



An Interpretative Phenomenological Analysis of Schema Modes in a Single Case of Anorexia Nervosa: Part 1

Background, Method, and Child and Parent Modes

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Abstract

Within the schema therapy model, schema modes are the shifting experiential states that individuals experience, and identification of these is central to case conceptualization and the planning of interventions. Differences in the naming and descriptions of modes in the literature suggest the need for systematic phenomenological investigation. This paper presents the first part of an interpretative phenomenological analysis of schema modes within the single case of Linda (20), a young woman with anorexia nervosa. The analysis, which is based largely on transcripts of seven therapy sessions, yielded phenomenological accounts of her experience of a number of modes. In this, the first of two papers, a phenomenological account of her Child and Parent modes are presented and discussed.

This is the first of two papers reporting on a study which aimed to identify and examine the psychological structure of schema modes within a single case, that of Linda, a young woman with anorexia nervosa treated with schema therapy (ST). Developed by Jeffrey Young during the 1980s, ST expanded on Beck's cognitive therapy by integrating experiential interventions with imagery and chair dialogues and an emphasis on a therapy relationship in which the therapist offered an honest and genuine presence and explicitly assumed a reparenting role. ST was intended for cases that did not respond to brief interventions, usually because of long-standing characterological problems (Behary & Dieckmann, 2013; Young, 1990; Young & Flanagan, 1998; Young, Klosko, & Weishaar, 2003; Young & Lindemann, 1992). Subsequently, randomized controlled trials provided evidence that ST is an effective approach for treating challenging cases of this kind (Bamelis, Evers, Spinhoven, & Arntz, 2014; Farrell, Shaw, & Webber, 2009; Giesen-Bloo et al., 2006; Jacob & Arntz, 2015). A schema therapy approach to eating disorders, the focus

of the present papers, is also well established (Archonti, Roediger, & de Zwaan, 2016; Ohanian, 2002; Simpson, Morrow, van Vreeswijk, & Reid, 2010; Waller, Kennerley, & Ohanian, 2007).

ST is one of several therapies that focus on the multiplicity of internal voices or self-states which underlie experience and behaviour. Appreciation of such multiplicity is not new. It can be found in Origen (born circa 185 CE) (Jung, 1946/1954) and in Durand, a French hypnotherapist, whose 1868 work is cited by Ellenberger (1970), and there is a large literature examining the implications of such multiplicity (Assagioli, 1965; Berne, 1961; Hermans & Dimaggio, 2004; Jung, 1948/1969; Rowan, 1990; Rowan & Cooper, 1999; Schwartz, 1997; Watkins & Johnson, 1982). The different modes of experience are memory-based, and their cognitive, sensory, motor and vocal features reflect the way in which they have been shaped by earlier experiences (Stiles, 2011). In ST, these states are called schema modes (Flanagan, 2010, 2014), defined as "the moment

to moment emotional states and coping responses – adaptive and maladaptive – that we all experience” (Young, Klosko, & Weishaar, 2003, p. 37). Schema modes are therefore phenomenological categories of experience that play a significant role in the process of unfolding experience and behaviour in any individual case.

Some modes are adaptive, contributing to healthy functioning, while others are maladaptive and give rise to psychological distress, and chronic psychological and behavioural problems. The ST model shares the perspective of Stiles (2011, p. 368) who points out that conflict and/or disconnection between different voices “underlies many forms of psychopathology”. “A dysfunctional schema mode”, write Young et al. (2003, p. 40), “is a part of the self that is cut off to some degree from other aspects of the self” so that an individual’s psychological responses are not integrated. Schema therapists listen for these different states, identify and name them, help clients see the nature of the conflicts between them, and work strategically to resolve the conflicts and promote corrective experiences (Behary & Dieckmann, 2013; Flanagan, 2014; Kellogg & Young, 2006).

The ST model offers an approach to classifying the many and diverse states of human experience into broad categories that are of practical relevance clinically. These are called schema modes, and there are four basic categories, each of which can be divided up into subcategories (Young et al., 2003). Firstly, in “Child” modes, individuals experience the world through an implicit memory system that developed mostly in their infancy and early childhood (as documented, for example, by attachment researchers). In the Vulnerable Child (VCh) mode, for instance, individuals experience vulnerability, embedded in early maladaptive schemas (EMSs), problematic cognitive-emotional patterns that incorporate negative beliefs about self and others. These arise from early childhood experiences of invalidation, inconsistency, neglect, or abuse, in which significant developmental needs were not met. The Young Schema Questionnaire (YSQ), developed by Young in 1990 and subsequently revised and refined, measures 18 such themes (Schmidt, Joiner, Young, & Telch, 1995; Simard, Moss, & Pascuzzo, 2011) and has been used to investigate EMSs in eating disorders, the focus of these papers (Sheffield, Waller, Emanuelli, James, & Meyer, 2009; Waller, Shah, Ohanian, & Elliott, 2001).

