Schema Modes in Eating Disorders:

An Interpretative Phenomenological Analysis

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Abstract

The DSM-5 prevalence rate of anorexia nervosa is 0.4%, bulimia nervosa is 1% to 1.5%, and binge eating disorder is 1.6% (American Psychiatric Association, 2013). Although treatment approaches for eating disorders have high drop-out rates and low rates of recovery, treatment modalities that address childhood factors contributing to the eating disorder, as well as the eating disorder behaviours, have better outcomes.

Schema therapy is an integrative approach that has been used for the treatment of eating disorders for more than a decade. Central features in schema therapy include the identification of early maladaptive schemas arising from unmet needs and schema modes. Schema modes, composed of schemas and coping mechanisms, are active for an individual at a particular time in response to triggers in the environment (Brown et al., 2016). Identifying an individual's modes is a crucial aspect that reflects the underlying structure of the individual's creation of reality. A phenomenological understanding of the modes is essential for developing a case conceptualisation and treatment plan.

Differences exist in the naming and description of modes in the current schema therapy literature, which suggests the need for a phenomenological investigation of these structures.

This research study used a mostly qualitative approach, in the form of clinical interviews, substantiated by questionnaires, to examine schema modes. Case presentations using the schema therapy model are provided for five women with either anorexia nervosa, bulimia nervosa or binge eating disorder. Then, through a process of interpretative phenomenological analysis, specific modes are examined as to how they are experienced by the participants and influence their behaviour. The features of schema modes in these clinical cases are compared to the existing literature to extend the understanding of schema modes in eating disorders.

The participants' experiences revealed that they had schema modes in common, regardless of the eating disorder presentation, but that the features of the individual modes varied. Modes found in the current literature such as the Detached Self-Soother and Perfectionist Overcontroller coping mode, were found in all the participants. Four of the five participants had an Eating Disordered Overcontroller mode. Features consistent with the

existing descriptions of the Perfectionist Overcontroller, Eating Disordered Overcontroller and Detached Self-Soother modes were noted, and new features were identified. The Perfectionist Overcontroller and Eating Disordered Overcontroller have been presented here as complex composite modes with sub-modes that work together in a coherent way in the service of the same project (Edwards, 2020b). Twenty-three features are identified in the parent modes. Blended parent modes, with multiple features active in a situation, were described. The blended parent modes expand on the existing literature on parent modes. The findings in this research support and extend the mode structure identified in the schema therapy theory, and highlight the idiosyncratic nature of the modes.

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Glossary of Abbreviations

The abbreviations listed in this table have been used throughout the thesis.

Abbreviation	**Meaning**
ED	Eating Disorder
AN	Anorexia Nervosa
BN	Bulimia Nervosa
BED	Binge Eating Disorder
ST	Schema Therapy

Chapter 1. Introduction

1.1. Context of the Topic

Eating disorder behaviour is not a recent phenomenon as descriptions of self-starvation are recorded from the fifth century (Keel & Klump, 2003). However, eating disorders (EDs) have been recognised as conditions with psychological and emotional components since the 1930s (Engel et al., 2007). First treated from a psychoanalytic approach, cognitive behavioural therapy (CBT) became the treatment of choice when Fairburn adapted CBT for use with bulimia nervosa (CBT-BN) in the 1980s. Since then, the development of enhanced CBT (CBT-E) provided treatment for other forms of EDs. As the most researched form of therapy for EDs, CBT and CBT-E in particular, has been considered the treatment of choice for bulimia nervosa (BN) by the UK's National Institute for Clinical Excellence (Wilson & Shafran, 2005) and the treatment of choice for BN and binge eating disorder (BED) by the Royal Australian and New Zealand College of Psychiatrists, and the Australian Psychological Society College of Clinical Psychologists (Brennan & Shelton, 2020). As a time-limited therapeutic approach, this form of treatment is more cost-effective than other long term, less structured treatment modalities and therefore more accessible. However, like other treatment modalities, drop-out rates are high, and recovery rates are low (Byrne et al., 2011; Signorini et al., 2018; Fairburn et al., 2013).

Research comparing CBT to psychoanalytic therapy to treat EDs (Poulsen et al., 2014) and comparing CBT to interpersonal psychotherapy (Fairburn et al., 1995; Agras et al., 2000; Carter et al., 2011) show comparable results with long term follow up. These results indicate that in the long term, these treatment approaches are as effective as each other. However, only approximately 30% of clients with EDs undergoing treatment achieve recovery (Byrne et al., 2011; Fairburn et al., 2013). When treatment approaches were combined so that treatment examined the underlying factors that led to the ED's development and the current factors that maintained the ED, the treatment proved more effective (Murphy et al., 2005). Studies like that of Murphy et al. (2005) set the stage for an integrative approach to the treatment of EDs, which considers childhood factors and ED behaviours.

Schema therapy (ST) is an integrated form of therapy developed for difficult to treat cases (Young et al., 2003) and has been used to treat EDs for two decades. Over the past decade, there has been an increase in research in this field that has contributed to our understanding of the application of ST to EDs (Cooper & Fairburn, 2011; Ford et al., 2011;

Edwards, 2016, 2017a, 2017b; Pugh, 2015; Simpson, 2012, 2020a, 2020b; Simpson et al., 2018).

Two central concepts within the ST approach are early maladaptive schemas (EMS) and schema modes. EMS are broad pervasive themes or patterns regarding oneself and one's relationships, comprised of memories, emotions, cognitions and bodily sensations, that develop in childhood from unmet needs and early childhood experiences (Young et al., 2003). These rigid and dysfunctional beliefs provide the framework through which one views oneself and engages with the world. If not addressed, the EMS create difficulty throughout one's life. One or more EMS can function together to form a part of the self known as a schema mode. Also, EMS may combine with coping mechanisms to form modes. Modes are triggered at different times and in different situations.

Four categories of schema modes were identified by Young et al. (2003). The categories include dysfunctional parent modes, which are introjects that develop from the words and experiences an individual had with significant adults in childhood. When the dysfunctional parent modes are active, individuals give themselves negative, destructive messages that trigger a child mode. The child modes represent the parts of the self, comprised of three elements; the unmet childhood needs, resultant EMS and related difficult emotions. When a child mode is triggered, an individual flips into a coping mode to avoid, shut down or soothe the emotion. The maladaptive coping modes form the third category of modes. These maladaptive coping modes cause harm to the individual and do not represent healthy coping. The healthy modes, which one aims to grow in ST, are the fourth category of modes; the Healthy Adult and Happy Child. The Happy Child has all their basic needs met, while the Healthy Adult represents adaptive functioning.

There are inconsistencies in the literature on the schema modes' naming and features because when working with individual cases, clinicians need to work idiographically. So idiographic research makes an important contribution to clinical theory. This research embarked on a phenomenological analysis of modes to contribute to the existing literature on how modes are represented in clinical cases. Current literature describes the modes in single case studies of either BN (Simpson, 2012) or anorexia nervosa ([AN]; Edwards, 2016, 2017a, 2017b). This largely qualitative research identifies the prominent modes in five individuals with EDs. Mode sequences are identified and how they contribute to the chronic self-defeating eating-related behaviour. The prominent modes are compared to one another and to the existing literature. This research is an extension of the current literature as it includes not

only multiple cases but also two case studies of BED which have not previously been examined in detail using the ST model.

1.2. The Motivation for Undertaking this Research

Throughout my one-year internship and my one-year community service in the public sector, I did not encounter an ED case. It was when I entered private practice that I first began working with EDs. I experienced a mixture of excitement at working with these notoriously difficult to treat cases and a sense of anxiety as I felt poorly equipped to assist. In the Upper Highway area of KwaZulu Natal, where I live and work, I knew of one psychologist who worked with EDs. For a psychiatric condition with such deleterious consequences, I was concerned that there was little accessible information and support.

Unable to locate a postgraduate course in South Africa, which would help me increase my knowledge and confidence in this area, I embarked on my own research. I discovered courses run overseas and associations with resources online, such as Eating Disorder Hope (www.eatingdisorderhope.com), the Academy for Eating Disorders (www.aedweb.org), and the National Eating Disorders Association (www.nationaleatingdisorders.org). Whenever I came across books recommended for EDs, I purchased them and studied them.

During my research, I came across ST, and the approach resonated with me. I believed I had found a therapeutic approach that integrated the most relevant and helpful aspects of a range of therapeutic approaches. Around the same time, I contacted a colleague in Cape Town who worked in an inpatient unit for people with EDs. Whilst seeking his advice, he put me in touch with Professor Dave Edwards, who later trained me in ST and supervised this research. From the outset, Professor Edwards and I were clear that I was embarking on this project in which I would not only contribute to research, but would also gain valuable knowledge and skills in working with people with EDs, a goal which I believe I have achieved.

1.3. Context of the Study

The research was conducted in the Upper Highway area of KwaZulu Natal. Upper Highway is a middle to upper-class area that consists of the main suburbs of Hillcrest and Kloof, and the smaller areas of Assagay, Botha's Hill, Forest Hills, Gillitts and Winston Park. According to the 2011 census (www.statssa.gov.za), the Upper Highway area covers 88,18 km^2 and has

a population of 60 295. This predominantly English area is comprised of 87% Whites and 13% Blacks, Coloureds and Asians.

As I had chosen to conduct an interpretative phenomenological analysis (IPA), I decided on a sample of 5 to 6 participants. In IPA research, data is mainly gathered through an interview process and then systematically analysed. As such, a small sample size of 3 to 6 is considered adequate (Smith et al., 2009). I approached healthcare practitioners in the area whom I recruited to advertise my research. Five White females approached me to participate in the study. Although I did not set out to recruit only females or White participants, the sample was representative of people who generally present for therapy for EDs (Szabo, 2002) and the demographics of the area in which I work. The participants attended a varied number of sessions, during which time I developed a case presentation for each of them. The case presentation formed the basis for identifying and understanding the presentation of modes. Information was obtained from clinical interviews, some of which were transcribed, and substantiated by quantitative measures developed for use in ST. Applying the process of IPA to this information allowed for the development of a comprehensive understanding of the modes as they presented in these individuals. This information led to the research findings and recommendations discussed in this thesis.

1.4. Synopsis of the Chapters

Eleven chapters follow the introductory chapter. A summary of the chapters is provided here.

Chapter 2. Literature Review

This chapter examines the existing literature on EDs. The chapter contains four sections. In the first section, I describe the history of EDs, which includes the progression of our understanding and identification of the categories of EDs. From the fifth century when self-starvation had a religious basis (Keel & Klump, 2003), to the recognition of AN as a distinct syndrome in 1874 (Keel, 2006; Vemuri & Steiner, 2007) and onto the late 1930s, where EDs were understood as having a psychological and emotional component (Engel et al., 2007). BN was a more modern disease, first recognised in the early 1900s and named in 1979 (Keel, 2006), whilst BED was first described separately from BN in 1959 (Plotkin, 2016).

The second section of this chapter focuses on the diagnostic aspects of EDs. The timeline for the classification of EDs according to the Diagnostic and Statistical Manual of

Mental Disorders (DSM) and the International Statistical Classification of Diseases (ICD) is provided. Also, the criteria for diagnosis, according to the DSM-5 and ICD-10, are provided.

Section 3 provides statistics on the prevalence of EDs. As South African statistics are limited, this section provides a review of prevalence rates across western, industrialised countries, which are considered to have similar frequencies to South Africa (American Psychiatric Association [APA], 2013). Studies that examine the eating attitudes and eating pathology amongst South African students are reviewed (Le Grange et al., 1998; Wassenaar et al., 2000; Caradas et al., 2001; Edwards et al., 2003; Edwards & Moldan, 2004). From this information, a conclusion is drawn that EDs occur across all ethnic groups.

The fourth section describes the theory of EDs from the perspectives of psychodynamic theory, interpersonal psychotherapy and CBT. A description of the treatment approach according to each theory is also provided. Research into the therapeutic approaches' efficacy highlights the need for more effective treatment approaches as the current methods are associated with high drop-out rates and low rates of recovery.

Chapter 3. Schema Therapy

This chapter describes the theory on which this research is based. A description of the basic concepts underlying the Schema Therapy (ST) approach is provided, followed by a description of the schema mode approach. An understanding of schema modes as parts of the self is presented that draws on concepts from other therapeutic approaches that recognise parts of the self. The four categories of modes in ST are then described. These categories include the child modes, maladaptive coping modes, dysfunctional parent modes and healthy modes. A description is provided of the modes that are found within these four categories.

The second section of the chapter focuses on the goals of ST. ST aims to help clients identify their EMS that develop because of childhood experiences in which their basic needs were not met. An understanding is formed of the individual according to a case conceptualisation which includes the four categories of modes. Then, through a series of cognitive, behavioural and affective interventions, an individual's schemas are healed, dysfunctional parent modes are eliminated, and maladaptive coping modes are replaced with more healthy, functional ways of coping. This leads to the strengthening of the healthy modes.

The third section looks at research on ST's efficacy in randomised controlled trials, pilot studies and case series. It concludes that ST has proven effectiveness in the treatment of chronic resistant clinical presentations.

In the fourth section, research into the schemas and modes relevant to EDs are described. A description of how these modes present in ED cases is included. Then the quantitative studies and clinical case studies involving schemas and modes in EDs are reviewed.

The final section in the chapter focuses on case conceptualisation. Following the assessment phase of therapy, a case conceptualisation is developed that considers the psychological processes that contribute towards and maintain the symptoms. This section touches on the ED behaviours as coping modes that shut down emotion before or after the emotion is experienced.

Chapter 4. Methodology

This chapter describes the methodological approach to this research. This research aimed to conduct a phenomenological analysis of schema modes in clinical ED cases and to compare this to the existing literature so that the understanding of modes in EDs can be refined.

The chapter includes a description of IPA, including the strengths and limitations of this approach. IPA is a qualitative approach in which the researcher interprets an individual's account of their experiences to understand the experience for that individual. Five research questions provided the focus for the research. The recruitment of the research participants is described, and the ethical considerations in obtaining the sample and analysing the data so that the moral principles of autonomy, beneficence, non-maleficence, fidelity and justice were maintained.

Data was obtained qualitatively from clinical interviews and quantitatively from questionnaires developed for use in ST. This information was used to develop case conceptualisations for each participant. Identified modes were then analysed and compared to existing literature.

Chapter 5. Interpretive Themes in the Prominent Modes

This chapter is divided into five sections that reflect on the interpretive themes relevant to prominent modes.

In the first section, I reflect on the Defectiveness/Shame and Failure schema as a blended schema. Although these two schemas are categorised in different schema domains, in situations both schemas are activated concurrently, presenting as a blended schema rather than as two discrete schemas.

The second section of this chapter focuses on the dysfunctional parent modes. The description of parent modes in the existing literature is provided. The difference between the concepts of shame and guilt is explored to determine if a Shaming Parent and Guilt-Inducing parent should be identified as two separate parent modes that are addressed differently therapeutically. All the features of parent modes are then presented in a table and classified using Peled's (2016) system of degrees of toxicity. The relevance of narcissism in the parent modes is addressed as all participants experienced a significant adult with narcissistic tendencies who formed part of the parent introject. Narcissistic features are described, including the impact this has on an individual's parenting style and how this influences the parent modes that are internalised.

The third section of the chapter focuses on the Perfectionist Overcontroller mode. Thirteen features are identified and described for this mode.

The fourth section of the chapter looks at the Eating Disordered Overcontroller mode. This specialised mode develops from a Perfectionist Overcontroller mode. Fifteen features are identified and described in this section which draws on Edwards' (2016) Anorexic Overcontroller and Simpson et al.'s (2018) Eating Disordered Overcontroller.

The fifth section of the chapter describes the behaviours that occur as part of a Detached Self-Soother mode. Although a particular focus was given to binge eating as a self-soothing behaviour, other self-soothing behaviours such as self-injurious behaviours and using work or being productive as a self-soother, were also explored. Also, individuals can engage in different self-soothing behaviours at different times and in different situations, which alters the flavour of the mode and its treatment.

Chapter 6 to 10. Individual Case Studies of the Participants

Each chapter presents a separate case study for each participant. The case study includes a description of the psychosocial history. This is followed by a description of the results found in ST questionnaires, the ED presentation and functioning at the time of the assessment. A mode map is provided for each participant that offers a visual representation of the modes present when the research was conducted. The prominent modes described in Chapter 5 are

described as they present in each participant. Each chapter concludes with a description of processes that perpetuated the individual's schemas and how these impacted the therapeutic process.

Chapter 11. A Critical Evaluation of the Place Questionnaires Have in Assessment and Case Conceptualisation

Attention is drawn to the value of questionnaires when used qualitatively as discussion points to gather additional information, or when discrepancies between scores and the history obtained provide information about activated modes. The limitations of the Schema Mode Inventory (SMI) are discussed, and items on the SMI that tap into modes other than the mode it is intended to measure. Relationships between responses on the SMI and Young Schema Questionnaire (YSQ) that I expected to encounter are noted and discussed with examples provided from the data obtained from the participants. Also, the modes and schemas expected to occur when binge eating was present were described with examples from the participants' data. Incongruency was noted between scores on the Young Parenting Inventory and the history provided by three participants. Examples from their history support these discrepancies whilst an explanation is provided for why this occurred.

Chapter 12. Conclusions and Recommendations for Further Research

The thesis is brought to a close with a review of the findings, including a summary comparing the features of modes in the participants to the existing literature. The benefits I achieved by using the questionnaires and the limitations I identified in the questionnaires are briefly discussed. Also, my reflections on the process of conducting this research are described. This is followed by the implications of my findings for theory and clinical practice, and the strengths and limitations of this research. Finally, recommendations are made for further research into schema modes in EDs.

Chapter 2. Literature Review

2.1. History of EDs

"Eating disorders refer to clinically meaningful behavioural or psychological patterns that are associated with distress or disability or with increased risk of morbidity or mortality" (Grilo, 2012, p.27). Cases of self-starvation were first recorded in the fifth century (Keel & Klump, 2003), mostly amongst Christian women and believed to be related to religious piety (Vemuri & Steiner, 2007). Saint Wilgefortis, thought to have lived between the eighth and twelfth centuries in central Europe, reportedly engaged in self-starvation resulting in emaciation and lanugo - a fine, downy hair covering the body that can result from AN and malnutrition (Keel & Klump, 2003). Between the 1200s and 1700s, saints of the Roman Catholic Church engaged in self-starvation (Keel, 2006) in what was known as "Holy Starvation" (Vemuri & Steiner, 2007) or "Anorexia mirabilis" (Hunt, 1993) as a way of cleansing a woman's spirit and reaching a higher plane of spirituality and closeness to God (Dell'Osso et al., 2016). A well-known example is St Catherine of Siena, an Italian Catholic woman whose self-starvation resulted in her death in 1380 and her elevation to sainthood for her extreme fasting and devotion to the church (Dell'Osso et al., 2016).

In the 1700s and 1800s in various parts of Europe, fasting girls were termed "Miraculous Maids" (Brumberg, 1989) as they starved themselves to show contempt for the physical body (Dell'Osso et al., 2016). During this time, prolonged abstinence from food appeared in young, middle-class women (Hunt, 1993) and was viewed as a sign of organic illness and described as a "wasting disease" (Deans, 2017). Richard Morton's thesis in 1694 is often cited as the first clinical description of anorexia as he described, "a state of 'nervous atrophy' characterised by decreased appetite, amenorrhea, food aversion, emaciation, hyperactivity and indifference to the condition" (Vemuri & Steiner, 2007, p.4). He considered this condition to be a "malfunction of the brain and nerves." In 1767, an English scientist, Richard Whytt, attributed food aversions and cravings to "gastric nerves" (Vemuri & Steiner, 2007).

AN was first considered a distinct syndrome when a British physician, Sir William Gull, used the term in 1874 to describe adolescent patients who engaged in self-starvation leading to severe weight loss without an exact gastric cause (Keel, 2006; Vemuri & Steiner, 2007). This description was the first time anorexia was seen as different from religious hysteria or biological eating problems (Slaby & Dwenger, 1993). Around the same time, a

French doctor, Ernest Charles Laségue, published an article with the term "l'anorexie hysterique", implying that this condition affected females only (Plotkin, 2016). He believed that anorexia developed in more affluent homes where food was abundant. Children were expected to eat everything on their plates, leading to stressful mealtimes and some children rebelling by refusing to eat their food (Engel et al., 2007). Laségue also believed that women who could not display emotional distress protested by not eating (Dell'Osso et al., 2016). This experience of anorexia occurring in affluent homes is in contrast to African tribal lore, which contains stories of adults who fasted during times of famine to save food for their children and then continued to restrict and were in danger of dying once the famine was over (Engel et al., 2007).

The beginning of the twentieth century saw a focus on the medical conceptualisation of the disease, with treatment focusing on the pituitary hormones (Deans, 2017). In the late 1930s, the medical community began to understand EDs as having a psychological and emotional component (Slaby & Dwenger, 1993) which was followed by psychoanalytic perspectives on the disease in the 1940s and 1950s (Vemuri & Steiner, 2007). In line with Laségue's views in the late 1800s, Brumberg (1989) believes that historically anorexia was used by women to express feelings like anger that were considered unacceptable for women (Hunt, 1993).

BN is reported as a more modern problem. However, deliberate induction of vomiting occurred before the twentieth century, as evidenced by the presence of "vomitoriums" in ancient Rome where the wealthy would vomit during meals so they could consume more (Deans, 2017; Engel et al., 2007). However, this bingeing and purging behaviour does not have the same psychological motivation as the binge-purge behaviours in BN. Access to food may have been a primary factor in the development of BN as, historically, food was scarce and consumed a larger portion of the household income, which could have made binge eating more difficult. Still, in the nineteenth century, as food became more abundant and family meals became a focal point in daily life, girls had an avenue to express themselves through their eating behaviours (Vemuri & Steiner, 2007). Pierre Janet first described patients with bulimic symptoms in 1903 (Plotkin, 2016) when he described a woman who engaged in compulsive binges in secret (Slaby & Dwenger, 1993). The term "bulimia nervosa" was first used by Gerald Russell in 1979 to describe female patients of normal weight who binged and vomited (Keel, 2006; Vemuri & Steiner, 2007).

Public awareness of AN increased in the 1970s as the disease spread beyond the Western world's upper class (Deans, 2017). The first paper on BN was published in 1979 (Deans, 2017). BN was considered a subtype of AN until 1987, when it was listed in the DSM-III-R as a separate disorder (Plotkin, 2016). Historical references to gluttony suggest that BED is also not a new disorder. Still, it was first described by Albert Stunkard in 1959 (Plotkin, 2016), recognised as separate from BN in the DSM-IV published in 1994 (Plotkin, 2016) and finally categorised as a distinct disorder in the DSM-5 published in 2013 (Plotkin, 2016).

Apart from the early religious beliefs that influenced EDs, their development may also have been affected by changing the Western world's ideal figure. Until the 17th century, a plump figure was admired but was later associated with the lower and middle classes. The "hour glass" figure then replaced the plump figure, and in the 1930s, a slender body was admired. In the 1960s and 1970s, models with androgynous figures were favoured, and this has slowly made way for the more recent lean, "tubular" body shape as the Western ideal (Vemuri & Steiner, 2007).

2.2. Diagnostic Aspects of EDs

EDs are classified in an international classification system for psychiatric conditions, known as the Diagnostic and Statistical Manual of Mental Disorders (DSM) and the International Statistical Classification of Diseases (ICD), used by more than 100 countries. AN and BN were introduced to the DSM-III in 1980 (APA, 1980) and the ICD-9 in 1979 (https://www.who.int/classifications/icd/en/). The weight loss criteria for AN in the DSM-III was "25 % below original body weight" (APA, 1980) and then revised in the DSM-IV to "body weight less than 85%" (APA, 1994). In the DSM-5, a "significantly low body weight" is defined as a weight that is less than minimally normal, where the lower limit of normal is recognised by WHO as a BMI equal to 18.5 (APA, 2013). The ICD-9 and current ICD-10 maintain criteria of body weight 15% below expected or a body mass index (BMI) of 17.5 or less (WHO, 1992). The DSM-III did not specify criteria for the frequency of binge eating and compensatory behaviour for BN. The DSM-IV frequency was revised to twice a week (APA, 1994) and then reduced to once a week in the DSM-5 (APA, 2013), allowing more individuals to meet the criteria. The ICD-9 and ICD-10 do not specify the number of episodes of binge eating. BED fell under Eating Disorder Not Otherwise Specified (EDNOS) in the DSM-IV and is recognised as a separate ED in the DSM-5. However, BED remains under

"Other Eating Disorders" in the ICD-10 (WHO, 1992), which was published more than 20 years before the DSM-5. The ICD-11, to be implemented in January 2022 (https://www.who.int/classifications/icd/en/), recognises BED as a separate diagnostic category.

AN is a condition in which an individual severely restricts their calorie intake, resulting in a weight lower than what is healthy for their height. A healthy weight is determined by BMI calculated by a person's weight (in kilograms) divided by their height (in metres squared). According to guidelines adopted by the WHO, a healthy BMI range is considered between 18.5 and 24.9. An individual is classified as overweight if they have a BMI ≥ 25 and obese with a BMI ≥30 (Grilo, 2012). DSM-5 (APA, 2013) diagnostic criteria for AN require individuals to have a BMI below 18.5. However, a body weight above BMI 18.5 can be considered significantly low if determined by the clinician when the individual's build, weight history and other physiological information is considered. The ICD-10 criteria for AN is a BMI of 17.5 or below, which is achieved by restriction of calorie intake, accompanied by an intense fear of gaining weight or becoming fat and a distorted perception of one's body. Individuals with AN can experience physical discomfort as a result of their low body weight. The DSM-5 identifies two subtypes of AN; restricting type, where weight loss is primarily accomplished through dieting, fasting and excessive exercise, and the binge-eating/purging type, where individuals with significantly low body weight from calorie restriction also engage in binge eating or purging behaviour. The severity of the disorder is specified according to the individual's BMI ranging from mild (with a BMI ≥ 17kg/m²) to extreme (BMI < 15kg/m²).

The DSM-5 (APA, 2013) and the ICD-10 (WHO, 1992) characterise BN by episodes of binge eating where an individual experiences loss of control over eating and consumes large amounts of food in a single sitting. As with AN, there is an overconcern with body weight and shape. To avoid weight gain, the individual uses compensatory behaviours such as abuse of laxatives and diuretics, self-induced vomiting, fasting, or excessive exercise. To meet the DSM-5 criteria for BN, the binge eating and purging behaviours should occur at least once a week for the past three months; however, this criterion is absent in the ICD-10. The severity of the BN is determined by the frequency of compensatory behaviours ranging from mild, one to three episodes of compensatory behaviour per week, to extreme where an individual experiences 14 or more episodes of compensatory behaviour per week (APA, 2013).

Whereas individuals with AN are underweight, individuals with BN tend to be of normal weight or overweight, typically with a BMI ≥ 18.5 and < 30 (APA, 2013). However, an exaggerated focus on weight and shape characterises both AN and BN. As a result, in between episodes of bingeing and purging, individuals with BN tend to restrict calorie intake, preferring low-calorie foods.

Binge eating episodes without accompanying compensatory behaviours characterise BED. As a result, individuals with this disorder tend to be overweight. A binge is defined as, "Eating, in a discrete period of time (within any two hour period), an amount of food that is definitely larger than what most people would eat in a similar period of time under similar circumstances" (APA, 2013, p.350). A sense of lack of control accompanies a binge. To meet the criteria for a binge eating episode, one must eat more rapidly than usual and until uncomfortably full, consume large amounts when not physically hungry, eat alone because of embarrassment regarding what one is eating, or feel disgusted, depressed or guilty after eating (APA, 2013). These criteria apply to binges in BN and BED. The severity of BED in the DSM-5 (APA, 2013) is determined by the number of binge episodes in a week ranging from mild (1-3 binges per week) to extreme (14 or more binge episodes per week). Whereas AN and BN typically develop in late adolescence or early adulthood following restrictive dieting, BED tends to have a later age of onset, generally early to middle adulthood.

When categorising EDs, Fairburn (2008) suggested a transdiagnostic perspective that challenges the traditional view of ED diagnoses as distinct and fixed. Fairburn indicates that as the presentation and treatment strategies for EDs are similar, they should be viewed as a single diagnostic category. In support of this, individuals diagnosed with an ED may at another time meet the criteria for a different type of ED. This point will be followed up later when the individual case conceptualisations of the participants are discussed.

2.3. Prevalence of EDs

Statistics for the prevalence of EDs in South Africa are limited; however, the DSM-5 (APA, 2013) reports that EDs occur with similar frequencies in industrialised countries. Thus, by considering the prevalence of EDs in western, industrialised countries, one can surmise the prevalence of EDs in South Africa.

The National Comorbidity Replication Survey (NCRS), conducted between 2001 and 2003 in the United States of America (Hudson et al., 2007), used the WHO Composite International Diagnostic Interview and applied DSM-IV criteria for EDs to a group of 5692

adults who met the criteria for either an anxiety, mood, substance use or impulse control disorder. Of the 5692 individuals, 2980 had a comorbid ED. The sample, believed to be representative of the population, equated to a lifetime prevalence of AN, BN and BED at 0.9%, 1.5% and 3.5% among women and 0.3%, 0.5% and 2.0% among men with a mean age of onset of 19.3, 20.0 and 24.5 respectively. A more recent study in the United States of America by Udo and Grilo (2018) on prevalence estimates of EDs using DSM-5 criteria, analysed a sample obtained from the 2012-2013 National Epidemiologic Survey on Alcohol and Related Conditions (NESARC-III) of 36 309 non-institutionalised citizens 18 years and older. All respondents completed computer-assisted face to face interviews, and data obtained were weighted to represent the US population based on the most recent census. A formal interview schedule administered by trained assessors was used to assess for DSM-5 defined psychiatric conditions. Results estimated a lifetime prevalence of 1.42% for AN, 0.46% for BN and 1.25% for BED in women and 0.12% for AN, 0.08% for BN, and 0.42% for BED in men. The mean age of onset was 19.3 for AN, 20.0 for BN and 24.5 for BED. The overall prevalence rates for BN and BED were lower than the NCRS study, and the rates for AN were slightly higher. The differing rates may be because the much larger sample allowed for stable estimation (Udo & Grilo, 2018). Both studies showed higher rates of EDs amongst women and that men are more likely to be diagnosed with BED than BN or AN. The age of onset was the same between the two studies and is in keeping with the theory that BED occurs in early adulthood, with the age of onset for BN and AN in the late teens.

Studies tend to focus more on the prevalence of EDs in females, and thus evidence of prevalence amongst males is still lacking. Dahlgren et al. (2017) noted this when they provided a systematic review of 19 studies, identified through a literature search, to determine the prevalence of EDs using DSM-5 criteria. The review included studies from the USA, Australia, Germany, Finland, Canada, Portugal, Sweden, the United Kingdom, Switzerland and the Netherlands. Their results highlighted a wide range of point and lifetime prevalence rates, primarily influenced by the methodologies applied, sample sizes and characteristics. In two-stage design studies, the lifetime prevalence of AN ranged from 1.7% to 3.6% and point prevalence from 0.67% to 1.2%. Point prevalence rates for BN reported in two of these studies were 0.59% and 0.6%, with three studies reporting point prevalence rates of BED between 0.62% and 3.6%. The prevalence of AN in interview-based studies was lower, ranging between 0.8% and 1.9% for females. The lifetime

prevalence of BN was rated at 2.6% and BED between 3.0% and 3.6%. Studies focusing on self-report methodology tended to report on point prevalence with AN rates ranging between 0.06% and 1.2% in females, BN between 0.45% and 8.7%, and BED rates around 4.1%. Dahlgren et al. (2017) argue that the studies that involved a two-stage design are likely to be of a higher quality as a clinical diagnostic interview followed the screening stage. However, the two-stage studies were not amongst the largest sample sizes studied. Although limits to this review are noted, it still highlights the higher rates of BED compared to other EDs and the tendency to focus on females when determining the prevalence of EDs.

A study with a large sample size and a two-stage screening approach was conducted in Holland between 2001 and 2010 (Smink et al., 2014). The community-based study of 1584 predominantly White, rural and urban adolescents, was part of a more extensive study tracking aspects of adolescents' lives over a period of 10 years. The mean age at enrolment was 11.1 years. Participants were assessed over the 10 years at mean ages of 13.6, 16.3 and 19.1 years. The two-stage screening approach included a structured clinical interview conducted by ED experts, which was used to estimate the prevalence of DSM-5 EDs. A total of 312 high-risk adolescents were identified, of which 296 were interviewed. Lifetime and prevalence of DSM-5 diagnosis were calculated by dividing the identified number of ED cases by the total number of adolescents placed in the high-risk group. The results indicated that 5.7% of the female and 1.2% of the male adolescents met the DSM-5 criteria for an ED in their lifetime. Also, BED was the most common. This supported evidence from other studies that EDs are more common in females and that BED is the most common ED.

BED as the most common ED was also supported by a 3-month prevalence study of DSM-5 disorders in a representative sample of older Australian adolescents and adults (Hay et al., 2015). The data, obtained from two independent Health Omnibus Surveys conducted in 2008 and 2009 under the auspices of the South Australian Health Commission, involved face-to-face interviews with a representative sample of the Australian population. A total of 6041 people ranging in age from 15 to 96 years, were interviewed. Four ED features, namely binge eating, purging, dietary restriction and overvaluation of weight and shape, were assessed based on questions from The Eating Disorder Examination. The 3-month prevalence of an ED was 0.46% for AN, 0.66% for BN and 5.58% for BED. Although the rates for BED are higher than those found in other studies, the results support other research that BED is the most common ED, followed by BN and then AN.

A study conducted by Solmi et al. (2016) supported earlier research that EDs are

more prevalent in women and that BED is the most common ED. Solmi et al. (2016) investigated the prevalence of EDs in a multi-ethnic sample of adults in the United Kingdom's general population. Random household sampling was conducted with individuals aged 16 and over eligible to participate in the research. A computer-based questionnaire, including screening questions for EDs, was administered to 1698 individuals between June 2008 and December 2010. From these individuals, a sample of 145 participants was randomly selected and interviewed for evidence of EDs. Of those interviewed, 21.3% had a 12 month DSM-5 diagnosis for an ED. This included 0.8% for BN and 3.6% for BED. No AN cases were identified in the sample, although this can result from the small sample size. The results translated to a prevalence of 7.5% for EDs in adults. EDs were more prevalent in women, with BED only identified in men. Of the participants who met the criteria for an ED, only 30% had sought help from a medical professional. Of this, only 15% saw a therapist, indicating that most individuals in this sample with EDs were previously undiagnosed and untreated.

As part of a project to investigate the prevalence of non-psychotic mental disorders in six European countries, namely Belgium, France, Germany, Italy, the Netherlands and Spain, 21 425 respondents were interviewed (Preti et al., 2009). A subsample of 4139 was randomly selected from the second phase of the interview procedure to undergo a detailed investigation of EDs. The second phase participants included a group of 8796 individuals, 6597 of whom exceeded a predetermined number of symptoms for specific mood and anxiety disorders, and a random 2199. All participants were interviewed using the WHO's Composite International Diagnostic Interview version 3.0, which generates diagnoses according to the DSM-IV, and where necessary adaptations were made to ensure criteria for DSM-IV diagnosis were met. Results indicated a lifetime prevalence of AN, BN and BED at 0.48%, 0.51% and 1.12%, respectively, with prevalence rates for women consistently higher than for men. Specifically, AN 0% for men versus 0.93% for women, BN 0.12% for men and 0.88% for women and BED 0.26% for men and 1.92% for women (Preti et al., 2009). Consistent with other studies, BED was the most prevalent ED and had a later age of onset.

The findings of prevalence studies have limitations in that large sample sizes are necessary to detect EDs. The studies discussed here ranged in sample size from 145 (Solmi et al., 2016) to 36 309 (Grilo et al., 2018). Despite the various sample sizes and sample techniques described, these studies all indicate a significant prevalence of EDs in Western populations, with results ranging from 0.46% (Hay et al., 2015) to 1.9% (Dahlgren et al.,

2017) for AN, 0.28% (Grilo et al., 2018) to 2.6% (Dahlgren et al., 2017) for BN, and between 0.85% (Grilo et al., 2018) and 3.6% (Dahlgren et al., 2017) for BED. AN accounts for the least number of diagnosed ED cases, followed by BN and then BED through all the studies. All studies noted higher reports of ED pathology amongst women, with the smallest discrepancy between men and women occurring with BED. AN and BN tend to have onset in late adolescence and early adulthood, with BED having a later age of onset in early to mid-adulthood.

As previously mentioned, there is little data available on the prevalence of EDs in South Africa; however, several studies examine eating attitudes and eating pathology amongst students in South Africa. The first published records of eating-related psychopathology of Black South Africans were three cases reported by Szabo et al. (1995). Le Grange et al. (1998) conducted a study with 1435 college students, 1069 female and 366 male, to investigate the presence and severity of unhealthy eating habits in students from different ethnic backgrounds in South Africa. The study, conducted between 1992 and 1994, included a demographic questionnaire with self-report measures of weight and height to determine BMI, and completion of the Eating Attitudes Test, or EAT (a 40-item self-report scale measuring symptoms of AN) and the Bulimic Investigatory Test, Edinburgh, or BITE (a 30-item self-report measure of symptoms and severity related to BN). The college students ranged in age from 17 to 25 years and were composed of 51% Caucasian subjects and 49% non-Caucasian subjects comprising Blacks, mixed-race and Asian. Results on both the EAT and BITE indicated that Black participants scored higher than Caucasian, Asian and mixed-race participants and that females scored higher than males. Thus Black participants demonstrated more significant ED pathology, and as reported in previous studies, eating pathology is more prevalent amongst females (Le Grange et al., 1998).

Wassenaar et al. (2000) studied the presence and severity of disturbed eating habits and attitudes in a sample of female university students between 1994 and 1995. The study group consisted of 520 female students, 52% White, 38.5% Black and 9.5% Asian. Biographical information was collected for all participants, and the Eating Disorders Inventory (EDI) was administered. The EDI is composed of 64 items in 8 subgroups that are rated on a 6-point scale. Findings revealed that Black participants scored higher on the subscales for drive for thinness and perfectionism and maturity fears, indicating levels of concern about body shape reinforced by ideas of perfectionism and expectations others may have of them (Wassenaar et al., 2000). White participants scored higher on the body

dissatisfaction subscale despite having the lowest BMIs. No differences between groups were noted on the bulimia subscale.

The results for Wassenaar et al.'s (2000) study were supported by a study conducted on South African school girls aged 15 to 18 (Caradas et al., 2001). The study, which included 228 participants, investigated eating attitudes and body shape concerns amongst different sociocultural groups. Three self-report questionnaires were used; the Eating Attitudes Test (EAT-26), Body Shape Questionnaire (BSQ), Body Silhouette Chart, and a demographics questionnaire. The EAT-26 measures symptoms characteristic of AN and BN, the BSQ measures body shape concerns, and the Body Silhouette Chart measures body image perception. The researchers assessed the participants' BMI. The sample was composed of 26.3% Black, 36.4% mixed race and 37.3% White subjects. No ethnic differences were noted in response to the EAT-26; however, overall results were considered significant as 17-21% scored above the cut-off, indicating possible eating pathology. Like Wassenaar et al.'s (2000) study, White girls had significantly higher body shape concerns and more significant body image dissatisfaction as measured by the BSQ and Body Silhouette Chart. Indicators for body shape concerns were found in 19.6% of the Black participants, 25.9% in the mixed-race and 32.9% in the White participants, thus indicating that ED pathology occurs in all cultural groups.

Similar results to Wassenaar et al.'s (2000) study were also reported by Edwards et al. (2003) on a study of 39 Black and 41 White university resident students who completed the EDI. BMI was calculated from self-reported body mass and height. Like Wassenaar et al.'s (2000) study, Edwards et al. (2003) showed Black respondents had higher BMIs and scored higher on the subscales for perfectionism, interpersonal distrust and maturity fears.

The second study reported by Edwards et al. (2003), was conducted in 1997 and included 134 high school and university students who completed the Bulimia Test (BULIT), a 36 item self-report questionnaire based on DSM-III-R criteria for BN. Self-reported weight and height were used to determine BMI. There were 49 participants aged 13-14 years, 44 participants aged 17-19 years and 31 university students aged 20-21 years. In line with previous studies, Black participants recorded a higher average BMI than White participants. A positive correlation was evident between BMI and BULIT scores; however, results for the BULIT did not indicate significant differences for ethnicity. As with previous studies, this study confirms the prevalence of disordered eating amongst both Black and White participants.

A larger study by Edwards and Moldan (2004) included the administration of the BULIT to 146 university residence students in 1997 to determine Black students' bulimic behaviours and attitudes. The questionnaires were completed by 30 Black males, 34 Black females, 41 White males and 41 White females. Although 5% of Black males fell above the cut-off, the results were considered invalid when it became clear that the respondents misinterpreted ED terminology. The results indicated 6% of Black females showed eating disordered pathology compared to 20% of White females with clinical levels of bulimic symptoms. These findings contrast to those reported by Le Grange et al. (1998), who found Black females to have higher levels of disordered eating than Whites. However, the results are consistent with observations that Whites present far more often for treatment than other race groups (Szabo, 1999, 2002).

Theoretical models tend to emphasise western sociocultural factors in the development of EDs, thus suggesting that Caucasian women are more at risk for the development of EDs (Le Grange et al., 1998; Caradas et al., 2001) and that these disorders are culture-bound syndromes (Swartz, 1985). As such acculturative stress was suggested as a reason for the high scores among Black participants in the study by Wassenaar et al. (2000) as social integration in post-Apartheid South Africa means that the consumer ideal of thinness also influences Black students. Higher scores for the Black subjects on the perfectionism scale may have been related to the pressure to assimilate to the consumer culture. Thomas (2018) states that Black women feel that the belief that EDs develop because of the pursuit of western ideas is not always true. Thomas interviewed a Black South African woman who developed an ED and depression after experiencing sexual traumas. This woman believed she was not in pursuit of an ideal body image and only developed self-image issues after she was subjected to body-shaming comments because of her weight loss. Developing an ED following a sexual trauma is not unique and has been reported by women across all cultural groups.

Although the South African research discussed is not current, studies conducted in the 1990s and early 2000s indicate the prevalence of disordered eating across ethnic groups with greater predominance in females. Higher body dissatisfaction levels were found amongst White females (Caradas et al., 2001; Wassenaar et al., 2000) while Blacks scored higher on perfectionism (Wassenaar et al., 2000; Edwards et al., 2003). In general, Blacks had higher BMIs than Whites and Whites presented for treatment more often than other ethnic groups. Thomas (2018) interviewed Black women with EDs in Nigeria, the US and South Africa and

discovered that they did not come forward because EDs are seen as a gateway to wanting to be White, and there is a shortage of Black female psychologists specialising in EDs. An interviewee in Thomas' programme stated that she would have remained in therapy if she could have seen a Black psychologist who gave her solutions to "Black problems."

In summary, the limited research in South Africa suggests that EDs are found in all ethnic groups. Still, people from the White ethnic group more frequently obtain treatment because of opportunities and referral networks. Clinical information from my practice and that of colleagues' indicate that women, in particular, have EDs, but there is no survey research like that conducted in first world countries.

2.4. Theories and Treatments of EDs

Since the 1930s, when EDs were believed to have a psychological component, there have been many theories and treatment programmes that address EDs by emphasising various aspects of aetiology. The main theories will be described here.

2.4.1. Psychodynamic Theories of EDs

2.4.1a. Psychoanalytic Theory

In the first half of the twentieth century, Freud's psychoanalytic theory was the dominant theory of the time. Freud viewed our behaviour as determined by unconscious motivations and biological and instinctual drives that evolve through key psychosexual stages in the first 6 years of life. Instinctual drives include life instincts that ensure the survival of the individual and human race, whilst deriving pleasure and avoiding pain. Death instincts include the aggressive drive where people have an unconscious wish to die or to hurt themselves or others (Corey, 2001).

EDs were understood as arising from problems in life instincts. Freud described the oral stage of development, which occurred in the first year of life and involved the infant sucking at the mother's breast to obtain food and pleasure. If an infant did not receive sufficient of this basic nurturing, later feelings of greediness could develop, accounting for bingeing in BN and BED. The phallic stage of development occurs between the ages of 3 and 6 and involves conflict around unconscious incestuous desires for the parent of the opposite sex. This conflict can be revived in the genital stage of development, which occurs from the age of 12 onwards (Corey, 2001), and accounts for anorexic behaviours, believed to arise from unconscious fantasies related to the wish or fear of oral impregnation by one's father.

These reawakened sexual strivings are defended against by the refusal to eat (Swift & Stern, 1982).

2.4.1b. Object Relations Theory and Attachment Theory

In the second half of the twentieth century, the emphasis shifted to internal object relations and developing a sense of self. Infants perceive others as objects for gratifying needs rather than individuals with separate identities (Corey, 2001). The successful completion of developmental stages in the first few years of life results in separation and individuation. The child comes to see others as individuals, separate from the child, with separate identities. Thus the child develops a sense of autonomy and a concept of self.

According to Mahler (David, 2015), in the first 5 months of life, the mother is acknowledged as the source of needs satisfaction, and hence she is the primary object. The availability and ability of the mother to adapt successfully to the infant's needs are crucial. From 5 to 24 months, the infant views the mother as a separate individual and develops a sense of self. From this period onward, object constancy is established where the child has an internalised mental model of the mother. This shifts to expanding awareness of others as self/other patterns are established, influencing later interpersonal relationships. In particular, people search for connections that match earlier established patterns of experience (Corey, 2001).

In the 1970s, psychoanalyst John Bowlby developed attachment theory which proposes that people are born with an innate need to make safe and affirming connections with others (Zerbe, 2010), including needs for nurturance, warmth and acceptance (Rafaeli et al., 2011). These early bonds help establish internal working models that serve as blueprints of the world, establishing how individuals understand themselves, significant others, and their interrelationships, thus encoding attachment patterns (Holmes, 2014). When an infant's needs for nurturance, warmth and acceptance are met, the infant develops a sense of reliable, secure attachments from which to move into the world (Zerbe, 2010). When unmet needs lead to disrupted attachment, the psychological growth of the individual is inhibited. An infant who develops insecure attachment may have restricted emotional development and struggle to process feelings such as anger, rage and abandonment, leading to self-regulation problems.

Attachment theory understands psychological disorders as occurring when disrupted attachment impacts the individual's psychological growth (Zerbe, 2010). From this perspective, binge eating in BN and BED can provide a sense of nurturance or self-soothing for individuals who do not believe significant others can meet these needs. Restrictive eating

or excessive exercise in AN is theorised to occur because of unresolved loss and unavailable or unwilling attachment figures to help process the accompanying affect.

Hilde Bruch (1973) further contributed to the understanding of EDs. She supported the view that early developmental problems impacted an individual's emotional and physiological experience of food and satiation by considering that inappropriate reciprocal feedback patterns between the mother and child around feeding resulted in disturbances of hunger awareness. For example, when feeding gratified a mother's needs rather than the child's, such as to keep the child quiet, or feeding was timed to suit the mother's schedule (Vemuri & Steiner, 2007). These disruptions affected a child's development of autonomy or inner-directedness so that they did not experience their bodies as their own. When the normal process of separation-individuation was harmed, the child sustained an intrapsychic injury resulting in impaired object constancy, intense anxiety and attempts to cling to the primary object or to find other methods of self-soothing. In EDs, food becomes a transitional object, reminding the individual of the mother when she is away, which helps the individual withstand separation (Zerbe, 2010). Thus EDs were seen to develop as individuals' attempts to assist in their struggle for independence, autonomy and age-appropriate dependence on people.

Bruch theorised that a client's striving for thinness originated from her trying to separate from an intrusive parent where she could not develop her thoughts, feelings or personality (Zerbe, 2010). Bruch speculated that clients with EDs, whether anorexic or overweight, all experienced their body as not truly their own but under the influence of another. From this perspective, anorexic behaviours were seen to undo the feelings of ineffectiveness, passivity and control by an outside force (Vemuri & Steiner, 2007). Clients with BN were seen to be holding onto self-destructive behaviours because of a need to be punished, based on a rejecting internal object such as an abusive or abandoning caretaker. These clients could not evoke in themselves a "good enough" other to assist in times of distress, and so the ED became a source of comfort (Zerbe, 2010).

2.4.1c. The Course of Treatment for Psychodynamic Approaches

Psychoanalytic therapy aims to make the unconscious conscious and strengthen the ego, which is the part of the self that is more reality-based, so that behaviour is based more on reality and less on instinctual cravings or irrational guilt. If therapy is successful, then modifications to the individual's character and personality occur. Therapeutic methods focus on the interpretation and analysis of childhood experiences to better understand the self, whilst emphasising the associated feelings and memories. Therapists in this modality

maintain a neutral stance to foster a transference relationship where clients project onto the therapist. The belief is that what clients feel towards the therapist will be a product of repressed feelings associated with significant figures from the client's past (Corey, 2001). Analysis of these projections is an important focus in the therapy. The therapist helps the client achieve greater self-awareness and more effective interpersonal relationships by working through and resolving old patterns and helping the client make new choices.

Further goals of therapy include dealing with anxiety realistically and gaining control over impulsive and irrational behaviour. This type of therapy focuses on relationships rather than specific behaviours as by working through the transference relationship, character change occurs. Techniques used in psychoanalytic therapy include free association, interpretation and dream analysis. Psychoanalytic therapy is long term, typically involving the therapist and client meeting several times a week for 3 to 5 years. Many of Freud's psychoanalytic concepts, such as unconscious motivation, the influence of early development, transference and countertransference, are applicable to more contemporary psychodynamic approaches (Corey, 2001).

Although not the current treatment of choice for EDs, understanding psychoanalytic therapy and other approaches under the psychodynamic umbrella provides a framework for understanding the role and impact of early childhood events on the client's present functioning. Object relations theory helps therapists to see how clients interacted with significant others in the past and how they superimpose these experiences onto current relationships (Corey, 2001). Many of the psychoanalytic concepts described here are integrated into the ST approach.

2.4.2. Interpersonal Psychotherapy

Interpersonal psychotherapy (IPT) was developed in the 1960s by Drs Klerman and Paykel for the treatment of depression (Weissman, 2006) and later adapted for use with EDs (Tanofsky-Kraff & Wilfley, 2010). IPT is grounded in the theory that interpersonal functioning is a critical component of psychological adjustment and well-being. Therefore an individual must be understood in terms of their interpersonal relationships as these enduring patterns either encourage self-esteem or result in anxiety, hopelessness and psychopathology. IPT acknowledges a two-way relationship between social functioning and psychopathology; that disturbances in social roles can serve as antecedents for psychopathology, and that psychopathology impairs one's social functioning (Tanofsky-Kraff & Wilfley, 2010).

IPT for EDs focuses on the link between low interpersonal functioning and EDs. Individuals with EDs experience interpersonal difficulties, partly due to social withdrawal

and low self-esteem that accompany the condition. These interpersonal difficulties may contribute to the maintenance of the ED (Murphy et al., 2012). For example, individuals with BN and BED have heightened sensitivity to interpersonal interactions. The distress accompanying interpersonal difficulties, combined with low self-esteem and negative affect, can precipitate and maintain bulimic or binge eating patterns. Less emphasis is placed on the ED's aetiology and more on identifying and adapting the interpersonal context in which it developed and is maintained (Tanofsky-Kraff & Wilfley, 2010).

2.4.2a. Course of Treatment for IPT

IPT is a time-limited therapeutic approach, the success of which depends on the therapist discerning patterns in interpersonal relationships and linking these patterns to symptoms of disordered eating in a timeous manner (Tanofsky-Kraff & Wilfley, 2010). Treatment for EDs generally involves 16-20, 50-minute sessions over the space of 4 or 5 months and occurs in three phases. Phase One, which typically constitutes three to four sessions, describes the rationale and nature of the treatment and identifies current interpersonal problems that will become the focus of therapy. Interpersonal problems fall within four social domains: (a) interpersonal deficits where clients are socially isolated or in unfulfilling relationships; (b) interpersonal role disputes which involve conflict with a significant other in the work, home or social environment; (c) role transitions which include difficulties associated with changes in life status such as marriage, a new job or retirement; and (d) grief where the onset of symptoms are related to the loss of a person or relationship (Tanofsky-Kraff & Wilfley, 2010). Phase two comprises up to 14 weekly sessions and helps the client understand the nature of the problem and address it. Phase three typically lasts three sessions and deals with maintenance of changes and relapse prevention (Murphy et al., 2012).

2.4.3. CBT

CBT is an umbrella term for more than 20 different therapies (Dattilio & Freeman, 1992), including Ellis' Rational Emotive Behaviour Therapy (REBT) and Beck's Cognitive Therapy (CT). All CBTs share common attributes, including a collaborative relationship between client and therapist, the belief that psychological distress arises from disturbances in cognitive processes, a focus on changing cognitions to bring about change in affect and behaviour, and a time-limited treatment focusing on specific problems (Corey, 2001). Also, various behavioural strategies, including homework tasks, place responsibility on the client to assume an active role.

REBT is based on the assumption that cognitions, emotions and behaviours interact and have a reciprocal cause-and-effect relationship (Corey, 2001). Thus people's

interpretations of events and situations contribute to psychological problems. In REBT, the emphasis is placed on cognition and behaviour rather than affect. The A-B-C theory of personality, central to REBT, stipulates that a person's belief (B) about an activating event (A) causes an emotional reaction (C). At the heart of REBT lies helping people to change their irrational beliefs. Changing beliefs is achieved through various cognitive techniques, including disputing irrational beliefs and changing one's language by removing absolutes such as "must", "should", and "always." Behavioural techniques, such as role-playing, are also administered.

Beck's CT is an insight-focused therapy that emphasises recognising and changing negative thoughts and maladaptive beliefs. Therefore, the goal is to use a client's automatic thoughts to identify core schemata and bring about schema restructuring. Beck's basic premise was that psychological problems develop from cognitive distortions, including faulty thinking, incorrect inferences, and failure to distinguish between fantasy and reality. The therapist teaches the client to recognise their negative automatic thoughts and to test them against reality. Both REBT and CT share the belief that distressing emotions typically result from maladaptive thoughts (Corey, 2001).

CBT considers that individuals with core low self-esteem internalise sociocultural ideals about the importance of thinness, believing that achieving these ideals will negate their low self-esteem and determine self-worth. Individuals who maintain severe dietary restriction develop AN, whereas restrictive dieting behaviour in BN makes an individual vulnerable to binge eating. Binge eating produces physical discomfort and emotional distress, combined with heightened concerns regarding one's weight and shape, which is then alleviated through purging behaviour. After purging, the individual recommits to restrictive dieting, and so the cycle begins again (Grilo, 2012; Lampard & Sharbanee, 2015). Thus ED symptoms are maintained by interactions between cognitive disturbances, such as over concern for eating, weight and shape, and behavioural disturbances in eating and weight control behaviour.

In 1981 Fairburn described CBT for BN (CBT-BN), for which a treatment manual was published in 1993 (Cooper & Fairburn, 2011). Since then, it has been adapted, and the scope broadened to make it suitable for all forms of EDs, known as enhanced CBT (CBT-E). As with IPT, CBT-E is time-limited, consisting of 16-20 sessions administered over 4 months. CBT-E maintains that in some clients with EDs, one or more of the four identified maintaining factors interact with the core eating pathology and provide obstacles to change (Fairburn et al., 2003). These maintaining factors include interpersonal difficulties, mood intolerance, core low self-esteem and clinical perfectionism (Cooper & Fairburn, 2011).

Clinical perfectionism suggests a system of self-evaluation where self-worth is judged based on striving towards and achieving demanding goals (Cooper & Fairburn, 2011). Clinical perfectionism becomes maladaptive when one strives for rigid standards despite significant deleterious consequences (Lampard & Sharbanee, 2015). When these demanding goals are applied to eating, weight and shape, aspects of the ED are intensified. This is accompanied by fear of failure as represented by overeating or weight gain and frequent attention to performance such as frequent weight and shape checking, and self-criticism arising from negative appraisals (Cooper & Fairburn, 2011), all of which maintain the ED. Mood intolerance usually refers to aversive moods such as anger, anxiety or sadness, which some clients cannot deal with appropriately and engage in binge eating and purging behaviours to regulate moods (Cooper & Fairburn, 2011; Lampard & Sharbanee, 2015). The inability to cope with these moods usually arises because clients think they will be unable to cope with their feelings and thoughts. Individuals with core low self-esteem have pervasive negative self-judgments, mostly independent of their performance (Cooper & Fairburn, 2011), which creates a sense of hopelessness about their ability to change. As a result, one pursues achievement in valued domains such as eating, weight and shape, which come to represent one's self-worth (Lampard & Sharbanee, 2015). Interpersonal difficulties contribute to the maintenance of EDs by leading to negative mood states and exacerbating low self-esteem. For example, in tense family environments, dietary self-control can provide an individual with a sense of control, or adverse social interactions may precipitate binge eating episodes as one attempts to modulate one's mood. When interpersonal difficulties undermine one's self-esteem, individuals may strive harder to control eating, weight and shape (Cooper & Fairburn, 2011).

2.4.3a. The Course of Treatment for CBT-E

There are two forms of CBT-E, the focused version, that concentrates on ED pathology and mood intolerance, and the broad version, that contains modules focusing on the other three maintaining factors discussed. CBT-E's process is to construct a unique formulation for each client identifying the processes that maintain the psychopathology and that need to be targeted in treatment. This, along with relevant education, forms the first stage of treatment. Clients are also introduced to the behavioural concepts of in-session weighing as well as regular eating. The second stage of treatment briefly reviews progress, identifies barriers to change and modifies the formulation if necessary. Stage three forms the main body of treatment as maintaining factors for the EDs are addressed through various cognitive and behavioural strategies. These strategies include self-monitoring records, restriction of

weighing at home, establishing good eating habits such as delaying urges to eat (in the case of binges), role play and identifying and challenging cognitive distortions. The fourth and final treatment stage focuses on maintaining changes and relapse prevention (Fairburn, 2008).

CBT bears some similarity to IPT in that both treatment approaches are time-limited and focus on the present. In contrast, psychodynamic therapies are not time-limited, and the impact of experiences in early development are considered.

2.4.4. Research into the Efficacy of Therapeutic Approaches

Poulsen et al. (2014) conducted a study in Denmark where 70 clients diagnosed with BN were randomly selected to receive two years of weekly psychoanalytic psychotherapy, or 20 sessions of CBT delivered over 5 months. ED psychopathology was assessed using the Eating Disorder Examination Interview version 14.4, administered at baseline, 5 months (to coincide with the end of the CBT treatment) and 24 months (to coincide with the end of the psychoanalytic treatment) following the onset of treatment. At their respective endpoints, 42% of clients in the CBT treatment had ceased binge eating and purging compared to 15% in the psychoanalytic psychotherapy group. The response to treatment was also quicker in the CBT group, with 42% of the clients ceasing bingeing and purging at 5 months compared to 6% of clients in the psychoanalytic treatment group. By the endpoints of each treatment, significant improvements had been made in restraint and eating, weight and shape concern. The results indicate that although psychoanalytic therapy addresses issues relevant to people with EDs, CBT is more effective in treating core bulimic symptoms. Psychoanalytic research did not keep up with CBT's research and so focus on this form of therapy for EDs diminished (Lunn et al., 2016).

As previously mentioned, psychodynamic therapy is a lengthy therapy and only available to a limited number of clients. This has led to a focus on adapting psychodynamic models to increase accessibility and to fit the needs of the eating disordered population (Murphy et al., 2005). An integration of psychodynamic principles with CBT interventions was suggested by Johnson et al. (1987) and Steiger (1989). Murphy et al. (2005) conducted a study on 21 female clients with a DSM-IV diagnosis of BN (14 participants) or BED (7 participants). Participants were selected for a treatment programme that consisted of 20 to 40 individual weekly therapy sessions with a psychodynamic focus, combined with behavioural aspects. The behavioural aspects included keeping a weekly diary to monitor food behaviours and report emotional states, implementing an eating plan and weekly weighing. Participants were assessed for ED symptoms before treatment, at the end of treatment and at 3 and 6 months follow up. Of the 14 participants in the BN group, 10 completed the programme, with

seven presenting symptom-free at the 6 month follow up. The BED subgroup had one participant drop out, and of the remaining six, five participants were symptom-free at 6 month follow up. Although this was a small study, the findings indicate that there are benefits to combining CBT with a psychodynamic approach.

Most research into treatment for EDs has focused on CBT, followed by IPT. Two studies conducted in the 1990s compared the efficacy of CBT versus IPT for BN (Murphy et al., 2012). In the first study, 75 individuals with BN were randomly chosen for treatment with CBT-BN or IPT (Fairburn et al., 1991). A follow up was conducted 12 months after treatment ended. The results indicated that CBT showed superior results in reducing ED symptoms at the end of therapy, but that clients who had undergone IPT continued to improve after treatment with the result that achievements at follow-up were equivalent (Fairburn et al., 1995). Thus although IPT was slower acting than CBT-BN, it was as effective in the long-term. These findings were replicated in a more extensive study with 220 participants (Agras et al., 2000). These findings are surprising as they indicate that although IPT does not address ED symptoms directly, there is no significant difference in the long term efficacy of CBT and IPT for BN.

A study of CBT and IPT for AN reported similar findings (McIntosh et al., 2005). Fifty-six clients who met DSM-IV criteria for AN, with a BMI between 14.5 and 17.5, were randomly assigned to IPT, CBT or non-supportive clinical management. The non-supportive clinical management was comprised of two aspects, clinical management and supportive psychotherapy. Clinical management included care, support and education (verbal and handouts) regarding weight restoration and learning to eat normally, whilst supportive psychotherapy included praise, reassurance and advice. All therapies consisted of 20 one-hour treatment sessions. Of the 56 participants, only 35 (62%) completed therapy. Only 9% of the original sample of participants were reported to have good outcomes as determined by no or few features of EDs, whilst 70% either had no or small gains or dropped out of the process. At the end of treatment, IPT was found to be the least effective treatment approach. CBT was as effective as non-supportive clinical management in addressing eating and weight concerns. Still, non-supportive clinical management was the most effective in addressing drive for thinness, restraint and weight concerns. Follow-up, on average 6.7 years after cessation of treatment, indicated that half the sample who completed treatment had a significant number of anorexic features. Although this was an improvement in the number of individuals who had made progress immediately post-treatment, it still indicates a high number of individuals for which treatment was not effective. Follow up also indicated that

individuals who received non-supportive clinical management had the highest levels of deterioration. In contrast, participants who received CBT had remained relatively stable, but individuals who received IPT had continued to improve to have the best outcomes at follow-up (Carter et al., 2011). From the low recovery rates immediately following treatment and in the long term follow up, we can conclude that brief interventions for AN are ineffective in treating this complex disorder.

A further study comparing CBT group therapy to IPT group therapy for BED was conducted on 162 clients randomly assigned to CBT or IPT (Wilfley et al., 2002). Treatment consisted of 20, 90-minute group therapy sessions and three individual sessions. A total of 9.9% of participants dropped out of treatment. Participants were assessed immediately after cessation of therapy and at 4, 8 and 12 months post-treatment. Immediately post-treatment, 82% of the CBT participants and 74% of the IPT participants had no bingeing behaviours. At the 12 months follow up, 72% of the CBT and 70% of the IPT participants were not bingeing (Wilfley et al., 2002). The results indicate that group CBT is slightly more effective in the short term than group IPT for BED. However, as individuals who received CBT regressed over time, the result is that the treatment approaches are equally effective. Yet, approximately 30% of individuals did not obtain or sustain recovery with either approach.

Fairburn et al. (2015) compared CBT-E's effects with those of IPT with various ED subgroups. The sample consisted of 130 eating disordered participants randomly assigned to CBT-E or IPT for a 20-week therapeutic process. Of the 130 participants, 40.8% were diagnosed with BN, 6.2% with BED, and 53.1% "other eating disorder." The number of participants that completed the treatment included 27.6% with BN, 6.2% with BED and 43.8% with "other eating disorder." As with previous studies, the changes were more significant for participants in the CBT-E group, with the number of participants in remission almost double that of the IPT group. By the 60 weeks follow up, the effects of CBT-E had been well maintained. Still, participants in the IPT group had continued to improve, so differences between the two groups were no longer statistically significant (Fairburn et al., 2015).

To summarise these studies' findings, psychoanalytic therapy and IPT can be viewed as alternative treatments to CBT for EDs. Although IPT does not specifically address ED pathology, it is as effective as CBT in addressing ED behaviours in the long term. However, both treatment modalities are ineffective for a large proportion of individuals with EDs. As CBT directly addresses ED pathology, the results are quicker, but IPT focuses on interpersonal functioning contributing to ED pathology. Also evident from the studies was

that research was conducted to combine treatment modalities because IPT and CBT have beneficial aspects. If they can be integrated into a single therapeutic approach, addressing ED behaviours and underlying childhood factors contributing to these behaviours, as ST does, this is better.

A study conducted in Western Australia by Byrne et al. (2011) researched the effectiveness of CBT-E for AN, BN and eating disorder not otherwise specified (EDNOS) with 125 clients referred to a public outpatient clinic. The treatment programme was completed by 53% of the participants, with the highest dropout rate (50%) for those with AN. By the end of treatment, 32% of the original sample were in full remission (no ED symptoms for 28 days). An additional 8% were in partial remission - not fulfilling one criterion for complete remission. There was no noticeable improvement in perfectionism or mood intolerance in this study, two maintaining factors addressed specifically in CBT-E. This, together with the fact that only one-third of clients were helped, means that the treatment modules are insufficient for many more challenging cases.

An additional study conducted in Australia between 2009 and 2013 (Signorini et al., 2018) involved 114 female participants with the DSM-IV diagnosis of EDNOS (42.5%), BN (36.8%) and AN (20.8%). These participants received 20-40 weekly CBT-E sessions at an outpatient clinic. Only 50% of the participants completed treatment, and one-third of the participants attended the follow-up. Of those who completed treatment, 69.1% showed a good outcome, as evidenced by a result of the Eating Disorder Exam Questionnaire within one standard deviation of community norms. These positive outcomes were still evident 20 weeks' post-treatment. Of significance is the dropout rate of 50%, which researchers claim may have been related to relationship discord and inadequate social support. These high dropout rates and limited recovery are in line with those reported by Byrne et al. (2011).

Fairburn et al. (2013) studied the impact of CBT-E on AN using a sample of 99 adults with a BMI between 15 and 17.5, who were recruited in the UK and Italy to undergo 40 weeks of CBT-E treatment. A total of 63 participants (63.6%) completed treatment, and 13 participants (13.1%) were withdrawn because of sustained lack of progress and were referred for more intensive treatment. Of the 63.6% who completed treatment, 88% achieved a global EDE-Q score of less than 1standard deviation (SD) above the community mean, and 62% achieved a BMI ≥ 18.5. The results translate to only 41.4 % of the original sample obtaining a healthy BMI post-treatment. At 60 week follow up, this percentage had decreased to 34.3%

of the original sample. Hence only one-third of participants who received CBT-E for AN maintained their progress long term.

As illustrated in these studies, there is still a large percentage of individuals with EDs for whom these treatment approaches are not effective enough, as evidenced by the high dropout rates and low rates of complete recovery. In the studies discussed here (Byrne et al., 2011; Signorini et al., 2017; Fairburn et al., 2013), the high dropout rates ranged from 27% in Fairburn et al.'s (2013) study to 50% in Signorini et al.'s (2017) study. Of those who completed treatment, only one-third were helped in Byrne et al.'s (2011) study, and only one-third sustained their progress in Fairburn et al.'s (2013) study. These results indicate a need for more effective treatment approaches that address difficult to treat cases and where results can be maintained long term.

In 2004 the UK's National Institute for Clinical Excellence (NICE) issued guidelines endorsing CBT as the treatment of choice for BN and BED based on empirical support (Wilson & Shafran, 2005). This endorsement might be because CBT, as the most researched form of therapy, has the most empirical support (Wildes & Marcus, 2010). However, as shown in the studies discussed, it is not more effective than other treatment approaches in the long term. NICE could not recommend specific treatments for AN because of the lack of research evidence indicating effective treatment for this disorder. The Royal Australian and New Zealand College of Psychiatrists and the Australian Psychological Society College of Clinical Psychologists also support CBT as the treatment of choice for BN and BED. Still, they do not specify a psychological approach for AN (Brennan & Shelton, 2020). These guidelines are again based on the fact that more studies assess the efficacy of CBT than other treatment approaches. Although some studies were assessing CBT for AN, the effect of this treatment approach was only considered moderate. The German guideline for EDs recommend Focal Psychodynamic Therapy, CBT and CBT-E for AN but do not prefer an approach due to insufficient evidence (Resmark et al., 2019). One might assume that there is less evidence regarding AN because this is the smallest group of EDs in the population. Due to the serious health implications, individuals with severe AN, who may be hospitalised, will be excluded from studies. All this information suggests that CBT, as the most widely researched form of therapy, is recommended as the treatment of choice for EDs. This recommendation is despite evidence suggesting it is no more effective than other approaches, has high dropout rates and low rates of complete recovery.

Le Grange (2016) states that AN does not respond uniformly to well-established psychotherapies and that treatments should be developed that apply to various subsets of

clients targeting specific ED behaviours, traits or cognitive styles. Although Le Grange's (2016) article only focused on AN, the same can be said of BN and BED. As EDs do not respond uniformly to treatment, a therapeutic approach that combines various treatment approaches might be more effective for treating EDs.

Chapter 3. Schema Therapy

ST, founded by Jeffrey Young, is an integrative approach developed for long-term disorders and treatment-resistant clients who were not adequately helped by traditional CBT treatment programmes (Young et al., 2003). ST expanded on CBT by integrating perspectives and techniques from attachment, emotion focused, object relations, constructivist and psychoanalytic models (Young et al., 2003). It has been used to treat EDs for more than a decade (Simpson, 2012). Ohanian (2002) reported the use of imagery rescripting, a central intervention in ST, in work with EDs and Mountford and Waller (2006) and Waller et al. (2007) discussed a ST approach to conceptualising ED cases.

A fundamental construct in ST is a schema, defined as "any broad organising principle for making sense of one's life experience" (Young et al., 2003, p.7). Early maladaptive schemas (EMS) are pervasive themes comprised of memories, emotions, cognitions and bodily sensations that develop due to unmet core emotional needs in childhood, toxic childhood experiences and emotional temperament. ST recognises that all people have universal needs, which, although lifelong, are most vital in childhood. Getting these needs met is an essential feature of healthy development; however, when these needs are not met, EMS develop. EMS develop during childhood or adolescence and are elaborated on throughout one's lifetime (Young et al., 2003). EMS are dysfunctional because they cognitively and emotionally render new situations similar to toxic situations from the past. As a result, the schemas maintain particular types of environments or relationships (Rafaeli et al., 2011).

