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INDIVIDUAL PSYCHOTHERAPY OF FEMALE PATIENTS DIAGNOSED WITH ANOREXIA NERVOSA, CONCENTRATED ON WORKING WITH THEIR BODY IMAGE — AUTHOR'S ORIGINAL THERAPY

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Summary

In the article I outline a therapeutic process for people with anorexia nervosa, which concerns viewing one's body image and self-esteem built around one's perceived figure. In the individual psychotherapeutic process presented here, which addresses the perception and evaluation of the body image experienced by patients, I focus on two major aspects: 1) striving for the so-called 'ideal' figure, created and fueled by the media, disconnected from the actual inherited body build, and 2) emotions that accompany the patients in the distorted perception of their body and associated with their interpersonal relationships or intrapsychic problems. Maintaining reference to the so-called 'ideal' figure, to which the patients aspire, I search together with each patient for similarities in their body build with that of their family of origin. As the therapeutic practice shows, this enables the teenage/adult female patients to increasingly accept their body build. However, working with emotions directed towards their own body, mostly consisting of anger, I consider together with the patient whether these emotions could have been transferred from interpersonal relations to body perception and to the negative attitude towards it.

Introduction

Conducting psychotherapy of female patients diagnosed with psychic anorexia for many years, I have often heard a familiar and recurrent body image-related narrative: 'I'm too fat', 'my legs, my belly are too fat' and 'I wish I had slimmer legs', 'a flat stomach', 'narrow hips', 'I wish I looked like Anja Rubik', etc. These statements repeated by my patients have led me to answer the question concerning references to the so-called 'perfect look'. As it transpires in talk with my patients, the phrase 'perfect look' often refers to the current ideal of the female silhouette promoted in the media. In the psychotherapeutic process of dealing with one's body image, I encourage a patient to identify parallels between her own build and the body parameters of her generational family – that is, similarities between the patient and her parents, grandparents and

the extended family. I claim that the generational perspective on one's body image can constitute some kind of reference to the transgenerational approach which I also adopt in family therapy [1].

As individual psychotherapeutic sessions with anorexia nervosa patients show, distorted body image can occur with varying degrees of severity. Patients then report hours or days when they do not perceive their bodies in a distorted way. These accounts have inspired me to uncover factors which could influence distorted body image. In the context of the psychotherapeutic process, I seek to identify with the patient intrapsychic and interpersonal factors which accompany a body image distortion. As regards the emotional sphere of body image, I consider not so much the patient's emotional attitude to her own body, viewed as primordial, as the displacement of emotions, in particular anger, from interpersonal relations, or intrapsychic frustration (e.g., dissatisfaction with school marks) onto herself/her own body image. In this article, I provide insights into conducting psychotherapy focused on distorted body image in patients suffering from anorexia nervosa. To better illustrate my clinical work, I use transcribed fragments of a psychotherapeutic process taken from therapy sessions with one of my female patients.

Anorexia nervosa

According to the latest versions of the International Classification of Diseases (ICD) and the DSM-5 published by the American Psychiatric Association, anorexia nervosa (anorexia, AN) is classified into a group of eating disorders [2]. Its global prevalence rates vary between 0.51 % (rigorously diagnosed anorexia nervosa) to 3.7% (borderline cases). The incidence of anorexia in patients aged 15-29 is 19 per 100 000 women and 2 per 100 000 men. First symptoms of anorexia can most often occur at the age of 14-18 years. An upward trend in the incidence of anorexia nervosa has been observed in the last 40 years. In the USA -research has shown an increase from 3 cases per 100 000 persons in 1965 to 17 cases per 100 000 persons in 1991. A similar tendency has also been observed in Europe. The causes of this increase remain equivocal. Researchers stress the increase in the number of individuals requiring psychiatric help in childhood and adolescence, which, inter alia, can be related to insufficient support from family and school, as well as the increasingly rapid pace of life [3]. The basis for the classification of psychic anorexia is a clinic-descriptive criterion. Multiple factors, including biological, personality, familial and socio-cultural, are thought to contribute to anorexia [4].