Secondly, Dysfunctional Parent modes are introjects, demands and rules (Demanding Parent – DemP) or disdainful, critical attacks (Punitive Parent – PunP) taken literally from the words of parents or other authority figures and perpetuated as entrenched habits of self-critical or demanding self-talk. The third category – Coping modes – covers habitual patterns of shutting down emotional distress in the VCh mode, processes

traditionally referred to as “defence mechanisms” (Freud, 1896/1962), “security operations” (Sullivan, 1953) or “defensive, pain reducing postures” (Maslow, 1962/1968, p. 205). There are three broad subcategories: in avoidant modes, individuals shut down or distract from painful emotional states; in overcompensator modes, they “act as if the opposite of the schema were true” (Young et al., 2003, p. 276), appearing to be strong and in control; in surrender modes, they implicitly accept negative beliefs associated with the EMSs and expect that their needs will not be met, and so relate to others in compliant and appeasing ways.

The fourth mode category, the Healthy Adult (HA), is one of mature and integrated human functioning. It includes the capacity for reality-oriented reappraisal of thoughts and attitudes that is an important focus in cognitive behavioural therapy (CBT) and existential therapy (Yalom, 1989). However, unlike the “Adult” in Transactional Analysis (TA), which Berne (1961) defined as a rational problem-solver, the HA is conceptualized as what Carl Rogers (1967) called a “fully functioning person”, with the capacity not only for rationality but also for reflective thought, mature judgment, mindfulness, engagement with emotions (one’s own and those of others), empathy, compassion and the capacity to care.

Schema therapists use this framework to develop a case conceptualization and will typically explain to their clients (a) how Parent and Coping modes interfere with the capacity to connect with and be guided by emotional responses, with the processing of painful emotions, and the resolution of losses; (b) how EMSs, as disowned distressing experiences in the VCh, are the source of distorted perceptions of present situations; (c) how Coping modes may masquerade as mature functioning, and as such displace the HA by creating what Winnicott (1965) called a “false self”; (d) how Coping modes become inflexible and limit the individual’s capacity to deal maturely with everyday challenges, or how rapid shifts between modes make behaviour inconsistent and unpredictable, which is confusing both for the affected individuals and for those with whom they interact (including their therapists). Schema therapists aim to help their clients

- (1) build/strengthen the HA;
- (2) access and heal the VCh and other Child modes, such as the Angry Child (ACh), that carry dissociated memories of emotional distress;
- (3) eliminate Dysfunctional Parent modes, and
- (4) modify or weaken Coping modes.

Therapists offer an empathic, caring relationship in a style referred to as limited reparenting that aims to provide corrective experiences, but also challenges dysfunctional attitudes and behaviour through empathic confrontation.

Schema modes are not meant to be imposed on clients, but to be allowed to emerge experientially. Therapists not only listen for the different voices and help clients differentiate them, but also use dialogue methods with imagery and chairwork to help clients experience, recognize and articulate the features of the different modes (Arntz, Bernstein, & Jacob, 2013; Kellogg, 2004, 2015; Young et al., 2003). They also allow the nature of conflicts between modes to be clarified and the beliefs and attitudes within specific modes to be articulated and re-evaluated. Imagery rescripting is a guided imagery technique where the therapist works with a memory of a distressing childhood event and promotes a corrective experience by, for example, introducing helpful figures such as the therapist him/herself or the client as an adult to empathize with and protect the child (Arntz, 2011, 2012; Brewin et al., 2009; Edwards, 2007; Ohanian, 2002). These and other methods, including cognitive and behavioural interventions, bring about changes within these modes or in the relationships between them.

While there is general consensus about the four broad categories of modes summarized above (although Flanagan, 2014, is an exception), there is nevertheless some diversity and inconsistency. One source of this is differences in definition. Parent modes, for example, are experienced as demanding and critical voices directed at the self. When the individual directs them at others, they are understood to be part of overcompensator coping modes (Lobbestael et al., 2007). However, Young et al. (2003, p. 277) define Parent modes as "usually self-directed", although they also make allowance for them to be directed at others. A second source of inconsistency lies in the scope of a particular mode category. Overcompensator coping, for example, initially referred to a state in which individuals present as strong, independent and emotionally invulnerable. However, with time, specific forms of overcompensation have been identified and named, including Self-Aggrandizer, Attention and Approval Seeker, Perfectionist Overcontroller, Suspicious or Paranoid Overcontroller, and Bully and Attack (van Genderen, Rijkeboer, and Arntz, 2012).