To a large extent, problems within the nuclear family are usually the primary origin of EMS. However, as children grow and move into other environments, needs not met with extended family, peers, school environment, and community groups can also lead to the development and intensification of EMS. Young et al. (2003) differentiate between conditional and unconditional EMS. Unconditional schemas develop earliest and contain irrefutable beliefs that regardless of what the individual does, the outcome will be the same, thus indicating that the individual has no choice in the matter. In contrast, conditional schemas are secondary to unconditional schemas because they develop as attempts to get relief from the unconditional schemas. Therefore, conditional schemas hold hope that if an individual behaves in a certain way, they can temporarily avert the negative outcome. The conditional schemas are, therefore, related to coping behaviours. Schemas exist on a continuum ranging in severity and pervasiveness. The more severe the schema, the more

easily it is activated and the more severe its consequences (Rafaeli et al., 2011). The 18 EMS identified by Young et al. (2003) are listed in Table 1.

Table 1

The EMS

EMS	**Description**
Unconditional Schemas	
Abandonment/Instability	Individuals with this schema have the sense that they cannot depend on important people in their life to be there. This schema can develop because of the death of a significant adult or an emotionally unavailable parent.
Mistrust/Abuse	The expectation that others will intentionally take advantage of, humiliate, cheat or lie to the person.
Emotional Deprivation	The expectation that one's desire for emotional connection will not be adequately fulfilled. This schema takes three forms; - deprivation of nurturance, which refers to the absence of affection and caring, - deprivation of empathy defined by the lack of listening and understanding, - deprivation of protection which is the absence of strength and guidance from others.
Defectiveness/Shame	One feels inferior, flawed and unlovable. There is also a sense of shame regarding one's perceived flaws which may be private, referring to character traits such as selfishness, or public, such as an unattractive appearance or social awkwardness.

EMS	Description
Unconditional Schemas	
Social Isolation/Alienation	An individual has a sense of being different from others and not fitting in.
Dependence/Incompetence	The belief that one cannot competently handle daily responsibilities without help from others.
Vulnerability to Harm or Illness	An exaggerated fear that catastrophe, either medical, emotional or environmental, will strike and cannot be prevented.
Enmeshment or Undeveloped Self	This schema occurs when one is overly involved with a significant other; usually, a parent, which inhibits full individuation and normal social development. This excessive involvement is accompanied by the belief that one of the enmeshed individuals cannot survive without the other.
Failure	The belief that one has failed or will inevitably fail relative to one's peers in areas of achievement such as school, career or sports.
Entitlement/Grandiosity	A belief that one is superior to others and entitled to special rights and privileges; or that they are not bound by the rules of reciprocity that guide normal social interaction.
Insufficient Self-Control/Self-Discipline	This schema entails difficulty exercising sufficient self-control, including the expression of one's emotions and impulses, and low frustration tolerance for achieving one's goals.

EMS	Description
Unconditional Schemas	
Negativity/Pessimism	One has a pervasive focus on negative aspects of life and an exaggerated belief that things will go wrong in important aspects of life.
Punitiveness	A belief that people, including oneself, should be harshly punished for mistakes. This belief leads to anger and intolerance towards those who do not meet the individual's expectations or standards. An individual with this schema struggles to forgive mistakes or to have empathy.
Conditional Schemas	
Subjugation	Feeling coerced to surrender control to others to avoid retaliation, anger or abandonment. The belief that one's opinions or beliefs are not valid or important to others is part of this schema. There are two forms of subjugation; - the subjugation of needs, where one suppresses one's preferences, decisions and desires, - the subjugation of emotions, where emotions, especially anger, are suppressed.
Self-Sacrifice	One voluntarily sacrifices ones' needs to meet the needs of others. This self-sacrifice may occur as one hopes to maintain a connection with others, avoid feelings of guilt related to perceived selfishness, or avoid causing pain.
Approval-Seeking/ Recognition-Seeking	One's self-esteem is dependent on the approval, recognition or attention of others. To fit in, one sacrifices the development of a true sense of self.

EMS	Description
Conditional Schemas	
Emotional Inhibition	One inhibits spontaneous action, feeling or communication to avoid losing control of impulses or avoid feelings of shame or disapproval by others. This schema takes the form of; - inhibition of anger and aggression, - inhibition of positive impulses such as joy and affection, - difficulty expressing vulnerability or freely communicating one's feelings and needs, - excessively emphasising rationality and disregarding emotions.
Unrelenting Standards/ Hypercriticalness	The belief that one must strive to meet high internalised standards of performance and behaviour to avoid criticism. Individuals with this schema are hypercritical towards themselves and others and can present with perfectionism, rigid rules and "shoulds", and a preoccupation with time and efficiency.

EMS are elaborated throughout one's lifetime and are activated by life events in adulthood that are unconsciously perceived as similar to traumatic experiences in childhood. This is referred to as schema triggering. When EMS are triggered, strong distressing emotions are experienced that an individual manages by developing maladaptive coping styles expressed through specific behaviours (Young et al., 2003).

The EMS were initially categorised into five domains, according to broad categories of unmet needs (Rafaeli et al., 2011). Over time the five domains have been revised, and four domains have been identified, representing unmet needs resulting from dysfunctional patterns of parenting (Lockwood & Perris, 2012; Bach, Lockwood & Young, 2017). The four

domains are; disconnection and rejection, impaired autonomy and performance, excessive responsibility and standards, and impaired limits (Bach, Lockwood & Young, 2017).

The disconnection and rejection domain is associated with emotionally depriving and belittling parents where the child does not feel accepted, loved and validated. This is theorised to lead to the development of Emotional Deprivation, Social Isolation/Alienation, Emotional Inhibition, Defectiveness/Shame, Negativity/Pessimism and Mistrust/Abuse schemas (Bach, Lockwood & Young, 2017).

The impaired autonomy and performance domain includes schemas that develop in an environment with overprotective and controlling parents who focus on unrealistic dangers and invalidate the child's expression of their feelings and needs. The child lacks opportunities to build self-confidence, independence and reliance and fears being left alone in a world that is perceived as dangerous. The resulting EMS that may develop include Dependence/Incompetence, Failure, Vulnerability to Harm or Illness, Subjugation, Enmeshment or Undeveloped Self and Abandonment/Instability (Bach, Lockwood & Young, 2017).

The excessive responsibility and standards domain is associated with perfectionistic parenting. High demands from parents result in the child feeling too much responsibility and pressure to live up to their own or other's standards. The schemas in this domain include Self-Sacrifice, Unrelenting Standards/Hypercriticalness and Punitiveness (Bach, Lockwood & Young, 2017).

Finally, the impaired limits domain includes schemas that may develop as a result of narcissistic parenting. Such parents ignore the child's basic emotional needs as they focus on the child satisfying the parents' needs for prestige and specialness. Alternatively, these schemas may develop when a child experiences spoiling parents who do not set limits, and the child develops a sense of entitlement as a result. The schemas in this domain include Insufficient Self-Control/Self-Discipline, Approval-Seeking/Recognition-Seeking and Entitlement/Grandiosity (Bach, Lockwood & Young, 2017).

Some schemas can be associated with more than one domain. For example, the Insufficient Self-Control/Self-Discipline schema can fall in the category of impaired autonomy and performance when a child in an overprotective environment does not develop healthy self-discipline. Alternatively, the Insufficient Self-Control/Self-Discipline schema can occur in the impaired limits domain when a child in a spoiling environment does not

develop healthy self-control. The Negativity/Pessimism schema can be associated with the impaired autonomy and performance, excessive responsibility and standards, and disconnection and rejection domains because of its features of demoralisation and general distress (Bach, Lockwood & Young, 2017). Although of theoretical interest, the domain that the schema is associated with has no implications for the therapeutic process and is therefore of limited interest clinically.

Two main processes perpetuate EMS. First, EMS are perpetuated through cognitive distortions where situations are misinterpreted by focusing on information that confirms the schema and minimising information incongruent with the schema. Second, EMS are maintained by self-defeating coping styles that block emotions associated with a schema. The beliefs associated with the schema do not reach conscious awareness where they can be challenged and healed. The dysfunctional coping styles take three forms; overcompensating for the schema, avoiding activation of the schema or surrendering to the schema, where one behaves as if the schema is true. These coping styles may be adaptive in childhood, but they become maladaptive as they perpetuate the schema as one grows.

3.1. The Schema Mode Approach

The mode approach in ST was the next step in the evolution of this theory. Schema modes represent parts of the self, composed of schemas or schemas and coping mechanisms, that are active for an individual at a particular time in response to triggers in the environment (Brown et al., 2016). Identifying modes or parts of the self is an important aspect that reflects the underlying structure of a client's personality that creates their experience of reality.

The idea of parts of the self is not new, and as such, schema modes bear similarities to concepts from other therapeutic approaches. In the 1930s, Jacob Moreno used drama techniques in psychotherapy where clients roleplayed parts of the self that interacted. In the 1940s, Fritz Perls simplified this approach in gestalt therapy using the empty chair technique and two chair dialogues to represent parts of the self (Edwards, 2018). In these techniques, a dialogue was created between the different aspects of the individual's personality, represented by the chairs. Then, from an object relations perspective, Paul Federn (1952, as cited in Abramowitz & Torem, 2018) applied the concept of "ego states" to provide a psychodynamic understanding of the phenomenon of multiplicity. These ego states are described as aspects of a personality composed of behaviours and experiences that are bound together and can be separated from other such states (Abramowitz & Torem, 2018). Ego

states can be created by trauma or identification with significant people in one's life (Federn, 1952, as cited in Abramowitz & Torem, 2018). Federn's work on ego states formed the foundation for Eric Berne's view of ego states in transactional analysis. In transactional analysis, three categories of ego states are identified; the Parent, Adult and Child. These ego states are present in everyone and together form the individual's unique personality. In transactional analysis, a Parent state is influenced by one's parents or caregivers. When individuals are in the Parent state, they respond as their parent would with the same posture, feelings, vocabulary and gestures. A Child state contains "recordings" of childhood memories and experiences. In the Child state, one reacts as they would have as a child with spontaneous feelings, compliance or rebellion. In the Adult state, one approaches a situation objectively and uses good judgement (Cooke, n.d.). An individual can be in different ego states at different times.

Cognitive theory also includes parts of the self. Teasdale's (1996) work on multiple minds described how individuals have many minds, each with a developmental history and serving a function. The mind-in-place refers to the mind that is "wheeled in" as it is relevant for the current situation. As circumstances change, that mind is "wheeled out", and another, more relevant mind is "wheeled in." Thus, environmental input determines the mind or mode employed at the time. Once a mind has occupied a position in a particular context, it tends to be retrieved in similar contexts. From a cognitive perspective, Beck refers to sub-organisations of personality as modes that are networks of cognitive, affective, behavioural and motivational components. Each person has many modes, specific to life settings or situations, that filter information from the outside world. The term "modes" is used in a broad sense by Beck as specific to someone's life situation; for example, a work mode, relationship mode or social mode (Mountford & Waller, 2006). Psychopathology occurs when one becomes stuck in a self-defeating mode or when there are conflicts between modes.

From a narrative psychology perspective, Hermans and Dimaggio (2004) refer to the self as a "multivoiced and dialogical process" made up of various positions or characters with their own memories and thoughts. Each character can temporarily take over control of the individual's mind and actions. Parts of the self are influenced by interpersonal relationships as these relationships influence memories and are incorporated into parts of the self.

The descriptions provided here illustrate how the concept of parts of the self is recognised in many theoretical perspectives. An individual is comprised of multiple facets based on memory and experiences. These facets or voices each have their own

characteristics, express different emotions and take on different perspectives on events and interactions (Dimaggio & Stiles, 2007).

In ST these aspects of the self are called schema modes. Flanagan (2014) describes modes in ST as ways of operating that become habitual involving "the operations of conscious and unconscious processes, to be context sensitive, to serve immediate focal goals and ongoing background needs, and to span a continuum from adaptive to maladaptive" (p.7).

There are four categories of schema modes which Young et al. (2003) described as "emotional states and coping responses that we all experience … adaptive or maladaptive … that are currently active for an individual" (p.37). These modes, which comprise thoughts, emotions and behaviours, represent different aspects of an individual's personality that operate independently (Lobbestael et al., 2007) and can vary over a day (Rafaeli et al., 2011). Thus, these psychological structures, or modes, are at times active and at other times inactive. The four categories of modes consist of child modes, parent modes, coping modes and healthy modes. All individuals have modes that fall into these four categories.

ST draws on Bowlby's concept of internal working models (see section 2.4.1b) to understand child modes and parent modes. Internal working models are constructed mainly on patterns of interaction between a child and their primary attachment figure. These interactions provide information about oneself; for example, if an attachment figure feels this about me, then I can feel this about me. Bowlby's attachment theory distinguishes between attachment style and attachment behaviour. Attachment style refers to the state and quality of attachment between a child and an attachment figure, generally a parent and most likely the mother. Attachment style can be secure, where a child's needs are met and a good parent is internalised, or insecure, where a child's unmet needs result in the child being left with emotions with which they cannot cope (Holmes, 2014). In ST, insecure attachment and the resultant unmet needs arise from dysfunctional parent modes, which will be described later.

When there is real or potential separation from the attachment figure, a child behaves in a way to try and maintain or re-establish the proximity. This is known as attachment behaviour. Attachment behaviour is a reciprocal relationship where the parent offers caregiving behaviour that complements the child's attachment behaviour (Holmes, 2014). In ST, this represents a dyadic relationship between a parent mode and a child mode.

The internal working model of themselves which a child develops, based on the primary carer's behaviour towards the child, influences attachment. Both attachment style

and attachment behaviour arise from the internal working model of the client, which is "a blueprint of the world in which the self and significant others, and their interrelationships, are represented, and which encodes the particular pattern of attachment peculiar to that individual" (Holmes, 2014, p.54). Thus, the internal working model incorporates schemas that are triggered by life situations. A child's characteristic response to the attachment figure is their coping style. When a child has dysfunctional coping modes, the internal working model is prevented from being updated. In this way, new information is distorted so that the existing schemas remain intact. Thus, EMS are seen as dysfunctional internal working models which become habitual over time and are mostly out of conscious awareness (Young et al., 2003).

This concept of internal working models explains how systems with the experiences, thoughts and feelings of a child (the child modes) can exist in an adult. Individuals with less dysfunctional coping modes allow for the internal working model to be updated as the individual grows and needs are met in new situations. In this way, the individual is not left stranded in the past, and their child modes evolve and become integrated into a healthy mode. This process explains why individuals with psychological disorders, represented by maladaptive coping, have several child modes.

The child modes arise from unmet needs in childhood and are associated with painful emotions related to these unmet needs. The child modes carry the memory of childhood experiences (Edwards, 2020b) and include unconditional schemas. When a current event triggers memories or feelings associated with a childhood experience, a child mode is triggered, and one's reaction resembles that of a child. For example, if a situation results in an experience of anger in a child mode, one may have a tantrum like a child.

The dysfunctional parent modes are introjected explicit and implicit messages received from parents and other authority figures in one's childhood. A current event triggers the child mode, with the associated schemas and feelings, usually in a dyad with a parent mode. Then, the individual flips into a coping mode to shut down the unpleasant feelings.

Coping modes are states in which an individual avoids, overcompensates for, or surrenders to the emotions connected to the child and parent modes (Arntz & Jacob, 2013). In the short term coping modes provide a sense of relief from these threatening emotions. However, the coping modes maintain the EMS as the behaviours that form part of the coping strategies block access to the child modes. Hence the process of healing the child modes and

providing for unmet childhood needs, which is necessary for healthy development, remain unmet.

Mode sequencing refers to the consecutive shifts between modes (Edwards, 2017b). When an individual abruptly switches between modes, this is referred to as mode flipping (Edwards, 2020b). Mode sequencing and mode flipping maintain problematic cycles of thoughts, feelings and behaviour.

Inconsistencies exist in the definition and naming of modes within the four broad categories. This is because modes are not abstract concepts but, as part of an individual's experience, are "derived phenomenologically by therapists in therapy sessions" (Edwards, 2017a, p.4). Thus, the naming of modes attempts to capture the phenomenology of that unique experience. Young's first schema mode model identified 10 schema modes (Young et al., 2003; Arntz & Jacob, 2013). Arntz and Jacob (2013) and Bernstein and van den Broek (2009) later described 18 schema modes, and Lobbestael et al. (2007) described 22 modes. Fourteen modes can be assessed using the Schema Mode Inventory (Young et al., 2007). New modes continue to be identified as the clinical practice of ST evolves.

3.1.1. Child Modes

Child modes describe an individual's experience of the world through implicit memory systems developed in early childhood (Edwards, 2016) and "involve feeling, thinking and acting in a 'child-like' manner" (Bernstein & van den Broek, 2009 p.1). The child modes mirror the concept of the "inner child" in transactional analysis (Arntz & Jacob, 2013) as feelings and behaviours are linked to childhood experiences. Also, Bradshaw's (1992) concept of the wounded inner child influenced the concept of the child modes. Bradshaw believed that when development is arrested and feelings are suppressed, a person grows up with a wounded inner child, that contaminates their behaviour. The individual needs to offer this child part the good parenting that was missing from their childhood to heal the wounded child.

Maladaptive child modes develop when core needs are not met in childhood (Farrell, et al., 2014). As mentioned earlier, these child modes contain the EMS related to the unmet needs and the corresponding emotions (Arntz & Jacob, 2013). When a child mode is triggered, the emotions and innate reactions of a child are evoked (Farrell et al., 2014). The themes the child modes centre on are vulnerability in the Vulnerable Child modes, anger in the Angry Child modes, or lack of discipline in the Impulsive/Undisciplined Child modes

(Lobbestael et al., 2007). The naming of child modes often reflects the emotional quality, for example, Angry Child (Edwards, 2017a). The healthy child mode is the Happy Child, whose core emotional needs are currently met (Young et al., 2003).

3.1.1a. Vulnerable Child Modes

Vulnerable Child modes can result from unmet childhood needs for secure attachment (Farrell et al., 2014) and include subtypes such as the Lonely Child, Abandoned and Abused Child and Dependent Child (Lobbestael et al., 2007). In the Vulnerable Child mode, the person feels vulnerable and overwhelmed with painful feelings, including anxiety, sadness, shame, grief, helplessness and humiliation (Bernstein & van den Broek, 2009; Young et al., 2003). This child mode needs a parent figure to care for them (Lobbestael et al., 2007; Arntz & Jacob, 2013). Primary, unconditional EMS are part of the Vulnerable Child mode, which is why this is seen as the core mode in schema work (Young et al., 2003).

The Lonely Child subtype feels alone, may lack a sense of identity and perceive one's existence as having no meaning (Bernstein & van den Broek, 2009; Arntz & Jacob, 2013). This mode is evident when the client talks about feeling invisible, unimportant, misunderstood or isolated (Bernstein & van den Broek, 2009) and experiences sadness, emptiness and disconnection from people (Bernstein & van den Broek, 2009; Lobbestael et al., 2007). The Abandonment/Instability, Emotional Deprivation, Social Isolation/Alienation schemas are related to this mode.

Different terminology can describe similar experiences, dependent on the emotions associated with the child mode. For example, Simpson described a Shamed/Deprived Child (2012) and a Shamed/Lonely Child (Simpson, 2020b) as one who feels rejected, hurt, unwanted, inferior and ashamed of normal emotions and needs due to messages from parents, either explicit or implicit, that such needs are unacceptable or unmanageable. Feelings of inferiority can also arise because of abuse or bullying. This child mode would include the EMS described for the Lonely Child, as well as the Defectiveness/Shame schema. These child modes are examples of blended modes where features of more than one mode can be activated simultaneously.

The Dependent Child mode, in which one feels incapable and overwhelmed by adult responsibilities, often results from an authoritarian upbringing (Lobbestael et al., 2007; Arntz & Jacob, 2013). In this mode, the person doubts their ability to make the right decisions and

so relies on the advice and guidance of others. The Dependent Child is associated with the Dependence/Incompetence schema.

The Abandoned and Abused Child can form a blended mode (Lobbestael et al., 2007) or be separated into two child modes. The Abused Child develops when an individual has experienced abuse. This child mode feels emotional pain, including sadness, vulnerability, defencelessness and hopelessness, and fears abuse (Arntz & Jacob, 2013). The Mistrust/Abuse schema occurs in this mode.

An Abandoned Child is often the result of specific abandonment experiences, for example, by a parent leaving because of being hospitalised for an illness, or abandonment through divorce or death. The abandonment leads to the development of an Abandonment/Instability schema. An Abandoned Child may also feel that they are defective and therefore responsible for the abandonment, suggesting the Defectiveness/Shame schema could also form part of this mode.

3.1.1b. Angry Child Modes

The Angry Child Modes include the Angry Child, the Enraged Child and the Defiant Child. These modes involve the person feeling and expressing uncontrolled anger or rage (Lobbestael et al., 2007) in response to perceived or real mistreatment, abandonment, humiliation or frustration. The person often feels a sense of being treated unjustly and may vent anger inappropriately; for example, acting like a child throwing a temper tantrum (Bernstein & van den Broek, 2009; Lobbestael et al., 2007; Arntz & Jacob, 2013). This child's anger and frustration occur because the core emotional and physical needs of the Vulnerable Child are not being met (Lobbestael et al., 2007; Arntz & Jacob, 2013), including validation of needs and emotions and freedom to express oneself within realistic limits (Farrell et al., 2014). The anger expressed by the Angry Child can be intense, but it is not expressed to intimidate others.

The Defiant Child expresses anger through more passive-aggressive means or rebellion. In EDs, this may include using bingeing or restricting behaviour that occurs in an entitled manner to communicate the message that the individual is not controlled by others and can do as they please (Simpson, 2020b).

The Enraged Child experiences feelings of rage and uncontrolled aggression. Whereas the Angry Child may lash out and express anger inappropriately, it lacks the intent of the

Enraged Child, which is to be destructive, whether to people or property (Lobbestael et al., 2007; Arntz & Jacob, 2013).

3.1.1c. Lack of Discipline Child Modes

The Impulsive Child acts on desires or impulses to get their way in a selfish and uncontrolled way. In the Impulsive Child mode, one cannot delay gratification (Arntz & Jacob, 2013) and has little tolerance for others who take their time or do not respond rapidly. Hence, an individual may quickly switch from Impulsive Child to Angry Child if the needs for action are not immediately met (Bernstein & van den Broek, 2009).

The Undisciplined Child gets frustrated quickly, gives up, and cannot follow through on routine, mundane tasks (Lobbestael et al., 2007; Arntz & Jacob, 2013). This mode lacks patience in engaging in long-term planning, evidenced by starting projects but losing interest and not completing them or frequently changing plans. The Undisciplined Child often results from avoidant coping where there is a lack of motivation related to Failure and Defectiveness/Shame schemas as the individual sees themselves as defective and believes they will fail.

The Impulsive Child and Undisciplined Child were initially considered separate modes (Young et al., 2013) and are still viewed as separate by many schema therapists (Lobbestael et al., 2007; Arntz & Jacob, 2013; Simpson, 2020b). However, these two modes are also combined in the literature. The Impulsive Undisciplined Child lacks patience, wants instant gratification and acts without thinking through the consequences (Bernstein & van den Broek, 2009) and without regard for limits or others' needs (Farrell et al., 2014). This behaviour can be due to a lack of frustration tolerance, a sense of entitlement, or not having developed the capacity to delay gratification (Bernstein & van den Broek, 2009) because the needs for realistic limits and self-control, and validation of needs and feelings, were not met (Farrell et al., 2014).

3.1.2. Maladaptive Coping Modes

The coping modes in ST are maladaptive forms of coping that function outside of conscious awareness (Farrell et al., 2014) to block the activation of EMS and their associated affect. According to Young et al. (2003, p.275), the "Maladaptive Coping Modes represent the child's attempts to adapt to living with unmet emotional needs in a harmful environment" in a way that was adaptive when they were younger.

Three coping styles are identified, namely overcompensation, avoidance and surrender, which Young et al. (2003) described as three broad maladaptive coping modes, namely Compliant Surrenderer, Detached Protector and Overcompensator. A particular behaviour may have its origin in different modes depending on the purpose of the behaviour for the individual (Arntz & Jacob, 2013). For example, self-injurious behaviour can be a form of self-punishment (an overcompensation mode that builds a tolerance to pain) or the ritual of self-injurious behaviour can be soothing (an avoidant mode to block off emotion). Although describing the same behaviour, the motivation behind the behaviour differs so that it forms part of different modes. When addressing the symptom in therapy, it is necessary to identify the mode the behaviour is associated with in that particular situation, as this will impact how the behaviour is addressed. This is achieved through a phenomenological analysis. For example, when behaviour is part of a coping mode, it serves a purpose and so it needs to be understood and then replaced by more healthy functioning. In contrast, when behaviour is part of a parent mode, it is an echo from the past that does not serve a purpose. Then the work in therapy is towards eliminating this mode.

3.1.2a. Avoidant Coping Modes

Avoidant coping modes involve physical, psychological and social withdrawal to shut off emotions (Farrell et al., 2014) when a schema is activated. The Detached Protector refers to emotional detachment, or emotional numbing, to protect from painful feelings (Young et al., 2003; Simpson, 2020a), which results in the individual appearing emotionally distant, flat or robotic and avoiding getting close to other people (Lobbestael et al., 2007; Bernstein & van den Broek, 2009; Arntz & Jacob, 2013). The individual shuts off emotion so that they may respond to a feeling question with thoughts or actions as they cannot connect with the emotion.

Although in a Detached Protector mode, an individual blocks off their emotions, this is not as extreme as the Spaced Out Protector mode described by Edwards (2020b). In the Spaced Out Protector mode, one shuts off emotions by going numb or dissociating, to the extent that states of depersonalisation may arise.

The Avoidant Protector is different from the Detached Protector as this mode entails behavioural avoidance. Hence the Avoidant Protector avoids people, activities or places which trigger the parent modes and child modes (Edwards, 2020b).

The Detached Self-Soother is an avoidant coping mode which "uses repetitive, 'addictive', or compulsive behaviours, or self-stimulating behaviours to calm and soothe oneself" (Bernstein & van den Broek, 2009, p.4) or to create a "pleasant physical state" (Bernstein & van den Broek, 2009, p.4) to distract from or to shut off emotions (Lobbestael et al., 2007; Arntz & Jacob, 2013).

The Over-Analyser mode is an avoidant coping mode characterised by repetitive negative thinking in the form of worry and rumination (Stavropoulos et al., 2020). Rumination and worry are both self-focused forms of thought that are associated with, and exacerbate, depression and anxiety (Nolen-Hoeksama et al., 2008). Worry is future-orientated and focused on themes of anticipated threat to help one prepare for such threat (Borkovec et al., 1999). Even when worry is related to a past event, the concern is generally about the implications this event has for the future. For example, if someone embarrassed themselves in a social situation, the worry may be, "Will everyone now think I am socially awkward?" (Nolen-Hoeksama et al., 2008). Borkovec and Roemer (1995) believe that worry helps individuals with generalised anxiety disorder to avoid thinking about more distressing topics.

Rumination is past orientated in response to an intrusive thought about a past behaviour or unachieved goal or standard (Treynor et al., 2003). The theme of rumination is generally loss, whether through fate, one's failure, or the failure of others to live up to one's expectations (Nolen-Hoeksama et al., 2008). Rumination involves self-reflection and repetitive and passive focus on one's emotions (Treynor et al. 2003), which results in one thinking more negatively about the past, present or future.

Worry and rumination are forms of experiential avoidance because focusing on the verbal content of distressing material enables one to avoid painful images. Avoiding painful images reduces the physiological arousal related to the distressing images, limiting their emotional impact and leaving one with a sense of control (Nolen-Hoeksema et al., 2008; Brockman & Stavropoulos, 2020).

Rumination can be a separate mode and not part of an Over-Analyser mode. Nolen-Hoeksema et al. (2008) focus on depressive rumination where, "Rumination is a mode of responding to distress that involves repetitively and passively focussing on symptoms of distress and on the possible causes and consequences of these symptoms" (p. 400). People who ruminate are trying to make sense of distressing memories, but they remain fixated on their problems and their feelings about their issues without taking action. So, when an

individual ruminates, they build evidence that a situation is hopeless and that they should give up. This creates a rationale that allows them to avoid action or responsibility and withdraw, reducing distress (Nolen-Hoeksema et al., 2008). Paradoxically, rumination exacerbates and prolongs distress by using the thoughts and memories activated by the distressing emotions to understand their current circumstances. Also, it interferes with effective problem solving as one becomes more pessimistic or anxious. Thus rumination and worry are forms of avoidant coping to shut down distressing emotions, but instead, they contribute to high levels of emotional distress such as anxiety or despair.

The Angry Protector mode creates distance from others by using a "wall of anger" to protect oneself from those who are perceived as threatening (Lobbestael et al., 2007; Arntz & Jacob, 2013). This "wall of anger" is achieved through controlled expressions of hostility such as being sullen, sulking or withdrawn. The Angry Protector is more controlled than the Angry Child, but non-verbal behaviour suggests that one should stay away. This individual feels mistreated and may vocalise their anger for the one that is mistreating them (Bernstein & van den Broek, 2009).

3.1.2b. Surrender Coping Modes

Surrender coping modes represent giving in to the activated EMS (Farrell et al., 2014) by acting as if the schema were true and surrendering to that schema's messages (Arntz & Jacob, 2013). In the Compliant Surrenderer coping mode, one "gives in to the real or perceived demands or expectations of other people in an anxious attempt to avoid pain or to get one's needs met" (Bernstein & van den Broek, 2009 p.5). This mode is driven by anxiety that others will hurt or dislike the person or leave if they do not comply with their demands or needs. To avoid rejection or abandonment, the individual in this mode completely subjugates themselves to the other, prioritising the other's needs over their own. Hence, in a Compliant Surrenderer mode, an individual behaves in a passive, subservient, self-sacrificing way to avoid conflict or rejection (Lobbestael et al., 2007; Arntz & Jacob, 2013).

Although there is a self-sacrificing element to a Compliant Surrenderer mode, a separate self-sacrificing mode is identified, the Rescuer. In the Rescuer mode, one sacrifices one's needs for the other. In the short term, sacrificing one's needs is experienced as fulfilling and rewarding, but in the long term, it can result in burnout (Edwards, 2020b).

Reassurance seeking is also a feature of a Compliant Surrenderer mode that can be a standalone mode related to anxiety disorders (Salkovskis & Warwick, 1986). Flanagan

(2014) describes a Worrywart mode where chronic obsessing and indecision results in reassurance seeking and dependency.

Edwards (2017b) identified a Self-Pity/Victim Mode which accepts the EMS associated with the Vulnerable Child. Unlike the Vulnerable Child mode, the Self-Pity/Victim evokes a sense of frustration and helplessness in the therapist rather than care as any attempts to offer advice or help are ignored or dismissed (Bernstein & van den Broek, 2009). This mode is often expressed as "poor me", highlighting this mode's victim belief (Edwards, 2020b). Simpson (2020a) refers to a similar mode as Helpless Surrenderer. The individual presents themselves as passive and helpless to change their circumstances and expects others to know what they need intuitively and then to help. Unlike the Self-Pity/Victim, the Helpless Surrenderer does not express a "poor me" attitude (Edwards, 2020b). In Helpless Surrenderer mode, one is dependent on others to meet their emotional needs without expressing genuine vulnerability, which leads to a sense of resignation that their needs will not be met. The Helpless Surrenderer, like the Self-Pity/Victim, can evoke a sense of frustration and helplessness in the therapist. This mode has links to Dependence/Incompetence, Emotional Deprivation and Subjugation schemas (Simpson et al., 2018).

3.1.2c. Overcompensating Modes

The overcompensating coping modes are evident when the individual acts as if the opposite of the schema were true (Luck et al., 2005; Waller et al., 2007). For example, a child who feels neglected because of an Emotional Deprivation schema may capture others attention by being flirty (Rafaeli et al., 2011). The overcontroller modes are overcompensating modes that provide predictability and security by maintaining tight control over behaviours to reduce the risk of criticism or shame (Simpson, 2020b). In these modes, individuals have a rigid black and white perception of events and obtain self-sufficiency by overriding all physical and emotional needs (Simpson, 2020b). More overcompensating modes are referenced in the literature than surrender or avoidant modes. Only the overcompensating modes relevant to this research are mentioned here.

The Perfectionist Overcontroller is characterised by overcompensatory behaviour where one tries to be perfect to ward off an underlying experience of defectiveness or to attain control and prevent criticism (Lobbestael et al., 2007; Arntz & Jacob, 2013). This mode continually sets more challenging and higher targets and focuses on rules, instructions

and doing things the "right" way. Thus, control is maintained by focusing on orderliness and minimisation of needs, excessive adherence to routine, setting goals, and a here and now focus (Simpson, 2020a). This mode is common in individuals with EDs who tend to be anxious, perfectionistic and achievement-oriented (Kaye et al., 2015). The Perfectionist Overcontroller is described in more detail in section 5.3.

The Perfectionist Overcontroller can develop into a more specific overcontroller that focuses on eating, weight and shape. This mode, described by Edwards (2017b) as an Anorexic Overcontroller, overcompensates for a sense of powerlessness, shame and guilt by controlling the body's basic needs and creating a sense of mastery. Described as the restrictive schema mode (Mountford & Waller, 2006), the "doing AN mode of mind" (Park et al., 2011), and the Eating Disordered Overcontroller (Simpson et al., 2018), this mode is active when comments regarding shape or weight trigger a child mode. The behaviours in the Anorexic Overcontroller consist of restrictive and ritualistic eating, body checking and exercise to control and improve body weight and shape. The Eating Disordered Overcontroller has been described in detail in section 5.4.

A person in a Self-Aggrandiser coping mode is filled with a sense of importance and is disdainful towards others to compensate for feelings of defectiveness or inferiority (Simpson, 2020a). They present themselves in a positive light, focussing on their success and attributes, frequently bragging to inflate their sense of self (Lobbestael et al., 2007) and believing that they are deserving of special treatment or attention (Bernstein & van den Broek, 2009). Hence this mode shows little empathy for the needs or feelings of others (Lobbestael et al., 2007; Arntz & Jacob, 2013).

The Attention and Approval Seeker (Lobbestael et al., 2007), also referred to as an Attention-Seeker Mode (Arntz and Jacob, 2013), "tries to get other people's attention and approval by extravagant, inappropriate and exaggerated behaviour" (Lobbestael et al., 2007, p.85). This mode may overcompensate for underlying loneliness.

Simpson's (2020a) Pollyanna Overcompensator mode is an overcompensating mode where an individual maintains a persistently positive attitude whilst minimising feelings such as anger, sadness or shame that could lead to rejection or criticism. This excessive positive outlook invalidates the emotions and difficulties of the individual and others. Individuals with this mode have learnt early in life that they are responsible for lifting those close to them who

are depressed, emotionally fragile, or pessimistic; for example, parents who have a Self-Pity/Victim mode.

The Complaining Protector is an externalising version of the Self-Pity/Victim mode as the individual's complaining draws attention to their suffering, and they come across as needy. Still, other people are left feeling that they are incompetent to help (Bernstein & van den Broek, 2009) as the individual seeks help but also rejects it. Emotional pain is not shown openly as in the Vulnerable Child but indirectly through irritation, frustration and helplessness (Bernstein & van den Broek, 2009). Like the Self-Pity/Victim and Helpless Surrenderer, the Complaining Protector has a passive-aggressive communication style, and the individual does not take responsibility for getting their needs met (Simpson, 2020b).

The Paranoid Overcontroller is a mode in which individuals believe others have ill intentions. So in this mode, one vigilantly focuses on perceived or real threats, ruminates about them and exercises control to protect oneself. As a result, the person misreads situations and arrives at incorrect conclusions that others are out to hurt or humiliate them (Bernstein & van den Broek, 2009).

In a Flagellating Overcontroller mode, one inflicts harm on, deprives, or criticises oneself to achieve self-improvement and obtain an internalised standard set by the Demanding Parent. The self-harming behaviour builds a tolerance to pain so that when others inflict hurt through rejection or criticism, it hurts less. Hence, the mode provides an illusion of control and minimises vulnerability. Minimising vulnerability distinguishes this mode from the Punitive Parent, which is experienced as critical and triggers feelings of vulnerability, including shame and worthlessness in a child mode. The Flagellating Overcontroller mode can develop when a child feels that expressing anger may lead to rejection or punishment. As a result, the individual turns the anger inward to preserve attachment and protect the fragile family system (Simpson, 2020a).

There are references in the ST literature to several overcontroller modes that have an antisocial aspect. In the Bully and Attack mode, individuals aim to make others feel unsafe or powerless (Bernstein & van den Broek, 2009) and to prevent abuse or humiliation (Lobbestael et al., 2007) by using threats or intimidation to get what one wants (Bernstein & van den Broek, 2009; Arntz & Jacob, 2013). Others are harmed physically, emotionally, sexually or verbally in a controlled and strategic way (Lobbestael et al., 2007) in the attainment of one's goal.

3.1.3. Dysfunctional Parent Modes

Dysfunctional parent modes are introjects taken from the negative words or behaviours frequently displayed towards the individual by parents or other authority figures (Edwards, 2017a). The parent modes are characterised by demands directed at oneself, self-hate and self-reproach (Arntz & Jacob, 2013). When a person is in a dysfunctional parent mode, they treat themselves as their parent or authority figure did when they were children (Young et al., 2003).

A Punitive, Critical Parent mode is an internalised critical or punishing parent voice that "functions as a punitive screen or filter through which one views oneself" (Simpson, 2012, p.150) and induces feelings of shame and guilt (Bernstein & van den Broek, 2009) for expressing needs or making mistakes. There is an exaggerated sense of responsibility when things go wrong. This voice is evident in how one views oneself negatively and critically with symptoms of self-loathing, self-denial, self-injury and other self-destructive behaviours (Arntz & Jacob, 2013). The messages of the Critical, Punitive Parent mode are introjects derived from implicit or explicit messages from parents or other significant adults in the past that evoke distress. This mode differs from a Flagellating Overcontroller mode, where the critical and self-punitive messages function to motivate the individual or provide a sense of relief from pain. For example, in a Flagellating Overcontroller mode, the individual hurts themselves to be immune to the hurt from others. Simpson (personal communication, September 20, 2020) describes the Flagellating Overcontroller as the parent one created for oneself to control them.

Although a Critical, Punitive Parent induces feelings of guilt, a separate Guilt-Inducing Parent mode is recognised. This mode tends to develop when a parent has a mental illness or a Self-Pity/Victim mode, and the child receives implicit or explicit guilt-inducing messages for expressing their emotions or needs. For example, "If you cared about me, you would…" (S. Simpson, personal communication, September 20, 2020). As a result, the child assumes responsibility for the parent's wellbeing and happiness (Jacob et al., 2015) and develops standards and ideals regarding how they should behave or feel in interpersonal relationships and situations. When the individual does not live up to the ideals they have set and believes they are disappointing others, feelings of guilt result. The standards one set in a Guilt-Inducing Parent are regarding how one should behave with others.

Lobbestael et al. (2007) differentiate a Punitive Parent from a Demanding/Critical Parent where the Demanding/Critical Parent pressures the child to meet excessively high standards for achievement and self-control and sees the expression of feelings or spontaneous action as wrong. The Demanding Parent, described by several authors (Young et al., 2013; Bernstein & van den Broek, 2009; Arntz & Jacob, 2013; Farrell et al., 2014), directs these impossibly high standards towards oneself. This parent mode tends to occur in individuals whose parents typically set high standards for themselves; that is, the parent has an Unrelenting Standards/Hypercriticalness schema. It may develop from a child's "perception that their needs were seen as unacceptable or unmanageable to the parent" (Simpson, 2012, p.150). As a result, the child develops an introject that they must behave the "right" way and then criticises themselves for having normal needs. In this mode, increasing demands related to different aspects of achievement or behaviour are set so that one never feels satisfied that one has done enough (Bernstein & van den Broek, 2009; Arntz & Jacob, 2013).

The Demanding Parent differs from the Perfectionist Overcontroller in that the Demanding Parent contains implicit and explicit messages from multiple sources in childhood which activate negative feelings in a child mode. In contrast, the Perfectionist Overcontroller overcompensates for schemas and feelings in the child mode triggered by the Demanding Parent. The Perfectionist Overcontroller serves a function by creating behavioural rules that, if followed, create a sense of pseudo-control and aim to get needs met. The Perfectionist Overcontroller is conditional and gives hope that things will be better if the rules are followed; for example, if you maintain a neat and orderly home, you will be a better person (S. Simpson, personal communication, September 20, 2020).

3.1.4. Mode Dyads

The concept of the parent-child mode dyad in ST recognises that a child mode occurs with a memory involving the parent (the parent mode). In this way, the self is defined according to an internal working model of the child with the experience of the parent. The type of child mode that is triggered will depend on that individual's internal working model, determined by what needs were not met and, therefore, the qualities of the internalised parent. Hence an activated parent mode results in an activated child mode and vice versa.

Peled (2016) introduced eight dysfunctional parent modes, representing more aspects of the parent modes than the three modes described in section 3.1.3. This is beneficial for identifying mode dyads where the characteristics of the parent modes point to the child

modes that the parent modes are in a dyadic relationship with and vice versa. Peled's modes will be described in section 5.2 because they are directly relevant to parent modes found in the analysis of the results of this study.

Rafaeli et al. (2011) describe how the Punitive/Critical Parent mode and the Vulnerable Child mode exist in an abuser-victim relationship where the parent mode's critical, punitive voices activate feelings of worthlessness and depression in the child mode. In terms of attachment theory, over-anxious parents may restrict a child's ability to explore, leading to the child feeling smothered and a dyad developing between an Anxious Parent mode (Peled, 2016) and an Anxious or Fearful Child mode. Alternatively, neglectful parents may limit a child's ability to explore by not providing a safe base, which leads to feelings of anxiety or abandonment and a dyad between a Neglecting Parent mode (Peled, 2016) and a Neglected Child mode. Bowlby's theory maintains that the attachment system is fully formed by the third year of life and persists throughout life (Holmes, 2014). Hence parent-child mode dyads may be triggered in later life when an experience triggers the internal working model of a child's earlier experience with a parent.

3.1.5. Healthy Modes

There are two healthy modes in ST, a Healthy Adult mode and a Playful or Happy Child mode. Both represent the absence of EMS activation and adaptive functioning.

3.1.5a. Healthy Adult Mode

In the Healthy Adult mode, one can reflect on themselves and their situation in a realistic manner (Bernstein & van den Broek, 2009), integrating thoughts and feelings and viewing situations from different perspectives. A Healthy Adult mode considers their strengths and weaknesses realistically and is therefore in touch with their vulnerable side and acknowledges feelings of inadequacy and related fears (Bernstein & van den Broek, 2009). It includes "functional thoughts and behaviours, and the skills needed to function in adult life" (Farrell et al., 2014, p.8). Bernstein's (2020) model of the Healthy Adult mode identifies 16 strengths that are positive attributes that enable an individual to adapt to challenges. These strengths, or characteristics of a Healthy Adult, are grouped into four dimensions. The first dimension, self-directedness, is the ability to focus on the course of one's life. To achieve this, one requires the ability to be authentic, introspective and self-aware. A healthy focus on oneself also includes self-confidence, which involves being self-reliant and self-assured. Also needed for a healthy focus is the ability to be assertive, creative and resourceful. The second

dimension identified for Healthy Adult functioning is the ability to regulate one's emotions, impulses, thoughts and behaviour. The characteristics required for this dimension include being emotionally balanced, resilient, having self-control, practising self-care, which includes being fit and healthy, and being rational, objective and realistic. A Healthy Adult can also connect with others and form meaningful relationships, Bernstein's third dimension of Healthy Adult functioning. To connect with others and develop meaningful relationships, one must have empathy, compassion, humour and responsibility. The fourth dimension of Healthy Adult functioning is transcendence. Transcendence is the ability to pursue higher meanings in life and relationships. This requires wisdom and thankfulness. Wisdom is characterised by the seeking of truth, knowledge, learning from experience and showing good judgement. Thankfulness includes gratitude and appreciation. All individuals have Healthy Adult strengths that are greater in some areas than in others. This is influenced by our genes, environment, role models and experiences (Bernstein, 2020).

The Healthy Adult meets the child's emotional needs by serving three primary functions; to nurture, affirm and protect the Vulnerable Child, to set limits for the Angry Child and Impulsive/Undisciplined Child in accord with principles of reciprocity and self-discipline, and to moderate maladaptive coping and dysfunctional parent modes (Young et al., 2003). These goals are achieved using and building on the Healthy Adult strengths one already possesses (Bernstein, 2020).

3.1.5b. The Healthy Child Mode

There are different terms used for the healthy child mode, including the Happy or Contented Child, the Playful Child (Young et al., 2003; Lobbestael et al., 2007; Rafaeli et al., 2011; Arntz & Jacob, 2013) and Authentic Child (Edwards, 2016). The healthy child mode develops when needs are adequately met in childhood so that the person feels loved, nurtured, contented, validated, self-confident, competent, connected, and optimistic (Lobbestael et al., 2007). In this mode, one acts in a playful, fun-loving way, can be spontaneous, and enjoys sharing one's interests and activities with others. In a healthy child mode, the individual is in tune with others' needs and feelings and will not push the boundaries (Bernstein & van den Broek, 2009).

The different names that exist for this mode capture the various qualities of this mode as they appear in a particular individual at a specific time. As mentioned in section 3.1.1, child modes are often named for the emotional quality associated with the mode. When a

child's needs are adequately met, that child feels happy or contented, hence the Happy or Contented Child mode. The Playful Child mode picks up on the playful nature of this mode. When a child is happy and playful and secure in their environment, this playfulness leads to curiosity and an open engagement with life. The spontaneity and self-confidence associated with open engagement suggest authenticity. This is reflected in the naming of the mode, Authentic Child.

3.2. The Goals of ST

ST aims to help clients identify their EMS and associated childhood memories, cognitions, sensations, and coping styles. Then, through cognitive, affective and behavioural interventions, dysfunctional parent modes are eliminated. Through the processes of limited reparenting, the Vulnerable Child and other child modes that carry emotional distress are healed (Edwards, 2016). The individual is supported to replace maladaptive coping with adaptive behaviours and strengthen healthy, adaptive modes, including the Healthy Adult and the Happy/Authentic Child modes. In this way, individuals learn to balance their own needs against the needs of others.

Limited reparenting refers to how the individual is helped to deal with difficult emotions by the therapist where the therapist cares for the child parts of the client and, by modelling the therapist's care, the client learns to better care for their own needs. Through this process, the unmet needs in childhood are attended to, which allows for schema healing. When schema healing occurs, EMS are activated less frequently, and the associated affect is less intense and prolonged. Cognitive techniques are applied to challenge the beliefs associated with the schemas. Experiential techniques provide corrective experiences for the schemas on an emotional level, and behavioural techniques replace maladaptive coping modes with adaptive patterns. The therapist-client relationship provides the context in which this work occurs by providing the client with a healthy relationship in which they feel genuinely cared for and can learn to trust (Young et al., 2003).

3.3. Research on the Efficacy of ST

ST has proven efficacy for various chronic, difficult to treat disorders through randomised controlled trials, pilot studies and case series. Several studies are described here that illustrate the effectiveness of ST.

As ST was traditionally used to treat personality disorders (Young et al., 2003), there are numerous studies on using ST with these disorders. Giesen-Bloo et al. (2006) conducted a

study in which 88 individuals with borderline personality disorder were randomly assigned to either schema-focused therapy or psychodynamically based transference-focused psychotherapy. The participants attended twice-weekly individual therapy sessions for 3 years. The fourth version of the Borderline Personality Disorder Severity Index (BPDSI) was administered to measure outcomes. The BPDSI results showed that both treatment approaches brought about a reduction in symptoms of borderline personality disorder, but that schema-focused therapy brought about a more significant reduction in symptom manifestations. In addition, the schema-focused therapy group had a lower attrition rate, 26.7% in the schema-focused group versus 52.4% in the transference-focused group.

Farrell et al. (2009) conducted a randomised controlled trial with 32 women diagnosed with borderline personality disorder. The study, which took place over 8 months, randomly assigned the women to one of two groups. The first group received weekly individual psychotherapy sessions that were eclectic in orientation but considered treatment as usual for borderline personality disorder. The second group received eclectically oriented individual psychotherapy sessions and an additional 30 weekly schema-focused group therapy sessions. No participants dropped out of the schema-focused therapy group, whereas there was a 25% dropout rate in the group that received individual psychotherapy only. At the end of treatment, participants in the group that received schema-focused group therapy in addition to individual psychotherapy had lower scores on the Borderline Syndrome Index, a self-report measure of borderline personality disorder symptoms, as well as lower scores on the Diagnostic Interview for Borderline Personality Disorders-Revised; a structured interview that measures aspects of borderline personality disorder pathology. Also, participants who received the schema-focused group therapy had higher scores on the global assessment of functioning scale, indicating improvement in their psychological, occupational and social functioning. These positive changes were maintained or improved upon at 6-month follow-up. In contrast, the group that received eclectically oriented individual psychotherapy only, showed little improvement. After treatment, 94% of the individuals who received schema-focused group treatment no longer met the criteria for borderline personality disorder, compared to 8% in the group that received individual psychotherapy only. These results indicate that the application of group ST was highly effective for the treatment of borderline personality disorder.

The studies conducted by Giesen-Bloo et al. (2006) and Farrell et al. (2009) either offered individual ST or group ST to treat borderline personality disorder. Later, Dickhaut

and Arntz (2014) conducted a pilot study that examined the effectiveness of combined individual and group ST. Eighteen women with a primary diagnosis of borderline personality disorder were included in the study, incorporating a weekly 90-minute group therapy session and a weekly one-hour individual therapy session. The group sessions were limited to 2 years, but the individual sessions continued past 2 years if deemed necessary by the treating therapist. Results were measured using the BPDSI and compared to the results for Giesen-Bloo et al.'s (2006) study. Dickhaut and Arntz's (2014) participants showed a higher percentage of recovery on the BPDSI, indicating that combined individual and group ST provides quicker results than individual ST alone.

The results of these studies show that ST has lower drop-out rates than other treatment approaches and that ST is an effective form of treatment for borderline personality disorder in both individual and group settings. Furthermore, combining individual ST with group ST can bring about results more quickly than individual ST alone as group ST facilitates the activation of ST techniques which amplifies the schema healing process (Farrell et al., 2009).

A randomised controlled trial conducted by Bamelis et al. (2014) illustrated the effectiveness of ST for six personality disorders, including dependent, avoidant, obsessive-compulsive, histrionic, narcissistic and paranoid. The treatment protocol consisted of 50 ST sessions compared to clarification-oriented psychotherapy and treatment as usual psychotherapy. Clarification-oriented psychotherapy is a client-centred therapy developed for personality disorders. The treatment as usual group received psychotherapy according to the Netherlands clinical guidelines for the treatment of personality disorders. The guidelines included insight-oriented psychotherapy, supportive therapy, CBT and eye movement desensitisation and reprocessing. Three hundred and twenty-three participants were recruited who met the criteria for at least one of the personality disorders mentioned. These participants were then randomly assigned to the three treatment groups. The treatment as usual group had the highest dropout rate. The ST group had a 25.8% dropout rate, and the clarification-oriented psychotherapy group had a 22% dropout rate. The Structured Clinical Interview for DSM-IV Personality Disorders was conducted at the beginning and end of the study. Results indicated that the ST group showed greater recovery from personality disorder symptoms than the treatment as usual group, which in turn showed better results than the clarification-oriented psychotherapy group. Also, the improvement in symptoms occurred in a shorter timeframe in the ST group than in the treatment as usual group. The results of the

study by Bamelis et al. (2014) support results in previous studies that ST has lower dropout rates than other treatment approaches (Farrell et al., 2009) and that ST is more effective than other treatment approaches in the treatment of personality disorders (Giesen-Bloo et al., 2006; Farrell et al., 2009).

Research has also been conducted on the use of ST for chronic axis I disorders. Carter et al. (2013) conducted a randomised controlled trial comparing ST with CBT to treat depression. One hundred participants who met the criteria for a DSM-IV diagnosis of major depressive disorder were recruited for the study. Participants were randomly assigned to weekly ST or CBT sessions for 6 months, followed by monthly sessions for 6 months. Improvement in symptoms was assessed by percentage improvement on the clinician-rated Mongomery Asberg Depression Rating Scale (MADRS) and the self-report Beck Depression Inventory-II (BDI-II). At the end of treatment, results on the MADRS and BDI-II showed similar remission and recovery rates for both treatment modalities. These results indicate that ST is as effective as CBT for the treatment of a major depressive disorder.

Malogiannis et al. (2014) conducted a case series study on the effectiveness of ST for 12 clients diagnosed with chronic depression. Participants met DSM-IV criteria for chronic depression using the Structured Clinical Interview for DSM-IV Axis I, and had a score of 15 or higher on the Hamilton Rating Scale for Depression. Treatment consisted of 55 weekly individual therapy sessions followed by 5 biweekly individual therapy sessions. One participant dropped out of treatment at session 50. At post-treatment assessment, five out of the 12 participants were in full remission. At 6-month follow up, one of those in remission had relapsed while one participant who at post-treatment had a satisfactory response was in remission. The mean score on the Hamilton Depression Rating Scale dropped from 21.07 at baseline to 9.4 post-treatment and 10.75 at the 6-month follow-up. This study indicates that ST is effective for the treatment of chronic depression and that the outcomes are maintained once treatment ceases.

ST has also been studied as a treatment for obsessive-compulsive disorder (OCD). Thiel et al. (2016) developed a 12-week inpatient treatment that combined exposure and response prevention with ST. This treatment was administered in a pilot study to 10 inpatients, nine of whom completed the treatment. All participants had a diagnosis of OCD and had failed to respond to CBT with exposure and response prevention. The treatment consisted of two individual therapy sessions per week and one group session per week. A clinical assessment was conducted by independent psychologists using the Structured

Clinical Interview for DSM-IV, before and after treatment and at 6-month follow-up. The Structured Clinical Interview for DSM-IV identified axis I diagnoses. In addition to OCD, seven of the participants met the criteria for major depressive disorder. The Yale-Brown Obsessive Compulsive Scale (Y-BOCS), a clinician-administered interview for assessing OCD symptom severity, was administered pre and post-treatment and at 6-month follow-up. Also, the participants completed a battery of self-report instruments. Post-treatment, four participants had at least a 35% reduction in OCD symptoms. At the 6-month follow-up, their reduction in symptoms had been maintained, and a fifth participant had achieved at least a 35% reduction in symptoms. At the 6-month follow-up, two participants had not experienced a reduction in their OCD symptoms. Also, five participants experienced a significant reduction in their symptoms of depression post-treatment, which was maintained at the 6-month follow-up. The nine participants who completed the treatment noted that it was helpful to understand their OCD within the schema mode model, including why particular events triggered their symptoms. This understanding made it easier for individuals to comply with exposure activities. The results not only indicate that ST is effective in the treatment of OCD but also reinforces the efficacy of ST for the treatment of major depressive disorder, as discussed in previous studies (Carter et al., 2013; Malogiannis et al., 2014).

The research described here illustrates the effectiveness of ST for treatment with chronic resistant clinical presentations. As EDs are challenging to treat clinical presentations, ST is a suitable treatment approach for these disorders.

3.4. Research into Schemas and Modes in EDs

Exploratory studies indicate EDs are associated with higher levels of EMS and dysfunctional modes than controls (Simpson, 2020a; Talbot et al., 2015). However, no clear patterns of EMS linked to ED symptoms have been identified in research to date (Simpson, 2020a; Simpson et al., 2020). A high prevalence of childhood trauma in clients with EDs (Simpson, 2020a) has been noted, with emotional abuse and neglect stronger predictors of eating pathology than physical or sexual abuse (Kennedy et al., 2007; Kent & Waller, 2000; Kent et al., 1999). Bullying and teasing about one's appearance are also significant risk factors for the development of EDs (Keith et al., 2009; Sweetingham & Waller, 2007).

3.4.1. Conceptualising ED Cases Within the ST Framework

ST offers an understanding of EDs rooted in the concept of unmet universal core needs that lead to the development of child modes with underlying EMS. One develops maladaptive

coping modes, including ED behaviours, to shut down these child modes (Munro et al., 2016) and accompanying affect, either before or after the affect is triggered.

Our knowledge and use of ST as a treatment approach for EDs has significantly improved over the past two decades. In 2002 Ohanian used imagery rescripting as an adjunct to CBT with a woman who had BN. The imagery rescripting was conducted in one session to evoke emotion associated with a schema and to restructure the meaning attached to early adverse experiences. The imagery rescripting was observed to bring about more change after one session than the eight CBT sessions that occurred beforehand (Ohanian, 2002). Since Ohanian's work with imagery rescripting, further articles have reported on imagery rescripting in working with EDs (Mountford & Waller, 2006; Cooper et al., 2007).

Eating disordered behaviours are understood as arising from maladaptive coping styles to help one deal with painful and overwhelming feelings triggered in the child modes. Waller et al. (2007) presented a schema-focused cognitive behavioural therapy model of EDs, which contributed to our understanding of EDs from a ST perspective. According to Waller et al. (2007), restrictive and bulimic behaviours both regulate affect, but differences occur in the point at which the individual attempts to reduce the affect. Thus restrictive and bulimic disorders are distinguished by schema maintenance processes.

Waller et al. (2007) refer to primary avoidance of affect, which involves the individual attempting to avoid activation of emotion in the first instance, and secondary avoidance of affect where one tries to reduce the already activated affect. Primary and secondary avoidance of affect occur through different schema processes. In EDs, overcontroller modes prevent the intense affect associated with schemas from being activated. As schema activation is avoided, this is known as primary avoidance of affect. Thus eating behaviour which forms part of the overcompensatory overcontroller modes isolates the person from potential triggers of their EMS. For example, an individual with AN flips into a Perfectionist Overcontroller mode (the Eating Disordered Overcontroller mode did not yet exist) with strict rules and a focus on weight and shape to avoid activating the Defectiveness/Shame schema.

In BN and BED, disordered eating alleviates affect after schemas have been triggered, known as secondary avoidance of affect, by more impulsive behaviour, such as bingeing (Waller et al., 2007; Pugh, 2015). An example provided by Waller et al. (2007) of secondary avoidance describes a woman with BN who is stood up on a date. This experience triggers

her Abandonment/Instability and Mistrust/Abuse schemas and accompanying feelings of loneliness and anger in the child modes. The woman then flips into a Detached Self-Soother mode in which she binges, which reduces the arousal of these negative emotions.

As people with EDs seldom have purely restrictive or bulimic behaviours, they may use both primary and secondary avoidance of negative affect, dependent mainly on the nature of the trigger and the strength of the EMS triggered (Waller et al., 2007). This is in keeping with Fairburn's view of EDs as transdiagnostic, where the diagnosis provides a broad brushstroke identifying the ED symptoms.

Research has also focused on particular coping modes related to EDs. For example, Corstorphine (2008) described the function of the Detached Protector in her work with EDs. According to Corstorphine, the Detached Protector functioned as both primary and secondary avoidance of affect. In individuals with restrictive ED pathology, the Detached Protector mode is a form of primary avoidance of affect as the individual intellectualises to avoid experiencing the emotion. In bulimic ED pathology, the Detached Protector functions as a form of secondary avoidance of affect, by "smothering" the emotions through bingeing or purging behaviours. Corstorphine's description of the Detached Protector as a form of primary avoidance of affect fits our understanding of the Detached Protector mode. In contrast, the behaviour she described as functioning as secondary avoidance of affect is what we now call a Detached Self-Soother mode.

3.4.2. Quantitative Studies

In addition to these clinical observations, several studies have used quantitative analyses of inventories to examine the relationships between schemas, modes, and aspects of ED pathology. Spranger et al. (2000) conducted a study to measure levels of schema avoidance amongst women with bulimic ED pathology compared to a female non-clinical population. Nineteen clinical participants were compared to a sample of 74 non-clinical volunteers. The clinical sample was composed of 11 women with BN, six with AN binge/purge type and two with BED. All participants completed the Young-Rygh Avoidance Inventory (YRAI) and the Bulimic Investigatory Test, Edinburgh (BITE). The YRAI offers two scales that measure the presence and degree of secondary avoidance strategies. The first scale measures cognitive avoidance (not thinking about something) and emotional avoidance (feeling numb or blocking emotional responses). The second scale measures somatic avoidance (the experiencing of physical symptoms) and behavioural avoidance (engaging in escape

behaviours). The BITE measures bulimic attitudes and behaviours. As expected, significant differences were noted in the BITE scores between the bulimic group and non-clinical participants. Also, the bulimic women experienced higher levels on the YRAI scales than the non-clinical group, indicating that women with bulimic behaviours had higher levels of schema avoidance.

Luck et al. (2005) conducted a study to measure schema avoidance in 121 females with EDs compared to 345 females in a control group. The females with EDs comprised 43 with AN restricting type, 28 with AN binge/purge type and 50 with BN. All participants completed the Young Compensatory Inventory (YCI), which measures methods used for schema compensation. These are measures for primary avoidance of affect, which prevent the initial triggering of the affect. Also completed by all participants was the YRAI. The highest levels for both primary and secondary avoidance measures were noted for the AN binge/purge subgroup. AN was characterised by high levels on the behavioural/somatic scale of the YRAI, which can be explained by this subgroup's control over the body as a way of gaining control of their lives. The behavioural/somatic scale was also high in the BN subgroup, which is consistent with the results found in Spranger et al.'s (2000) study. Unlike Spranger et al.'s research, the cognitive/emotional subscale results on the YRAI did not differ amongst the subgroups, which suggests that these avoidance strategies do not play a role in ED pathology.

Although the studies conducted by Spranger et al. (2000) and Luck et al. (2005) do not identify specific coping modes, they highlight that AN is characterised by overcompensatory and avoidance coping strategies whilst BN and BED are characterised by avoidance coping strategies.

Masley (2012) conducted a study in Scotland with 31 participants who met the criteria for AN or BN. All participants were required to complete the Eating Disorder Examination Questionnaire (EDE-Q) and the Schema Mode Inventory (SMI). The results showed a relationship between schema modes and ED severity. The more severe the ED symptoms, the more severe the maladaptive modes and vice versa. In particular, a positive relationship was identified between elevated levels of the Vulnerable Child, Angry Child, Undisciplined Child, Compliant Surrenderer, Detached Self-Soother, Self-Aggrandiser, Demanding Parent and Punitive Parent on the SMI, and ED severity on the EDE-Q. The high levels of the three child modes suggest that individuals with EDs have significant unmet needs, which result in strong negative affect. Stepwise regression was conducted to determine the modes most

predictive of ED severity. This analysis revealed that the higher the scores on the SMI for Detached Self-Soother and Vulnerable Child, the more severe the ED symptoms. High levels of Vulnerable Child underlie psychopathology as it indicates that basic needs were not met, contributing to psychological dysfunction. High levels of Detached Self-Soother can be explained by the compensatory behaviours experienced as part of an ED; for example, bingeing and purging in BN and compulsive exercise in AN.

Talbot et al. (2015) conducted a similar study that compared schema modes in an eating disordered population to those of a community sample using the SMI and EDE-Q. Forty-seven women with EDs, including AN, BN, and other specified feeding or eating disorder (OSFED), which included BED, were compared to a community sample of 89 women. Women with EDs scored significantly higher than the community sample on 10 out of 12 maladaptive modes. The modes that were not significantly different between the ED sample and community sample were Self-Aggrandiser and Bully and Attack. This differs from Masley's findings, where Self-Aggrandiser was measured as prominent in EDs. This points to the fact that simplistic relationships between modes and complex psychopathologies do not exist. Angry Child and Impulsive Child were scored highly in the BN sample only, indicating that impulsiveness, anger and loss of control characterise this group. The Impulsive Child scores were not significant in Masley's study. Undisciplined Child was significantly high in the AN and BN sample but not in the OSFED group. The result in the AN subgroup is surprising because AN is characterised by extreme control. However, the statement, "I'm lazy", which is meant to measure the Undisciplined Child, might tap into an individual's Flagellating Overcontroller mode, which is not measured by the questionnaire. Also, the item, "I can't bring myself to do things that I find unpleasant, even if I know it's for my own good", could reflect the anorexic's conflict as the individual recognises that restriction is problematic. One would expect high levels of Undisciplined Child in the OSFED group, as this group includes other binge eating disorders, including BED. All ED groups scored significantly higher than the community sample on Vulnerable Child, Demanding Parent, Punitive Parent, Compliant Surrenderer and Detached Self-Soother. In the ED sample, Demanding Parent was highest in the AN group and lowest in the BN group. Eating disordered participants also scored significantly lower than the community sample on the adaptive modes of Happy Child and Healthy Adult. This research supported Masley's findings that individuals with EDs rely on maladaptive schema modes more frequently than adaptive modes. Masley identified Self-Aggrandiser as significant where Talbot et al. did not,

and Talbot et al. identified Impulsive Child as significant where Masley did not. The difference in these findings may occur because Masley did not differentiate the results for the subgroups AN and BN. If Masley's sample was mostly comprised of individuals with anorexic symptoms, then the elevated Self-Aggrandiser scores could be explained as anorexics experience a sense of pride regarding their control over their eating behaviour and subsequent body shape. Likewise, as anorexic clients exhibit such control over their eating behaviour, this would account for lower levels of the Impulsive Child.

Quantitative studies rely on self-report measures. It is important to bear in mind that individuals can under-report or over-report symptoms or misinterpret the statements they are scoring. This would explain the conflicting results reported by various studies. Therefore, although larger sample sizes are included in quantitative studies, more detailed analysis and a greater understanding of ED cases can be achieved from qualitative studies.

In conclusion, these quantitative studies show that individuals with EDs have high levels of EMS, indicating significant unmet needs; however, specific EMS have not been linked to ED symptoms. All categories of EDs have a significant Vulnerable Child mode and low levels of healthy adaptive modes, indicating that individuals with EDs rely more on maladaptive modes than on adaptive modes. Similar patterns of modes occur across EDs; for example, there appears to be high Demanding and Punitive Parent, Compliant Surrenderer and Detached Self-Soother across ED subgroups. BN has a unique schema profile characterised by high impulsivity (Impulsive Child) and anger (Angry Child).

3.4.3. Clinical Case Studies

Simpson et al. (2010) conducted a pilot study in which group ST was adapted for use with eight individuals with chronic EDs and high levels of comorbidity. Six participants completed the 20 sessions of treatment in which EMS were identified, and eating disordered behaviour was linked to modes. In this way, participants were able to track their mode sequences. Group therapy provided opportunities for *in vivo* exposure to situations that triggered schemas and modes so that schema processes could be worked with as they arose. Each participant attended a pre, post and mid-treatment appointment with the group therapy leaders to discuss progress. Also, quantitative measures were completed mid-treatment, post-treatment, and at 6-month follow-up to measure schema levels, eating disordered behaviour, anxiety, depression, shame and health-related quality of life. At the end of the treatment, individuals showed improvement in all the measures, although the improvement in

depressive symptoms was not significant. Also, participants reported a greater understanding of the causal and maintaining factors of their EDs, which enabled them to reduce their self-critical thinking and increase self-compassion. The study conducted by Simpson et al. (2010) was the first to apply group ST to EDs. It supports findings from previous studies (Farrell et al., 2009; Dickhaut & Arntz, 2014) regarding group ST's effectiveness for chronic psychological conditions.

When this research was undertaken, only one case study was published for ST and EDs. This was a case study of a woman with BN (Simpson, 2012). In 2016 Edwards published an article in German that presented a case study of a woman with AN, binge/purge type. A detailed analysis of schema modes in this same case was published in English in 2017 (Edwards, 2017a, 2017b). The schema modes identified in these two cases are described here.

Simpson and Edwards both recognised features of the Demanding Parent and the Punitive Parent. Aspects of the Punitive Parent include harsh messages of disgust and criticism triggered by behaviours that lead to weight gain, such as not following a strict diet, or perceived signs of weight gain such as bloating. The Demanding Parent uses the body as a target for imposing rules and standards. Messages incorporated into the Demanding Parent include that there is a right, healthy diet, that one should strive to achieve what one has determined as an ideal weight, and that breaking of dietary rules leads to loss of control, weight gain and undesirability (Simpson, 2012). Edwards' (2017a) case study described the Demanding Parent and Punitive Parent as part of a mixed parent mode that included features of the Guilt-Inducing Parent, as all elements were present in the same situation. This is examined in more detail in section 5.2.

Edwards (2017a) identified a Vulnerable Child who felt inferior, unimportant and blamed. However, Simpson (2012) specified a particular form of Vulnerable Child, namely a mixed Shamed/Deprived Child who feels rejected, hurt, ashamed, anxious, unwanted and inferior. Simpson (2012) also identified a form of impulsive child, a Needy Child. The Needy Child, which was not described in the general ST literature, is desperate for nurturance, protection and attention. So in this mode, the individual acts impulsively to obtain nurturance or get one's way without regard for others. In Edwards' (2017a) case study, impulsiveness formed part of a Defiant Child. Edwards (2017a) and Simpson (2012) both recognised a prominent Angry Child mode whose anger was based on the child's unmet emotional needs and directed towards those responsible for the unmet needs.

The overcompensatory coping identified by Simpson (2012) and Edwards (2017b) included the Perfectionist Overcontroller. When this case study was presented, Simpson had not yet developed the concept of the Eating Disordered Overcontroller. Instead, the eating disordered behaviour, which included restrictive eating, body checking and exercise to improve weight and shape, formed part of the Perfectionist Overcontroller. Edwards' article situated the ED behaviour in an Anorexic Overcontroller mode described in section 5.4.

The surrender coping mode identified by Simpson and Edwards included the Compliant Surrenderer. Edwards (2017b) also acknowledged a Self-Pity/Victim mode. At the time Simpson's article was written, the Self-Pity/Victim was not recognised in the ST literature. Instead, Simpson identified the helpless attitude of "What should I do?" and "Can you fix me?" as part of the Compliant Surrenderer mode.

Simpson (2012) and Edwards (2017b) identified Detached Self-Soother coping, which included binge eating and induction of vomiting. The Detached Self-Soother plays a role in individuals with binge or neutralising behaviour aspects to their EDs. An event triggers EMS and distress in a child mode, and then the individual flips into Detached Self-Soother to neutralise the feelings. Also, Simpson (2012) identified Detached Protector coping, which included ED behaviours such as food restriction, excessive exercise and preoccupation with weight and shape, to block feelings of sadness and emptiness, as well as overwhelming body sensations. Edwards (2017b) identified an Avoidant Protector mode that did not include ED behaviours. However, Edwards (2017b) identified a Deceptive Protector mode, which was a form of avoidant coping, that was evident when the subject took, without permission, her colleagues' food for her binges.

