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An Interpretative Phenomenological Analysis of Schema Modes in a Single Case of Anorexia Nervosa: Part 2

Coping Modes, Healthy Adult Mode, Superordinate Themes, and Implications for Research and Practice

by **David J. A. Edwards**

Abstract

In schema therapy, the identification of schema modes is central to case conceptualization and the planning of interventions. Differences in the naming and description of specific modes in the literature suggest the need for systematic phenomenological investigation. This paper presents the second part of an interpretative phenomenological analysis of schema modes within the single case of Linda (20), a young woman with anorexia nervosa. In this paper, the focus is on Linda's Coping modes (of which an Anorexic Overcontroller mode was prominent, and to which parallels are drawn in the literature) and on several important superordinate themes: mode dyads, mode conflicts and balance of power, mode differentiation, and mode sequences. The findings support the value of the mode framework that is standard in schema therapy, based on Child modes, Parent modes, Coping modes, and the Healthy Adult. They furthermore highlight the idiosyncratic nature of schema modes within an individual case. Research and clinical implications of the findings are discussed, and links are made to the phenomenological perspective of Merleau-Ponty.

This is the second of a sequence of two papers that examine the schema modes of Linda (20), who had presented with anorexia nervosa and major depression, based on the interpretative phenomenological analysis (IPA) of transcripts of several sessions of psychotherapy. This paper presents the analysis of Linda's Coping and Healthy Adult modes, and also examines superordinate themes that reflect the nature of, and the relationship between, modes. It concludes with an examination of the implications for further research and clinical practice.

Linda's Coping Modes

Linda's coping modes were congruent with the three categories used in schema therapy: overcompensatory, avoidant, and surrender (Farrell, Reiss, & Shaw, 2015; Young, Klosko, & Weishaar, 2003), as defined in Part I of this case study (Edwards, 2017).

Overcompensatory Coping

The Anorexic Overcontroller

Notably prominent was an overcompensatory Anorexic Overcontroller (A-OC) mode in which Linda's main focus was on losing weight and enforcing on herself detailed rules about her diet. Exercising rigid control over management of her body mass and eating offered Linda a sense of stability and control that was in marked contrast to the experience of her Vulnerable Child (VCh), which it effectively shut down. The A-OC is vividly portrayed in two images. The first is the scale on

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which she and her cousin weighed themselves in the dream reported in S28 (see Part I). "*It was a little black scale*", she said, "*and then it just turned into ... a computery thing ... with like blue lights*". A voice announced her body mass and gave instructions about which parts of her body were too fat and needed to be reduced. The complex system of rules, instructions and processes portrayed here is implicit in a second image that Linda experienced in S30. Asked to picture her Healthy Adult (HA) side and the A-OC, she saw the A-OC as a woman who "*is thin, and always scowling and frowning and with long fingers able to pinpoint, and ... scolding and – sometimes she even has a whip. And she's often dressed in black, with high heels ... and very professional and classy, ... like a polished look but untouchable*".

Linda was aware that this "dictator side" had developed in childhood to cope with her "*fear of not doing stuff right and getting into trouble all the time and getting scolded*". Initially its focus was on doing everything perfectly and in an orderly manner – a Perfectionist Overcontroller (PerfOC) (Lobbestael, van Vreeswijk, & Arntz, 2007). However, particularly after she was diagnosed with diabetes, it had developed the specialized focus on body mass and weight loss to become the A-OC. This had not replaced the broader perfectionism: in session 40 she described how, in times of stress, both these aspects are activated: "*Sometimes during exams I almost kick into like this restricting type frame of mind or want to have my life so ordered ...*".

Drawing on these images, the A-OC can be seen to be a complex, multifaceted system. Its first feature is the promise of a happier life. This is made explicit in S30, where, after describing the classy woman dressed in black, Linda says, "*She says that if you look ... thin and if you can get everything under control and be strict enough on yourself, then you will be pretty or beautiful or acceptable ... [and] you will have more fun and ... other people will want to spend more time with you ...*". A further benefit is made explicit in S40: "*Your life will be more controlled and more disciplined and you will be a success*". The second feature follows from this: Linda's set of private rules about goal weight and what she is permitted to eat, and a third feature, her consequent impulse to restrict her eating in order to lose weight. In S30, she mentions how this "*side of me that wants to lose weight*" leads her to ignore the diet given her in hospital. In S33, although her body mass is equivalent to a BMI of 22.6, she says, "*I don't want to be that weight ... I want to be thin*" and mentions going for a run to contribute to this aim. In S40, she speaks of how she wants to lose weight to prepare for being seen on the beach in summer and to create a good impression when she goes home for the vacation. Even as she says this, she recognizes (from her HA) that the last thing her parents or friends back home want to see is her losing weight and regressing back into anorexia.