A third source of variation in the naming of modes results from the idiographic approach of clinicians in practice. As therapists attune to a particular mode in a particular client, they seek to find a name that best expresses its qualities in that client. Thus, although the terms Punitive Parent and Demanding Parent are widely used, there are references to compound terms such as "Demanding/Critical Parent" (Lobbestael et al., 2007, p. 85) or "Punitive/Critical Parent" (Young et al., 2003, p. 277), as well as additional terms such as "Guilt-Inducing Parent" (Jacob, van Genderen, & Seebauer, 2015) and "Disapproving Parent" (Young et al., 2003, p. 193). Similarly, when child states are accessed, terms such as "Lonely Child", "Abandoned and Abused Child"

or "Dependent Child" (Lobbestael et al., 2007) may be used to reflect the salient emotional quality of particular states.

Fundamentally, the identification and differentiation of modes is an idiographic process. That is, the various modes are derived phenomenologically by therapists in therapy sessions. This accords with Berne's (1961, p. 4) claim that Parent, Adult and Child, "ego states" central to Transactional Analysis (TA), were "not just concepts but phenomenological realities" that can be reliably discriminated from the language and behaviour of clients. Phenomenological research is based on identifying and explicating the patterns that underlie the structure of experience. To see these patterns calls for a capacity to perceive them – a psychological mindedness (Finlay, 2011), or what Husserl called "intuition" (Giorgi, 2014, p. 237). The widespread recognition of multiplicity already cited shows how the capacity to identify and work with multiple states is something that therapists learn. The claim that schema therapists learn to recognize modes as phenomenological realities is supported by the ease with which, within the schema therapy community, they use the language of modes to communicate about clients' experience and behaviour.

A schema mode can be thought of as what Merleau-Ponty (1942/1967, p. 220) referred to as "a structure of consciousness". There has been little formal research into the phenomenology of schema modes, and the kinds of inconsistencies referred to above point to the need for a programme of phenomenological research into the nature and psychological structure of different modes. Three decades ago, in setting out a programme for phenomenological research, Giorgi (1986, p. 165) described as appropriate questions to guide psychological enquiry "How many types of perception are there? What styles of memorizing exist? ... How many kinds of depressive behaviours are there?" The aim of the present study was to identify and examine the psychological structure of schema modes within a single case, that of Linda, a young woman with an eating disorder. A second aim was to see whether this kind of idiographic phenomenological research could contribute to resolving some of the inconsistencies in the literature on schema modes. It was expected that detailed analysis of this kind would also allow some recommendations to be made that might be relevant to increasing the effectiveness of schema therapy in practice. To address these aims, several sessions of Linda's therapy were examined intensively, in many of which experiential work with guided imagery and imagery rescripting was prominent.

Method

Methodological Approach

Methodologically, the research is an application of

interpretative phenomenological analysis (IPA) (Finlay, 2011; Smith & Osborn, 2003). Brooks (2015, p. 644) points to IPA as "meticulously idiographic, requiring an in-depth examination of each case in its own terms before moving to the next case. ... IPA is not in principle averse to moving to more general claims, but such a move for IPA will be a slow, painstaking one". The present study is of a single case, and so it is indeed "meticulously idiographic". Nevertheless, the findings will be examined later in light of the many relevant observations in the existing literature, some of which have already been cited.

Research Participant

Linda (20) had met the criteria for Anorexia Nervosa, purging type (her BMI fell to 16.3) and was severely depressed. I saw her for 43 sessions over 15 months, and she also voluntarily entered a hospital programme between sessions 22 and 23. A CBT approach aimed at helping her stabilize her weight, develop a stable eating pattern, and stop the induction of vomiting had limited impact. ST was then gradually introduced and schema modes were identified and used as the basis for case conceptualization. In accordance with the University's ethical procedures, Linda gave informed consent for the use of the material for publication. To protect her privacy, a pseudonym is used and limited identifying information is included.

Sources of Data

A summary of the assessment process and process notes on all 43 sessions were available, with audio recordings made of the last 17 sessions, in several of which intense emotion-focused work took place. Sessions 28, 30, 32-35 and 40 had previously been transcribed as a basis for an extended case study (Edwards, 2016) and were the main source of data for the present analysis.

Qualitative Analysis Steps

The author, who also conducted the therapy, had already had several opportunities to engage with and reflect on the material after the therapy was over. He had included segments of the recordings as part of conference presentations and training workshops, and wrote an extended systematic case study, published in German (Edwards, 2016). For the purpose of the present study, the steps described below were followed:

Step 1: A data condensation was written that briefly summarized salient features of the case history.