Edwards (2017b) also identified a coping mode not previously described in the ST literature, namely a Protector Child. The Protector Child is a coping mode that developed in early childhood to overcompensate for the impulsiveness of the Defiant Child. The Protector Child enables the individual to function in important life areas by presenting a façade of a content and well-adjusted child that conceals emotional distress. This is recognition that most coping modes have their origins in early childhood and that in experiential work, these modes may give rise to an image of a child who is not a Vulnerable Child but a child in a coping mode.

3.5. Case Conceptualisation

These case studies are an important reminder of the centrality of case conceptualisation in the implementation of ST and show how a ST conceptualisation provides a meaningful understanding of an ED's development and how it is perpetuated by coping modes.

The case studies named modes differently, but both recognised aspects of impulsivity in a child mode, which fits with the binge eating component of the EDs described. Both case studies identified ED behaviours that form part of overcompensatory, surrender and avoidant coping modes. The type of coping mode that the ED behaviour is classified in depends on the function of the behaviour. The function of the behaviour was understood by interviewing the individual about their behaviour and understanding the case. This is not achieved in quantitative studies, and so the classification of ED behaviours in quantitative studies can be misplaced.

Edwards (2017a, 2017b) identified more modes than Simpson (2012) did that related to the ED. As Edwards' articles were written several years after Simpson's, this illustrates how ST has evolved, and the understanding of schema modes has been refined. The depth of clinical analysis found in these case studies shows the value of qualitative case-based studies. Quantitative multivariate studies, mostly based on questionnaires that were developed more than a decade ago and do not assess all the currently recognised modes, can provide only limited insight into actual clinical cases. Since undertaking this research, our understanding of schema modes in EDs has increased, and new modes have been introduced. For example, the Eating Disordered Overcontroller, Helpless Surrenderer and Pollyanna Overcompensator modes had not been conceptualised at the beginning of this research. This highlights how our understanding of ST and EDs is continually evolving.

A strength of ST is that it addresses the disordered eating behaviours and the underlying schema level beliefs and emotions with which the disordered eating behaviour is coping. Once all information is gathered in the assessment phase of therapy, a case conceptualisation is developed that considers the psychological processes that contribute towards and maintain the symptoms. The effectiveness of the ST approach lies in developing a comprehensive case conceptualisation from which a treatment plan is developed. The EMS and modes are identified, including how the ED behaviour occurs in a mode sequence. A treatment plan is then established that addresses the underlying functions of the ED.

ED behaviours in the coping modes dissociate from the body and, in this way, shut down the distress experienced by the Vulnerable Child. However, ED behaviours can have different functions in individuals (Simpson, 2020b). So it is important to understand the function of the behaviour phenomenologically rather than to categorise the behaviour.

A mode map conceptualises the case according to how the EMS are manifested and how the ED symptoms and comorbid symptoms are incorporated into the modes. The mode map is used to identify mode sequences; that is, how an event triggers a parent mode in a dyadic relationship with a child mode, and then the individual flips into a maladaptive coping mode. The mode map and case conceptualisation provide an understanding of how the modes are perpetuated, and the ED is maintained.

As mentioned in section 3.4.1, individuals with EDs use both primary and secondary avoidance of affect (schema compensation and schema avoidance) to avoid experiencing negative affect. The type of coping depends on the nature of the trigger, the strength of the schema triggered and the rapidity of the onset of the emotions. If one cannot avoid the negative affect by using overcompensatory coping, then one may engage in schema avoidance behaviours to block the emotion that is experienced (Waller et al., 2007).

In AN, coping modes shut down emotions before they are experienced. Thus, an event triggers an EMS. So as not to feel the intolerable negative affect associated with the schema in a child mode, the individual flips into an overcompensatory coping mode, such as the Eating Disordered Overcontroller, which reduces the potential of the affect being experienced.

In individuals with BN or BED, one is already experiencing the emotion and then tries to shut it down. Thus, an event triggers schemas and associated affect in a child mode. The individual then flips into avoidant coping, such as Detached Self-Soother, to shut down their emotions. At other times an individual with BN may have primary avoidance of affect. Like individuals with AN, they can shut down the emotion before it is experienced through overcompensatory coping, such as an Eating Disordered Overcontroller.

Through the process of the individual flipping into coping modes to shut down the schemas and related affect in the child modes, the needs remain unmet, and the Vulnerable Child is never healed. Thus a cycle of dysfunctional behaviour is maintained where schemas and emotions are repeatedly triggered in the child modes and then shut down through maladaptive coping modes, including ED behaviours.

3.6. Conclusion

As referred to in chapter 2, there is a significant prevalence of EDs in western populations and a need for more effective treatment approaches that can maintain long term results for difficult to treat cases. In section 2.4.4, the benefits of integrating treatment interventions from various therapeutic approaches were noted. ST is a therapeutic approach that combines techniques from multiple therapeutic models, resulting in increased efficacy.

As I mentioned at the beginning of this chapter, ST has been used for the treatment of EDs for over 20 years, beginning with the use of imagery rescripting when working with EDs (Ohanian, 2002) and then conceptualising ED cases using the ST approach (Mountford & Waller, 2006; Waller et al., 2007). ED behaviours have been understood as avoidant and overcompensatory coping behaviours. As overcompensatory coping behaviours, ED behaviours were firstly understood as behaviours in the Perfectionist Overcontroller (Waller et al., 2007), then Edwards (2016, 2017a, 2017b) specialised Anorexic Overcontroller and Simpson et al.'s (2018) Eating Disordered Overcontroller. As avoidant coping behaviours, ED behaviours were recognised as part of a Detached Self-Soother (Waller et al., 2007). ST has investigated EDs through the use of quantitative studies to examine relationships between schemas, modes and ED pathology (Spranger et al., 2000; Luck et al., 2005; Masley, 2012; Talbot et al., 2015) which highlighted the high levels of EMS in individuals with EDs, and patterns of modes across EDs (see section 3.4.2).

As mentioned in section 3.4.3, when this research was undertaken, only one case study was published for ST and EDs (Simpson, 2012). In 2016 Edwards published a case study in German, which was then presented in English in 2017. Edwards' case study is the only published research conducted on ST and EDs in South Africa. No studies have been published on multiple ED cases. Simpson's (2012) case study was an individual with BN and Edwards' (2016, 2017a, 2017b) case study was an individual with AN. So there are currently no published case studies of ST and BED. This study expands on existing knowledge of ST and EDs by examining and comparing case studies of AN, BN and BED.

Chapter 4. Methodology

4.1. Research Rationale

The categories of modes described in ST are nomothetic as all individuals have parent modes, child modes and coping modes. However, the particular characteristics of these modes differ from case to case as they reflect the phenomenology of an individual's life and are an accurate portrayal of the underlying structure generating their experience. Edwards (2017b) argues that a nomothetic mode model might overly simplify phenomenology, thereby missing subtle aspects of clients' conflict. Thus identifying the characteristics of the modes unique to an individual is essential for the case conceptualisation and the targets of therapy.

4.2. Research Aims

This research aimed to do a mostly qualitative study on schema modes and examine, through phenomenological analysis and interpretation, how these modes are experienced by the individuals and influence their behaviour. Using the information of how schema modes appear in clinical cases and comparing this to existing literature, the understanding of schema modes in EDs can be refined.

4.3. Methodological Approach and Principles

This research project came from naturalistic case studies based on information from research interviews, including voice recordings and transcriptions, self-report scales and self-report records of weight and BMI. This research took a phenomenological approach to explicate the unique features of each individual's experience.

4.3.1. General Principles of Interpretative Phenomenological Analysis

The research was an application of interpretative phenomenological analysis (IPA), which "aims to explore in detail participants' personal lived experience and how participants make sense of that personal experience" (Smith, 2004, p.40).

IPA first emerged as a research approach in health psychology in the mid-1990s. It is a qualitative research method that examines how people make sense of their life experiences by exploring experience in their terms rather than in predetermined categories. In IPA, the researcher, who only has access to the parts of the experience shared by the participant, interprets these accounts to understand the experience (Smith et al., 2009). "IPA do not seek to find one single answer or truth, but rather a coherent and legitimate account that is attentive to the words of the participant" (Pringle et al., 2011, p.23). IPA is, therefore, a

dynamic form of research where one is interested in subjective reports from the individual (Smith, 1996). The resulting findings are a combination of the reflections of the participant and the researcher (Brocki & Wearden, 2006). IPA is conducted on small, homogeneous samples (Smith et al., 2009) and seeks to explore the divergence and convergence within this small sample (Brocki & Wearden, 2006). Data is mainly gathered through an interview process and then analysed in a systematic qualitative manner with verbatim extracts providing supporting evidence for the findings (Smith et al., 2009).

IPA is informed by three key concepts; phenomenology, hermeneutics and idiography. Phenomenology is "concerned with the study of experience from the perspective of the individual" (Lester, 1999, p.1). So phenomenology focuses on the individual's perception of objects and events and their subsequent attempt to make meaning out of their experiences (Smith et al., 2009), all of which the researcher then interprets. A principle of phenomenology entails studying the experience in the way it naturally occurs.

Whereas phenomenology uncovers meaning, hermeneutics interprets the meaning. As the theory of interpretation, hermeneutics explores the methods and purposes of interpretation (Smith et al., 2009). In IPA, hermeneutics considers whether it is possible to uncover the meanings of the original author. The concept of the hermeneutic circle explores how a part can only be understood in terms of the whole, and conversely, the individual parts help understand the whole. For example, a word or phrase can be understood in the context of a sentence, and a sentence can be understood in the context of the larger extract. Likewise, the meaning of the individual sentences determines the meaning of the extract, and the meaning of the sentence requires taking into account the meaning of the individual words. In this way, the interpretation of data is dynamic and non-linear. IPA also involves a double hermeneutic in that the researcher is making sense of the participant, who in turn is making sense of their experience (Smith et al., 2009). The researcher only has limited access to the participant's experience based on what the participant chooses to share about that experience. In analysing the data for this research, I became aware of instances where I missed rich information because I had not thought to ask for additional information, and the participant had not been aware that further information would have proved valuable.

Idiography refers to analysing information in detail from an individual's perspective or in a specific context to understand the individual's unique experience in terms of patterns or themes that characterise their life. I aimed to achieve IPA's balance between focus on the particular whilst acknowledging the importance of identifying patterns across case studies

(Smith et al., 2009) by developing unique case conceptualisations for each participant and then comparing them to establish more general claims. Nomothetic research, in contrast, uncovers trends that characterise relationships among variables measured across a group of participants. ST applies the nomothetic approach when broadly defined modes are described, such as the parent modes or a Vulnerable Child mode. Nomothetic and idiographic approaches can be complementary (Edwards, 2016). For example, the study also used questionnaires that have been developed within a nomothetic framework to describe and assess particular schemas and modes broadly. However, in clinical practice, these are typically utilised idiographically to enrich the clinician's understanding of the cognitive and emotional patterns unique to the case.

The first step in IPA research is to access detailed personal information from the participant about the phenomena under investigation. This material is then interpreted to, in this case, identify schema modes in EDs. In-depth interviews on a one-to-one basis allowed for building rapport and were the primary source of data collection. Questions asked were open and exploratory, reflecting on "people's understandings, experiences and sense-making activities" (Smith et al., 2009, p.47) rather than the outcome.

Participants in IPA research are purposively selected because they offer insight into a particular experience. In this research, that is EDs. Only five participants were chosen for the study as IPA requires a detailed analysis of individual transcripts and writing in detail about the perceptions and understandings of the individual participants (Smith et al., 2009). For this reason, a sample size between three and six participants is considered adequate (Smith et al., 2009). IPA interprets participants' stories and their beliefs. Implications need to arise from what participants have said by using direct quotes to substantiate findings (Pringle et al., 2011).

4.3.1a. Strengths and Limitations of IPA

A strength of IPA is that the small sample size allows for an in-depth, rich analysis of the data, including quotes from the text to support findings. Also, important issues can be explored further in the interviews, and ambiguous data can be clarified (Smith, 2004).

Limitations noted in IPA is that the researcher's background and perspective influence interpretations, and as such, two analysts working with the same data might not exactly replicate each other's analysis (Brocki & Wearden, 2006). This limitation was not considered significant in my research as the interpretation of modes was made using a clear

interpretative framework and derived from the existing literature on schema modes. Also, I received extensive supervision from a qualified schema therapist at all stages of the analysis. The supervision is a protective factor that makes it unlikely that someone else analysing the data within this framework would arrive at a markedly different mode analysis.

4.3.2. General Principles of Case Study Research

In clinical case study research, the "individual case is the unit of analysis and qualitative data are used to construct an assessment and case formulation" (Young & Edwards, 2013, p.313). Each case provides data used to reach a psychological understanding of each participants' problems (Edwards & Young, 2013). This relied on the participants' ability to articulate their thoughts and experiences and my ability, as the researcher, to ask focused questions and then to reflect on and analyse the data (Brocki & Wearden, 2006). The data analysis to formulate the case conceptualisation involved me gaining an understanding of the meaning of the information for the person's experience. This involves a phenomenological analysis of the data beyond what the participant was able to articulate and understand.

4.3.2a. Strengths and Limitations of Case Study Research

A strength of case study research is that it allows for a deeper relationship between the researcher and the participant. This relationship results in in-depth material that is of a high quality from which meaning is extrapolated. In this way, the information provided in case study research is far richer than that obtained from quantitative studies. A large number of observations on each case allows for the "identification and analysis of complex patterns of interplay between different factors or processes" (McLeod & Elliott, 2011, p.3). The influence of contextual factors is examined. Case study research contributes to theory building by providing examples to support existing concepts and allowing for the emergence of new concepts to extend the theory (McLeod & Elliott, 2011). Stiles (2007) states, "understanding grows not by stacking fact upon fact, but by infusing observations that expand the theory" (p.123).

McLeod and Elliott (2011) note a limitation of case study research is that findings cannot be applied to a large group based on a single or small group of case studies in the way that conclusions derived from analysis of many diverse cases can be. However, commonalities across accounts can provide useful insights (Reid et al., 2005), contributing to existing research and theory. Yin (2010) refers to this as analytical generalisations, which

are based on a two-step process. Firstly a conceptual claim is made where the researcher shows how the findings bear upon a particular existing theory. Then this theory is used to connect other similar situations where these events may occur. Principles of analytic generalisation have been applied here as specific claims or arguments are grounded in the phenomenology of the case material in the context of the existing research literature on ST for EDs and modes in EDs, as summarised in chapter 3 and referred to in the chapters to support or challenge arguments (Yin, 2010). Using five case studies allows for more robust analytic generalisations than a single case study as there are multiple results to support the arguments made.

Another limitation to case study research where the clinician is also the researcher is that a risk exists that the clinician biases interpretations or chooses aspects of the material and shapes it to suit their conclusions (Spence, 1986). This bias is counteracted by recording all interviews, which can be revisited by the researcher or supervisor (Edwards et al., 2004). As already mentioned, I discussed all aspects of the analysis with the research supervisor, a certified schema therapist.

4.3.3. An Argument for Integrating Case Study Research and IPA

Case study research and IPA contribute to theory by summarising multiple case observations, which then expand on existing theory. This is advantageous as the contribution to theory is based on practical, real-life situations, and generalisations are based on drawing together multiple studies.

4.3.4. The Concept of Trustworthiness in Qualitative Research

Trustworthiness in qualitative research is equivalent to rigour in quantitative research. Rigour has traditionally been understood as "a systemised, ordered," approach to research methods and "the authoritative evaluation of good research" (Davies & Dodd, 2002, p.280). In quantitative research, rigour includes validity, reliability and objectivity, whilst trustworthiness in qualitative research has four corresponding criteria. These criteria include credibility (corresponding to internal validity), transferability (corresponding to external validity), dependability (corresponding to reliability) and confirmability ([corresponding to objectivity]; Shenton, 2004).

Credibility in a research project is achieved through employing research methods, including those for data collection and analyses, successfully used in previous comparable research projects (Shenton, 2004). Edwards (2016, 2017a, 2017b) has written several articles

where IPA has been conducted on a single case study of AN using the schema mode approach. Simpson (2012) has written a book chapter illustrating a case study of BN using the schema mode approach. McIntosh et al. (2020) described a composite case study using ST for BED. These articles were referenced extensively in this research project. Credibility was further established by collating many hours of material gathered from interviews with the participants (Morrow, 2005) and the use of quotes from the interviews to substantiate arguments.

Transferability refers to the extent to which the findings of this research can be generalised to other ED populations (Morrow, 2005). The findings will be relevant to other clinicians treating EDs from a ST perspective. It supports current information and contributes new findings that extend the existing literature and what we know about schema modes in EDs. The more information clinicians can draw on, the richer their interpretations of schema modes in their cases will be.

Dependability refers to the criteria that the process through which findings are derived should be explicit and repeatable as much as possible. This is achieved by tracking the research design and providing a detailed description of the research activities and processes and the influences on data collection and analysis (Morrow, 2005). Dependability in this research project has been achieved through the description provided in this chapter on how data was obtained, both quantitatively and qualitatively. Peer researchers can then examine this process. Alternatively, the process can be repeated by a different researcher at a later stage using a new sample. The use of transcriptions meant that data analysis did not rely on my recall of information and that an independent researcher could access and analyse the same material and then draw their conclusions.

Confirmability suggests "the integrity of findings lies in the data and that the researcher must adequately tie together the data, analytic processes, and findings in such a way that the reader is able to confirm the adequacy of the findings" (Morrow, 2005, p.252). Many of the steps applied to determine dependability also apply to confirmability. For example, providing a detailed description of the actions taken to obtain and analyse the data using the ST theoretical framework allows the reader to confirm the adequacy of the findings. The discussion of the analysis with my supervisor, a certified schema therapist, also helped to manage the subjectivity of the analysis. Confirmability will further be determined by clinicians who assess ED cases and confirm the adequacy of the arguments that lead to the conclusions to be presented later.

4.4. Research questions

Particular questions to be answered included;

1. What modes are prominent in a sample of individuals with EDs and how do these individuals behave, and what do they experience in these modes?
2. What kinds of mode sequences can be identified, and how do these contribute to the chronic self-defeating eating-related behaviour?
3. What individual differences are there in particular kinds of modes?
4. How do the identified modes fit with the modes already described in the ST literature?
5. Are there modes in EDs that have not yet been identified and described in the ST literature?

4.5. Participants

4.5.1. Research Participants

The five participants ranged in age from 28 to 52. The sample was composed of Caucasian females who spoke English as their first language. Although this sampling was not purposive, it represents the population who tend to engage in therapy for EDs, as discussed in chapter 2. Cases selected for the study represented a range of clinical presentations diagnosed according to criteria from the DSM-5 (APA, 2013). The participants included two who met criteria for BED, one who met criteria for BN, one who met criteria for AN, restricting type and one who at different stages met the criteria for AN binge/purge type and BN. Each participant;

- met the full criteria for an ED, as outlined in the DSM-5 (APA, 2013),
- was treatable on an outpatient basis,
- had not previously engaged in psychotherapeutic treatment using the ST approach,
- was fluent in English,
- was older than 18 years.

One participant was engaged in psychotherapy with another psychologist before the onset of the research. Written consent from the treating psychologist to participate in the study was obtained before the participant engaged in the study. However, she and her psychologist mutually agreed to suspend their therapy for the duration of the research project.

4.5.2. Research Sample Selection

An advertisement was designed (Appendix A) that outlined the basic tenets of the research project, including criteria for inclusion, expectations of the participants and potential benefits. I met with healthcare practitioners in the area, explained the research project and provided them with copies of the advertisements to distribute to their patients whom they believed met the criteria and would benefit from their participation. Healthcare practitioners completed a document consenting to distribute the advertisements (Appendix B). This document clarified that they would not receive information regarding their patients who participated in the research, except with their patients' written consent, and if to do so would enhance their intervention with the patient. The patient's autonomous choice to participate or not participate in the research was also emphasised, and that their choice should in no way influence the service provided to them by the healthcare practitioner. I approached numerous healthcare professionals, but all participants were referred by a dietician in the area who worked with EDs as part of her practice.

4.6. Ethical Consent Procedures

Five moral principles inform research in the field of psychotherapy, namely autonomy, beneficence, non-maleficence, fidelity and justice. The principle of autonomy concerning research means that the individuals taking part should have made an autonomous decision to engage by giving informed consent (McLeod, 2010). In this research project, I ensured this in three ways. First, I had no way of knowing who had received the advertisement and been informed of the research project until the potential participant made contact with me of their own accord. Second, each potential participant received an additional information sheet (Appendix C) by email before the initial meeting, which outlined the basic tenets of ST, what was required from the participants, information about the recording of sessions and what the information would be used for, as well as the potential benefits to the participants. Third, when the participants agreed to participate in the project, they provided signed consent (Appendix D), which also stipulated that they had the right to, at any time, withdraw their consent to participate and for the information to be used in the research project. This document also contained contact details for myself and my supervisor, should the participant have any queries or concerns that they would like to discuss. As part of the informed consent, each participant signed a document permitting recording of the sessions and transcription by a third party (Appendix E), and for me to retain this for use for further study. These documents were given to the participants at the end of the initial session for their perusal and

completion before the next meeting. The completed forms were returned at the next session, and a copy was given to each participant for their records.

The second principle is that of beneficence which refers to the moral obligation of psychologists to act for the benefit of others (Allan, 2008), including protecting the rights of the participants and preventing harm from occurring to them (Beauchamp & Childress, 1994). As already stated, the participants were informed of their right to participate or refuse participation in the research and their right to withdraw their participation at any stage with impunity (Appendix F). However, none of the participants chose to withdraw early. The participants stood to benefit from the assessment process by gaining greater self-awareness. All the participants at various stages expressed how they were benefiting from the meetings, and all were willing to continue meeting well past the initial eight sessions to which they had agreed.

The moral principle of non-maleficence, the instruction to "do no harm" (McLeod, 2010), was applied as the assessment process was the same as would occur in the early stages of a typical therapeutic process. I, as a clinical psychologist, was experienced in the process of gathering data for an assessment. Although some information that was asked about was sensitive and likely to evoke distressing emotions, I focused on putting the participants at ease and building trust (Edwards & Young, 2013). Whilst monitoring responses, no undue distress was noted. The process of understanding their ED and the patterns that maintained this disordered behaviour also provided hope that their ED could respond favourably to treatment, should treatment be sought.

Three forms of harm that can occur from case study research include intrusion in the assessment process, the impact of reading the case report and adverse consequences arising from confidentiality breaches (McLeod, 2010). Intrusion in the assessment process can occur once participants have agreed to participate in the research project but then become inhibited or fearful regarding the security of the information provided. McLeod (2010) suggests that the best way to avoid this is to offer participants the opportunity to ask questions about the study at any stage during the research process. As mentioned earlier, the participants received contact details for myself and my supervisor, whom they could contact with any questions or concerns. Another form of intrusion occurs when the therapist focuses on aspects that would be particularly beneficial to the case study. This form of intrusion is irrelevant here as all participants agreed to take part, knowing that the focus of the research, and therefore the assessment, was schema modes involved in EDs.

In case study research, an individual's life is examined, specifically the problematic or shameful aspects. The researcher needs to be aware that these individuals may read the case study and, in this way, be confronted by personal truths that either they wish to avoid or that they consider to be distortions of their truth (McLeod, 2010). Also, the individual might read personal insights about themselves from the therapist of which they were unaware. In this research, the participants received the case conceptualisation during the sessions, which precludes information provided here that is relevant to the participant and has not been discussed with them.

In terms of harm from confidentiality breaches, I assured participants that research information was stored securely and that personal details were kept separately from participant information (McLeod, 2010). Selected interviews were transcribed by a third party who signed a confidentiality agreement (Appendix G) agreeing to reference all audio recordings with a coded label provided by myself, store audio recordings and transcribed texts in a password-protected file on the computer, and delete the copy of the audio recording and transcription once they had been received and approved by myself. Where participants had consulted other healthcare practitioners regarding their EDs and were willing to have these practitioners contacted to provide collateral information, they completed a consent form specifying the healthcare practitioners I could contact and their contact details (Appendix H).

The moral principle of fidelity refers to reliability, dependability and acting in good faith (McLeod, 2010). I maintained fidelity as the interests of the participants took precedence over myself and the research project (Allan, 2008). In this project, I was interested in each participant's lived experience, so there was no deception or exploitation and transparency with the participants was maintained at all times. Maintaining the participants' confidentiality is an important aspect of fidelity (McLeod, 2010); however, according to Smith et al. (2009), a qualitative researcher can only offer anonymity as confidentiality implies that no one else will have access to the information. Thus, as a qualitative researcher, I endeavoured to protect the participants' privacy rather than maintaining confidentiality.

Unique features of each participants' life story may make them identifiable to others, and once in the public domain, the document can be read by anyone at any time. For this reason, I altered identifying information that would not change the context, such as names, professions (to one requiring similar education), and omitting details regarding where one resides or works (McLeod, 2010). Participants were informed in our agreement (Appendix D)

that the thesis would include information about personal experiences, attitudes and behaviours, and quotes from interviews, but that identifying information would be removed. Pseudonyms were provided for the participant and other people mentioned, including friends and family members. I anonymised data and omitted personal information such that it is improbable that general readers would be able to identify participants. However, it is more difficult to disguise the participant's identity to the extent that family members or close friends who knew of the participants' contribution to this research would not recognise the participant should they read this document. I omitted all personal information irrelevant to my theoretical concerns to safeguard the participants. Our agreement (Appendix D) stated that the participant did not have to answer questions about aspects of their lives that they were unwilling to disclose.

The moral principle of justice is concerned with the fair distribution of resources and services (McLeod, 2010). The participants in this research project received psychological services and resources they may otherwise not have been able to access.

4.7. The Researcher

I am a qualified clinical psychologist. I completed my training in 2006. I am registered with the Health Professions Council of South Africa (HPCSA). I have been in private practice since 2008, where I have worked with clients with various presentations, including EDs. I began my ST training in 2014 and obtained a South African Diploma in Schema Therapy in 2016, which means I have completed the 40 workshop hours of training in ST as specified by the International Society of Schema Therapy. Since 2016 I have engaged in regular ST supervision with a certified schema therapist and trainer. I have also attended two workshops, in 2019 and 2020, run by Susan Simpson on ST for EDs. At the time of writing, my individual supervision hours totalled more than 100 hours.

4.8. Data Collection

Quantitative data in the form of self-report scales, and qualitative data from recorded and selectively transcribed clinical interviews and my notes made during and after each session, were collected to develop a rich case record that allowed for links to be made to ST theory (Stiles, 2007). The interviews I chose for transcription were those which contained rich information that could contribute to my understanding of the prominent modes under investigation. These interviews also contained particular phrases or descriptions which would help to clarify the features of the modes and their presentation for that particular participant.

I drew on all this information to write a case narrative that included information salient to the development and understanding of a ST perspective. I omitted information that was of little or no relevance (Edwards, 2019).

4.8.1. Qualitative Data Collection

The research was mostly qualitative, and the primary data was acquired through a clinical assessment process primarily based on interviews whose format drew on existing clinical knowledge and theory (Edwards & Young, 2013). An interview guide was set for the initial interview to determine the participant's suitability for the research project (Appendix I). After that, interviews were in-depth and semi-structured (Smith, 2011) with open-ended questions (Brocki & Wearden, 2006), which allowed for interaction and responsiveness from the participants.

I undertook the general process of a clinical assessment described by Edwards and Young (2013), which included gathering information about the presenting problem, namely the ED, and other prominent psychological issues. The participants presented with comorbid posttraumatic stress disorder, dependent personality disorder, generalised anxiety disorder, illness anxiety disorder, persistent depressive disorder and major depressive disorder. The onset of the ED and its severity, symptoms, and impact on social and occupational functioning was of particular relevance for this research. I obtained a detailed case history that included information about their birth circumstances, their family relationships, peer and intimate relationships, education, occupational history, significant life changes, traumatic events, and medical history. Also, I screened for substance abuse, self-harming behaviour and suicide risk. One participant expressed suicidal thoughts, which I monitored throughout the research. The participants' current context, including social support, financial circumstances and home environment, were considered in terms of how they impacted the ED and everyday functioning. This information is provided in chapters 6 to 10 when the case studies for each participant are presented.

Information obtained through clinical interviews and experiential techniques such as chair work and emotion-focused work was incorporated into the assessment process as a means of accessing participants' experiences of different modes. These kinds of experiential techniques are a normal part of ST, even at the assessment phase. All sessions were audio-recorded and selectively transcribed (see section 4.8). The research supervisor, a certified schema therapist, monitored the progress of these cases and ensured adherence to the ST

model as this provided the framework for the research and hence the case conceptualisations that were developed.

The data collection process was initially expected to take at least eight one-hour sessions for each case. In reality, it took far longer. After the agreed-upon eight sessions, each participant was willing to continue meeting for an indefinite number of sessions, resulting in a shift from the assessment phase into a therapeutic phase. In this way, interviews were initially structured along the lines of doing a clinical ST assessment and then later structured around ST interventions. The number of sessions conducted with participants ranged from 18 weekly sessions to 50 weekly sessions. Although the sessions moved into a therapeutic phase, the only relevance of the therapeutic phase to the research was in how it contributed to my understanding of the modes. At no stage were participants required to pay for any of the sessions that were held. Furthermore, during the period that the participants engaged with me, none of them elected to engage in an alternate form of therapy with another therapist. The initial assessment and conceptualisation were revised after the formal assessment phase. As the participants became more comfortable and areas were explored in more detail, information emerged, which enriched and altered the case conceptualisation and helped understand the participant's modes. As the case conceptualisation was updated, this information was shared with each participant.

4.8.2. Quantitative Data Collection

Although the clinical interview forms the foundation for the assessment process in a therapeutic setting, this information can be supplemented by quantitative assessment techniques that guide the clinician to areas requiring further inquiry and contribute to the development of a case formulation (Young & Edwards, 2013). The quantitative methods used to provide supplementary data included assessment inventories designed specifically for ST: the Young Schema Questionnaire version 3 ([short version]; Young, 2005), the Schema Mode Inventory version 1.1 ([SMI]; Young et al., 2008) and the Young Parenting Inventory ([YPI]; Young, 1999). Also, the Beck Anxiety Inventory (BAI) and the Beck Depression Inventory-II (BDI-II) were administered to all participants to objectively assess levels of comorbid anxiety and depression. In one case where symptoms of dissociation were experienced, the Dissociative Experiences Scale (DES II) was administered. Using more than one data collection method allowed for a more complete set of data that enhances findings (Pringle et al., 2011).

The short forms of the YSQ-S3 (from here on referred to as the YSQ) and SMI were administered as these are proven to have equal clinical utility to the long versions (Lobbestael et al., 2010; Bach et al., 2017). The YSQ addresses the 18 EMS across 90 items, five items per schema. Participants are asked to rate a series of statements based on how they have felt over the past year. The individual responds to a statement by scoring on a 6 point Likert scale ranging from 1 (*completely untrue of me*) to 6 (*describes me perfectly*). Scores of 5 (*mostly true of me*) and 6 indicate that a schema may be present, but confirming its presence is achieved through the interview process.

The SMI was initially designed to measure schema modes in borderline and antisocial personality disorders (Simpson et al., 2018) but was later used to measure schema modes across all disorders. The SMI identifies six child modes, five coping modes, two parent modes and a Healthy Adult mode. The child modes include Vulnerable Child, Angry Child, Enraged Child, Impulsive Child, Undisciplined Child and Happy Child. The coping modes include Compliant Surrenderer, Detached Protector, Detached Self-Soother, Self-Aggrandiser and Bully and Attack. The two parent modes identified in the SMI are the Punitive Parent and the Demanding Parent. The SMI contains 124 items, with between four and ten items per mode. Individuals score on a 6 point Likert scale ranging from 1 (*never or almost never*) to 6 (*all of the time*). An average of items for that scale determines the final score for each mode.

Additional information is obtained from the YSQ and SMI by questioning the participant about their responses to individual items. A two or three letter code appears after each statement to indicate to the therapist the schema or mode measured. This code, which is hidden when the participant responds to the items and made visible on the computer version afterwards, is helpful for the clinician and participant when reviewing the items together. A score of 5 or 6 on any item on either questionnaire is considered noteworthy (Young et al., 2003), and all such items were explored with the participants. Inconsistencies between responses to statements and the participant's history were also noted and further explored. This is a normal part of an assessment for ST.

The YPI is a measure of the most common origins for the development of EMS. It provides a series of statements about specific behaviours of the participant's mother and father that are hypothesised to contribute to the development of EMS. It consists of 72 statements that are scored separately for each parent (Young et al., 2003). The corresponding schema appears after the statement in a hidden column, made visible on the computer after completion of the questionnaire. Like the YSQ and SMI, items are scored on a 6 point Likert

scale. Items scoring 5 (*mostly true*) or 6 (*describes him/her perfectly*) are considered clinically significant, except for the items measuring Emotional Deprivation where a score of 1 (*completely untrue*) or 2 (*mostly untrue*) is significant. One high scoring item for a schema on the YPI suggests that the schema is present (Young et al., 2003), but this is clarified in the clinical interviews. Although the YPI explores the origin of schemas, it can also be an indirect measure of the presence of schemas. In this way, responses to the YPI and YSQ can be compared, and any discrepancies in schemas noted and explored (Young et al., 2003). The YPI can also be given in a self-report format completed by the participant or as a structured interview. The therapist tries to probe deeply what the parents were like and seeks examples from the individual's childhood to illustrate the parent's behaviour. In this research, the YPI was given in a self-report format as an Excel file which was completed at home on a computer. The answers were then discussed and further elaborated on in a face to face session.

Scales like the BDI-II, BAI and DES II are usually validated in the USA or UK (Young & Edwards, 2013; Wang & Gorenstein, 2013; Beck et al., 1988; Carlson & Putnam, 1993) but are likely to be appropriate for the South African context (Makhubela & Mashegoane, 2016) with clients who have similar socio-economic, educational and cultural backgrounds to the normative samples. The BDI-II and BAI provide cut-off points that guide clinicians on whether symptoms of depression and panic and anxiety respectively are in the mild, moderate or severe range of clinical concern. The DES II provides cut-off scores to determine those who might have a dissociative disorder or a disorder with a dissociative component.

When providing self-report scales, it was necessary to consider whether participants understood what was expected in the completion of the scales and that they understood the content of individual items (Young & Edwards, 2013). The BDI-II and BAI were administered in the session so that queries regarding the statements could be addressed. The DES II, YSQ, SMI and YPI were completed at home, but as the results were discussed in the following session, I was able to identify questions that were misinterpreted. The scales completed at home were primarily used as a source of qualitative data.

4.9. Data Analysis

The collected data included a summary of the presenting problem, case history and quantitative scores from questionnaires. This information was used to develop a case

conceptualisation following the recommended ST model and guided by the International Society of Schema Therapy's Case Conceptualisation form. Following a structured case conceptualisation process ensured the account was coherent, relevant and systematic (Edwards et al., 2004). The case conceptualisation for each case centred on phenomenological accounts of the individual's experiences (Smith, 2004) within modes. Smith et al. (1999) note that the analysis of the content requires close interaction between the researcher and the data as "the analyst seeks to comprehend the presented account whilst concurrently making use of his or her own interpretative resources" (p. 223). In analysing a particular passage, information obtained from the participant in other sessions was sometimes referred to in support of the analysis and interpretation (Brocki & Wearden, 2006).

The case conceptualisation includes an account of schema modes. These modes were intensively described using the principles of IPA in more depth than is usual in a formal case conceptualisation. IPA is idiographic as each case was individually examined in detail for schema modes before conducting cross-case analysis for commonalities and differences (Smith, 2004; Brocki & Wearden, 2006; Smith, 2011). The first step involved me immersing myself in the data by reading and rereading transcripts (Smith et al., 2009) and identifying areas of rich information pertaining to the research questions. Any information of interest was noted, and patterns of meaning in the participants' accounts were identified. Thereafter keywords, phrases and explanations given by participants were all noted and repetition of words or phrases, tone and pauses (Smith et al., 2009). This information led to a more interpretative understanding of the data using my experiential and professional knowledge. Although this interpretation may move away from the original text, it is inspired by and arose from the participant's actual words. Quotes from transcribed sessions were provided to communicate the lived experience of the modes. Where quotes are given, the session the quote is taken from is noted by 'S' and the number of the session. For example S12 denotes the quote is from the twelfth session. Superfluous material was omitted from quotes, and is indicated by an ellipsis (…). The next step entailed identifying emergent themes in the data and how these themes fit together.

4.10. Data Interpretation

Applying the ST framework to the cases was the first step. This resulted in a case presentation for each participant, which included a detailed history and case conceptualisation. Each case was then applied to existing theory to determine how it corresponded with existing literature and what new observations emerged (Stiles, 2007),

which could extend and refine the theory (Edwards & Young, 2013). Similarities and differences between cases were noted. Prominent modes were identified, and mode sequences, to determine how these lead to chronic self-defeating behaviour. The prominent modes, which included the parent modes, Perfectionist Overcontroller, Eating Disordered Overcontroller and Detached Self-Soother, were examined in detail, including an examination of the literature relevant to gaining a deeper understanding of the modes. This information is presented in chapter 5. In chapters 6 to 10, each case is presented in detail, including a detailed history, case conceptualisation and mode map that details specific modes across each participant and how the coping modes perpetuate the problem. The case conceptualisations provided an account of schema modes likely to be prominent in other ED cases. Chapter 11 then provides a critical evaluation of the place ST questionnaires have in the assessment and formulation of case conceptualisations, with reference to my cases. The analyses of this information allowed for a critical review of the mode concepts in the existing literature (Smith, 2004) for ST of EDs.

Chapter 5. Interpretive Themes in the Prominent Modes

When I set out to analyse the data and develop case conceptualisations for the participants, I was confronted with a massive body of information that I needed to interpret according to ST theory and, more specifically, ST for EDs. When the case material was reviewed, several prominent modes were identified, including the dysfunctional parent modes, the Perfectionist Overcontroller, the Eating Disordered Overcontroller and the Detached Self-Soother. However, having such extensive case material provided an opportunity for reflection on the nature of these modes and how they impacted the participants' functioning. This led to the identification of prominent themes, which contributed to a conceptualisation of these modes. My reflections on the interpretive themes relevant to the modes are presented in this chapter.

5.1. Reflections on the Defectiveness/Shame and Failure Schemas

A question arose in examining the data as to whether there is a difference in the feeling of failure and defectiveness. Defectiveness/Shame is a schema in the disconnection and rejection domain, which includes schemas relating to one's needs for security, safety, stability, nurturance and empathy, and the belief that these needs will not be predictably met (Young et al., 2003). These schemas tend to occur in cold, rejecting, lonely and abusive families. The Defectiveness/Shame schema is a feeling of being bad, unwanted or inferior and unlovable to others if these aspects are exposed. This leads to hypersensitivity towards criticism, rejection and blame and a feeling of shame regarding one's perceived flaws.

The Failure schema occurs in a different schema domain, namely the impaired autonomy and performance domain, which includes schemas relating to expectations about oneself and the environment that interfere with the perception of one's ability to separate, survive or function independently comparable to people one's age. Schemas in this domain tend to develop in families that are enmeshed, overprotective and where a child's confidence is undermined. However, schemas in the impaired autonomy and performance domain can also develop where children were not cared for in families. Thus the same types of families in which Defectiveness/Shame schemas develop can also provide a basis for developing a Failure schema.

The Failure schema is a belief that one has failed, will inevitably fail or is inadequate in areas of achievement. It can include the belief that one is stupid, inept, untalented or less successful (Young et al., 2003); in other words, defective. The Failure schema overlaps with the Defectiveness/Shame schema in that there is a perception of inadequacy or defectiveness

in an important area of achievement. These two schemas, which are separated in the literature, tend to occur together in practice. In this study, all the participants had a Defectiveness/Shame schema. In four participants, where there was also a Failure schema, a blended Failure and Defectiveness/Shame schema occurred as both these schemas were activated concurrently and appeared to be interlinked in a situation. This blended schema is further explored in each participant.

5.2. Dysfunctional Parent Modes

When parents have pathology, they may be unable to provide a secure base for children, thus leading to the development of insecure attachment. Individuals with insecure attachment are, in turn, more prone to develop pathology (Bowlby, 1988). Therefore, when working with individuals with psychological disorders, one commonly observes pathological personality traits in their parents (Dentale et al., 2015). In ST, these personality traits contribute to the development of the dysfunctional parent modes.

Parent modes are predominantly based on experiences of how parents responded to us in childhood. These experiences create introjected working models of authority figures, mostly parents. Still, they may also include other family members such as aunts or uncles or influential figures such as teachers or family friends. The way dysfunctional parent modes are historically presented in the ST literature is described in section 3.1.3. When parent modes were introduced to ST, they focused on the words spoken by parents or other authority figures (Young et al., 2003). The Punitive Parent and Demanding Parent were the first dysfunctional parent modes recognised in the literature (Young et al., 2003), followed by the Guilt-Inducing parent mode (Jacob & Arntz, 2011).

The concept of blended parent modes was then introduced where features of separate parent modes can be present in the same situation. For example, Jacob's (2012) Guilt-Inducing Demanding Parent included demanding messages such as, "You are responsible for the wellbeing of others," and "It is important that everyone feels good with you." When the demands of this parent mode were not met, the individual experienced guilt. Edwards (2017a) identified a blended parent mode with elements that were demanding, punitive and guilt-inducing. For example, the child is scolded (Punitive Parent) and gets into trouble (Guilt-Inducing Parent) for breaking the rules or doing things that the parents discouraged (Demanding Parent).

Peled (2016) identified eight dysfunctional parent modes and graded these according to the severity concerning toxicity. The parent modes were graded as a mild, moderate or extreme degree of severity. The level of dysfunction determines the level of confrontational intervention required. For example, when the parent mode is at a mild level of toxicity, the parent-child relationship is not devastating, and the therapist can use empathic confrontation to address the parent mode. At the mild degree of severity, the therapist coaches the client by validating the parents' attempts to meet the child's needs, supporting the child to move away from harmful aspects of the parent mode and to get their needs met more appropriately. At a moderate degree of severity, it is more challenging to validate the parents' good intentions as the internalised parent lacks empathy for the child. At this level, the therapist's interventions are more assertive in providing guidelines for how the Vulnerable Child should be treated, and the therapist may need to set limits to protect the child. At the severe level of toxicity, the internalised parent has no good intentions and is harmful to the child. At this level, the therapist cannot validate the internalised parents' intentions but must instead take action to stop the harm caused to the child and to expel the internalised parent to save the Vulnerable Child.

Dysfunctional parent modes with the mildest degree of severity include the Naïve, Anxious and Permissive Parent modes. Although the parenting experienced by these types of parents is distressing, the parents have good intentions but lack the knowledge and skills to meet a child's needs appropriately.

The Naïve Parent is easily influenced by others and accepts people and circumstances at face value. When this parent mode is present, the child is not taught how to anticipate consequences, handle situations of daily life, and recognise right from wrong. When there is a Naïve Parent mode, the child has unmet needs for protection, guidance and realistic limits (Peled, 2016). The Anxious Parent worries that things will go wrong, and so is overprotective and intrusive, not allowing the child to develop a sense of competence and autonomy. The Permissive Parent is indulgent and does not set limits for the child or encourage self-regulation. The Permissive Parent admires and praises the child, at times even aggrandising them (Peled, 2016).

The second level of dysfunctional parent modes have a moderate degree of severity as these internalised parents impose their wishes and unobtainable standards on the child. The parent modes at the moderate level of severity include the Victim-Like and Demanding and Critical Parent modes. Peled's (2016) Demanding and Critical Parent mode blends these two

separate modes described by Young et al. (2003). The Demanding and Critical Parent sets high standards and expresses criticism through words, tone of voice and other non-verbal gestures that induce shame, guilt and a sense of failure.

Peled's (2016) Victim-Like Parent shares the qualities of the Guilt-Inducing Parent (Jacob et al. 2015). The Victim-Like Parent believes others are responsible for their bad experiences, and as a result, they demand care and use their suffering to keep others emotionally tied to them. When the Vulnerable Child tries to assert their needs, the Victim-Like Parent uses accusation, emotional, or sick-role behaviours to restore their grasp on the Vulnerable Child (Peled, 2016). The standards that form part of this mode specifically relate to how one should feel or behave in a situation where the focus is on the other's needs, and guilt results when one does not see to the other's needs. As a result, the child's needs for autonomy, authenticity, spontaneity and ability to express needs and emotions remain unmet.

The Demanding and Critical Parent and the Victim-Like Parent both have a demanding aspect, and both induce guilt, although the experiences are phenomenologically distinct. The guilt that results from a Demanding and Critical Parent is about making mistakes and taking responsibility when things go wrong. In contrast, the guilt related to a Victim-Like Parent is subtle and manipulative, arising when others' needs are not prioritised. The demands related to a Demanding and Critical Parent are about meeting high standards of performance that make the parent look good. In the Victim-Like Parent, the demands are related to taking care of the parent because the implicit or explicit message is that the parent is a victim who cannot be expected to take on adult responsibilities.

The dysfunctional parent modes that are the most toxic represent internalisations of parents who did not have good intentions and were most harmful to the Vulnerable Child. These parent modes include the Neglecting, Chaotic, and Abusive and Punitive Parent modes (Peled, 2016).

The Neglecting Parent assumes little parental responsibility. This disengaged parent neglects the child's emotional needs and is dismissive or invalidating of their emotional experiences, thus communicating an implicit message that the child's needs and experiences are not important (Peled, 2016). People who persistently experience such invalidating responses do not learn to trust their reactions as valid and struggle to label their experiences appropriately and regulate their emotions. Instead, they look to the social environment for cues on how to respond (Salsman & Linehan, 2006). Children raised in invalidating

environments struggle with distress tolerance, including the ability to sit with negative emotions so that problem solving can take place (Mountford et al., 2007).

The Chaotic Parent is unpredictable, emotionally labile and disorganised. This parent is so self-involved that they are unable to consider another person, including their child. A child in relation to a Chaotic Parent is afraid and hypervigilant (Peled, 2016).

The Abusive and Punitive Parent mode represents an extreme form of the Punitive Parent mode described by Young et al. (2003). This parent mode humiliates, exploits, is cruel and physically or sexually abusive to the child. All emotional needs are unmet, especially the need for a secure attachment (Peled, 2016).

As previously mentioned, the dysfunctional parent modes initially focused on the words spoken by parents and other authority figures. However, Peled (2016) and Edwards (2017a) note that children do not only internalise the verbal messages of parents, but also the attitudes and implicit messages that arise from the parents' overall behaviour. Parent modes do not occur in isolation but rather in a dyadic relationship with child modes, as the activation of one results in the activation of the other.

As the child modes incorporate experiences and beliefs resulting from the parents' behaviour (Edwards, 2017b), looking at parent modes from the perspective of mode dyads provides a higher intensity lens that allows one to see and process information that may have previously been missed. As will be seen later, when this approach was used to draw out information from the data, it highlighted how complex dysfunctional parent modes are and how the qualities in the parent modes differed according to the individuals who were internalised, reinforcing the concept of idiosyncratic blended parent modes.

5.2.1. The Difference Between Shame and Guilt and the Impact on Parent Modes

As previously mentioned, a Guilt-Inducing Parent mode is identified in ST, but there is no reference to a Shaming Parent. When the parent-child mode dyads were considered, the data revealed a Shamed Child in relation to a parent mode. This leads to an examination of the difference between guilt and shame and whether a Shaming Parent should be identified separately from a Guilt-Inducing Parent.

Our interactions with others provide information about ourselves; namely, if others feel this about me, I can feel this about me (Gilbert, 2003). In the experience of shame, one fears revealing something of themselves that opens them to potential ridicule and negative evaluation by others (Gilbert, 1988) who are perceived as intact, threatening or

overpowering. This shame evokes a sense of helplessness and a desire to hide the self or the experience the self is having (Lewis, 1986).

Internal and external shame are differentiated where, "Internal shame relates to experiences of the self as devalued in one's own eyes in a way that is damaging to the self-identity" (Lee et al., 2001, p.452). Thus, internal shame is a sense of being undesired or flawed arising out of social interactions (Gilbert, 2003). In ST, this is a Defectiveness/Shame schema that arises from interactions with parents, in a mode dyad, in early childhood. So, the feeling of being undesired or flawed is a Vulnerable Child or Shamed Child with a Defectiveness/Shame schema in relation to a Shaming Parent.

External shame is associated with beliefs that others look down on the self and see the self as "inferior, inadequate, disgusting or weak in some way" (Lee et al., 2001, p.452). So external shame refers to the triggering of a mode dyad in a social setting where the Shaming Parent is projected onto the environment or community, and the person imagines that people see and are responding to their Shamed Child. This results in the person becoming self-conscious and self-focused, focusing on physical sensations of shame, images of themselves looking shameful or being shamed, or thoughts about themselves as shameful. Thus the element of self-consciousness and the projection of the Shaming Parent onto others is what differentiates internal and external shame.

A Critical, Punitive Parent has a shaming element that raises the question of whether a separate Shaming Parent is necessary. On examination of the case material, it became clear that it is useful to separate two distinct experiences. The first is shame resulting from being blamed for making mistakes and being "bad" and hence deserving punishment. This experience is phenomenologically different from that of a Shaming Parent that evokes images of oneself as shameful and fundamentally unacceptable, leading to helplessness regarding one's shame and a desire to hide.

Guilt is about having let others down through one's actions or lack thereof. Guilt is therefore unlikely to activate helplessness as shame does, but rather to motivate one to make reparations (Tangney et al., 1996) as one has an exaggerated sense of responsibility when things go wrong (Bernstein & van den Broek, 2009). A Guilt-Inducing Parent mode leads individuals to set high standards for how they should behave or feel in a situation (Jacob et al., 2015) as this impacts others. This mode leads to a sense of responsibility for the wellbeing of others, and if these ideals are not upheld, guilt is the result. A Victim-Like or

Guilt-Inducing Parent mode occurs when a parent has a mental illness or a Self-Pity/Victim mode. Hence, the child takes responsibility for the parent's wellbeing and happiness (Jacob et al., 2015) and takes on a parent role by "parenting the parent." Unlike shame, where the other is experienced as threatening, guilt results from the perception that the other is hurt or suffering. Thus guilt is related to responsibility, fault and blame for specific events (Lewis, 1986). Unlike shame which evokes a desire to hide, guilt evokes a desire to take remedial action.

5.2.2. Features of Parent Modes

Existing literature on the Demanding Parent, Punitive Parent and Guilt-Inducing Parent, and Peled's eight dysfunctional parent modes, are used as analytic tools to determine the features that can be found in the parent modes. These descriptions were used to identify 23 features. These features are supported by the parent-child mode dyads, as for every internalised parent, there's a child responding to the parent. Therefore the child mode that is triggered helps identify the features of the related parent mode and vice versa. These features have been summarised in Table 2, according to Peled's degrees of toxicity. However, features with a moderate degree of toxicity can sometimes have a severe degree of toxicity and vice versa. For example, a Shaming Parent can have a moderate degree of toxicity when the shaming is an attempt to coerce the child to meet a parents' wishes or standards of behaviour. Alternatively, shaming can be a feature with a severe degree of toxicity when the shaming is intentionally harmful to the child. Thus the degree of toxicity can be determined when the parent mode is examined phenomenologically.

Table 2

Features of Dysfunctional Parent Modes

Features with a mild degree of toxicity The parent has good intentions but lacks knowledge and skills.	
Feature	**Description**
Spoiling	Parents are excessively generous in the provision of material goods.
Indulgent	Parents are lenient, fail to set appropriate limits or encourage the child to learn to exercise self-control.

Features with a mild degree of toxicity The parent has good intentions but lacks knowledge and skills.	
Feature	**Description**
Aggrandising	The parent praises the child beyond what is justified according to the facts.
Naïve	The parent lacks experience, wisdom or judgement, and is, therefore, unable to guide the child to handle daily life.
Anxious	The nervous parent imparts the message that the world is not safe.
Overprotective	The parent's desire to protect the child from harm is excessive and prevents the child from developing appropriate autonomy.
Intrusive	The parent is overly involved in the child's life and does not allow the child appropriate privacy or encourage development as an independent being.
Features with a moderate degree of toxicity The parent imposes their wishes and standards on the child.	
Feature	**Description**
Demanding	The parent imposes high standards and expectations.
Critical	The parent offers disapproving judgements using words, tone of voice and other non-verbal gestures.
Punitive	The parent inflicts verbal or physical punishment and gives the message, "You are bad and deserve punishment."
Complaining	The parent finds fault and expresses dissatisfaction.

Features with a moderate degree of toxicity The parent imposes their wishes and standards on the child.	
Feature	**Description**
Guilt-Inducing or Victim-Like	The parent seeks sympathy and care from the child by evoking guilt and a sense of responsibility for the parent who cannot take on adult responsibilities.
Dependency Inducing	The parent relies on the child for their emotional wellbeing and keeps the child close to them, giving the message, "You cannot cope on your own without me," thus preventing the child from developing independence and separating from the parent.
Invalidating	The parent invalidates the child's feelings and experiences, telling them that what they feel is incorrect.
Features with an extreme degree of toxicity Parents do not have good intentions and are the most harmful to the child.	
Feature	**Description**
Shaming	The child is perceived as inferior by the parent who belittles and humiliates.
Neglectful	The parent does not assume parental responsibility and give proper attention and care to the child.
Abandoning	The parent leaves and is unavailable to the child, thereby no longer offering physical or emotional support.
Dismissing	The parent does not take the child seriously or treat them as worthy of consideration.
Controlling	The parent influences the child's behaviour to achieve the parent's intended goal.

Features with an extreme degree of toxicity Parents do not have good intentions and are the most harmful to the child.	
Feature	**Description**
Abusive	The parent engages in habitual violence and cruelty, either physical, verbal or sexual.
Unpredictable	The parent's behaviour is inconsistent. Reactions of the parent in similar situations can be vastly different.
Emotionally Labile	Rapid mood shifts contribute to the parent being unpredictable.
Disorganised	The parent has an extreme lack of order and structure.

An examination of the data highlighted three features of dysfunctional parent modes in light of the above analysis. First, several features listed in Table 2 can be blended into one parent mode that may incorporate features of both parents and extended family members and community members. Second, where a particular individual, for example, the mother, flips between modes, that person can be the source of more than one distinct parent mode. A mother who is sometimes angry and scolding and sometimes victim-like and passive can be the source of separate introjects representing each.

Third, Peled's (2016) concept of classifying parent modes according to degrees of toxicity can be applied to all the parent modes. Table 2 separates the parent features described in Peled's parent modes and includes the Shaming Parent described in section 5.2.1. These features are then classified according to the degrees of toxicity provided by Peled. However, the features can be graded on a spectrum according to how toxic they are in that particular individual. For example, a shaming feature has been classified at the most severe level of toxicity, but this feature may be classified as moderately toxic in some individuals. Thus the severity of a parent mode is determined by the level of toxicity of the predominant features in that mode. These features determine whether the parent had good intentions (mild degree of toxicity), imposed their views on the child (moderate degree of toxicity), or if the parent lacked good intentions (extreme degree of toxicity).

5.2.3. Parent Modes and Features of Narcissism

Narcissistic personality traits are commonly observed in the parents of individuals with psychological disorders (Horne, 1998). These personality traits are examined here because they were particularly relevant to the data. Parents with narcissistic traits lack empathy, are self-focused and deny their children's emotional needs. Instead, they use their children as "props" to fulfil their own needs for admiration and recognition (Horne, 1998; Dentale et al., 2015; Miller & Keith Campbell, 2008). For example, "Look at how perfect my children are. I did a good job."

Two types of narcissism are grandiose and fragile narcissism. Narcissism occurs on a spectrum, suggesting that various narcissistic features can be present in an individual and to varying degrees of severity. The severity of the narcissistic traits in an internalised parent influences the degree of toxicity of that internalised parent mode. Fragile and grandiose narcissism both impact the dysfunctional parent modes that are internalised.

The DSM-5 (APA, 2013) lists the features of a narcissistic personality disorder (NPD) as;

- a grandiose sense of self-importance,
- fantasies of unlimited success,
- a belief that one is special and unique,
- a sense of entitlement,
- requiring excessive admiration,
- taking advantage of others to achieve one's ends,
- lacking empathy,
- envious of others and believes others are envious of them.

An individual with NPD is conceited, boastful and arrogant and is likely to have Self-Aggrandiser, Bully and Attack and Scolding Overcontroller coping modes.

Many of the features of dysfunctional parents listed in Table 2 are found in NPD. For example, as the narcissistic parent perceives their child to reflect themselves, the parent will be demanding, critical, punitive and aggrandising. Also, if the narcissistic parent feels shamed by being associated with the child's appearance or behaviour which is perceived as inferior, the parent will be shaming. Narcissistic parents are self-involved and, therefore, neglectful and abandoning. As grandiose narcissists lack empathy, they are dismissive and invalidating. Individuals with NPD believe they are special and, as their children reflect

them, they may be indulgent and spoiling towards them. If the grandiose narcissist has a Bully and Attack coping mode, they will be abusive.

In contrast to this grandiose type of narcissism is the fragile narcissist (Campbell & Waller, 2010), who uses grandiosity (in a Self-Aggrandiser mode) defensively by attempting to control others through criticism. The fragile narcissist may have a Complaining Protector coping mode, as others are seen as abusive, putting their own needs first. There is a self-aggrandising quality to the complaining as the narcissist blames others for their problems and, in the process, disparages them. This alternates with feelings of inadequacy in a Self-Pity/Victim mode as the fragile narcissist acts in a martyred way. The fragile narcissist is likely to be associated with the features of a complaining, victim-like, anxious and controlling parent. There is overlap in the parent features related to narcissism as some features are applicable to both fragile and grandiose narcissists. For example, grandiose and fragile narcissists are self-involved, and so the dismissing and neglectful parent mode features apply to both.

5.2.4. Summary

Twenty-three features have been identified that can occur in various combinations in parent modes. These features were identified from reflecting on the characters of the parent figures in the present case studies and using the existing literature on the Punitive Parent, Demanding Parent and Guilt-Inducing Parent, and Peled's (2016) eight dysfunctional parent modes. The data derived from the case material supported these features described in the literature. The parent modes that occur in an individual can have the characteristics of a parent mode identified in the existing literature or represent a unique blended parent mode. Identifying and naming the parent modes is made easier when the parent-child mode dyad is taken into consideration.

The features described in this section were used, combined with the parent-child mode dyads, to identify and understand the parent modes in each of the participants. As will be illustrated in chapters 6 to 10, the features occurred in combinations that presented complex, blended modes unique to each of the participants.

5.3. The Perfectionist Overcontroller

The Perfectionist Overcontroller, as it is currently conceptualised in the ST literature, was described in section 3.1.2c. This description, combined with my experience analysing the data for this research, formed my conceptualisation of the Perfectionist Overcontroller. In this

section, I will describe how I see the Perfectionist Overcontroller as a complex composite mode. This means that the Perfectionist Overcontroller is composed of a set of different sub-modes that work together coherently in the service of the same project (Edwards, 2020a).

I have identified thirteen features in the Perfectionist Overcontroller. These include;

1. striving for excellence and perfect results,
2. discounting successes and resetting goals once they are met,
3. the marginalisation of other aspects of life,
4. rigidity regarding morals, ethics and values,
5. preoccupation with details, order, lists and schedules,
6. suppression of emotional vulnerability,
7. rigid rules and standards,
8. seeking approval and acceptance from others,
9. the promise of a happier life,
10. concern over mistakes,
11. self-punitiveness,
12. repeated checking behaviours,
13. rumination.

Striving for excellence and perfect results is a central feature of the Perfectionist Overcontroller. This feature of perfectionism is recognised by several authors (Frost et al., 1990; Hill et al., 2004; Szymanski, 2011). Frost's Multidimensional Perfectionism Scale (Frost et al., 1990) noted that one sets personal standards and then evaluates oneself based on their performance. This fits with the Perfectionist Overcontroller as an over-compensatory mode for Failure and Defectiveness/Shame schemas (Simpson, 2012) as one sets high standards, and if one believes they have not met these standards, then the Defectiveness/Shame and Failure schemas are triggered in a Defective Child mode. The desire to do things perfectly and equating imperfections to personal defectiveness is also a feature of Fairburn's (2008) clinical perfectionism.

Related to the striving for excellence is the second feature of the Perfectionist Overcontroller, discounting successes and resetting goals once they are met. As new standards are set, achieving them becomes unobtainable. Hewitt and Flett's Multidimensional Perfectionism Scale (1991) recognises this setting of unrealistic high standards as a feature of self-oriented perfectionism. Discounting successes and resetting goals is a feature of clinical

perfectionism, highlighting the harmful consequence of perfectionism as one is never satisfied with one's achievements and is always aiming for more. From a ST perspective, discounting successes is a schema driven behaviour where one looks for evidence that supports the Defectiveness/Shame and Failure schemas and discounts other evidence.

The Perfectionist Overcontroller has been identified as a coping mode in individuals with obsessive compulsive personality disorder ([OCPD], Bamelis et al., 2010) and obsessive compulsive disorder (OCD). In particular, there is a strong correlation between perfectionism and obsessive-compulsive ruminations (Hill et al., 2004). Early writings in personality analyses of anorexic individuals identified a character configuration described as obsessive-compulsive, with constriction of affect, excessive conventionality, perfectionistic and moralistic tendencies and strong achievement orientation (Swift et al., 1986). This was supported by Rothenberg's (1986) suggestion that AN is a manifestation of OCD. Perfectionism and obsessiveness are core features of EDs that predate the ED's development (Halmi et al., 2005). Godart et al. (2002) highlight the comorbidity of EDs and OCD with between 10-60% in AN and 0-40% in BN. Similarly, the rate of OCPD in ED clients ranges from 3-60% (Herzog et al., 1992; Wonderlich et al., 1990). There is overlap with elements of perfectionism and obsessive-compulsive behaviours and between ED and obsessive-compulsive behaviours. Thus the Perfectionist Overcontroller mode has features of obsessive-compulsive behaviour that will be referred to here.

A feature of OCPD found in the Perfectionist Overcontroller is excessive devotion to work and productivity to the exclusion of leisure activities and friendship (APA, 2013). This third feature of the Perfectionist Overcontroller, the marginalisation of other aspects of life, is also a feature of clinical perfectionism (Fairburn, 2008). In the Perfectionist Overcontroller mode, one strives for complete self-control in areas such as general appearance, work, studies or cleaning, to the detriment of other aspects of life that become marginalised. This investment in control alienates the individual from their core needs so that these needs are not taken into account or met and shuts down the Vulnerable Child (Edwards, 2016).

Another feature of OCPD that is found in the Perfectionist Overcontroller is rigidity regarding morals, ethics and values. This fourth feature of the Perfectionist Overcontroller is included in Szymanski's (2011) six dimensions of perfectionism. Rigidity regarding morals, ethics and values includes the perfectionistic dimension of "just right" and absolutes, where one requires complete comprehensive knowledge and absolute conviction that a decision is the right one.

The fifth feature of the Perfectionist Overcontroller, which is also a feature of OCPD (APA, 2013), is excessive organisation. Excessive organisation is a frequently recognised aspect of perfectionism (Frost et al., 1990; Hewitt & Flett, 1991; Antony & Swinson, 2009; Szymanski, 2011; Simpson, 2012) which consists of a tendency to be neat and orderly with a preoccupation with details, order, list and schedules. Hill et al. (2004) describe a similar feature in their dimensions of perfectionism which includes forming deliberate plans before making decisions. The Perfectionist Overcontroller invests significant energy in planning to ensure that life is predictable and controllable (Simpson, 2012). This sense of control shuts down emotional vulnerability, the sixth feature of the Perfectionist Overcontroller.

The rules and standards that form part of the organisation element of the Perfectionist Overcontroller might be adopted from the individual's parents. These rules generally form part of the Demanding Parent mode, which occurs in a dyad with a Defective or Shamed Child, against which the Perfectionist Overcontroller protects. Incorporating rules and standards from a parent as part of this mode, the seventh feature of the Perfectionist Overcontroller, fits with elements from Frost et al.'s (1990) multidimensional scale of parental expectation, namely the belief that parents set very high standards. Although part of a Demanding Parent mode, when the individual chooses to adopt these rules as part of the coping mode, the Perfectionist Overcontroller has recruited the Demanding Parent as part of the mode. Therefore it has become a part of the self to meet the parent's standards to gain their approval (Edwards, 2019).

Seeking approval and acceptance from others is the eighth feature of this mode. This feature fits with Hewitt and Flett's (1991) socially prescribed perfectionism, where one needs to attain high standards set by others to gain approval. Achieving a sense of acceptance and approval from others shuts down the Lonely Child mode and creates the promise of a happier life, the ninth feature of the Perfectionist Overcontroller.

The tenth feature of the Perfectionist Overcontroller is concern over mistakes. This feature includes hypervigilance for signs that one is inferior or that events are not unfolding as planned, fear of failure and repeated checking of one's performance. Concern over mistakes is an aspect of perfectionism recognised by Frost et al. (1990), Hewitt and Flett (1991), Hill et al. (2004), Antony and Swinson (2009) and Szymanski (2011). This feature of the Perfectionist Overcontroller is also part of Fairburn's (2008) analysis of clinical perfectionism, namely fear of failing to meet personal standards. If one has a rule that they cannot make a mistake, they have set that as a standard.

The eleventh feature of the Perfectionist Overcontroller is self-punitiveness which motivates the individual not to make further mistakes. When one is self-punitive, one reacts negatively to errors because they are perceived as failures that will result in a loss of respect. Self-punitiveness is a feature of Hewitt and Flett's (1991) perfectionism, where one scrutinises one's flaws, and Burns and Beck's (1978) self-evaluation feature of perfectionism. Burns and Beck (1978) described how perfectionists measure self-worth in terms of productivity and accomplishment, setting unobtainable goals of achievement. As specific standards are met, new standards are imposed, which increase the chance of failure. When failure occurs, self-criticism leads to lowered self-esteem, as one's self-worth is determined by success and performance. The setting of unachievable goals leads to failure and self-criticism. Frost et al. (1990) included parental criticism as an element of perfectionism, where parents are perceived as overly critical. In ST, this parental criticism would be a Punitive Parent. However, this critical voice can be recruited by the Perfectionist Overcontroller. The critical and punitive messages that one experienced from a parent are now internalised as part of the coping mode to motivate the individual. Identifying the recruited Punitive Parent in the Perfectionist Overcontroller is achieved through experiential work. When the Punitive Parent's critical messages are recruited into the coping mode, the parent mode cannot be sent away through experiential work.

The self-punitive messages in the Perfectionist Overcontroller can come from the recruited Punitive Parent or a Flagellating Overcontroller sub-mode. As described in section 3.1.2c, a Flagellating Overcontroller harms, deprives and criticises oneself to achieve self-improvement. As a sub-mode of the Perfectionist Overcontroller, the Flagellating Overcontroller provides the motivational activities that encourage the individual to maintain the rules and standards of the Perfectionist Overcontroller and punishes the individual for breaking them (Edwards, 2020b). The behaviours in the Flagellating Overcontroller sub-mode are either verbal, for example, critical messages directed at the self, or physical, for example, withholding sleep until a task has been completed according to one's standards. The critical messages and punishing behaviours that are part of the Flagellating Overcontroller come from an Angry Child who, fearing negative consequences, cannot express their anger towards the parent. So the anger is turned inward (Simpson, 2020a). Like the critical messages from the recruited Punitive Parent, identifying the critical messages as part of the Flagellating Overcontroller sub-mode is achieved through experiential work.

Another mechanism for avoiding making mistakes is repeated checking behaviours, a feature of clinical perfectionism (Fairburn, 2008) and the twelfth feature of the Perfectionist Overcontroller. Like obsessional checking in OCPD, this behaviour can lead to repeating work and falling behind. Performance checking can be behavioural; for example, checking lists, or cognitive; for example, ruminating.

Rumination, the thirteenth feature of the Perfectionist Overcontroller, refers to repetitive negative thoughts about doing something perfectly. This is a feature of clinical perfectionism (Fairburn, 2008) and an element of perfectionism acknowledged by Hill et al. (2004). Frost et al. (1990) referred to this feature as doubts about actions. In ST, rumination (excessive thinking about past events) can be a separate coping mode, or when it is combined with worrying (focusing on future events), it forms part of the Over-Analyser mode. It is viewed as a sub-mode of the Perfectionist Overcontroller when the content of the rumination is related to perfectionistic coping. Rumination, as a sub-mode in the Perfectionist Overcontroller, has been recognised by Brockman and Stavropoulos (2020). They state that rumination "may be viewed as a form of maladaptive coping, either as a part of the repertoire of a broader coping mode (e.g. Perfectionist Overcontroller, Detached Protector) or as a coping mode in and of itself (e.g. Over-Analyser mode)" (p.72).

The Perfectionist Overcontroller has been described here as a complex composite mode with thirteen features. Some of the features occur in sub-modes. These sub-modes can be standalone modes in ST, but here they form part of the broader Perfectionist Overcontroller mode because they work together to achieve the goals of the Perfectionist Overcontroller. The central feature of the Perfectionist Overcontroller is setting high standards and striving for excellence. This is achieved through the core features of discounting successes and resetting goals, excessive organisation and concern over mistakes. By achieving high standards, one gains a sense of control which shuts down emotional vulnerability and obtains approval and acceptance, which the individual believes will lead to a happier life.

Excessive organisation can be achieved by extreme attention to details, orders and lists, rigidity and absolutes. The rules and standards that come from the recruited Demanding Parent are a feature that contributes to the excessive organisation. The core feature, concern over mistakes, leads to hypervigilance for errors. Mistakes are avoided through the features of the Perfectionist Overcontroller, including repeated checking behaviours and the Rumination sub-mode with repetitive negative thoughts. The recruited Punitive Parent and

Flagellating Overcontroller use self-criticism. In the Flagellating Overcontroller, punishing behaviours are a motivational tool to ensure the individual avoids mistakes and maintains the standards of the Perfectionist Overcontroller. Trying to achieve the high standards set by the Perfectionist Overcontroller results in the final core feature, the marginalisation of other aspects of life, as one's narrow focus on the achievement of perfection draws time and attention away from other aspects of life.

Although thirteen features were identified, not all features are present in an individual's Perfectionist Overcontroller. This is because of the idiosyncratic nature of modes; that individuals combine different elements in a distinctive way. The features of the mode relevant to each participant in this research will be described in chapters 6 to 10.

5.4. The Eating Disordered Overcontroller

Fairburn et al. (2003) described perfectionism in people with EDs as "the overvaluation of eating, shape and weight, and their control" (p.516). In ST, these aspects form part of the Eating Disordered Overcontroller mode, which is understood as a specialised form of Perfectionist Overcontroller. It shares elements of the Perfectionist Overcontroller but with a focus on eating, weight and shape. Like the Perfectionist Overcontroller, the Eating Disordered Overcontroller is a complex composite mode with features that work together towards a common goal.