A fourth feature involves the offering of happiness by suppressing the pain in her VCh, symbolized by the "*polished look*" of the woman in black and her being "*untouchable*". This figure also portrays a fifth feature, self-punitiveness, as seen in her vigilant fault finding, frowning, scolding and brandishing a whip. In S33, in response to being weighed, Linda says, "*I'd be much happier if I was thinner*", a bland statement that belies her anger at herself for allowing her weight to be, for her, unacceptably high. This dictatorial aspect is related to a sixth feature, the generation of images that induce fear, shame and self-disgust. After bingeing, she sees herself with "*extra skin and flab around your stomach and eyes and double-chin and ... [and] my thighs [are] really a lot bigger and ... there's like cellulite build-up and ... with hips as well, ... a lot wider and like extra skin on the side of the bone ... I can almost see myself not fitting into my clothes*". As we explore these in S30, I mention the scale with the blue flashing lights from her dream. She says "*that police person is ... showing you what's going to happen now because you've binged. She's yelling ... 'How could you let this happen? How could you?'*" Emphasized by the reference to the police and "yelling" is the coercive and self-directed scolding nature of this mode.

A seventh feature is the offer of a sense of feeling strong and in control. This is central to a psychodrama in S40 where I play the A-OC and encourage Linda to respond from her HA. At one point, I say, "*You'll feel strong if you show that you can resist the urge to eat. You'll feel better. I make you feel better*". Linda stops to reflect on the accuracy of this, and then says, pensively, "*That's what I battle with ... the whole thing of feeling stronger and getting more in control*". This is the payoff from the A-OC mode, something she does not want to give up.

Restricting her eating is motivated by the hope of getting thin so as to be popular, and by offering a sense of certainty and control. Part of the strategy of the therapy, therefore, is to help her see that this is a misguided overcompensatory activity that serves to suppress painful feelings, but will not lead to her deeper needs being met. We examine this in S40. At one point, I prompt her to say to the A-OC, "*I don't want the kind of life you're offering me*". Then she indicates what she does want: "*... to be more free-going and just light-hearted and not worrying and not punishing myself the whole time for everything and not ever enjoying life ... or enjoying treating myself*". This is an emerging alternative to the A-OC, grounded in the Authentic Child (AuthCh) and HA modes.

Other authors have identified such a specialized eating disordered mode. Mountford and Waller (2006, p. 534) refer to a "restrictive schema mode" which one client named "my anorexia". Similarly, Linda and I would refer to her A-OC as "Anorexia". Cruzat-Mandich, Diaz-Castrillón, Escobar-Koch, and Simpson (2016, p. 5)

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identified an "anorexic identity", focused on restrictive eating, arising from the client's "not wanting to be here" and resulting in her "not being connected". Hodge and Simpson (2016, p. 19) describe a client who experienced "Anorexia Nervosa as a substitute identity which had provided her with a sense of control and certainty over her often abusive and unpredictable childhood experiences". Simpson (2012), in her ST conceptualization of an eating disorder case, described a similar mode; but her assimilating it under the PerfOC mode belies the complexity of the mode we are examining here. Perfectionism has long been recognized as prominent in eating disorders (Garner, 1991). It is "a system for self-evaluation in which self-worth is judged largely on the basis of striving to achieve demanding goals and success at meeting them", which, in eating disorders, becomes elaborated around "the overvaluation of eating, shape and weight, and their control" (Fairburn, Cooper, & Shafran, 2003, pp. 515 & 516). But this is only one aspect of Linda's A-OC. An account of a mode that has the complexity of that found here is given by Park, Dunn, and Barnard (2011, 2012). They describe a mode "in which there is a focus on specific conceptual meanings about the control of eating, shape and weight, with the neglect of broader emotional meaning and body states associated with starvation" (2012, p. 87). This creates "an over-controlling cut off relationship toward the body" (2011, p. 425) and provides a reassuring sense of "structure, certainty, simplicity and purpose" (2011, p. 429). Their account of several components working together accords with the above description of Linda's mode. Naming it "Anorexic Overcontroller" or "Eating Disordered Overcontroller" seems aptly to capture the specialized focus of this kind of mode.

The Protector Child

Other overcompensatory behaviour was evident. As already noted, a broader perfectionism (PerfOC) still applied to other areas of her life, and there was also a long-standing pattern of independent and self-sufficient behaviour. In S32, she recognized how, around age 5 or 6, she was already behaving like this, "*thinking of things in advance ... having to care for myself*", as a way of suppressing the impulsiveness of the Defiant Child (DefCh, as described in Part I). It appeared in imagery again in S33, where Linda says, "*I have to be strong and ... independent and I don't need anyone*", and again, in S34, as a "*strong*" side of her, seemingly happy, apparently unaffected by events that distressed her. However, this child was "*in a bubble*", dissociated from her VCh, and further exploration disclosed the negative impact of the mode which, by "*push[ing] stuff aside*", compounded the invalidation she experienced from her parents and further angered the suppressed feeling child (see Part I, Anger in Child modes). In S35, she acknowledges the overcompensatory aspect of this mode: she refers to as "*lies*" the message it gives to the VCh, whose "*feelings are so raw*". In S35, there is a further example of this conflict. One part – the overcompensator – is "*fighting and being loud and saying, 'No, you can do anything you want and you are good enough and you can succeed'*". Meanwhile "the other part" (VCh) is saying, "*It's just not going to happen or it's just not ever going to work out*".