Step 2: The selected session transcripts were read systematically and examples of identifiable modes were highlighted and clustered. In any form of therapy, dialogue between therapist and client is mediated by specific discourses. It is a normal feature of schema therapy for the language of schemas and modes to be used by the therapist, and communicated to clients. Linda used several of these terms and had learned to

identify several of her modes. This served, therefore, as an explicit forestructure (Packer & Addison, 1989) for the therapist, and to some extent for Linda herself. However, if, as has been argued, modes refer to distinct, identifiable experiences, then these will be apparent from the material itself, particularly since emotion-focused experiential interventions featured prominently. For this research project, this language continued to be an explicit forestructure, and the categories of modes from within the schema therapy literature were used as *a priori* categories for interrogating the material. This is a common strategy in the thematic analysis of qualitative data. As has been shown above, these categories are phenomenologically grounded in an extensive clinical literature. At the same time, there was a careful focus on the actual phenomenology of the experiences in the transcripts, along with an openness to adding other mode categories to accommodate material that did not fit the existing ones. In presenting the different modes identified, there is extensive use of verbatim quotations as well as of psychologically rich descriptions. Several instances will also be referred to where mode language was used in the therapy in a manner that was imprecise or even incorrect and where the present analysis pointed to a more accurate classification.

Step 3: The diverse material was condensed and then synthesized into an in-depth phenomenological rendering of Linda's experiences within each category. The extensive use of verbatim quotations contributes to communicating the lived experience of each mode by means of rich, thick descriptions. The inclusion of these verbatim quotations is also intended to allow readers to judge for themselves whether the material in fact fits the relevant categories. Within the account of each mode, specific themes were identified and articulated, if and where appropriate. The accounts were then shortened by removing repetitious material. Sessions are referred to as S1 (= session 1) and so forth. In extracts quoted verbatim, pauses are indicated by a dash (-), where repetition or superfluous material is omitted this is indicated by (...), and linking words are added in square brackets.

Step 4: Superordinate themes were identified that arose from the author's reflections on the whole process of engaging with the material. These were pertinent to understanding the nature of schema modes, the relationship between them, and conceptual challenges for those working with them clinically. Material relevant to each theme was gathered together and synthesized, and the theoretical concerns and questions raised by each were articulated.

Presentation of Results

The IPA yielded detailed descriptions of some modes, brief references to others, and several superordinate themes. Given the extent of the qualitative material being examined, and the commitment to presenting

experientially grounded arguments, the analysis (with the introductory material above) cannot be fitted into a single paper. The remainder of this paper presents an examination of Linda's experience within the Child and Parent mode categories. A second paper presents her experience of Coping modes and an examination of the superordinate themes that emerged from the data (Edwards, 2017).

Linda: A Case of Anorexia Nervosa

Linda was born after a labour that was long and hard. Reportedly, when the infant was put on her mother, her mother "could not handle it". Subsequently, her mother had been depressed and frequently irritable, physically shaking her child on occasion. The situation had been exacerbated by Linda's having severe colic for several months, and, at age two, being hospitalized with asthma. The emotional deprivation she experienced increased on the birth of her sister when Linda was two and a half. Linda reported various ways in which she coped with the resulting neglect, unpredictability and invalidation: in primary school, she recalls day-dreaming and living "*in this other world*", and later she became overly responsible and perfectionistic. She saw a psychologist for depression at age 17. The year thereafter, she gained weight following the introduction of insulin after she had been diagnosed with diabetes mellitus, and had a few more sessions with the psychologist for depression. At the same time, she also behaved rebelliously, and had begun inducing vomiting. The following year, away from home at University, she felt lost and isolated, and described the first semester of her second year as like "*going through hell*". She became anorexic and her BMI fell to 16.2. At home for the vacation, her parents made it a condition of her return to university that she receive psychological treatment. This then led to her consulting me. She had gained some weight, so that at assessment her BMI was 17.8, but she was still severely depressed and highly anxious, worrying a great deal. Although she was effective academically and in leadership positions in student organizations, much of her time was preoccupied with food and food rules, and her self-starvation regime was threatening her health. There was no room for fun and spontaneity, and her withdrawal and focus on food rules had alienated her from her family and friends, contributing to her loneliness and depression.