The idea of sub-modes working together that maintain ED behaviour is supported by Park et al.'s (2011) view of AN from an Interacting Cognitive Subsystems (ICS) framework. According to the ICS framework, information flows between two cognitive subsystems that code information differently. The propositional subsystem, known as the "doing mode", stores conceptual, intellectualised meanings such as verbal messages and mental images. In contrast, the implicational subsystem, known as the "mindless bodily emoting mode", stores abstract, emotional meanings obtained from the senses. These partially independent subsystems that focus on intellectual and emotional aspects, respectively, work together with the common goal of maintaining the ED behaviour.

Edwards' (2017b) Anorexic Overcontroller mode relates to Park et al.'s (2011) model of AN as both describe a complex system with several components working together. Park et al. (2011) identified two subsystems that work together, whereas Edwards' (2017b) Anorexic Overcontroller includes intellectual and emotional aspects in one mode. The features of Edwards (2017b) Anorexic Overcontroller include suppression of emotional vulnerability,

self-punitiveness, the generation of images that induce fear, shame and self-disgust, rules about goal weight and what one is permitted to eat, the impulse to restrict eating and lose weight, a sense of feeling strong and in control and the promise of a happier life. Some of these features are recognised in the Eating Disordered Overcontroller in the SMI-ED (Simpson et al., 2018). I use the term Eating Disordered Overcontroller to describe this mode because although the Eating Disordered Overcontroller is more influential in individuals with AN (Tierney & Fox, 2010), it also occurs in individuals with bulimic presentations.

I identified fifteen features in the Eating Disordered Overcontroller, which include;

1. rules about goal weight and what one is permitted to eat,
2. the decision to restrict eating and to lose weight,
3. discounting successes and resetting goals once they are met,
4. self-punitiveness and self-loathing,
5. focus on the body and eating patterns to generate a sense of competence, power and control,
6. suppression of emotional vulnerability,
7. the marginalisation of other aspects of life,
8. fear of losing control and hypervigilance to maintaining rules and routines,
9. checking behaviours,
10. rumination,
11. the generation of images that induce fear, shame and self-disgust,
12. looking ill to gain attention,
13. seeking approval and acceptance from others,
14. a feeling of being special,
15. the promise of a happier life.

The first feature of the Eating Disordered Overcontroller, also a feature in the Anorexic Overcontroller (Edwards, 2017b), is rules about goal weight and what one is permitted to eat. This feature, described in the Perfectionist Overcontroller as rigid rules and standards, included rules recruited from the Demanding Parent. In the Eating Disordered Overcontroller, the individual may choose to incorporate food rules and beliefs about goal weight from the Demanding Parent mode so that the Demanding Parent is recruited by the Eating Disordered Overcontroller. However, these rules are not always from a recruited Demanding Parent, as the individual may design their own rules or incorporate rules from other sources, such as media. Preoccupation with eating plans is a feature of the “doing mode” in the ICS

framework (Park et al., 2011), which dominates AN's restrictive phases. In the short term, one has a sense of achievement and pride when rules and ideals for thinness are fulfilled as the person tries to appear "perfect" (the first feature of the Perfectionist Overcontroller) to compensate for underlying shame, powerlessness and guilt in the Vulnerable Child. This sense of achievement and pride when one's weight and shape is controlled is a feature of the Eating Disordered Overcontroller recognised by Simpson et al. (2018).

Related to rules about goal weight and what one is permitted to eat is the second feature of the Eating Disordered Overcontroller; the decision to restrict eating and to lose weight. Also, a feature of the Anorexic Overcontroller (Edwards, 2017b) and the "doing AN mode" (Park et al., 2011), restrictive eating and weight loss is achieved through calorie counting and exercise schedules. Related to this feature are two features described in the Perfectionist Overcontroller; firstly, discounting successes and resetting goals. This feature is evident in the Eating Disordered Overcontroller as the individual strives to achieve a lower weight, restrict further, or exercise more. Secondly, calorie counting, eating plans and exercise schedules fit with the Perfectionist Overcontroller feature of preoccupation with details, lists and schedules.

At first, the Eating Disordered Overcontroller appears encouraging in efforts to lose weight and change body shape, but as the ED progresses, the Eating Disordered Overcontroller becomes critical, a feature observed by Serpell et al. (1999) and Edwards (2017b) in the Anorexic Overcontroller. Simpson et al. (2018) also recognise a punitive aspect to the Eating Disordered Overcontroller as eating is perceived as a sign of weakness. Thus, self-punitiveness and self-loathing, a feature of the Perfectionist Overcontroller, is the fourth feature of the Eating Disordered Overcontroller. As with the Perfectionist Overcontroller, I consider the self-punitiveness and self-loathing as part of the Flagellating Overcontroller and Punitive Parent sub-modes. When the individual broke the food rules that were part of the Eating Disordered Overcontroller, the Flagellating Overcontroller sub-mode was activated to assist the Eating Disordered Overcontroller to achieve its goal, motivating the individual to follow the rules and maintain the standards of eating and weight. The Eating Disordered Overcontroller contained the rules and standards, whilst the Flagellating Overcontroller sub-mode motivated the individual to maintain these rules and standards and punished the individual for breaking them (Edwards, 2020b). The behaviours in the Flagellating Overcontroller sub-mode were either verbal, for example, calling oneself a "fat pig" and "disgusting", or physical, for example withholding food from oneself as a form of

punishment. When the critical messages originated from a parent or significant adult, they formed part of the recruited Punitive Parent. For example, an internalised critical message from a parent about one's body was incorporated into the recruited Punitive Parent, where it motivated the individual to follow the rules of the Eating Disordered Overcontroller.

A fifth feature of the Eating Disordered Overcontroller is the focus on the body and eating patterns to generate a sense of competence, power and control that overcompensates for feelings of vulnerability and distress in the Vulnerable Child (Simpson et al., 2018). This feeling in control is a feature of the Anorexic Overcontroller (Edwards, 2017b) and the Eating Disordered Overcontroller in the SMI-ED (Simpson et al., 2018). The eating plans, calorie counting and exercise schedules that are part of the first two features identified above provide a sense of structure, purpose (Serpell et al., 1999; Vitousek & Hollon, 1990) and control. By controlling the body, one attains a sense of purity and accomplishment by overcoming the body's basic needs (Simpson et al., 2018).

The disordered eating behaviours disconnect one from feelings held in the body and shut out vulnerability (Simpson et al., 2018). The suppression of emotional vulnerability, recognised as a feature by Edwards (2017b) and Simpson et al. (2018), and a feature of the Perfectionist Overcontroller, is the sixth feature of the Eating Disordered Overcontroller. The Eating Disordered Overcontroller's sense of control when rules are followed shuts down anxiety. Following self-imposed rules regarding eating and exercise alienates the individual from their core needs so that these needs are not taken into account or met (Edwards, 2016), and so the Vulnerable Child is suppressed.

The Eating Disordered Overcontroller takes priority over relationships, a feature recognised by Serpell et al. (1999), which leads to the marginalisation of other aspects of life. This marginalisation of other aspects of life, the seventh feature of the Eating Disordered Overcontroller, reinforces feelings of loneliness and emotional vulnerability. For example, if one chooses not to socialise because it would involve consuming food or alcohol, which are contrary to the strict rules of the Eating Disordered Overcontroller, then one remains socially isolated.

Contrary to the Eating Disordered Overcontroller's sense of control is a fear of losing control. This fear of losing control is the eighth feature of the Eating Disordered Overcontroller, which leads to hypervigilance regarding the following of rules and routines. This feature is described in the Perfectionist Overcontroller as concern over mistakes. In the

Perfectionist Overcontroller, hypervigilance led to checking behaviours. In the Eating Disordered Overcontroller, the checking behaviours, the ninth feature of this mode, focused on the body. For example, checking behaviours include weighing, checking the fit of clothes, grabbing the stomach and thighs, and measuring the gap between fingers and thighs. These checking behaviours ensure that one is safe from criticism, a feature of Simpson et al.'s (2018) Eating Disordered Overcontroller. Body checking behaviours are not explicitly a feature in the Anorexic Overcontroller (Edwards, 2017b) or the SMI-ED (Simpson et al., 2018). Park et al. (2011) considered that checking behaviour was not a common feature of AN.

In the Perfectionist Overcontroller, another form of checking behaviour included rumination. In the Eating Disordered Overcontroller, rumination, the tenth feature of this mode, can take the form of repetitive negative thoughts about what one has consumed, how many calories remain after a purge, or how much one has exercised. As described in section 5.3, Rumination can be a standalone mode in ST, but when it is recruited as a sub-mode by the Eating Disordered Overcontroller, it serves the purpose of the Eating Disordered Overcontroller.

In the Eating Disordered Overcontroller, one is motivated to follow the rules and routines by generating images that induce fear, shame and self-disgust, the eleventh feature of this mode. This feature, absent in the SMI-ED (Simpson et al., 2018), was recognised in the Anorexic Overcontroller (Edwards, 2017b). The ICS framework described this as the "mindless bodily emoting mode" in which the individual experiences overwhelming emotional and bodily sensations, which lead to a sense of being fat, bloated and out of control. Visual images can include picturing oneself as overweight, and somatic clues include feeling "big" and perceiving one's clothes as tight.

The twelfth feature of the Eating Disordered Overcontroller, which was not a feature of the Perfectionist Overcontroller, was getting thin to look ill. This feature is not recognised in the Anorexic Overcontroller (Edwards, 2017b) or Simpson et al.'s (2018) Eating Disordered Overcontroller. Simpson (2020a) describes this feature as part of a Helpless Surrenderer mode where the restriction is used to communicate frailty and seek attention. Thus the Helpless Surrenderer can be seen as a sub-mode of the Eating Disordered Overcontroller that is particularly evident in individuals with AN where an "ill" appearance enables them to access attention and care, to which they otherwise feel unentitled. As a sub-mode of the Eating Disordered Overcontroller, the Helpless Surrenderer's surrendering to ED

behaviours such as calorie counting and seeing themselves as helpless to change their ED behaviours allows them to maintain the sick role and so try to obtain the nurturing and care that remain unmet needs from childhood.

The thirteenth feature of the Eating Disordered Overcontroller, which was also a feature of the Perfectionist Overcontroller, was seeking approval from others. This feature is evident in participants with bulimic and binge-eating behaviours who make healthy food choices in the presence of others to obtain a sense of approval and acceptance and avoid feelings of shame (in the Shamed Child) as they expect to be judged for their food choices. Following food rules and exercise regimes in the Eating Disordered Overcontroller are also to gain acceptance as individuals believe that weight loss will result in approval and acceptance. This feature is related to the Approval-Seeking/Recognition-Seeking schema as ones' self-esteem is dependent on the reactions of others.

An uncommon feature of the Eating Disordered Overcontroller is the feeling of being special. This, the fourteenth feature of the Eating Disordered Overcontroller, was recognised by Park et al. (2011) in the "doing mode" of AN. In the current data, when this feature was present, the ED formed a large part of the individual's identity, and so treatment was perceived as a threat to the self (Wilson et al., 2007).

The fifteenth feature of the Eating Disordered Overcontroller, which was also a feature of Edwards' (2017b) Anorexic Overcontroller, was the promise of a happier life. In the Perfectionist Overcontroller, the promise of a happier life was related to a sense of acceptance by others as well as a sense of control. In the Eating Disordered Overcontroller, this feature is also related to a belief that one will feel happy when one obtains a specific weight and shape.

Fifteen features have been identified that form part of an Eating Disordered Overcontroller mode, including the Flagellating Overcontroller, the Helpless Surrenderer, Rumination and recruited Punitive Parent and Demanding Parent as sub-modes. Although not all features are present in any one individual's Eating Disordered Overcontroller, the features that are present interact to focus on weight, shape and eating and to shut down distressing feelings in the Vulnerable Child. Like the Perfectionist Overcontroller, the Eating Disordered Overcontroller is viewed as a complex composite mode, but with a specific focus on food rules and mass.

The Eating Disordered Overcontroller is more prominent in individuals with AN. Individuals who engage in bingeing behaviours tend to have a prominent Detached Self-Soother, which includes many of their ED behaviours. However, they may flip between the Eating Disordered Overcontroller and the Detached Self-Soother. The Detached Self-Soother is described in the following section.

5.5. The Detached Self-Soother

The Detached Self-Soother is an avoidant coping mode that uses behaviours in an addictive or compulsive way (Bernstein & van den Broek, 2009) to shut off the emotions (Lobbestael et al., 2007; Arntz & Jacob, 2013) and triggered schemas in a Vulnerable Child mode (Young et al., 2003). The behaviours associated with a Detached Self-Soother occur in an impulsive manner (Simpson, 2020a).

The Detached Self-Soother is comprised of recognisably distinct experiential states that have different developmental roots and are addressed differently in therapy. Most of the behaviours are time-consuming, and some are physically harmful, but all are maladaptive as they prevent the needs from being met in the child modes. Detached Self-Soother behaviours include excessive time spent engaging in work (occupational and domestic tasks), binge eating, inducing vomiting, other neutralising behaviours such as the use of diuretics, laxative abuse and excessive exercise, watching television, playing computer games, daydreaming, smoking, gambling, use of drugs, both illegal and "self-medicating" with prescription medication, and self-injurious behaviours such as skin cutting.

The affect phobia model (Fox & Egan, 2017), a combination of psychodynamic and learning theory, is congruent with aspects of ST. Both describe how children raised in invalidating environments develop negative attitudes towards emotion and expression of emotion. In ST terms, invalidating environments lead to the development of Emotional Deprivation and Emotional Inhibition schemas in a Vulnerable Child mode. The affect phobia model describes how individuals then engage in compulsive behaviours to regulate distress. In ST, these compulsive behaviours are conceptualised as Detached Self-Soother coping that shuts off the negative affect.

Binge eating is a self-soothing behaviour particularly relevant to this study. Binge eating refers to the abnormal response of eating, particularly energy-dense foods (van Strien et al., 2013), in greater quantities than are physiologically needed (Fox & Egan, 2017). Binge eating is also referred to as "emotional eating", inferring that this is a coping mode for

negative emotional states (van Strien & Ouwens, 2007). Research shows that individuals experience increased stress, anxiety and depression before a binge. This negative affect is reduced during a binge (Abraham & Beaumont, 1982; Hsu, 1990; Lingswiler et al., 1989), thus supporting the view of binge eating as a self-soothing behaviour.

The concept of binge eating as a coping mode to shut down difficult emotions is recognised in the psychosomatic theory of obesity (Kaplan & Kaplan, 1957), the affect phobia model (Fox & Egan, 2017), the escape theory of bingeing (Heatherton & Baumeister, 1991) and CBT-E (Fairburn et al., 2003). In these approaches, individuals narrow their focus to a stimulus such as food to escape negative affect.

In the present research, binge eating as a self-soother was associated with a permission-giving belief. The individual gave themselves permission to binge and focus on healthy eating later. Although not explicit in the existing literature on the Detached Self-Soother, a permission-giving belief is referred to as rationalisation in psychoanalytic theory. As an ego defence mechanism, it helps the individual cope with anxiety. Rationalisation is an adaptive behaviour that becomes pathological when it enables the individual to deny or distort reality. For example, by manufacturing reasons to justify specific behaviours (Corey, 2001). Beck's cognitive theory also recognised permission-giving cognitions in clients who abused substances (Beck, 2010). The permission-giving belief can apply to many self-soothing behaviours where one permits oneself to engage in the self-soothing behaviour and focus on healthier behaviours later. Examples of permission-giving beliefs include, "I deserve to reward myself" and, "Others are doing this, so it is okay if I do it."

Negative feelings such as guilt and disgust can occur during or after a binge. Inducing vomiting and other neutralising behaviours (Beebe, 1994; Simpson, 2012), such as excessive exercise and consuming diuretics or laxatives, "undo the act of eating" (Mizes & Arbitell, 1991) and reduce the negative affect. These neutralising behaviours that undo the effects of the binge are also self-soothing because they provide a sense of relief. The neutralising behaviours bear similarities to compulsions in OCD, where the primary goal of compulsions is to prevent guilt. In the Detached Self-Soother, inducing vomiting and other neutralising behaviours are emotional regulation strategies that avoid guilt and disgust, but at the same time, they maintain the ED (Tenore et al., 2018).

The self-soothing behaviours where one excessively engages in work for one's occupation or keeps busy with domestic tasks are perceived as positive, constructive pursuits.

Therefore, these behaviours do not result in feelings of guilt. However, as self-soothing behaviours, they are maladaptive because they prevent the needs being met in the child mode, maintaining the EMS.

Self-injurious behaviours are "behaviours involving the deliberate infliction of direct physical harm to one's own body without any intent to die as a consequence of the behaviour" (Simeon & Favazza, 2001, p.1). The function of the self-injurious behaviour determines the coping mode of which it forms a part. For example, self-injurious behaviour can be self-punitive and form part of the Flagellating Overcontroller. However, when self-injurious behaviour is self-soothing, it forms part of Detached Self-Soother coping. Like all self-soothing behaviours, self-injurious behaviour provides "rapid but short-lived relief from various intolerable states" (Simeon & Favazza, 2001, p.15). Skin cutting is one of the most common forms of self-injurious behaviour. Leibenluft et al. (1987) describe the stages of self-injurious behaviour where a precipitating event, which involves real or perceived loss, rejection or abandonment, leads to an escalation of intolerable affect. In ST, one would understand this as an event that triggers Emotional Deprivation and Abandonment/Instability schemas and associated feelings in a Vulnerable Child mode. The individual then engages in self-injurious behaviour (flips into Detached Self-Soother mode), providing short-term affective relief by shutting down these emotions.

When individuals are in a Detached Self-Soother mode, they may lack conscious awareness of their behaviour. The escape theory of bingeing (Heatherton and Baumeister, 1991) describes how one's awareness can be shifted to such low levels in response to negative affect that one's experience is reduced to sensation and muscle movement. This low level of awareness results in a lack of rational thought, which allows an individual to binge. This view is supported by La Mela et al. (2010). They note that narrowing one's focus to food results in a temporary loss of inhibition as one is stripped of patterns of reasoning associated with possible actions. Without reason, one can engage in previously suppressed self-soothing behaviours to escape from one's feelings. Although Heatherton and Baumeister and La Mela et al. refer to binge eating behaviour, all behaviours in the Detached Self-Soother mode result in a narrowing of one's focus as one disconnects from modes that occurred before the self-soothing, including the Vulnerable Child.

Various self-soothing behaviours have been described here, which all function to shut down distressing emotions in the Vulnerable Child. An individual's Detached Self-Soother mode can include more than one self-soothing behaviour. The choice of behaviour that one

engages in may be influenced by ones' early experiences, availability of the behaviour, the emotions the behaviour is shutting down, and the duration of the behaviour.

It is not always developmentally clear why an individual engages in particular self-soothing behaviours. However, in some cases, one can identify a behaviour that was modelled for the individual by an adult or peers. For example, if one observes a parent using alcohol or food to cope with difficult emotions, they may use the same coping behaviour. In the data, self-injurious behaviour was learnt from peers.

Some self-soothing behaviours occur to shut down the emotions evoked by other self-soothing behaviours. For example, one may binge to soothe loneliness or anxiety and then induce vomiting or engage in other neutralising behaviours to shut down the guilt or disgust that the bingeing evokes.

As mentioned, the behaviour one engages in may be influenced by availability. For example, smoking may be easier to engage in in the workplace than binge eating. Another factor that may influence the choice of behaviour is the duration of the behaviour. For example, self-injurious behaviour is rapidly effective, but the results can be short-lived, whereas binge eating takes longer and can have a longer-lasting effect. Alcohol takes even longer to feel the effects, but the effects can last throughout the day (Waller et al., 2007).

The choice of behaviour one engages in as part of the Detached Self-Soother mode can only be understood when it is examined phenomenologically, the developmental history is made clear, and the behaviour is understood as part of a mode sequence. This information and the behaviour itself all influence how the behaviour is treated in therapy. This points to the idiosyncratic nature of the mode, that multiple individuals can present with Detached Self-Soother coping, but the flavour of the mode, and therefore it's treatment, differ.

5.6. Conclusion

This chapter analysed interpretive themes in the modes most common in the participants. In the chapters that follow, I describe the participants and their case conceptualisations influenced by these interpretive themes.

Chapter 6. The Case Study of Jackie

6.1. Psychosocial History

Jackie was the second born of three children. Her father was an extrovert and unaffectionate man who travelled for business and, when home, spent more time with her older brother. Jackie's Vulnerable Child desperately wanted her father's attention, but instead, she felt unloved by him and had little memory of time spent with him. Despite this, she maintained an idealised image of her father as loving and involved (Pollyanna Overcompensator mode).

Jackie's parents married because her mother fell pregnant with her brother. The pregnancy before marriage caused her mother shame and, believing she was not good enough for her husband, insecurity that resulted in subjugation. Jackie's stay-at-home mother had features of fragile narcissism as she was self-centred, chronically depressed and engaged in the victim role. This combination rendered her unable to provide nurturance or affection and contributed to her exasperation with the children. Jackie's unmet needs for love and nurturance by her emotionally unavailable parents contributed to her Vulnerable Child mode (Emotional Deprivation and Abandonment/Instability schemas). Her mother was unable to tune into her needs. For example, when Jackie asked for a hug, her mother accused her of being "that demanding child again" and "that there was something wrong with her." These internalised messages contributed to her Shamed Child (Defectiveness/Shame schema) and Jackie's coping, where she learned not to communicate her needs (Compliant Surrenderer coping). Her mother was critical and shaming in other ways as well. For example, she told Jackie that she needed to wear dresses and look more like a girl, again implying that there was something wrong with her. These comments reinforced her Shamed Child and belief that "I can't be good enough for anybody" (S3) and her critical view of herself in which, "I'm trying to think of anything I like about myself, and there's not one. I can give you all the negatives. I wouldn't want to hang out with me" (S7).

When her mother told her how to dress and commented that she was not good at schoolwork, Jackie experienced herself as incompetent and unable to make decisions for herself, contributing to a Dependent Child (Dependence/Incompetence schema). These critical comments and those she overheard her mother make to friends about her schoolwork contributed to a Failure schema where she saw herself as failing relative to her peers, even though there is no evidence to support this. Jackie coped with the feelings of defectiveness and fear of failure by becoming hyper-focused on doing things perfectly (the first feature of

the Perfectionist Overcontroller). Her mother's critical comments also contributed to a critical introject (Punitiveness schema) where she "beat herself up way too much", reinforced when her mother compared her to her relaxed, easy-going brother.

From the age of 9, a chubby Jackie was teased at school about her weight and called "fat", reinforcing her Shamed Child and leading her to believe that she was fat. Jackie's mother and the school authorities were unable to stop the teasing, and so Jackie did not experience a sense of security and protection. Jackie had one close friend in primary school who, like Jackie, was excluded by the other girls for being too "childlike", playing with Barbies while the other girls focused on boys. Lacking a sense of belonging and social acceptance contributed to her Lonely Child mode (Social Isolation/Alienation schema).

When Jackie was 11 years old, her father suffered an asthma attack and died. Jackie felt abandoned by her father, reinforcing her Abandoned Child (Abandonment/Instability schema). She also experienced irrational guilt for not preventing his death.

Jackie's mother took over the running of her father's company and, a month later, gave birth to her sister. Anxious that her mother would die, Jackie engaged in magical thinking that if she helped her mother and made her happy, she would live. This led to Compliant Surrenderer coping, including Jackie caring for her sister. Her mother became dependant on alcohol and befriended a woman with whom she spent many hours drinking and getting drunk, thus neglecting the children. The family no longer ate meals together, and Jackie's experience was that the children were a chore as her mother appeared relieved when they went to bed. An example of her mother's neglectful and abandoning behaviour, fuelled by her narcissistic self-involvement, was that in the first year after their father's death, she vacationed with her friend for a month while the children stayed with extended family.

In high school, Jackie's Lonely Child was desperate for a sense of belonging. So she joined a rebellious crowd, where, to gain acceptance, she flipped into Compliant Surrenderer coping and was influenced into smoking and drinking. From the age of 14, Jackie became promiscuous, believing this was the only way to keep a boys' attention. Jackie's friends were more popular with boys than her, which she attributed to her being overweight (BMI 25.6). Jackie recalled that a boy told her to "stop throwing her weight around", which, because of her Defectiveness/Shame schema, Jackie interpreted as him telling her she was fat, triggering her Shamed Child. This reinforced her belief of herself as fat, and so she began dieting and

restricting food (evidence of an Eating Disordered Overcontroller) and, at the age of 15, developed AN (BMI 17.5).

After matric, Jackie travelled and worked overseas for approximately 3 years. When she returned to South Africa at the age of 21, she held varied employment, including as a personal assistant, book-keeper and sales representative. In her thirties, she opened her own small business.

Jackie had one serious relationship from the age of 21 to 23. The relationship lacked a meaningful connection as it was based on sex, alcohol and partying. Jackie, who lived with her boyfriend, feared he would leave her, triggering her Abandoned Child, so she coped through Compliant Surrenderer. At the age of 23, Jackie was hospitalised for AN. During this time, her boyfriend cheated on her and then ended the relationship.

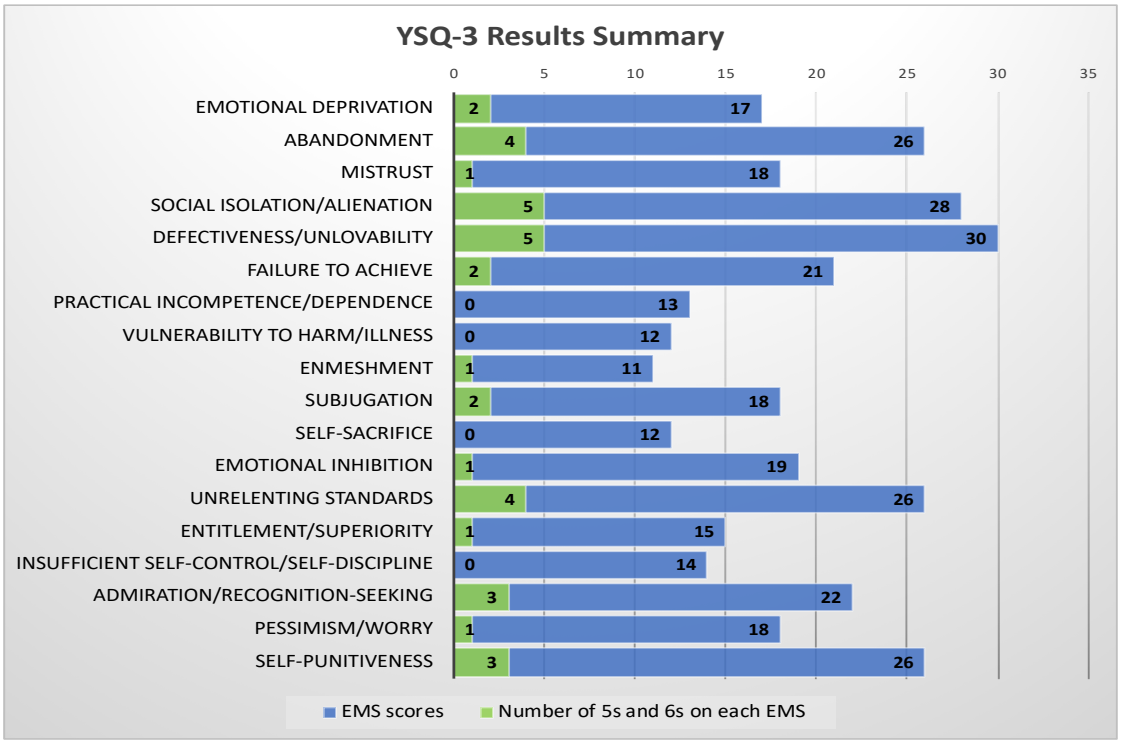
After the break-up, Jackie moved in with her mother and continued to live with her for most of her adult life because she did not want to be alone, and she felt responsible for her mother's wellbeing. This sense of responsibility and enmeshment with her mother was reinforced following a traumatic experience when Jackie was 33, and she witnessed her intoxicated mother almost choke to death while eating. This incident created fear that if she were not present, her mother might choke and die. Jackie coped with the fear and sense of responsibility through her Compliant Surrenderer mode.

6.2. Results on the YSQ and SMI

Figure 1 shows the results of the YSQ, and Figure 2 shows the results of the SMI conducted after the fifth session. In developing the case conceptualisation, the scores and qualitative information from responses to specific items were used in conjunction with the information obtained in the clinical interviews and observations of her behaviour.

Figure 1

Jackie's Results on the YSQ



Jackie had significant scores for 12 of the 18 schemas, including Emotional Deprivation, Abandonment/Instability, Mistrust/Abuse, Social Isolation/Alienation, Defectiveness/Shame, Failure, Subjugation, Emotional Inhibition, Unrelenting Standards/Hypercriticalness, Approval-Seeking/Recognition-Seeking, Negativity/Pessimism (referred to as Pessimism/Worry on the table) and Punitiveness (see Figure 1). These schemas fit with the history provided, except for the Mistrust/Abuse and Negativity/Pessimism schemas. Jackie had one score of 5 (*mostly true of me*) on the Mistrust/Abuse schema (see Figure 1), but further exploration revealed that she had misinterpreted the question. Jackie's score of 6 (*describes me perfectly*) for one of the Negativity/Pessimism items (see Figure 1), "I worry a wrong decision could lead to disaster", related more to her Failure schema as she worried that a wrong decision would result in failure. The number of schemas for which Jackie had severe scores (5 or 6 in Figure 1) suggests that she was in a vulnerable state when completing the questionnaire. However, this may have been a pseudo-vulnerability. Jackie had a Helpless Surrenderer mode in which she presented herself as a helpless victim. The Helpless Surrenderer mode lacked authentic

vulnerability, but in this mode, Jackie experienced herself as suffering. Hence, if Jackie was in a Helpless Surrenderer mode when she completed the YSQ, she may have over-reported her scores.

Figure 2

Jackie's Results on the SMI Compared to Normal Controls

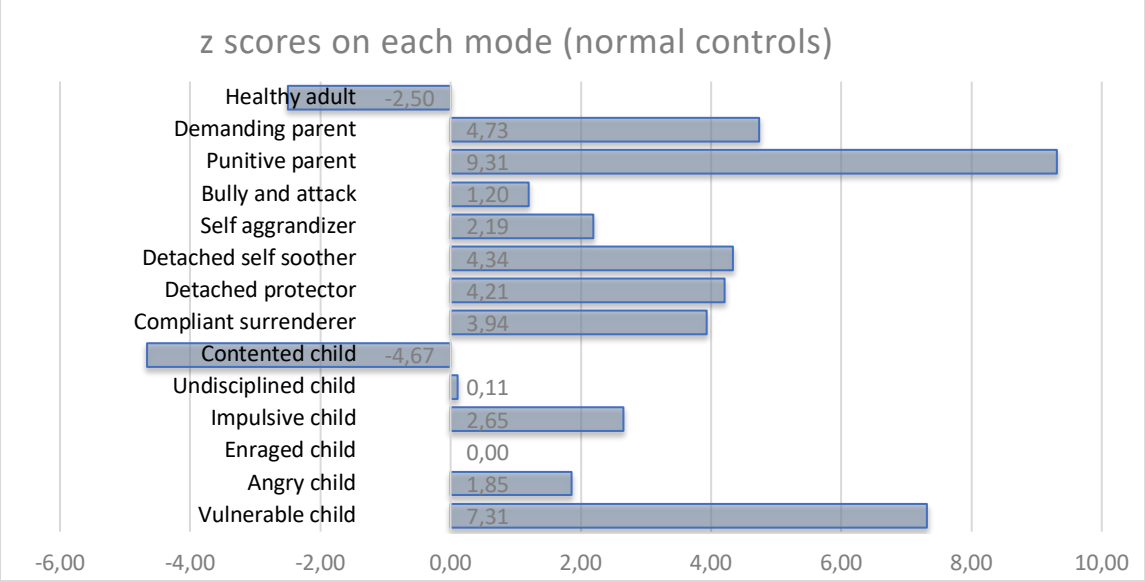


Figure 2 illustrates Jackie's scores on the SMI compared to the average population without clinical disorders. A z score expresses an individual's distance from the mean in terms of SD units. Positive z scores indicate above-average performance, and negative z scores below-average performance, compared to the normative sample (Wolfaardt, 2002). Jackie's scores for Demanding Parent, Punitive Parent, Detached Self-Soother, Detached Protector, Compliant Surrenderer and Vulnerable Child were all more than 3 SD above the norm, indicating that these modes were particularly dominant. These severe scores were supported by her history described in section 6.1 and elaborated on later in section 6.4. Although there was not much evidence of an Impulsive Child provided in Jackie's history, her score of 2,65 SD above the norm suggests that this mode was present. Jackie's score for Impulsive Child was influenced by her score of 6 for the Impulsive Child item, "I don't think about what I say, and it gets me into trouble or hurts other people" and a score of 5 for the item, "If I feel the urge to do something, I just do it." However, there were no examples provided in our sessions to support the scores for these statements. Negative scores on the SMI for the healthy modes (Contented Child and Healthy Adult) indicate these modes are

present in lower levels than for the average population without clinical disorders. As Jackie had a large Vulnerable Child, there was no evidence of a Contented Child (supported by her score of more than 4 SD below the norm). Also, as Jackie spent most of her time in coping modes, there was little Healthy Adult (evident in her score of more than 2 SD below the norm).

6.3. ED Presentation

Jackie had a self-defining memory when she was around 10 years old and, sitting in a pool in a bathing costume, she looked down at her bulging stomach and thought, "I'm fat." This activated the critical aspect of her blended parent introject, which included messages from her peers that she was fat, as well as the nickname from her uncle, "Fat Jacks", which implied she was fat. Subsequently, she repeatedly looked in the mirror and told herself she is fat and ugly and needs to stop eating. Although Jackie did not restrict food at this time, this was the foundation for her Eating Disordered Overcontroller mode, with Punitive Parent and Flagellating Overcontroller sub-modes, and subsequent AN.

In high school, many of Jackie's peers experimented with dieting, which was normalised through media advertisements. So, at the age of 15, Jackie began to restrict food. She gradually cut out an increasing number of food groups until, eventually, what she ate was very limited:

> I remember how it started, I loved gravy, and I thought to myself, okay, I'm going to stop eating gravy, so I stopped gravy. Then it was over a matter of a month that I just started cutting things out. And then I only stuck to eating muesli…and so it carried on. (S3)

Jackie's Perfectionist Overcontroller developed into a specialised Eating Disordered Overcontroller focused on food rules and weight loss (the first and second feature of the Eating Disordered Overcontroller), of which the food restriction was a part. The restricting behaviour occurred over the summer holidays so that by the time Jackie returned to school, she had lost a significant amount of weight (her BMI decreased from 25.6 to 19.9). The positive feedback she received from peers reinforced her Eating Disordered Overcontroller (the eighth feature of the Eating Disordered Overcontroller) and subsequent restricting behaviour. Her popularity with boys increased, and so did her confidence. "And all this attention I was getting and the guys were like, 'she's looking good', so I was 'this is good', and so it carried on" (S3).

Jackie's restricting behaviour also blocked anxiety (the sixth feature of the Eating Disordered Overcontroller) by giving her a sense of control. When Jackie felt out of control, her anxiety increased. Jackie coped by exercising more control over her eating (the eighth feature of the Eating Disordered Overcontroller). For example, when work became busier, Jackie feared failing, and she felt defective and incompetent (Failure, Defectiveness/Shame and Dependence/Incompetence schemas in the Vulnerable Child modes). She then flipped into an Eating Disordered Overcontroller, and her restricting behaviour increased. The Eating Disordered Overcontroller gave Jackie a sense of power and control which shut down the feelings in her Vulnerable Child modes.

Jackie first received treatment for AN at the age of 15, but she struggled with symptoms throughout high school. After school, at the age of 18, Jackie went overseas. Her eating became "chaotic" as she binged because she had restricted and was hungry. The bingeing is understood as an Impulsive Child working in tandem with a Detached Self-Soother to meet the needs of physiological hunger whilst soothing underlying unpleasant emotions associated with the desire to restrict. The binge triggered feelings of guilt and remorse in a Guilty Child, which were shut down by purging (Detached Self-Soother). At this stage, she had a healthy BMI of 20.7 and would have met DSM-5 criteria for BN.

When Jackie returned to South Africa, aged 21, her socialising and heavy drinking caused some weight gain (BMI 22.6) despite her food restriction. Jackie perceived herself as fat and further restricted food, eating only vegetables (the first feature of the Eating Disordered Overcontroller). Her weight decreased, and she again met the criteria for AN (BMI 17), for which she was hospitalised at the age of 23. This was the first of five hospital admissions, of between 3 weeks and 2 months duration, that Jackie had over the next 6 years. Despite her severe, continued weight loss (BMI dropping to 12), Jackie attempted to lose weight before each hospital admission so that she would "look sick and as though I deserved to be there" (S1). This is the twelfth feature described in the Eating Disordered Overcontroller, needing to look ill to access attention and care to which one otherwise feels unentitled. Jackie reached her lowest weight at the age of 29 when her BMI dropped to 10.9, and her organs began to fail. This was a turning point for Jackie, as she acknowledged she was dying. However, her desire to live led to her increasing her food intake until she obtained a BMI of 14, which she has maintained ever since.

Jackie's ED behaviours include a fear of losing control over eating and gaining weight (the eighth feature of the Eating Disordered Overcontroller). To avoid weight gain,

she severely restricts the types of food she eats (the first feature of the Eating Disordered Overcontroller), avoiding salt, sugar, fat, oil or butter. She also limits portion sizes (the second feature of the Eating Disordered Overcontroller) so that they are smaller than the recommendations given by the dietician she consulted since the age of 29. Jackie's control included avoiding food items not on her meal plan, fearing that she would lose control and overeat. Another aspect of control includes eating meals at specific times and eating the same food daily (the fifth feature of the Eating Disordered Overcontroller). If she does not have access to these foods, then she will not eat. Jackie prepares bland, unappetising meals that require little preparation, that she quickly eats while working. She fears that if she enjoys her food, she will not be able to stop eating. If ever she attempted to eat something out of the ordinary, she felt guilt and a "complete failure", for which she punished herself by skipping her next meal, evidence of the Flagellating Overcontroller sub-mode in the Eating Disordered Overcontroller. Jackie gave herself negative all-encompassing messages, such as, "You're so ugly, you're such a bitch, you don't know how to run a business" (S7). These messages, also part of the Flagellating Overcontroller sub-mode in the Eating Disordered Overcontroller, were intended to motivate her to follow the rules of the Eating Disordered Overcontroller.

Jackie avoids looking in the mirror because she "looks disgusting", seeing herself as a "skinny, stick ugly thing" (Eating Disordered Overcontroller with a Flagellating Overcontroller sub-mode) but experiencing somatic cues (the eleventh feature of the Eating Disordered Overcontroller) where she "feels fat." Jackie engages in body checking behaviours (the ninth feature of the Eating Disordered Overcontroller) as she evaluates her body size by grabbing her stomach, looking at her fingers to see the size of the gap in between and evaluating whether her clothes feel tight or baggy.

Jackie has met with a dietician every 2 weeks for the past 10 years, and before engagement in the research, she met with a clinical psychologist for 3 years, but she did not know the therapeutic approach used. From a Healthy Adult perspective, Jackie acknowledged these steps deluded her that she was trying to help herself get better, while at the same time, she did not take any of the advice she was given.

Jackie is delusional in that she wants to be healthy but not increase weight, believing that, "The bigger I get, the more people won't like me" (Shamed Child). Jackie's anorexic state gets her attention and care (the twelfth feature of the Eating Disordered Overcontroller), reinforcing this mode. "If people aren't concerned about me, then I am not doing the right thing, and I have something to work towards. This then makes me feel worthy" (S12).

Feeling worthy is the fourteenth feature of the Eating Disordered Overcontroller. However, her anorexia maintains her Lonely Child mode and her disconnection from people. For example, Jackie does not go out because she is always cold. She will not meet people at a pub for drinks because she does not drink alcohol (because of the calories). Also, she is reluctant to meet people for dinner, believing they will be uncomfortable if she asks for items to be left out of her salad or returns a salad because it was served with dressing. Thus the Eating Disordered Overcontroller marginalises other aspects of her life (the seventh feature of the Eating Disordered Overcontroller).

6.4. Case Conceptualisation at the Time of the Assessment

Table 3

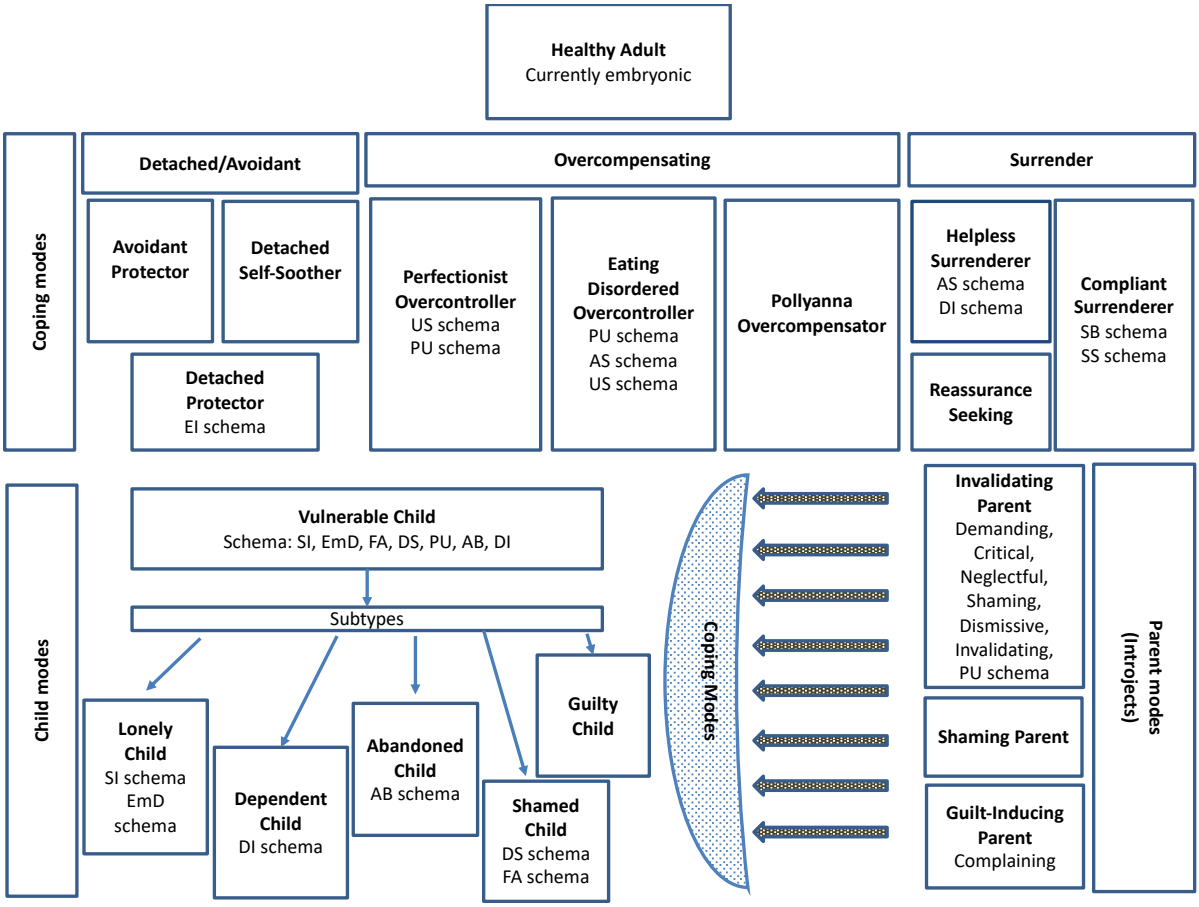
Jackie's DSM-5 Diagnosis at the Time of the Assessment

DSM-5 Diagnosis	**ICD-10-CM Code**
Anorexia nervosa, restricting type, extreme	F50.01
Persistent depressive disorder, with anxious distress, early onset, with intermittent major depressive episodes, without current episode	F34.1

Table 3 presents Jackie's diagnosis at the time of the assessment. This will be made evident in the description to follow in this section. Jackie's current schema modes are represented in a mode map (see Figure 3).

Figure 3

Jackie's Current Mode Map



Note. AB = Abandonment; AS = Approval-Seeking/Recognition-Seeking; DI = Dependence/Incompetence; DS = Defectiveness/Shame; EI = Emotional Inhibition; EmD = Emotional Deprivation; FA = Failure; PU = Punitiveness; SB = Subjugation; SI = Social Isolation/Alienation; SS = Self-Sacrifice; US = Unrelenting Standards/Hypercriticalness.

At the time of the assessment, Jackie was 38 and had been single since the age of 23. Being on the fringes of friendship groups in adolescence and developing AN at 15 contributed to social incapacitation, as Jackie missed out on adequate experiences to learn social skills. As a result, she lacked close friendships and had no meaningful connections, perpetuating the Lonely Child mode. Jackie went on first dates with men she met on Tinder but, anxious that they would not accept her because of the AN or would only want her for sex (Defectiveness/Shame schema in the Vulnerable Child), she cut contact (Avoidant Protector coping).

Jackie's Shamed Child was activated because she was not in a relationship and did not have a family of her own. The Shamed Child was reinforced by patronising responses from acquaintances such as "Agh shame!" or "Once you pick up weight, you will meet someone", which implied that she was not loveable because of her weight.

Her mother's previous choking incident contributed to Jackie's inability to break away from her because she was fearful that her mother would die. Not only did they live together, but Jackie also spent the majority of her free time with her mother. This was partly because her Guilt-Inducing mother triggered her Guilty Child. Jackie's mother demanded her time and would induce guilt if Jackie was not available to her. Also, Jackie felt responsible for her mother's safety because she was an older woman living in a freestanding house in an area with a high crime rate. A mode dyad existed between a Guilt-Inducing Parent and a Guilty Child who felt responsible for her mother's wellbeing. Jackie coped with the guilt through Compliant Surrenderer coping, spending time with her mother.

Jackie's mother made critical and shaming comments (features of her Invalidating Parent mode) about Jackie's health and physical appearance, including, "Well, you know it's your anorexia, so just eat properly" and "You need to cover up your legs". These comments reinforced her Shamed Child and her belief that she was ugly. Jackie minimised her mother's behaviour (Pollyanna Overcompensator mode), stating, "In my eyes, she's perfect" (S2).

Jackie, who was close to her brother in childhood, distances herself as she believes that because of her AN, she has disappointed him. This belief is influenced by the Shaming Parent introject, where in childhood, her mother compared her unfavourably to her brother. She also assumes, because of her Shamed Child, that he will find her boring, so she limits their conversations to his life and her work. Jackie's Pollyanna Overcompensator is evident when she idealises her brother, stating that "he's a wonderful man, a wonderful husband, he's like my god, so caring, so honest" (S2), and as a result, she feels unworthy of his love (Shamed Child) because she is not perfect. Jackie shuts down the feelings of shame (in the Shamed Child) with Perfectionist Overcontroller coping. Her Perfectionist Overcontroller includes the belief that to be liked or accepted, she needs to be perfect (the eighth feature).

Jackie also idealises her younger sister (Pollyanna Overcompensator), describing her as having a "beautiful body" and being "funny as hell." She believes that she and her sister were not close growing up because Jackie took on a parent role which her sister experienced as controlling, and, as her sister grew older, she was angry about the AN. As a result, Jackie

fears rejection from her sister. So she copes through Compliant Surrenderer, "I walk on eggshells with her because I don't want to hurt her any more than I have" (S9). Jackie's inability to be authentic with her siblings prevents her from having genuine, close relationships with them and maintains her Lonely Child.

Jackie's company had grown so that she employed six people. Still, she was uncomfortable acknowledging its success as she did not feel "big enough or old enough" (Dependent Child) to have her own company. "It feels too good a thing for me. Only clever people, successful people, can have businesses" (S4). Jackie's sense of defectiveness and inability to see herself as an adult hampered Healthy Adult acknowledgement of her accomplishments.

Jackie's Dependent Child caused her to doubt herself and her decisions. So Jackie sought others' opinions (Reassurance seeking mode), including at work, where she relied on employees to assist her with decisions about the running of the company. Once Jackie had sought out others' advice, she felt obliged to take it (Compliant Surrenderer coping). At other times when her Dependent Child was triggered, she coped through Helpless Surrenderer, where she presented herself as stuck and helpless, relying on others to rescue her from her problems. Jackie's low body weight was a passive way to communicate her frailty and need to be taken care of, which initially elicited sympathy from others (the twelfth feature of the Eating Disordered Overcontroller). Using restriction to communicate frailty and to seek attention is a feature of the Helpless Surrenderer sub-mode in the Eating Disordered Overcontroller. However, the Helpless Surrenderer, which initially elicits sympathy, led to others becoming frustrated with her. For example, Jackie's sister commented on how Jackie appeared to have accepted her anorexia and was not attempting to get better.

Jackie worked long hours as she used work as a self-soother (a Detached Self-Soother coping mode) to avoid the triggering of her Lonely Child. When her work was complete, her Lonely Child was triggered, and she felt lonely and depressed, with no friends to phone. Jackie's score of 41 (severe) on the BDI-II supported her DSM-5 diagnosis (APA, 2013) of a persistent depressive disorder (see Table 3).

Jackie's Eating Disordered Overcontroller and avoidant coping perpetuated the Lonely Child mode, which was prominent throughout the assessment. She had an undeveloped sense of self (in the Dependent Child) reinforced by the AN, which had been her identity for 23 years. She described the AN as 99% of her identity, and she was afraid of

what would remain if she beat it. As Jackie lacked a sense of self, she was unable to establish meaningful connections. Her focus on her AN in her Eating Disordered Overcontroller mode blocked her feelings of loneliness and anxiety which maintained this coping mode. Although she obtained attention by being in the sick role, this was a pseudo connection. The AN maintained the Lonely Child because, as previously mentioned, it kept her isolated as she avoided social activities. Being isolated and alone maintained her depression and sense of hopelessness and kept her trapped in a chronically toxic relationship with her mother, where her Vulnerable Child was repeatedly triggered.

6.5. Jackie's Parent Modes

Jackie had a blended parent mode with various features that were active concurrently in the same situation, including being neglectful, dismissive, invalidating, critical and shaming (see Table 2). This parent mode was moderately toxic (see Table 2) as Jackie's mother imposed her wishes and standards on her. For the sake of simplicity, I refer to this mode as her Invalidating Parent mode. Her Invalidating Parent mode was primarily comprised of introjects from her narcissistic mother. However, some aspects of this mode reflected experiences from both her parents. Jackie's description of her father as "the life and soul of the party" and "the centre of attention" suggests grandiose narcissistic traits, which included a desire for attention and an exaggerated sense of self-importance. This contributed to his lax attitude towards Jackie.

The neglectful aspect of this Invalidating Parent mode is evident early on as Jackie had no recollection of her parents being affectionate with her. Instead, when she asked her mother for a hug, her mother told her she was "that demanding child again", which was shaming, dismissive and invalidated her needs. In S3, she shared an example where her mother told her, "There's got to be something wrong with you; you're too demanding…right from little, little, little." Jackie introjected the message that there was something wrong with her and that she was too demanding, which contributed to her Shamed Child (Defectiveness/Shame schema). As a result, Jackie struggled to assert her needs, resulting in Compliant Surrenderer coping, or else she tried to be perfect (Perfectionist Overcontroller) to overcompensate for her defectiveness. This message also highlights the element of neglect as her mother did not understand the needs of a child. Jackie's introjected Neglectful and Invalidating Parent was evident in that not only did Jackie not prioritise herself and pay attention to her needs, but she did not expect anyone else to pay attention to her. Thus the dyad between the Neglecting, Invalidating Parent and the Neglected Child led to Compliant

Surrenderer coping where Jackie prioritised others (Subjugation schema) to gain approval and acceptance.

When Jackie was sick, her parents' response would be to "throw it away" (S49), which implied that Jackie should somehow push aside what she was feeling and carry on. This response, which was both dismissive and neglectful, invalidated Jackie's experience of feeling ill. She did not receive nurturing or care when she was sick from this Invalidating Parent, and as a result, Jackie sees sickness as a weakness and, when ill, will not care for herself or tend to her own needs. She has developed an avoidant coping mode of "pushing it away" as her parents suggested. The Invalidating Parent is also evident in Jackie's response to her AN as she sees herself as a burden to the family because she cannot "throw it [the anorexia] away". This experience of neglect and being a burden was heightened after her father's death. Jackie felt that her mother did not have time for her and her siblings and that they were a burden. "When we went to bed it was like, 'Thank God they're going to bed', that kind of feeling…when I look back now and the images I'm getting [of the expression on her mother's face which she interpreted as relief], it feels as though we were just a chore" (S6). This feeling is the experience of Jackie's emotionally deprived Lonely Child in a dyadic relationship with an Invalidating Parent who is dismissive, neglectful, invalidating, critical and shaming. An example where Jackie projects the Invalidating Parent onto others is that she does not want to talk with her brother about her life because she believes he will be bored; projecting onto her brother that listening to her will be a chore.

Jackie provided several examples to highlight the critical and shaming aspects of this Invalidating Parent Mode. As described in section 6.1, when Jackie did not want to wear dresses, her mother told her she "needed to look more like a girl" (S3). This is a self-aggrandising aspect of Jackie's mother as she needs Jackie to project a particular image so that she, the mother, will not be shamed. This critical and shaming message implied that Jackie was somehow defective, triggering her Shamed Child. This message also had a demanding element where her mother insisted that she needed to wear dresses to fit in with what her mother required. The evoked shame was further reinforced by her mother's messages as she got older, including, "Once you've put on weight, you will get a boyfriend" (S3). This comment led to Jackie thinking, "But what's wrong with me now?" As a result, Jackie devalued herself and perceived herself as shameful, reinforcing her Shamed Child as evidenced in her comment in S3, "So it's been reiterated to me that there's something wrong with me…and until I improve, then I'm not going anywhere." In this statement, there is a

combination of guilt and shame. Jackie's reference to improving suggests that she is not fundamentally flawed but can do something to improve, thus inferring the demand associated with guilt that you need to look a specific way to succeed. These shaming interactions were internalised as part of the Invalidating Parent introject in a dyadic relationship with a Shamed Child.

This internalised Invalidating Parent's shaming features were projected onto other people in the community who became an extension of the Shaming Parent and therefore represented a separate Shaming Parent mode. This is an example of external shame as the experience triggered self-consciousness in the Shamed Child who feared negative evaluation by others. "My friend will say to me, 'so have you found anybody yet? Ah, don't worry, it will happen'." (S3). This statement activates an experience of failure and defectiveness in the Shamed Child in a dyadic relationship with a Shaming Parent. The feeling of failure and defectiveness represents the complex schema comprising of Failure and Defectiveness/Shame, that are triggered concurrently (described in section 5.1). When Jackie described how she did not like herself and did not see herself as successful, both could be linked to the internalised shaming messages from her mother, that were triggered by experiences in the wider community. There is, then, a mode dyad where judgmental behaviour from others (the Shaming Parent) leads to a sense of shame in the self (the Shamed Child):

> I can put it down to not succeeding in having a boyfriend, not succeeding in having a child of my own, embarrassed about who I am, because I haven't got a boyfriend and I don't have somebody who loves me, and I don't have a child. To me, that's success, and I haven't succeeded. (S3)

Jackie's Defectiveness/Shame and Failure schemas were blended as not succeeding (failing) resulted in her feeling inadequate and defective and subsequently shamed. This is described in section 5.1.

Jackie's mother was the source of a separate moderately toxic Guilt-Inducing Parent mode (see Table 2). Her mother had a history of depression which she struggled with all of Jackie's life. Also, her mother had a Self-Pity/Victim coping mode, where she played the part of the victim and expected to be cared for. Therefore, it is likely that Jackie's focus on her mother's needs and feeling responsible for her mother's happiness occurred from a young age; however, there was insufficient data to support this. Jackie recalled that at the age of 11,

she took responsibility for her mother's happiness. This was after her father's death when her mother developed alcoholism and battled depression. A mode dyad existed between a Guilt-Inducing Parent and a Guilty Child who copes by being over-responsible and parenting the parent (Jacob et al., 2015). This mode dyad developed from an internal working model where Jackie's needs were not met and were not considered important. Instead, she focused on her mother's needs and deemed them a priority. Jackie's belief regarding her mother was, "If she says jump, I need to jump; I need to go then" (S8). Jackie's guilt was related to themes of responsibility and obligation in a Guilty Child and, when triggered, created a desire to make reparations (Lewis, 1986), that is, to go to her mother when she called (Compliant Surrenderer coping).

Jackie coped with the demands of the Guilt-Inducing Parent through Compliant Surrenderer. If she did not tend to her mother's needs, her mother induced guilt with comments such as, "You work too hard, I just want a little of your time" (S3). The Self-Pity/Victim approach, suggestive of her mother's fragile narcissism, triggered a Guilty Child who feels responsible for her mother's wellbeing. Jackie's mother uses her suffering (Guilt-Inducing parent in a mode dyad with a Guilty Child) to keep Jackie tied to her (Compliant Surrenderer coping).

Jackie's mother is demanding in two different ways in the Invalidating and Guilt-Inducing Parent modes. In the Invalidating Parent mode, the demands are of the type, "I am busy don't bother me", but in the Guilt-Inducing Parent, the demands are more about, "Look after me, take care of me." These contrasting messages illustrate a mode flip in her mother from a detached dismissive mode, in the Invalidating Parent, to a more Self-Pity/Victim mode in the Guilt-Inducing Parent. When Jackie offered to assist her mother with computer work, her mother responded, "Oh no, you're way too busy, you're always telling me you're too busy", which triggered a Guilty Child that felt she was not making time for her mother. To cope with this demanding Guilt-Inducing Parent mode, Jackie set high standards for herself, focusing on how she should feel or behave in a situation (Jacob et al., 2015), combined with a self-sacrificing Compliant Surrenderer mode. "On a Saturday, I wouldn't mind just working in the garden, but then I feel guilty that I'm not going to mom, so I'll go" (S7). This mode combines elements of surrender and overcompensation as Jackie wants to subjugate herself perfectly. If Jackie did not live up to the ideals she had set for herself to care for her mother and be responsible for her happiness, she experienced guilt.

6.6. The Perfectionist Overcontroller

Jackie's Perfectionist Overcontroller contained nine of the 13 features described in section 5.3, namely;

- striving for excellence and perfect results,
- discounting successes and resetting goals once they are met,
- the marginalisation of other aspects of life,
- rigidity regarding morals, ethics and values,
- preoccupation with details, order, lists and schedules,
- suppression of emotional vulnerability,
- seeking approval and acceptance from others,
- concern over mistakes,
- self-punitiveness.

As described in section 5.3, the core feature of the Perfectionist Overcontroller is striving for excellence and perfect results. If Jackie does not do something perfectly, then her Failure schema is triggered. For example, when we added items to Jackie's meal plan, and she did not eat them all, she felt, "like a failure because it wasn't perfect" (S6). Jackie strove to be the best in her industry. This was related to her need for approval and acceptance (the eighth feature of the Perfectionist Overcontroller). For example, Jackie ran a stall at a local market. When preparing for the market, she felt nervous "because I want to do well…to me, it's not the money…it's just not having one negative response" (S4). Jackie's desire to avoid criticism was to overcompensate for her Defectiveness/Shame schema.

Related to her striving for excellence, Jackie discounted her business success (the second feature of the Perfectionist Overcontroller) and was not satisfied with her achievements. This was a schema driven behaviour where she looked for evidence to support her Defectiveness/Shame and Failure schemas and discounted other evidence. Jackie struggled to delegate tasks as she believed others would not strive for the same high standards. Being in control shut down her emotional vulnerability (the sixth feature of the Perfectionist Overcontroller). Still, at the same time, her devotion to achieving perfect results led to the marginalisation of other aspects of life as she focused on work to the exclusion of other activities (the third feature of the Perfectionist Overcontroller).

Jackie repeatedly mentioned that she believed she was poor at comprehension and expressing herself (Dependence/Incompetence schema in the Dependent Child); (S3) "I'm so

conscious of how I express myself. Like talking to you now, I'm thinking; I'm sure she's thinking I'm such an idiot because I keep stumbling over my words." In this statement, Jackie's Shamed Child is evident as she projects her shame onto me, an example of external shame. Her hypervigilance for mistakes when expressing herself is the tenth feature of the Perfectionist Overcontroller, which overcompensates for her Shamed Child. The blended Failure and Defectiveness/Shame schemas (in the Shamed Child) are evident as Jackie fears making mistakes and being shamed by my judgement.

Jackie became frustrated with herself because she struggled to remember specific details about past events. For example, the particular year in which she weighed her lowest weight or the number of years since her relationship ended. This illustrates her rigidity about getting the facts "just right" (the fourth feature of the Perfectionist Overcontroller). When asked why this accuracy mattered, she replied, "Because if people ask me questions, I don't want to look like an idiot" (S3). Jackie was hypervigilant for mistakes (the tenth feature of the Perfectionist Overcontroller) as she expected to be judged. Referring to herself as "an idiot" if she did not get something entirely right was evidence of the Flagellating Overcontroller sub-mode (the eleventh feature of the Perfectionist Overcontroller) where Jackie gave herself negative messages to motivate her to follow the rules of the Perfectionist Overcontroller and to do things perfectly. In the same session, she commented, "I can't remember exactly what happened, so I battle to express exactly what happened…so then I would rather just not tell you"(S3). Rather than make a mistake, which would trigger Jackie's complex Failure and Defectiveness/Shame schemas, Jackie flips into Avoidant Protector coping.

Jackie was preoccupied with details, the fifth feature of the Perfectionist Overcontroller. This was illustrated in an example in S3:

> I've written my life story so many times. Because I think, well, I've got to go back, I forgot about that, and then I think again, oh no, but I forgot about that, and then, okay, but I didn't say that part. And it's like I don't know where to draw the line with my life story, and that's always – it's so overwhelming.

In this example, Jackie is preoccupied with getting all the details right (the fourth feature of the Perfectionist Overcontroller).

6.7. The Eating Disordered Overcontroller

This account of Jackie's prominent Eating Disordered Overcontroller mode draws on the account of this mode already presented in section 6.3. Jackie's Eating Disordered Overcontroller contained 13 of the 15 features identified in section 5.4, including;

- rules about goal weight and what one is permitted to eat,
- the decision to restrict eating and lose weight,
- self-punitiveness and self-loathing,
- focus on the body and eating patterns to generate a sense of competence, power and control,
- suppression of emotional vulnerability,
- the marginalisation of other aspects of life,
- fear of losing control and hypervigilance to maintaining rules and routines,
- checking behaviours,
- the generation of images that induce fear, shame and self-disgust,
- looking ill to gain attention,
- seeking approval and acceptance from others,
- a feeling of being special,
- the promise of a happier life.

Jackie focused on her restricting calorie intake and maintaining a low weight (the second feature of the Eating Disordered Overcontroller) through rigid rules around her eating (the first feature of the Eating Disordered Overcontroller) and punitiveness (the fourth feature of the Eating Disordered Overcontroller, which includes the Flagellating Overcontroller) if these rules were not followed. This offered her a sense of power and control (the fifth feature of the Eating Disordered Overcontroller) which shut down her emotional vulnerability (the sixth feature of the Eating Disordered Overcontroller).

From the age of 9, Jackie was teased at school about her weight which led to self-loathing messages such as, "You are so ugly…stop eating" (S16). Although Jackie did not restrict food until the age of 15, this statement illustrates the development of her Eating Disordered Overcontroller. The self-loathing messages were part of the Flagellating Overcontroller sub-mode intended to motivate Jackie to restrict her eating. Jackie also had messages from the Punitive Parent sub-mode, as these were messages received from other people that she internalised. As mentioned in section 6.3, this included explicit messages

from her peers that she was fat, as well as implicit messages from her uncle because of the nickname "Fat Jacks."

Jackie was diagnosed with AN at the age of 15. The Perfectionist Overcontroller developed into a specialised Eating Disordered Overcontroller as Jackie endeavoured to lose weight to obtain the "perfect body." Her Eating Disordered Overcontroller initially entailed severely restricting food (the second feature of the Eating Disordered Overcontroller), as described in section 6.3. As Jackie lost weight, she felt more accepted by her peers (the thirteenth feature of the Eating Disordered Overcontroller). The emerging Eating Disordered Overcontroller was reinforced as it provided two critical elements; that she became thinner and more popular, and it blocked the difficult feelings in her Lonely Child. Thus restricting food and losing weight provided Jackie with the promise of a happier life (the fifteenth feature of the Eating Disordered Overcontroller).

When Jackie returned to South Africa from her overseas travels at the age of 21with a BMI in the normal range, her mother's comment that she looked "well" triggered restricting behaviour. Jackie believed she needed to appear ill to attract care and attention (the twelfth feature of the Eating Disordered Overcontroller). This is reinforced by her belief that it is not okay to ask for help but that if she is anorexic, people can see she is unwell and needs help. In keeping with this, Jackie attempted to lose weight before being admitted to the hospital for treatment as she felt she needed to "look as sick as possible…so I actually deserve to be there" (S11).

The Eating Disordered Overcontroller also allowed Jackie to feel "special" (the fourteenth feature of the Eating Disordered Overcontroller):

> If I am anorexic, then people will like me. If I am not, then I am just normal…what's going to be special about me? Nothing….If I am normal, then I'm going to be rejected. So I need to have a special quality…I need to be special in some way, and anorexia was the way I chose to be special. (S10)

Throughout her teenage and adult life, the Lonely Child that is needing care has been hidden behind the Eating Disordered Overcontroller coping mode.

Jackie's Eating Disordered Overcontroller suppresses her emotional vulnerability (the sixth feature of the Eating Disordered Overcontroller) by shutting down the child mode and painful memories. In S6, she describes her anorexia as "kind of a shield I think. A mask, a way to hide, which is all part of being a mask. Not having to deal with what I really

feel…masking who I am because I don't feel good enough." In this statement, Jackie references the Shamed Child which is shut down by her Eating Disordered Overcontroller. The Eating Disordered Overcontroller also has an element of self-punitiveness and self-loathing when Jackie does not follow the rules (the fourth feature of the Eating Disordered Overcontroller). The Eating Disordered Overcontroller caused Jackie to feel extreme guilt about eating "like I've been really, really, bad and that I need to be punished…It's almost as bad as I've committed a murder, you know, like I've done something that bad" (S6). This guilt and self-punitiveness are also evident when she does not exercise. In S47, she described that when she does not go to the gym, the Eating Disordered Overcontroller "screams" at her that she's a "lazy bitch" and then she feels guilty (Guilty Child mode) the rest of the day. Self-loathing and self-punitiveness are part of the Flagellating Overcontroller sub-mode. There was no evidence that Jackie had internalised the message that she was a "lazy bitch" from someone else, so this was a message that she gave to herself to motivate herself to follow the rules of the Eating Disordered Overcontroller. This represents a verbal aspect of the Flagellating Overcontroller sub-mode. Not allowing herself to eat for the rest of the day was a physical aspect of the Flagellating Overcontroller sub-mode as Jackie punished herself for breaking the rules.

Although Jackie has an eating plan from a dietician, she restricts the food on the plan (the second feature of the Eating Disordered Overcontroller), allowing herself smaller portions and removing certain food groups (the first feature of the Eating Disordered Overcontroller). Jackie eats her meals and snacks at the same time every day (the fifth feature of the Eating Disordered Overcontroller). On the days when Jackie works in the laboratory developing flavour combinations related to her work, she skips lunch as she rationalises that the calories she has consumed whilst tasting the flavours she developed compensate for lunch (the first feature of the Eating Disordered Overcontroller). "For those four hours, I allow myself to taste that, but then I don't eat lunch… I make myself not feel guilty about doing those tastings because it's for my business" (S4). This focus on her eating patterns provides Jackie with a sense of control (the fifth feature of the Eating Disordered Overcontroller).

All the food Jackie eats is weighed and measured. She eats the same food daily and will go without rather than substitute if she does not have one of the food items (the first feature of the Eating Disordered Overcontroller). Jackie goes so far as to take her food on business trips because, "The minute I put anything else in my mouth that I'm not supposed to [according to the meal plan 'in her head'] I feel guilty, and then I'll cut back on the rest of my

food for the day" (S4). This statement highlights the interaction between the food rules and the Flagellating Overcontroller sub-mode, where Jackie punishes herself for breaking the rules.

Restricting her calorie intake leads to a sense of being in control (the fifth feature of the Eating Disordered Overcontroller) which suppresses her anxiety (the sixth feature of the Eating Disordered Overcontroller). Jackie noted that she could not control her father's death or the girls bullying her in school, or her mother's alcohol dependence, but she could control what she ate and how she looked. Thus the experience of being in control by controlling her calorie intake was essential to Jackie. This was evident over time when Jackie experienced periods of heightened anxiety, for example, because of work stress. During these times, she would further restrict her food intake to gain a sense of control and shut down her anxiety.

Jackie's Eating Disordered Overcontroller generated images that induce fear, shame and disgust if she breaks any of her food rules or increases weight (the eleventh feature of the Eating Disordered Overcontroller). The Eating Disordered Overcontroller warns her when she breaks the rules by providing visual and somatic clues; for example, her clothes feel tighter, and she feels "bigger." An example of a visual clue was mentioned in S16, "My instant image of myself is 'the blob'. If I eat that, I'm going to be 'the blob'." In S6, Jackie stated, "All I can imagine is this plump thing, ugly and back to what I was when I was 13, you know, quite chubby, not pretty…and also just alone." This statement amplifies the feelings in the Lonely Child, suggesting to Jackie that if she "loses control" and eats, the emotions that the Eating Disordered Overcontroller is repressing will come to the fore. Jackie's fear of losing control and overeating was the eighth feature of the Eating Disordered Overcontroller. To this end, Jackie prepared bland meals for herself, fearing that if she enjoyed her food, she would be tempted to overeat (the eighth feature of the Eating Disordered Overcontroller).

To guard against gaining weight, Jackie evaluates her body size by grabbing her stomach, assessing the size of the gap between her fingers and thighs and checking if her clothes are tight or baggy (the ninth feature of the Eating Disordered Overcontroller).

6.8. The Detached Self-Soother

Jackie's Detached Self-Soother was not prominent and did not focus on food. This is because Jackie's anorexic behaviour was controlled by her Eating Disordered Overcontroller.

