriate anger	global distress anger, tears crying and laughing at same time block to full anger even internally. black was fear
	Two-chair Self-interruptive	self-interruption of anger	bright red more red and less black confusion		anger acknowledged less confusion → <i>shift</i>

Session and task		Body experience / Felt-sense	Symbolic representation	Episodic memory	Felt-shift / Symbol shift / Primary Emotion
4.	Focusing Stubbornness	chest	sadness, anger, grief and stubbornness were in the black box with red edges of fear, but there was a white light in the middle of it... like a diamond but naive a glass cage that the white light... given a chance... break open by itself Archangel Michael	David's death – she was 16 confusion	global distress tears of sadness her diamond was very tough and resilient sat upright and took a deep breath and said "I broke it" palpable sense of relief - breathe more easily → <i>shift</i>
5.	Focusing Anorexia	spanned from her throat right down into her abdomen chest	a protective grey cloud-like area "sense of control" unlovable	teenager – body image mother and sister "tried to control my life" – IC – adult Chloe advocate for little Chloe and counsel teenager on better ways to eat damaged by ex- boyfriends	"feels good" "you are lovable." tears of sadness cloud was "lighter" → <i>shift</i>

Session and task		Body experience / Felt-sense	Symbolic representation	Episodic memory	Felt-shift / Symbol shift / Primary Emotion
6.	Two-chair A self-interruptive process not a conflict Focusing <i>Stuckness</i>	FEAR OF SUCCESS chair – pressure in her chest DESIRE FOR SUCCESS chair –	stuck		
		heat in her chest and solar plexus	bright orange red “like anger” persona of intelligence	5 yo having trouble writing – hid it so no one will notice	adult Chloe helped child Chloe reminded of successes → <i>shift</i> “positive affirmation helps negatives reduce”
7.	Focusing Overwhelm Sabotage	tightness in her shoulders, neck and back of her head	a heavy, dull, dark- green, metal brace black spongy tar protects white star inside glass box	anger at self sabotage towards cousin – IC mother didn’t protect her – IC dad – IC – blocked adult support child feeds on the agitation – IC father – IC give anger back to him as taken it on stubbornness	anger tears sadness → <i>shift</i> tears - “ she’s listening” → <i>shift</i> listen to needs - “settled down” black tar shifted stretched shoulders deep breaths → <i>shift</i> vs. determination last of the amour dissolving away → <i>shift</i>
			orange case... keeps escaping		

Session and task		Body experience / Felt-sense	Symbolic representation	Episodic memory	Felt-shift / Symbol shift / Primary Emotion
8.	Focusing	back, shoulders, neck and head	weighty tarnished black amour with grey underneath greyness black tar is covering the positives sticky grey fairy- floss	holiday with Steve	tears shame anger
	Overwhelm			not follow patterns of her parents – she knows Steve	blackness lifting sat straighter “much lighter”
				love and support from those around her	grey dissolved fairy-floss “pink” → <i>shift</i>
9.	Focusing	left-hand side of her neck and shoulder	heavy grey cloud	waiting for Steve to come and rescue me	sad and alone
	Two-chair Conflict	DREAM chair – fantasyland procrastination			
	Focusing	RELATY chair – gloomy pressure in her head on the left side	black pressure in her head	alone as a child → fantasyland create a bridge between reality and fantasyland	anger at being alone bridge to move between the two internally → <i>shift</i> “Feels good”

Session and task		Body experience / Felt-sense	Symbolic representation	Episodic memory	Felt-shift / Symbol shift / Primary Emotion
10.	Focusing People let her down	back of her head and shoulders	a grey heavy weight	"I want to be needed... to be loved."	tears
			old wooden gate covered in barbed- wire kept people out blocked	had opened in past but got hurt little Chloe "waiting to be loved and reassured"	reassurance
		in her chest	rock-like crystal	disappointment in others	be own best friend open the gate to let people in - felt a "lot better" → <i>shift</i>
11.	Focusing Overwhelm Process it her way	pressure in her head, neck and chest	dark grey cloud around head and neck thick black-brown tar around her heart mesh covering her heart and brain blockages between her head and heart	disappointment in her brain disappointment in herself – IC to self	if I let go and speak to people the disappointment will subside tension lifted → lovely pink heart "unblock" these pressures and allow energy to flow between these areas → <i>shift</i>
		neck		fear of failure	