Since this mode originated in her early childhood, as many coping modes do (Behary, 2015, p. v), I call it the *Protector Child* (ProtCh) (Edwards, 2016). It is in essence a survival strategy that enables the child to keep functioning in important areas of life, at home and at school, for example.

Avoidant Coping Modes

Detached Self-Soother

Detached Self-soothing (DetSS) occurs when individuals comfort or distract themselves with various activities to assuage painful VCh states. In S33, Linda mentioned spontaneously that comfort eating fulfilled this function: "[If there's] *anything that I want comfort for, it's food I want first*". In S32, she links comfort eating to coping with loneliness, "*I've noticed wanting to eat something nice ... to make that mood better*". Asked what happens to the lonely part in response to the self-soothing, Linda insightfully replies, "*She actually intensifies, it even feels worse*". This in turn motivates further comfort eating. She finds herself craving food after lunch when her stomach is full and she doesn't need to eat, and she wants "*food that I haven't eaten since high school ... things ... my mom would put in my lunchbox or [give me] as a treat now and then... It's definitely a comfort thing*". When, in S33, she confirms my suggestion that this is a way of pushing aside her childhood longing, she concurs, "*I don't want to feel it... Because it hurts ... and .... I hate feeling lonely, so often I feel lonely*". Comfort eating was also used to cope with her feelings of over-responsibility - it "*just ignores the responsibility, almost tunes it out for that time*" – and with self-pity and feeling "*like the victim*". In S34, she recalls how she used comfort eating to cope with the distress she felt when diagnosed with diabetes. As a consequence, any attempts to limit her eating "*just went out the window*". Through the reparenting work, she was beginning to experience how the loneliness and fear in the VCh could be directly addressed, and later, in imagery rescripting, she tells the child that she "*doesn't have to be scared or keep retreating to food the whole time*".

Linda refers to other self-soothing behaviours: in S33 she says, "*I'll just block it off, watch TV, waste time*", and, in S30, she describes how, when younger, she had coped with her frustration and anger at her mother by focusing on her school work: "*I probably did just take it out on work because I was able to keep busy and put all my effort into studies or school*". Now, by contrast, self-soothing by eating or drinking interferes with her working effectively as she is distracted by "*thinking about what I can eat or, or get up and make something to drink or do anything else*".

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The role of behaviours such as these in eating disorders is recognized by Simpson (2003) within an ST framework, and, within a cognitive behavioural framework, by Fairburn et al. (2003, p. 517) who refer to them as "dysfunctional mood modulatory behaviour[s]". On the surface, eating, watching TV, and focusing on work are diverse behaviours. They are all nevertheless categorized as DetSS coping because they serve a common function of shutting down VCh experiences.

Avoidant Protector

Behavioural avoidance of people, places or situations that might evoke distressing emotions is referred to as Avoidant Protector (AvProt), a term that points to its coping function. There were many examples of this. In S28, Linda says, "*You don't ... over-extend yourself* [i.e. make the effort to socialize] *because you're just going to be met with other hurts or rejection*". In S35, Linda describes withdrawing to her room when the other students in the house had upset her: "*I get stubborn and I'll be very much 'well then I'll just cut you all out'*". In S33 she explains how "*I come home and I'm already like, agh! I don't want to walk inside; I sit in the car for a few seconds ... and then I go straight to my room and shut the door*". In S30, she recalls how she did this as a child: "*I would just keep quiet and walk away ... Mom would always have the last say on something, but still inside I'd be fuming and angry*". When there is a build-up of unexpressed anger, Linda copes by withdrawing altogether so that others don't get to experience this side of her. The section to follow on the HA mode documents how she was able progressively to give up this kind of coping.

Deceptive Protector

In S32, she described how other students in the house had confronted her angrily about taking their food from the fridge when she wanted to binge. Some of them had taken to hiding their food in their own rooms. She was aware that her actions were deceitful and described herself "*trying to hide stuff or keep something secret and pretending like nothing is happening when it is happening*". Linda would plan to replace the food, but this would have been no solution, and, afterwards, she hated herself for it. In the literature, lying and deceiving are features of the Conning and Manipulative (ConM) mode (Lobbestael et al, 2007, p. 85) in which a person "Cons, lies, or manipulates in a manner designed to achieve a specific goal, which involves either victimizing others or escaping punishment". A problem with this definition inheres in the fact that it combines such contrasting motives. Victimizing others has a clear overcompensatory quality, while escaping punishment is avoidant. Bernstein, de Vos, and van den Broek's (2009) expanded criteria for this mode also feature behaviours with marked antisocial features such as, for example, "may seek information that he can use against someone, or probe for emotional weak points that he can use to blackmail or manipulate others". Linda's behaviour does not share this antisocial, overcompensatory quality. It is avoidant coping that could perhaps be subsumed under AvProt behaviour, or separated out as a Deceptive Protector (DecProt) mode.