Body image

In contemporary clinical psychology, the experience of one's own body is considered in terms of body schema, body self, body image and body concept [5]. In the context of body experience, one distinguishes body schema and body image. According to Bielefed [after: 5], body schema is composed of body orientation, i.e. surface body orientation and internal body orientation, body size estimation, i.e. the estimation of body size and the space which one's body occupies in public space, and body knowledge, i.e. knowledge concerning one's build and body parts. In turn, for Bielefed, body image encompasses body awareness, that is, the mental representation of one's body or one's body parts, body boundary, i.e. the experience of separating one's own body from the outer world, as well as body attitude, i.e. one's attitude to the body, including one's satisfaction/dissatisfaction with the body [after: 5]. According to Cash [6], body image consists of body schema and body attitude. In his words, body schema denotes a cognitive representation of body knowledge. On the other hand, body attitude relates to the level of satisfaction with the body as well as body-related cognitive, emotional and behavioural contributions towards one's overall self-satisfaction. Rabe-Jabłońska and Dunajska [7, 8] also stress the multidimensional nature of body image, distinguishing a perceptual component as well as an body-related emotional stances, thoughts and attitudes, as well as body estimation which in turn shape perception. The authors claim that body image is also determined by a degree of convergence/divergence between ideal body image and objective conditions. For them, body-related intrapsychic and interpersonal experiences create an inner picture of body image, determine body attitudes and in consequence one's self-assessment. The claims and their assumptions discussed above do not contradict but complement one another. Bielefeld [after: 5] distinguishes: body schema [based on cognitive processes (body orientation, body knowledge)) and body image (referring to both cognitive (body awareness, mental representation of the body) and emotional processes (body attitude)]. In turn, Cash's [6] theorization of body image includes both cognitive (body schema) and emotional processes (body attitude, the degree of satisfaction).

Rabe-Jabłońska and Dunajska [7] also consider a perceptual and emotional dimension in their understanding of body image. Additionally, the researchers postulate their interdependence and the modulating influence of perception on one's self-assessment, and vice versa. The in-depth analysis of various conceptualizations of body image can be found in Brytek-Matera and Rybicka-Klimczyk's monograph entitled 'Wizerunek ciała w anoreksji i bulimii psychicznej ['Body image in anorexia and psychic bulimia']' [5].

Body image in female patients with a diagnosis of anorexia nervosa

The development of body image in patients suffering from anorexia nervosa can be considered through various lenses, inter alia, biological – related to thought disorder – cognitive-behavioural, psychoanalytic as well as socio-cultural, and social constructionist.

The biological perspective – in the context of cognitive processes – foregrounds false beliefs concerning one's body image. Psychic anorexia patients – despite significant underweight – are strongly convinced of their overweight or even obesity. It is their overriding objective to maintain slim body shape. They are often diagnosed with a disorder of thought content. Depending on one's retained insight, disorders of thought content occur in various degrees of severity, and can be arranged along the following continuum: obsessions, overvalued thoughts and delusions [9]. As Pytlińska [9] claims, thoughts about physical appearance and their accompanying emotions are frequently obsessive: patients report a subjective sense of compulsive symptoms, simultaneously keeping a critical distance to the content of the obsession. However, it often happens that this critical distance is shortened, and patients partially or completely accept the irrational content of their obsession. Their thinking is then entirely fixated on the issue of overweight and ways of reducing body weight. Most patients are of the conviction that they are 'too fat', which can be classified as overvalued thinking. On the other hand, behaviours whereby patients strongly believe in their overweight, despite unequivocal evidence to the contrary, in particular when this belief is life-threatening, can be considered delusions since these individuals are unable to rationally assess their thoughts [9, 10]. In the context of anorexia, the occurrence of disorders of thought content in the form of delusions has been scientifically proven, for instance, by Powers et al., [after: 9], who measure psychopathology in patients with anorexia nervosa, with the use of the PANNS scale [9]. Having eliminated schizophrenia, schizoaffective disorder and bipolar disorder in their research participants, Powers et al. observe high symptom intensity on the subscale for thought disorder and on the subscale for delusions. The researchers point out that such escalation of disorder of thought content in schizophrenia patients would qualify them for pharmacotherapy [9, 11].