Session and task	Body experience / Felt-sense	Symbolic representation	Episodic memory	Felt-shift / Symbol shift / Primary Emotion
12. Two-chair Conflict (? Self- interruption)	DESPONDENT chair – try so hard FEMALE tension in her throat and heart CONFIDENT chair – can do it MALE	blanket of depression having goal gave her confidence won't give up dark grey blanket of depression	disappointment fear of failure	global distress anger expanded in her heart excitement happiness → <i>shift</i> female – holder of compassion male – holder of confidence lifted → <i>shift</i>

Appendix W • Adherence to the PE-EFT Manual

I asked Dr George Wills, my first principal supervisor, to assess my competence in following the PE-EFT model by viewing segments of my counselling work with Sarah, Katie, Ava and Chloe. I used the manual for PE-EFT (Elliott, Watson, Goldman, & Greenberg, 2003) and the Experiential Therapy Session (ETS) Form to develop a checklist (Appendix K) to use as a guide for assessing my adherence to the PE-EFT model. In order to make this assessment clearer for the reader I have tabulated the results of Dr Wills' assessment and ranked his responses on a scale of 1 to 9 (see Table W1 and W2). Where it was not necessary to make a particular PE-EFT intervention the lettering N/A representing "not applicable" is noted. I asked Dr Wills to view the first 10 minutes, a mid 10 minutes and the final 10 minutes of the videotaped sessions. The aim was to use the scale to ascertain whether each task or intervention was adequately adhered to. Dr Wills assessed the entire set of sessions on one checklist for each client. As part of Dr Wills' analyses he wrote some additional comments about the counselling I undertook with Sarah, Katie and Ava and I have included a summary of his observations. However, the amount and quality of these additional observations varies somewhat.

Table W1. Adherence to manual scale.

Always		More often than not		About half the time		Not often		Never
9	8	7	6	5	4	3	2	1

Table W2.

	Sarah	Ava	Katie	Chloe
a) Empathically responds when relevant to do so (i.e. by accurately reflecting thoughts, feelings and behaviours as presented.				
	8	9	9	8
b) Is respectful toward the client (i.e. is 'for' the client, wants to help, regards the client as unique and self-determining, assumes goodwill and respects confidentiality.				
	8	9	9	9
c) Is genuine (i.e. authentic, flexible, spontaneous, non-defensive, consistent and open.				
	9	9	9	9
d) Identifies and reflects problem-relevant experience by asking general exploratory questions.				
	9	8	9	9
e) Appropriate probing of content.				
	8	8	8	8
f) When client is vulnerable, only empathises.				
	9	9	6	7
g) Maintains a safe working alliance.				
	9	9	8	8
h) When the alliance is under pressure, counsellor seeks dialogue about it.				
	N/A	N/A	N/A	8
i) Facilitates emotion expression when the client is in difficulties.				
	8	9	9	9
j) When client is puzzled or unclear about a felt-sense, initiates appropriate focusing strategies.				
	8	9	4	9
k) Facilitates expression of feelings that may be difficult to express.				
	8	9	8	9
l) Helps client to re-tell traumatic experiences.				
	8	8	8	9

m) Uses systematic ways of unfolding problematic reactions.	8	9	6	8
n) Assists in the creation of meaning for meaning protest.	8	8	8	8
o) Accurately identifies and implements two-chair work for Conflict Spilt.	8	7	6	8
p) Accurately identifies and implements two-chair work for self-interruptive split.	N/A	7	6	8
q) Accurately identifies and implements empty-chair work for unfinished business.	N/A	8	8	N/A

Dr Wills observed that Sarah was a client who was restrained in her self-expression and so my adaptation of the two-chair work to internal work for a conflict split “seemed to suit the introverted client” and that I implemented the empty chair work “...in subtle way.” He also commented that I had a tendency to explain and advise Sarah and this mirrored her problem. He added this was *out-of-mode* and questioned whether there was a place for it. He further stated that I quite often interacted as if in a “normal conversation” with Sarah, which is inconsistent with PE-EFT model. Whilst he acknowledged that there was empathy present, he suggested that my focus on the client’s thoughts, feelings and behaviours was compromised by the conversational style. He suspected that this mode was my response to the sort of engagement that characterised Sarah’s mode of exchange. I must admit that I find Dr Wills comments about Sarah quite interesting because he consistently ranked me very highly on the empathic aspects of my work with Sarah. I suspect I was also mirroring or matching her style. I also recognise that there were more psycho-educational elements in my work with Sarah and perhaps this was what Dr Wills was alluding to.