Linda's Child Modes

Vulnerable Child Mode

Vulnerable Child (VCh) states are characterized by distressing emotions such as disappointment, sadness, fear, shame and guilt associated with negative beliefs about self, others and the world. The source of these can most often be traced back to problematic childhood experiences. Three themes are prominent in Linda's VCh experiences: – (1) being a burden, to blame, responsible for causing others trouble, (2) being

inferior, not good enough, unlovable, and (3) not being noticed, listened to, of interest to others. These themes are present in a dream Linda reported in S28. Her parents are quarrelling and her aunt and female cousin are present. She describes feeling "*terrible*" but later differentiated her feelings: "*Anxious and very stressed ... like almost [it's] your fault or that it rests on you. ... I don't know what I've done or what I did but ... like sometimes I just think I add to the burden or make things more difficult ...*". The dream locates these feelings within the dynamics of the family. She is aware that her mother always had "*a very quick tongue ... so there's a lot of talking and just stressing*". Her relationship with her cousin is competitive, while her aunt is "*nosy and asks a lot of questions*" including about what Linda has eaten. In a second scene of the dream, she and her cousin weigh themselves on a scale. Her cousin's weight is "*perfect*", but Linda is overweight and feels inadequate. "*Half the time nobody really knows who I am, and the other half the time I don't know how to get her out there*", she adds.

The same themes are evident in the following sessions. In S30, as we look into what underlies her need to be in control, Linda speaks of "*fear of not doing stuff right and getting into trouble ... everything you do is either wrong or not appropriate or ... and whenever she tried to explain herself ... she ... wasn't taken seriously*". In S34, another dream about her aunt leads Linda to reflect on her "*feeling of inferiority from that big family or being judged ... [not] measuring up*". Linda speaks of "*never quite meeting up or being ... the one who gets the awards or the one who people will want on their team*". In S35, Linda describes how this is triggered when, walking in town, she sees a young man she likes. He has a girlfriend, whom she sees as "*perfect*", and thinks, "*You're not worth it ... you're never good enough ... [because he's] interested in other people ... who are beautiful and fit and intelligent and hard-working; and I'm just not quite there*". An explicit theme of failure emerged during a psychodrama in S40. When I asked Linda, "Do you have to be a success?", her tearfulness intensified (the transcriber noted "*heartfelt sobs*") and after a while she said quietly, "*I don't know if there's room for failure*".

Emotion-focused questioning would deepen Linda's access to vulnerability in S33; when I gently enquire about the distress she is experiencing, she says, "*It's ... sore and ... it hurts my heart and I hate ... feeling [like this] because ... these questions come up ... are you ... worth love or worth it, or why are you alone?*" Implicit in the questions are the conclusions she has come to: that she is alone because she is worthless and unlovable. But this is too painful to face. When I say, "It's got nothing to do with you, has it? ... that you were somehow some horrible unlovable baby ...?", Linda's distress intensifies. I point this out and say, "That's hitting something, because deep down you think ..." – and Linda

continues: “*I am [unlovable], and I just feel like a burden, so often I feel like everything I do is stepping on someone’s toes or in the way or an inconvenience*”. Generally, she avoids these feelings, afraid that, as I suggest, “the bottom line in your life is you’re defective and unlovable and nothing can be done about it”. She concurs, “*... that’s why I battle to not only expect love ... but to understand it and to receive it – that someone would love you and does love you [is inconceivable]*”.

In these VCh states, therefore, Linda appears to be re-experiencing emotions and associated beliefs that reflect her experience of herself as a child who felt unnoticed, unloved, and invalidated, and believed that this treatment meant that there was something wrong with her. These states point to EMSs that are often a focus in schema therapy: Emotional Deprivation, Defectiveness/Shame, Social Isolation (the sense of not fitting in, differing from everybody else) and Subjugation (the sense that one’s needs are not important and the focus needs to be on meeting the needs of others). Another less prominent theme that was noted was that of pessimism. In S35, in an imagery dialogue, the VCh says, “*It’s not going to happen. Even though you say this, it’s just not going to happen or it’s just not ever going to work out*”.

These implicit beliefs were challenged experientially through imagery rescripting. In S34, when invited to visualize, she sees herself as a lonely child of six or seven. After some time, I suggest Adult Linda enter the scene, speak empathically to the child, and offer her care. In due course, Adult Linda stretches out her hand, then puts her arm around the child and Linda says, quietly and sensitively, “*Draw her close and she ... like buries her face in you ... holds you*”. When I ask if there is something she wants to say to her, Linda says, “*to reaffirm that it’s not her fault and she is loved and ... she’s got so much to give*”.

In S35, reflecting on her experience of imagery work, Linda makes the vulnerability she feels explicit: “*Just putting yourself in a place feeling that – all the emotions again and actually speaking to ... the child parts of me – [it’s] as if I can actually hear them and actually speak to them, what they need to hear But it leaves you feeling very raw and very vulnerable*”. Accessing this vulnerability also evoked spontaneous insights into developmental links. In S35, we review her beliefs that she is not interesting, not wanted, that something is wrong with her. Linda recalls how in primary school she had only a few friends, and concluded from this that “*if people could have someone else they would*”. On the theme of being a burden, she connects with her childhood illnesses: “*a one year old ... forever sick all the time and ... just not a healthy normal child, and ... when I was small I had asthma all the time and I was in and out of hospital*”. Being diagnosed with diabetes had re-evoked these feelings. Again, she felt as if she was a burden on parents who already had enough to deal

with without the additional demands imposed on them by her medical condition.