In his research, drawing on the BABS scale (Brown Beliefs Assessment Scale), Ciesielski [10] measures disorders of thought content in anorexia patients. He analyzes the frequency and severity of irrational beliefs about body image. The results show that 56.7% of the patients demonstrate abnormal thinking in the form of overvalued ideas, and 2.1% of the patients exhibit a disorder of thought content in the form of somatic delusions [10, 11].

Steinglass J. et al. [12] also apply the BABS scale to measure the dominant beliefs of female anorexia patients which mostly concern body image and eating attitudes. The results reveal that

for 20% of the research participants, their beliefs reach the level of delusions [9, 12]. Clinical observations of the progression of anorexia nervosa point to a connection between the severity of disorder of thought content related to body image, and the severity of other symptoms of anorexia nervosa, which negatively affects treatment results and a medical prognosis [9]. Probst, Vandereycken and Van Coppenolle develop the BAT (Body Attitude Test) [12, 13], which measures one's subjective body experience and body attitude. It includes 20 items describing the severity of specific symptoms to be scored on a 6-point scale. 3 major subscales can be discerned: 1) negative body size appreciation, 2) body unfamiliarity, 3) body dissatisfaction. Probst and associates' research clearly identities statistically significant ($p < 0.001$) correlations between the cognitive component (irrational beliefs (BABS)), and the affective component (affective attitude (BAT)) of body image [14, 15]. According to many researchers, false beliefs, such as 'I'm too fat', co-exist with a negative emotional attitude to one's physical appearance [10, 14, 15]. Probst [15] distinguishes three types of body dissatisfaction caused by negative body experience as a consequence of perceived discrepancy between real and ideal body image in an anorexia nervosa population: 1) patients are dissatisfied with their body size and yearn to lose even more weight (negation of the objectively emaciated body), 2) patients are satisfied with their body size and do not intend to change it (resistance to weight gain), 3) patients are aware of their thinness and yearn to gain weight (expressed in various degrees of insight) [10, 14, 15]. In the light of irrational beliefs about body image discussed above such as overvalued thoughts or a disorder of thought content in the form of somatic delusions, work focused on the body can also entail the danger of undue concentration and fixation on the body, As a consequence, it can reinforce thought disorders as well as the negative assessment of one's body and one's self.

In the cognitive-behavioural perspective, an important factor in the aetiopathogenesis of anorexia nervosa is body image. According to Cash [6], body image is a cognitive representation of knowledge about one's body as well as body-related feelings. Cash forwards a cognitive-behavioural model of body image whereby body image is formed by two groups of factors: historic-developmental and mediating. The former include hitherto operative experiences, thoughts and actions related to the body, including interpersonal experiences, eating habits, features of one's physique and body weight (BMI), as well as an individual's self-esteem. Mediating factors refer to thoughts, interpretations and emotions related to the body as well as behavioural strategies of self-regulation [5, 6]. In the context of cognitive behaviourism, Williamson et al. [16] develop a cognitive model of body image whereby they postulate that body shape and body size, as a cognitive schema, are shaped by an individual's idiosyncratic

features, the type of external stimulation, cognitive processes (including cognitive errors) and emotions. The researchers observe a feedback relation between the cognitive representation of the body and emotions. What is postulated here is that individuals with a negative cognitive representation of their physical appearance can demonstrate negative emotions. In turn, one's bad mood can activate an unsatisfactory schema of body image. This can further contribute to one's low mood, thereby exacerbating the body image distortions [5, 16].