Jackie's Detached Self-Soother behaviour included an excessive focus on work. She worked until late at night because when she was busy and focused, she felt worthy and calm. "It is very self-soothing because it also makes me feel that I'm worth something and I'm not so bad" (S8). Jackie's work shut down feelings of defectiveness (in the Vulnerable Child). When her work was complete, Jackie's feelings of sadness and loneliness (Lonely Child) came to the fore, which triggered a sense of panic:

> When I'm busy and…I know I've got a lot of work to do, it makes me feel worthy. When…I've already done all my work, and I could pretty much close my computer and go and do other things, I don't feel worthy at all, and I panic…I just feel lost…I go into a depression because then I start thinking oh, I'm so alone, I'm lonely, I don't have anybody to phone, and so it's like a vicious circle. Because then I don't know what to do with my time. (S7)

Jackie's self-soothing behaviour provided her with a sense of worth, shutting down feelings (in her Vulnerable Child). Jackie's Detached Self-Soother included behaviour that is considered constructive and, therefore, does not evoke guilt. This was described in section 5.5.

6.9. Schema Perpetuation and the Therapeutic Process

In this section, I will look at how Jackie's problems were perpetuated and the therapeutic process in which we engaged.

Not only was Jackie's mother introjected as her Invalidating and Guilt-Inducing Parent modes, but as Jackie lived with her mother, the messages she introjected were repeatedly reinforced. When a remark from her mother triggered a dyad between the Guilt-Inducing Parent and a Guilty Child, Jackie flipped into Compliant Surrenderer coping. Also, Jackie's demanding and critical introjects activated the Shamed Child and Lonely Child, which she coped with through Compliant Surrenderer, Eating Disordered Overcontroller or Perfectionist Overcontroller. So Jackie flipped between coping modes which prevented access to the Vulnerable Child modes (see Figure 3). As a result, her needs remained unmet, and schema healing could not occur. Jackie spent most of her time in an Eating Disordered Overcontroller mode which shut down her prominent Shamed Child and Lonely Child. However, her ED kept her isolated from other people and ashamed of herself, which reinforced the schemas in these child modes. Jackie's poorly developed Healthy Adult meant

that she lacked insight into her coping behaviours and the purpose that they served in shutting down difficult emotions, which in turn reinforced the coping modes.

Jackie was seen for 50 weekly sessions. After a comprehensive assessment process, we moved into a therapeutic process informed by ST. Therapy sessions included emotion-focused work to assist Jackie to identify and experience her emotions. Jackie struggled to identify and name emotions because of her Detached Protector coping and Dependent Child mode, which looked to others to tell her how she feels. Also, Jackie avoided cues that triggered distress (Avoidant Protector coping) because she feared that if she allowed herself to experience emotions, they would overwhelm her.

Imagery rescripting was used to rescript distressing events related to Jackie's neglectful parenting and bullying incidents in her childhood. However, as I was unable to access Jackie's Vulnerable Child, the imagery rescripting was not effective. Chairwork enabled us to identify the characteristics of modes and to create dialogues between the modes to build insight and understanding. However, once again, the absence of emotional connection to Jackie's Vulnerable Child limited these interventions' success.

Throughout the therapy process I struggled to access Jackie's Vulnerable Child as the coping modes (Detached Protector, Helpless Surrenderer and Avoidant Protector) blocked access to the child modes. As a result, schema healing did not occur. The therapeutic process helped Jackie gain insight into her modes and her mode sequences, in particular how her anorexic behaviour was maintained because the Eating Disordered Overcontroller shut down her distressing emotions in the Vulnerable Child modes and gave her a sense of control. However, the Eating Disordered Overcontroller coping also maintained her sense of defectiveness and ultimately increased her anxiety as she feared she might die from starvation.

There were moments of Healthy Adult appraisal. For example, when Jackie acknowledged that her severe restricting could ultimately lead to her death and that meeting with the dietician was part of her Eating Disordered Overcontroller coping as she only attended appointments to ensure that her weight remained low.

In S38, Jackie expressed that she did not want to attend sessions. She did not want to talk about her feelings and issues because then she had to acknowledge them, which she did not want to do (Avoidant Protector coping). Jackie was also avoiding feelings of failure, because if she engaged in therapy and did not get better, she would perceive herself as having

failed (activating her Failure schema). Following this session, Jackie's commitment to our sessions decreased. She arrived late for her appointments or cancelled with short notice. Her Avoidant Protector coping was also evident when she made excuses to avoid her regular appointments. Finally, she stopped attending sessions and cut contact. Although Jackie's AN did not improve, through the ST process, she gained an understanding of her anorexia and how it is maintained.

Chapter 7. The Case Study of Tina

7.1. Psychosocial History

Tina was one of twin girls, and she had a sister 1 year older. Tina and her sister were born at 29 weeks and spent the first 2 months in hospital, laying the foundation for her Abandoned Child (Abandonment/Instability schema). Tina, born with Cerebral Palsy (CP), blamed her mother for her premature birth and CP because her mother smoked and drank throughout her pregnancy. Her CP caused deficits that required physiotherapy, speech therapy and occupational therapy, and several surgeries during childhood to address issues with her Achilles tendon and hamstring. These disabilities contributed to her Defective Child (Defectiveness/Shame schema). Her experience reinforced Tina's Vulnerable Child (Defectiveness/Shame, Failure and Social Isolation/Alienation schemas), "I was always the black sheep of the family, and I never did anything right. I always felt I couldn't live up to other people's expectations" (S1). Tina recalled an incident around the age of 6, which reinforced her Defective Child. Tina was walking in town with her parents when she became aware of people watching her. When she caught sight of herself in a shop window, she realised that they were looking at her because she walked with a limp. As a child with CP, Tina was unable to engage in activities with other children, such as sport and "dress up" activities like walking in her mother's high heels. This exclusion contributed to her Vulnerable Child modes (Lonely Child, Defective Child, Dependent Child) which were reinforced because of her CP:

> I've had these things in my life where people like me chatting over the phone, and then I met them in person, and then they see that I have a disability and they're not interested…I can't help but feel like I wasn't good enough. (S1)

Tina's parents divorced before she turned 3 because her father had an affair, so she has no recollection of them being together. She and her sisters lived with her mother. They would see her father alternate weekends until he moved to another country when she was 7, after which she had limited telephonic contact and only saw her father during school holidays. Tina likely experienced the divorce and subsequent limited contact with her father as an abandonment, triggering her Abandoned Child (Abandonment/Instability schema). Whilst living away, her father remarried. When Tina was 15, her father and stepmother returned to South Africa and settled in a town a half-hour away from Tina. Tina regarded her stepmother as "weak" because her father was demanding and narcissistic, and she was subjugated to him.

Due to the challenges caused by the CP, Tina started school a year later than her twin, contributing to her Vulnerable Child (Social Isolation/Alienation, Defectiveness/Shame, and Dependence/Incompetence schemas). For the first 3 years, she attended the same mainstream school as her sisters. However, Tina was unfavourably compared to her twin by the staff (activating and reinforcing Dependence/Incompetence and Defectiveness/Shame schemas) and, as the only child with a disability in the school, she was bullied. The bullying further contributed to her Defective Child and Dependent Child. These painful feelings were shut down by Detached Protector coping, where Tina disconnected emotionally, resulting in chronic depression, from the age of 9 onwards.

When Tina was 9, she accompanied her sister to a birthday party where she was teased by the other children and excluded - even to the extent that the boy whose party it was offered her money if she would sit in the room on her own for the party's duration. Thereafter Tina believed she was always the sympathy or obligatory invite to parties, triggering her Vulnerable Child and feelings of sadness and loneliness.

From grade 4 to 7 (11 to 14 years), Tina attended a school for children with physical and learning disabilities because she was expected to have several surgeries during this period, and the school provided physiotherapy and occupational therapy on campus. At this school, Tina was teased because of her limp and because she was not as physically developed as the other girls. Also, Tina had confrontations with physically and sexually aggressive students. Tina was angry with her treatment (Angry Child mode) and coped by becoming a bully (Bully and Attack coping mode). In high school, Tina returned to mainstream schooling and again, as the only child with a physical disability in the school, was bullied. Tina continued to cope through a Bully and Attack mode, physically or verbally attacking "to scare people off" (S2).

Tina's academic performance throughout school was poor because she believed she could not do well enough (Defective Child), a belief that was exacerbated by her Demanding Parent introject (Unrelenting Standards/Hypercriticalness schema). So Tina procrastinated and struggled to follow through on tasks she did not enjoy (Avoidant Protector coping). This Avoidant Protector coping initially shut down the emotions, but Tina became anxious when she was alerted to the possibility of failure as projects became due (Defective Child). She then flipped into a scrambling overcompensation coping mode in which she "threw projects together" at the last minute.

Tina's experiences of being teased and, when in the mainstream, being the only child with a disability, contributed to her Lonely Child (Social Isolation/Alienation schema). However, at the age of 12, Tina developed her first meaningful connection when she befriended a boy in her class named George. When Tina's Lonely Child was activated and looking to George to meet her needs, she experienced this as a crush, but her Defective Child was also triggered as she felt she was "never quite good enough for him" (S2). Despite maintaining a friendship through their teenage years and into adulthood, they never dated. Although Tina received a form of acceptance from George, it was conditional as he established contact on his terms. As adults, their friendship developed a sexual aspect where, although they were both married, they engaged in phone sex. There was a subjugated element to this Compliant Surrenderer coping as the phone sex was about meeting George's needs whilst allowing Tina to maintain some form of connection and avoid rejection.

Tina's mother never remarried, but for a few years, she was engaged to a punitive and critical man whom Tina despised and nicknamed "Sergeant Major." He complained if they took food from the fridge, telling them that it was his food because he paid for it. The family moved in with him when Tina started high school at the age of 14. Tina, who was struggling to adapt to an all-girls' school, and was experiencing conflict with her siblings and her mother's fiancé, was desperately unhappy. The following year (age 15), she moved in with her father and his wife and changed to a school closer to their home.

Tina's father was narcissistic, stern and demanding and pushed them to read motivational books. His love was conditional, and his approach "do it my way, or we don't talk" (S2). Thus Tina had an introjected Critical and Demanding Parent in a dyad with a Vulnerable Child (Emotional Deprivation schema). Tina coped through Compliant Surrenderer and by striving to be perfect (the first feature of the Perfectionist Overcontroller) to win his love, "I take very highly my dad's opinion of me" (S2).

Tina regretted moving in with her father, but she did not want to offend him by returning to her mother (Compliant Surrenderer mode). The following year Tina's father relocated to another province, and so Tina moved back to her mother and attended her third high school. Desperate for a sense of belonging, Tina became part of the rebellious but popular crowd, which provided a sense of importance and protection by the group and countered her social isolation (Self-Aggrandiser coping). This Self-Aggrandiser coping was also evident in Tina's efforts to project a perfect image which involved spending a lot of time on her hair, clothing and makeup because she was self-conscious about coming from a low-

income family and expected people to judge her. This focus on presenting a perfect image continued into adulthood as Tina would not leave the house without spending hours on her clothing and makeup.

Throughout her childhood, Tina's mother struggled with depression which made her emotionally unavailable to Tina, contributing to her Lonely Child mode. Her mother obtained low paying jobs, resulting in financial difficulty and reliance on extended family for financial assistance. Tina assisted her mother throughout high school (Compliant Surrenderer mode) by giving her mother the money she earned from part-time jobs for food and household expenses. Tina listened to her mother's complaints about the problems in her marriage, their father's infidelity and her frustrations about maintenance payments. Thus Tina met her mother's needs (Compliant Surrenderer), while her own needs remained unmet. As a result, her Angry Child mode was activated as she expressed anger towards her mother for criticising their father, believing this was her mother's attempt to influence their perception of him.

From the age of 13 to 21, Tina struggled with untreated depression and engaged in self-injurious behaviour (cutting) to cope with feelings of anger and sadness. Part of a Detached Self-Soother mode, she described it as "making an emotional pain physical" (S4). Still in a Detached Self-Soother mode, she tended to the wounds, which provided a distraction from her emotional pain. Another Detached Self-Soother behaviour was Tina's abuse of codeine-based painkillers, that she took in large doses to create a feeling of euphoria that masked her emotional pain and loneliness (in the Lonely Child).

After matric, Tina's symptoms of depression increased, and she experienced anxiety. Tina's depression represented a mode sequence where her Demanding, Critical Parent introject with messages regarding what she should be achieving in life and criticism related to her perceived lack of achievement, triggered her Defective Child and associated feelings of shame. This was then followed by ruminating, which focused on self-loathing and hopelessness about her situation (Rumination coping mode). Whilst attending hotel school, Tina's Defective Child was triggered by approaching exams as she became preoccupied with anticipation of failure. Tina, who was subjugated to her father because of his conditional love, feared disappointing him. So she overdosed on a bottle of Paracetamol tablets, a Detached Self-Soother response. Afterwards, she regretted her decision and told a friend what she had done. The friend took her to the hospital, where she was treated with activated charcoal and later prescribed an antidepressant by her general practitioner. She then dropped

out of college (a further example of Avoidant Protector coping when her Failure schema was activated). Months later, Tina's depression was reinforced by her inactivity (Avoidant Protector coping) and rumination (Rumination mode) about being an unemployed college dropout (which had triggered her Defective Child). Feeling hopeless about the future, she flipped into Detached Self-Soother coping and overdosed on her antidepressants.

Tina's father loaned her money for hotel school, for which she signed a contract with repayment terms. When she broke the contract by not making repayments, her father sued her. Tina, who was subjugated and used to the "terms and conditions" which accompanied her father's love, believed he was justified to take such extreme steps against her and repaid the money she owed him over 4 years (Compliant Surrenderer coping).

Tina's Lonely Child was desperate for love and a meaningful connection. So she fell into intense relationships in which she idealised her partner and dismissed the negative aspects of the relationships (Pollyanna Overcompensator coping). For example, Tina's first relationship, at the age of 19, was with a man whom she described as her "great love", an unemployed compulsive liar who supported himself by stealing. The relationship was co-dependent as he supported Tina's medication abuse by illegally obtaining prescription painkillers for her, and when their excessive use made her vomit, he cared for her. Their unstable relationship was punctuated by frequent break-ups, reconciliations, and arguments that escalated to physical aggression, where they pushed each other. Tina ended the relationship at 21 because she acknowledged that they had different morals and that the relationship was destructive (Healthy Adult). However, emotionally deprived and desperate to be loved, she maintained a positive view of the relationship; (S2) "Out of everyone in my whole life, he has seen the real me at my lowest, and he loved me anyway."

After the breakup, Tina's mood improved, she felt more confident and stopped engaging in self-destructive behaviours. Four months later, she met her husband, Craig, online and, after a 5-year courtship, they married. Tina was attracted to his stability, as he was in a chronic avoidant pattern, and she believed this was a healthier relationship for her. However, Tina and Craig had contrasting personalities. For example, Tina likes the outdoors and socialising, but Craig, an introvert, was addicted to computer games and could play for more than 5 hours at a time. Craig would "throw money at her" (S8) and encourage her to go out with friends so that he could stay at home and play computer games uninterrupted. He was emotionally disconnected, and so Tina's Lonely Child was triggered as she was lonely in the marriage. Tina could not have meaningful discussions with Craig and, in a Defective

Child mode, believed, “I think deep down he thinks I’m the biggest joke” (S4). She gave examples where he would argue with a statement she made but then would accept the same information if it was provided by someone else.

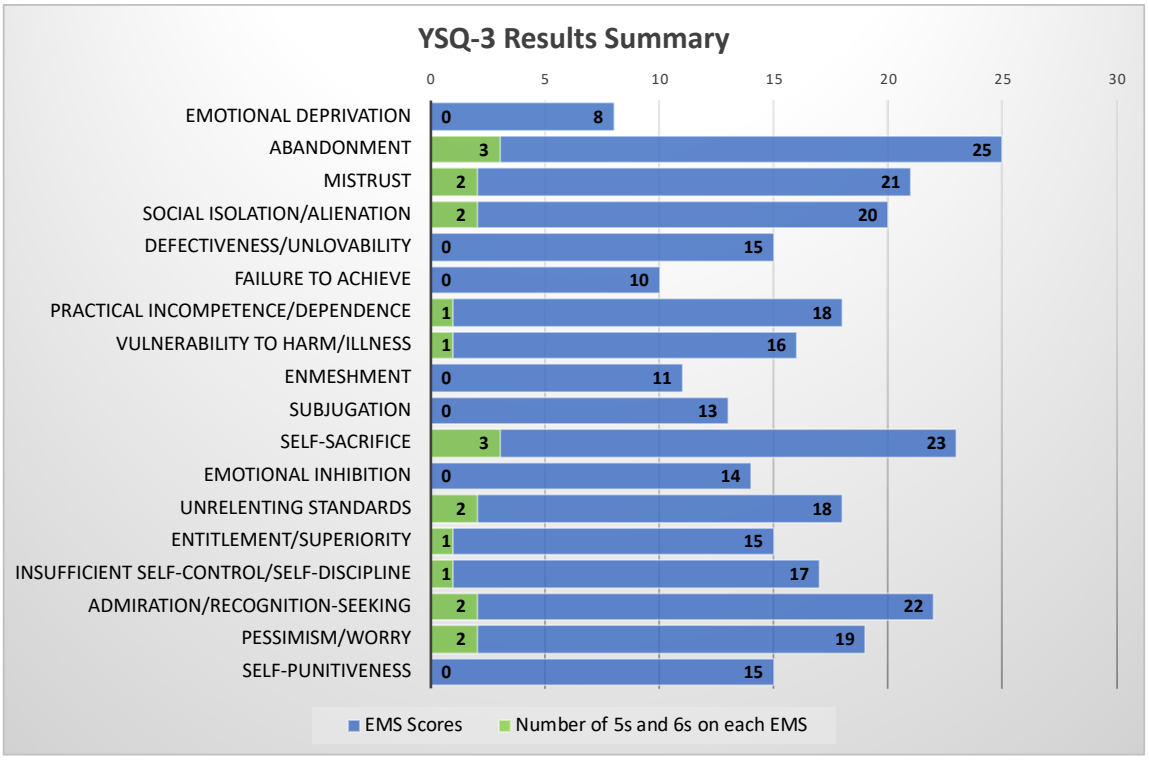
Several later events activated Tina’s Abandoned Child. At the age of 22, her father relocated to another country for 4 years. Then, at 25, her mother, twin sister and maternal gran moved overseas, and at the age of 28, her oldest sister and her best friend, Sally, moved to another province. Shortly after Sally’s move, Tina met with George after not having in-person contact for a decade. After the meeting, he distanced himself from Tina which triggered her Vulnerable Child (Defectiveness/Shame and Abandonment/Instability schemas); “If I’m not good enough for George, then who am I good enough for?” (S1). When Tina experienced abandonment, it resulted in hurt, sadness and anger, which she coped with through a Bully and Attack coping mode as she wanted to hurt those who hurt her, (S8) “Everyone knows when I have my temper I’m actually heart sore about something…you hurt my feelings, and I had to protect myself.” For example, Tina told Sally about her ED because she wanted to hurt Sally for leaving by inducing shame about how little she knew of Tina’s life.

7.2. Results on the YSQ and SMI

The results of the YSQ are shown in Figure 4, and the results of the SMI are shown in Figure 5. The questionnaires were conducted after the fifth session. In developing the case conceptualisation, the scores and qualitative information from responses to specific items were used in conjunction with the information obtained in the clinical interviews and observations of her behaviour.

Figure 4

Tina's Results on the YSQ



The prominent schemas on the YSQ (see Figure 4) were the Abandonment/Instability, Mistrust/Abuse, Social Isolation/Alienation, Dependence/Incompetence, Self-Sacrifice, Unrelenting Standards/Hypercriticalness, Approval-Seeking/Recognition-Seeking and Negativity/Pessimism (labelled Pessimism/Worry on the graph). However, information provided in sessions suggested that Tina's scores for Emotional Deprivation, Failure, Defectiveness/Shame, Punitiveness, Subjugation and Insufficient Self-Control/Self-Discipline significantly underestimate the degree to which these schemas were active. Tina's higher score on the Mistrust/Abuse schema was influenced by one score of 6 for the statement, "I feel that people will take advantage of me." This statement was related to Tina feeling that a close friend, with whom Tina flipped into a Compliant Surrenderer mode to avoid activation of her Abandonment/Instability schema, took advantage of her. This statement, therefore, relates more to her Compliant Surrenderer coping than her Mistrust/Abuse schema.

Figure 5

Tina's Results on the SMI Compared to Normal Controls

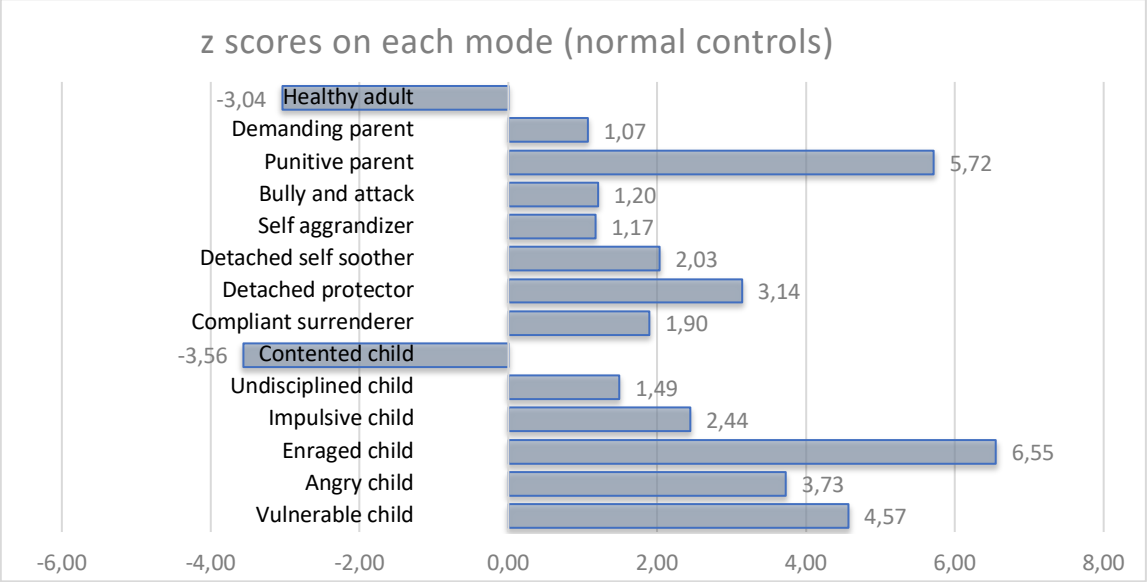


Figure 5 illustrates Tina's scores on the SMI compared to an average population of individuals without a clinical disorder. Tina had high scores (more than 3 SD above the norm) on the scales for Punitive Parent, Detached Self-Soother, and Vulnerable Child, which were supported by the information she provided in sessions. Also, Tina had Angry Child modes supported by her significant score for Enraged Child (6,55 SD above the norm) and Angry Child (3,73 SD above the norm). Although her Angry Child score was lower than her Enraged Child score, Tina had severe scores for two items on the Angry Child scale. She scored 6 for the item, "I'm angry with someone for leaving me alone or abandoning me", and 5 for the item, "It makes me angry when someone tells me how I should feel or behave." Tina only scored one Enraged Child item a 5, "Once I start to feel angry, I often don't control it and lose my temper." This statement also supports her Bully and Attack mode (1,20 SD above the norm). Her scores for Demanding Parent (1,07 SD above the norm) and Compliant Surrenderer (1,90 SD above the norm) were lower than expected when her case conceptualisation was developed. Several statements for Detached Protector referenced feeling isolated from people. These related to Tina's prominent Lonely Child, not measured by the SMI. Other Detached Protector statements about feeling flat and feeling "nothing" can be understood as related to Tina's chronic depression. Tina's scores significantly below the norm for the healthy modes of Contented Child (3,56 SD below the norm) and Healthy Adult

(3,04 SD below the norm) support the case conceptualisation that Tina had a poorly developed Healthy Adult and Contented Child.

7.3. ED Presentation

At the age of 15, Tina began inducing vomiting as a form of weight maintenance after eating junk food or what she considered to be large amounts of food. Tina was self-conscious about her weight and wanted to maintain a "perfect image", but she enjoyed food and believed inducing vomiting was a way to maintain a BMI of 19 whilst eating whatever she wanted. Thus her Perfectionist Overcontroller coping developed into a specialised Eating Disordered Overcontroller of which the induction of vomiting was a part. Tina's bingeing and purging escalated to at least 3 times a week, which met the criteria for BN. Tina struggled with undiagnosed and untreated BN intermittently until the age of 20.

From the age of 20 to 28, Tina did not experience symptoms of an ED. Then, at the age of 28, shortly after feeling rejected by George and Sally, Tina thought she was pregnant. After a negative pregnancy test, she became self-punitive, restricting food and having the thought that she did not need to nourish her body if she was not nourishing a baby (the Flagellating Overcontroller sub-mode in the Eating Disordered Overcontroller). Tina wanted a baby, and so she was deeply disappointed when she was not pregnant. Hence, her restricting behaviour shut down feelings of sadness. Tina's food restriction developed into AN which she hid for 8 months. After disclosing her AN to Sally, Craig and her father, Tina was admitted to a psychiatric facility for 2 weeks, where she met with a dietician, psychologist and psychiatrist. Her BMI was 17.3 at the time she was admitted.

In the months following her discharge from the hospital, she fasted for 3 days at a time (the second feature of the Eating Disordered Overcontroller), believing it was easier not to eat than to deal with the anxiety related to choosing what to eat. However, living "on energy drinks and strong coffee" caused extreme hunger, which triggered the Impulsive Child, trying to get her nutritional needs met, working in tandem with the Detached Self-Soother to detach from and escape the feelings of loneliness, sadness and anxiety in the background, which resulted in bingeing. Once she started bingeing, the compulsion to continue eating was "gross, overwhelming and uncontrollable." During a binge, Tina ate "anything she can find" until she ran out of time or ran out of food. She gave an example of a binge which included tinned soup, a box of crackerbread, a bowl of cucumber, celery and tomato, 3 cups of cereal and barbecue sauce. Tina binged in secret when Craig was out or, if

he was home, she hid in the garage and binged. After a binge, she flipped into an Eating Disordered Overcontroller mode that activated disgust, sadness and guilt (in the Vulnerable Child), which she shut down by clearing away the evidence of the binge (Avoidant Protector). This was followed by anxiety as Tina ruminated about the calories consumed and loss of control (the tenth feature of the Eating Disordered Overcontroller). So, in the Detached Self-Soother mode, Tina pushed her toothbrush down her throat to induce vomiting. Tina's neutralising behaviours included excessive exercise for up to 3 hours a day. The self-flagellating aspect of the Eating Disordered Overcontroller (the fourth feature), where she punished herself for bingeing and breaking the food rules, included a "guilty bath" in which she bathed in scalding hot water. Also, she would not allow herself to eat the following day to compensate for the calories she consumed.

Tina referred to her bulimic side as "Mia" and her anorexic side as "Ana." She kept a journal as part of her Eating Disordered Overcontroller in which she recorded calories she consumed, binges, induction of vomiting, workouts, her weight, photographs of women with AN and "inspirational quotes"; for example, "Waking up thinner is worth going to bed hungry." Tina's journal is associated with the fifth feature of the Eating Disordered Overcontroller; the focus on the body and eating patterns to generate a sense of competence, power and control. Tina was preoccupied with thoughts of food and was unable to maintain consistently healthy eating patterns, as she alternated between bingeing and restricting. Also, she struggled to recognise cues for hunger or satiety. When Tina was not fasting (the second feature of the Eating Disordered Overcontroller), she restricted food. She would not allow herself to eat more than 400 calories in a day (the first feature of the Eating Disordered Overcontroller), although if she managed only 200 calories, she felt empowered (the fifth feature of the Eating Disordered Overcontroller). Tina described it as exhausting having Ana and exhausting trying to get better.

When bulimic symptoms emerged, Tina had days where she flipped into a Rumination mode and wanted to lie in bed and think about her ED and find ways to get back to Ana. Tina experienced conflict as she enjoyed food, but she wanted to be anorexic because she felt happy and safe with Ana (the fifteenth feature of the Eating Disordered Overcontroller), as it allowed her to avoid dealing with problems in her marriage. During these times, she and Craig fought less because she was disconnected and focused on her ED (the seventh feature of the Eating Disordered Overcontroller). By counting calories and restricting in the Eating Disordered Overcontroller mode, (S7) "Anorexia was just my only

focus. I didn't have to think about anything else; it took over every other worry in my life…it made me not face my problems."

Tina's Eating Disordered Overcontroller shut down feelings of loneliness (the sixth feature of the Eating Disordered Overcontroller) and gave her a sense of control (the fifth feature of the Eating Disordered Overcontroller):

> I just had a smile on my face…and because I had my anorexia, that's all I cared about, and Craig and I were fantastic. When I'm not restricting, and I don't have this anorexia, in my head, I feel like I'm mentally insane. When I have the anorexia, I feel like I'm not. I'm only anorexic, and that's it. (S4)

The Eating Disordered Overcontroller also shut down suicidal thoughts when her Vulnerable Child was triggered. "People around me don't realise that when I'm not restricting, I'm so suicidal and I'm so confused, and I'm so overwhelmed…I'm screaming inside. But when I'm restricting, I feel just fine" (S8). However, her ED maintains her loneliness and isolation because it prevents her from developing meaningful connections. For example, she stays home and isolates when she is unhappy with her weight.

Tina's mother visited when her BMI was 20.5 and commented that Tina looked "fantastic." Tina experienced a sense of failure (her Failure schema was activated) because she wanted to look unwell so that her mother would see that she was not okay (the twelfth feature of the Eating Disordered Overcontroller). A cycle of restricting (Eating Disordered Overcontroller) and bingeing (Detached Self-Soother) ensued over the next few days, which resulted in weight gain (BMI 21.4). When her father visited a week later, she was embarrassed about her weight. She again wanted to be skinnier to prove that she was not okay (the twelfth feature of the Eating Disordered Overcontroller), a belief that was reinforced because Craig believed that as she was at a healthy weight, she was better. Tina was unable to share with Craig how she was struggling with the ED because she did not want to disappoint him that she was not better (evidence of a Compliant Surrenderer), and she feared that he would leave her (triggering her Abandoned Child) as he had threatened to do. However, Tina was desperate for someone to notice her suffering (Vulnerable Child), but she did not have a Healthy Adult that could healthily seek the care she needed. Instead, the complex Eating Disordered Overcontroller provided access to this care (the twelfth feature of the Eating Disordered Overcontroller).

Over 3 months, Tina's weight increased to a BMI of 22.9. She felt angry with herself (the fourth feature of the Eating Disordered Overcontroller) and that she had failed because her weight was not as low as she wanted it to be. Tina then restricted (the second feature of the Eating Disordered Overcontroller), and over 2 weeks lost 4 kg (BMI 21.1), which resulted in "quiet in her head" as her self-punitive thoughts in the Vulnerable Child subsided. As part of Tina's efforts to lose weight, she created food rules (the first feature of the Eating Disordered Overcontroller), from her own beliefs and information from the internet, regarding what she was allowed to eat for the day. If she ate more than allocated, she induced vomiting to calm the anxiety (Detached Self-Soother). For example, Tina allowed herself two fruits and a packet of popcorn for the day but still feeling hungry, she ate a peach. Having broken her food rule created a panic that she would not stop eating, but inducing vomiting calmed her (Detached Self-Soother).

Tina swung between periods where she weighed herself several times a day (the ninth feature of the Eating Disordered Overcontroller), and then she was afraid to weigh herself. When Tina believed she was overweight, she experienced feelings of shame (in the Vulnerable Child). Tina flipped into Avoidant Protector coping, and she withdrew, not wanting to go out and be seen. Alternatively, Tina slept to avoid thinking about food (Avoidant Protector coping).

Tina's ED behaviour met DSM-5 criteria (APA, 2013) for AN binge-eating/purging type, as well as BN at different stages of the research (see Table 4).

7.4. Case Conceptualisation at the Time of the Assessment

Table 4

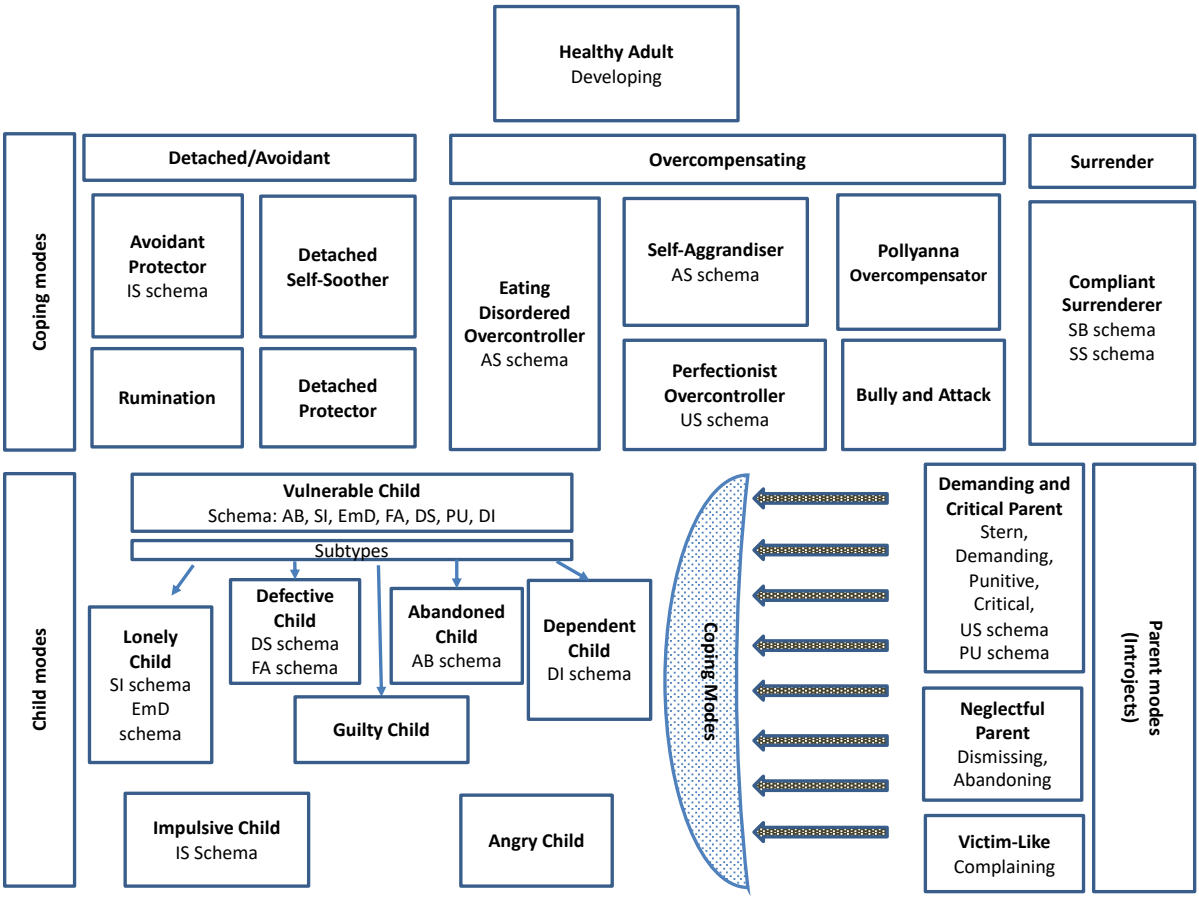
Tina's DSM-5 Diagnosis at the Time of the Assessment

DSM-5 Diagnosis	**ICD-10-CM Code**
Anorexia nervosa, binge-eating/purging type, mild	F50.02
Bulimia nervosa, moderate	F50.2
Major depressive disorder with melancholic features, moderate	F33.1
Generalised anxiety disorder	F41.1
Dependent personality disorder	F60.7

Table 4 presents Tina's diagnosis at the time of the assessment. This will be made evident in this section. Tina's current modes are represented in the mode map (see Figure 6).

Figure 6

Tina's Current Mode Map



Note. AB = Abandonment; AS = Approval-Seeking/Recognition-Seeking; DI = Dependence/Incompetence; DS = Defectiveness/Shame; EmD = Emotional Deprivation; FA = Failure; IS = Insufficient Self-Control/Self-Discipline; PU = Punitiveness; SB = Subjugation; SI = Social Isolation/Alienation; SS = Self-Sacrifice; US = Unrelenting Standards/Hypercriticalness.

Tina's assessment began 3 weeks after her discharge from the hospital for AN. She was 28, had been married for a year and did not have children. Tina held a managerial position at a tennis club where she had been a coach for 7 years.

Craig's job involved shift work so that every second week when he worked the night shift, their only time together was during her lunch break. Her disconnected relationship with Craig made it easy for her to deceive him about the ED. For example, Tina worked in her "ED journal" recording calories whilst sitting next to him, and she lied about eating, a

deceptive feature of the Eating Disordered Overcontroller. Tina was frustrated by his ignorance and lack of concern and support. This lack of support included being unwilling to engage with Tina about business ideas she had so that when she had children, she could work flexible hours.

Tina's Dependent Child was evident in her dependence on Craig. For example, she relied on him to make decisions, fill in paperwork, drive her (although she had a licence and a car) and deal with service providers. Tina met the DSM-5 criteria for a dependent personality disorder (see Table 4).

Tina wanted to be protected by Craig, to have him defend her to other people but, when they were in public, he corrected Tina's grammar and behaviour. Tina felt unsupported by him as he was dismissive of her feelings and needs, triggering her Lonely Child; (S4) "I'm on my own. I'm a one-woman show." Tina felt insecure in her marriage, and her Abandoned Child was triggered, "I feel like if I don't pull up my socks, he will leave me" (S4). As mentioned, he did threaten to leave because of her ED.

Tina experienced frequent suicidal ideation, a low mood and low energy levels. There were two occasions during the research when, to cope with anxiety and hopelessness, Tina overdosed on medication (Detached Self-Soother). The first time Tina took five times the recommended dose of a cough mixture, and the second time she took nine sleeping tablets. The first time Tina wanted to be hospitalised to have time away from everyone she knew, and the second time she wanted to be "comatose" to escape the distress caused by her focus on her ED and her weight. Her score of 47 (severe range) on the BDI-II supported a DSM-5 diagnosis of major depressive disorder (see Table 4).

Tina also struggled with generalised anxiety and panic attacks that were exacerbated by the large amounts of caffeinated energy drinks she consumed. She had a BAI score of 37 (severe). Although the number of panic attacks decreased once her caffeine intake was reduced, her anxiety met the DSM-5 criteria for generalised anxiety disorder (see Table 4). When things did not go as planned, and when she thought about being trapped in a job where she was unhappy, Tina's rumination (Rumination mode) triggered anxiety and panic attacks (in the Vulnerable Child), followed by hopelessness. Tina coped with the hopelessness by withdrawing and spending the day in bed (Avoidant Protector).

Tina's Perfectionist Overcontroller coping was still evident in her current functioning as she spent a lot of time writing elaborate lists of goals and schedules which were "about

being perfect" (S5). This coping resulted when the demanding introjects caused anxiety and a feeling of being overwhelmed (Vulnerable Child), that flipped Tina into Perfectionist Overcontroller coping, which suppressed her emotional vulnerability (the sixth feature of the Perfectionist Overcontroller). Tina then became stuck as she lacked a Healthy Adult mode where she could put thoughts into action.

Tina's friend, Paula, was in an abusive on-again/off-again relationship. When she was single, she spent all her time with Tina, but when Paula returned to her boyfriend, she saw less of Tina, triggering Tina's Abandoned Child. Tina tried to please Paula and maintain the connection by loaning her clothes and makeup and engaging in activities Paula enjoyed (Compliant Surrenderer coping). On one occasion, when Tina observed Paula and her boyfriend engaging in an activity that she and Tina usually did together, Tina coped with the feelings of betrayal by bingeing (Detached Self-Soother mode). Paula colluded with her ED. For example, if Tina binged when Craig was home, she went to Paula's home nearby to induce vomiting so that he would not know.

Tina's ED was maintained because she lacked a Healthy Adult mode in which she could tell people that she was struggling and needed support. So, she wanted to look unwell (underweight) to communicate this (the twelfth feature of the Eating Disordered Overcontroller). At the same time, she felt defective (Defective Child) and undeserving of support (because of the guilt-inducing aspects of the complex parent mode); "I feel I should just be tossed to the wind. I feel like everyone should just give up on me. I feel so much of a mission" (S3). Also, her developing Healthy Adult voiced her fear that she will outgrow Craig, and so by focusing on her ED, she avoided facing the deeply unsatisfactory nature of her marriage. This maintained her loneliness in the marriage, triggering her Lonely Child, which she used the Eating Disordered Overcontroller to cope with and block out.

7.5. Tina's Parent Modes

Tina's "cold and rational" father was introjected as a Demanding and Critical Parent mode (see Figure 6) because he was demanding, punitive, critical and stern (see Table 2). This parent mode was moderately toxic as her father imposed his wishes and standards on Tina (see Table 2). At other times, he was abandoning and dismissive (see Table 2), and so he was also introjected as a more severely toxic Neglectful Parent (see Figure 6) as this introjected parent did not have good intentions towards her (see Table 2).

Tina's father was neglectful and dismissive when she was ill, and he would tell her to "take a pill and get over it." Thus she did not experience nurturing and care from him, and she introjected the belief that she was not important and would be neglected. Tina projected this Neglectful Parent onto Craig in the example given in section 7.4, where his lack of enthusiasm about her work goals triggered a dyad between a Neglectful Parent and a Vulnerable Child, so Tina experienced Craig as not taking her seriously. Also, Tina's description of herself in relation to Craig as "on her own, a one-woman show" (in section 7.4) illustrates the dyad between the Neglectful Parent and Vulnerable Child as Tina expected Craig to neglect her.

Tina also experienced her father as abandoning when he moved away and maintained little contact with her. As her father was unavailable to her, the implicit message was that Tina's needs were not important and that she could not rely on people to be there. A mode dyad existed between a Neglectful Parent and an Abandoned Child, which Tina coped with by prioritising others' needs (Compliant Surrenderer coping) so that they would not abandon her. For example, when Paula spent time with her boyfriend and not Tina, this triggered a dyad between Tina's Neglectful Parent and Abandoned Child. Tina then flipped into Compliant Surrenderer coping, where she did things to make Paula happy so that she would not abandon her. As a result of the Neglectful Parent and Abandoned or Neglected Child mode, Tina looked forward to hospitalisation because she would be cared for. Thus she experienced secondary gain from receiving medical treatment as a hospital environment provided for at least some of Tina's unmet needs.

In the Demanding and Critical Parent mode (see Figure 6), Tina's father was emotionally punitive as he would withhold attention, for example, by not talking to Tina if she did not do things his way. Tina was aware that his love was conditional as she commented that it came with "terms and conditions." Thus, Tina's father set standards for her, and if she failed to meet these standards, he punished her by withholding love. As a result, Tina developed an Unrelenting Standards/Hypercriticalness schema and set high standards for how she "should" behave as she sought her father's, and subsequently, everyone else's, approval to avoid rejection. Thus a mode dyad existed between a Demanding and Critical Parent and a Defective Child, which she coped with by Perfectionist Overcontroller and Compliant Surrenderer coping.

Another aspect of the Demanding and Critical Parent was physical punitiveness. Every time Tina visited her father, she would be reprimanded and then sent to her room

where she would get a hiding. Although she acknowledged that she was naughty, Tina also believed that many of the hidings were because she was not doing things the way her father wanted them done, again illustrating the demanding feature of this parent mode. An example of her father's demanding nature was evident in S1 when Tina stated, "We used to have to study *The Seven Habits of Highly Effective Teens* and *Young Succeed* magazines and always these pushing self-motivating things." Another example of the demanding and stern aspect is how her father took a business-like approach to interactions with her. "My dad's the kind of person like you make a deal with him, you're going to sign a contract" (S2). This was evident in the example given in section 7.1, where Tina's father loaned her money for her studies and then took legal action when she reneged on payments. This punitive response is further supported by Tina's comment that, "You didn't bend the rules with my dad" (S1). Tina's Compliant Surrenderer coping with this introjected Critical and Demanding Parent, with strict rules and the belief that you are bad and deserve punishment, led her to accept her father's legal action against her.

Her father's critical nature, along with Tina's awareness of her disability, contributed to the development of her Defectiveness/Shame schema and an accompanying self-consciousness where Tina expected to be judged. Tina also developed a blended Failure and Defectiveness/Shame schema, evident when Tina feared failing and saw this as a sign that she was defective, which resulted in shame. There existed a mode dyad between a Defective Child who sought the love of her Demanding and Critical Parent. To overcome the feelings of shame, defectiveness and fear of failure, Tina coped through Perfectionist Overcontroller, seeking the approval of others (the eighth feature of the Perfectionist Overcontroller) on whom she had projected the Demanding and Critical Parent, or Avoidant Protector in which she avoided the disapproval of others; for example, avoiding school projects when she had projected the Demanding and Critical Parent onto her teachers.

Tina's mother, a fragile narcissist, was a complaining victim-like parent (see Figure 6) who induced guilt if she was not looked after. Thus, her mother was introjected as a moderately toxic Victim-Like Parent (see Table 2). Tina believed that her mother's anger and bitterness towards her father sabotaged her (Tina's) relationship with him. As a child, Tina felt guilty for loving her father (Guilty Child) and choosing to spend time with him. This guilt came from her guilt-inducing victim-like mother, who implied that Tina was choosing her father over her, thus creating a mode dyad between a Victim-Like Parent and a Guilty Child. Tina never spoke to her father about the things her mother said about him. She was aware

that her mother had told them in confidence and that they should not talk about them. This is the impact of her mother's victim-like behaviour and the implicit demand that the child will protect the victim-like parent in various ways and do multiple things to help this parent. In this case, there was an internalised rule that Tina must not tell her father. This could be motivated by loyalty to her mother as well as her being protective of her mother. Both are impacts of the guilt-inducing Victim-Like Parent.

Tina described her mother as her "best friend." However, this belief was delusional and was an aspect of her Pollyanna Overcompensator coping. Her relationship with her mother was subjugated as they did not reciprocally confide in each other. Instead, her mother confided in Tina. Another delusional belief was that they "worked as a team." Tina rationalised her contributing to household expenses as a teenager by stating, "That's what we do. The responsibility couldn't be completely on my mother" (S30). This is delusional as it was her mother's responsibility to provide for her basic needs. Instead, her mother was not someone Tina could depend on to provide safety and security. Tina's mother was irresponsible, victim-like and guilt-inducing and Tina's Pollyanna Overcompensator, in which she believed and stated what a nice mother she had, merely rationalised and obscured the reality of the unmet needs of the child.

7.6. The Perfectionist Overcontroller

Tina's Perfectionist Overcontroller (already referred to in section 7.4) contained six of the 13 features described in section 5.3, namely;

- striving for excellence and perfect results,
- the marginalisation of other aspects of life,
- rigidity regarding morals, ethics and values,
- preoccupation with details, order, lists and schedules,
- suppression of emotional vulnerability,
- seeking approval and acceptance from others.

In a Perfectionist Overcontroller mode, Tina spent a lot of time writing elaborate lists of goals and schedules and drawing mind maps (the fifth feature of the Perfectionist Overcontroller) which were "about being perfect" (the first feature of the Perfectionist Overcontroller). This led to the marginalisation of other aspects of her life (the third feature

of the Perfectionist Overcontroller), as she became so caught up in writing the elaborate lists that she felt anxious and overwhelmed and accomplished little.

Tina had elements of rigidity and inflexibility, especially the need for things to be "just right" (the fourth feature of the Perfectionist Overcontroller). When she and her husband moved into an apartment Tina would "look at pictures of the apartment for hours and decide where the rug is going to go…I used to cry about it" (S7). Tina was unable to decide because she felt that the décor had to be "just right."

7.7. The Eating Disordered Overcontroller

Tina's Eating Disordered Overcontroller contained 11 of the 15 features described in section 5.4, including;

- rules about goal weight and what one is permitted to eat,
- the decision to restrict eating and lose weight,
- self-punitiveness and self-loathing,
- focus on the body and eating patterns to generate a sense of competence, power and control,
- suppression of emotional vulnerability,
- the marginalisation of other aspects of life,
- checking behaviours,
- rumination,
- the generation of images that induce shame, fear and self-disgust,
- looking ill to gain attention,
- the promise of a happier life.

As described in section 7.3, Tina struggled with BN as a teenager. This was mostly part of a Detached Self-Soother coping mode where her bingeing provided comfort from feelings of anger, sadness and loneliness. However, Tina's Eating Disordered Overcontroller also developed in her teenage years and was evident when she induced vomiting to maintain her BMI (the second feature of the Eating Disordered Overcontroller). Thus much of the Eating Disordered Overcontroller was discussed in section 7.3.

Tina's Eating Disordered Overcontroller became more prominent at 28 when she developed AN. After discovering she was not pregnant, Tina thought, "If I don't have a baby to nourish, then I'm not going to nourish myself" (S1). The disappointment she felt at not being pregnant triggered self-loathing and a punitive attitude towards herself (evidence of a Flagellating Overcontroller sub-mode). So, Tina restricted food and counted calories (the second feature of the Eating Disordered Overcontroller). This suppressed her emotional vulnerability (the sixth feature of the Eating Disordered Overcontroller) and, according to Tina, made her feel "happy and safe" (the fifteenth feature of the Eating Disordered Overcontroller) as other areas of her life were marginalised (the seventh feature of the Eating Disordered Overcontroller):

> Anorexia was just my only focus. I didn't have to think about anything else. It took over every worry in my life…it made me not face my problems. So long as I am concentrating on my anorexia, I don't have time for anything else. (S7)

Before Tina disclosed she had an ED, she described how she and Craig were happy because she did not complain that he spent hours playing computer games and not spending time with her. When Tina is focused on the Eating Disordered Overcontroller, her Lonely Child is shut down so that she does not feel how lonely she is. Without the Eating Disordered Overcontroller, she is opened up to the Vulnerable Child, where the sadness, loneliness, hopelessness and despair are. In this way, the Eating Disordered Overcontroller provided an essential element; it blocked difficult feelings (the sixth feature of the Eating Disordered Overcontroller).

Tina's Eating Disordered Overcontroller had a Flagellating Overcontroller sub-mode (part of the fourth feature of the Eating Disordered Overcontroller) as she wrote critical messages to herself when she felt she was not strict enough, which motivated her to continue following the rules of the Eating Disordered Overcontroller. S2 "You either have an eating disorder, or you don't…if I feel like I failed, I have to say something to myself about it. I can't just let it slide." She felt this would help her "do better" (restrict more) the next day. When Tina was overwhelmed by the urge to binge, this led to disgust (the fourth feature of the Eating Disordered Overcontroller). "I'm disgusted. It's not the weight I'm disgusted at; it is myself that I'm disgusted at, that I've gone from being able to restrict to the point where I cannot stop myself once I start eating" (S3). In turn, if she "failed" by giving in to a binge, she would punish herself by having a "guilty bath" where she bathed in scalding hot water. The behaviour described here are examples of the Flagellating Overcontroller sub-mode of

her Eating Disordered Overcontroller, where Tina punished herself physically or verbally to compensate for feelings of failure related to her ED. As well as the feelings of failure, Tina felt disgusted if she was not restricting. This was accompanied by somatic cues (the eleventh feature of the Eating Disordered Overcontroller), such as her clothes feeling tighter.

The core feature of the Eating Disordered Overcontroller is the impulse to restrict eating and lose weight, which is partly achieved through rules about what one is permitted to eat (the first feature of the Eating Disordered Overcontroller). However, for Tina, "It was easier to not eat at all than to contemplate with myself now what I can and cannot eat" (S7). This attitude resulted in Tina fasting for three days at a time (the second feature of the Eating Disordered Overcontroller), but self-starvation caused hunger which led to a binge. If Tina binged, she punished herself (the fourth feature of the Eating Disordered Overcontroller) by not allowing herself to eat the next day, (S4) "I can't eat today, because I binged yesterday." This is an example of the Flagellating Overcontroller sub-mode. For a time, Tina would not allow herself to eat during the day because then she felt less guilt if she binged at night, justifying that the calories she missed during the day allowed for the calories consumed in her binge. Thus the fifth feature of the Eating Disordered Overcontroller, focus on the eating patterns to generate a sense of control, and the second feature, the decision to restrict eating, interacted with each other.

As mentioned in section 7.3, Tina kept a journal in which she recorded her weight almost daily as well as food and calories consumed, binges and induction of vomiting. Included in the journal were pictures and quotes obtained from Proanna websites, websites aimed at promoting and supporting EDs, which Tina turned to for inspiration. The journal relates to the first feature of the Eating Disordered Overcontroller; rules about goal weight and what she was permitted to eat, and the fifth feature, a focus on the body and eating patterns to generate a sense of competence, power and control. Tina's food rules included not eating after 8 pm. She also counted calories. "I'm not really allowed to eat. I just have to eat as little as possible; otherwise, my whole day is ruined" (S9). If Tina ate more than what she had allowed for herself, she would be filled with self-loathing as her Eating Disordered Overcontroller co-opted the Flagellating Overcontroller (the fourth feature of the Eating Disordered Overcontroller) with messages that she was disgusting, useless and a failure. This caused feelings of anxiety which Tina shut down by inducing vomiting (in a Detached Self-Soother mode).

Tina engaged in body checking behaviours (the ninth feature of the Eating Disordered Overcontroller) which included weighing herself daily, checking the tightness of the fit of her clothes and grabbing her stomach and thighs to see if she had "excess fat."

Tina's Eating Disordered Overcontroller gave her a sense of power and control (the fifth feature of the Eating Disordered Overcontroller). When talking about restricting, she said, "I feel like I've got more power again" (S2). This sense of control helped to alleviate anxiety (the sixth feature of the Eating Disordered Overcontroller) and gave her a sense of independence.

When Tina was restricting (the second feature of the Eating Disordered Overcontroller) and became anorexic, she could access attention and care (the twelfth feature of the Eating Disordered Overcontroller), for which she felt unable to ask. Tina was hospitalised for two weeks at the height of her AN. Thereafter she frequently expressed a desire to return to the hospital because she felt cared for by the nurses, and she had the attention of friends and family who phoned and visited. When Tina was bulimic, and her BMI was in the normal range, she was distressed that people could no longer "see" that she was ill and needed help.

7.8. The Detached Self-Soother

Tina had several self-soothing behaviours (Detached Self-Soother coping). First, she engaged in self-injurious behaviour as part of her Detached Self-Soother coping mode. From the age of 13 throughout her teenage years, Tina cut herself to soothe sadness by distracting with physical pain. Then, a second Detached Self-Soother behaviour, she tended to the wounds, further distracting herself from the emotional pain.

A third self-soothing behaviour Tina developed during her teenage years was to abuse medication. This was an impulsive behaviour where Tina consumed over the counter or prescription medication she found at home, with the intention of gaining a sense of euphoria when she felt anxious or sad. Tina did not have the intention of overdosing on this medication, but she consumed doses higher than recommended to achieve the sensation of euphoria.

A fourth self-soothing behaviour was bingeing. Tina regularly fasted for three days (in an Eating Disordered Overcontroller mode), which created such physical hunger that she would binge:

> It is excruciating, mentally excruciating, trying to beat a binge. It is like a coke addict having coke in front of them, and you can't have it…you're in so much despair and… there's that part of you that just doesn't want to eat, and you don't want to put yourself through going to have to throw your food up. (S3)

The conflict that Tina experiences as excruciating is between the part that wants to eat, the Detached Self-Soother, and the part that wants to maintain control, the Eating Disordered Overcontroller. As Tina is physically hungry, the Impulsive Child is triggered that wants to get her nutrition needs met. The Impulsive Child works in conjunction with the Detached Self-Soother that wants to escape the difficult emotions that are evoked. There is a mindfulness part of Tina observing the conflict, the Healthy Adult.

There is a permission-giving belief component to Tina's Detached Self-Soother, "This thought comes over you…just eat it because then you can just throw it up. It is okay if you eat it" (S3). During a binge, Tina feels calm, but she lacks conscious awareness of what she is eating, a feature of the Detached Self-Soother. As Tina is not reflecting on what she is eating during a binge, there is no evidence of a Healthy Adult at this time. After a binge, Tina feels panic about what she has eaten when she sees "the chaos" of empty food wrappers and food remains in the kitchen. Tina flips into an Eating Disordered Overcontroller focused on the calories consumed. The Eating Disordered Overcontroller then deploys the Flagellating Overcontroller sub-mode with punitive messages, which Tina shuts down by inducing vomiting; "But the binge is almost not worth the purge, because it's so painful to throw up my food, and it's so time-consuming" (S5).

Inducing vomiting represents a fifth self-soothing behaviour. When talking about inducing vomiting in S31, Tina stated, "I love it, but I hate it. You feel high after you're done." The euphoria is a feeling which Tina enjoys and is one aspect of inducing vomiting as a self-soothing behaviour. Another motivation is to undo the binge by removing the calories and thus soothe the anxiety evoked by the Eating Disordered Overcontroller. However, "It's terrible to feel like you haven't got it all out" (S31). After inducing vomiting, Tina still regrets the binge as she flips into a Rumination coping mode in which she ruminates about whether she expelled all the food.

7.9. Schema Perpetuation and the Therapeutic Process

This section will look at how the schemas were perpetuated and the therapeutic process that unfolded with Tina.

Tina's large Lonely Child and Abandoned Child contributed to Compliant Surrenderer coping to develop and maintain relationships with others and overcome her fears of rejection and abandonment. Also, in a Pollyanna Overcompensator mode, Tina dismissed the unsatisfactory nature of relationships so that these relationships could be maintained. However, these coping modes kept Tina engaged in relationships in which her needs remained unmet, and her schemas were reinforced. Tina's ED behaviours provided an illusion of control (Eating Disordered Overcontroller coping) by preventing the activation of schemas (in the Vulnerable Child modes). When her schemas were activated, she shut them down and their associated feelings with ED behaviours (in an Eating Disordered Overcontroller or Detached Self-Soother coping mode). The dyad between the Demanding and Critical Parent and the Vulnerable Child, that Tina coped with through her ED reinforced the introjected messages from the parent mode and hence the schemas.

Tina was seen biweekly for 35 sessions. After a comprehensive assessment process, we moved into a therapeutic process based on ST. Tina's chronic depression resulted in a prominent Detached Protector mode which prevented access to the Vulnerable Child. Tina feared establishing a relationship with me and sharing her vulnerabilities (Vulnerable Child) because she feared that I would abandon her (triggering her Abandoned Child). This fear of abandonment maintained the coping modes in therapy, preventing me from accessing the Vulnerable Child and initiating a healing process. Thus, although I was able to educate Tina about her ED and make her aware of her mode sequences, I was unable to work with and reparent the Vulnerable Child. Also, Tina experienced conflict about wanting to get better but not wanting therapy to end. This shows the influence of the Eating Disordered Overcontroller as Tina believed that she could only avoid abandonment, and access attention and care, by maintaining the sick role.

Tina was obsessed with having a baby. She had a strong desire to nurture, and she believed that she would "be that child's everything. That baby will always find me number one…that baby's never going to abandon me" (S6). For Tina, having a baby was a way to heal her schemas (Emotional Deprivation, Social Isolation/Alienation, Defectiveness/Shame and Abandonment/Instability). When she did fall pregnant, Craig was more present and

nurturing, providing for Tina's unmet childhood needs. For example, he walked her home after work and sat with her while she fell asleep at night. This had a significant impact on Tina as important Vulnerable Child needs were being met, and so she no longer needed to escape into the Eating Disordered Overcontroller. To break out of her disordered eating patterns, she needed to break out of the loneliness and develop an emotional connection with Craig. Tina's developing Healthy Adult was evident as she believed that her ED behaviours could harm the foetus, so she stopped fasting and attempted to eat regular meals. Also, her bingeing and neutralising behaviours decreased to less than once a week. However, Tina expressed fear that after the baby was born, she would again restrict.

Tina did not attend sessions once the baby was born. An attempt to make contact with her months later proved unsuccessful, so it is unknown if the shifts in the marriage and her ED behaviour were maintained or if the stresses of a new-born reactivated old coping patterns.

Chapter 8. The Case Study of Vicky

8.1. Psychosocial History

Vicky and her younger brother were raised in a small farming community. Her father, a shift worker in a sugar cane factory, was often absent from home and did not engage much with the children. Childrearing and discipline were left to Vicky's narcissistic mother, who was quick-tempered and physically and verbally punitive, even abusive; "I was well whipped into behaving" (S9), which contributed to Vicky's Abused Child.

Vicky's parents were not tuned in to a child's needs and lacked affection, empathy, and care. So she "never really felt loved from anyone" (S11), which contributed to her Neglected Child (Emotional Deprivation schema). She was never told that her parents loved her but instead was verbally abused by her mother. Her mother told Vicky that she wished she had not been born, triggering and reinforcing Vicky's Vulnerable Child (Emotional Deprivation and Defectiveness/Shame schemas) so that she did not "see many likeable aspects to myself" (S11; Defective Child mode). This mode has been referred to as Vicky's Defective Child mode because she was explicit about feeling defective when this mode was triggered. When Vicky was upset (her Vulnerable Child was triggered), her punitive, dismissing mother told her that she was not allowed to cry and smacked her, so Vicky flipped into Detached Protector coping (Emotional Inhibition schema) to shut off her emotion. Growing up, she did not have a mother in tune with her or someone to mirror her, which contributed to her undeveloped sense of self (Neglected Child). As an adult, Vicky recognised that "the desire to have her [her mother] acknowledge my needs…is probably very high. I get upset over the fact that she doesn't know her own flesh and blood or my emotional needs, or my emotional downfalls" (S18; Healthy Adult). In this statement, Vicky recognises her unmet needs for care, nurturing and validation in the Vulnerable Child.

As a child, Vicky wanted her mother to play "Barbies" with her but her mother, who believed that "adults don't play", and instead "yelled and smacked but didn't play" (S9), threatened to throw her toys away if she did not play by herself. This example illustrates the punitive and neglectful nature of her mother. Vicky's Neglected Child sought affirmation from her mother by asking, "Am I good looking? Can I be a supermodel when I grow up? Am I smart?" Her mother's response that she was normal encouraged her to prove her mother wrong and contributed to her Perfectionist Overcontroller coping mode (Unrelenting Standards/Hypercriticalness and Approval-Seeking/Recognition-Seeking schemas) as she

believed that, “To be acknowledged you have to be extraordinary” (S7). Vicky’s Defective Child was triggered and reinforced by the demanding and punitive aspects of her mother as Vicky recalled, “As an older kid…I remember…just not ever feeling as if I was up to standard…It felt like I was constantly being reprimanded for never being good enough” (S9). Feeling “not good enough” flipped Vicky into Perfectionist Overcontroller coping (Unrelenting Standards/Hypercriticalness schema), where she “always wanted to be more than what people expect of me” (S12), combining the first and eighth features of the Perfectionist Overcontroller.

Vicky’s mother worked intermittently but was mostly at home. Despite this, Vicky prepared the family dinners from the age of 12 because her mother did not want to cook, again illustrating the neglectful, self-involved features of her mother. Family meals were not eaten together as, until the age of 14, Vicky and her brother were made to eat in the kitchen whilst her parents ate in the lounge. Although Vicky did not witness her parents argue, she knew they were unhappy and sensed the tension in the house. Her mother coped with the marital problems by staying away from home for days at a time and leaving the children in their father’s care. This is a further example of her mother’s neglect. As Vicky was not close to her mother, her absences did not cause distress. However, her mother did not model appropriate coping skills. Vicky was raised in an environment where she was neglected, and her emotional needs were not prioritised, which contributed to a Neglected Child mode.

A further example of Vicky’s neglectful parenting related to a bicycle accident Vicky had at the age of 4. She fell off her bicycle, hit her head, and lost consciousness. Vicky required stitches to her head. After the accident, Vicky developed stroke-like migraines, accompanied by nausea, tiredness, slurring, numbness in her hands and paralysis down one side of her body. These symptoms occurred between once a week and once a month. However, Vicky’s parents did not seek medical treatment until the age of 10, when a computerised tomography (CT) scan revealed a twisted vertebra in her neck. The twisted vertebra was corrected with regular chiropractic treatments. Vicky’s Neglected Child is evident in the statement, “I know what it feels like to be less important than everything else. If I was sick, I would be left in bed, and she [her mother] would go off to work and come home at four” (S9).

Vicky’s earliest memory was from the age of 4 when she and her pregnant mother visited her mother’s friend. The friend asked if Vicky had touched her mother’s stomach to feel the baby. When Vicky replied that she had not, her mother, with a look of revulsion,

offered for Vicky to feel her stomach. Vicky's Vulnerable Child was triggered by her mother's reaction, and, as she wanted to be included and not disappoint her mother, she flipped into Compliant Surrenderer coping and lied that she could feel the baby. Vicky described this as her first sad memory, but she experienced chronic sadness throughout her childhood and recurring thoughts about when she was going to feel happy.

As an anxious child, Vicky developed a stutter in early childhood. This stutter reinforced and triggered her Defective Child. To avoid drawing attention to her stutter and to shut down the feelings of shame, Vicky flipped into Avoidant Protector coping by withdrawing and becoming more introverted. This Avoidant Protector coping reinforced her Lonely Child (Social Isolation/Alienation schema). Eventually, Vicky outgrew the stutter.

Vicky's family were not churchgoers, and her mother was disdainful of "happy clappies" who rejoiced in church. Despite this, Vicky wanted to attend church. So, she attempted to sleep at a friend's house on Saturday nights so that she could accompany their family to church on Sunday. However, not wanting to be portrayed as the "crazy happy-clappy" (her Defectiveness/Shame schema was triggered), she withdrew and did not clap and sing in church (Avoidant Protector coping).

At the age of 6, Vicky was sexually molested by a house painter whilst at home with the domestic worker (triggering and reinforcing her Abused Child). When her mother returned from shopping, Vicky told her what had happened. Her mother took the necessary steps by taking Vicky to the doctor and reporting the incident to the police, but she showed little emotional reaction. Vicky was not given emotional support, which contributed to her belief that she was an inconvenience and somehow to blame (triggering her Defective Child). Vicky believed her experience disrupted her safe community and that she became the "problem child" (triggering her Defective Child). Her parents' emotional neglect triggered her Neglected Child, "I don't understand why nobody saved me …how could they allow me to feel that insignificant. You feel at your absolute worst and no one to pick you up other than yourself" (S7). Vicky believed that she could not trust nor depend on anyone to protect her (Mistrust/Abuse and Emotional Deprivation schemas). As an adult, Vicky recognised, from a Healthy Adult perspective, that her Vulnerable Child needed "someone to be close for a really long time, and to teach me that it's okay and that I'm protected" (S7). Instead, "I felt like a burden and immediately I felt like an outcast, like I had done this to myself and that no one's going to help me" (her Defectiveness/Shame, Emotional Deprivation and Social Isolation/Alienation schemas were activated).

Also, around the age of 6, when Vicky was home with the domestic worker, someone repeatedly phoned the house and, when Vicky answered, asked her sexual questions. Vicky told her mother, but she was dismissive and did not take steps to protect Vicky, such as telling her not to answer the phone.

Vicky was sexually abused by her father's best friend from as early as she can remember until the age of 13 (triggering and reinforcing her Abused Child). Her most explicit memory entailed the abuser taking her into his daughter's room to show her a dolls' house and, whilst there, holding her hand over his crotch and forcing her to stimulate him until he climaxed. Vicky felt terrified, panicked and trapped, and although she did not understand what was happening, she knew it was wrong but believed she would get into trouble if she told. The abuser gave her ice cream after these incidents, which, although she felt obliged to eat it (in a Compliant Surrenderer mode), she believed made her complicit, triggering a Guilty Child.

When Vicky was 13, the abuser and his wife emigrated. When they announced their emigration at a party, Vicky cried. Her tears were from anger that he had ruined her life, relief that he was leaving, and sadness that she allowed the abuse to happen. Vicky was angry with herself that she did not disclose the abuse at the party (her Angry Child turned inward). So Vicky flipped into a Flagellating Overcontroller mode:

> I don't cry about it because I almost feel like every time I cry; it just takes me back to that point where I could have made it right but didn't. So I just feel angry with myself, almost like, well, you don't deserve to cry because I probably made it a lot worse for myself. (S11)

In the Flagellating Overcontroller mode, Vicky punished herself by not allowing herself to cry.

When Vicky's Abused Child was triggered, she coped with the extreme anxiety that was evoked by flipping into a Spaced Out Protector mode:

> During high levels of stress in my life, at the time, I lose speech, so formulating sentences or just simple verbs or nouns…and then the long term effect of those stressful periods is that I don't actually remember the majority of it. (S2)

As a result of this coping mode, periods of Vicky's life were a "complete blackout." For example, "Between being abused and reaching a teen, it is just tracks are missing from my life…I would spend the majority of my time in blackout mode" (S9). As a result, Vicky

recalled little from her childhood, except withdrawal, sorrow and a desire to be supported and feel safe.

As a child, Vicky did not develop close friendships as her Social Isolation/Alienation and Defectiveness/Shame schemas contributed to the belief that, "There was no one like me" (S16) and "I couldn't imagine a friend loving me because I'm me" (S16). Vicky developed a Social Overcompensator mode in which she used humour and friendliness, the "brave face and smile", and "fake Vicky", to hide her real emotions:

> I pretended throughout my life that everything was fine, and it hasn't been…I'm still trying to cope and be boxed into normal…it's a bit of a charade because I'm perceived as happy and bubbly, and the light that keeps everyone positive and uplifted. (S2)

Vicky's sexual awakening with her first kiss at the age of 14 triggered thoughts and feelings related to her sexual traumas (Abused Child). Subsequently, sexual experimenting caused anxiety which she soothed by bingeing (Detached Self-Soother). Vicky then flipped into an Eating Disordered Overcontroller mode and restricted (the second feature of the Eating Disordered Overcontroller) because she was "going to get fat and no one likes a fat person" (S2). Physical hunger ended her restricting, and a cycle of bingeing and vomiting ensued as the Impulsive Child tried to get her nutritional needs met in tandem with the Detached Self-Soother, which tried to shut off the feelings of shame and self-loathing (in the Defective Child). A friend observed Vicky inducing vomiting on a school excursion and threatened to tell her mother if she did not. Vicky told her mother, who reacted with anger and then took Vicky to their general practitioner, who prescribed an antidepressant. Vicky felt "incredibly broken", and she wished someone would help her (Emotional Deprivation and Defectiveness/Shame in the Vulnerable Child). She soothed these feelings with Detached Self-Soother coping by bingeing and inducing vomiting. When her grandmother was visiting, she walked in on Vicky vomiting. Thereafter, when her grandmother visited, she accompanied Vicky to the bathroom. Although her grandmother did not address why Vicky was vomiting, she felt a sense of safety that her grandmother had taken charge and never again vomited in her presence.