Surrender Coping Modes

Compliant Surrender

In surrender modes, individuals cope by accepting the negative beliefs associated with their own maladaptive schemas (e.g. "I am defective", "I am unlovable", "I am different"). Compliant Surrender (CS) mode is a pattern of pleasing and placating, predicated on a belief system such as that "I am unlovable and unworthy, so the only way to keep connection with others is to subordinate my needs to those of others". This was an established way of coping for Linda. In S16, already, she had spoken of being "*tired of hiding, tired of putting up a facade, of meeting others' expectations*". As she put it in S30, "*You just want to please ... please your parents*". In S28, she told how, at school, she had gone out of her way to be friendly with a girl in the hockey team who "*was just a hard person to get along with ... who other people didn't like at all*". Linda "*put up with her for ages ... it was always me who got stuck in the car with her and things like that, and I'd always put myself out there*". Linda recalls going on a school mission where she had supported another girl who had been "*crying in her room because she was missing home and* ***I*** *was the one comforting her and ... doing all the other work*". Subsequently, this girl misrepresented herself on her CV and was publicly praised for her contribution while Linda's was ignored. Linda realized that she had paid the price for "*being extremely loyal and being a hard worker*" by then being "*taken for granted or used or trampled on*". A similar lack of assertiveness was evident in her current behaviour. In S28 she described how, on a committee, she let the Chairperson take credit for her (Linda's) ideas. As she puts it in S35, "*I'll just keep quiet or I'll just hide behind a person who's trying to steal the limelight*". In S33, she tells of how she would at times clean up after the students with whom she shared a house.

Self-Pity/Victim

On several occasions during S33, Linda spontaneously referred to a *Self-Pity/Victim (SPV)* mode. When she gets depressed, she says, "*I don't want to be active and I get these almost self-pity victimized thought patterns*". Later she elaborates, "*I'll say 'no' if I get asked to go somewhere .... I'd rather just be the victim in my self-pity*". She remembers feeling like this when she was first diagnosed as diabetic and comfort eating to cope with feeling a "*victim and feeling sorry for yourself*". Although described in the broader literature, this mode is not included in the lists of schema modes referred to earlier, except by Flanagan (2014) and Edwards (2015). Edwards conceptualizes it as a surrender mode, in that the beliefs associated with the maladaptive schemas are accepted. He warns that therapists may confuse this

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mode with the VCh mode. However, in contrast to CS, it also involves pushing others away, and therefore it does not respond to reparenting.

Healthy Adult Mode

In schema therapy, the HA mode is conceptualized as one in which individuals can distance from emotional states, remain emotionally balanced but also emotionally aware, accurately appraise the meaning of everyday situations, and make mature and adaptive judgments and decisions. Linda had a good foundation for this mode that was strengthened as therapy proceeded. She was committed to therapy and to recovery from the eating disorder, and attended regularly. Furthermore, she was a conscientious student and played a leadership role in a student organization. When asked to image her HA in S30, she saw a woman who was "*comfortable but well-posed, like she stands tall and is proud and ... soft and gentle but, rational and logical and ... she doesn't under-dress or over-dress*". This portrays the maturity and balance that characterizes the HA.

Linda's HA was often eclipsed by the Coping modes examined in the previous section, and particularly by the A-OC that drove her eating disorder. As therapy progressed, she increasingly understood that the A-OC mode could not give her what she needed and that her DemP hindered her recovery. As she put it in S33, "*in recovery it's okay not to have the same expectations that I've got to do extremely well and put all that pressure on me*". This was associated with a realistic appraisal of a significant change in her parents' attitude. Aware now that their high expectations had proven counterproductive, they had become supportive and accepting. Her father had "*phoned me about my test the other day and said, 'You know, don't stress about all the stuff ... just take each day as it comes'*". The third scene of the dream Linda shared in S28 portrays the changed attitude of her mother, who says: "*Take a break and just come home, or, it's okay to take a break or to just work for a year*". In response, Linda felt "*a whole lot of pressure really like come off from me*". Linda could now appraise social situations more accurately, and was realistically positive about herself and her capabilities. In S32, she felt appropriately guilty about taking food belonging to others and lying about it (DecProt mode). In S33, she referred to wishing that she was thinner as her "*old pattern of thinking*". When asked, "What is the alternative new pattern of thinking?", Linda responded, "*I can be happy just as I am, ... content where I am now; and ... you're recovering from that – you don't want to go back there*".

In S35, she described experiences with friends that had contradicted her beliefs about being unwanted, unlov-able, a burden: "*... people actually notice you there and enjoy your company ... and you actually contribute something*" and "*people have enjoyed your company or wanted you there*". She accepted an invitation for coffee with a young man, and, despite initial doubts, found it "*so great talking about stuff that I'm interested in and who I am ... it was good for my self-confidence to ... see that people actually are interested in you as a person, just to spend time with you and it's not like a burden ... . To see that I can carry on a conversation by myself or ... that I have something to offer – is a big thing*". Her growing sense of capability and social inclusion was also enhanced by efficiently organizing accommodation for a group going to a wedding in Europe. She was also becoming more spontaneous in reaching out socially. In S40, preparing for the summer vacation, she could see that there was no need to be ashamed of her body at the beach, and that her parents and friends back home would be dismayed if they saw her restricting her food and trying to get thin.