In psychoanalysis, researchers point to the mother-child relation in early childhood as the basis for body self which constitutes the first image of the self to be created in one's consciousness. A mother's touch and sensory-proprioceptive stimulation help a new-born baby to create a primordial body schema and body boundaries. For Kreuger, the regulation of basic states, such as hunger/satiety, sleep/wakefulness, activity/rest, as well as basic needs, such as affiliation, bond, expression, exploration, takes place in a relationship with one's mother [17]. The progression of anorexia nervosa is thought to be significantly influenced by both body image distortions caused by the lack of integration of the body self and the psychological self, and by diffused body boundaries [17, 18]. As Bruch [19, 20] remarks, body image distortions in anorexia patients are related to perception disorder (domination of analysis over synthesis) and the cognitive interpretation of stimuli from the inner body – interceptive awareness. For Bruch, body image disturbance relates to the difficulties in the process of separation/individuation in the first three years of life. During this time, a child can be 'programmed' according to the mother's needs, which can be observed in that she does not sufficiently try to identify the child's own needs but views them through the lens of her needs. In such situations, the child cannot learn to recognize his/her own emotions and desires, feeling confused and helpless. As a consequence, he/she experiences difficulties in forming boundaries of body image and integrating the self [19, 20].

Socio-cultural context and the social constructionist perspective. The image of the perfect female body shape has been evolving along with historical changes. Accordingly, the thinking and understanding of as well as the attitude to eating disorders have been changing too. The historic-cultural preferences for particular female body shapes can be observed in literature and painting. In particular, female silhouettes captured in the latter enable one to compare various images of the female body across centuries. In the Renaissance, Titian's famous works of art depict curvy women who, according to the contemporary norms, would be considered overweight or even obese. Also, 'a Rubensque figure', a well-known and widely used phrase today, refers to the Baroque and Rubens's works, which portray women of ample figure [21, 22]. Conversely, later epochs, e.g., Rococo or the Belle Époque, presented a woman's body

as slimmer but retained its feminine shape and highlighted the waistline. In the 20th century, the perfect female body image was changing too [23]. The twenties promoted a very slender and skinny figure; the thirties and forties favoured a more curvy female body; in the fifties, fuller breasts and hips, and a highlighted waistline were desirable; finally, the body ideal of the sixties was a very slim silhouette. For Jablow [23], promoting the unfeminine body shape, also associated with helplessness and girl-like attributes, has contributed to a skinny figure becoming increasingly popular [23]. As a consequence of portraying this body ideal in the media (actresses, fashion models and celebrities), slenderness has become the standard symbolizing success, happiness and appeal.

In anorexia nervosa, body image-related socio-cultural factors can be approached through the lens of social constructionism. According to this perspective, the investigation of various phenomena should consider their temporal, spatial and social contexts. In line with social constructionism, all knowledge is social, that is, it is brought into being and sustained through agreement in social interaction. Knowledge also implies social behaviour: cultural factors stipulate whether particular behaviour can be treated as a disorder or not [19, 24–26].
Given that, the examination of anorexia nervosa from a social constructionist standpoint postulates that the interpretation of anorexic behaviour and the socially accepted norms for the female body depends on the cultural context and dominant discourse at a given time. Hence, not only is the social constructionist perspective attuned to the temporal context but also to spatial and social parameters, thereby showing that behaviour which is globally interpreted as a disorder can locally acquire a normative status. For instance, the aspired-for and widely promoted image of a very slim, or sometimes even emaciated body, accepted as the norm in certain local contexts (e.g. for fashion models or ballet dancers) can become a widely accepted social standard [27].

In my clinical practice, I observe the phenomenon of 'displacement' of various kinds of negative emotions and mental discomfort onto a person's body image. Against this backdrop, I put forward a hypothesis that patients with a diagnosis of psychic anorexia direct their frustrations at their body image and accumulate them in it. For example, a patient who is dissatisfied with her school marks or interpersonal relations, as if automatically, displaces these negative emotions onto the sphere of body image, which further intensifies the dissatisfaction with her build, body shape and weight.