Due to the BN, at the age of 14, Vicky was sent to a psychiatrist to whom she disclosed the sexual abuse. The psychiatrist insisted that Vicky tell her mother about the abuse. However, her mother's response was dismissive, and the abuse was never again

discussed. As a result, Vicky was unaware if her father knew of the abuse. Vicky's Vulnerable Child needed the abuse to be acknowledged and addressed (S9), "Will somebody please acknowledge the magnitude of the situation? My entire childhood was based on sex." Vicky's Angry Child mode was triggered as she wanted to "yell at anyone that put me in a corner, that was just cruel" (S6). This included her mother, with whom Vicky was angry for frequently leaving her with the domestic worker instead of in childcare, and for her dismissive response to the abuse. Vicky could not rely on her mother for support (S18), "I hold little expectations for my mom because she's prone to letting me down consistently," which triggered her Neglected Child.

Vicky's struggle with BN left her feeling helpless. Around this time, a suicidal boy joined the school. This boy's presence introduced the idea of suicide to Vicky as part of a Detached Self-Soother coping mode to shut down the feelings of sadness and helplessness. Vicky's first suicide attempt occurred at the age of 14. Vicky overdosed on her antidepressants, but because of her religious beliefs, she panicked that she would go to hell. Vicky told her mother that she had overdosed and was then rushed to the hospital. After returning home, her overdose was not discussed. Shortly thereafter, Vicky read an article titled, *Cutting is the new norm*. The article was accompanied by a picture of girls standing in a row and smiling. However, one girl was covered in cuts. Vicky, who felt she did not fit in (Lonely Child mode), identified with the girl with the cuts. So, Vicky began cutting herself below her waist and on her upper leg. Although embarrassed by this behaviour, the cutting, which was part of a Detached Self-Soother mode, created physical pain, which shut down the emotional pain.

Vicky's second overdose, approximately 3 months after the first, included a combination of 105 antidepressants, anxiolytics and Myprodol (an analgesic and anti-inflammatory). After swallowing the tablets (Detached Self-Soother), Vicky panicked about what would happen to her after she died (Vulnerable Child). So she told her mother, who took her to the hospital where a gastric suction was performed. Her mother expressed embarrassment at the suicide attempt, because she had to borrow money from a family member to pay the hospital account. After this attempt, Vicky continued her self-soothing behaviours of cutting, bingeing and inducing vomiting.

Vicky experienced another sexual trauma at the age of 15 when she was raped by a male friend. The rape occurred when Vicky stayed at his house after a night of drinking, something she had done in the past. The rape triggered her Abused Child, but as Vicky had

never felt supported by her parents, she did not disclose the rape to them (Avoidant Protector coping) as she believed they would blame her.

Girls at school discovered that Vicky was self-harming and shamed her, accusing her of attention-seeking. Her parents were called to the school and informed that she would be removed if her self-harm behaviour continued, because it was damaging to the other children. Vicky's Angry Child was triggered as she believed that she was the injured party, not the other children, because of the bullying, humiliation and isolation she had experienced.

Vicky was tired of pretending that she was okay (Social Overcompensator mode). However, her depressed state caused more conflict with her peers, leading to further isolation which triggered her Lonely Child. Vicky coped by attempting suicide (Detached Self-Soother) a year after the second attempt. In Vicky's third suicide attempt, she swallowed all the medication in the cabinet. She did not write a note nor tell anyone what she had done. Her brother noticed she was talking incoherently and called their mother, who took her to the hospital. Vicky overheard a nurse at the hospital tell her parents to leave her and that she needed to learn her lesson. When Vicky called for a nurse, no one came. Vicky crawled to the bathroom and collapsed. When she came to, she was lying in her vomit. This traumatic experience triggered Vicky's Vulnerable Child as, "I couldn't find anyone who cared enough to fix me" (S15). After she was discharged, her dismissive parents told her to stop the suicide attempts because they could not afford it. Vicky shut down her feelings (Detached Protector mode) as she realised no one was going to help.

Vicky stayed home for the remainder of the school year and was taught by the principal at the principal's home. The principal began the process of reparenting Vicky's Vulnerable Child by providing a nurturing environment. For example, she allowed Vicky to snuggle in her bed and study. In this supportive environment, Vicky achieved good academic results.

Vicky's school board felt they could not cope with her self-harming behaviour, and so, in the new year, at the age of 16, Vicky was sent to boarding school to complete grades 11 and 12. Vicky felt relieved as she perceived the move as an opportunity to escape who she had been (Avoidant Protector coping). Vicky's Lonely Child was triggered at the new school as she was lonely and afraid to build relationships with anyone for fear that they would reject her. "I was fighting the urge to be part of something, but not. I wanted to be part of something, but I didn't want the attachments that went with it, where I had to always agree or

follow" (S17). In this statement, Vicky shares her desire for a sense of belonging without flipping into Compliant Surrenderer coping, which she believed was necessary to achieve acceptance.

Vicky had a short-lived relationship with a boy, which she ended when he wanted to become more physical. Vicky's guilt over ending the relationship (Guilty Child) and her subsequent feelings of isolation (Lonely Child) resulted in her soothing with food binges (Detached Self-Soother) and becoming overweight. Later in the year, Vicky befriended a boy, but the girls criticised her for the friendship. So, to avoid conflict, she distanced herself from him (Avoidant Protector coping).

Throughout her schooling, Vicky was isolated and felt defective. "It's been hurtful when I've tried to invest time into different groups, and I'm just not their cup of tea, and then I'm left out, and it's not nice to feel as if you don't make the cut" (S6). Vicky's Defective Child triggered a Lonely Child. Her isolation continued until she befriended a girl in grade 12, with whom she maintained a lifelong friendship.

Although Vicky struggled to be accepted by her peers at boarding school, she felt nurtured by the hostel parents. Vicky went from the "problem child" at home to receiving positive affirmation and a leadership position, that of hostel prefect. At the end of grade 12, Vicky's Vulnerable Child was triggered as she was anxious about the end of school, uncertain about her plans and unwilling to return home. She alleviated her anxiety by inducing vomiting (Detached Self-Soother), which resulted in weight loss and a return to a normal BMI.

In the December holidays, aged 18, Vicky worked as a camp counsellor at a children's holiday camp, where she began dating a fellow counsellor, Mark. After leaving the camp, Vicky studied at night school and maintained three jobs to support herself and pay for her studies. During her training, Vicky went overseas for a few months to work as an au pair. Upon her return, she completed her studies and moved in with Mark and his parents. Conflict developed between Vicky and Mark because he still worked as a camp counsellor and maintained an active social life. The relationship ended when Vicky was 22.

Vicky coped with the break-up in an Avoidant Protector mode, as she "ran away" overseas for 8 months. A year after she returned, she reunited with Mark. When Vicky was 25, Mark was diagnosed with testicular cancer. Although cohabiting at the time, his mother "pushed her aside" and took control during his treatment, triggering Vicky's Vulnerable

Child as she felt abandoned and insecure about their future and, unable to support Mark fully, believed that, "I didn't get to be the woman he needed me to be; instead the woman was his mother" (S14).

At 27, Vicky and Mark married, but Vicky struggled to believe that Mark loved her (Defective Child), as she believed that during their courtship, she presented a false image of independence and control (Social Overcompensator mode). Vicky viewed her marriage as a fresh start, and she coped with the feelings triggered by the Defective Child in a Perfectionist Overcontroller mode (Unrelenting Standards/Hypercriticalness schema) as she determined to be the best wife and mother (the first feature of the Perfectionist Overcontroller, striving for excellence).

After the wedding, Vicky started her own business working with mothers in the field of infant stimulation. Vicky worked hard as she wanted to be the best she could be (the first feature of the Perfectionist Overcontroller).

Vicky's pregnancy in the first year of marriage caused severe morning sickness. Unable to run the home or prepare meals, her Defective Child was triggered as she felt she was failing as a wife. Sarah's birth by emergency caesarean distressed Vicky, who wanted to be "whole and in control" (Perfectionist Overcontroller coping). Vicky struggled with post-natal depression, which triggered her Defective Child as she was not "perfectly put together" and felt she was failing as a wife and mother. Vicky's extended family was unsupportive. For example, her mother-in-law expected Vicky to prepare a meal when she visited, and she commented on home maintenance that needed to be attended to, which triggered Vicky's feelings of inadequacy (Defective Child).

Throughout her life, Vicky's Abused Child was triggered daily, causing anxiety and flashbacks to her sexual traumas. The flashbacks and accompanying anxiety intensified after Sarah's birth caused fear that Sarah might be molested. Vicky shut down the fear and anxiety by flipping into a Spaced Out Protector mode in which she dissociated. As a result, Vicky had few memories of Sarah's early history. For example, she had no recollection of Sarah's first steps.

When Sarah was 4 months old, Vicky wanted to try for a second child as doctors had told them she might struggle to conceive because of Mark's cancer treatment. Mark believed they were not ready for another child and refused. More than a year later, Mark agreed to try for another child. Over the next 4 years, Vicky was unable to conceive naturally nor through

In Vitro Fertilisation (IVF). Although she did not express it, Vicky was angry with Mark because she blamed him for delaying the process and for their subsequent difficulty in conceiving.

Eleven rounds of IVF resulted in multiple miscarriages, which caused Vicky immense sadness. However, Vicky did not express her sorrow because she flipped into a Rescuer mode (Self-Sacrifice schema) where she prioritised Mark's feelings and wellbeing:

> When I do lose the kids, I don't really feel much for myself; I feel more guilt for Mark because I know that …he's going to take it harder…I don't really think about me, I more think about him, because he's the one that's going to be more hurt. (S3)

Vicky felt guilty (her Guilty Child was triggered) that her eggs did not compensate for Mark's low-quality sperm because she wanted to spare him from blaming himself for his incomplete family (Rescuer mode). In the Rescuer mode, Vicky wants to rescue Mark from his emotional pain. During one of the miscarriages, Vicky was aware she was miscarrying but continued to work. This is evidence of Vicky's self-sacrificing behaviour (in the Rescuer mode) as she put the needs of her clients before herself.

Six years after starting her business, Vicky sold it because she wanted to focus more on her family. She also began studying a diploma through correspondence.

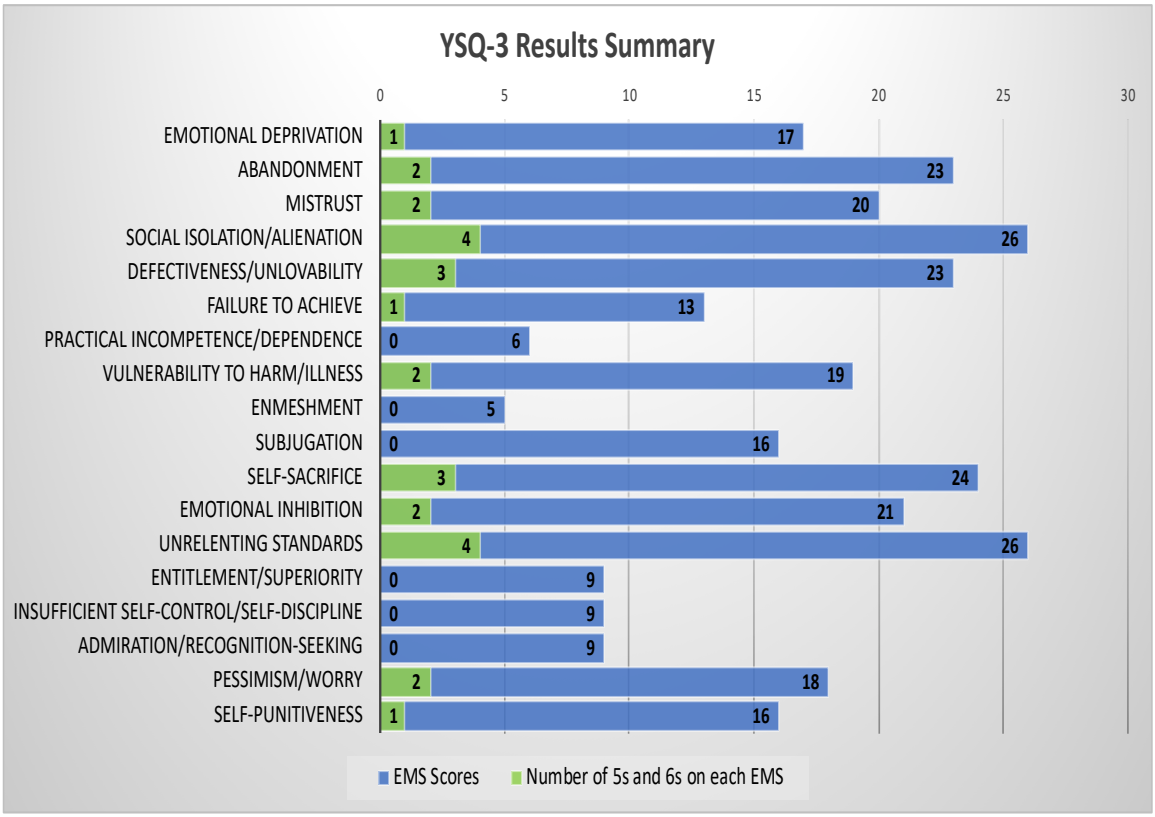
A month before the research, Vicky was diagnosed with irritable bowel syndrome (IBS), triggered by stress. Also, she developed lactose intolerance, and so she removed dairy from her diet.

8.2. Results on the YSQ and SMI

Figure 7 shows the results of the YSQ, and Figure 8 shows the results of the SMI conducted after the third session. The scores on the questionnaires and qualitative information from responses to specific items were used in conjunction with the information obtained in the clinical interviews and observations of her behaviour to develop a case conceptualisation.

Figure 7

Vicky's Results on the YSQ



Vicky's scores on the YSQ indicated the presence of Abandonment/Instability, Mistrust/Abuse, Social Isolation/Alienation, Defectiveness/Shame, Vulnerability to Harm or Illness, Self-Sacrifice, Emotional Inhibition, Unrelenting Standards/Hypercriticalness and Negativity/Pessimism (labelled Pessimism/Worry on the graph) schemas. The information provided by Vicky during her sessions indicates that she underscored on Emotional Deprivation, Failure, Punitiveness and Approval-Seeking/Recognition-Seeking schemas. Vicky may have underscored on Emotional Deprivation because she was unaware of the extent to which her needs were unmet. Vicky scored at least two items with a 5 or 6 (see Figure 7) on nine schemas. This number of high scoring items is indicative of her complex trauma.

Figure 8

Vicky's Results on the SMI Compared to Normal Controls

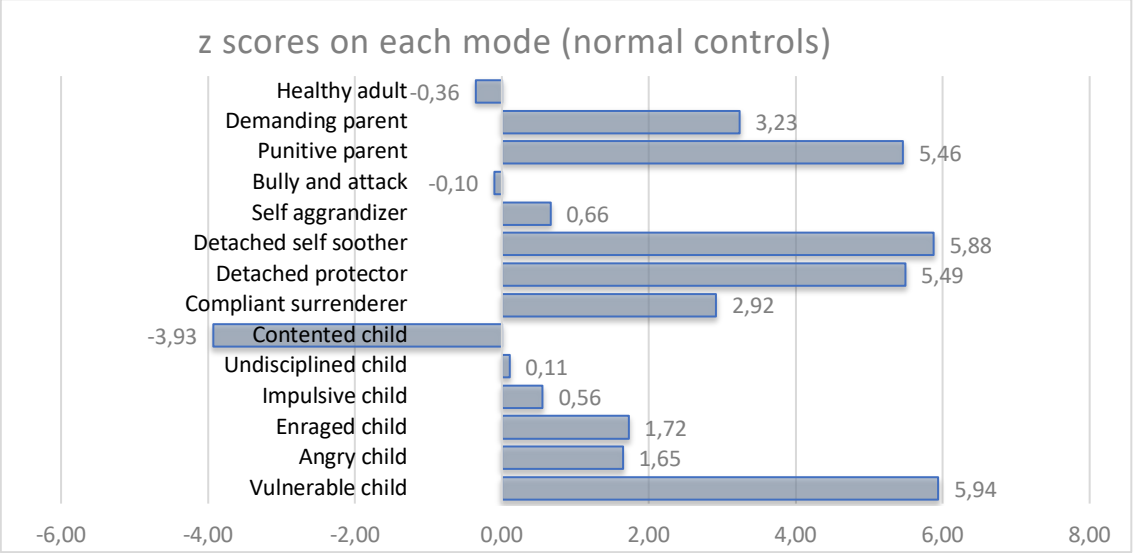


Figure 8 represents Vicky's results on the SMI compared to the average population of individuals without a clinical disorder. Her high scores on the scales for Demanding Parent, Punitive Parent, Detached Self-Soother, Detached Protector, Compliant Surrenderer and Vulnerable Child are supported by the information she provided during sessions. Vicky's large Vulnerable Child (5,94 SD above the norm) supports the significantly low score (3,93 SD below the norm) on the Contented Child, suggesting little evidence of a Contented Child. Vicky's score on the Healthy Adult mode, which is only slightly below the norm (0,36 SD below the norm), indicates that there is only marginally less Healthy Adult than what would be expected in normal controls (without any diagnosed Axis I or Axis II conditions).

8.3. ED Presentation

As noted earlier, Vicky's BN began at the age of 14 as part of a Detached Self-Soother mode. Vicky binged to soothe feelings of anxiety and then, fearing weight gain, induced vomiting. Vomiting to avoid weight gain is the second feature of the Eating Disordered Overcontroller. The first time Vicky induced vomiting was after eating too many marshmallows on a school excursion. She believed the marshmallows would make her fat if she "didn't get rid of them." Vicky maintained a normal BMI until she started boarding school at 16. At that time, her BN was in remission. Faced with unfamiliar foods in boarding, Vicky limited her food intake, which resulted in weight loss (BMI of 17). Later in the year, when her Guilty Child was

triggered because she ended a relationship, Vicky soothed the guilt by binge eating in a Detached Self-Soother mode. Her BMI increased from 17 (underweight) to 25.2 (overweight). At this stage, she would have met the criteria for BED.

Vicky was overweight until the end of grade 12, when she shut down her anxiety about her future by inducing vomiting (in a Detached Self-Soother mode). Vicky lost weight and obtained a normal BMI, which she maintained until she went overseas to work as an au pair at the age of 20. Whilst overseas, Vicky intentionally restricted food (the second feature of the Eating Disordered Overcontroller mode), obtaining a BMI of 17 and meeting the criteria for AN. Upon her return to South Africa, Vicky's eating patterns stabilised, and she maintained a normal BMI until she went overseas again at the age of 22 after a breakup. For the 8 months Vicky was overseas, she self-soothed with binge eating (Detached Self-Soother). During this time, Vicky again met the criteria for BED.

After returning to South Africa, Vicky joined Weighless, a weight-loss club that provided her with a meal plan and weekly weigh-in sessions in a group setting. Vicky lost weight and once again achieved a normal BMI.

Vicky's BN returned around the age of 24, but she maintained a normal BMI until after her daughter's birth at 26. Thereafter Vicky coped with the anxiety regarding Sarah's safety by binge eating (Detached Self-Soother). Her weight increased (BMI 28, overweight), and she was again diagnosed as prediabetic at the age of 28. At this stage, Vicky would have met the criteria for BED once again. Vicky was prescribed medication to reduce her blood sugar levels. The medication's side effects included weight loss (BMI 23), and Vicky became physically ill when she binged. As a result, she reduced her bingeing behaviour. However, when Vicky stopped the medication a year later, she again binged and induced vomiting (Detached Self-Soother coping) and met the criteria for BN.

After Sarah's birth, Vicky was distracted during the day and did not think about bingeing until after putting Sarah to bed at night. Then, she sat in front of the television and experienced flashbacks to the abuse, triggering her Abused Child and leading to panic attacks. Alternatively, Vicky ruminated over everything she could have done better or that she felt she had failed at during the day (the thirteenth feature of the Perfectionist Overcontroller). These thoughts triggered the Defective Child, which Vicky soothed by bingeing (Detached Self-Soother mode). "Nobody chooses to feel negative. You can try not to feel that way; food does that" (S3).

Vicky's binges historically began with a tin of caramelised condensed milk. The caramel was associated with a happy memory from her adolescence when Vicky visited a friend, and the friend's mother made them caramelised condensed milk. Vicky's association of the caramel with her feelings of happiness at her friend's house led to her description of caramel as "a hug in a can." Vicky waited the 35-40 minutes necessary for the condensed milk to boil and turn into caramel before commencing a binge. After eating the caramel, Vicky consumed chewy sweets such as jelly tots, soft gums and chocolate-coated fudge, that Mark bought for her binges on his way home. After developing lactose intolerance, the condensed milk was replaced by koeksisters, strands of deep-fried dough coated in syrup.

Vicky drew out the process of eating because, "The longer I sit and chew, in that time, it's just very soothing. I suppose like an extended hug" (S3). Vicky described a binge as the only time her mind is still, that she loses conscious awareness of her behaviour and her thoughts stop. She experienced bingeing as a grounding technique as she focused on the crunch, texture, smell and taste. Vicky binged at least once a week for between 45 minutes and 2 hours. Bingeing caused guilt because Vicky had broken the food rules of the Eating Disordered Overcontroller (the first feature of the Eating Disordered Overcontroller). Vicky coped with the guilt by going straight to bed, so she did not have to think about the binge (Avoidant Protector coping), or by inducing vomiting (the second feature of the Eating Disordered Overcontroller). Vicky used to binge in secret, but once married, she binged in front of Mark, who colluded with her binges by buying the food.

Vicky prepared for binges when she anticipated stressful periods, such as family holidays with Mark's family, which were stressful because of the family dynamics. When packing for these holidays, Vicky packed her "binge foods", believing that she would not be able to cope with the stress of the holiday without them.

Vicky's desire to lose weight made her ideal weight "as small as possible" (the third feature of the Eating Disordered Overcontroller), which resulted in constant dissatisfaction with her weight (the second feature of the Eating Disordered Overcontroller). Vicky always aimed to weigh 10 kg less than her current weight (the third feature of the Eating Disordered Overcontroller). Vicky persistently feared gaining weight and losing control over her eating (the eighth feature of the Eating Disordered Overcontroller), even after weight loss (the third feature of the Eating Disordered Overcontroller). As a result, approximately 12 hours of every day, 2 hours before a meal and 2 hours after, were focused on food-related thoughts (the eighth feature of the Eating Disordered Overcontroller). Thus the Eating Disordered

Overcontroller led to the marginalisation of other aspects of Vicky's life (the seventh feature of the Eating Disordered Overcontroller). Vicky was regimented about eating meals at the same time and, whilst eating, planned the next meal (the fifth feature of the Eating Disordered Overcontroller). Deviations from the meal plan resulted in guilt (the fourth feature of the Eating Disordered Overcontroller). Vicky restricted food during the day, and she avoided carbohydrates (the first feature of the Eating Disordered Overcontroller). She experienced guilt when consuming any foods other than vegetables, also related to the first feature of the Eating Disordered Overcontroller. She was aware of the calorie content of meals but discounted the calories of a binge because "Food will make me feel better" (S1). This highlights the permission-giving belief, which is a feature of the Detached Self-Soother. In an Eating Disordered Overcontroller mode, Vicky would not eat Kentucky Fried Chicken because it is unhealthy, but in a Detached Self-Soother mode, she allowed herself three bowls of sticky toffee pudding to comfort herself.

Vicky's Eating Disordered Overcontroller included body checking behaviours (the ninth feature of the Eating Disordered Overcontroller), such as weighing herself daily and checking her body in the mirror if it was a "good" day where she had eaten healthily and believed she would feel okay with what she saw. Her bingeing and inducing vomiting met the DSM-5 criteria for BN (APA, 2013). Her BMI of 27.28 at the time of the assessment placed her in the overweight category.

8.4. Case Conceptualisation at the Time of the Assessment

Table 5

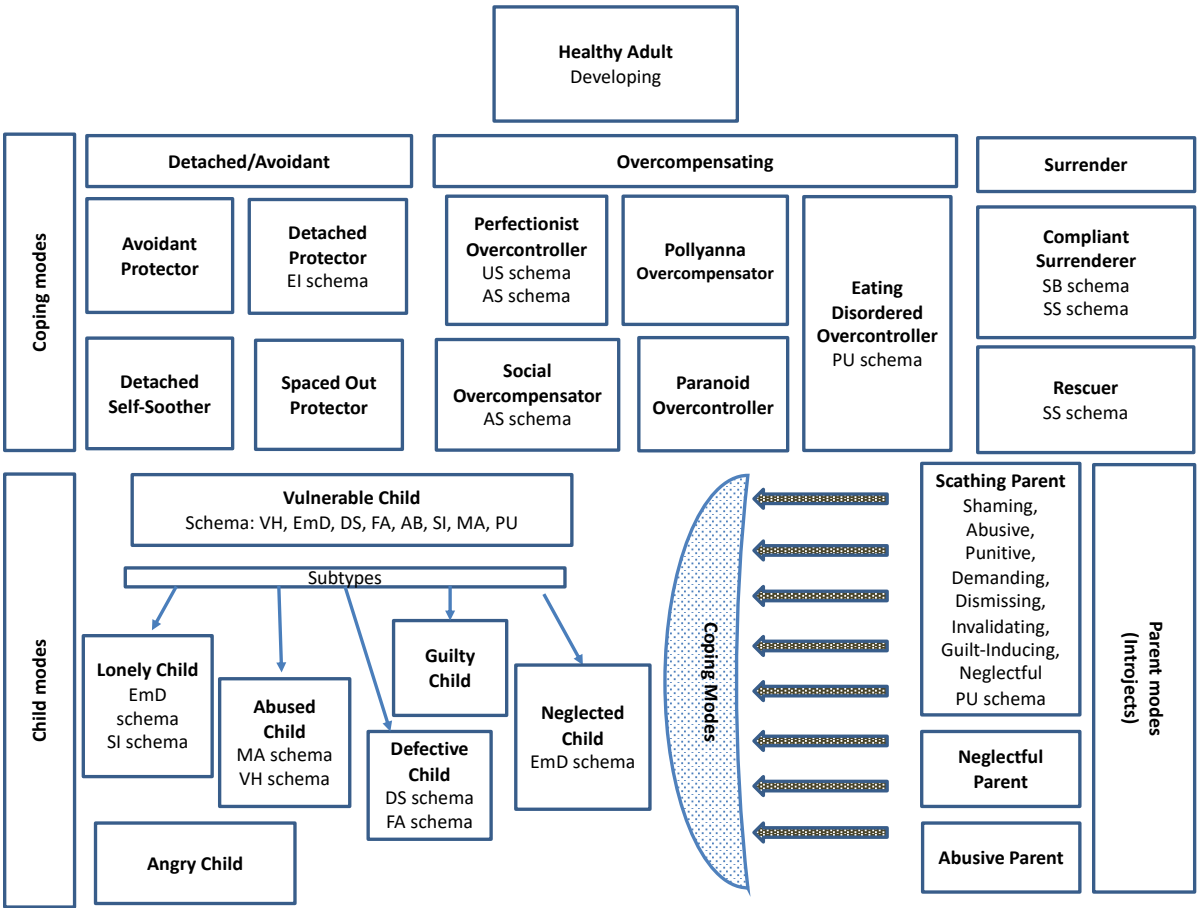
Vicky's DSM-5 Diagnosis at the Time of the Assessment

DSM-5 Diagnosis	**ICD-10-CM Code**
Bulimia nervosa, moderate	F50.2
Persistent depressive disorder with melancholic features, early onset, with pure dysthymic syndrome, moderate	F34.1
Generalised anxiety disorder	F41.1
Posttraumatic stress disorder, with dissociative symptoms	F43.1

Table 5 presents Vicky's diagnosis at the time of the assessment. This will be elaborated on in this section. Vicky's current modes are represented in the mode map (see Figure 9).

Figure 9

Vicky's Current Mode Map



Note. AB = Abandonment; AS = Approval-Seeking/Recognition-Seeking; DS = Defectiveness/Shame; EI = Emotional Inhibition; EmD = Emotional Deprivation; FA = Failure; MA = Mistrust/Abuse; PU = Punitiveness; SB = Subjugation; SI = Social Isolation/Alienation; SS = Self-Sacrifice; US = Unrelenting Standards/Hypercriticalness; VH = Vulnerability to Harm or Illness.

Vicky was 31 years old, married to Mark for 6 years and her daughter, Sarah, was 5. When Vicky narrated her history, she detached from emotion, in a Detached Protector mode, "It's been a good couple of years where I haven't been able to feel emotion when needed" (S6). Vicky shut down feelings of sadness because, "I think if I do cry, it's a symbol that I've broken, and I don't want to feel that. So if I can hold it together and not cry, it means that I'm

still together" (S3). Vicky's Detached Protector coping allowed her to shut down and even deny the Vulnerable Child.

Vicky's parents were still married but lived in separate countries and seldom saw each other. Her father lived approximately 40 minutes away, but his contract work in a different province kept him away for 6 months of the year, during which time he did not maintain contact with Vicky.

Vicky censors what she tells her mother because her mother becomes abusive. For example, her mother expressed disappointment and berated Vicky because she was not studying 6 hours a day. Her mother had worked overseas as a carer for the past 13 years, and, like Vicky's father, she did not maintain contact. So Vicky still experienced her parents as neglectful (triggering her Neglected Child). "My parents don't message or call every week…I have to make the first move just to see that everybody's okay" (S11). Vicky maintained a superficial relationship with her brother, who worked overseas.

Mark was emotionally disconnected, and because of Vicky's Defective Child, she struggled to share her thoughts with him, fearing he would reject her. "I don't think I'd want Mark to see into my head every single day because there's more darkness than there is light, and I'd rather show him the light" (S7). This Social Overcompensator mode overcompensated for Vicky's distressing feelings, "How I behave on the outside and then how I behave on the inside is chalk and cheese" (S11). Vicky felt unsupported by Mark when there were disputes with his family because of his own Compliant Surrenderer mode. Her marriage lacked physical intimacy (Avoidant Protector coping) because this triggered flashbacks to her sexual traumas (in the Abused Child). Vicky felt unimportant to people, including Mark. This was reinforced when Mark forgot her birthday. Vicky minimised his behaviour (in a Pollyanna Overcompensator mode) to shut down the hurt and disappointment (in her Vulnerable Child), describing him as kind-hearted but forgetful of what is important to her.

When Vicky's Defective Child was triggered, she flipped into an Avoidant Protector mode in which she avoided attachments and friendships. "I don't want to get to the stage where I invest time, and I build a connection and then come to realise that I just don't make the cut" (S6). Also:

> When someone gets close to me, I don't want to be in that position anymore because I don't feel I have the ability to connect properly with them, plus I don't want to…open my heart and then have someone rip it out. (S11)

For example, after a friend's daughter commented that she and Vicky saw each other so often they must be best friends, Vicky cut contact. This was to protect herself from being vulnerable and then risking rejection and hurt. Her Avoidant Protector was also evident in her reluctance to share about herself because of her Defective Child:

> I know everything about someone, but I share very little. I don't know what to share with people. I can relate, but I don't know what to share. I think I'm worried that I don't have a lot of goodness to share. (S11)

Vicky avoided speaking about specific topics, for example, religion, fearing she would be judged (Avoidant Protector coping). Her fear of judgment was related to her childhood experience where her mother criticised people she described as "happy-clappy." Vicky described herself as, "Kind of like an empty box…it has a label, but there's not a lot inside… I don't know a lot about myself. I worry I might not like what I find" (S11). When this Defective Child is triggered, Vicky flips into Social Overcompensator coping where, to be accepted, she changes her accent or "personality role" to "stay at home mentality" or "career-driven mentality", to suit the people she is with so that they approve of and accept her. "It's almost like there's a lot of characters that I can play…because I relate to them all" (S6). However, Vicky's Vulnerable Child lacks a sense of who she is, "I don't know where I fit or what kind of sticker I have on my forehead. Like, am I a sloppy mom or a slapdash mom…a sporty mom or a baker mom?" (S6).

Vicky experienced frequent tension headaches and migraines, as well as generalised anxiety symptoms and panic attacks that met the DSM-5 (APA, 2013) criteria for generalised anxiety disorder. This diagnosis was supported by her score of 20 (moderate range) on the BAI. Vicky also met the criteria for posttraumatic stress disorder. Attempts to explore Vicky's past traumas triggered an Abused Child, which she coped with by flipping into a Spaced Out Protector mode. In this mode, she experienced dissociative symptoms, which included a sensation of talking down a long tunnel and light-headedness, followed by tiredness, disorientation, clamminess, a dry mouth, and an inability to recall the conversation. Vicky scored 145 on the DES-II, which indicated severe dissociation and possibly a dissociative disorder.

> I've built this autopilot thing that switches on when I'm about to just remove things from my memory…I know when it's starting to happen, because I start to go a bit fuzzy and like the room gets dull and my voice is a lot louder in my head…I can feel my body is starting to shut down….give a couple of months or a couple of years the conversation, or actual situation is gone…Sometimes I can't dig it out, and it's just nothingness. (S2)

An example that illustrates the impact of her Spaced Out Protector mode was given when Mark, in conversation with Vicky, referred to a hospital stay he had the previous year. However, Vicky had no recollection that he had been in the hospital.

Vicky's Abused Child was triggered when she experienced extreme anxiety that Sarah would be molested. For example, when Sarah stayed with her paternal grandmother, Vicky felt "petrified" that a family member may abuse Sarah, stating that, "Very normal happy things petrify me" (S13). Vicky flipped into a Paranoid Overcontroller mode in which she excessively talked to Sarah about her personal space and appropriate touching.

Vicky also had symptoms of a persistent depressive disorder, supported by her history and BDI-II score of 31 (severe range of depression), and her comment, "When am I going to be happy?"

Vicky's routine included transporting Sarah to school and extra-curricular activities, studying and volunteering for a foundation for abused children. Vicky's Rescuer mode was evident in her belief that if she could "save someone from one aspect, then it is one less hurt person and a step towards a healthier, happier world" (S13). Vicky wanted to be a full-time mother who did charity work, but she felt inadequate if not in paid employment because she believed people would judge her (her Defective Child was triggered). Vicky's charity work, where she focused on the needs of others, was a Rescuer mode to compensate for her own unmet needs. "I've pretty much moved through life being everything for everyone that I have wanted or needed at different stages" (S11). Prioritising others' needs extended to Vicky's work with infant stimulation, where her Rescuer mode was evident as she offered free consults to people who could not afford the service. Vicky strove to be busy, using work as a self-soother (Detached Self-Soother) to avoid feeling defective (Defective Child), "I've got my checklist to validate that I'm also worth something" (S2).

During the research process, Vicky had another failed round of IVF, which triggered her Angry Child at not being able to conceive, at having to repeat the IVF, and at losing "the

littlies" (implanted embryos). Asking Mark for a second child also triggered Vicky's Guilty Child. Vicky experienced the miscarriage as a personal failure (triggering her Defective Child) because she had let Mark down by not completing "a perfect family" and putting his mind at ease. This was accompanied by punitiveness (in the Vulnerable Child), "What I bring to the table isn't good enough to keep people happy or safe" (S8). Vicky focused on her studies to avoid her grief (Avoidant Protector coping). Still, her emotional distress led to poor performance and negative feedback from her lecturers, triggering her Defective Child. Vicky's initial reaction was to give up (Avoidant Protector coping) to shut down the feelings triggered by her schemas (Defectiveness/Shame and Failure). However, she flipped into Perfectionist Overcontroller coping, "If I push myself to be really good at what I do…it will result in some form of acknowledgement"(S17). This statement, where Vicky is looking for approval and acceptance from others, represents the eighth feature of the Perfectionist Overcontroller. Vicky had to redo work, which delayed her completion of the course and caused distress (in the Defective Child) because she had set a goal for when she wanted to complete the course, which was not achieved (the first feature of the Perfectionist Overcontroller).

The week after the miscarriage, Vicky went on holiday with her mother and Sarah. Vicky sought comfort from her mother by confiding in her about the miscarriage. However, her mother was critical and dismissed Vicky's feelings before turning the conversation to herself. Vicky struggled to ask for emotional support, but she wished she had someone to support her (evidence of her Neglected Child). During the holiday, her mother developed a knee problem that required surgery and 6 weeks' bed rest. Her mother informed Vicky that she would stay with her, instead of her husband, for the duration of her recovery. Vicky accepted her mother's decision (Compliant Surrenderer coping). During this time, Vicky fell ill, but she continued to see to everyone's needs and to complete all the chores (Rescuer mode). The thought of asking for help triggered her Guilty Child, related to childhood memories of her punitive and guilt-inducing mother shouting at her and telling her she's self-centred if she asked for help. As a result, Vicky flipped into a Rescuer mode with the belief that, "Mommy comes last" (S18).

8.5. Vicky's Parent Modes

Vicky's narcissistic mother was at times punitive, abusive, blaming, shaming, guilt-inducing and dismissive. This was introjected as a blended parent mode with features of a Demanding Parent, Punitive Parent, Abusive Parent, Neglectful Parent, Guilt-Inducing Parent and

Chaotic Parent (see Table 2). This severely toxic parent mode that did not have good intentions and was harmful to the child (see Table 2) is referred to as Vicky's Scathing Parent (see Figure 9).

An example that illustrates her mother's punitive nature was that, as a child, Vicky was smacked daily. As a child, she asked her mother why she got a smack every day, to which her mother replied, "Because you are just that naughty." "That's pretty much all I actually remember, is getting klapped [smacked] or being in my room or, you know, just not ever feeling as if I was up to standard" (S9). As well as being punitive, this statement illustrates her mother's neglectful nature as Vicky was left alone in her room without engagement from her mother. Vicky introjected the belief that she was "not up to standard" (which contributed to her Defectiveness/Shame schema) and that others would neglect her (contributing to her Emotional Deprivation schema). The hidings Vicky received from her mother were not only physically punitive but also abusive. In S9, Vicky recalled a conversation she had with her mother as an adult in which, "My mom almost used to gloat…she turned around and said that as a toddler … she had to send me to school in long pants because I had purple welts down my legs." That the "hiding" resulted in welts shows the abusive nature of the incident, whilst Vicky's perception of her mother as "gloating" illustrates her mother's sadistic nature. Vicky was in pain, but her mother's dismissive response was just to cover it up as if there was nothing wrong. Vicky internalised this dismissive attitude towards her physical and emotional pain which contributed to Self-Sacrifice and Subjugation schemas and her prioritising others (in Compliant Surrenderer and Rescuer coping). The example of Vicky's "hidings" illustrates multiple features of the parent mode (abusive, invalidating, punitive), supporting the description of a blended parent mode. An example that illustrates how Vicky introjected the abusive, invalidating and punitive aspects of the Scathing Parent mode is that Vicky expected her parents to blame and shame her for the rape at the age of 15 (described in section 8.1). Thus, after the rape the Scathing Parent and Vulnerable Child dyad was triggered, and Vicky flipped into avoidant coping and did not disclose the rape. This also illustrates the abusive and neglectful aspects of the Scathing Parent mode in which Vicky believed that the world is unsafe and no one will keep her safe, and the dismissing feature that she would not be taken seriously.

The abusive aspect of Vicky's Scathing Parent mode related to her mother being physically and verbally punitive. As mentioned in section 8.1, her mother repeatedly told her that she wished she had not been born (contributing to her Emotional Deprivation and

Defectiveness/Shame schemas). “Her words were so incredibly hurtful that I should have burst into tears, but I learnt not to because I knew that if I cried about the things that she would say to us, that I would get a hiding” (S9). Vicky flipped into Detached Protector coping to protect her from the Abusive Parent. The hidings Vicky received for crying illustrates the invalidating nature of this parent mode as her mother was unable to acknowledge and allow Vicky’s hurt and sadness. Instead, Vicky’s mother believed that crying was a manipulative behaviour, and so, at the same time she invalidated Vicky’s feelings, her mother shamed her for them. “When I’d cry when I was little, I was always told to stop it, or stop manipulating…so I guess I was kind of raised in the sense that don’t use your feelings to get your way” (S6). Vicky introjected the belief that crying is manipulative, and so throughout her life, she would not let herself cry. Another example of Vicky being shamed for her feelings was that when Vicky felt sad or fearful, her mother accused her of “being pathetic” and told her to “stop being pathetic” (S9). As well as being invalidating and shaming, the message that Vicky was “pathetic” was also very critical. As a result:

> I don’t ask for emotional support, but internally I always need it…even though I wish that someone would just hug me or say, ‘How are you doing? Are you okay?’, no one does that because I am not prepared to ask for it because I instinctively feel like, me, me, me. (S18)

Vicky introjected a Scathing Parent with the belief that to express sadness is manipulative and “pathetic.” Thus a mode dyad exists between a Scathing Parent and a Vulnerable Child, which Vicky copes with by flipping into Detached Protector mode to shut down the feelings of distress. So, Vicky’s Emotional Deprivation schema is maintained because she is unable to access the love and nurturance necessary for schema healing. An example that illustrates the introjected messages from this Scathing Parent was given in section 8.4 when Vicky was sick and did not ask for help from her family. In this example, she dismissed her own needs because she had internalised the message from her mother that she was manipulative and to ask for help was selfish.

Vicky’s Scathing Parent mode was neglectful, punitive and threatening. For example, in section 8.1, I described how Vicky begged her mother to play “Barbies” with her, but her mother threatened to throw her toys away if she did not play on her own. Vicky introjected the belief that she was not important to others and that she would be judged by others. Vicky projected this Scathing Parent mode onto others where she could not make herself vulnerable as she expected to be judged. An example to illustrate this was given in section 8.4, where

Vicky adapts who she is to fit in with the people she is with. For example, if Vicky is with a group of stay-at-home mothers, she cannot talk about how she enjoys work because she projects the Scathing Parent onto the other mothers, and so she expects them to judge her for having views that are different to theirs.

Vicky's complex Scathing Parent mode also had demanding elements. Growing up, Vicky described herself as shy. Despite this, her mother insisted that she participate in modelling shows and play the lead in school plays and concerts. Vicky's mother boasted about her and her brother to other people as a way of boosting her image, illustrating the narcissistic feature of her mother where she saw her children as a reflection of her. However, her mother never told Vicky or her brother that she was proud of them. Vicky's mother did not consider Vicky's feelings and whether or not she wanted to participate in these activities, thus illustrating a dismissing element to this parent mode. Vicky gave an example when she was 12 years old and at the beach with her mother and her mother's friend. Her mother impulsively enrolled Vicky in a modelling competition on the beach without discussing it with her. Vicky did not want to participate and ran away for a few hours. When she returned, she explained to her mother that she had not wanted to participate in the competition. Her mother dismissed her feelings, telling Vicky that what she was feeling was "nonsense" and that she would have won. Vicky introjected the belief that her feelings are not valid and that others will not take her seriously. This was illustrated in an example where Vicky experienced a miscarriage whilst teaching a class. When a client phoned later in the day and complained that Vicky had been distracted, Vicky projected the Scathing Parent onto her client, believing that she was not a priority and her feelings were not valid. As a result, she did not tell the client about the miscarriage but instead flipped into a Compliant Surrenderer coping mode in which she prioritised the client's needs and feelings.

When Vicky did not do what her mother expected of her, her mother told Vicky that she had disappointed her. For example, when an adult Vicky did not spend six hours a day studying, her mother told Vicky she had disappointed her and that she needed to "pull herself towards herself." This example illustrates a demanding and critical aspect of this Scathing Parent. Vicky described how, "My self-doubt voice is definitely my mom's voice, where I second guess myself and say, 'I'm going to fail'." (S14). As a result, when she had to ask for extensions on an assignment or received critical feedback, a mode dyad between a Demanding and Critical Parent and a Defective Child was triggered. This is the traditional Demanding Parent described in ST, where there is an internalised message from a parent that

she is going to fail. In this statement, one can see the triggering of the blended Defectiveness/Shame and Failure schema (described in section 5.1) as Vicky fears and expects failure and sees criticism as a sign that she is defective and has failed.

Although elements of abuse were part of Vicky's Scathing Parent mode, there was also a separate severely toxic Abusive Parent mode (see Table 2). This mode was an introject of her father's friend, who sexually abused Vicky for most of her childhood. Although the Abusive Parent is not an introject of a parent, in this research, I have used the term "parent mode" to refer to introjects, and so referring to this mode as an Abusive Parent provides consistency. Vicky had many memories of her father's friend and the abuse. When Vicky was touched by someone or heard about a stranger's traumatic experience, it triggered her abuse memories. Vicky projected the Abusive Parent onto Mark. For example, when Mark attempted to be physically affectionate with Vicky, it triggered the Abusive Parent and Abused Child dyad and Vicky experienced a trauma response.

Vicky's mother and father were represented in a separate Neglectful Parent (see Table 2) that was considered extremely toxic as they did not assume parental responsibility and provide a sense of safety or nurturance and care. When Vicky was sexually molested at the age of 6, her parents took practical steps, including taking her to the doctor and reporting the molestation, but they did not offer any comfort:

> No one ever showed any form of like 'ah shame; I'm so sorry my darling, this should never have happened'…I was never made to feel like it wasn't my fault. I was never made to feel like, you know, we're here, we'll always protect you. (S7)

Vicky recognised the lack of protection she received from her parents, which was reiterated when, as a teenager, Vicky disclosed to her mother the years of sexual abuse she experienced at the hands of her father's friend. Her mother's response was dismissive in that she said, "Oh, I had no idea. Why didn't you tell me?" According to Vicky:

> That was the end of the conversation…There was just really no acknowledgement of it, that it was just, 'oh well'…I would've liked some anger in her …her reaction didn't justify what happened…I just needed a parent to display feelings that equalled the event. (S7)

This reaction from Vicky's mother was both dismissing and neglectful as she did not consider the impact this abuse had on Vicky or try to help her cope with the feelings or even seek justice for the abuse. Thus Vicky introjected the belief that no one would protect her or

even acknowledge the extent of her feelings. As an adult, Vicky projected the Neglectful Parent mode onto Mark as she was unable to share with him how she felt unsafe in their home. Vicky wanted to improve their home security features, but she expected Mark to be dismissive of her feelings and so she did not raise the topic with him.

8.6. The Perfectionist Overcontroller

Vicky's Perfectionist Overcontroller contained eight of the 13 features described in section 5.3, including;

- striving for excellence and perfect results,
- rigidity regarding morals, ethics and values,
- preoccupation with details, order, lists and schedules,
- suppression of emotional vulnerability,
- rigid rules and standards,
- seeking approval and acceptance from others,
- concern over mistakes,
- rumination.

The core feature of the Perfectionist Overcontroller is striving for excellence. This was evident in Vicky's statement, "I just want to be A-class in everything" (S6). This included trying to be the perfect parent. "I've tried to be like the perfect mommy who sets activities every day and makes homemade playdough" (S6). Vicky's striving for excellence and perfect results was overcompensation for her Failure schema (in the Defective Child). "If you don't do it the best possible way you can, then there is actually no point in doing it. You will most likely fail" (S11). This statement also highlights the tenth feature of the Perfectionist Overcontroller, concern over mistakes.

Vicky was studying a course for which she had to write reports. When she sent out a report a day late, she experienced this as a failure because she had not met the rigid rules and standards she set for herself (the seventh feature of the Perfectionist Overcontroller). Vicky's high standards were linked to her need for approval and reassurance (the eighth feature of the Perfectionist Overcontroller), "If I push myself to be really good at what I do…it will result in some form of acknowledgement" (S7). When she received critical feedback on her assignments, the Defective Child was triggered, and she wanted to give up because she did not want people to know that she had failed. Thus a blended Failure and Defectiveness/Shame schema (see section 5.1) was activated (in the Defective Child) as

Vicky believed she had failed and experienced this as a sign she was shameful and defective. This example also shows an element of absolutes (the fourth feature of the Perfectionist Overcontroller), where Vicky interpreted criticism as a sign of failure. This fourth feature of rigidity and "just right" behaviour was evident when Vicky arrived an hour early for her second appointment. This caused Vicky distress as she commented that, "I am never early, and I am never late." This, in turn, related to her need for the approval of others (the eighth feature of the Perfectionist Overcontroller).

Vicky's Perfectionist Overcontroller also contained a feature of keeping busy so that she did not feel she had "failed at being productive" (S11). This is the fifth feature of the Perfectionist Overcontroller, organisation, which suppresses emotional vulnerability (the sixth feature). In S4, Vicky stated, "If I know something needs to be done, having it linger can be very unnerving for me. I'm a person who looks in advance what I need to do so that by the time I get there, it's already done." This shuts down Vicky's feelings of defectiveness.

8.7. The Eating Disordered Overcontroller

Vicky's Eating Disordered Overcontroller contained 11 of the 15 features described in section 5.4, including;

- rules about goal weight and what one is permitted to eat,
- the decision to restrict eating and to lose weight,
- discounting successes and resetting goals once they are met,
- self-punitiveness and self-loathing,
- focus on the body and eating patterns to generate a sense of competence, power and control,
- the marginalisation of other aspects of life,
- fear of losing control and hypervigilance to maintaining rules and routines,
- checking behaviours,
- rumination,
- the generation of images that induce fear, shame and self-disgust,
- seeking approval and acceptance from others.

Many of the elements of the Eating Disordered Overcontroller have been described in section 8.3. Vicky's Eating Disordered Overcontroller mode developed when she was 14 and developed BN. Vicky restricted food outside of binges (the second feature of the Eating Disordered Overcontroller) as a way to control her weight, believing that she would not be accepted if she was "fat" (the thirteenth feature of the Eating Disordered Overcontroller).

When Vicky travelled overseas at the age of 20, she intentionally restricted food to lose weight (the second feature of the Eating Disordered Overcontroller). Vicky sought approval and acceptance (the thirteenth feature of the Eating Disordered Overcontroller) and believed that to be noticed, she had to have a slim body. Her Eating Disordered Overcontroller developed rules about what she was permitted to eat (the first feature of the Eating Disordered Overcontroller). In the Eating Disordered Overcontroller, Vicky restricted portion sizes and was regimented about mealtimes (the fifth feature of the Eating Disordered Overcontroller). However, when her control slipped, and she was overwhelmed with feelings of sadness or anxiety, she flipped from the Eating Disordered Overcontroller into a Detached Self-Soother coping mode in which she binged.

As part of Vicky's Eating Disordered Overcontroller, she wanted to lose weight (the first feature of the Eating Disordered Overcontroller). Vicky discounted her weight loss successes and reset her goals (the third feature of the Eating Disordered Overcontroller) as she desired to weigh 10 kg less than her current weight, irrespective of her current weight. This was fuelled by her childhood belief that "no one likes a fat person" (S1), and so, to achieve approval and acceptance from others (the thirteenth feature of the Eating Disordered Overcontroller), she needed to be slim.

When Vicky was undergoing fertility treatment and had to lose weight, she weighed herself daily, before and after each meal. This body checking behaviour was the ninth feature of the Eating Disordered Overcontroller, which motivated Vicky to follow the rules of the Eating Disordered Overcontroller. "If I see that I have lost point five or even point two, then it keeps me motivated [to eat healthy] for the next meal" (S6). Vicky also spent vast amounts of time checking herself in the mirror. Vicky experienced somatic cues (the eleventh feature of the Eating Disordered Overcontroller), including the feeling that she was fat and that her clothes were tight. This triggered punitive messages towards herself (the fourth feature of the Eating Disordered Overcontroller), that she was fat and disgusting, from the co-opted Flagellating Overcontroller, which motivated her to increase her restricting behaviour.

Vicky's Eating Disordered Overcontroller included food rules (the first feature) so that she avoided food groups, including fats and carbohydrates. She perceived vegetables as a "safe food" and the only food not accompanied by guilt, a self-punitive feature of the Eating Disordered Overcontroller. Outside of binges, Vicky did not allow herself to eat unhealthy foods, including takeaways (the first feature of the Eating Disordered Overcontroller). Associated with the food rules was a focus on eating patterns (the fifth feature of the Eating Disordered Overcontroller). Vicky was regimented about the times she ate and plated portion sizes that were smaller than those stipulated on the meal plan provided by the dietician. She also planned her next meal whilst eating (the tenth feature of the Eating Disordered Overcontroller) and experienced guilt if she did not follow through and eat what she had planned (the fourth feature of the Eating Disordered Overcontroller). The guilt was a punitive aspect that motivated Vicky to follow the food rules and was related to her fear of losing control over her eating and gaining weight (the eighth feature of the Eating Disordered Overcontroller).

8.8. The Detached Self-Soother

Vicky's BN from the age of 14 included binges (the first self-soothing behaviour) to soothe the sadness and anxiety triggered by her sexual awakening. Sexual experimentation was experienced as traumatic because of her history of sexual trauma. The binges she engaged in "calmed her" and "quietened her mind", accompanied by the belief that "food will make me feel better" (S1).

Vicky continued to use binge eating to shut out uncomfortable emotions. "I think I just learnt a coping mechanism so that I don't feel intense sadness, because I'd rather not feel…eating made me feel better" (S2). This was elaborated on in S4, "As long as I am eating, I feel nothing…it's soothing." A binge comforts Vicky, "I probably eat to feel comforted…bingeing makes me feel better momentarily" (S6). Bingeing not only shut off distressing feelings but also distressing thoughts. However, once Vicky stops chewing, she "starts feeling." Thus the Detached Self-Soother provides temporary relief, and then Vicky needs to flip into another coping mode to shut off the emotions. For example, going to bed after a binge (Avoidant Protector coping) allows her to avoid the distressing feelings that arise from a binge.

Vicky's bingeing tended to be impulsive, a feature of Detached Self-Soother behaviours. "I lack the ability to not binge. If I feel the need to binge, there's absolutely

nothing that can stop it" (S2). However, this impulsiveness was in the mode flip, as once the mode flip occurred, her self-soothing was a planned sequence of behaviours. As described in section 8.3, Vicky's binges tended to be slow as she waited 45 minutes for a tin of condensed milk to caramelise. In this way, preparing for the binge was part of the self-soothing behaviour as it distracted her from feelings of sadness or anxiety.

A food binge (Detached Self-Soother) was followed by a focus on the number of calories consumed (Eating Disordered Overcontroller), which triggered a Guilty Child. "You feel so guilty and so terrible that you're like, was it actually even worth it?" (S4). To cope with the triggered Guilty Child, Vicky purged through self-induced vomiting. This neutralising behaviour was the second self-soothing behaviour in the Detached Self-Soother, which provided a sense of relief and allowed Vicky not to feel the guilt.

Bingeing and purging were not the only self-soothing behaviours in which Vicky engaged. As a teenager, Vicky's Detached Self-Soother included self-injurious behaviour (cutting). This third self-soothing behaviour distracted Vicky from the emotional pain by creating a physical pain on which to focus. She related the act of cutting with receiving comforting words from someone else and the sight of the blood leaking from the wounds as her tears falling. Vicky struggled to express sadness, but by seeing the blood as her tears, she could link the act with expressing her sadness. After cutting, Vicky tended to the wounds, a fourth self-soothing behaviour which gave her access to comforting the Lonely Child.

Vicky's fifth self-soothing behaviour involved keeping busy to avoid acknowledging uncomfortable feelings:

> Keeping busy is my new binge. It's not a food substance, but it is something in excess…I kept myself busy and tried to keep myself busy to prevent having panic attacks…it was almost petrifying knowing that I'd be done in like an hour because I knew the moment I sat down that I'd go into panic. (S6)

This statement illustrates how keeping busy was a self-soother because it shut off the anxiety related to Vicky's Abused Child. Vicky's work, in this sense, was not related to her desire to be perfect and keeping active to produce perfection. Keeping busy was part of the Detached Self-Soother mode that Vicky implemented during the day whilst her food binges were a self-soothing behaviour that occurred at night. Vicky explained this as follows:

> I think the only reason why my binges happen after dinner is because I don't stop moving until after dinner. So I'm pretty much active in work and house and

> childminding until my daughter's asleep and chores have been done, then it's downtime. (S4)

When Vicky had "downtime", she became overwhelmed with anxiety and experienced frequent flashbacks to past traumas (her Abused Child was triggered). Bingeing, in a Detached Self-Soother mode, helped to distract her from this.

8.9. Schema Perpetuation and the Therapeutic Process

In this section, I will look at how Vicky's problems were perpetuated, as well as the process we underwent therapeutically.

Vicky's Defective Child and Abused Child were prominent in therapy. Vicky coped with the feelings triggered in her Defective Child by being submissive and prioritising others' needs in a Compliant Surrenderer or Rescuer mode. Vicky's Compliant Surrenderer and Rescuer coping and limited Healthy Adult prevented her from verbalising her needs and, in this way, possibly having them met. Unable to verbalise her needs contributed to her lack of meaningful connections in the Lonely Child. Vicky's Abused Child and associated anxiety and panic maintained her ED behaviours in the Detached Self-Soother as a way of shutting down these emotions. However, overeating and fear of weight gain contributed to feelings of defectiveness (Defective Child) which flipped Vicky into an Eating Disordered Overcontroller mode.

Vicky was seen for 45 weekly sessions. After a comprehensive assessment process, we moved into a therapeutic phase based on ST. Trauma-focused work enabled Vicky to emotionally process her traumatic experiences so that her Abused Child was less triggered. Vicky experienced fewer flashbacks and, subsequently, less Spaced Out Protector and Detached Self-Soother coping. A list of graduated anxiety-provoking behavioural activities was developed to assist Vicky to overcome her anxiety and develop intimacy in her marriage. Grounding techniques, breathing techniques and imagery, assisted Vicky to progress through these activities, as well as increase her window of tolerance for working through her traumas.

Chairwork was used to access Vicky's Vulnerable Child modes. The empty chair technique allowed Vicky to confront her mother and her abuser. Imagery rescripting was used to address distressing memories from Vicky's childhood. Through limited reparenting, we began healing Vicky's Vulnerable Child by providing for her unmet needs.

At the time that Vicky terminated sessions, she had fallen pregnant. She was still disconnected from Mark as, although Vicky had made progress in expressing her needs to him, his coping modes prevented him from appropriately meeting her needs.

Vicky made contact more than a year after therapy ceased. She no longer experienced flashbacks, and she had a healthy intimate relationship with Mark. She no longer engaged in eating disordered behaviour. Vicky's BMI was 21.3, and she was "100% comfortable in my skin." Vicky stated that she had learnt not to be critical of herself.

With Vicky, I was able to bypass the coping modes and access the Vulnerable Child. Using experiential techniques to help Vicky resolve her traumatic memories and see her value resulted in schema healing. As a result, Vicky no longer needed to flip into maladaptive coping to shut down the distressing feelings these child modes evoked. Instead, Vicky functioned predominantly in her newly developed Healthy Adult mode.

Chapter 9. The Case Study of Donna

9.1. Psychosocial History

Donna, the only daughter of a wealthy farmer, was materialistically spoiled by emotionally neglectful parents who did not spend time with her nor express love and affection towards her. Her parents' behaviour contributed to a Spoilt Child mode (Entitlement/Grandiosity schema) and a Lonely Child (Emotional Deprivation schema). Her narcissistic father, a successful but ruthless businessman, was dishonest and self-aggrandising. Donna's father had a reputation in the community for treating his workers poorly. The poor treatment of his workers resulted in incidents of violence on the farm. In one incident, a man visiting her father was murdered, and the police thought that her father was the intended target. For a time, the family were escorted by armed soldiers for their protection. The constant threat contributed to Donna's Anxious Child (Vulnerability to Harm or Illness schema).

Donna's parents had an unhappy marriage, exacerbated by her father's infidelity and rumours in the community that he had sex with prostitutes. The rumours were a form of external shame that contributed to Donna's Shaming Parent mode in a mode dyad with a Shamed Child (Defectiveness/Shame schema). Her stay at home mother struggled with chronic depression and accompanying pessimism. Donna experienced her mother's Complaining Protector mode as a "dark force." Donna developed Compliant Surrenderer coping (Self-Sacrifice and Subjugation schemas) to maintain the connection with her complaining victim-like mother. Donna's one older and two younger brothers ganged up on her and bullied her whilst her parents did little to protect her, reinforcing her Subjugation schema.

Food was a focal point in Donna's childhood home, and she modelled her obese father's "gluttonous" approach to food (Impulsive Child). Her mother allowed the children to choose whatever they wanted to eat at the shops because she could not decide what to cook. The message that you could eat what you wish was reinforced on weekends when food was laid out all day so that they could help themselves, triggering Donna's Impulsive Child. Donna used food (in a Detached Self-Soother mode) to cope with feelings of boredom (in a Detached Protector mode) and subsequently became overweight from a young age. Her BMI was 25.6 (overweight) in matric, and due to poor food choices and binge eating behaviour, her BMI increased to 33.9 (obese) the following year.

Donna developed a Dependent Child (Enmeshment or Undeveloped Self and Dependence/Incompetence schemas). The Enmeshment or Undeveloped Self and Dependence/Incompetence schemas were perpetuated by her coping by becoming prematurely independent, owing to neglectful parenting (Arntz & Jacob, 2013). Donna was a weekly boarder at an all-girls school from the age of 11. She enjoyed school, where she was involved in many extracurricular activities, and held several leadership positions as a senior. Thus there were two sides to Donna; one side was dependent and enmeshed, and the other was independent. This contributed to her anxiety from an early age. Despite Donna's involvement in school, her parents were disinterested. Donna was popular and well known at school (activating her Approval-Seeking/Recognition-Seeking schema and Self-Aggrandiser coping mode), which made her feel special in an environment she described as loving and nurturing. This contrasted with her home life, where she was left alone or in the care of a childminder. At school, special concessions were made for Donna, triggering and reinforcing her Spoilt Child. For example, the timetable was arranged to fit with her subject choices, and she was excused from participating in compulsory sports events to allow more time for the cultural activities she preferred.

When the family were together, Donna's father gave them large sums of money to entertain themselves (triggering her Spoilt Child). Having vast sums of money and no limits to what they could have, contributed to Self-Aggrandiser coping (Entitlement/Grandiosity schema), but Donna then flipped into a Shamed Child where she was ashamed of her father's wealth and how he flaunted it, believing that if you were wealthy, you should be humble. Donna overcompensated for the shame by striving to do things perfectly (Perfectionist Overcontroller). In her teenage years and early adulthood, Donna's Shamed Child was triggered when she was associated with her brothers, who had developed reputations for fighting and drug use. The shame, exacerbated by the gossip regarding her father's infidelity (the community as a Shaming Parent), was so great that she looked forward to getting married to change her surname and, in this way, distance herself from her family (Avoidant Protector coping).

After school, Donna obtained a diploma, pushing herself to do her best (the first feature of the Perfectionist Overcontroller) so that she came second in her class. Her father then bought her two businesses in the hospitality industry, another example of her being materially spoiled, which reinforced her Spoilt Child. Donna owned and managed the businesses for two years. She worked long hours to make them successful (the first feature of

the Perfectionist Overcontroller), taking it to an extreme where she would, on occasion, spend 20 hours a day at work. This marginalisation of other aspects of life is the third feature of the Perfectionist Overcontroller. Donna suffered burnout and was hospitalised for two weeks, after which she sold the businesses. Donna then obtained varied employment in the hospitality industry.

When Donna was 21, her parents divorced, and her father ensured that her mother received little financial compensation. Donna was appropriately angry with her father because of how he treated her mother (Healthy Adult), so she distanced herself from him and limited contact (Avoidant Protector coping).

At the age of 25, Donna had two traumatic experiences in two months - an armed robbery at her workplace and a home invasion. These experiences resulted in anxiety which Donna coped with in a Paranoid Overcontroller mode, where she tried to control perceived threats by excessively spending on home security measures. This included bulletproof roller shutters over all windows and doors, security gates, burglar guards, a security wall, electric fence, closed circuit television (CCTV) cameras and a home security system with armed response. Donna deluded herself into believing she felt safe in her home (Pollyanna Overcompensator mode), but she would not step into the garden if she were home alone. Donna experienced a trauma response if the home alarm was triggered, including flashbacks to the home invasion, and severe anxiety.

Months after these two traumas, Donna married Jack, her boyfriend, from the age of 15. Jack was also raised in a wealthy family and, as a director of a large company, could maintain the lifestyle in which Donna was raised.

Donna experienced a series of medical traumas at the age of 30 related to her pregnancy and the birth of her daughter, Jodie. Due to high blood pressure, Donna was hospitalised between 10 and 15 times during the pregnancy. Fearing for her baby's wellbeing, Donna coped with the anxiety by bingeing (Detached Self-Soother coping). Donna's BMI reached 47 (morbidly obese). She was admitted for dangerously high blood pressure and breathing difficulty when she was 30 weeks pregnant, at which time Jodie was born by emergency caesarean. After the birth, Donna was in a critical condition because her organs were failing. She was transferred to ICU, whilst Jodie was transferred to Neonatal ICU, where Jodie spent 4 weeks. Due to Donna's poor health, she did not see Jodie for the first 5 days of her life. After they were both discharged from the hospital, Donna was ill for weeks

as her caesarean wound became septic. The resulting separation from Jodie meant that Donna did not properly bond with her. Donna's experience throughout her pregnancy and the birth of Jodie resulted in anxiety related to hospitals and a fear of falling pregnant again. The home invasion, armed robbery and medical traumas Donna experienced resulted in posttraumatic stress disorder.

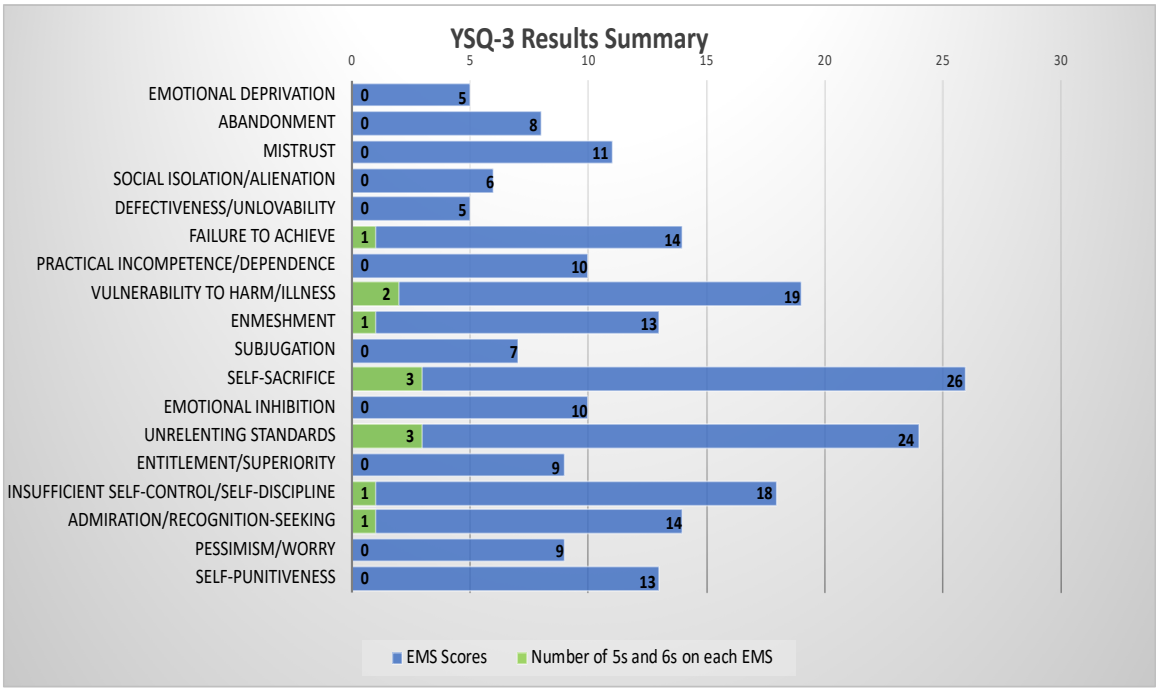
When Donna was in a situation that reminded her of past traumatic experiences, she experienced anxiety. Donna coped with the anxiety in an Over-Analyser mode which included worry about future events and rumination about past events. This Over-Analyser coping exacerbated Donna's anxiety so that she flipped into Avoidant Protector coping, avoiding the situations or places causing her distress, for example, hospitals. Alternatively, Donna sought reassurance (Reassurance Seeker mode) from people close to her.

9.2. Results on the YSQ and SMI

Figure 10 shows the results of the YSQ, and Figure 11 the results of the SMI conducted after the fourth session. The scores and qualitative information from responses to specific items were used in conjunction with the information obtained in the clinical interviews and observations of her behaviour to develop a case conceptualisation.

Figure 10

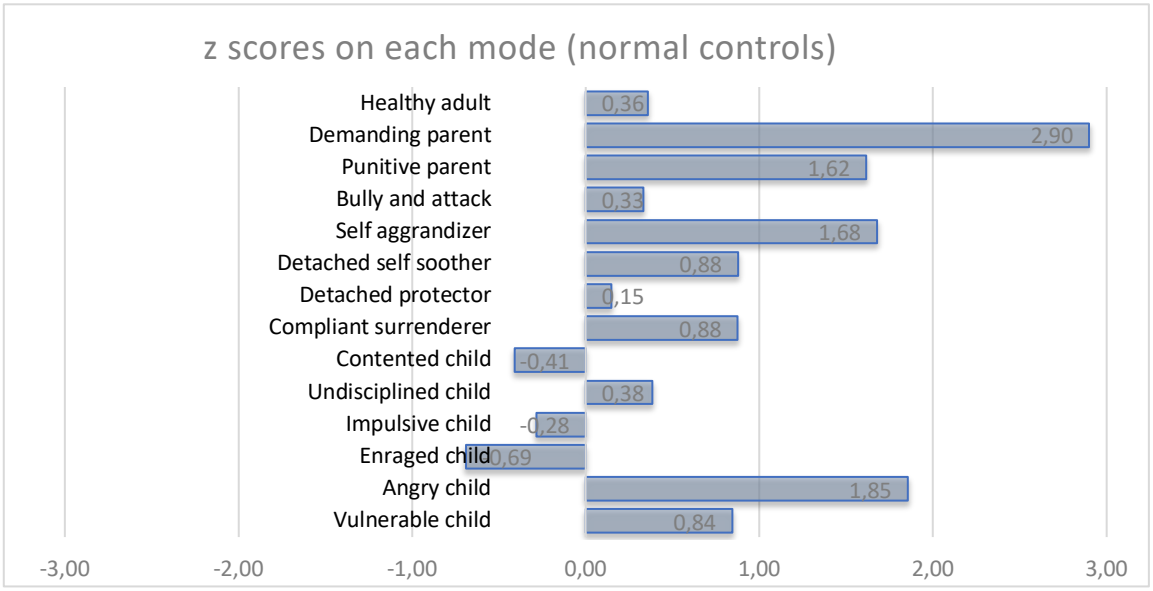
Donna's Results on the YSQ



Donna's scores on the YSQ were lower than expected. The results showed significant scores for Vulnerability to Harm or Illness, Self-Sacrifice, Unrelenting Standards/Hypercriticalness and Insufficient Self-Control/Self-Discipline. However, Donna only provided 2 or 3 severe scores (5 or 6) on three schemas, namely Unrelenting Standards/Hypercriticalness, Self-Sacrifice and Vulnerability to Harm or Illness (see Figure 10). These three schemas were openly acknowledged by Donna because she deemed them as socially acceptable. However, Donna also had Subjugation, Defectiveness/Shame, Emotional Deprivation, Dependence/Incompetence, Entitlement/Grandiosity, and Approval-Seeking/Recognition-Seeking schemas which had low scores on the YSQ. Donna's low scores on the YSQ could be because the schema attitudes and beliefs are socially undesirable, such as Entitlement/Grandiosity and Approval-Seeking/Recognition-Seeking schemas, so she denied them when completing the questionnaire. Also, Donna underestimated the extent to which her needs were not met, which could account for her lower scores on statements (Cutland Green & Balfour, 2020).