Her capacity to show compassion and care, another feature of the HA, was evident in the imagery rescripting in S30. Adult Linda "*takes my* [the child's] *hand first and leads me and then bends down and hugs me and comforts me ... and explains to me but listens to me as well. And she goes on one knee ... and really takes to heart the things that I feel and I have to say because they're important*". Later she goes further, "*The healthy adult wants to also say ... she's sorry* [that she neglected you] *and ... 'You can trust me ... I won't abandon you, I won't leave you alone'*". This feature of the HA, called the "empathically attuned caregiver mode" by Behary (2016), is portrayed in an image Linda described in S35. After rescripting, she saw herself as "*happy as I am now – a young woman who's been through a lot and had good times as well and who is soft and gentle and can approach and embrace and draw in, like draw in that little child – and just full of love and acceptance*".

The HA is a composite mode that includes a range of distinct experiences that have in common that they are aspects of mature psychological functioning. In this mode, Linda was able to separate accurate appraisals from those distorted by childhood maladaptive schemas and act on them confidently. In contrast to the A-OC, which was disconnected emotionally, her HA was emotionally connected, with the result that she felt increasingly more connected to other people and also to her own spontaneity and her potential to develop and grow and realize her unique individuality.

Superordinate Themes

Parent-Child Mode Dyads

Parent-Child Mode dyads is the first of the superordinate themes identified in the IPA. It is illustrated by Linda's experience, in S35, of feeling that she was a burden on her parents because of the demands placed on them by her eating disorder. Implicit here is a dyadic relationship between Child and Parent modes. The VCh experience of being a burden is evoked by the internalized demand

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(DemP) that she be "*healthy and normal*". There is a relational structure to Linda's experience, in that the DemP and VCh modes are activated together. Again, in S32, in exploring her fear of disappointing her mother, the VCh feels scared and invalidated in response to a DemP who is invalidating and intimidating, giving the message: "*you and your needs are not important, you are a nuisance and a burden*". This was expressed in imagery dialogue work when, as her child self, she says to her mother, "*I'm scared to disappoint you and I'm scared to speak to you and to show you what I'm feeling or what's happening because it's either not important or you don't see it from my angle*".

This would suggest that Linda's experience is generated from an underlying dyadic interpersonal schema which represents, in parallel, the experience of the parent (as dissatisfied, disappointed, disapproving, angry) and the experience of the child (scared to express herself or to share her feelings, and focused primarily on meeting expectations). Discussing borderline personality disorder, Rafaeli, Bernstein, and Young (2011, p. 64) also note a dyadic relationship between Parent and Child modes in which the Punitive/Critical Parent mode and the Vulnerable Child mode exist in a victim-abuser relationship to one another, with the critical, punitive Parent voices triggering painful feelings of worthlessness and depression.

Like other Child modes, the AuthCh is also part of a mode dyad. Its development depends on the individual experiencing attunement and compassionate acceptance. Linda had not experienced this from her own parents, but began to experience it in the therapy relationship as part of the reparenting process. This allowed her to introject a healthy, caring, accepting parent and thus to access her own capacity for authenticity.

Terms such as "Demanding", "Punitive" and "Guilt-Inducing" identify Parent behaviour that is actively harmful. However, a focus on mode dyads points to the significance of parental neglect. A prominent theme in Linda's VCh was that of being invisible, not valued, not affirmed. While she was growing up, her parents failed to attune to her experience and needs in the kind of responsive manner that builds a secure sense of self. She experienced them as not only punitive, demanding, and unpredictable, but essentially unavailable, neglecting important needs; which is an aspect not captured by the standard Parent mode categories The introject of a parent who is not there when needed does not translate into explicit self-talk modelled on the parent's words. It is, however, implicit when, in S33, Linda says, "*These questions come up ... are you ... worth love or worth it, or why are you alone?*" This is the experience of a child who was not taken seriously, and did not experience attuned nurturing care. Consideration should, therefore, be given to differentiating a "Neglectful Parent" mode. A PunP may be projected on to others, resulting in the individual perceiving criticism in behaviour that is in fact neutral. Similarly, Linda projects her Neglectful Parent on to others. She is talking about an entirely new experience when she says in S35, after having engaged socially, "*people actually notice you there and enjoy your company ... and you actually contribute something*" and "*people have enjoyed your company or wanted you there*". She is surprised because, previously, under the influence of the quiet but damaging presence of her internalized Neglectful Parent, she had experienced others as not noticing her, not expecting her to contribute anything, not really caring whether she was there or not.

This dyadic view of interpersonal schemas is central to object relations theories. It is illustrated by Kernberg's (1976, p. 57) concept of "self-object-affect units" which are an internal representation of the VCh (Kernberg's "self") and the Parent (Kernberg's "object") characterized by a particular emotional experience (Kernberg's "affect") that arises when the system is activated. Practically, therefore, when therapists detect one side of this system they should be alert for the presence of the other so they can be aware of the full constellation of the mode dyad experience.

Mode Differentiation

Mode differentiation refers to the conceptual task of discriminating modes from each other within the experience of a particular individual on the basis of their phenomenological characteristics. Several questions related to mode differentiation have already been examined. In the first paper (Edwards, 2017), different experiences of anger in Child modes were identified and discriminated. It was also noted that Linda, rather than having separate PunP and DemP modes, experienced a Parent mode that combined both aspects. In this paper, when examining overcompensator modes, an A-OC mode was differentiated from a Perf-OC, and a DecProt mode was separated out from a ConM mode. In discussing mode dyads, a new Neglectful Parent mode was suggested.