Transcribed fragments of therapy concentrated on working with one's body image

To illustrate my work in the context of individual therapy concentrated on working with body image, I use transcribed fragments of a psychotherapeutic process taken from therapy sessions with one of my female patients, Monica (aged 15). The patient's name and all personal details which could disclose her identity have been changed into fictive ones. The transcribed fragments are presented in the original version; no corrections have been introduced. The patient and her parents have given written informed consent to quote and publish the patient's contributions during individual therapy sessions in a scientific journal.

Context of referral – the patient was referred to therapy by the school psychologist who also gave her parents my contact details. Due to the patient being underage (15 years old), a consultation was arranged by the parents.

Context of therapeutic intervention – therapy sessions took place in my private consulting room. The first appointment, made by the parents by telephone, was attended by the patient and her parents. Before the referral to therapy, the patient was hospitalized due to fainting in the Pediatrics Department of a local hospital, and discharged with a diagnosis of anorexia nervosa. Data collected from an interview with the parents: Monica, aged 15, had been developing correctly since birth and had not had any medical condition (except for childhood diseases). She had been on a diet for 10 months before the appointment and had lost 17 kg. Her period had stopped. The patient's height: 173 cm; her weight during the first appointment: 46 kg (BMI: 15). Monica was a second grade middle school student. In terms of her physical appearance, she was well-groomed, although one could notice her tiredness and underweight. There were five people in the patient's family: mother, father, sister (aged 13) and brother (aged 10).

Psychotherapeutic contract — for the purpose of psychotherapy, as part of a nosological diagnosis and due to the patient's age, I discerned a need for individual work with the patient focused on, inter alia, the function of anorexia symptoms in her developmental period, and a need for work with the family, concentrated on both anorexia symptoms and their reduction, as well as on family relations. Hence, I recommended Monica and her parents individual and family therapy. I also recommended that these two different forms of therapy be conducted by either the same therapist or two different therapists. The parents and their daughter opted for one therapist to conduct both types of therapy. In my therapeutic work with children and adolescents, in certain cases, I decide to deliver individual and family therapy single-handedly. I then draw on the multi-layered integrative model developed by L. Feldman, which postulates the relevance of intrapsychic and interpersonal processes to child and adolescent

therapy [28]. An in-depth account of why I integrate individual and family therapy in my clinical practice can be found in my article entitled 'Łączenie terapii indywidualnej i rodzinnej w zaburzeniach psychicznych dzieci i młodzieży w kontekście relacji terapeutycznej, dialogowego Ja oraz praktyki terapeutycznej ['Combining individual and family therapy of child and adolescent psychic disorders in light of therapeutic relation, the dialogical self and therapeutic practice']' [1], where I refer to the notion of therapeutic relation and the dialogical self, and consider the pros and cons of such an approach. Unfortunately, a more thorough discussion of these issues would be beyond the scope and topic of this article.

Together with the patient and her parents, I established the frequency of family and individual sessions which would take place alternately. Each of them would be held on a monthly basis. This meant that the patient would see the therapist every second week (first with the parents and then individually). I also recommended that the patient's siblings be co-present at appointments. According to the systemic paradigm, it is a standard practice to have family sessions once a month. However, the frequency of individual sessions was dictated by the financial resources of the patient's parents (therapy sessions were held in my private consulting room). During the psychotherapeutic intervention, the patient did not receive psychiatric treatment but remained under a psychiatrist's care.

After four individual and three family sessions, the therapy focused on work with body image. In the family therapy, I drew on the systemic paradigm, applying a few approaches, including structural, strategic and transgenerational perspectives. In turn, the individual therapy was tailored to the patient's age, and was informed by the cognitive-behavioural paradigm as well as a narrative approach, in particular in the context of work dealing with issues related to the perception of one's body image, the pros and cons of the eating disorder, the subjective sense of control, the sense of freedom and the substitute gratification provided by the disorder. Below I present transcribed fragments of two therapy sessions during which I was helping the patient to process issues related to her body image. A more comprehensive description of therapeutic work with an anorexia nervosa patient, informed by the integrative insights of individual and family therapy, is currently in preparation.

A transcribed fragment of a therapy session presenting the perception of one's body in the generational context.