Figure 11

Donna's Results on the SMI Compared to Normal Controls



Donna's low scores on the SMI were not a true reflection of her modes. The scores indicate that she was most likely in an overcompensator mode when she completed the questionnaire. Donna scored six of the 10 Healthy Adult items with a 5 or 6. These items included, "I'm capable of taking care of myself", "I know when to express my emotions and

when not to", "When there are problems, I try hard to solve them myself" and "I feel that I'm basically a good person" which are statements that also tap an overcompensator mode. As Donna had little evidence of a Healthy Adult when interviewed, the high scores on these items support the hypothesis that she was in an overcompensator mode when she completed the questionnaires.

9.3. ED Presentation

As previously mentioned, Donna was an overweight child. After school, her weight steadily increased due to poor food choices and overeating until, at the age of 22, she embarked on a diet that she followed rigidly. Her Perfectionist Overcontroller developed into a specialised Eating Disordered Overcontroller mode with food rules (the first feature of the Eating Disordered Overcontroller). An example to illustrate her rigidity with the rules was that if she felt like eating crisps, she would suck the spice off the crisps and then spit them out. When Donna went to a wedding, she packed her food but, when this spoiled in the car, she did not eat at all. As a result of this dieting, Donna lost 40 kg in 5 months, obtaining a healthy BMI (23.3). Her motivation was sustained by her rapid weight loss (1½ kg per week) as she saw quick results. The day after she reached her goal weight, Donna threw a party to celebrate and ate all the foods she had been denied (Impulsive Child). She then reverted to her poor eating patterns, and her weight steadily increased again.

When Donna and I first met, her BMI of 38.7 placed her in Obese Class 2. Donna had attempted many diets, supplements and even medication with harmful side effects to lose weight. She had also engaged with a dietician and a life coach to address her eating patterns, but she was unsuccessful as she did not implement the advice she was given. When the dietician provided a meal plan, Donna felt deprived that the foods she enjoyed were taken away (her Vulnerable Child was triggered), so she ignored the meal plan (Defiant Child).

Donna feared gaining additional weight and losing control of her eating (the eighth feature of the Eating Disordered Overcontroller). Thus thoughts of food, eating or calories consumed most of her time (the seventh feature of the Eating Disordered Overcontroller). Donna felt uncomfortable with her weight and in her body. She labelled unhealthy foods such as pasta, pies and pastry as "illegal foods" (the first feature of the Eating Disordered Overcontroller), and so, when she ate these, the punitive aspect of the Eating Disordered Overcontroller triggered a Guilty Child. Donna had food rules related to her eating patterns (the fifth feature of the Eating Disordered Overcontroller), including having to drink 500 ml

of water before leaving the house and not allowing herself to eat carbohydrates at lunchtime. Donna dismissed the large portions she ate and instead focused on the fact that she was consuming healthy foods. In this way, she convinced herself that she was eating healthily (Pollyanna Overcompensator).

Outside of meals, Donna binged several times a week to soothe feelings of boredom, anxiety or loneliness (Detached Self-Soother). Her binges involved eating rapidly and until uncomfortably full, despite not feeling hungry. These binges had elements of a Defiant Child, "If there's something nice to eat and it's illegal, I'll eat a lot of it" (S3). Binges were followed by feelings of disgust, sadness or guilt (in the Vulnerable Child) because she had broken her food rules. Donna also used food as a reward (Detached Self-Soother). For example, if she lost weight, she rewarded herself with food. Donna expected people to judge her for what she ate (Shamed Child). So, Donna would not order an "unhealthy meal" in a restaurant, and when she ordered a 'Tab', she drank it from the can so that people could see it was the less fattening 'Tab' and not Coca Cola. In this way, Donna was seeking approval and acceptance for her eating behaviour (Compliant Surrenderer).

When Donna and Jack ordered take-aways, Donna ordered the largest meal available and ate the same amount as Jack. This Detached Self-Soother coping was to avoid feeling deprived (in a Vulnerable Child). According to her food rules (in the Eating Disordered Overcontroller), burgers were "illegal foods." When she ate a burger, the punitive part of her Eating Disordered Overcontroller triggered a Guilty Child, but "it tastes good for the 3 minutes you're wolfing it down" (S3). With every bite, she thought, "I shouldn't be eating this" (the tenth feature of the Eating Disordered Overcontroller), but she would finish the take away even if she felt full halfway through (Defiant Child). Donna's eating behaviours met the DSM-5 (APA, 2013) criteria for BED.

9.4. Case Conceptualisation at the Time of the Assessment

Table 6

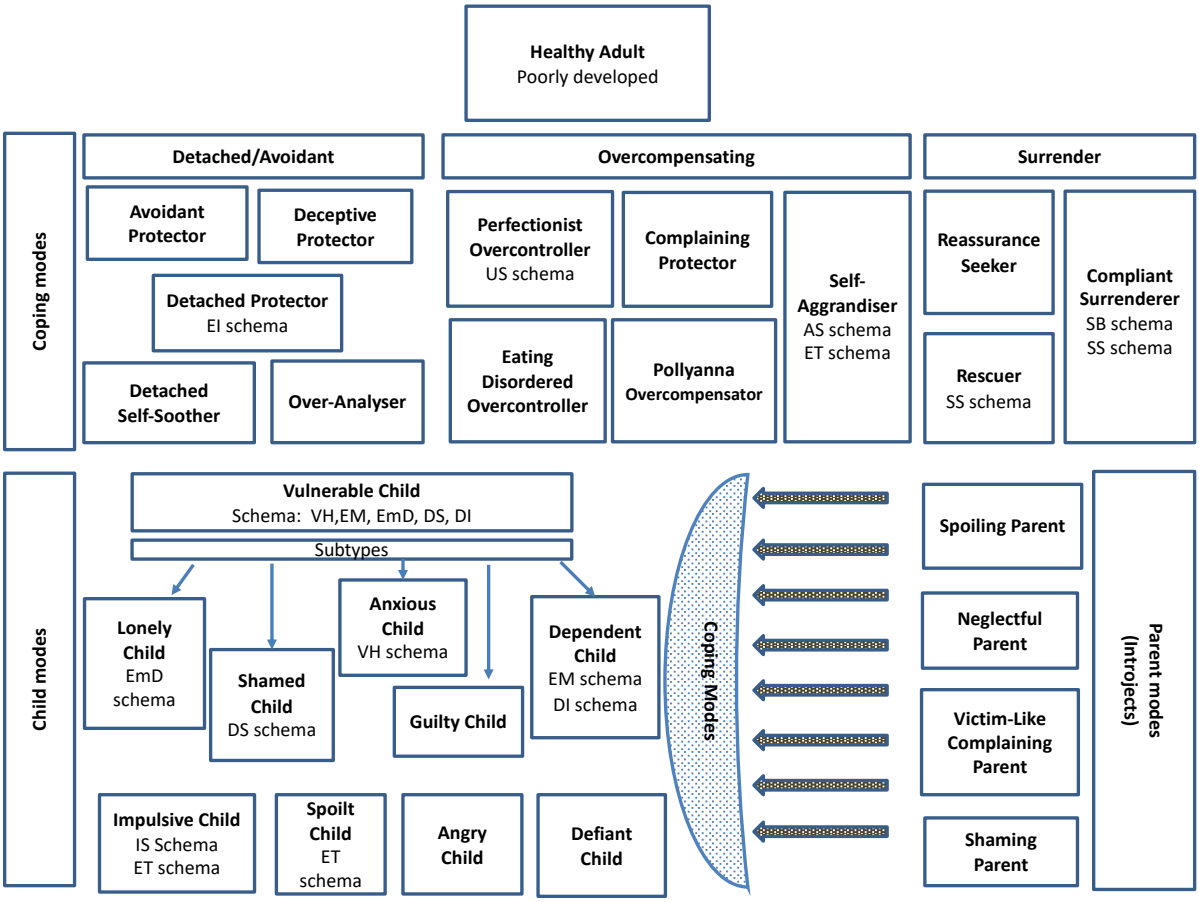
Donna's DSM-5 Diagnosis at the Time of the Assessment

DSM-5 Diagnosis	**ICD-10-CM Code**
Binge-eating disorder, moderate	F50.8
Major depressive disorder, with melancholic features, mild	F33.0
Posttraumatic stress disorder	F43.1
Illness anxiety disorder	F45.21

Table 6 presents Donna's diagnosis at the time of the assessment. This will be made evident in this section. Donna's current modes are represented in the mode map (see Figure 12).

Figure 12

Donna's Current Mode Map



Note. AS = Approval-Seeking/Recognition-Seeking; DI = Dependence/Incompetence; DS = Defectiveness/Shame; EI = Emotional Inhibition; EmD = Emotional Deprivation; EM = Enmeshment or Undeveloped Self; ET = Entitlement/Grandiosity; SB = Subjugation; SS = Self-Sacrifice; US = Unrelenting Standards/Hypercriticalness; VH = Vulnerability to Harm or Illness.

At the time of the research, Donna was 32, married for 6 years, and her daughter, Jodie, was 2. Donna had her own part-time business, which required less than 12 hours of work per week, mostly from home. However, not contributing financially to the family triggered Donna's Guilty Child. She then flipped into a blended Perfectionist Overcontroller and Compliant Surrenderer mode by making "her home a castle that her prince [Jack] would be glad to come home to every day."

Jack's income allowed for a lavish lifestyle, and, like her father, he materialistically spoiled her but was emotionally disconnected (triggering her Lonely Child). Jack frequently bought Donna expensive gifts, which triggered her Shamed Child as she believed they were

excessive and that if her less wealthy friends knew, they would judge her. For example, Jack returned from a brief business trip with a R70 000 watch as a gift for her. Donna coped with the shame caused by their excessive spending on home alterations or purchases by being dishonest or evasive when speaking to friends or family members about the amount of money spent (Deceptive Protector). When she saw her husband counting "piles of cash on the bed", it triggered a memory of her father counting buckets of money and triggered her Shamed Child related to not being humble about one's wealth.

Donna depended on Jack to make decisions for her (Dependent Child mode). For example, he accompanied her to doctor's appointments, and he would make decisions with the doctor regarding her health and treatment plans. Donna consulted Jack on every decision she made, which came from her Dependent Child mode and Compliant Surrenderer coping because she wanted Jack's approval.

Jodie was an overindulged child. Donna was not nurturing with her and became exasperated at engaging with her, describing her as "an ankle snapper" and "a brat." As already described, the circumstances surrounding Jodie's birth had resulted in significant attachment problems.

Donna maintained a distant relationship with her father. Although she invited him to birthdays and celebrations, he made excuses not to attend. Donna was still angry with her father for his treatment of her mother, and she was angry that he was uninvolved in Jodie's life.

Donna still had poor relationships with her brothers, of whom she was disdainful and critical (Self-Aggrandiser mode). She described her eldest brother, a pastor, as hypocritical in that he did not practise what he preached, the second brother struggled with addiction, and the third had a self-pity victim approach to life.

Donna had an enmeshed relationship with her mother, who visited daily, before and after work, and stayed over on weekends. "When I open my peepers, there's a message from my mother, 'can I come over now'. " (S4). Her mother was intrusive and did not respect Donna's personal space. For example, her mother followed her into the bathroom. Despite her frustration with her mother's constant presence, Donna relied heavily on her mother to help with Jodie's care (Dependent Child). Donna felt pressure to provide her mother with emotional and financial support (Compliant Surrenderer coping). Her mother's Complaining

Protector mode triggered Donna's Angry Child, but because of Donna's Dependent Child and Compliant Surrenderer coping with her mother, she did not express this anger.

Donna's friend, June, came to her house daily for lunch and stayed for hours. She too had a Complaining Protector mode, that Donna experienced as draining and that triggered her Angry Child. Still, Donna's Shamed Child that was triggered because of her wealth, led to Rescuer coping in which she felt she had to support her mother and June, because, "I'm lucky in some ways. I have a lot, so I need to give a lot" (S12). However, the routine of spending time with two people in a Complaining Protector mode and the pressure of maintaining a "perfect home" (Perfectionist Overcontroller mode) left Donna feeling de-energised and demotivated (Detached Protector), which was exacerbated by her depression (see Table 6), supported by her score of 35 (moderate depression) on the BDI-II. Donna also had a Complaining Protector mode which was evident when she complained to me about her mother and friend who took advantage of her, but she had no willingness to change the situation.

Donna befriended the mothers of children at Jodie's preschool, whom she regularly socialised with out of a sense of duty, believing it was required to maintain friendships rather than because it was something she enjoyed (Compliant Surrenderer mode). Donna was critical of her friends' behaviour and condescending of their conversation topics (Self-Aggrandiser mode). Donna lacked meaningful connections, which left her feeling unfulfilled and questioning her purpose (Detached Protector). "Sometimes I just don't see that I have much purpose other than being a wife and mom…like what else am I here for" (S9). Donna deluded herself that she has a "perfect life" and a "perfect husband" (Pollyanna Overcompensator).

Donna wanted to have a "perfect home", so she kept her home obsessively neat and orderly (the fifth feature of the Perfectionist Overcontroller). This Perfectionist Overcontroller coping was to avoid triggering of the Shamed Child as she expected people to judge her. Donna also overcompensated for her Shamed Child by trying to maintain a perfect image. Thus she would not leave home unless she was well-groomed (Self-Aggrandiser coping). Maintaining a perfect home and a perfect image was to gain others' approval (the eighth feature of the Perfectionist Overcontroller). So when Donna was home, she kept busy tidying and rearranging cupboards (in the Perfectionist Overcontroller) to shut off feelings of boredom.

Donna had ongoing medical problems, including high blood pressure, swollen feet, chronic headaches and backache. Doctors attributed her medical issues to her weight, triggering her Shamed Child. Donna also had food allergies, so that when she ate certain foods, she developed boils. However, Donna's Defiant Child mode was triggered when she felt that she was being told what she could eat, and so she continued to consume the foods that caused her allergies. Donna experienced health anxiety (Vulnerability to Harm or Illness schema in an Anxious Child), and she convinced herself that her symptoms were indicative of a severe medical condition (Over-Analyser mode). For example, Donna worried that a headache is a symptom of a brain tumour (Over-Analyser mode). The Over-Analyser coping caused severe anxiety, so that Donna booked expensive medical diagnostic tests. However, on some occasions, Donna realised the tests were not necessary (Healthy Adult), so she did not follow through with them. These symptoms met the DSM-5 (APA, 2013) criteria for illness anxiety disorder (see Table 6).

Donna's weight stopped her from participating in the activities she enjoyed. For example, she had been asked to get off amusement park rides because the safety harness did not fit. On a recent holiday, she could not go on the pedal boat in case her weight caused it to capsize. These experiences triggered her Shamed Child as she felt judged by people for her weight. Thus Donna experienced the community as a source of external shame (in a Shaming Parent). Donna's Shamed Child questioned, "When will I be good enough?" (S2). Donna experienced her weight as a constant reminder that she was not good enough (triggering and reinforcing her Shamed Child). When a doctor referred her for a breast reduction to relieve her headaches, her Shamed Child was triggered:

> So it's like I just need to change myself to feel better, like make your boobs smaller and your headaches will stop, get thinner, and your blood pressure will get better; it's like constantly having to change who I am to be healthier. (S2)

In this statement, one hears features of the Shaming Parent and the Demanding Parent with rules about what Donna "should" do to make herself acceptable. This triggered a Shamed Child, and then Donna flipped into a Complaining Protector mode in which she felt victimised and embittered.

Jack wanted another baby, which caused Donna anxiety because of her traumatic experience with her first pregnancy. Despite this, she agreed to another pregnancy because

she believed it was selfish not to have another child if this was what Jack wanted (Compliant Surrenderer coping).

After meeting for 20 sessions, Donna had bariatric surgery. Donna's decision to have the surgery was impulsive (Impulsive Child). Once she made the decision, Donna wanted the surgery done as soon as possible (Impulsive Child). She contacted a surgeon and made it clear that if he did not do the surgery within a week, she would find another doctor (Self-Aggrandiser coping). Before the surgery, Donna was required to meet with a dietician and be assessed by a psychologist who was part of the bariatric team. Following the surgery, Donna's Anxious Child was triggered, and she coped by ruminating about rushing the surgery and worrying that she had harmed her body (Over-Analyser coping). Donna sought reassurance (Reassurance Seeker mode) by obsessively reading about bariatric surgery complications online and reading, on average, one thousand WhatsApp messages per day on various bariatric support groups.

Donna's belief that the surgery would result in happiness (Pollyanna Overcompensator) distracted her attention from her real psychological problems. However, after the surgery, Donna's embryonic Healthy Adult acknowledged that her weight loss had not led to happiness. Also, she still focused a lot of her time and energy on food. The surgery had not healed Donna's child modes, and so she still flipped into Detached Self-Soother coping to shut down distressing feelings. However, her reduced stomach size meant that she could not binge to the extent she had before the surgery, making this coping mode less effective in shutting down her feelings.

Over time Donna was able to tolerate larger food portions and more variety. Her Impulsive Child and Detached Self-Soother led to poor food choices and weight gain. When a healthier approach to eating was explored, Donna's Defiant Child was triggered as, "I feel you are taking everything I like away from me" (S30). When her Defiant Child was triggered, Donna continued to use food as a self-soother (Detached Self-Soother).

9.5. Donna's Parent Modes

Donna had four parent modes. The first parent mode was a moderately toxic Neglectful Parent mode (see Table 2), an introjection of her parents who were emotionally and physically absent but did not have ill intent. Her grandiose narcissistic father was self-involved because he worked long hours and, when he was home, did not spend time with the children. Donna is aware that she did not get nurturing or quality time with her father. "I

don't really remember doing anything with him [her father], except for when I was out of school, he bought me a business" (S1). Her fragile narcissistic mother was also self-involved because she was unhappy and harassed. So Donna and her siblings were "left to run around on the farm" or in the care of other people. For example, when the family went on holiday, Donna and her siblings travelled with a childminder and a driver, whilst her parents travelled by helicopter. Her parents were also uninvolved with her school life and did not attend school functions nor show interest or pride in Donna's school achievements. Donna's parents did not attend to her needs, and as a result, Donna did not know what her needs were. Further evidence of the neglect was noted when Donna stated that she felt more nurtured at boarding school than at home. Part of Donna's neglect was that there was no parent to protect her. Her lack of protection was evident in the examples Donna gave of her parents not intervening when her brothers bullied her (see section 9.1). These examples all provide evidence of a mode dyad between a Neglectful Parent and a Lonely Child. Donna's introjection of the Neglectful Parent was experienced as her being unaware of her needs and dismissing her needs as unimportant in relation to others. When Donna's in-laws visited, they spoiled Jodie by giving her sweets to eat instead of meals and disrupted her daily routine. Donna projected the Neglectful Parent onto her in-laws as she did not expect them to see her as important or to consider her opinion. So Donna did not express her feelings about their behaviour to them, but instead, she flipped into Compliant Surrenderer mode when they visited, allowing them to disrupt Jodie's routine and to feed her sweets until, having consumed too many, she vomited.

Donna's second parent mode was a Spoiling Parent (see Figure 12) as her parents spoiled her materially and did not set limits. This parent mode was mildly toxic (see Table 2) as her parents had good intentions but lacked knowledge and skills. At the shops, Donna was told by her mother, "Put anything you want to eat in the trolley, because I can't think of what to cook, so if you feel like something, put it in" (S2). This statement was symbolic of her mother's harassed nature and neglectful as Donna and her siblings did not have healthy, home-cooked meals in a family setting. At the same time, it was spoiling as no limits were set on what the children could choose.

Donna's father was neglectful and spoiling in that he gave his children money rather than spend time with them:

> He wouldn't really spend a lot of time with us or do anything with us. He was very, very wealthy, and he used to just buy us everything we wanted, like ridiculous things for no occasion whatsoever. I remember…we had a beach cottage, and he wanted to

> sleep, so he gave us each R5 000 to go the shops with my mom…he used to want to just rest, so he bought us all a 4-wheeler and put us on the beach for the day. (S1)

The dyad between a Spoiling Parent and a Spoilt Child resulted in limited frustration tolerance and a sense of entitlement (Entitlement/Grandiosity schema in an Impulsive Child). Donna's Spoiling Parent introject was evident in her belief that she could walk into any shopping centre and buy whatever she wanted. When the Spoiling Parent and Spoilt Child dyad was triggered, Donna flipped into a Self-Aggrandiser coping mode. Donna enjoyed being spoilt by her husband, on whom she projected the Spoiling Parent. For example, if Donna found a coat she liked, she knew that her husband would buy it for her in every colour. Donna was materially spoilt, but her emotional needs remained unmet as she disconnected from her needs early on and therefore did not know what they were (evidence of the Neglectful Parent). As a result, Donna is unable to recognise Jodie's needs and parents her the way Donna was parented; by materially spoiling her but not giving her attention and care.

Donna's third parent mode, an introject of both her parents, was a Shaming Parent (see Table 2). When parents are neglectful, and a child attempts to get love but is rejected, this behaviour is shaming and leads to the belief that the child is defective (Defectiveness/Shame schema). Her father's dismissive attitude to her needs and vulnerability was shaming. Donna gave an example in her final year of schooling, where her mother shamed her. In the example, Donna told her mother that she had been chosen as head girl of her school, and her mother laughed at her because she did not believe that Donna was capable of such an achievement. Donna's Defectiveness/Shame schema was the source of external shame as it set Donna up for self-consciousness she experienced in social settings (Shamed Child) because she imagined others seeing her in a certain way. Thus she felt as if her Defectiveness/Shame schema was visible to others. This self-consciousness was evident when, as a teenager, Donna's father arrived to fetch her from school in the helicopter, triggering Donna's Shamed Child. Donna enjoyed being noticed for personal achievements at school, but her Shamed Child was triggered when she was seen because of her father flaunting his wealth. This is an example of external shame as, in a social setting, Donna projected the Shaming Parent onto the environment or community, which triggered her Shamed Child. In this example, Donna projected the Shaming Parent onto her schoolmates and her teachers. Donna provided many examples of how she projected the Shaming Parent onto those around her in a social setting, and so she expected to be judged and shamed for

how she dressed, her weight, or what she ate. The Shaming Parent and Shamed Child dyad was triggered when Donna attended doctor's appointments, and she had to lift her shirt for the examination. Donna experienced shame as she expected the doctor to judge her appearance.

Donna's mother was also internalised as a fourth parent mode, a moderately toxic complaining Victim-Like Parent (see Table 2). Donna's mother had a Complaining Protector mode in which she would complain about her hardships but not be motivated to make changes. For example, Donna's mother presented herself as a victim because of the treatment of her husband. This complaining Victim-Like parent in a mode dyad with a Guilty Child evoked feelings of guilt which Donna coped with by flipping into Compliant Surrenderer mode and caring for her mother. The introjected Victim-Like Parent included the message that Donna was responsible for others' wellbeing, which contributed to her Rescuer coping mode. An example to illustrate the Victim-Like Parent and Guilty Child dyad was when Donna told June that she was not at home and therefore unavailable to meet for lunch. As Donna believed she had to care for June, she felt guilty for not making herself available.

9.6. The Perfectionist Overcontroller

Donna's Perfectionist Overcontroller mode had a more perfectionist than obsessive flavour. It contained seven of the 13 features described in section 5.3, including;

- striving for excellence and perfect results,
- the marginalisation of other aspects of life,
- preoccupation with details, order, lists and schedules,
- rigid rules and standards,
- seeking approval and acceptance from others,
- the promise of a happier life,
- concern over mistakes.

The core feature of the Perfectionist Overcontroller, striving for excellence, was evident in Donna's approach to jobs and hobbies. "If I find something I'm interested in, I make sure I'm really going to be good at it before I do it" (S1). When Donna owned the businesses in her early twenties, she wanted to be "excellent", so she would "sleep there, shower there…live

there…I had no life" (S1). Donna's desire for excellence led to the marginalisation of other aspects of her life (the third feature of the Perfectionist Overcontroller).

Donna's preoccupation with order (the fifth feature of the Perfectionist Overcontroller) was evident when Donna made references to her home as "excessively neat, to the point that we don't really entertain much anymore, because I spend the whole night picking up beer bottles and wiping dripped juice" (S1). Donna's need for her home to be perfectly neat resulted in her marginalising other aspects of life (the third feature of the Perfectionist Overcontroller). In this example, Donna could not enjoy her time with friends because she was cleaning and tidying to maintain a perfect home. "I don't like when my house is not perfect…I like to walk through my lounge, and the throws are not all sat on and the cushions on the floor…I like order." Donna's preoccupation with order was also noted in S4; "I'm so neat like everything is square and on the edge…I don't like things out of place." Her excessive focus on a neat and orderly home was related to her need for approval (the eighth feature of the Perfectionist Overcontroller) as, "My home is a place where people can see how much I actually do and how good I am." Donna's home represented an ideal self that she wanted to show others.

Donna was hypervigilant for signs that she was inferior (the tenth feature of the Perfectionist Overcontroller). "I feel like I have the opportunity to have a perfect life, but when I look in the mirror, I'm not perfect" (S3). This comment highlights Donna's evaluation of herself based on the standards she set in the Perfectionist Overcontroller (the seventh feature of the Perfectionist Overcontroller) to overcompensate for her Shamed Child. Donna believed that her obesity was a personal defect (triggering her Shamed Child) that prevented her from presenting a perfect physical appearance (in a Perfectionist Overcontroller mode). Striving for a perfect image was related to her belief that this would provide a perfect, happier life (the ninth feature of the Perfectionist Overcontroller). Thus Donna's obesity maintained the problem because there was always a gap between the ideal self she projected onto her "perfect home" and her Shamed Child.

9.7. The Eating Disordered Overcontroller

Donna's Eating Disordered Overcontroller contained nine of the 15 features discussed in section 5.4, including;

- rules about goal weight and what one is permitted to eat,
- the decision to restrict eating and lose weight,

- self-punitiveness and self-loathing,
- focus on the body and eating patterns to generate a sense of competence, power and control,
- fear of losing control and hypervigilance to maintaining rules and routines,
- checking behaviours,
- the generation of images that induce fear, shame and self-disgust,
- seeking approval and acceptance from others,
- the promise of a happier life.

Donna's ED behaviour was mostly related to Detached Self-Soother comfort eating that began in childhood. However, she developed an Eating Disordered Overcontroller at the age of 22 when she embarked on a strict diet (the second feature of the Eating Disordered Overcontroller). So, in adulthood, Donna flipped between an Eating Disordered Overcontroller and Detached Self-Soother.

When Donna wanted to lose weight at 22 and embarked on a strict diet, she rigidly followed the meal plan (the eighth feature of the Eating Disordered Overcontroller). "I rather didn't eat than eat the food I wasn't allowed" (S4). However, after she completed the diet and achieved her goal weight, Donna lacked self-discipline and quickly regained the weight she had lost. Thereafter in adulthood, although Donna wanted to lose weight, she frequently flipped into Detached Self-Soother coping and binged. These binges were followed by self-punitiveness and self-loathing (the fourth feature of the Eating Disordered Overcontroller) as the Flagellating Overcontroller sub-mode was activated to motivate Donna to restrict her eating. The Flagellating Overcontroller sub-mode gave Donna punitive messages when she ate what she had labelled "illegal" foods. Images were evoked of Donna as fat (the eleventh feature of the Eating Disordered Overcontroller) which triggered the Shamed Child. The "illegal foods" were unhealthy foods with high-fat content such as pies, pasta with creamy sauce, burgers and pastries. Labelling foods as "illegal" is the first feature of the Eating Disordered Overcontroller; rules about what one is permitted to eat. Donna controlled her eating patterns to generate a sense of control (the fifth feature of the Eating Disordered Overcontroller). For example, she would not allow herself to eat carbohydrates at lunchtime.

Donna engaged in body checking behaviours (the ninth feature of the Eating Disordered Overcontroller) which included weighing herself daily. She experienced self-loathing (the fourth feature of the Eating Disordered Overcontroller) when she gained weight or if her weight stayed the same. Donna's obesity caused her discomfort and despair, but her

Eating Disordered Overcontroller provided her with a way out of these feelings because it promised her a happier life (the fifteenth feature of the Eating Disordered Overcontroller). Donna believed that if she obtained a healthy weight, she would be confident, happy and accepted (the thirteenth feature of the Eating Disordered Overcontroller).

9.8. The Detached Self-Soother

Donna engaged in four self-soothing behaviours as part of a Detached Self-Soother. Donna's primary self-soothing behaviour was binge eating, which was influenced by her early experience of her father's eating behaviour. Donna binged during the day when she was bored. When her daughter was at playschool, she felt "lost" as she had nothing to do, so she would go to the kitchen and find food on which to snack. Donna also used food as a self-soother to shut off feelings of frustration, anger or anxiety. As mentioned in section 9.4, June visited daily and, in a Complaining Protector mode, verbally "offloaded" about her emotional issues. Donna felt frustrated that she had listened to June complain about the same problems for years (Compliant Surrenderer coping). When June left, Donna shut off the frustration by bingeing to "comfort herself" (S27). In another example, Donna wrote a letter to herself prior to her bariatric surgery, intending to open it on the ten-month anniversary. The day Donna was due to read the letter, she felt anxious that she would not have achieved what she had set out to accomplish by having the surgery and that she would be disappointed by what she read. Donna shut off the anxiety by binge eating. Donna believed that if she were slimmer, she would be happy, her problems would be resolved, and she would no longer binge. However, after the surgery, Donna's needs were still unmet (in the Vulnerable Child), and so she still coped by shutting off her feelings with binge eating.

Donna's second self-soothing behaviour, that she engaged in infrequently, was to use alcohol when she was in social settings, and her Shamed Child was triggered. For example, when Donna went to a wedding and was the only woman wearing trousers, her Shamed Child was triggered. Donna flipped into a Detached Self-Soother and drank alcohol, becoming inebriated to avoid the feelings of discomfort.

Donna's third self-soothing behaviour to avoid difficult emotions was by keeping busy. Donna kept herself busy shopping and with tasks in the home, as "my mood is good when I am busy and feel I have a purpose" (S45).

Donna coped with the health anxiety she experienced by self-medicating, her fourth self-soothing behaviour. Donna consumed a family member's prescription tranquilisers in doses higher than prescribed (Detached Self-Soother coping) whenever she felt anxious.

9.9. Schema Perpetuation and the Therapeutic Process

This section will look at how the schemas were perpetuated and the therapeutic process that unfolded with Donna.

Donna's parents were neglectful and dismissive. So, she learned that emotions were invalid or that they should be suppressed, which contributed to Detached Protector coping. Donna shut down emotions by bingeing (Detached Self-Soother) or ruminating and worrying (Over-Analyser). Donna's poorly developed Healthy Adult was evident in her inability to engage in reflection, including her inability to acknowledge her loneliness and lack of genuine connections and express her anger appropriately. Donna had never experienced meaningful connections, and so she did not know what she was looking for. Her conscious narrative about her wonderful life (Pollyanna Overcompensator mode) illustrated how out of touch she was with her experiences and needs. Donna flipped from one coping mode to another so that her Vulnerable Child modes remained inaccessible. This prevented her needs from being met and schema healing from taking place.

Donna attended 45 sessions. Initially, we met once a week, but after approximately 25 sessions, Donna requested that we meet biweekly. Following a comprehensive assessment, we moved into a therapeutic phase using a ST approach.

Attempts to point out Donna's modes triggered her Shamed Child, and then she flipped into Pollyanna Overcompensator and would be dismissive of the issues she had discussed. Donna's low self-awareness, poorly developed Healthy Adult, and flipping from one coping mode to another impacted my ability to access the Vulnerable Child and for her to understand her coping modes and how they were being maintained. As I was unable to access the Vulnerable Child, we could not begin the process of schema healing.

Chapter 10. The Case Study of Candice

10.1. Psychosocial History

Candice was the oldest of two children. Her brother, who was 7 years younger, had significant health problems, and so, in the school holidays, Candice was sent to stay with her strict aunt while her mother cared for him (contributing to her Emotional Deprivation schema). As her brother's needs were prioritised and hers dismissed, she came to believe that others had more value than herself (contributing to Subjugation and Self-Sacrifice schemas). Candice spent little time with her brother, and so their relationship was distant, and she had few childhood memories of him.

Candice was raised in an environment that was not nurturing, and she did not have a close relationship with either parent. Not feeling connected to any family member contributed to her Lonely Child mode. Emotional issues were not discussed, and emotional expression was not encouraged in her family, where the explicit message from her uncle was that, "If you cry, you are weak." This environment contributed to the development of her Detached Protector coping (Emotional Inhibition schema). Candice's father, a refrigeration mechanic, worked long hours. He was strict and emotionally disconnected from the family. Her mother was at different times a complaining victim, dependent or controlling. She relied on others to complete forms for her and complained about how, at social gatherings, nobody liked her. Candice had a conflictual relationship with her mother, which reinforced her Emotional Deprivation and Defectiveness/Shame schemas where, "I don't have confidence in myself, I feel that I'm not good enough to be loved" (S6). Candice gave an example from her teenage years, that illustrated her mother's scathing attitude towards her. Candice's boyfriend lived 40 minutes away, so he stayed over at the house when he visited on weekends. On one occasion, Candice and her boyfriend had argued whilst out. After they returned home, she called down the passage to him when he was in his room, intending to apologise. Candice's mother heard her calling and shouted at her, calling her a "whore" (which triggered her Shamed Child).

Her mother was an obese woman who "scoffed food" and was a source of embarrassment to Candice (her Shamed Child was triggered). She often awoke at night and went to the kitchen to eat, and Candice would awaken and eat with her. This seemed to be the one way she could feel any sense of love and acceptance from her mother, which also laid the foundation for her seeking connection through food in adulthood.

A significant influence on Candice's family was her narcissistic paternal uncle, Dave, a successful and wealthy entrepreneur. Her parents were emotionally, and to some extent financially, dependent on him and always sought his approval. No decisions were made without first consulting him, and a common refrain was, "What will Dave think." Candice learnt to tune out her needs and to be alert to what others wanted (Compliant Surrenderer coping) because of the experience in her family where, "Everything in our lives has always been Dave first" (S4). Donna also had a strong desire to please Dave (Compliant Surrenderer), fearing that if she disappointed him, she disappointed her parents too. "I…put the most effort into everything, to make it perfect for him" (S4). In this process, Candice developed a blended Failure and Defectiveness/Shame schema (described in section 5.1) as she believed that mistakes were unacceptable because they showed weakness and that she was a failure (Shamed Child). Candice coped with the triggering of the Shamed Child by flipping into Perfectionist Overcontroller (Unrelenting Standards/Hypercriticalness schema). "I wanted to be perfect. I wanted to be the person who didn't make mistakes, who always had it right" (S3). This statement illustrates the first and fourth features of the Perfectionist Overcontroller. When she made mistakes, Candice's Punitive Parent was co-opted by the Perfectionist Overcontroller (the eleventh feature of the Perfectionist Overcontroller) and made berating comments such as, "I am stupid, I'm such an idiot" (S3), which motivated her to do better. These messages were internalised from Dave's comments that "fat people are stupid."

Candice grew up in Zimbabwe during a time of sanctions and food shortages. She recalled queueing for hours to buy bread and not being able to purchase basic products such as matches, sanitary pads, butter, or toothpaste. In response, Candice's parents hoarded items, afraid to throw anything away in case it could be used to repair something later. Her father did not allow food wastage and instilled in her the belief that "plates must be left clean." Candice recalled a family holiday in her early childhood during which the family stayed in a hotel. At dinner, her father insisted that he had paid for all four courses, so they must eat everything. Candice, in a Compliant Surrenderer mode where, "All I want to do is please everybody" (S1), ate all the food, despite not liking it and feeling satiated.

Growing up, Candice felt that she did not fit in at home or with her peers (Social Isolation/Alienation schema), and she had no close, meaningful relationships (Lonely Child mode). At school, she coped with these feelings by making jokes at her own expense and acting like the class clown (Comic Overcompensator), "I always tried hard to be the clown in the class, to make everything smooth by clowning around" (S2). At her all-girls high school,

Candice had only one friend, Mary, whom she let take advantage of her to maintain the connection (Compliant Surrenderer coping). For example, Mary told her parents she was spending time with Candice after school. However, after Candice accompanied her to the tennis courts, Mary would spend the afternoon with her boyfriend, leaving Candice sitting alone, until afterwards, Candice accompanied her home. Candice's Shamed Child contributed to her belief that she was the "ugly friend", however wanting to be like her "slim, trim, pretty and popular" friend Mary, she lived her life vicariously through her (in a Compliant Surrenderer mode), experiencing an illusion of a connection.

During high school, Candice found a sense of acceptance as part of the crew involved in stage productions, participating in the chorus and backstage. It was also here, at the age of 15, that she had her first meaningful connection when she met her first boyfriend, Richard, aged 17. After he completed school, Richard moved to South Africa in search of work and better prospects, believing there was little future for him in Zimbabwe. Candice's Lonely Child was triggered as she was left in a cold home environment where she felt she did not belong. Candice latched onto Richard, and so, the following year, aged 18, she completed her schooling and followed him. Candice described leaving Zimbabwe as "running away" (Avoidant Protector coping) as, "Home wasn't what I wanted it to be, so I got the hell out of there" (S2). She renounced her Zimbabwean citizenship and became a South African citizen to cut herself free from her unhappy childhood and have a fresh start.

Candice obtained secretarial work at the bank where Richard worked, and they rented rooms in a boarding establishment. The following year they married. Richard's parents moved from Zimbabwe to South Africa and settled in the same town as Candice and Richard.

Their life was unsettled as Richard, who worked his way up to Bank Manager, was required to relocate every few months for his work. This resulted in 22 moves before he was retrenched at the age of 38. At the age of 22, Candice gave birth to twins (girls), and at 27, she gave birth to a third daughter. Throughout this time, she continued to do secretarial work.

When Candice was 38, Dave decided that he wanted her family to relocate to Kwa-Zulu Natal (KZN) and for her to start a business. Candice, who always "jumped through hoops to please him" (S1), complied (Compliant Surrenderer coping). Richard obtained employment in a company's financial department, whilst Candice, with Dave's assistance, started a business. Due to her mismanagement, the business was unsuccessful and closed within a year. Candice then obtained work in a company's accounts department.

When Candice and her family moved to KZN, her parents came to live on the property in a flat. Her father, then 64, had been responsible for maintenance work on Dave's

farm in Zimbabwe. However, fearing for their lives because of farm invasions taking place in the area as part of Mugabe's forcible land redistribution, they decided to leave. Having her parents stay with her was stressful for Candice. Her mother (then 59) continued to be dependent and to "draw energy from her" (evidence of a Victim-Like Parent and Guilty Child dyad), and her parents' hoarding behaviour continued. For example, her mother would buy large quantities of a single food item, fearing that it would be unavailable at a later stage. This behaviour resulted in more food in the home than they could eat. Her father, in turn, became obsessed with foods. For example, he ate noodles for lunch and dinner for months before tiring of it and then moving onto boerewors (a type of sausage) which he ate twice a day for months.

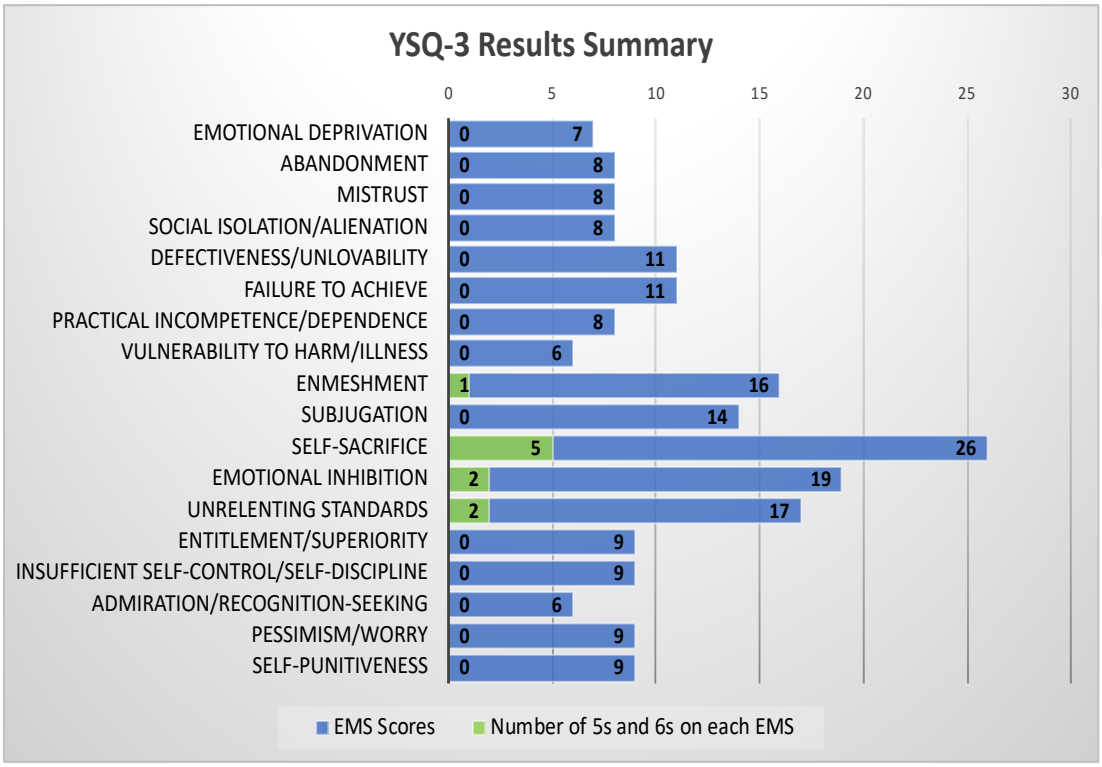
In adulthood, Candice's distant relationship with her brother, who lived overseas, continued. Two of Candice's daughters were married. One of the twins married when she was 27, and Candice was 50 and now had two children, a daughter aged 5 (born out of wedlock) and a son aged 17 months. Candice saw her grandchildren daily as she would often fetch them from school, and they would then spend afternoons at her home. Candice's youngest daughter married when Candice was 51, and she was 23. The eldest twin was single and lived at home with Candice and Richard.

10.2. Results on the YSQ and SMI

Figure 13 shows the results of the YSQ, and Figure 14 shows the results of the SMI conducted after the fourth session. In developing the case conceptualisation, the scores and qualitative information from responses to specific items were used in conjunction with the information obtained in the clinical interviews and observations of her behaviour.

Figure 13

Candice's Results on the YSQ



Candice's results on the YSQ suggested Unrelenting Standards/Hypercriticalness, Emotional Inhibition and Self-Sacrifice schemas (see Figure 13). Candice had severe scores (a score of 5 or 6) for two items on Unrelenting Standards/Hypercriticalness and Emotional Inhibition, five items on Self-Sacrifice, and one item on Enmeshment or Undeveloped Self (see Figure 13). This indicates that these schemas are significant. Candice scored one Enmeshment or Undeveloped Self item 5, "I have not been able to separate myself from my parent(s) the way other people my age seem to do." However, when Candice's reality is taken into consideration; that her parents lived on her property and she was financially responsible for them (described in section 10.1), and her propensity to flip into Compliant Surrenderer coping (see Figure 14) with her parents, the score for this item does not indicate an Enmeshment or Undeveloped Self schema. When the information provided during sessions is considered, it is clear that Candice underscored on the YSQ as she also had Subjugation, Punitiveness, Emotional Deprivation, Failure, Defectiveness/Shame and Insufficient Self-Control/Self-Discipline schemas. This was, most likely, Candice's Pollyanna

Overcompensator mode, discussed in section 10.4, which led her to under-report the schemas.

Figure 14

Candice's Results on the SMI Compared to Normal Controls

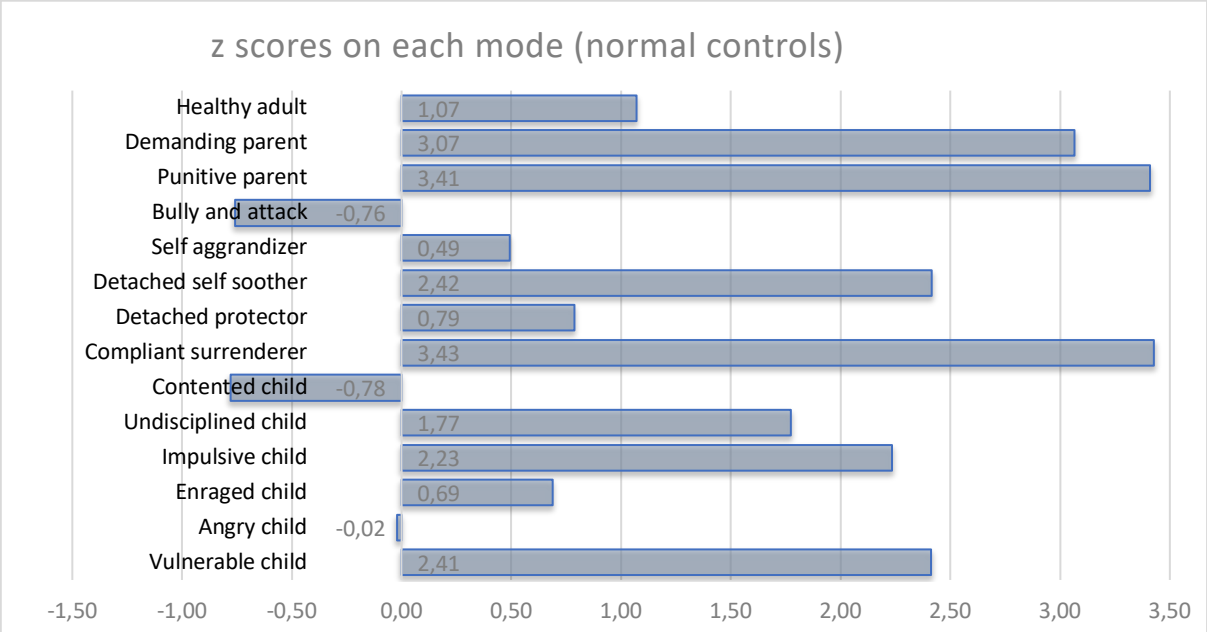


Figure 14 shows Candice's scores on the SMI compared to the average population without clinical disorders. Her SMI results showed significant scores (above 3,00 SD) for Demanding Parent, Punitive Parent and Compliant Surrenderer. This was consistent with the information she provided in sessions. However, Candice underscored the Detached Protector and Detached Self-Soother items. Candice's high score on the Healthy Adult mode (1,07 SD above the norm) suggests that she was in an overcompensator mode when completing the questionnaire. Candice scored 5 or 6 on the Healthy Adult items, "I can solve problems rationally without letting my emotions overwhelm me", "I can stand up for myself when I feel unfairly criticised, abused, or taken advantage of", "I feel that I'm basically a good person", and "I have a good sense of who I am and what I need to make myself happy." These high scores do not fit with Candice's Shamed Child and predominant Detached Self-Soother and Compliant Surrenderer coping, suggesting that she is deluded in her responses. The high Healthy Adult scores are indicative of Candice's Pollyanna Overcompensator mode and unrealistic view of herself.

10.3. ED Presentation

As an underweight (BMI 17) teenager, Candice's parents were concerned she was anorexic, but they did not seek treatment. Although she denied restricting food, her low body mass, parents' concern, and her distorted body image, evident in her unfavourable comparison of herself to Mary, provide evidence that Candice was indeed anorexic and at this time would have had an Eating Disordered Overcontroller. A hypothesis is that her embarrassment regarding her mother's weight and approach to food (in a Shamed Child) contributed to her restricting (in an Eating Disordered Overcontroller). Candice maintained a BMI of 17 until after she married, when she reported being too tired after work to prepare healthy meals. At that time, her Eating Disordered Overcontroller mode receded as she increasingly ate carbohydrate-based meals and junk foods, leading to weight gain (BMI 21.2).

Despite her healthy BMI, when she fell pregnant with twins, her mother-in-law attempted to control her food by only allowing her one sandwich at lunch and taking away any food she believed was unhealthy. "I was quiet and shy, and I allowed my in-laws to rule how I ate and how I lived my life" (S9). Her mother-in-law was as controlling as Dave, and Candice coped in the same compliant, submissive way (Compliant Surrenderer). However, her Defiant Child was evident as she hid food when visiting them, "I put slabs of chocolate in the cubbyhole of the car. And I actually don't think I really wanted the chocolate, it was just a defiant thing, that she said I couldn't have it, so, therefore, I wanted it" (S9). Another example that illustrates Candice's Defiant Child was when her mother-in-law humiliated her in public by snatching a packet of crisps out of her hands, exclaiming that the salt would give her toxaemia. This triggered Candice's Defiant Child, and so she went home and ate four packets of crisps.

After the twins' birth, her continued weight gain led to criticism from her in-laws and Dave. Candice, now overweight, continued the childhood habit of eating at night (Detached Self-Soother). As she put it, "What will I eat that's going to make me feel warm and fuzzy?" (S4). She continued comfort eating and subsequently gaining weight after the birth of her third daughter. Comfort eating (Detached Self-Soother) was a way to cope with the stress of frequent moves for Richard's work and having to pack and unpack, make new friends and become part of the community.

When her children were young, Candice lost 25 kg through Weighless. Her maintenance of the eating plan could be an Eating Disordered Overcontroller mode or

Healthy Adult. However, there is insufficient evidence to be able to distinguish which mode she was in. After achieving the weight loss, Candice resumed her poor eating patterns (Impulsive Child) and gained 30 kg. At the age of 42, Candice ended the habit of night eating because home security measures prevented access to the kitchen.

At 45, an obese Candice (BMI 30.7) consulted a dietician for weight loss but failed to follow the eating plan because of her binge eating (Detached Self-Soother coping). Lacking a strong desire to lose weight, she convinced herself that she was "okay, not getting bigger" (Pollyanna Overcompensator), despite evidence from the dietician of a 13 kg weight gain over 7 years.

Candice was preoccupied with thoughts of food which distracted her from other concerns (Detached Self-Soother). After eating and despite feeling satiated, she ate additional portions, which seemed to be driven by an Impulsive Child mode, "I have to eat it all now, I can't leave it" (S1). Candice's Vulnerable Child feared that she would not get her share, which could result from the experience growing up of shortages during sanctions and which was further reinforced by the starvation from restricting food when she was a teenager. At home, a healthy supper was followed by the belief that she would miss out and not get her share, which triggered feelings of deprivation in the Vulnerable Child. Candice shut down these feelings by eating dessert (Detached Self-Soother).

Candice's bingeing was done in secret because she felt embarrassed and judged by her family for the amount she ate, triggering her Shamed Child. In S1, she described "sneaking" extra pieces of pizza:

> I'll go and take another piece when everybody is not looking because I'm embarrassed to eat in front of them. So I know that what I'm doing is naughty, I know I'm not supposed to have that, and I will hide it, I will eat it in the kitchen quickly so that nobody else sees it because I can see my family raise their eyebrows at how many pieces of pizza I eat.

This secret eating included eating leftovers off other people's plates in the kitchen, as this food would not be missed, and it was a throwback to her father's message growing up that "plates must be left clean." Many of Candice's co-workers also engaged in binge eating, which resulted in the acceptance of binge eating at work, where she did not have to hide her eating behaviour.

Candice's weekly binges were part of a Detached Self-Soother mode to cope with feelings of anxiety, loneliness or boredom (Vulnerable Child). She was most at risk for bingeing when her time was unstructured, after work between 3 pm and 6 pm, until she was distracted by the night time routine of spending time with family and cooking dinner. Candice's binges triggered a Shamed Child and Avoidant Protector coping. For example, after an evening binge, Candice went to bed to avoid thinking about the binge. In a second example, after a week of increased bingeing, Candice expected to be judged by me (Shaming Parent and Shamed Child dyad), so she considered cancelling her appointment (Avoidant Protector). In a third example, when Dave criticised her for overeating (triggering the Shamed Child), Candice would "stop eating and scuttle off and hide somewhere" (S4).

Candice's Shamed Child contributed to the belief that:

> I don't think I'm worthy enough. If I'm not doing something for someone they won't like me…I don't have enough confidence in me as a person…so I have to add that Candice comes with a package of food, or Candice will do extra because that's the way you'll like me. I suppose I'm frightened that nobody will like me if I did nothing. (S1)

Candice's Lonely Child feared that no one would like her and that she would be alone. So Candice uses food to form connections, "Everything I do I throw food at…Food is my solution to everything…I feed everybody around me…I want people to like me, and if they can't like me, then I'll feed them" (S1). Candice kept food in her desk drawers for colleagues because when they came for food, they talked to her. Candice tried to maintain a connection with her family by preparing a weekly family dinner where, unable to express love (Detached Protector mode), she showed love by preparing food they enjoyed (Compliant Surrenderer). This approach was learnt from her parents as, when Candice visited, her mother plied her with food as an expression of love, and Candice ate what was offered so as not to offend her (Compliant Surrenderer).

Candice's BMI of 34.9 placed her in Obese Class 1, whilst her eating behaviour met the DSM-5 (APA, 2013) criteria for BED.

10.4. Case Conceptualisation at the Time of the Assessment

Table 7

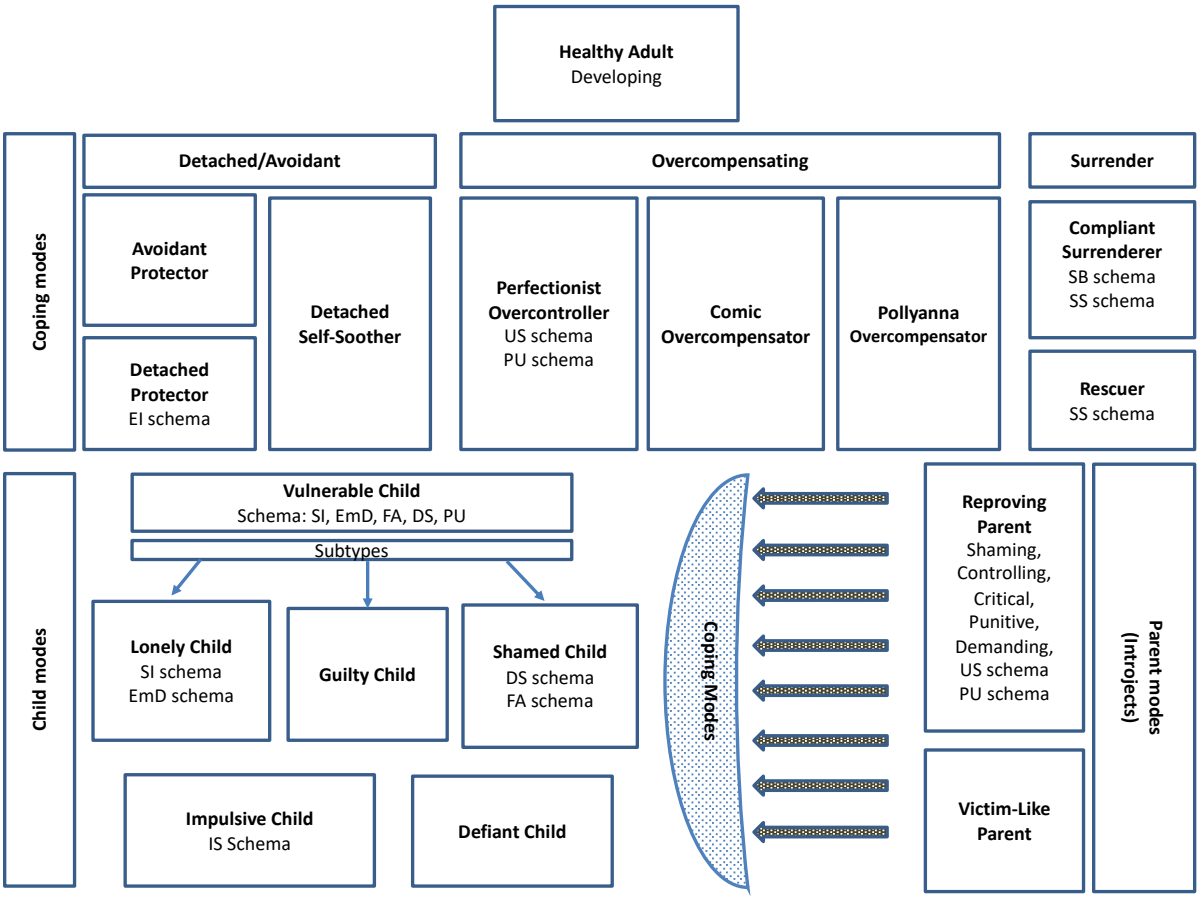
Candice's DSM-5 Diagnosis at the Time of the Assessment

DSM-5 Diagnosis	**ICD-10-CM Code**
Binge eating disorder, moderate	F50.8
Major depressive disorder with melancholic features, moderate	F33.1
Generalised anxiety disorder	F41.1

Table 7 presents Candice's diagnosis at the time of the assessment. This will be made evident in this section. Candice's current modes are represented in the mode map (see Figure 15).

Figure 15

Candice's Current Mode Map



Note. DS = Defectiveness/Shame; EI = Emotional Inhibition; EmD = Emotional Deprivation; FA = Failure; IS = Insufficient Self-Control/Self-Discipline; SB = Subjugation; SI = Social Isolation/Alienation; SS = Self-Sacrifice; US = Unrelenting Standards/Hypercriticalness; PU = Punitiveness.

Candice was 52 and had been married for 33 years. She described her marriage as happy, despite poor communication and lack of affection (Pollyanna Overcompensator). Richard was disengaged from her and their children, which was evident when Candice spoke about her family. She only mentioned her involvement with the children, never any engagement between Richard and herself or Richard and their children.

Her employment in a company's accounts department for the past 12 years was monotonous, but Candice avoided change because of the stress she believed it would bring (Avoidant Protector). Candice discovered that over 6 years, she had erroneously paid over R2 million into an incorrect account. Such a significant error was made possible by the lack of systems to check payments, despite her repeatedly bringing this to her employer's attention.

Furthermore, the company that should have received the payments only indicated after 6 years that no payments had been received. This event triggered a dyad between a Victim-Like Parent and Guilty Child as Candice felt responsible for her employer's stress and the possibility that the company may close, resulting in her colleagues' unemployment. Candice offered to resign and hand over her pension to the company as compensation for her mistake (Rescuer mode). However, her employer did not believe this was necessary, and the company's insurance covered the loss. Following this incident, Candice felt disgusted, disappointed, and angry with herself (a Punitive Parent and Vulnerable Child dyad), which she shut off by bingeing (Detached Self-Soother). During the binge, Candice felt ecstatic and in control, but afterwards, she felt shame and disappointment (Shamed Child).

Prior to this incident, Candice's approach to work was disciplined, organised and focused (evidence of her Perfectionist Overcontroller coping). Her Perfectionist Overcontroller was also evident in her clothing choices where she exercised strict control; for example, pairing black shoes and black trousers with a black shirt and not wearing blue and black together. These obsessive-compulsive features in the Perfectionist Overcontroller are described in section 5.3.

When Candice's Shamed Child was triggered at work, she did not "feel pretty enough or well-dressed enough" (S4), and so she flipped into a Comic Overcompensator and made critical comments about herself in a joking manner. For example, when Candice arrived at the office, and a young, slim, black woman was sitting in her chair, she jokingly said, "You just want to be a fat old white lady." Candice struggled to believe that people liked her because of her weight (Shamed Child). For example, when a man at work stopped at her desk daily to chat, Candice wondered, "Why would he want to talk to me? I'm fat, I'm just there in the background, I'm invisible" (S5).

When a "super-skinny" person entered the office, Candice's Shamed Child was triggered as she felt self-conscious and ashamed of her weight. She coped by flipping into an Avoidant Protector mode and hiding. Candice flipped between stating that her weight did not define her (Pollyanna Overcompensator) and being ashamed of her weight (Shamed Child). Her comment, "I'm not a pretty girl, so if I lose weight, I won't be prettier" (S3), minimises her weight and the associated shame (Pollyanna Overcompensator mode).

Candice was drawn to people she could rescue as a way of feeling a connection with others (Rescuer mode). "I am helping them, and they need me, so, therefore, I feel wanted…I'll do everything that I can, to my detriment, I'll help people, and I'll give the shirt

off my back" (S1). For example, when a work colleague needed money, Candice took a personal loan to help her.

Candice subordinated her needs and sought approval in relationships (Compliant Surrenderer coping). She consulted a doctor for health problems that included Diabetes Type II, high cholesterol, hypertension and hypothyroidism, but she found the doctor intimidating. When her Vulnerable Child was triggered, she flipped into Compliant Surrenderer coping and tried to please the doctor. "I am trying to be good, so I can get good results for the doctor" (S6). The thought of displeasing the doctor triggered a Shamed Child which she coped with by flipping into an Avoidant Protector mode and delaying appointments. Also, Candice's bingeing (Detached Self-Soother coping) increased two weeks before appointments. At the appointments, Candice did not ask questions (Compliant Surrenderer) and, although she briefly considered consulting a doctor that she felt more comfortable with (Healthy Adult), her Compliant Surrenderer would not let her.

Candice's Compliant Surrenderer was also evident in her interactions with her family, where she sought to develop and maintain connections. For example, Candice cleaned and kept the house in a way she believed would please her eldest daughter. Her second daughter, an apprentice hairdresser, repeatedly used her to practice on, and Candice felt unable to refuse. Although her youngest daughter was married, Candice continued to support her financially.

10.5. Candice's Parent Modes

Candice's narcissistic paternal uncle, Dave, was controlling, disdainful and very involved in her family's lives from the time Candice was born. Her parents placed a lot of emphasis on pleasing him and insisted that Candice please him as well. As a result, Candice had an internalised parent that was demanding and critical (contributing to her Unrelenting Standards/Hypercriticalness and Punitiveness schemas) and was composed of messages she received from Dave and her parents about pleasing him. At the same time, if she did not please Dave, she was blamed and shamed by her parents. Thus a moderately toxic parent mode, where her parents and Dave imposed their wishes and beliefs on her, developed with demanding, critical, blaming and shaming features (see Table 2). For simplicity sake, this blended parent mode is referred to as the Reproving Parent mode (see Figure 15).

Candice recalled, "My whole life was being brought up, 'what would Dave think? What does Dave want us to do?' If he said 'jump', my parents said 'jump'…So I jumped through hoops to please him all the time" (S1). Candice's father would say, "Don't do that;

you'll disappoint Dave." These comments led to the belief that Candice could not make mistakes, "because if you make a mistake, then that was the end of the world" (S1). This belief arose because Dave "put her on a pedestal" (S4), and if she made a mistake, she was not living up to his standards for her. Then she would be blamed and shamed by her parents for disappointing him. She also believed that mistakes showed that you are weak, which led to a sense of shame (the blended Failure and Defectiveness/Shame schemas described in section 5.1). The messages from this Reproving Parent left Candice feeling responsible for disappointing her parents because if she was disappointing Dave, she was disappointing her parents.

Another shaming, critical message Candice internalised from this Reproving Parent mode was that fat people are stupid:

> I associate stupid with fat…I'm almost positive it comes from Dave because he's always on about your weight…He can't look at you and say, well, Candice is Candice, and she's good at what she does…it's because you have to lose weight. You have to look a certain way; you have to be skinny. (S11)

In this statement, Candice also highlights the demanding aspect of this parent mode related to how one should look. Candice shared a memory of watching a girl ballroom dancing at a school function. Dave commented that the girl's dancing was "unacceptable because of her size." The explicit shaming by him of people who were not slim led to Candice's belief that "because you're fat you can't do it. People don't like you" (S11). The impact of the Reproving Parent mode was evident in a statement Candice made in S13:

> I have got a lot of the child voice in my head, where I automatically change into being a child…I never assert myself…I think it's because I don't have confidence because I think fat people are stupid, so, therefore, I am not expected to answer the question correctly if I am stupid.

The child voice Candice was referring to was the Shamed Child in a dyad with the Reproving Parent whose message she internalised as "I am stupid." Candice lacked confidence because of the parent voices that programmed her Defectiveness/Shame schema. The parent introject that "fat people are stupid" activated feelings of defectiveness that Candice responded to by behaving compliantly (Compliant Surrenderer coping). Thus this Reproving Parent mode triggered the Shamed Child afraid of making mistakes.

Candice provided other examples which illustrated the Reproving Parent and Shamed Child dyad. For example, when a skinny person walked into the office and Candice hid (described in section 10.4), she projected the shaming and critical features of the Reproving Parent onto the slim person she expected to judge and shame her, triggering her Shamed Child. Candice then flipped into Avoidant Protector coping and hid.

An example that illustrates the demanding and critical aspects of the Reproving Parent, was Candice's attitude towards her work. Candice set high standards for her work (the traditional rules and standards of the Demanding Parent), and when she believed that she had not achieved these standards, she was critical of herself and gave herself scathing messages (the traditional Punitive Parent in ST).

Candice's mother was introjected as a separate Victim-Like Parent mode that was moderately toxic (see Table 2). This parent mode was evident in how Candice cared for her parents and spent time with them. If Candice did not visit her parents frequently, a dyad between the Victim-Like Parent and Guilty Child was triggered, and Candice experienced guilt and a sense of responsibility for her parents. Candice then flipped into Compliant Surrenderer coping and visited. When Candice paid money into the incorrect account at work (described in section 10.4), the dyad between a Victim-Like Parent and Guilty Child was triggered as Candice felt responsible for her employer's stress, and she worried that her error would impact the jobs of her colleagues. Candice then flipped into a Rescuer mode (see section 10.4).

10.6. The Perfectionist Overcontroller

Candice's Perfectionist Overcontroller was more obsessive than perfectionistic. Related to this was her desire to be neat and orderly and for her clothes to match, to an obsessive level. Her Perfectionist Overcontroller contained seven of the 13 features identified in section 5.3, including;

- striving for excellence and perfect results,
- preoccupation with details, order, lists and schedules,
- suppression of emotional vulnerability,
- rigid rules and standards,
- seeking approval and acceptance from others,
- concern over mistakes,

- self-punitiveness.

Candice's striving for excellence, and perfect results (the first feature of the Perfectionist Overcontroller) was related to the rules and standards of the Demanding Parent that was recruited as part of the Perfectionist Overcontroller (the seventh feature of the Perfectionist Overcontroller). Candice strove to meet these standards to gain the approval of her parents and Dave (the eighth feature of the Perfectionist Overcontroller). Along with Candice's striving for perfect results (the first feature of the Perfectionist Overcontroller) was concern over mistakes (the tenth feature of the Perfectionist Overcontroller) as Candice was hypervigilant for signs that she was inferior or weak (Shamed Child). "I wanted to be perfect. I wanted to be the person who didn't make mistakes, who always had it right…You mustn't make mistakes, it shows that you are weak" (S3).

Also, a feature of Candice's Perfectionist Overcontroller was organisation (the fifth feature), which was evident in her excessive attention to her neat and orderly appearance. As mentioned in section 10.4, when Candice dressed, she needed everything to match; her shirt, trousers and shoes should all be the same colour, otherwise, she experienced discomfort. This points to the suppression of emotional vulnerability (the sixth feature of the Perfectionist Overcontroller). Candice gave an example where she went to work wearing navy trousers, a black shirt and black shoes. She only realised when she was in the car that her clothes did not match. This caused such discomfort that Candice phoned her daughter to bring a navy shirt and shoes for her to change.

10.7. The Detached Self-Soother

Candice had a strong association with food as a source of comfort. Thus her Detached Self-Soother behaviours included eating food (the first self-soothing behaviour) or thinking about food (the second self-soothing behaviour). An example that illustrates her association of food with comfort was the family dinner that Candice hosted every Wednesday for her adult children and their families. When planning what to cook, she thought, "I must make a warm stew with all the vegetables…so it's all that comfort; I don't know if it's trying to comfort me or comfort them" (S1).

Candice was aware that coping through food, her first behaviour in the Detached Self-Soother, was a learnt behaviour that was modelled by her parents. "My parents have issues with food. Food makes them happy, so they've taught me….food is how I fix things…it makes me happy" (S1). This was accompanied by thoughts such as, "What will I eat that's

going to make me feel warm and fuzzy" (S1). During a binge, Candice felt "happy scoffing my face" (S2). In S4, Candice reported how she had eaten a bowl of coco pops before bed and that she felt happy at the time of eating because she associated the coco pops with happy memories of feeding her children coco pops when they were "young and laughing and having fun" (S4). Thus eating the coco pops evoked these same positive feelings in Candice.

Focusing on food and eating was the second behaviour in Candice's Detached Self-Soother, which distracted her from schema level issues. Her comment that if she was not busy, her focus was on food, supports this. "When you're happy and busy, you don't eat. When you're unhappy and thinking about things, then food becomes an issue" (S4). Candice was most at risk for bingeing between 3 pm and 6 pm. This was the time between finishing work and preparing supper. Candice gave an example of this in S2, "I was bored this afternoon, so I bought dry wors [a form of dried sausage] and ate it." This sense of boredom implies that Candice is emotionally disconnected from her unmet needs (Detached Protector).

There was a permission-giving belief component to Candice's Detached Self-Soother. When overeating, Candice would tell herself, "Have it, you can start again [with the healthy eating] tomorrow" (S1). This permission-giving belief extended to her seeing food as a reward, "You've had a good day now eat" (S1).

Candice binged to shut off uncomfortable feelings such as sadness, loneliness and anxiety. S4 "Stress just makes me eat; I know that. So if I'm uncomfortable or stressed or anything, I'll go off and eat." Candice's granddaughter was sexually abused by a family member. The abuse caused tension and divisions in the family when it was disclosed. Candice shut off the feelings of distress by bingeing, "Every time this blows up, it just causes shit in our family, which then causes me to go and eat" (S3). After spending time with her granddaughter, Candice felt she "was brave for her, strong for her, but then as soon as she went I ate, and I have binged the whole weekend. Anything I can get my hands on I have eaten" (S3). When Candice was with her granddaughter, she detached from the emotions (Detached Protector), but she flipped into a Detached Self-Soother and binged when her granddaughter left. When her granddaughter spoke to Candice about the abuse, "I just want to stop and eat a slab of chocolate….I don't know how to deal with it. The only way I know how to deal with it is to eat…my way of fixing things is to eat…it makes me feel better at the time." Candice did not have healthy coping skills for managing difficult emotions. Instead, her prominent coping mode was to binge to shut off the emotions.