Self-Critical and Self-Shaming Thoughts

A challenging issue for mode differentiation is where to locate self-critical or self-shaming thoughts. Schema therapists usually locate them within a Parent mode. However, many of them were located within Linda's A-OC mode. When self-critical or self-shaming thoughts are a parental introject, it is often easy to identify this by questioning. Individuals remember a parent saying the same words that they say to themselves now as self-talk (Young et al., 2003, p. 276). Linda's A-OC, however, incorporated self-blaming and self-shaming messages that were not obviously explicit introjects. Even if they could be shown to have been learned from parents or authority figures, they acquire a different character when incorporated into an overcompensator. Coping modes have a history within the individual's

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development and, as we saw above, there was evidence that Linda's ProtCh was already operating by the time she was about 6. Linda also described making an explicit decision around the age of 10 to "*be strong*" instead of allowing herself to be emotional and cry a lot. In the genesis of a coping mode, a child may make an implicit coping decision or "script decision" (Woollams, 1977) to exclude painful feelings. The overcompensating mode that results incorporates messages like, "don't be weak, don't be childish, grow up, do everything perfectly" as a means to shut down the unwanted emotions. It is hypothesized that, in this process, existing Parent introjects may be recruited by the coping mode. When this happens, a message that starts off as a PunP voice (and therefore alien to self) becomes part of a coping mode and feels like part of the self.

Two examples provide evidence for this. I had suggested that Linda put time aside to experience painful emotions and express them through drawing. In S33, she told me that she had considered this: "*I'll try drawing and actually feeling ... those feelings, and, ja, I battle between actually feeling them and then you have this critical parent that's like 'You don't have time for this, it's stupid, push it out the way'*". Although she refers to her "*critical parent*", the message is in line with her childhood coping decision to conceal weakness or vulnerability, and its function is to give the appearance to others that she is functioning well. Similarly, in S35, Linda says her feeling side "*gets shut out because it gets hurt so often... it's like my security mechanism and I just become very harsh and critical on myself but so then with others as well*". By referring to "*my security mechanism*" she is in effect saying that being critical of herself is part of her coping mode.

Critical and Shaming Thoughts Directed at Others

This reference to being "*harsh and critical on myself but so then with others as well*" brings into focus another important issue for mode differentiation. In the literature, the fact that the same punitive or demanding messages that are turned on self can also be turned towards others led Young et al. (2003) to refer to both behaviours as PunP or DemP mode: the PunP, they write, "criticizes or punishes the self *or others*" and the DemP "pressures the self *or others* to achieve" (p. 277; italics added). When they describe a therapist behaving like a scolding parent towards a client, they call it a "Disapproving Parent mode" (p. 193).

Farrell et al. (2014, Table 2.3, p. 13) also make mention of directing Parent modes at others, but Rafaeli et al. (2011) and van Genderen, Rijkeboer, and Arntz (2012) locate criticizing and making demands of others in over-compensator modes. This is reflected in the construction of the Schema Mode Inventory (SMI) (Lobbestael, van Vreeswijk, Spinhoven, Schouten, & Arntz, 2010), where all items tapping Parent modes describe criticism or demands directed at self, whereas all those reflecting demands or criticisms directed towards others tap overcompensator modes. An earlier version of the SMI, the Young-Atkinson Mode Inventory (YAMI-PM, 1B) (Young, Atkinson, Arntz, & Weishaar, 2005), is not consistent, since there are some PunP items that refer to criticism directed at others. This suggests that, with time, there has been a shift with respect to preferring to locate anger and demands directed at others in over-compensator modes.

Mode Conflicts and Balance of Power

Conflicts between modes and power differentials were a third superordinate theme. Modes compete with each other to direct an individual's behaviour. The conflict between Linda's emerging HA and the various coping modes that displaced it was a regular focus of therapy sessions. Although she could understand that coping modes were usually not in her best interests, they were repeatedly re-activated: behaving non-assertively (CS), withdrawing (AvProt), comfort eating (DetSS), getting caught up in self-pity (SPV), and, of course, focusing on diet and body mass (A-OC). The process of S40 portrayed the struggle for power. I reviewed a HA perspective on her current body mass, stating that it is normal, that her body is nothing to be ashamed of. Asked how her HA was hearing that, Linda said she knew "*deep down ... it's true - but... there's always that part of me that denies, in denial*". This is "*the driving* [part]" (the A-OC). In the psychodrama that followed, already referred to, I took the role of the A-OC and countered her HA arguments. Particularly persuasive was when I offered her the prospect of feeling in control. Linda tearfully expressed helplessness "*when I feel like her arguments are true and I don't know how to battle them ... I feel that when I don't listen to her then I'm not* [a success]". In the therapy, three main strategies were used to challenge the power of the A-OC. One was to reduce the emotional charge of the maladaptive schema experiences of being invisible, unlovable, defective and a failure by accessing the VCh and offering her reparenting in order to provide a corrective experience. Secondly, as in S40, I worked to unmask the A-OC as a mode that could not meet her true needs in the long run. Thirdly, I supported behaviour change in life situations as she increasingly discovered that, by giving up her coping modes and acting more spontaneously, her needs could be met more and more in everyday situations with friends and family.