The sequence of imagery in the rescripting sessions (presented more extensively in Edwards, 2016) provided evidence that the meaning of these underlying memories and their associated schemas could be changed by the rescripting process facilitating corrective experiences.

Anger in Child Modes

Angry Child mode (AnCh) refers to experiences that occur with the activation of schemas arising from childhood experiences of being unfairly treated or abused and experiencing anger about that (Young et al., 2003). Linda frequently experienced anger as one of several simultaneous emotional responses to her mother’s unpredictability. For example, in S34, during dialogue work, she is in touch with herself at around six years old. Speaking for the Child, she says, “*I am hurt and I am angry and I feel betrayed and alone*”. My empathizing with these feelings cleared the way for her to visualize the VCh who was experiencing this, and then to reach out to her. As described earlier, Linda saw this little girl coming to her, Adult Linda, burying her face against her body and holding her close. Here, although the anger is a phenomenologically distinct experience among the other emotions, it is part of an overall VCh experience which incorporates a range of emotions. It does not present itself as a separate AnCh mode.

By contrast, there is a distinctive AnCh response in S33 and S35, where Linda expresses to me her anger towards the students she shares a house with. There is an appropriate basis for this, as they are untidy, noisy, and had so alienated the landlady that she would not renew the lease for the next year. She also feels an envious anger because it seems unfair that, while she is working very hard, they are just coasting, sleeping late, going out in the evenings. This is classified as AnCh, because Linda cannot express this anger and feels helpless and trapped and this emotional pattern has its origin in how she was parented. Linda’s parents were not able to attune to her responsively, and so she did not learn appropriate expression of these emotions. As she observed in S34, her anger at her mother “*got internalised and kept inside*”. There are two modes here. The one that suppressed the anger is an overcompensator (to be examined in the second paper). This part “[acted as if] *life is simple and easy and then she can just push stuff aside and carry on like ... you’re not affected*”. In the second mode is a Child who is “*angry ... because she [the overcompensator] shouldn’t be having all that fun. She should be serious and ... deal with the stuff*”. Here the anger of the AnCh is directed at Linda’s own coping mode (the overcompensator) which is perpetuating the experience of being ignored and invalidated. So there are two phenomenologically distinct sources of anger, the first being anger at her mother, and the second being anger at her own coping mode.

This experience of anger, unexpressed due to helplessness, comes into focus in S40 during a psychodrama dialogue dramatizing her ongoing “battle” with her eating disordered mode, her Anorexic Overcontroller (A-OC), to be described in the second paper. At one point she says to the A-OC, “*You don't belong here ... You've had your time and your time is over*”. This looks like HA, as there is firmness and anger in her voice. But she is also tearful and helpless – as the transcriber noted, “speaks forcefully and convincingly through tears”. This is an interesting mixed state in which the helplessness and desperation of the VCh and HA assertiveness are present together. At a later point in the session, while being coached by me to confront the A-OC, she spontaneously blurts out, “*You're a liar!*” This is the painful emotional charge of the AnCh, subdued by helplessness, but breaking through this time, rather than the clear assertiveness of the HA mode.

In S35, Linda describes experiencing an undifferentiated and pervasive anger: “*I've been very bitter and very ... angry the last few days ... angry at the place and where I am and ... with people around me*”. This pervasive anger results from a build-up of unexpressed AnCh anger, and she copes with it by withdrawing (see the second paper).

Another distinct experience is of a defiant, impulsive anger that Linda recognizes as contributing to her experience of craving and bingeing. As we look at her bingeing in S32, I ask, “Who wants to eat that stuff?” Linda replies, “*Angry Child*”, and continues, “*She wants to have it her way when she wants it and ... probably to be noticed and ...*”. When I ask her to sit in the Angry Child chair, Linda continues, “*I want to be noticed. And I want to do what I want, when I want and I don't want any rules ... I don't even want consequences ... I hate having to be responsible ... having to think of things in advance ... having to care for myself And sometimes it's just too much of an effort*”. She locates this around age five or six, “*just wanting ... time and attention and competing with my sister*”. In S33, she makes the same connection. Earlier in her life she had been strong and determined: “*I had so much discipline at one stage*” (an overcompensator). But this conflicted with “*that little child who doesn't want rules ... doesn't even want responsibility, doesn't want to make decisions about the future or anything*”.