In the work with Katie, Dr Wills acknowledged that he observed me mirroring Katie’s voice style and body language. He identified appropriate use of minimal encouragers and the presence of empathy, respect and acceptance. He saw evidence that Katie trusted me. My empathy was observed through a strong alignment with her,

and further emphasised in the acceptance of Katie's dilemma about wanting to change but not being ready to do so yet. Dr Wills documented many occurrences of *accurate advanced empathy* (see Egan, 2002), and noted that the level of empathy strengthened over the course of the therapy. He acknowledged that I had set up the two-chair work on the mind-body split well but there was more of an interviewing quality in the work and not enough depth. Getting to the recognition that the mind was abusing the body was however usefully achieved. Other two-chair work was well implemented. Dr Wills acknowledged that the focusing task was very well done as I encouraged Katie "...to face her pain" despite her resistance. I appropriately left time and space when undertaking the empty-chair work that enabled Katie to warm up to the task. As the sessions progressed, Dr Wills observed that Katie was more able to get in touch with her anger and I was able to normalise this and support her. He also acknowledged the optimism I held for Katie.

Dr Wills wrote of my work with Ava that I was empathic, respectful and understanding and made good use of minimal encouragers. By session 2 the rapport was already strong, I was empathic to Ava's pain and I supported her to "...need to unload." Dr Wills observed the non-verbal mirroring of Ava's physical movements as sign of advanced empathy and strongly characteristic of my work with Ava. The level of safety that I had created was acknowledged by Dr Wills, in addition to the presence of accurate advanced empathy. I was gentle in bringing out Ava's criticism of her mother but also was somewhat provocative at times. In the two-chair dialogue I undertook the enactment subtly and validated Ava's experience by affirming her normality. However, according to Dr Wills, I used an interviewing style in the enactment task and didn't encourage enough direct expression from the experiencing self. Fortunately I was still able to facilitate the integration. Some crisis management and action planning was observed in session 9, as Ava dealt with the discovery of her mother's invasion of her privacy. I subtly used the empty chair, without the setting up the task, by indirectly encouraging Ava to talk to her mother about her anger. I mirrored Ava's resolve. According to Dr Wills, the focusing in session 10 was more therapist-directed than usual. Dr Wills observed that Ava struggled to confront her mother's pathology and that I had gently tried to assist her to acknowledge this. I also attempted to assist Ava to make contact with her resourcefulness. The body awareness

work was a consistent means by which I worked with Ava. Surprisingly to me, Dr Wills made no additional comments on my work with Chloe.

The conclusion I draw from Dr Wills quantitative analysis is that I was appropriately and consistently emphatic and affirming. I accurately reflected thoughts, feelings and behaviours as they presented and was at all times respectful, authentic, open and genuine. I maintained a safe working alliance throughout and supported the re-telling of traumatic experiences. I nearly always assisted and supported emotional expression that may have been difficult to express. I facilitated the use of the tasks competently more often than not. However, by Dr Wills's report that in my work with Ava I initiated appropriate focusing strategies less than half the time.

Dr Will's feedback on my chair work was valid too, as I acknowledge that only having had limited training (6 months) in the PE-EFT model. In addition, I was somewhat nervous in front of the cameras and I was certainly very eager to assist these young women. When I observed and critiqued my own work with these young women I was pleased to identify a particular style that is still present with me now. I am able to be *present* to my clients that puts them at ease and encourages them to share with me their painful experiences in a way that they feel heard and acknowledged. I enter their world gently and with curiosity. However, in my work now, 4 years on and thousands of hours later, I notice I am less eager, more patient, I can "trust the process" more comfortably and I take the approach that "less is more." I speak less and attend to the content less and follow the process more carefully. These qualities I recognise develop over time with experience and supported practice.

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