Mode Sequences

Edwards (2016) identified sequences of modes in Linda's behaviour where a series of modes unfold consecutively within a short space of time. Rapid and dramatic mode changes (as often seen in clients with borderline personality) is referred to as "mode switching" or "mode flipping" (Kellogg & Young, 2006, p. 453), while Flanagan (2014, p. 210) refers to less dramatic "mode shifts". The punitiveness of Linda's A-OC would sensitize her to feeling hurt and defective so that her

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VCh "*shrinks and gets put in a corner*" (S28). This would be exacerbated by feeling dismissed by the other students, and she would become angry (AnCh) and withdraw altogether (AvProt), perpetuating her loneliness (VCh). She recognizes this in S32: "*I'm just so sick of being alone ... When I walk between here and there and go to town, everything's always by myself*". The loneliness impacts negatively on her work, which is something else she does alone, and contributes to her difficulties in concentration. Another example of a mode sequence begins with Linda preparing to study (HA). This evokes her DemP (pressure to study and do well) which evokes her VCh (responsible but helpless) followed by a shift to SPV (helpless self-pity). She copes with this by comfort eating (DetSS), and her DefCh joins in (bingeing out of control and including non-diabetic foods). This in turn is followed by self-punitive messages, and images of body fat (from her A-OC). The consequent fear and disgust (VCh) leads to inducing vomiting (DetSS), and in the end she is left feeling defective, a failure, and alone (VCh).

Such sequences maintain problems, because there is no exit from the loop to the HA mode which can exercise appropriate self-control and provide a compassionate stance towards the distressed VCh. The analysis and targeting of factors maintaining clients' problems is an important focus in cognitive behaviour therapy. Analysis of mode sequences offers a comprehensive understanding of such self-perpetuating cycles. Without a full account of the mode sequence, attempts to target specific links in the sequence may be ineffective. Earlier attempts to increase Linda's self-control in order to reduce her bingeing and vomiting had thus been unsuccessful due to failure to recognize the role of distress in the Child modes (VCh and DefCh) that the DetSS and A-OC were activated to cope with.

Discussion and Conclusions

One of the goals of phenomenological research is to understand the underlying structure of human experience by going beyond the bare verbal descriptions people often give and reading between the lines to provide an in-depth explication. The foundation of mode analysis and mode based interventions in schema therapy has been the identification of modes from clinical material. The schema modes, identified phenomenologically here, fit well within that broad system. While this was the interpretative forestructure (Packer & Addison, 1989) of the therapist that was carried forward to the investigation of the sessions included in this research, this retrospective examination provided evidence that the broad schema therapy approach to identifying the different facets and voices within Linda's experience is coherent and phenomenologically grounded. This should not be surprising, since the work with modes in schema therapy goes back two decades (Flanagan, 2014) and, drawing on well over a century of experience of psychotherapists (Edwards, 2007), integrates concepts which have stood the test of time.

However, the identification and naming of modes has mostly been based on informal case examples, and only a few publications contain more extended case studies. Behary (2012) situates some of the schema modes of a narcissistic client within the transcript of a large part of a session, but it is not a systematic analysis. Bamber (2004) describes several modes in a man with chronic and severe agoraphobia and shows how he was able to bypass the DetProt mode, confront and reduce the power of his PunP, and access and work with the VCh. Simpson (2012) provides a detailed mode analysis of a woman with bulimia nervosa, which has already been referred to above. However, the present papers may be the first systematic qualitative examination of the phenomenology of modes within an individual case.

Clinical theory grows from clinicians' observations of individual cases, and it is important to situate such observations as part of the research process and not as some informal prescientific activity that science can take off from. Systematic phenomenological research of the kind presented here is a means of giving proper status to such clinical knowledge. In future, such research would be of value in providing grounding for modes that schema therapists are aware of but which do not yet significantly feature in the literature, for instance coping modes such as rumination and worrying (Behary, 2015; Brockman, Haire, & Meade, 2016; Edwards, 2012), and "hypervigilant clinging" (Behary, 2015, p. v).

Many of the inconsistencies in the literature arise from conflict between an idiographic and a nomothetic approach. The former seeks an in-depth understanding of individual cases, where uncovering the subtlety of the phenomenology of idiosyncratic processes is essential for clinical practice (Allport, 1937; Vertue, 2011). A nomothetic approach seeks to develop theory that enshrines general principles and laws. When describing the characteristics of a mode based on a large number of cases, features from many individual cases are aggregated. Such broad categories simplify the treatment model and can aid communication, but they can also collapse phenomenological distinctions. This was shown above, where Bernstein, de Vos, and van den Broek (2009) listed deception as a criterion for ConM mode irrespective of whether motivated by the desire to victimize others or the desire to escape punishment. This is part of the built-in limitation of such aggregation: generalizations derived from samples or populations can tell us nothing about any single case (Eells, 2007; Flyvbjerg, 2006).