Currently, when in this mode, she not only binges, but also eats non-diabetic foods which are a threat to her health. Although, in this session, Linda and I refer to the “*Angry Child*”, this is phenomenologically distinct from the AnCh experiences referred to earlier. Rather than being primarily a response to mistreatment, the “*I want it now!*” quality suggests a very young child who has not learned to delay gratification. This mode is characterized by impulsivity (“*I want it now*”), along with recklessness (with respect to health consequences), anger, entitlement, and defiance, and might best be

called her Defiant Child (DefCh) mode. Linda's mode is similar to states described in the literature. Young et al.'s (2003, pp. 309-310) “*Angry and Impulsive Child*” also includes anger, impulsiveness and recklessness. In this mode, Linda is reckless in that she will eat non-diabetic foods which can harm her, but she is not “devaluing”, “abusive”, or “enraged”, which are other features Young et al. have described. Lobbstaal et al. (2007) also differentiate Angry, Enraged, Impulsive and Undisciplined Child modes. But Young et al.'s case examples, referred to above, as well as Linda's own experience, demonstrate that these various features do not necessarily separate out into phenomenologically discrete modes.

To summarize, four phenomenologically distinct experiences of anger in the Child were evident. Firstly, there was anger as one emotion among others in the VCh. Secondly, there were distinct AnCh experiences, which arose from schemas, memories of how Linda had felt as a child in response to perceived neglect or unfair treatment, and were directed at those people whom she perceived as mistreating her. Thirdly, her AnCh anger is directed at her own overcompensatory coping that suppressed her AnCh. Fourthly, there was the DefCh – impulsive, entitled, defiant and reckless. These were not the only experiences of anger that were identified. However, others are located in Parent modes, to be examined next, or in overcompensator modes, to be examined in the second paper.

Healthy Child

A healthy, adaptive Child mode has been variously named “*Happy Child*” (Young et al., 2003), “*Playful Child*” (Bernstein, de Vos, & van den Broek, 2009) and “*Contented Child*” (Rafaeli et al., 2011). Linda experienced such a mode on several occasions. In S28, she says, “*I feel like there's so much inside me to offer but she just can't get it out there or get people to see*”. Here the “*so much inside me*” is referring to the healthy potential that has been hidden since childhood. As therapy progressed, she increasingly accessed this. In S32, during dialogue work, she says to the VCh, “*You have worth, ... you deserve ... to be heard and to be taken seriously, ... to be loved and ... to have fun – to be able to make a noise when you want to and not be yelled at for it, or be scared to have friends over and ... it's okay to be upset or ... confused and [you] don't have to think of everything all the time in advance and be so responsible*”. When I suggested she tell her mother that she is a normal little girl with normal human feelings, she saw the girl standing taller, “*she even seems to grow up a little bit ... she's happy and ... can approach people and speak to them. ... she uses what she's good at and she works hard, but she has fun and she lets go of things*”. These features all reflect the potential that can develop when the child's needs are met. In S34, when she says of the child that “*she's got so much to give*”, she refers to another potential – to give and to care. This

freedom and spontaneity also generalize to her current life. In S35, she tells me how she said to her friend, “*I feel like watching this movie, do you want to go?*” Even though this keeps her up late, she is glad to have done it. She also accepted an invitation to an informal group lunch on the lawn.

The terms “Happy”, “Playful” and “Contented” Child capture some of the qualities of these experiences, but Linda’s spontaneity and self-confidence and her sense of being a real person with her own unique individuality are better captured by the term authenticity (Kernis & Goldman, 2006). I therefore prefer to call this mode the Authentic Child (AuthCh) (Edwards, 2012). This both includes the spontaneity and creativity of the “Free Child” of TA (Trautmann & Erskine, 1997) and resonates with terms from object relations theories such as Winnicott’s (1965) “true self”, which is attained by “unfreezing the authentic self” (Rubin, 1998, p. 97), and Summers’s (1999, p. 69) “buried self” which is the source of the child’s “authentic experience”.