Candice's comfort eating was sometimes related to a sense of deprivation. This was evident in a mode sequence she described where she had eaten a healthy dinner, after which the family ate dessert. Candice was trying to eat healthily and rejected the dessert, but she felt "deprived, 'I'm not allowed to eat it'. While everybody else is eating around me, why are they allowed to eat it? Why can't I do the same?" (S1). In this sequence, the sense of deprivation indicates a Vulnerable Child mode that is triggered, followed by a Defiant Child as Candice feels it is unfair that others are allowed to eat, and she cannot. She copes with the feelings triggered by the Defiant Child by standing in the kitchen, eating dessert. Whilst eating the dessert, she described "feeling good" (Detached Self-Soother). In this sequence, it is unclear whether the defiant attitude in the Defiant Child and the bingeing (Detached Self-Soother) were co-occurring during her eating of the dessert. Thus the data does not allow one to conclude whether the Defiant Child and Detached Self-Soother was a blended mode or occurred in a mode sequence.

10.8. Schema Perpetuation and the Therapeutic Process

This section will look at how Candice's problems were perpetuated and the therapeutic process in which we engaged.

Candice was raised in a home where emotions were not acknowledged or expressed (contributing to her Emotional Inhibition schema). As a result, Candice lacked appropriate coping skills for dealing with emotional distress. When distressing emotions were experienced in her Vulnerable Child modes, Candice flipped into a maladaptive coping mode to shut down the feelings. However, this maintained her isolation and lack of meaningful connections. Candice was out of touch with what her needs were, so she could not express her needs and possibly have them met. Instead, she tried to develop and maintain connections by being submissive and prioritising others. This was evident in her Compliant Surrenderer coping, where Candice cooked meals for her family, provided snacks for her colleagues and maintained the home in a way that would please her daughter. Candice also prioritised others when she behaved in a self-sacrificing Rescuer mode. For example, when she took out a loan to assist a colleague. At times Candice's submissiveness triggered her Defiant Child, which Candice shut down with Detached Self-Soother coping. The Detached Self-Soother coping in which Candice binged triggered a dyad between the Reproving Parent and Shamed Child as Candice had internalised the beliefs that "fat people are stupid" and "you can't be expected to know what you are doing if you are fat." Candice then flipped into avoidant coping (Avoidant Protector or Detached Self-Soother) to shut off the feelings in the Shamed Child.

Candice's limited Healthy Adult and Detached Protector coping prevented her from identifying and verbalising her needs and feelings and having them addressed appropriately. In this way, her schemas in the child modes were maintained, and the need to flip into maladaptive coping to shut down the schemas and associated feelings. This prevented Candice from healing her schemas and developing healthy methods of coping.

Candice attended 18 weekly sessions. This allowed for an extended assessment process that included ST techniques. Candice responded well to the case conceptualisation and mode map, which helped her understand her mode sequences and the role food played as a coping mode. Candice's Detached Protector coping prevented access to the Vulnerable Child. However, through chairwork, she was able to identify the messages associated with the parent introject. The process of limited reparenting helped Candice develop a Healthy Adult that could challenge these messages in imagery rescripting exercises. Through these experiences, Candice's schemas were challenged, and her binge eating behaviour decreased as she developed more healthy coping modes.

Candice's developing Healthy Adult recognised that a binge is "not healthy and you want your sugars lower [referring to her diabetes]" (S2), which was accompanied by attempts to challenge a binge by telling herself, "You actually don't need this, it doesn't make you happy, if anything it makes you feel blah when you are finished with it. You don't feel nice" (S8). Candice continued to progress so that by the time she terminated sessions, her Detached Self-Soother coping was less prominent and Candice was "trying to make better decisions so that food doesn't rule my world" (S15).

Contact was made with Candice 2 years after her engagement in the research project. She was no longer binge eating, but she still turned to food as a self-soother in stressful times; for example, after her mother died and her father fell ill. During a period where circumstances beyond her control led to the loss of her routine and feeling out of control, she resorted to her previous coping mode, soothing herself with junk food (Detached Self-Soother). This was not the same as in the past, as Candice ate food for comfort but did not binge. Despite these relapses, Candice's approach to food was generally healthier, and her Healthy Adult was more developed in that she could recognise parent introjects and challenge them. Candice commented that she heard my voice in her head as part of a Healthy Adult reminder. For example, "Will that nourish you? You are not hungry; you are bored, so don't eat that, it won't make you feel better." This enabled her to control the Detached Self-Soother

coping. Thus the process of strengthening her Healthy Adult was going on even though there was limited access to the Vulnerable Child.

Candice's Lonely Child was also being healed. Her relationship with Richard had not improved, but Candice had joined a karate dojo where she developed meaningful connections and became less socially isolated. The external validation provided by achieving a purple belt challenged her Defectiveness/Shame schema, also evident in her description of herself as "fit and healthy" and when she shared an incident where she performed well in the dojo and described herself as "one tough granny." Karate also allowed her to express her aggression (in the Defiant Child) so that she no longer had to "squash her feelings with food."

Candice attributed the positive changes in her life and her recovery from BED to her experience with ST. The insight she gained and the reparenting she experienced taught her to recognise the sequence when the parent introject triggered schemas, and she used food to cope (in a Detached Self-Soother). From her developing Healthy Adult, she challenged the introject's messages. ST guided her to a more constructive path and allowed for the breaking of her old coping patterns.

Chapter 11. A Critical Evaluation of the Place Questionnaires Have in Assessment and Case Conceptualisation

The questionnaires used in this research, namely the YSQ, YPI and SMI, are designed to identify schemas and modes. Also, they provide additional information when there is a discrepancy between scores on the questionnaires and information gathered in interviews. In this research, the questionnaires provided discussion points as exploring responses with the participants led to questioning areas that may otherwise have been overlooked. There are benefits to administering the questionnaires, but there are also limitations which some researchers have commented on (Sheffield & Waller, 2015; Lobbestael et al., 2005; Lobbestael et al., 2008). My experience of the limitations of the questionnaires and other noteworthy observations are explored in this chapter.

11.1. Limitations of the SMI

The first significant limitation noted in the SMI was that only one overcompensator mode, the Self-Aggrandiser, is measured. The absence of other overcompensatory modes is a disadvantage when working with ED cases. This research illustrated how all the participants had a Perfectionist Overcontroller mode that was not measured on the questionnaire. Also, an overcontroller mode related to food rules and eating behaviour, the Eating Disordered Overcontroller, is common in ED patients and was found in four participants.

Another limitation of the SMI is that only one surrender mode is measured, the Compliant Surrenderer. The addition of a Self-Pity/Victim mode would be beneficial, as although both are surrender modes, the behaviour in each is vastly different. In Compliant Surrenderer mode, one often does things to gain approval or to avoid rejection from others, whereas in the Self-Pity/Victim mode, one seeks help passively by taking a complaining role (Simpson et al., 2018) which can be off-putting to those around the person in this mode.

The administration of the SMI-ED developed by Simpson et al. in 2018 can address the limitations of the overcontroller and surrender modes described here as the SMI-ED has two additional coping modes, the Helpless Surrenderer, which is similar to the Self-Pity/Victim mode, and the Eating Disordered Overcontroller. The SMI-ED was not administered in this research project as it was not available when the research was conducted.

11.1.1. Cross Over Items on the SMI

Questioning participants about their responses in the questionnaires highlighted how individuals misinterpreted specific statements. In the SMI, some statements would be more

applicable for a coping mode different from that which it actually taps. For example, several Self-Aggrandiser items tapped into Jackie's Perfectionist Overcontroller mode. Jackie scored 6 (*all of the time*) for three of the Self-Aggrandiser items on the SMI. These statements were; "It is important to be number one", "I won't settle for second best" and "I have to be the best in whatever I do." Jackie related these responses to her business, where she strove to be the best in the industry. Although a director of her own company, Jackie did not feel that she fit in with other directors whom she perceived as more capable and more successful than her. Thus Jackie's drive to be the best was to overcompensate for feelings of defectiveness. It was part of her Perfectionist Overcontroller mode rather than Self-Aggrandiser coping as Jackie was not seeking admiration but a sense of belonging. Jackie did not have a Self-Aggrandiser coping mode, as supported by her score of 1 (*never or almost never*) for the Self-Aggrandiser item on the SMI, "I feel special and better than most other people." Jackie's responses to the Self-Aggrandiser items fit with her Defectiveness/Shame schema, where Jackie felt that she only had worth or was acceptable if she was the best at what she did. Her desire to be the best was overcompensation for her Failure and Defectiveness/Shame schemas.

Another item on the SMI which did not clearly fit its intended mode was the statement "I have to take care of the people around me." This item which measures Demanding Parent was scored 6 (*all of the time*) by Donna, Jackie and Candice and 4 (*frequently*) by Tina and Vicky. A Demanding Parent is in a dyad with a Subjugated Child who then copes through Compliant Surrenderer coping. All participants had a Compliant Surrenderer coping mode with self-sacrificing elements; however, all participants expressed guilt connected with this statement. For example, Donna perceived herself as privileged because of her wealth and subsequently believed that people around her needed more than she did. As a result, she saw it as her "job" to take care of those around her, and if she did not, she experienced guilt. Jackie felt responsible for her mother's happiness and wellbeing, a decision she remembers making after her father's death because she did not want to see her mother struggling. Jackie provided examples where she prioritised her mother's needs over her own to avoid guilt. For example, if Jackie's mother needed assistance with her computer, Jackie would leave work to help her. If she did not, then she felt guilty for being unavailable to her mother. Another example is that Jackie would spend weekends with her mother, even if she wanted to be alone because she believed her mother expected this. Subsequently, if she did not, she felt guilty. Candice related her high score to always having to take care of her parents, who lived on her property and relied on her for emotional and financial support. Tina

was also financially and emotionally responsible for her mother. This responsibility was established in early childhood with her mother, who had a Self-Pity/Victim mode. Vicky also felt that she needed to care for those around her who were experiencing difficulties, as she tried to spare people from the pain that she experienced growing up. Thus when her Vulnerable Child was triggered, she coped through Compliant Surrenderer.

All participants scored highly on this statement, and it does reflect some aspect of an internalised parent. However, this statement seems to relate more to a Guilt-Inducing parent who induces guilt so that the individual has to take care. This fits with Peled's (2016) description of a Victim-Like parent mode which overlaps with a Guilt-Inducing parent mode as described in section 5.2. All the participants had elements of a Guilt-Inducing Parent in their complex parent modes. However, these modes are not measured on the SMI. This item could be a useful flag for a Guilt-Inducing Parent mode. However, in later versions of the SMI, this item was removed as factor analyses revealed inadequate item loadings for this Demanding Parent item (Lobbestael et al., 2010).

The above point highlights another limitation of the SMI; that only two parent modes are measured; the criticising Demanding Parent and the punishing Punitive Parent. No Guilt-Inducing Parent mode is measured. The Guilt-Inducing Parent mode may be absent as it was not recognised when the SMI was developed. This research has explored many parent modes as well as the different features in each parent mode. It would be advantageous to include more differentiated parent modes in a questionnaire. Although, as several parent modes have been identified, a consideration may be to have a separate questionnaire specifically to measure parent modes.

11.2. Relationships Between the SMI and YSQ

When results on the SMI and YSQ are compared, certain relationships were expected. For example, a high score for Compliant Surrenderer on the SMI was expected to be related to high scores for Subjugation and Self-Sacrifice on the YSQ. The definition for Compliant Surrenderer is that one "acts in a passive, subservient, submissive, reassurance-seeking, or self-deprecating way towards others out of fear of conflict or rejection" (Arntz & Jacob, 2013, p.44). The Subjugation and Self-Sacrifice schemas tie in with this mode as both describe prioritising the needs of another person, which can lead to anger and resentment as one's own needs are not met. These two related schemas are phenomenologically different. The Subjugation schema is passive as one feels coerced to surrender control to avoid anger,

retaliation or abandonment. In contrast, the Self-Sacrifice schema refers to one voluntarily or actively meeting other's needs, at one's own expense, to avoid causing pain, feeling guilt, or to maintain connections. The relationship that was expected between the Compliant Surrenderer mode and Subjugation and Self-Sacrifice schemas was not evident in the participants' responses to the questionnaires. Each participant had evidence of Compliant Surrenderer coping, as provided by the information in the interviews and supported by results in the SMI. Still, none of the participants had high scores for both Subjugation and Self-Sacrifice schemas.

Candice had high scores (5-*mostly true of me* and 6-*describes me perfectly*) for all the Self-Sacrifice statements on the YSQ. The statements, "I'm the one who usually ends up taking care of the people I'm close to" and "I am so busy doing for the people I care about that I have little time for myself" were related to her caring for her family. Candice was overly involved in her family's lives. She supported her parents financially and emotionally, she was involved in her grandchildren's care, and she took on her adult daughters' stressors and tried to resolve them. All this self-sacrificing behaviour left Candice with little time for herself. In response to the Self-Sacrifice statement, "I've always been the one who listens to everyone else's problems", Candice believed she attracted negative people because she took the time to listen to their complaints and tried to help. Candice took this to the extreme; for example, she obtained a loan to lend money to a work colleague who was experiencing financial difficulty. Therefore Candice's high scores for the Self-Sacrifice items were congruent with the history provided.

In contrast, Candice underscored the Subjugation items on the YSQ. Her highest scores for Subjugation included two statements where she scored 4 (*moderately true of me*). One of these statements was, "I've always let others make choices for me, so I don't really know what I want for myself." Candice related this score to unquestioningly doing what her uncle wanted, to please him and her parents. Examples are provided in section 10.1 that illustrate the extreme lengths Candice went to to please her uncle. The second Subjugation statement for which Candice scored 4 was, "In relationships, I always let other people have the upper hand." Candice struggled to assert her needs because she wanted to please people so that they would like her and not reject her. For example, Candice tried to maintain the house in a way that would please her daughter, as she tried to win her daughter's love and approval. These examples where Candice did not assert herself for fear of rejection contradict her low score of 3 (*slightly more true than untrue*) for the Subjugation item, "I feel I have no

choice but to give in to other peoples' wishes, or else they will retaliate or reject me in some way" and 2 (*mostly untrue of* me) for the Subjugation item, "I have a lot of trouble demanding that my rights be respected and my feelings taken into account." Although Candice provided examples of subjugation, her scoring of only two Subjugation items as 4 (*moderately true of me*) indicates that although partially aware, she lacked insight into how subjugated she is.

Tina had a high score of 23 for the Self-Sacrifice schema on the YSQ and a low score (13) for Subjugation. The Self-Sacrifice statement "I'm the one who usually ends up taking care of the people I'm close to" related to Tina caring for her mother emotionally and financially. From a young age, Tina provided examples where her mother used her as a confidant. In this way, Tina emotionally cared for her mother. When Tina was a teenager, caring for her mother included financial care. This pattern continued into adulthood, where Tina still provided for her mother's financial and emotional needs. Self-Sacrifice and Subjugation schemas were evident in Tina's interactions with her friends. Tina feared rejection and abandonment from friends, and so she behaved in subjugated and self-sacrificing ways. Tina scored 5 (*mostly true of me*) on the Self-Sacrifice statement, "I've always been the one who listens to everyone else's problems." This is congruent with Tina's examples of how she listened to Paula's relationship problems and tried to be there for her. She described this as "trying to fill the void for Paula" so that she would not "abandon" Tina by going back to her boyfriend and investing less time and attention in their friendship.

Tina scored 4 (*moderately true of me*) for the Subjugation statement, "I feel I have no choice but to give in to other peoples' wishes, or else they will retaliate or reject me in some way." To support this, Tina described how she loaned clothes to Paula to keep her happy, and with other friends, she would go along with plans they made, despite not wanting to, because she wanted them to be happy. However, for the Subjugation statement, "In relationships I usually let people have the upper hand", Tina scored 1 (*completely untrue of me*). Although this is incongruent with the behaviour displayed towards Paula and other friends, Tina described conflict situations where she coped with power struggles in a Bully and Attack coping mode. Tina's Compliant Surrenderer had features of self-sacrifice, where she tried to meet others' needs to prevent their feelings of pain. When there was subjugation, it was to maintain relationships so that her Abandonment/Instability schema was not triggered. Tina had insight into the fact that she behaved in a subjugated way to maintain connections with others. Her low score on the Subjugation schema might indicate that she was unaware of how

subjugated she was, or it could be because Tina flipped between subjugation and aggressively standing up for herself in a Bully and Attack coping mode.

Vicky's mean score of 4,14 for Compliant Surrenderer was high (2,92 SD above the norm) on the SMI. In addition, she had a high score on the Self-Sacrifice schema (24) and a lower score on the Subjugation schema (16). Vicky's Compliant Surrenderer coping had a strong rescuing aspect, as supported by the statement on the YSQ, "I'm the one who usually ends up taking care of people I am close to", for which Vicky scored 5 (*mostly true of me*). Vicky wanted to spare other people from the hurt and sadness she had experienced growing up, and so she tried to rescue others from these feelings. Vicky achieved this by volunteering in organisations for abused children, listening to people's problems and offering her professional services free of charge to people who could not afford them. In this way, Vicky was so busy caring for other people that she had little time for herself, as noted by the Self-Sacrifice statement to this effect in the YSQ, for which Vicky scored 5.

Vicky scored 4 (*moderately true of me*) for two Subjugation items on the YSQ. These statements were, "I feel I have no choice but to give into other people's wishes, or else they will retaliate or reject me in some way" and "In relationships, I usually let the other person have the upper hand." Vicky changed herself in situations to fit in with the people around her. This was described in section 8.4. Evidence of subjugation and giving in to others wishes was evident in Vicky's relationship with her mother. Vicky did not challenge anything her mother said, fearing that her mother would become critical or reject her. In the example described in section 8.4, when Vicky's mother had surgery and told Vicky she would spend her six weeks' recovery with her, Vicky was unable to express her needs and have them taken into account, for fear her mother would become angry and reject her. However, for the Subjugation item on the YSQ, "I have a lot of trouble demanding that my rights be respected and that my feelings be taken into account", Vicky only scored 3 (*slightly more true than untrue*). Vicky stated that she has "gone through life being everything to everyone." This statement highlights Vicky's Subjugation and Self-Sacrifice schemas as she has tried to see to other's wants and needs, ultimately to the detriment of herself and her needs. For the Subjugation item, "I've always let others make choices for me, so I really don't know what I want for myself", Vicky scored 3 (*slightly more true than untrue*). This score fits with examples Vicky provided where she could choose for herself, including travel, studies and careers.

Donna's mean Compliant Surrenderer score of 3,00 on the SMI was in the moderate range (0,88 SD above the norm). As with Candice, Vicky and Tina, she also had high Self-

Sacrifice scores (26) and a low score for Subjugation (7) on the YSQ. Donna scored 6 (*describes me perfectly*) for the Self-Sacrifice statements, "I'm the one who usually ends up taking care of the people I am close to" and "I've always been the one who listens to everyone else's problems." These high scores are congruent with information Donna provided where she believed it was her "job" to emotionally and financially care for her friends and family. This belief arose because Donna saw herself as "financially privileged"; "There's always people in my life that need more than I need. I need to give it to them" (S4). Donna's mother and close friend both had aspects of Self-Pity/Victim and were described by Donna as very negative, so Donna felt drained after listening to their daily complaints. At times Donna felt like hiding from people who drained her as it was exhausting, but she saw it as selfish if she tried to implement healthy boundaries because she believed these people needed her help. The Self-Sacrifice statement, "I am a good person because I think of others more than myself" that Donna scored 4 (*moderately true of me*) and the statement, "I am so busy doing for the people that I care about that I have little time for myself" that Donna scored 6, support this belief. This score is supported by her comment in S4, "When do I have time to put myself first?"

Donna scored four out of five Subjugation items on the YSQ as 1 (*completely untrue of me*). The only Subjugation item she scored as 3 (*slightly more true than untrue*) was the statement, "In relationships, I usually let the other person have the upper hand." This statement relates to Donna's relationship with her husband. An example described in section 9.4 related to Donna agreeing to have another child, despite her fear because, "I always do what people want to do. I don't put myself first" (S4). Although Donna could express her concerns relating to another pregnancy to her husband, she could not assert herself and stand by her desire not to have another child. This example contradicts Donna's score of 1 (*completely untrue of me*) for the Subjugation statement, "I have a lot of trouble demanding that my rights be respected and my feelings taken into account."

As described here, four of the five participants all provided evidence of Subjugation schemas, yet this was not reflected in their Subjugation scores on the YSQ. This fits with Cutland Green and Balfour's (2020) view that individuals deny schema attitudes and socially undesirable beliefs. A hypothesis is that it was easier for the participants to acknowledge self-sacrificing behaviour because it is ego-syntonic and behaviour that is often admired in society. This hypothesis is supported by the scores of 4 (*moderately true of me*) by three of the participants and 5 (*mostly true of me*) by one of the participants for the Self-Sacrifice

statement, “I am a good person because I think of others more than myself.” Of these four participants, Donna was the only participant who expressed resentment at her self-sacrificing behaviour, describing it as exhausting and leaving no time for herself.

Jackie differed from the other participants in that she had a higher score (18) for the Subjugation schema and a low score (12) for the Self-Sacrifice schema. Jackie scored 3 (*slightly more true than untrue*) for three Self-Sacrifice items on the YSQ. Two of the statements, “I’m the one who usually ends up taking care of the people I am close to” and “I am so busy doing for the people I care about that I have little time for myself”, related to Jackie’s mother. Jackie took responsibility for her mother’s happiness (as discussed in sections 6.1 and 6.4) as well as her mother’s physical wellbeing. Jackie lived with her mother because she was concerned for her mother’s safety and wellbeing if she lived alone. Her concerns related to crime and her mother’s alcoholism. Jackie’s mother had elements of a Guilt-Inducing Parent, so when Jackie was not available for her mother, she experienced guilt. As a result, Jackie rushed to attend to her mother’s needs and had little time for her own. Jackie’s mother was demanding of her time, as her sister had commented on in the past, yet for the statement, “Other people see me as doing too much for others and not enough for myself”, Jackie scored 1 (*completely untrue of me*). Her low scores on the Self-Sacrifice statements show that she was out of touch with this schema.

Jackie scored 5 (*mostly true of me*) on the YSQ Subjugation item, “I feel I have no choice but to give in to other peoples’ wishes, or else they will retaliate or reject me in some way.” Also, she scored 6 (*describes me perfectly*) for the statement, “In relationships, I usually let other people have the upper hand.” Jackie feared rejection or abandonment from her mother if she did not do what her mother wanted. Jackie not only subjugated her needs for those of her mother, but she also subjugated her emotions. This subjugation relates to the YSQ statement, “I have a lot of trouble demanding that my rights be respected and that my feelings be taken into account”, for which Jackie scored 4 (*moderately true of me*). This statement was especially true of Jackie’s inability to express anger towards her mother for her mother’s drinking and associated inappropriate behaviour. The build-up of this unexpressed anger led to Jackie’s irritation with her mother, which then triggered feelings of guilt.

Examining the Compliant Surrenderer items on the SMI revealed that the items related to subjugation only, so that self-sacrifice and rescuing are not tapped by the SMI at all. A relationship between subjugation and self-sacrifice behaviour has been described here, suggesting an association between subjugation, self-sacrifice and Compliant Surrenderer.

The self-sacrifice behaviour in the participants had different motivations. Jackie and Donna both had parents who had aspects of a Guilt-Inducing Parent which contributed to their self-sacrificing behaviour to soothe feelings of guilt. Also, Jackie, Tina and Candice feared rejection, and so their self-sacrifice and subjugation behaviour was to maintain relationships and avoid abandonment. This supports the self-sacrifice behaviour as part of a Compliant Surrenderer mode.

Vicky's self-sacrifice behaviour arose as she projected her pain and sadness onto others and then rescued them as a way of vicariously soothing her pain. Thus, Vicky's self-sacrifice behaviour had elements of overcompensation, which contrasts to the passivity of the Compliant Surrenderer mode and would fit better with a separate rescuing mode. Although not defined as a separate mode in ST, Karpman (1968) described a "rescuer" role as part of the drama triangle where the rescuer takes care of others to feel good about themselves whilst at the same time their needs are neglected. This rescuer mode is also described as the "White Knight Syndrome" (Lamia & Krieger, 2009), where one attempts to "repair the negative or damaged sense of herself that developed in childhood" (p.2).

The YSQ helped identify schemas but not the processes. This has relevance for the case conceptualisation and working in therapy as the way the Self-Sacrifice schema is addressed in therapy is influenced by the underlying dynamic. For example, if a person behaves in a self-sacrificing way because of fear of abandonment, it will be necessary to address the abandonment and self-sacrificing behaviour for the therapy to be more effective.

11.3. Bingeing Behaviour and Expected Modes and Schemas

In participants who had a history of bingeing, one would expect to find elevated scores in the SMI for Impulsive Child with an accompanying high score for Insufficient Self-Control/Self-Discipline on the YSQ. However, this was not the case for Donna and Vicky. On the YSQ, Donna's score of 18 for Insufficient Self-Control/Self-Discipline was moderate, but this was only accompanied by one score of 6 (*describes me perfectly*) for the statement, "I have rarely been able to stick to my resolutions." Donna related this to not being able to stick to resolutions about losing weight. There were three additional items for this schema on the YSQ for which Donna had low scores, but that could relate to her eating behaviour. These items include, "If I can't reach a goal, I become easily frustrated and give up" (score of 2, *mostly untrue of me*) and, "I have a very difficult time sacrificing immediate gratification or pleasure to achieve a long-range goal" (score of 3, *slightly more true than untrue*). These two

items could refer to Donna's inability to follow a healthy eating plan and her failure to delay and distract from binge eating behaviour. Also, Donna scored 3 (*slightly more true than untrue*) for the statement, "I can't force myself to do things I don't enjoy, even when I know it's for my own good." Donna related this to not being able to follow through on exercise regimes that she believed were necessary for her desired weight loss. The description here highlights a discrepancy between Donna's scores on the YSQ and the information she provided in the interviews.

Regarding specific items on the SMI measuring Impulsive Child, there were three statements that did not relate to eating behaviour and for which Donna's low scores were congruent with the history she provided. These statements were, "I act impulsively or express emotions that get me into trouble or hurt other people", "I blindly follow my emotions", and "I don't think about what I say, and it gets me into trouble or hurts other people." However, there were Impulsive Child statements that could be related to Donna's eating and for which she had low scores. These included, "I break rules and regret it later", which Donna scored 3 (*occasionally*). However, she could not follow the "rules" of particular diets or rules she developed for herself regarding her eating. For the statements, "I have trouble controlling my impulses" and "It is impossible for me to control my impulses" Donna scored 1 (*never or almost never*), and for the statements "I act first and think later" and "I say what I feel, or do things impulsively, without thinking of the consequences" Donna scored 3 (*occasionally*). Also, for the statement, "If I feel the urge to do something I just do it", Donna scored 2 (*rarely*). These scores were incongruent with Donna's actual behaviour as she impulsively binged almost daily. For example, if she was home alone and feeling bored, she binged to cope with the feeling of boredom. Also, while preparing lunch boxes for her family, Donna ate items she was putting in the lunch boxes, even though she was not hungry. There was a disconnect between Donna's scores and her eating behaviour. Despite Donna's resolutions to control her eating, her binges suggest the presence of an Impulsive Child. One might hypothesise that Donna misinterpreted the items or did not relate them to her eating behaviour. Unfortunately, these low scores were not discussed with Donna, so the reason for these scores cannot be known.

Vicky engaged in binge eating behaviour as part of her Detached Self-Soother coping mode; however, she had an average score for Impulsive Child (0,56 SD above the norm) and a low score (9) for Insufficient Self-Control/Self-Discipline. Vicky scored 5 (*most of the time*) for one Impulsive Child item, "I have trouble controlling my impulses." This score

related to Vicky's decision to binge as once the decision was made, she could not be distracted. In response to this statement, Vicky said, "If something pops in my brain, then it has to be done at the soonest time." For example, if she decides to paint a room, she has chosen the colour and painted the room within a week. For the remainder of the Impulsive Child items, Vicky scored between 1 (*never or almost never*) and 3 (*occasionally*); however, none of the items related to binge eating. For the Insufficient Self-Control/Self-Discipline items on the YSQ, Vicky scored 2 (*mostly true of me*) or 3 (*slightly more true than untrue*). Low scores on the statements, "If I can't reach a goal, I become easily frustrated and give up", "I have a very difficult time sacrificing immediate gratification or pleasure to achieve a long-term goal" and, "I can't force myself to do things I don't enjoy, even when I know it's for my own good", are congruent with the history provided by Vicky. Vicky demonstrated self-discipline by setting aside time for her part-time studies whilst managing her home and caring for her daughter. Vicky's past did not provide much evidence of other impulsive behaviour. Her binge eating behaviour occurred at night when she had "free time" and could no longer distract herself from distressing thoughts and feelings by keeping busy. Although the flip into Detached Self-Soother where she decided to binge was impulsive, the time-consuming ritual leading up to the binge was as much a self-soother for Vicky as was the binge itself. This is described in section 8.3. Outside of binges, Vicky was disciplined about the types of food she ate and portion sizes. Thus, although one would expect a high score on Insufficient Self-Control/Self-Discipline schema on the YSQ and a high score for Impulsive Child on the SMI with a diagnosis of BN, Vicky's low scores for both are understood when her history is taken into account.

11.4. Inconsistencies Between the YPI Results and the Participants' History

The YPI provided valuable insight when results were considered qualitatively, and responses to statements proved to be incongruent with how the participants responded to interview questions. In Jackie's case, she tended to idealise her parents. For example, Jackie provided a history of emotional deprivation. She described how she had never experienced affection from her parents, whether in the form of physical affection such as hugs or verbal affection such as saying "I love you." However, on the YPI for the Emotional Deprivation item, "Was warm and physically affectionate", Jackie scored 6 (*describes him/her perfectly*) for both parents. Jackie also scored 6 for both parents for the statement "Spent time with and paid attention to me", yet in the history taking, she described how her father spent more time with her brother, playing games and talking to him. Jackie was only able to recall one memory of

the quality time she spent with her father. Also, she described feeling that she and her siblings were "a chore" to her mother, and so she sensed her mother's relief when they went to bed at night.

The trend to present her parents in a positive light was noted in other statements as well. Concerning Defectiveness/Shame questions, Jackie scored her mother a 1 (*completely untrue*) for the statements "Treated me as if there was something wrong with me" and "Made me feel ashamed of myself in important respects." These scores are incongruent with her references to shaming messages from her mother that "there must be something wrong with you" and that she is "being that demanding child again", that she internalised. Likewise, she scored 1 (*completely untrue*) for the statement that her mother "Criticised me a lot", yet she had a Punitive Parent which arose from the critical statements her mother made such as, "Cover your legs" and, "You need to dress more like a girl."

Jackie struggled to acknowledge her unmet needs in childhood despite evidence to the contrary. This denial was evident in her response to the statement "Did what he/she wanted regardless of my needs", for which Jackie scored 1 (*completely untrue*) for her mother. Jackie provided many examples in section 6.1 that highlighted her unmet needs for safety, security, nurturing and a loving environment.

Jackie's scores show how she presented her parents in a positive rather than a realistic light. The tendency to idealise her parents was supported by information in sessions where Jackie talked about having "wonderful parents" and a "perfect father" whilst giving examples that contradicted this. An additional hypothesis is that Jackie was in an overcompensator mode whilst completing the questionnaire (Cutland Green & Balfour, 2020). When Jackie returned the completed questionnaire, she stated that she felt guilty that she may have been presenting her parents negatively. This sense of guilt was related to Jackie having a Guilt-Inducing parent. To cope with the feelings of guilt elicited, Jackie flipped into a Pollyanna Overcompensator mode, giving high scores on the YPI.

Candice also had an Emotional Deprivation schema from parents who were uninvolved and unloving towards her, yet this was not evident in the YPI. For example, Candice scored both parents 5 (*mostly true*) for the statements, "Loved me and treated me as someone special", and "Spent time with and paid attention to me." However, the information she provided in interviews (summarised in section 10.1) indicated a disconnected father and a mother who was absorbed with Candice's sickly brother. Candice and Jackie's Emotional

Deprivation schemas influenced their self-assessment, as the implicit message that their emotionally deprived experiences were typical meant that they did not recognise their needs and, therefore, that they were unmet (Cutland Green & Balfour, 2020).

Candice also had an Unrelenting Standards/Hypercriticalness schema that arose from the high demands on her from her parents and uncle. Yet, for the statement, "Expected me to do my best at all times", Candice scored her parents 3 (*slightly more true than untrue*), and the statement, "Placed more importance on doing things well than on having fun and relaxing", she scored her parents 2 (*mostly untrue*).

Tina also displayed discrepancies in her responses to items on the YPI and the history provided. For example, Tina scored her mother 1 (*completely untrue*) for the statement, "Was unable to handle daily responsibilities, so I had to do more than my share." This score contradicts the score of 5 (*mostly true of me*) for the YSQ item, "I'm the one who usually ends up taking care of the people I'm close to." As described earlier in this chapter, Tina cared for her mother. Also, Tina scored 2 (*mostly untrue*) for statements that her mother was unhappy and relied on her for support and understanding. However, Tina expressed anger in sessions that her mother shared inappropriate information about their father, and she described her mother as victim-like and unhappy.

Further discrepancies were noted in items scored for Tina's mother. The statement, "Provided very little discipline or structure for me", Tina scored her mother 2 (*mostly untrue*). This score is incongruent with Tina's decision to live with her father in high school because he provided the structure lacking in her mother's home. Tina scored 3 (*slightly more true than untrue*) for the statement her mother, "Was an undisciplined person." This score underestimated her mother's lack of discipline as Tina provided examples of her mother not managing finances well, spending money on alcohol and cigarettes instead of groceries. Also, Tina expressed anger that her mother smoked and drank throughout her pregnancy with Tina. Like Jackie, Tina felt guilty that she might be presenting her parents in a negative light. This guilt was influenced by the Guilt-Inducing aspects of Tina's mother and suggested that she was in a Pollyanna Overcompensator mode when she completed the YPI.

The unrealistic, high scores provided on the YPI by Tina, Candice and Jackie were influenced by growing up with emotionally unresponsive parents, which resulted in avoidant attachment. As a result, they learnt to disconnect from their attachment needs and, in responding to the YPI, did not recognise that these needs were not met. As described earlier

in this chapter, these participants had Subjugation schemas meaning they did not expect to have their needs met. The presence of a Guilt-Inducing parent introject triggered feelings of guilt when the participants believed themselves to be presenting their parents unfavourably. These feelings of guilt provide information about the nature of the parent-child relationship, such as the expectation of loyalty to one's parents. When the feelings of guilt in a Guilty Child were triggered, they flipped into Pollyanna Overcompensator coping to block the feelings. When an individual is in an overcompensator mode, there is an explicit narrative that is at odds with reality. In this case, the narrative is that their parents loved and cared for them and provided for their needs. Discrepancies were evident between information provided during sessions and results on the YPI. The contrasts are explained through mode flipping in that the participants were in a Pollyanna Overcompensator mode when they completed the questionnaires. However, in sessions, when they provided information and examples relating to their needs not being met, they were in a different mode. This mode could have been a more realistic, healthy mode such as Healthy Adult, or a child mode where they were expressing their difficult feelings based on childhood experiences, or the parent mode was identified in the session through experiential work or the content expressed by the participant.

11.5. Conclusions

The idea that an EMS, mode or relationship with a parent can be measured by selecting from a small number of statements in a questionnaire is simplistic. My understanding of the case from information gathered over many sessions provided the primary source of evidence for schemas and modes. The information provided by the questionnaires either supported the information collected or highlighted discrepancies. Thus, the inventories proved more beneficial when used qualitatively, as Young et al. (2003) recommended.

The ST inventories relied on self-report. So individuals who use avoidance or idealisation as ways of coping may score low (Sheffield & Waller, 2015). Also, if there is no current trigger when the inventory is completed, this can affect the score (Cutland Green & Balfour, 2020). Incongruency between the information provided in interviews and scores for statements on the YPI arose because of participants idealising their parents or overcompensation because of feelings of guilt triggered by internalised Guilt-Inducing parent modes. In this way, overly positive responses to statements on the YPI indicated a Pollyanna Overcompensator coping mode in the participants. This mode, however, was not identified in the SMI as the SMI only identifies one overcompensator, the Self-Aggrandiser.

The Young Compensation Inventory, which was written before mode theory was introduced, provides statements that describe overcompensatory behaviours as a coping style (Young et al., 2003). Over time there has been a shift to differentiating types of overcompensatory behaviour. For example, Arntz and Jacob (2013) describe the Self-Aggrandiser, Attention-Seeker, Overcontroller, which included Perfectionist Overcontroller and Paranoid Overcontroller, Bully and Attack, Conning and Manipulative mode and Predator Mode. Also, Edwards (2016) has referred to an Anorexic Overcontroller and Simpson et al. (2018) to an Eating Disordered Overcontroller and a Pollyanna Overcompensator (Simpson, 2020a). This differentiation highlights the different flavours of overcompensatory behaviours, which are addressed differently in therapy. Therefore, the acknowledgement of only one overcompensator mode on the SMI represents an outdated approach that is unhelpful for the case conceptualisation and therapeutic approach.

In particular, with EDs, the absence of the overcompensatory Perfectionist Overcontroller and Eating Disordered Overcontroller is significant. To overcome this, one could add an existing clinical perfectionism scale to the battery of questionnaires such as the Clinical Perfectionism Questionnaire (CPQ), The Frost Multidimensional Perfectionism Scale or the Hewitt and Flett Multidimensional Perfectionism Scale. The absence of the Eating Disordered Overcontroller can be overcome by administering the new Schema Mode Inventory for EDs (SMI-ED). The SMI-ED combines items from the original SMI with a set of additional questions, specifically representative of the ED population (Simpson et al., 2018).

The development of the SMI-ED and its introduction of two new modes highlight a significant point; that as research into ST continues, additional modes are identified, so the number of modes absent from the questionnaires will increase. When administering a questionnaire like the SMI, it is important to remember that it was developed when fewer modes were recognised. Although it has value and can contribute to one's understanding of modes, one needs to be mindful of modes not assessed by this measure.

Clinically one is less interested in high scores on the questionnaires and more interested in high scoring items (Young et al., 2003). Traditionally this would include looking at items that score 5 or 6 (Cutland Green & Balfour, 2020). The in-depth analysis on these questionnaires revealed that looking at scores of 4 on the questionnaires is also beneficial, otherwise, important information that can be obtained when questioning individuals who tend to underscore would be missed.

In summary, the questionnaires provide additional information for the assessment process, but the results should not be taken at face value. Instead, their real value lies in their qualitative use, identifying discrepancies between responses and what is known from the history and using the information obtained from the questionnaires to pursue areas of discussion that may otherwise be overlooked. Exploring the discrepancies between responses to statements and examples given during history taking can increase an individual's insight into their schemas and modes. Thus, the administration of the YSQ, SMI and YPI, combined with a full history and examples from daily life, provides information necessary for the case conceptualisation and subsequent approach to therapy.

Chapter 12. Conclusions and Recommendations for Further Research

"Because human life is so rich and complex, it seems probable that in any specific area of psychopathology and treatment there will always be room for new observations within cases that will contribute to and extend theory" (Edwards et al., 2004, p592). The findings in this research have provided observations that refine the existing theory on schema modes in EDs.

A cross-case comparison of the modes was presented in chapter 5 where the different features of the modes were identified. The main points that came out of the cross-case comparison are summarised in the following paragraphs.

Firstly, although the Failure and Defectiveness/Shame schemas occur in different domains, there is an overlap in these two schemas. The Failure and Defectiveness/Shame schemas were activated concurrently in four of the participants and were interlinked in a situation, suggesting a blended Failure and Defectiveness/Shame schema. This was explored in detail in section 5.1.

Secondly, in section 5.2, I presented a more systematic approach to understanding parent modes than is generally found in the ST literature. I integrated ideas from Peled's (2016) description of eight parent modes with references in the literature to the Punitive, Demanding and Guilt-Inducing parent modes to show that there are features of parent modes that can be blended to form unique parent modes. This information, combined with my reflections on the qualities of the introjected parents in the participants, was used to establish a list of 23 features that can be found in parent modes. Highlighting the complexity of the dysfunctional parent modes and how the qualities of the parent modes differed according to the individuals that were internalised, reinforces the concept of blended parent modes first identified by Jacobs (2012) and Edwards (2017a). The blended parent modes identified in the participants were unique to the individuals. Also, it was helpful to categorise the parent modes according to the three levels of toxicity presented by Peled (2016). The level of toxicity was dependent on the features in the parent mode and the severity of the dysfunction, determined by the amount of distress that resulted from the parent mode. Different from Peled's view was my conclusion that the parent mode must be examined phenomenologically to determine the degree of toxicity. Thus, the same feature of a parent mode can have a different degree of toxicity in different individuals.

Thirdly, identifying the parent modes was simpler when considering the parent-child mode dyads, as the parent mode and child mode are activated together. Parent-child mode

dyads are described in the literature by Rafaeli et al. (2011), when discussing borderline personality disorder, and Edwards (2017b) in his case study on an individual with AN. The parent-child mode dyads help identify parent features that are passively harmful and not based on explicit self-talk modelled on a parent's words (Edwards, 2017b). For example, a Neglectful Parent is an experience of a parent who is not there when needed. Considering the mode dyad also helps to understand the experience of the child that is evoked by the parent introject.

The schema modes identified in this research fit with the schema modes named in the existing ST literature. However, unlike the existing ST literature, The Eating Disordered Overcontroller and Perfectionist Overcontroller were described as complex composite modes with sub-modes that contributed to the functioning of the mode.

The fourth significant outcome in this research is the 13 features I identified in the Perfectionist Overcontroller mode in section 5.3. These features are based on current literature and a phenomenological understanding of the mode in these participants. The features of the Perfectionist Overcontroller included the recruited Demanding Parent and Punitive Parent, Rumination and the Flagellating Overcontroller as sub-modes. These modes, which are usually treated as standalone modes in ST, were considered sub-modes within a larger system because they worked together to help the Perfectionist Overcontroller achieve its goals. The participants in this research all had a Perfectionist Overcontroller with the core feature, striving for excellence and perfect results. However, the combination of features differed among the participants, and not all features were found in each participant's Perfectionist Overcontroller.

The fifth significant outcome, in section 5.4, related to the understanding of the Eating Disordered Overcontroller which, as a specialised form of the Perfectionist Overcontroller, shared features of the Perfectionist Overcontroller but with a focus on eating, weight and shape. The Eating Disordered Overcontroller drew on Edwards' (2017b) Anorexic Overcontroller and Simpson et al.'s (2018) Eating Disordered Overcontroller, but in this research new components were identified. I identified 15 features in the Eating Disordered Overcontroller, including the Flagellating Overcontroller and recruited Punitive Parent as sub-modes that contributed to the self-loathing and self-punitiveness in a physical or verbal form. Edwards' (2016) description of an Anorexic Overcontroller mode does have self-punitive features, but these were not identified as part of a recruited Punitive Parent or Flagellating Overcontroller sub-mode. The Helpless Surrenderer was also identified as a sub-

mode which was evident when the individual was motivated to look ill to gain attention and care but then perceived themselves as helpless to change their situation. Although Simpson identifies the Helpless Surrenderer as a mode commonly occurring in individuals with EDs, it is not seen as part of the Eating Disordered Overcontroller (Simpson, 2020a).

The thirteenth feature of the Eating Disordered Overcontroller, seeking approval and acceptance from others, is not included in Edwards' Anorexic Overcontroller nor Simpson et al.'s (2018) Eating Disordered Overcontroller. Checking behaviours (the ninth feature of the Eating Disordered Overcontroller) are represented in Edwards (2016) Anorexic Overcontroller in the form of visual images and somatic cues, but not in Simpson et al.'s (2018) Eating Disordered Overcontroller. Simpson et al. (2018) identified as a feature of the Eating Disordered Overcontroller, eating healthily to provide a sense of purity. This feature is absent from Edwards' description of the Anorexic Overcontroller and did not occur in any of the participants' Eating Disordered Overcontroller. The fourteenth feature of the Eating Disordered Overcontroller, a feeling of being special, is absent from Edwards' Anorexic Overcontroller (2016) and Simpson et al.'s (2018) Eating Disordered Overcontroller. Thus the Eating Disordered Overcontroller described in this research draws on the existing literature of an Eating Disordered Overcontroller and Anorexic Overcontroller but provides additional elements.

The sixth important outcome that arose from the cross-case comparison, related to the Detached Self-Soother mode (section 5.5). All the participants had a Detached Self-Soother coping mode that fits with existing literature on this mode's features. The Detached Self-Soother shuts down unpleasant emotions, but many of the self-soothing behaviours, such as bingeing, purging, and self-injurious behaviours, induce guilt. In contrast, when the self-soothing behaviour was considered constructive; for example, work or keeping busy, guilt did not occur. This feature has not been made explicit in the existing mode literature. Also not explicit in the current ST literature, is the permission giving belief identified here in the Detached Self-Soother. For example, when Candice told herself that she had had a hard day, so she could binge and then focus on healthy eating later (see section 10.7). The participants engaged in multiple self-soothing behaviours, the choice of which were influenced by availability and duration. The choice of self-soothing behaviour can only be understood when it is examined phenomenologically and understood as part of a mode sequence.

Although the cross-case comparison was presented before the cases, the research process was a recursive process. Presenting this analysis before the cases enriched the

presentation of the cases because it provided the foundation for how I understood the modes in the individual cases.

In the case conceptualisations in chapters 6 to 10, it was noted that behaviours that one may generally associate with a particular mode can be related to a different mode for that individual (Simpson, 2020b). For example, as a teenager, Tina induced vomiting as part of her Eating Disordered Overcontroller to prevent weight gain after eating what she considered large food portions or after eating junk foods. As an adult, Tina induced vomiting to soothe feelings of anxiety following a binge. Although the action was the same, the underlying motivation, thoughts and emotions, differed. In the Eating Disordered Overcontroller, the induction of vomiting aimed to maintain an internalised standard for her body whilst achieving a sense of safety and control. In the Detached Self-Soother, she experienced anxiety in response to the shame and guilt of bingeing. The induction of vomiting shut off this emotion and created a sense of calm. The Detached Self-Soother shuts down the emotion once the schema is triggered (Waller et al., 2007), whereas the Eating Disordered Overcontroller prevents the schema's triggering.

The use of questionnaires was discussed and how they provide valuable information when viewed qualitatively. The benefit of questionnaires, when used qualitatively, is well recognised (Cutland Green & Balfour, 2020; Young & Edwards, 2013). If the ST questionnaires were merely used as quantitative measures, I would have missed the participants' descriptions, which provided a clearer understanding of the modes. For example, individuals can have a similar score on the SMI but have different characteristics to the mode, which are not noted by the questionnaire (Edwards, 2017b). This was evident in the high scores for Compliant Surrenderer in all the participants. However, the features of the Compliant Surrenderer, including subjugation and self-sacrificing features, differed amongst the participants. This has been discussed in section 11.1.1.

Another benefit to discussing the participants' responses to statements was that it highlighted discrepancies between the statement and the mode it was intended to measure. For example, Jackie had elevated scores for some Self-Aggrandiser items, but these items tapped her Perfectionist Overcontroller (see section 11.1.1).

The absence of modes from the questionnaires was also noted as a limitation in section 11.1. For example, the Eating Disordered Overcontroller, Helpless Surrenderer and Perfectionist Overcontroller, all relevant for EDs, were absent from the SMI. As mentioned

in section 11.1, this can be overcome by administering the SMI-ED. However, as the SMI only measures the Demanding Parent and Punitive Parent, there is currently no questionnaire that adequately measures the parent modes. Thus, an opportunity exists to develop a questionnaire that measures the features of parent modes (see Table 2) drawn from Peled's (2016) parent modes and the Demanding Parent, Punitive Parent and Guilt-Inducing Parent modes.

All clinical work is idiographic because, as a clinician, you are working with an individual whom you want to understand, with their unique history and characteristics. This is central to IPA, where one works with the unique details of a case. Later one can draw more general conclusions about the range of experiences uncovered. Researchers desire a nomothetic conclusion that this research cannot provide because the idiographic approach does not give simple generalisations. In qualitative research, one builds theory based on observations across cases. This is what Yin (2010) refers to as analytic generalisations (see section 4.3.2a). Principles of analytic generalisation have been applied here as specific claims are grounded in the phenomenology of the case material in the context of the existing research literature on ST for EDs and modes in EDs. From this research, one can conclude that individuals with a bulimic presentation have a significant Detached Self-Soother, whereas individuals with a restrictive presentation have a prominent Eating Disordered Overcontroller mode. Also, parent modes tend not to be as clear cut as the discrete categories described in the existing ST literature. Instead, blended parent modes, with multiple features active in a situation, were observed in the participants. Although it is useful to assign a generic mode name that is recognised in the ST literature, in practice, an idiographic approach is vital for the therapist to understand the subtle processes of each mode and, ultimately, the case. This was especially evident in the naming of the blended parent modes.

12.1. My Reflections

Data collection is an ongoing process, and so the case conceptualisation and treatment plan are refined over time. In my experience, the more the participants grew to trust me, the less guarded they were in terms of the information they shared. The experiences participants were hesitant to share often triggered the Shamed Child and the belief that they would be judged for their experiences. Although initially eight sessions were allocated for the data collection, if I had stopped at that point, the case conceptualisations would not have been as rich, and my understanding of the modes would have been limited. Thus, a clinical assessment does not cease once intake is completed. Instead, when treatment is implemented, new information is

obtained, and the clinician engages in an ongoing assessment process that may lead to modifying the case conceptualisation (Edwards & Young, 2013).

As described in section 4.8.1, all the sessions were recorded and selectively transcribed. Although making the transcripts and reading them is time-consuming and not always practical in a work setting, I became aware of the valuable information that I had missed in the session when I read the transcripts. Asking questions after reviewing the transcripts, or even just the process of reviewing the text, made me look deeper at the information to see what was shared, although not neatly spelt out. Although it is unrealistic as a clinician to listen to all sessions or transcribe many, this process made me more mindful of digesting the information uncovered in a session so that this can be responded to promptly. In some instances, I only picked up information months later when the participants had moved on, and it was too late to address what was uncovered.

In almost all cases, there was difficulty in accessing the Vulnerable Child. Despite this, some positive changes still occurred. For example, Candice stopped bingeing, and Tina's ED symptoms decreased. ED clients tend to be shut off from their emotions, so accessing the Vulnerable Child presents a challenge. However, it is reassuring to know that by sharing a ST case conceptualisation and building an understanding of mode sequences, positive changes can still occur. Yet, the more I was able to access the Vulnerable Child, the more significant progress was made. For example, I was able to access Vicky's Vulnerable Child, and long term follow up with her revealed that she no longer engaged in ED behaviours, she no longer met the criteria for PTSD, and she had developed a robust Healthy Adult mode.

Although recognising that people are individuals, there were some similarities in the participants, which can be extrapolated to other individuals with EDs. For example, none of the participants had meaningful emotional connections with significant others, and the ED behaviour prevented them from acknowledging and experiencing these feelings of loneliness.

Even when specific modes were expected, how the mode presented in the individuals differed. This is supported by Simpson (2020b), who states that personalised mode maps "capture the cognitive, behavioural and visceral experience of the modes and the way they interact in the here-and-now" (p. 66). This emphasises a strength of ST that each case is conceptualised individually, not just concerning the particular modes but also concerning the idiosyncratic characteristics of each mode within the individual. Understanding the dynamic

processes behind the modes influences the case conceptualisation and a specific treatment plan for each individual.

12.2. Implications for Theory and Clinical Practice

My conclusions and reflections on the research process have the following implications for theory and clinical practice;

1. When identifying modes, it is necessary to take into account mode sequences in order to fully understand the motivation, thoughts and emotions and how best to address the mode in therapy.
2. The questionnaires are useful as a qualitative tool to focus attention to areas that require further exploration. However, it is important to remember that the modes identified by the questionnaires are limited. Also, the mode the person is in when the questionnaires are completed, and their interpretation of the statements, influence the results.
3. Assessment in ST is an ongoing process and the case conceptualisation needs to be modified as new information arises.
4. Although it is impractical to transcribe all sessions or to revisit recordings of all sessions, there is great value in setting aside time to review and process information that is gathered in a session as soon after the session as possible.
5. If one has limited sessions with a client, sharing a case conceptualisation and building an understanding of mode sequences can bring about change.

12.3. Strengths and Limitations of the Research

The participants were all seen for an extended period of time (18 to 50 sessions) which allowed for an intensive assessment process. This enabled me to develop a thorough understanding of these individuals and a detailed case conceptualisation from which to draw my conclusions. Also, as mentioned in section 3.6, this is the first research that looks at case studies of BED using ST, and the first research to provide a cross-case comparison of AN, BN and BED.

A limitation of this research is that the participants were all English speaking White females and so culture and ethnicity were not considered as factors that may impact on presentation of modes in EDs. As such, the results may not be generalisable to other cultural or ethnic groups. However, as I am English and the questionnaires were presented in English,

there was no language barrier to prevent me from obtaining rich accounts from the participants.

12.4. Recommendations

Clinical theory grows from observation of individual cases (Edwards, 2017b). Thus, future research can benefit from further phenomenological analysis of case studies. Points that would be particularly useful to follow up would be;

1. How parent modes are experienced in the moment, not just as voices and how the experience may blend various elements of the parent.
2. How parent and child modes are in a dyadic relationship and how the parent mode and child mode experience arise together.
3. Identifying mode sequences that assist in developing case conceptualisations.

Further research which replicates my results, or adds new information, will contribute to the existing knowledge of schema modes in EDs. As this research only presented participants from one cultural and ethnic group, replicating this study with participants from other cultural or ethnic backgrounds would provide a comparison that could further contribute to our understanding of schema modes in EDs and to provide insight into the impact of culture and ethnicity on schema modes.

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Appendix A: Recruitment Advertisement

Do you know or think that you have an eating disorder?

Do you need help?

Are you 18 years or older and willing to help with a research project?

Preoccupation with losing weight, thinking about food and dieting all the time, wanting to lose weight even though you are medically underweight, lurching between strict dieting and binge eating – all these can be very distressing emotionally, create conflict with friends and family, and interfere with your social life and work life. If any of these are troubling you, you may have an eating disorder such as anorexia nervosa, bulimia nervosa or binge eating disorder.

If you think you have one of these eating disorders you can apply to participate in this research project.

This research project is undertaken by a clinical psychologist, Chantal Bowker, for fulfilment of a PhD in Psychology degree from Rhodes University, Grahamstown.

What is the research about?

The focus of this research entails looking at you and your eating disorder through the lens of schema therapy. Schema therapy considers how early patterns of thinking develop out of experiences we have in infancy and childhood. When experiences are negative or traumatic we can develop poor thinking patterns and unhelpful or destructive coping mechanisms, such as eating disordered behaviours. The research takes the form of the assessment phase of therapy and will look at your life history, your core beliefs about yourself and how you cope with them through various behaviours.

What will be required of you?

An initial screening interview will be conducted to determine if you meet the criteria for an eating disorder. If you do, you will be eligible to participate in the research. If you do not, you could still receive some advice about your situation.

You will need to commit to meeting with the researcher for at least 8 one hour sessions at the researcher's psychology practice in Hillcrest. During this time you will participate in clinical interviews as well as completing questionnaires. To maintain your privacy, your participation will be on a one on one basis.

How can you benefit?

You will receive feedback on the findings of your assessment. This will provide you with a greater psychological understanding of yourself and your eating disorder and can also form the foundation for ongoing therapy work.

If you have not engaged in psychotherapy before, this will give you an opportunity to experience the process at no cost.

Should you be interested in participating, or if you would like to read a document that gives more information about the research project, please contact the researcher, Chantal Bowker, telephonically at 082 736 0375 or via email at chantal@chantalbowker.co.za

Please Note:

You may have been given this pamphlet by your healthcare practitioner but this is an independent research project. Declining to participate in this research will in no way influence the care you are receiving from this or any other healthcare practitioner.

Appendix B: Consent to Distribute Advertisements

CONSENT TO DISTRIBUTE ADVERTISEMENTS

I _____(name of healthcare practitioner) in my capacity as _____ (position and or medical field) acknowledge that I have met with Chantal Bowker who has explained the nature of her research entitled "An Interpretative Phenomenological Analysis of Schema Modes in Eating Disorders" to me.

I consent to distribute her advertisements to patients' of mine whom I believe meet the criteria and may benefit from participation in this research project.

I acknowledge that this research project is run independently of my work with the participant and that should any of my patients choose to participate I may not receive feedback unless it is with my patient's written consent and to do so will enhance the intervention that I provide to them.

I further acknowledge my patient's autonomous choice to participate or not participate in this research project. Their choice will in no way influence the service I provide to them.

Practice Details:

Physical Address	Telephone Number	Email Address
_____		
_____	_____	_____
_____		
_____		

_____

Signature

Thus signed at _____ on this _____ day of _____ 201__.

Appendix C: Additional Information About the Research Project

Information Pertaining to the Research Project

Schema therapy and eating disorders project: Further information

Chantal Bowker, PhD student, Rhodes University

chantal@chantalbowker.co.za or 082 736 0375

Thank you for considering participation in this research project. This document gives you additional information about the research. Should anything be unclear, or if you have any concerns, please feel free to discuss them with me.

This research is being undertaken for a PhD degree in Psychology at Rhodes University, Grahamstown. The formal title is "An Interpretative Phenomenological Analysis of Schema Modes in Eating Disorders". My supervisor is Professor David Edwards. His contact details are telephonically 021 701 0203 or via email d.edwards@ru.ac.za . If you would like to read the full proposal that was approved by the University please let me know.

The aim of this research is to contribute to the schema therapy approach to assessment and treatment. Schema therapy is a form of psychotherapy that addresses longstanding psychological difficulties. The schema therapy approach is based on the understanding that all our everyday behaviour is governed by automatic habitual patterns that have developed in the course of our lives. Many of these patterns have their origins in childhood. Behavioural and/or emotional difficulties in adolescence and adulthood often arise as a result of the way these patterns were formed earlier in life. If, as psychologists, we can understand these patterns we can help individuals to see how they could change them and so get relief from psychological problems. Examples of habitual patterns that are often important are self-critical thinking states, states associated with feeling lonely, or not good enough, and states in which we cope with life by trying hard (sometimes too hard), or avoiding situations or problems that seem too difficult. These kinds of psychological states are what we call "schema modes" and these are an important focus of the present research.

What you will be asked to do

You will need to attend an initial screening interview to confirm that you meet the criteria for an eating disorder according to the Diagnostic and Statistical Manual 5 (DSM-5). The DSM-5 contains all internationally recognised psychiatric conditions, including eating disorders. Once we have confirmed the presence of an eating disorder, you will need to commit to meeting with me for at least 8 one hour sessions, although additional sessions may be required. During this time I will conduct clinical interviews with you, which involve you answering questions about your early history and current functioning. To draw out further information you may be required to participate in some experiential techniques such as imagery and chair work. You will also be asked to complete questionnaires. All sessions will be conducted on a one-on-one basis. Our sessions will be audio recorded and selectively transcribed. The information obtained will be used for my PhD thesis and possibly case conferences and academic publications. The information I use will include your personal experiences, attitudes and behaviours and may also include quotes from our sessions. All reports will be designed in such a way that it will not be possible for the reader to identify you.

The interviews you will take part in and the questionnaires that you will complete are the same as those that form the basis for the kind of clinical assessment process usually conducted before a course of psychotherapy is undertaken. It is designed for us to gain a greater psychological understanding of you and for this reason, areas that are sensitive and may evoke distress will be covered in the interviews. If this occurs we will address this together.

Benefits to you

Because you will be taking part in a clinical assessment process, you stand to benefit by gaining greater understanding of yourself and your eating disorder. During the course of the interviews you are free to ask questions and I will also share my understanding of your problems with you. Furthermore, once the assessment phase is completed, you will have the option of attending up to an additional 6 sessions. This does not form part of the research but will be focused on a self-help programme using internet based resources. You are under no obligation to attend these additional sessions. Should you wish to take advantage of these, they will be offered free of charge.

Appendix D: Informed Consent

RHODES UNIVERSITY – DEPARTMENT OF PSYCHOLOGY

AGREEMENT BETWEEN STUDENT RESEARCHER AND RESEARCH PARTICIPANT

I _____ (participant's name) agree to participate in the research project of Chantal Bowker entitled "An Interpretative Phenomenological Analysis of Schema Modes in Eating Disorders."

I understand that:

1. The researcher is a student conducting the research as part of the requirements for a PhD in Psychology degree at Rhodes University. The researcher may be contacted on 0827360375 or chantal@chantalbowker.co.za. The research project has been approved by the ethics committees, and is under the supervision of Professor David Edwards in the Psychology Department who may be contacted on 021 701 0203 or d.edwards@ru.ac.za.

2. The researcher is interested in identifying the different psychological states (called schema modes) that are experienced in individuals with eating disorders. Commonalities and differences between participants will be noted and the findings will be discussed in relation to the existing scientific literature on modes in schema therapy.

3. My participation will involve attending at least 8 one hour sessions with the researcher. However the process is open ended and further sessions will probably be required. These sessions will include participating in in-depth semi-structured clinical interviews. As part of these interviews I may be asked to participate in experiential techniques such as imagery, chair work and emotion focused work, as explained to me by the researcher. I will also be expected to complete a number of questionnaires.

4. I will be asked to answer questions of a personal nature, but I can choose not to answer any questions about aspects of my life which I am not willing to disclose.

5. The clinical interviews will require me to examine closely aspects of my life – past and present – which may evoke distressing emotions. If this occurs, the researcher undertakes to provide me with coping skills to address and contain these emotions.

6. It has been explained to me that all research information will be stored securely, with personal details being kept separate from participant information.

7. I am invited to voice to the researcher any concerns I have about my participation in the study, or consequences I may experience as a result of my participation, and to have these addressed to my satisfaction. In this regard I can contact the researcher telephonically on 082 736 0375 or via email at chantal@chantalbowker.co.za outside of our sessions.

8. It has been explained to me that I may benefit from my participation in this research project by gaining insight into psychological processes which contribute to and maintain the eating disorder from a professional with some experience in schema therapy and eating disorders. This can assist me in dealing with the eating disorder. The assessment will also provide me with insight into the process of therapy as well as the possible benefits without any financial implications.

9. I understand that once my participation in the research is complete I have the option of receiving six free sessions with the researcher which will take the form of a guided self-help programme using internet based resources.

10. I have been made aware that participation in this research project will assist the researcher, Chantal Bowker, in completing her PhD degree and that her intention is not to recruit patients for her practice. If after completing the self-help programme I wish to continue with therapy, in order to avoid conflict of interest, Chantal Bowker undertakes to make me aware of options regarding psychologists in the area. As there

are no psychologists in the area known to the researcher that practice schema therapy, I will also be provided with details of schema therapists outside of the area with whom schema therapy skype sessions could be conducted. I can then make my own informed decision.

11. I am free to withdraw from the study at any time – however I commit myself to full participation unless some unusual circumstances occur, or I have concerns about my participation which I did not originally anticipate.

12. Reports on the project, which may include a PhD thesis, conference presentations and academic publications, may contain information about my personal experiences, attitudes and behaviours, as well as quotes from the clinical interviews, but identifying information will be removed from the reports in such a way that it will not be possible for me to be identified by readers.

Signed on (Date): _____

Participant: _____ (Signature)

_____ (Name)

Researcher: _____ (Signature)

Chantal Bowker

Appendix E: Permission and Release Form

Rhodes University — Department of Psychology

USE OF TAPE RECORDINGS FOR RESEARCH PURPOSES

PERMISSION AND RELEASE FORM

Name of participant	
Participant's contact details	Email address: Phone number:
Name of researcher	Chantal Bowker
Level of research	PhD
Brief title of project	An Interpretative Phenomenological Analysis of Schema Modes in Eating Disorders
Name of supervisor	Professor David Edwards

DECLARATION

(Please initial blocks next to the relevant statements)

I, _____, hereby confirm that			
1.	The nature of the research and the nature of my participation have been explained to me in writing and verbally.		
2.	I agree to be interviewed and to allow audio recordings to be made of all the interviews.		
3.	The audio recordings may be transcribed	only by the researcher.	
		by one or more third parties who will undertake to respect and maintain the confidentiality of the material.	

4.	After the research has been completed, and the reports written …	I would like the audio recordings to be erased from all storage devices.	
		The recordings may be retained for the researcher to use for further study, and to share with other researchers provided that conditions of strict confidentiality and anonymity are maintained. Should the data be required for further research or study, my written consent will be sought before the data is accessed by a party beyond the scope of this research.	

Signature of participant: _____ Date: _____

Witnessed by researcher: _____ Date: _____

Appendix F: Early Withdrawal

EARLY WITHDRAWAL FROM THE RESEARCH PROJECT

I _____ (participant's name) have chosen to withdraw my participation in the project conducted by Chantal Bowker for her research entitled "An Interpretative Phenomenological Analysis of Schema Modes in Eating Disorders" in fulfilment of a PhD degree in Psychology from Rhodes University.

My reason(s) for withdrawing from the research project is/are;

_____

_____

_____

_____

(*Please initial blocks next to the relevant statements*)

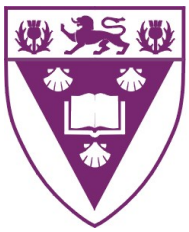
I consent to Chantal Bowker using the information provided thus far in so keeping with the conditions of informed consent provided.	
I do not consent to Chantal Bowker using any of the information obtained to date and I require the information to be destroyed.	
I would like to take advantage of the three debriefing sessions offered.	
I decline the offer of the three debriefing sessions made to me.	

_____

Signature

Thus signed at _____ on this _____ day of _____ 201___.

Appendix G: Confidentiality Agreement for Transcription Services



RHODES UNIVERSITY
Where leaders learn

CONFIDENTIALITY AGREEMENT:

Transcription Services

I, _____, (name of transcriber) agree to maintain full confidentiality in regards to any and all audio recordings and documentation received from Chantal Bowker related to her research study on An Interpretative Phenomenological Analysis of Schema Modes in Eating Disorders.

Furthermore, I agree:

1. To hold in strictest confidence the identification of any individual that may be inadvertently revealed during the transcription of audio-recorded interviews, or in any associated documents.
2. To use the coded label provided by Chantal Bowker in all references to the audio recordings to be transcribed.
3. To maintain the confidentiality of the participant by changing in the transcriptions the name of the participant and any significant others whose names might enable identification, to the pseudonyms provided by Chantal Bowker.
4. To make one copy of any audio recordings or computerised files that I receive from Chantal Bowker and to store these on my PC in a password protected file.
5. To store all transcribed interview texts in a password protected file on my PC.

6. Once Chantal Bowker has received the transcription and informed me that it is satisfactory, I undertake to delete the audio recordings and interview texts immediately from my computer hard drive.

I am aware that I can be held legally liable for any breach of this confidentiality agreement, and for any harm incurred by individuals if I disclose identifiable information contained in the audio recordings and/or files to which I will have access.

Transcriber's name (printed)

_____

Transcriber's signature

_____

Date _____

Appendix H: Consent to Consult Healthcare Practitioners

CONSENT TO CONSULT HEALTHCARE PRACTITIONER(S)

I _____ (participant's name) hereby give my consent to Chantal Bowker to consult with the following healthcare practitioners. This consultation between Chantal Bowker and the below named practitioner may take the form of written or verbal communication, or of Chantal Bowker having access to my medical records.

I consent to Chantal Bowker contacting the following healthcare practitioners and making use of the information provided by the practitioners for this research project.

Name of healthcare practitioner	Medical Field	Contact Details
		Telephone no: Physical address: Email address:
		Telephone no: Physical address: Email address:
		Telephone no: Physical address: Email address:

I acknowledge that I give my consent willingly and without being unduly influenced to do so by Chantal Bowker or any other person.

_____

Signature

Thus signed at _____ on this _____day of _____201__.

Appendix I: Screening Questions to Establish Existence of an Eating Disorder

Full Name:

Age: **DOB:** **Contact Number:**

Email address:

How did the participant hear about the research:

Screening Questions for ED

1. Have you consulted a healthcare practitioner before for eating or weight related issues? Elaborate.
2. Are you currently or have you previously engaged in some form of therapy? If yes, elaborate.
3. Have you previously been diagnosed with an ED?
4. Is there a family history of EDs?
5. Does thinking about food, eating or calories make it difficult to concentrate on other things eg. Work, reading, daily tasks?
6. What percentage of your day do you think is taken up with thoughts of food or eating related issues?
7. Do you have any medical problems?
8. What is your height?
9. What is your weight?
10. What, do you believe, would be your ideal weight?

AN

1. Do you have a fear of gaining weight or becoming fat?
2. Do you fear losing control over your eating?
3. Do you have a strong desire to lose weight?
4. What behaviour do you have that interferes with weight gain or encourages weight loss, For example;

- Deliberately restricting food
- Controlling portion sizes
- Eating only certain meals or at specific times of the day
- Fasting; that is, going for 8 waking hours or more without eating to influence your weight or shape
- Avoiding food groups
- Counting calories

5. Do you feel uncomfortable with your weight or shape? In what way?
   For example, are you uncomfortable with others seeing your body?
   Do you not like to see your reflection in a mirror or shop window?
6. How long have you struggled with these feelings?
7. How often do you employ the following techniques to evaluate your body size, weight or shape;
   - Weighing
   - Measuring of body parts
   - Checking yourself in mirrors
   - Any other techniques
8. How much weight have you lost over the last;
   - Month
   - 3 months
9. Does your fear of gaining weight persist even when you lose weight?

BN

1. In the last 3 months have you had episodes of binge eating. That is, eating in a discrete period of time, for example, less than 2 hours, an amount of food far larger than what most individuals would eat in a similar time period?
2. Describe a typical binge. Note that snacking throughout the day is not a binge.
3. Is your binge eating associated with at least 3 of the following;
   - Eating more rapidly than normal.
   - Eating until uncomfortably full.
   - Eating large amounts when not physically hungry.
   - Eating alone because you are embarrassed of how much you are eating.

- Feeling disgusted, depressed or guilty after eating.

4. Over the past 28 days how many times have these binges occurred?
5. Do you have a lack of control over what you are eating during this time? That is, do you feel like you cannot stop yourself?
6. Do these binges tend to occur in secret or when you are alone?
7. Do you feel guilty about these binges because of their effect on your shape or weight? Are you distressed by these binges?
10. Have you engaged in purging behaviour in an effort to control your weight or to lose weight? (This feature also applies to AN)
    - Self-induced vomiting
    - Misuse of laxatives
    - Diuretics
    - Enemas
    - Excessive exercise
8. Have binges and purges occurred at least once a week for the last 3 months?
9. Is your evaluation or view of yourself heavily influenced by your body weight and shape? Elaborate.

Clarify there is no inappropriate compensatory behaviour following a binge. If so, this meets the criteria for BED.

Is there any additional information that the individual would like to add in terms of their eating.

Why is this individual interested in participating in the research?