The same happens with the construction of assessment scales such as the SMI. From a nomothetic perspective, modes do not exist until validly measured in a large population. And yet, quantitative research on modes has

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largely been based on the SMI, which only measures 14 modes. Van Genderen et al. (2012, p. 33) recognize that "experiences with patients with both forensic problems and Cluster C personality disorders" show that there are modes that are not in the SMI. But they refer to these as "modes not yet investigated" (p. 35), implying that no psychometric or experimental work has been done, and that the clinical observations from which they have been derived do not count as scientific investigation. The step to measurement with a self-report inventory does not make the modes thus measured more valid scientifically. What is valid is the scale (if it measures what it is supposed to measure), not the mode. A nomothetic scale is an imperfect instrument. Response bias or outright deception may invalidate responses (Lobbestael, 2012). The grouping together of features from a large number of cases means that its phenomenology in any particular case will tend to be oversimplified. Two individuals might have a similar score, but different characteristics of the mode are salient. Focusing on schema modes as measured by the SMI can mislead therapists into ignoring subtler aspects of clients' conflicts. While there are useful applications of such self-report inventories, the primary investigative tool for schema modes must be phenomenological, whether in routine clinical interviewing and observation or through the kind of systematic IPA research presented here.

Mode complexity could also have been identified here as a superordinate theme. Some modes seem relatively simple and undifferentiated, for example, Linda's PunP or AvProt modes. By contrast, the A-OC mode driving her eating disorder is a complex system with many interlocking facets, as portrayed in the dream image of the electronic scale and the evoked image of the dictatorial woman. It is this kind of complexity that has led some authors to use the term "subpersonalities" (e.g. Cooper & Cruthers, 1999). In a different way, the HA must also be conceptualized as a complex system. A concept of "mature adult functioning" is an important pragmatic reference clinically. But it inevitably covers a wide range of psychological states, processes, attitudes and behaviour, as was evident in the above review of the different manifestations of Linda's HA mode. A systematic phenomenological examination of different facets of the HA would be an appropriate focus for future research.

Another strength of phenomenological research is that it allows investigation of the dynamic aspects of modes that are of central significance for clinical practice: for example, the processes by which Coping modes shut down child states, the processes by which the Child modes can be accessed, the processes that unfold in response to reparenting, and the running off of mode sequences. In future, it would be valuable to use the phenomenological method to investigate how mode sequence analysis can inform interventions that break up self-defeating cycles, and to look at the impact of such interventions within the individual case. Another promising research direction is to examine the developmental trajectory of modes. Modes grow and evolve through time and become refined and specialized. This is particularly true of the HA, which may continue to evolve towards greater wisdom and maturity throughout life. With respect to coping modes, there was evidence that Linda's A-OC developed in late adolescence from an existing PerfOC mode, a process already referred to by Fairburn et al. (2003). There was also evidence for overcompensator coping in early childhood: the prematurely self-sufficient ProtCh mode. The functioning of this mode in adulthood was not the focus of the present material, but this mode, with its exaggerated sense of responsibility and self-sufficiency, was clearly contributing to Linda's current problems. An examination of mode development might also throw light on the hypothesis advanced above that existing parent introjects become incorporated into overcompensator modes.

In his critique of Freud, Merleau-Ponty (1942/1967, p. 220) referred to a complex as being "a structure of consciousness". There is clearly an overlap between the classic concept of the complex and the territory of early maladaptive schemas and schema modes in the Dysfunctional Parent, Child and Coping categories. Merleau-Ponty was fully aware that a complex becomes "a durable structure of consciousness" (p. 177) arising from a childhood situation "that could not be mastered at the time", with the result that "integration has been achieved only in appearance" in a person who has reached adulthood. This perspective is shared by schema therapists (as well as, of course, by therapists of many other traditions). His argument with Freud was not about the phenomena he described, but concerned the causality within Freud's theory, where the complex was understood as "a thing outside of consciousness that would produce its effects in it" (p. 220):

> The childhood memory that provides the key to a dream and the traumatic event that provides the key to an attitude … are not therefore the causes of the dream or the behaviour. They are a means for the analyst to understand a present structure or attitude. (p. 178)

Concerned that Freud's theory did not do justice to the potential for maturity in human development, he emphasized the importance of "distinguish[ing] cases in which Freudian mechanisms function from others in which they can be transcended" (p. 179). Schema therapists share this concern. Their goal is to promote "schema healing". This can bring about a process of what Merleau-Ponty calls "normal structuration" which reorganizes the structures of consciousness on an ongoing basis so that "infantile attitudes no longer have a

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place or meaning" in a new system of "perfectly integrated behaviour" (p. 177). The schema therapist's focus on building the HA mode is in the service of just such a vision, and the clinical analysis of schema modes, as investigated in the papers presented here, can make a valuable contribution to understanding such underlying structures of experience and how best to promote the integration process.

Referencing Format

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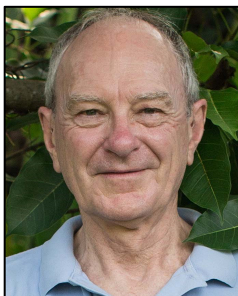
About the Author



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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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