Therapist: Monica, during our last conversation, you said that you are dissatisfied with your appearance because you do not look perfect. What did you mean by the perfect look?

Patient: Well, I meant that I do not look the way I would want to.
T.: So what would you want to look like?
P.: I do not know, I would like to have thinner thighs, narrower hips and a smaller belly.
T.: As regards your appearance, would you like to be similar to anybody?
P.: Well, I do not know, perhaps yes.
T: To whom?
P.: I like Anja Rubik, I would like to look like her.
T.: Is Anja Rubik similar to somebody in your family?
P.: No.
T.: And your figure, who in your family has a similar figure?
P.: I don't know maybe my mum a bit.
T.: How is your figure similar to your mum?
P.: I have hips like my mum, my mum has such wide hips too.
T.: Who else in your family has a build similar to yours?
P.: Also my grandma a bit because she has such thicker thighs.
T.: Grandma, on your mother's or father's side?
P.: On my father's side but the grandma on my mother's side has in turn a paunch.
T.: Do your grandmas and mum look like that now or perhaps have you seen their photos when they were your age?
P.: I haven't seen photos of my mum.
T.: What can you say about your mum's figure when she was your age?
P.: My mum was slim, in fact she looked nice, she would only wear funny clothes.
T.: And the grandmas, have you seen photos of them from their youth?
P.: Yes, I can remember seeing a photo of the grandma on my mum's side in the album.
T.: What figure did she have?
P.: Just right, rather slim.
T.: Could you and your parents look for photos of your grandma on the dad's side at home? Maybe, you will find other photos of your mum and her mum from their youth.
P.: Okay, I have not considered watching their photos.
T.: Monica, in this case, is it possible for you to look like Anja Rubik if you have nothing in common with her family?
P.: Well, no.
T.: And is it possible for you to be similar to your family?
P.: Yes, I am similar to my family.
T.: And what do you think about that?
P.: (on second thought) well in fact, it is logical and great because now I know why I have such a build.
T.: And you know too what you inherited from what relative.
P.: Yes.
T.: So in this case, is your desire to be similar to Anja Rubik the same, smaller or bigger now?
P.: Smaller [patient's laughter]
T.: Would you like to return to this topic after seeing photos of the grandma on your dad's side and perhaps of other relatives?
P.: Yes.

A transcribed fragment of a therapy session presenting the displacement of negative emotions onto one's body image in the context of individual therapy.

Therapist's question.: Your self-perception is also changing, right? Is it more often closer to what you see in photos and to what others say about your appearance? There is always such a comparison with what others say, or still sometimes not yet?
Patient.: Mhm, sometimes not.
T.: And when not?
P.: That is?
T.: Can any factors affect the fact that you do not sometimes perceive yourself adequately, that is, you see yourself too fat?
P.: No, I do not know. Simply, I do not know, maybe some silly thought.
T.: What silly thought?
P.: Well, for example, that something is protruding.
T.: What is protruding?
P.: I do not know, I sometimes think it is the stomach or something like that, but then I put these thoughts out of my mind. But I do not care because I know that in a moment I am going to think that everything is alright.
T.: Mhm. And Monica, is it possible that you sometimes see this protruding stomach when for example for some other reason you are dissatisfied with yourself? Are these things somehow related?
P.: I think so.
T.: How are they related?
P.: I do not know, maybe when I am angry at something.
T.: At what? At whom?
P.: I do not know, even when my sister irritates me.
T.: What then?
P.: I do not know, then I am angry and everything seems wrong to me, that when I look at myself, it seems to me that I have a protruding stomach.
T.: Mhm right, is it possible that when you are angry or dissatisfied, when something is not going your way, you see such a bad image of yourself in the mirror, in a sense that you see a protruding stomach. So you do not like yourself then, do you?
P.: Yes [whispering]
T.: In what sense can this be related to external circumstances, for instance related to what is going on between you and your sister? In percentage terms, how does this influence how you see yourself in the mirror?
P.: 70%?
T.: Oh, that is a lot.
P.: Well because probably when I am angry, I see myself differently.
T.: Mhm. So next time when you see a bad image of yourself in the mirror, could you reflect on who you are anger with and why?
P.: Mhm [confirming]
T: Could you then reflect on that? Could you think of what causes you to see such a bad image of yourself? Right?
P.: Yes.
T.: What do you think of such a link and of identifying such relations?
P.: [Roughly 2-min pause] When I am angry or dissatisfied with myself, I see myself differently than when I am happy and satisfied.