Dysfunctional Parent Modes

Dysfunctional Parent modes have their early origin in attitudes and demands directed at children by parents or various other authority figures. Linda had a particularly prominent Demanding Parent (DemP) voice. Above, we examined her sense of being a burden on her parents, which gave rise to a voice that demanded that she “*should*” be “*normal*”, “*should not*” be causing trouble. Living with awareness of what others appear to require of her was a prominent experience for Linda. In the early sessions (S8-S13), while preparing for and writing exams, Linda frequently described the pressure of her parents’ expectations. In S16, she said that she was “*tired of hiding, tired of putting up a facade, of meeting others’ expectations*”. The hospital psychologist’s report had independently noted “her fears around disappointing her parents”. The demanding quality is evident when, in S33, she expresses concern “*that I’m not spending enough time studying and that I waste a lot of my time, and that I’m not ... productive in my studying and I ... can’t get the results that I should be getting or that are higher and worthwhile*”. These are realistic concerns, in as far as a bursary award depends on her marks. But the implicit parental demand exacerbates Linda’s sense of “*pressure ... from home just being a financial burden and I’ve got to do what I can to not be that burden*”. In S35, there is a similar DemP voice, “*Your parents have to pay and medical aid has to pay ... why can’t you just be healthy and normal and live this life that’s fine and your parents don’t have to keep paying for everything?*”

However, these voices also have punitive and critical features. Her question in S35, “*Why can’t you just be healthy and normal?*” is self-critical and blaming. The punitive aspect is more explicit in S28, when she refers to her mother’s “*quick tongue*” and when she speaks of

specific rules that were made, particularly by her mother, and how she would be in trouble if she broke them. She says, for example, “*If you ate stuff that shouldn’t have been eaten because she [my mother] was going to use it for our next meal or, or – so many rules about stuff in the kitchen*”. And, in S30, she recalls “*fear of not doing stuff right and getting into trouble all the time and getting scolded*”, while, in dialogue work, in the HA role, she counters the Parent mode by telling the Child that she should “*be able to make a noise when you want to and not be yelled at for it, or be scared to have friends over*”.

Although punitive and demanding aspects of parent voices are typically separated in the ST literature, they tend largely to be concurrent in Linda’s experience. The example above from S30 illustrates this: the Child is scolded (Punitive) and gets into trouble (Guilt-Inducing) for breaking rules or doing things that her parents discourage such as making a noise or having friends over (Demanding). As Young et al. (2003, p. 277) observe, many individuals “have a combined Punitive and Demanding Parent mode, in which they set high standards for themselves and punish themselves when they fail to meet them”. During the sessions, Linda and I referred to these Parent voices in ways that reflected this ambiguity, using the terms “Demanding Parent,” “Punitive Parent” and “Critical Parent” to try to capture the quality of Linda’s experience in the moment. In S33, I used the phrase “Demanding, Critical Parent” several times as I showed her cards on which the formal definitions of PunP and DemP modes were printed. At one point, Linda referred to her “*critical expectations side*”. The term “Coercive Parent” might better capture the combination of these features.

Conclusion

For the most part, the distinctions between the different kinds of modes described in the schema therapy model fit with the phenomenology of Linda’s experience in these sessions. Many of her experiences of emotional states in the present were found to link to implicit as well as explicit memories of her childhood, of herself as a child, and sometimes of specific childhood episodes that were distressing or overwhelming. This is the kind of experience that the terms VCh and AnCh refer to in the theory on which schema therapy is based. Similarly, the experiences of having to meet others’ expectations, and to be at risk for criticism or anger if she failed, could be sourced to experiences of her parents. This fits with the theoretical claim that the Parent modes are introjects of the attitudes and behaviour of either parents or other authority figures which persist and are “played back” like a recording. However, rather than experiencing this as a specific memory of a parent making a demand or criticism, Linda experienced it as a felt sense (Gendlin, 1978), an embodied experience whose meaning could be uncovered through emotion focused investigation.

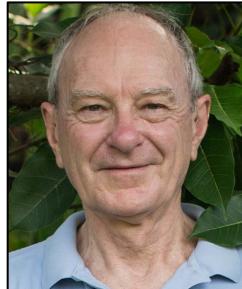
A similar in-depth examination of Linda's coping and Healthy Adult modes will be presented in the second paper (Edwards, 2017), as well as of several important superordinate themes that emerged from the analysis.

Further conclusions and implications for further research and the practice of therapy will be presented at the end of that paper.

Referencing Format

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Professor Edwards has over 100 academic publications in the form of journal papers and book chapters. These include several clinical case studies documenting the systematic treatment of conditions such as social anxiety, posttraumatic stress disorder, and disruptive behaviour problems. Several publications reflect his interest in case study methodology in the development of applied clinical science, and he is one of the editors of the recently published *Case Studies within Psychotherapy Trials: Integrating Qualitative and Quantitative Methods* (Oxford University Press). He has also written articles and book chapters on the history of imagery methods in psychotherapy and is the author, with Michael Jacobs, of *Conscious and Unconscious* in the series Core Concepts in Therapy (McGraw Hill, 2003). Many of David Edwards's publications are available in full text from his ResearchGate page at https://www.researchgate.net/profile/ David_Edwards16/contributions

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