T.: So when you are angry, dissatisfied, you focus this anger on yourself, right?
P.: Mhm [confirming]
T.: Mhm. And what could you do with anger? Other than see yourself badly?
P.: I do not know.
T.: Did you sometimes happen to feel anger before you fell ill?
P.: Mhm [confirming]
T.: And what did you do with anger?
P.: When I am angry, for example, with somebody, I cannot keep calm, only scream.
T.: But by 'being angry', do you mean anger? Or other emotions too, for example that you are sorry?
P.: That too.
T.: Too?
P.: When I am in a bad mood.
T.: In a bad mood, so you feel such unpleasant emotions, right?
P.: Yes.
T.: Yes, then you scream, you screamed, right? Do you also scream now?
P.: Now too, when I am dissatisfied with something, when I am unsuccessful then I pick holes, then I can direct all my anger at somebody else.
T.: Mhm. But now when you are ill and when you saw yourself fat so often, was this anger also directed outside? Or somehow to a smaller extent?
P.: No, then I wanted to be alone all the time.
T.: Could it be that the anger which you had previously expressed by shouting, that this anger was copied onto how badly you saw yourself? And then you were angry with yourself?
P.: Yes.
T.: Are you sure?
P.: Yes, then I was angry with myself that I had not succeeded in something and that it was my fault. And that I looked that way and that I should still try to lose weight.
T.: Could it be that the anger with somebody else which, as you say, had once been outwardly expressed by shouting, was now re-directed at you and at your anger with yourself, right?
P.: Yes.
T.: Mhm. And now if you are seeing yourself fat less and less often, does it mean that you are less angry or do you do something else with this anger?
P.: Then I rather shout at others.
T.: So you are returning to what you did in the past?
P.: Mhm [confirming]
T.: Is it more or less beneficial to you?
P.: Perhaps less since when I am angry, I cannot tell somebody something more, do harm.
T.: And then you are sorry for saying too much, right?
P.: Mhm [confirming]
T.: How about finding a solution which will not hurt others but which will not be against you either? Would you be interested in such a solution?
P.: Yes.
T.: Yes. Because anger is a natural emotion, people get angry. It can possibly be our task to work out what to do with this anger, how to tackle it, if you are dissatisfied with how you did that. Previously, as you say, you were angry with

others, shouted and then you entered the life stage whose integral part is defiance against others. Was your anger focused on you and the perception of that negative appearance at that time?
P.: Yes.
T.: How do you think, to what extent might your illness have been caused by anger?
P.: [2-min pause] I think a lot since I demand a lot of myself and if I saw that I was not successful at something or that I did not like something, I wanted to change that. Then it went too far somehow.
T.: But what went too far?
P.: Well because at the beginning I planned to lose a few kilos, then I started somehow push that limit and then I sort of lost myself.
T.: But you said that you often demand too much of yourself. Did that refer to food only, or other things too?
P.: Other things too.
T.: For instance, what?
P.: I do not know. School.
T.: Have you ever been dissatisfied with your school marks, with achievements?
P.: Mhm [confirming]
T.: What did you do with this dissatisfaction, with this anger?
P.: I do not know, well later I studied harder, I wanted to improve marks.
T.: But with this very feeling, with this emotion when you get a mark and feel anger, you are sad. Is that what you did? Before you fell ill.
P.: I do not know.
T.: Did you talk about that with the parents, did you cry, what did you do?
P.: [Roughly 2-min pause]. I do not know, I probably did something, I do not know, I cannot remember.
T.: Mhm, but you also said that you had tried to study harder to improve [marks], right?
P.: Mhm [confirming]
T.: Your anger might have been caused not only by school and your demands. Was it caused by something else? I might have been caused by relations with people, for example.
P.: Well, arguments with the sister or parents.
T.: But were these arguments, that is you expressed anger, right?
P.: Mhm [confirming]
T.: But when you started to slim down, when the illness started, did you stop expressing that anger, or not?
P.: At the beginning, yes, later I stopped. I only wanted to sit alone.
T.: Mhm. And then, did you start getting angry with yourself?
P.: Mhm [confirming]
T.: And now?
P.: Now it is rather like it the past, I do not get so much angry with myself but like in the past, I do not become withdrawn and do not want to be alone but I transfer this anger, I do not know, onto someone else by shouting.
T.: Mhm, in such severe anorexia, as far as I know, since your parents also said that, this anger was related mainly to food, right? Or food aversion?
P.: Mhm [confirming]
T.: Food aversion, right?
P.: Mhm [confirming]

T.: And your anger was focused on that?
P.: Mhm [confirming]
T.: And now, as far as I understand, you start getting angry with others, right?
P.: Yes
T.: And how do your parents react to your anger?
P.: [Roughly 2-min pause]. They are sorry since I can say somehow too much. I mean, I do not watch my words, and they must be upset.
T.: What does it mean to you?
I: I feel upset too.
T.: Mmm. Would you like to find solutions to anger which everyone feels?
P.: Yes.
T.: In order not to hurt others but to still show them this anger.
P.: Yes.
T.: Mhm. And in your case, do you immediately say what you feel or do you bottle this up and then explode?
P.: No, I rather say immediately.
T.: Immediately. Mhm [confirming]. And now do you get angry about relations with people or your stomach, which is too big?
P.: No, about relations with people.
T.: Aha, so your emotions are again focused on interpersonal relations, the outer world, right?
P.: Yes.
T.: Do you think, can this also influence how you see yourself in the mirror?
P.: That I am more in touch with people, right?
T.: As we said earlier, perhaps that you were so angry with yourself about this belly which you saw was related to the anger caused by something else? So, you were angry, for example, with someone or yourself about something and punished yourself for this big belly.
P.: Well, it was once so.

Conclusions

Offering therapy to female adolescents diagnosed with psychic anorexia, I usually recommend two forms of therapy: individual and family. In the former, I focus on various aspects, including predisposing factors which trigger and sustain the eating disorder. One of them is body image distortion which, depending on its severity, is the focus of one or two sessions. I introduce the topic of working with a patient's body image after making a therapeutic alliance and establishing a good rapport with her, which, in the case of anorexia patients, does not happen at the beginning of the therapeutic process. My work on body image in particular concentrates on two issues: the influence of emotions on one's body image and the role of hereditary factors determining one's build. By focusing on the influence of intrapsychic and interpersonal emotions, I draw on the cognitive model of body image and the feedback relation between emotions and the cognitive representation of one's physical appearance. As clinical experience shows, the negative representation of patients' appearance evokes in them a low mood. In turn, a negative emotional stance projected on the body aggravates the unsatisfactory

schema of body image and further reinforces negative emotional reactions. In my opinion, it is of crucial importance for therapists to recognize and identify the impact of emotions on body image perception. They can then alter patients' body image-related assessment, beliefs and thoughts.

The second important aspect of working with one's body image is to make the patient realize her own body proportions and body size. This becomes possible by referring to transgenerational 'messages' in the therapeutic process. From a biological standpoint, this means genetic similarity in body shape and size between patients and their relatives. Not only does the recommended transgenerational perspective on the body helps the former discern but also accept their own bodies, and hence helps them stop the pursuit of the so-called 'perfect' body. For a couple of years, I have been applying the methods presented above in my clinical practice with patients diagnosed with psychic anorexia. I have been observing their curiosity and positive attitude to the topics initiated by me, as well as a positive outcome of these therapeutic techniques on their self-concept as observed in the gradual acceptance of their body shape and body size.

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